

ORIGINAL

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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

APPLICATION FOR PERMIT- May 2010 Edition

RECEIVED

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

JUN 01 2012

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

HEALTH FACILITIES &
SERVICES REVIEW BOARD

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: DuPage Medical Group, Medical Office Building		
Street Address: 430 Warrenville Rd.		
City and Zip Code: Lisle, 60532		
County: DuPage	Health Service Area: HSA 7	Health Planning Area: A-05

Applicant /Co-Applicant Identification

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

Exact Legal Name: DuPage Medical Group, Ltd.
Address: 1100 W. 31st St., Suite 300, Downers Grove, IL
Name of Registered Agent: Elizabeth Miller
Name of Chief Executive Officer: Michael Kasper
CEO Address: 1100 W 31st St., Suite 300, Downers Grove, IL
Telephone Number: 630-942-7966

Type of Ownership of Applicant/Co-Applicant

Applicant: DuPage Medical Group, Ltd.

☐ Non-profit Corporation	☐ Partnership
☒ For-profit Corporation	☐ Governmental
☐ Limited Liability Company	☐ Sole Proprietorship ☐ Other
- Corporations and limited liability companies must provide an Illinois certificate of good standing. - Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.	
APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Primary Contact

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

Name: Monica Hon
Title: Vice President
Company Name: Murer Consultants, Inc
Address: 58 N. Chicago St. 7th Floor, Joliet, IL 60432
Telephone Number: 815-727-3355
E-mail Address: mhon@murer.com
Fax Number: 815-727-3360

Additional Contact

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

Name: Anne M. Murphy
Title: Sr. VP of Legal Affairs and General Counsel
Company Name: Rush University Medical Center
Address: 1700 W. Van Buren St., Suite 301, Chicago, IL 60612
Telephone Number: 312-942-6886
E-mail Address: Anne_Murphy@rush.edu
Fax Number: 312-942-4233

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: DuPage Medical Group, Medical Office Building		
Street Address: 430 Warrenville Rd.		
City and Zip Code: Lisle, 60532		
County: DuPage	Health Service Area: HSA 7	Health Planning Area: A-05

Applicant /Co-Applicant Identification

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

Exact Legal Name: Rush University Medical Center	
Address: 1725 W. Harrison St., Suite 364, Chicago, IL 60612	
Name of Registered Agent: Anne M. Murphy, Sr. VP of Legal Affairs and General Counsel	
Name of Chief Executive Officer: Larry J. Goodman, M.D.	
CEO Address: 1725 W. Harrison St., Suite 364, Chicago, IL 60612	
Telephone Number: 312-942-7073	

Type of Ownership of Applicant/Co-Applicant

Applicant: Rush University Medical Center

☒ Non-profit Corporation ☐ For-profit Corporation ☐ Limited Liability Company	☐ Partnership ☐ Governmental ☐ Sole Proprietorship
☐ Other	
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Telephone Number: 312-942-6886
E-mail Address: Anne_Murphy@rush.edu
Fax Number: 312-942-4233

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: Michael Kasper
Title: CEO
Company Name: DuPage Medical Group, LTD
Address: 1100 W. 31st St. Suite 300, Downers Grove, IL 60515
Telephone Number: 630-942-7966
E-mail Address: Michael.Kasper@DuPagemd.com
Fax Number: 630-790-9135

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: DMG Real Estate, LLC
Address of Site Owner: 1100 W. 31st St. Suite 300, Downers Grove, IL 60515
Street Address or Legal Description of Site: 430 Warrenville Rd, Lisle, IL 60532
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.
APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name: DuPage Medical Group, Ltd.	
Address: 1100 W. 31st St., Suite 300, Downers Grove, IL 60515	
☐ Non-profit Corporation ☒ For-profit Corporation ☐ Limited Liability Company	☐ Partnership ☐ Governmental ☐ Sole Proprietorship
☐ Other	
- o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. - o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. - o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
APPEND DOCUMENTATION AS ATTACHMENT-3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT**1. Project Classification**

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

Part 1110 Classification: ☐ Substantive ☒ Non-substantive	Part 1120 Applicability or Classification: [Check one only.] ☐ Part 1120 Not Applicable ☐ Category A Project ☒ Category B Project ☐ DHS or DVA Project
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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.

DuPage Medical Group, Ltd. (DMG) is constructing a Medical Office Building (MOB) at 430 Warrenville Rd, Lisle, IL 60532. This MOB has been wholly financed, through cash and debt, by DMG which will also remain the owner of the entire building. This is a non-substantive project in that it will, per the CON staff's interpretation of 77 Ill. Adm. Code § 1110.40, establish a clinical service area. Rush University Medical Center (RUMC) has been named a co-applicant based on guidance from senior staff to the Health Facilities and Services Review Board.

This MOB, which will have a total area of 87,075 sq. ft., is intended to house the following:

- (1) A linear accelerator which, including build out, will occupy 965 sq. ft. (1.1% of the total building);
- (2) Radiation Oncology which will occupy 5,655 sq. ft. (6.5% of the total building);
- (3) Chemotherapy and Infusion Medical Services, a Rush University Medical Center outpatient service, the space for which shall constitute 12,927 sq. ft. (15% of the total building); and
- (4) Other, nonclinical areas, including physician offices for primary, specialty, and immediate care, which shall constitute 53,390 sq. ft. (61% of the total building).

Rush University Medical Center will lease space for the primary purpose of delivering the Chemotherapy and Infusion Medical Services listed above. Rush intends to treat this leased space as a Provider-Based Clinic for Medicare reimbursement purposes. Applicable guidelines for Provider-Based Clinic status allow this classification for certain outpatient clinics located within 35 miles of a hospital.

As to the space in the MOB not leased to RUMC for Chemotherapy and Infusion Medical Services (approximately 85% of the total building), DMG will lease solely to physicians within DMG. Physician office space will constitute approximately 32% of the total building. It is contemplated that, in the future, perhaps 1% to 5% of that physician office space may be leased to physicians employed by RUMC on a timeshare basis.

The building will also house a linear accelerator. This equipment will be wholly financed, owned, and operated by DMG.

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	\$7,868.54	\$12,471.46	\$20,340.00
Site Survey and Soil Investigation	\$23,501.16	\$37,248.84	\$60,750.00
Site Preparation	\$198,020.60	\$313,858.40	\$511,879.00
Off Site Work			\$0
New Construction Contracts	\$10,461,790.01	\$16,581,711.99	\$27,043,502.00
Modernization Contracts			N/A
Contingencies	\$235,165.59	\$372,732.41	\$607,898.00
Architectural/Engineering Fees	\$722,988.61	\$1,145,921.39	\$1,868,910.00
Consulting and Other Fees	\$415,610.84	\$658,734.23	\$1,074,345.07
Movable or Other Equipment (not in construction contracts)	\$2,862,172.00	\$0	\$2,862,172.00
Bond Issuance Expense (project related)			N/A
Net Interest Expense During Construction (project related)	\$85,107.09	\$134,892.91	\$220,000.00
Fair Market Value of Leased Space or Equipment			N/A
Other Costs To Be Capitalized	\$1,138,457.01	\$2,089,725.99	\$3,408,183
Acquisition of Building or Other Property (excluding land)	\$696,330.75	\$1,103,669.25	\$1,800,000
TOTAL USES OF FUNDS	\$16,562,456.31	\$21,714,655.76	\$39,477,979.07
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$6,761,363.48	\$10,716,615.59	\$17,477,979.07
Pledges			N/A
Gifts and Bequests			N/A
Bond Issues (project related)			N/A
Mortgages	\$8,510,709.16	\$13,489,290.84	\$22,000,000.00
Leases (fair market value)			N/A
Governmental Appropriations			N/A
Grants			N/A
Other Funds and Sources			N/A
TOTAL SOURCES OF FUNDS	\$15,272,072.64	\$24,205,906.43	\$39,477,979.07
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

Land acquisition is related to project ☒ Yes ☐ No
Purchase Price: \$ 3,267,178
Fair Market Value: \$ 3,000,000

The project involves the establishment of a new facility or a new category of service
☒ Yes ☐ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is \$ 0.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): 12/1/2012

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

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

APPEND DOCUMENTATION AS **ATTACHMENT-8**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals

Are the following submittals up to date as applicable:

- ☒ Cancer Registry
☒ APORS
☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
☒ All reports regarding outstanding permits

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

State Agency submittals questions are not applicable to applicant DMG. They are applicable to co-applicant Rush University Medical Center. Information pertaining to its submittals is included above.

Cost Space Requirements

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
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							
APPEND DOCUMENTATION AS <u>ATTACHMENT-9</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

See Attachment 9 for details on Cost Space Requirements

Facility Bed Capacity and Utilization NOT APPLICABLE

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

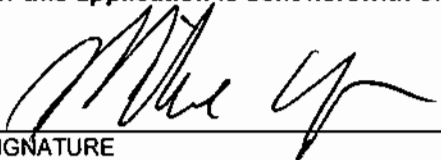
FACILITY NAME:		CITY:			
REPORTING PERIOD DATES:					
		From:		to:	
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness	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

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 manger 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 DuPage Medical Group, Ltd. *
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

Michael Kasper

PRINTED NAME

Chief Executive Officer

PRINTED TITLE



SIGNATURE

Dennis Fine

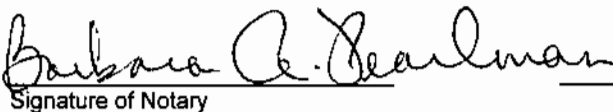
PRINTED NAME

Chief Operating Officer

PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 24th day of May 2012



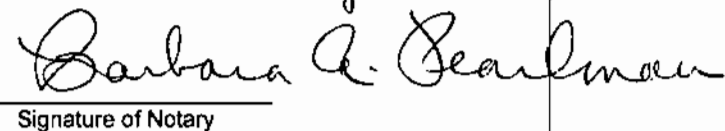
Signature of Notary

Seal

*Insert EXACT legal name of the applicant
OFFICIAL SEAL
BARBARA A PEARLMAN
Notary Public - State of Illinois
My Commission Expires Dec 26, 2015

Notarization:

Subscribed and sworn to before me
this 24th day of May 2012



Signature of Notary

Seal

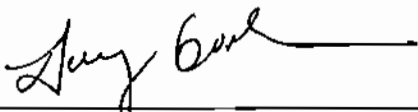
OFFICIAL SEAL
BARBARA A PEARLMAN
Notary Public - State of Illinois
My Commission Expires Dec 26, 2015

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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 Rush University Medical Center *
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.



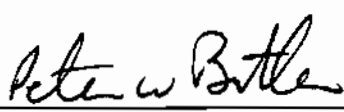
SIGNATURE

Larry J. Goodman, M.D.

PRINTED NAME

Chief Executive Officer

PRINTED TITLE



SIGNATURE

Peter W. Butler

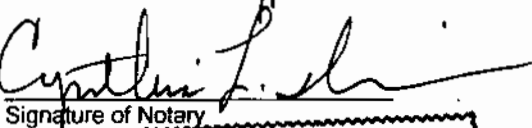
PRINTED NAME

President, Chief Operating Officer

PRINTED TITLE

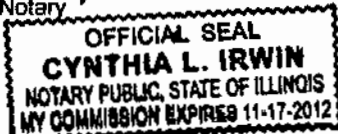
Notarization:

Subscribed and sworn to before me
this 25th day of May, 2012.



Signature of Notary

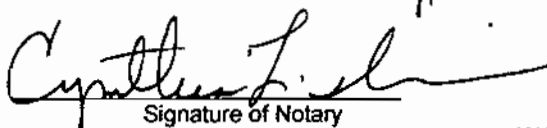
Seal



*Insert EXACT legal name of the applicant

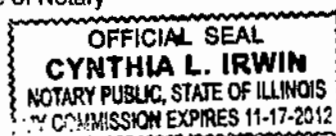
Notarization:

Subscribed and sworn to before me
this 25th day of May, 2012.



Signature of Notary

Seal



NOT APPLICABLE**SECTION II. DISCONTINUATION**

This Section is applicable to any project that involves discontinuation of a health care facility or a category of service. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 60 days following the date of discontinuation.

REASONS FOR DISCONTINUATION

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

IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.
3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

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

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
- B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
- C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
- D) Provide the reasons why the chosen alternative was selected.

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

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

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

SECTION IV - PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE**Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space**

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.

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 tot 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:**

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.

This project does not involve any unfinished or shell space. Therefore, the applicants have not included an assurance that existing shell space will be used as it is not pertinent.

SECTION V. - MASTER DESIGN AND RELATED PROJECTS**NOT APPLICABLE**

This Section is applicable only to proposed master design and related projects.

Criterion 1110.235(a) - System Impact of Master Design

Read the criterion and provide documentation that addresses the following:

1. The availability of alternative health care facilities within the planning area and the impact that the proposed project and subsequent related projects will have on the utilization of such facilities;
2. How the services proposed in future projects will improve access to planning area residents;
3. What the potential impact upon planning area residents would be if the proposed services were not replaced or developed; and
4. The anticipated role of the facility in the delivery system including anticipated patterns of patient referral, any contractual or referral agreements between the applicant and other providers that will result in the transfer of patients to the applicant's facility.

Criterion 1110.235(b) - Master Plan or Related Future Projects

Read the criterion and provide documentation regarding the need for all beds and services to be developed, and also, document the improvement in access for each service proposed. Provide the following:

1. The anticipated completion date(s) for the future construction or modernization projects; and
2. Evidence that the proposed number of beds and services is consistent with the need assessment provisions of Part 1100; or documentation that the need for the proposed number of beds and services is justified due to such factors, but not limited to:
 - a. limitation on government funded or charity patients that are expected to continue;
 - b. restrictive admission policies of existing planning area health care facilities that are expected to continue;
 - c. the planning area population is projected to exhibit indicators of medical care problems such as average family income below poverty levels or projected high infant mortality.
3. Evidence that the proposed beds and services will meet or exceed the utilization targets established in Part 1100 within two years after completion of the future construction of modernization project(s), based upon:
 - a. historical service/beds utilization levels;
 - b. projected trends in utilization (include the rationale and projection assumptions used in such projections);
 - c. anticipated market factors such as referral patterns or changes in population characteristics (age, density, wellness) that would support utilization projections; and
 - d. anticipated changes in delivery of the service due to changes in technology, care delivery techniques or physician availability that would support the projected utilization levels.

Criterion 1110.235(c) - Relationship to Previously Approved Master Design Projects

READ THE CRITERION which requires that projects submitted pursuant to a master design permit are consistent with the approved master design project. Provide the following documentation:

1. Schematic architectural plans for all construction or modification approved in the master design permit;
2. The estimated project cost for the proposed projects and also for the total construction/modification projects approved in the master design permit;
3. An item by item comparison of the construction elements (i.e. site, number of buildings, number of floors, etc.) in the proposed project to the approved master design project; and
4. A comparison of proposed beds and services to those approved under the master design permit.

APPEND DOCUMENTATION AS ATTACHMENT-18, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VI - MERGERS, CONSOLIDATIONS AND ACQUISITIONS/CHANGES OF OWNERSHIP
NOT APPLICABLE

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

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

A. Criterion 1110.240(b), Impact Statement

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

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

B. Criterion 1110.240(c), Access

Read the criterion and provide the following:

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

C. Criterion 1110.240(d), Health Care System

Read the criterion and address the following:

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

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

R. Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than Categories of Service must submit the following information:
2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☒ Radiation Therapy	0	1
☒ Infusion Therapy	N/A	N/A
☐		

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

PROJECT TYPE	REQUIRED REVIEW CRITERIA	
New Services or Facility or Equipment	(b) -	Need Determination - Establishment
Service Modernization	(c)(1) -	Deteriorated Facilities
		and/or
	(c)(2) -	Necessary Expansion
		PLUS
	(c)(3)(A) -	Utilization - Major Medical Equipment
		Or
	(c)(3)(B) -	Utilization - Service or Facility
APPEND DOCUMENTATION AS ATTACHMENT-37, 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:**

\$17,477,979.07	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
		1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
		2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
\$22,000,000	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:
		1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated;
		2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate;
		3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.;
		4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment;
		5) For any option to lease, a copy of the option, including all terms and conditions.
	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
\$39,477,979.07	TOTAL FUNDS AVAILABLE	

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

Note: See Attachment 39 for statement describing how co-applicant Rush is not providing any funding for the project.

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

Provide Data for Projects Classified as:	Category A or Category B (last three years)			Category B (Projected)
Enter Historical and/or Projected Years:				
Current Ratio	See Note Below Referring to Attachment 41			
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

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

2. Variance

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

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

Note: See Attachment 41 for viability ratios as well as data and methodology relevant to determining viability ratios. See Attachment 40 for documentation of Rush University Medical Center's Bond Rating.

X. 1120.140 - Economic Feasibility

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

Note: See Attachment 39 and 40 regarding Rush's non-involvement in financing of project and its Bond Rating.

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

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

XI. Safety Net Impact Statement**NOT APPLICABLE**

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			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			

	Medicaid (revenue)			
	Inpatient			
	Outpatient			
	Total			

APPEND DOCUMENTATION AS ATTACHMENT-43, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

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-44, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Note: Charity information for co-applicant Rush is included in Attachment 44, along with the relevant documentation.

SECTION I – IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Type of Ownership of Applicant/Co-Applicant

Co-Applicant

Rush University Medical Center is a co-applicant. It is a non-profit corporation.

Certificates of Good Standing

Per the requirements listed on page 1 of the application, Illinois Certificates of Good Standing are included in this Attachment for:

- DuPage Medical Group, Ltd.
- Rush University Medical Center



To all to whom these Presents Shall Come, Greeting:

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

DU PAGE MEDICAL GROUP, LTD., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JULY 22, 1968, 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 IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1212401698

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 3RD
day of MAY A.D. 2012*

Jesse White

SECRETARY OF STATE

File Number 0200-214-1



To all to whom these Presents Shall Come, Greeting:

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

RUSH UNIVERSITY MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JULY 21, 1883, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1134900456

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 15TH day of DECEMBER A.D. 2011 .

Jesse White

SECRETARY OF STATE

SECTION I – IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Site Ownership

The site, 430 Warrenville Road, Lisle, IL 60532 is owned by DMG Real Estate, LLC, which is in turn wholly owned by DuPage Medical Group, Ltd. (see Attachment 4).

In order to demonstrate ownership of the site, applicant DuPage Medical Group, Ltd. has included a copy of:

- Attachment 2-Exhibit 1, The Term Sheet for a loan between DMG Real Estate, LLC and a syndicate of lenders. This loan was arranged and Bank of America, N.A. which is also included in the syndicate of lenders. DuPage Medical Group, Ltd. is listed as a guarantor of the loan (page 1) and the site is used as collateral (page 4), thus demonstrating DuPage Medical Group, Ltd.'s ownership of the site. It has been signed on behalf of DuPage Medical Group, Ltd. by Mike Pacetti, CFO (page 8).
- Attachment 2-Exhibit 2, The lease between DuPage Medical Group, Ltd. and Rush University Medical Center for the leasing of 12,927 sq. ft. of space at DMG's Medical Office Building at 430 Warrenville Road, Lisle, IL 60532 (page 1). This lease is signed by Dennis Fine, COO of DuPage Medical Group, Ltd. and Dr. Larry Goodman, CEO of Rush University Medical Center (page 22).

It should be noted again that co-applicant **Rush University Medical Center does not have any ownership interest in the site whatsoever**. Likewise, it did not assist in financing the acquisition of the land or construction of the building. Its only interest in the property is as a tenant for a portion of the space in the building as described above.

Attachment 2-Exhibit 1

Term Sheet for Construction Loan

Note: Some portions of this Term Sheet have been redacted. The portions redacted are those that provide specific terms regarding interest rates or fees. This information is considered proprietary and confidential. Furthermore, this information is not necessary for the purpose intended by inclusion of this document in the CON submission, i.e. demonstrating DuPage Medical Group's ownership of the property.

Attachment 2-Exhibit 1
Term Sheet for Construction Loan



TERM SHEET PROPOSAL
DMG Real Estate, LLC
October 17, 2011

This Term Sheet Proposal is presented for discussion purposes only, and replaces the Proposal dated August 3, 2011. It is not a commitment to lend by Bank of America or any of its affiliates. Bank of America may withdraw or amend it at any time in its sole discretion. If Bank of America does extend a loan commitment, the actual terms and conditions (including pricing and financial covenants) will be subject to completion of due diligence, Bank of America's credit and documentation standards, necessary credit approval, market conditions and other considerations determined by Bank of America in its sole discretion.

BORROWER: DMG Real Estate, LLC (the "Borrower").

ADMINISTRATIVE AGENT & ARRANGER: Bank of America, N.A. (the "Administrative Agent," "Arranger" or "BANA") will act as sole and exclusive administrative agent and arranger.

LENDERS: A syndicate of financial institutions (including BANA), arranged by the Administrative Agent and acceptable to the Borrower and BANA.

GUARANTOR: Unlimited guaranty of payment of Du Page Medical Group, Ltd. ("DMG")

CREDIT FACILITY: Construction-to-Permanent Term Loan Facility ("Credit Facility") consisting of an initial Construction Loan ("Construction Loan") and a subsequent permanent Term Loan ("Term Loan").

CREDIT FACILITY AMOUNT: The lesser of:
(i) \$22,000,000; or
(ii) 70% of the Fair Market Value of the Property, as evidenced by a satisfactory as-completed appraisal performed by the Bank.

BANA SHARE/ PARTICIPATION: BANA will hold up to \$11,220,000 or 51% of the Credit Facility.

On a best efforts basis, BANA will pursue a participation(s) in the facility for up to \$10,780,000 or 49% of the Credit Facility.

"BEST EFFORTS" SYNDICATION BANA will use its best efforts to form a syndicate of financial institutions ("Lenders") for the Credit Facility, based on the indicative terms and conditions contained herein. This Proposal represents our current view of where a transaction such as this would clear the market, but are subject to change.

The Borrower agrees to actively assist BANA in achieving a successful syndication of the Facility. To assist BANA in its syndication efforts, the Borrower agrees to: (i) provide, and cause its advisors to provide, BANA and each other Lender that becomes part of the syndicate of financial institutions upon request with all information reasonably deemed necessary by BANA to complete the syndicate; (ii) assist BANA upon reasonable request in the preparation of marketing materials to be used in connection with the syndication of the Facility; and (iii) otherwise assist BANA in its syndication efforts, including making available officers and advisors of the Borrower/Guarantor and its affiliates and subsidiaries from time to time to attend and make presentations regarding the business and prospects of the Borrower/Guarantor and at a meeting or meetings of prospective syndicate members.

MARKET FLEX

The Borrower will cooperate with BANA's recommendations to change the structure or terms (including pricing) of the Credit Facility, if BANA determines that such changes will be necessary in order to ensure a successful syndication of an optimal credit structure of the Credit Facility. Such change to structure, terms or amount may occur before or after initial close of the Credit Facility. If the Borrower withholds consent, BANA or the Borrower may terminate any commitments that may have been issued and any further discussions or efforts with respect to the Credit Facility. The Borrower shall remain liable for all costs actually incurred during the negotiation, preparation, execution and syndication of the Credit Facility whether or not such Credit Facility closes.

CLEAR MARKET PROVISION:

From the date of acceptance of this Proposal and continuing until execution and delivery of the Credit Facility, there shall be no competing offering, placement or arrangement of any debt securities or bank financing by or on behalf of the Borrower/Guarantor. The Borrower will immediately notify BANA if any such transaction is contemplated.

PURPOSE:

The proceeds of the Credit Facility shall be used for the construction and permanent financing of an approximate 100,000 sq. ft. medical office building in Lisle, IL (the "Property").

MATURITY:

- Construction Loan: 12 months from Closing Date
- Term Loan: 5 years from Term Loan Conversion.

CLOSING DATE:

Targeted December 31, 2011

INTEREST RATE:

- Construction Loan: [REDACTED]
- Term Loan: LIBOR [REDACTED]

The [REDACTED] shall be renewed upon the expiration of the initial interest period for a like tenor, or other tenor as agreed to by the Bank, and the rate adjusted to the applicable [REDACTED] in effect at the time of such renewal.

INTEREST CALCULATION

All calculations of interest and fees shall be made on the basis of actual number of days elapsed in a 360-day year.

INTEREST RATE PROTECTION

The Borrower shall enter into interest protection agreements acceptable to BANA for up to 50% of the principal amount of the Credit Facility for a term no less than 3 years, within 60 days of Term Loan Conversion. The terms of such interest rate swap shall be governed by the standard ISDA Master Agreement and related documentation.

UPFRONT FEE:

[REDACTED] payable at closing to Lenders based on their pro rata share.

ARRANGER FEE:

[REDACTED] payable at closing to Arranger.

AGENCY FEE:

[REDACTED] payable annually to Administrative Agent.

**CONSTRUCTION LOAN
DISBURSEMENTS:**

The Borrower may request disbursements up to the Credit Facility Amount. Conditions to each disbursement will be usual and customary for transactions of this type, including, without limitation: (i) all representations and warranties are true and correct as of the date of each loan, and (ii) no event of default has occurred or is continuing under the Credit Facility or would result from such loan.

Conditions applicable to construction disbursements include, but are not limited to, the following:

- The Credit Facility shall be subject to the receipt, review, and acceptance of the plans and specs of the proposed project by BANA's Commercial Banking Construction ("CBC") Division and an outside consultant hired by the Bank to perform a Front End Plan and Cost Review. This cost is paid by the Borrower. The Bank shall provide a checklist of all construction related documents and permits required for closing.
- The Credit Facility shall be further subject to approval of the contractor and the contract for the proposed project by BANA's CBC Division.
- Construction costs and disbursements shall be administered by BANA's CBC Division during the construction phase.
- Each Construction Loan disbursement will be evidenced by a monthly inspection plus a cost review by BANA's construction monitoring consultant, which will be paid for by the Borrower.
- The Borrower's equity in the construction draws shall be determined based on formation of current equity in the Property and formal credit approval, and either:
 - (i) Shared with each draw; or
 - (ii) Lump sum upfront

**TERM LOAN
CONVERSION:**

The Construction Loan shall convert to a Term Loan ("Term Loan Conversion"), subject to satisfaction of usual and customary conditions for transactions of this type, including but not limited to:

- Final Construction Loan disbursement
- Construction completion on the Property
- Confirmation of waiver of all mechanic's lien claims
- Delivery of ALTA Loan policy
- Delivery of permanent insurance
- Delivery of certificate of occupancy
- Execution of all applicable Property leases
- Confirmation that no judgments or tax liens exist on either the Property or the Borrower.

REPAYMENT:

The Credit Facility shall be subject to monthly interest payments.

The Term Loan shall be subject to equal monthly installments of principal based on a 20-year amortization schedule.

PREPAYMENTS:

The Borrower may prepay any variable rate loan under the Credit Facility in whole or in part at any time without penalty, except for reimbursement of BANA's breakage and redeployment costs in the case of prepayment of LIBOR based borrowings.

**REAL ESTATE
COLLATERAL:**

A first priority mortgage on real property commonly known as 430 Warrenville Road located in Lisle, Du Page County, Illinois. Any existing leases on the real property shall not contain any right to purchase the property or any right of first refusal unless such rights are subordinated to BANA's lien in a manner satisfactory to the Bank. At BANA's request, Borrower shall provide the Bank with a complete copy of any existing lease on the real property.

Such lien on the real property shall be subject to such terms and conditions as the Bank may reasonably impose including, but not limited to, a loan to value ratio not to exceed 70%, an appraisal (to be ordered by Bank of America), instrument survey, title insurance (with all required endorsements) and environmental Phase I survey (to be completed by Borrower), all of which shall be acceptable to Bank of America and its counsel.

The foregoing security shall also secure any liabilities of Borrower to the Bank arising under any interest rate swap/foreign currency swap or other hedging arrangement.

**CONDITIONS
PRECEDENT:**

The closing (and the initial funding) of the Credit Facility will be subject to satisfaction of the conditions precedent deemed appropriate for transactions of this type including, but not limited to, the following:

- (i) The negotiation, execution and delivery of definitive documentation for the Credit Facility satisfactory to Bank of America, which shall include, without being limited to satisfactory opinions of counsel to the Borrower and Guarantor and such other customary closing documents as Bank of America shall reasonably request.
- (ii) There shall not have occurred a material adverse change in the business, assets, liabilities (actual or contingent), operations, condition (financial or otherwise) or prospects of the Borrower and Guarantor taken as a whole or in the facts and information regarding such entities as represented to date.
- (iii) The absence of any action, suit, investigation or proceeding pending or threatened in any court or before any arbitrator or governmental authority that purports (a) to materially and adversely affect the Borrower or Guarantor, or (b) to affect any transaction contemplated hereby or the ability of the Borrower or the Guarantor to perform their respective obligations under the documentation for the Credit Facility.
- (iv) Additional due diligence on the Property consistent with transactions of this type, including, but not limited to, as-completed appraisal of the Property, environmental due diligence, evidence of all required insurance, satisfactory title insurance, and review of the construction and architect contracts and documents by BANA's CBC Division and the outside consultant hired by the Bank.
- (v) Payment of all fees and expenses then due and payable.
- (vi) Receipt of items as listed on Exhibit A.

RELATIONSHIP:

DMG shall maintain BANA as its principal depository bank, including for the maintenance of business, cash management, operating and administrative deposit accounts.

**REPRESENTATIONS
AND WARRANTIES:**

Usual and customary for transactions of this type, to include, without limitation: (i) due organization, valid existence and good standing (ii) due authorization/enforceability; (iii) correctness of specified financial statements and no material adverse change; (iv) binding effect and enforceability of loan documents; (v) no liens or encumbrances other than as disclosed to Bank of America; (vi) compliance with environmental laws; (vii) no material litigation; (viii) payment of taxes.

COVENANTS:

Usual and customary for transactions of this type, to include, without limitation: (i) due organization, valid existence and good standing (ii) due authorization/enforceability; (iii) correctness of specified financial statements and no material adverse change; (iv) binding effect and enforceability of loan documents; (v) no liens or encumbrances other than as disclosed to Bank of America; (vi) compliance with environmental laws; (vii) no material litigation; and (viii) payment of taxes.

The Borrower may be required to obtain a payment and performance bond for the general contractor, subject to BANA's review of the contractor's AIA Statement of Qualifications and financial statements.

**FINANCIAL
COVENANTS:**

Financial covenants of the Borrower will include:

- Minimum Debt Service Coverage Ratio ("DSCR") of 1.20x, measured quarterly and calculated on a three-months basis.

DSCR shall be defined as the ratio of (a) Cash Flow to (b) the sum of scheduled principal and interest payments on all long-term debt.

"Cash Flow" is defined as (a) net income, after income tax, (b) less income or plus loss from discontinued operations and extraordinary items, (c) plus depreciation, amortization and other non-cash charges, (d) plus interest expense on all obligations, and (e) minus dividends, withdrawals, and other distributions.

Financial covenants of the Guarantor will include:

Financial covenants and definitions for the Guarantor will be consistent with those contained in the Loan Agreement between BANA and DMG dated 12/31/2010, as follows:

- Minimum Tangible Net Worth of \$40,000,000 + 50% of net income after 12/31/2009, tested quarterly on a year-to-date basis.
- Minimum Debt Service Coverage Ratio of 1.50x, tested quarterly on a trailing 12-months basis.
- Maximum Senior Debt/EBITDA of 3.50x, tested quarterly on LTM basis
- Minimum Fixed Charge Coverage of 1.10x, tested quarterly on a trailing 12-months basis.

- Maximum unfunded capital expenditures in any fiscal year, tested quarterly on a year-to-date basis, of:
 - \$15,000,000 for fiscal year ended 12/31/2011
 - \$20,000,000 for fiscal years ended 12/31/2012 and thereafter
- Maximum aggregate rental payments under operating leases in any fiscal year, tested quarterly on a year-to-date basis, of:
 - \$25,000,000 for fiscal year ended 12/31/2011
 - \$30,000,000 for fiscal years ended 12/31/2012 and thereafter

**REPORTING
REQUIREMENTS:**

Financial reporting from the Borrower will include:

Prior to Term Loan Conversion:

- Project reporting as required by BANA's CBC Division.
- Copy of any executed lease(s) on the Property, as well as any future amendments and/or modifications

After Term Loan conversion:

- Quarterly financial statements of the Borrower within 45 days of quarter end (including the fourth fiscal quarter of each year), certified and dated by the Borrower's authorized financial officer
- Annual rent roll for the Borrower and the Property within 45 days of year end

Financial reporting from the Guarantor will include:

Financial reporting for the Guarantor will be consistent with that outlined in the Loan Agreement between BANA and DMG dated 12/31/2010, as follows:

- Annual audited consolidated financial statements within 120 days of FYE, certified and dated by DMG authorized financial officer
- Quarterly consolidated financial statements within 45 days of quarter end (including the fourth fiscal quarter of each year), certified and dated by DMG authorized financial officer
- Annual consolidated budget within 60 days of commencement of each fiscal year, certified by CFO
- Quarterly compliance certificate within 45 days of each quarter end, signed by authorized financial officer showing calculations of financial covenants
- Monthly summary A/R aging by payor class, within 30 days of month end

In addition, reporting will include the following:

- Any other information from the Guarantor and/or Borrower as the Bank shall reasonably request.

EVENTS OF DEFAULT:	Usual and customary in transactions of this type, to include without limitation: (i) nonpayment of principal, interest, fees or other amounts; (ii) violation of covenants; (iii) inaccuracy of representations and warranties; (iv) cross-default to other material agreements and indebtedness; (v) bankruptcy and other insolvency events; (vi) creditor or forfeiture proceedings; (vii) actual or asserted invalidity of any loan documentation or security interests; (viii) material events affecting guarantor; (ix) change in control and (x) material adverse change.
GOVERNING LAW/ARBITRATION:	State of Illinois. Any dispute arising out of or related to this letter or the final loan documentation shall be determined by binding arbitration in accordance with the Federal Arbitration Act. All arbitration proceedings shall be conducted through the American Arbitration Association (an independent, alternative dispute resolution service).
EXPENSES:	Borrower will pay all reasonable costs and expenses associated with the preparation, due diligence, administration and enforcement of all documentation executed in connection with the Credit Facility, whether or not the loan closes, including, without limitation: • BANA's attorneys' fees (including the allocated cost of internal counsel), estimated at [REDACTED] • Applicable construction-related administration fees, including but not limited to: appraisal(s), cost analysis, site inspection, title, environmental review, flood certification and, if applicable, contractor payment and performance bond.
CREDIT PROCESS TIMEFRAME:	The credit process will take 15 business days from the point at which BANA is officially awarded the transaction and has in its possession all materials necessary to undertake a full credit analysis.
EXPIRATION OF TERMS AND CONDITIONS	Unless rescinded earlier, consideration of a financing based on the terms and conditions presented in this term sheet shall automatically expire 30 days from the date hereof. BANA reserves the right to terminate, reduce or otherwise amend its commitment if the subject transaction is not closed within 90 days of the receipt of a signed term sheet

This Term Sheet Proposal contains confidential and proprietary loan structuring and pricing information. Except for disclosure on a confidential basis to your accountants, attorneys and other professional advisors retained by you in connection with the credit facilities contained in this Term Sheet Proposal or as may be required by law, the contents of the Term Sheet Proposal may not be disclosed in whole or in part to any other person or entity without our prior written consent, provided that nothing herein shall restrict disclosure of information relating to the tax structure or tax treatment of the proposed credit facilities.

**AGREEMENT BY THE
BORROWER:**

The Borrower hereby agrees to engage BANA to provide the Credit Facility which is the subject hereof, pursuant to the terms and conditions stated herein.

Please evidence your acceptance of the foregoing by signing and returning a copy of the document to BANA.

Accepted and Agreed to:

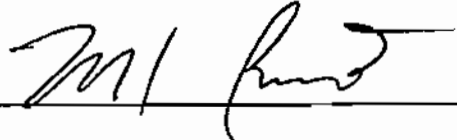
By:  Date: 10/17/2011

Exhibit A

- Satisfactory ALTA Survey – Signed, sealed and certified to Lender, Title Company and Borrower
- Detailed project construction cost breakdown from the contractor including an itemization and schedule of disbursements
- Sets of detailed construction plans and specifications for all architectural, structural, mechanical, plumbing, electrical, site development (on and off-site) and other work for or in connection with the Improvements which have been approved by the municipality
- Fully executed copies of Borrowers' construction, architectural and engineering contracts regarding the Improvements
- Project description of improvements
- Construction schedule (provided by the contractor – usually a bar chart)
- Architect and/or Engineer list of permits required and site development permit status data
- Insurance – Fire, all-risk replacement cost coverage, builder's risk, Contractor's liability, Borrower Liability and flood insurance if project is in a flood zone
- Satisfactory Soil Report with recommendations
- Satisfactory Environmental information
- Zoning and concurrency letter
- Utility availability letters (should also state that capacity is available and appropriate for this project)
- Title commitment
- True and correct copies of valid building permit for the Improvements and all other applicable permits, licenses and approvals necessary for construction.
- Performance and Payment bonds (Unconditional) for each original construction contractor (and any material subcontractor as required by Lender) naming Lender as an additional obligee and in amount, form and content, and issued by sureties, satisfactory to Lender and in compliance with applicable law.

The above list is provided for informational purposes only.

A more detailed and all inclusive listing of the construction requirements will be included in the Construction Loan Agreement and related loan documentation.

Borrower Indemnification Letter

On this 17th day of October, 2011, DMG Real Estate, LLC (the "Borrower") wishes to induce Bank of America, (the "Bank") to waive its right to retain sole possession of the appraisal report (the "Appraisal"), prepared by CB Richard Ellis (the "Appraiser") with respect to the property consisting of DuPage Medical MOB as of the date of the Appraisal, and located at 1807 S. Highland Ave., Lombard, DuPage County, IL (collectively the "Property").

In consideration of the Bank's agreement to deliver a copy of the Appraisal to the Borrower, the Borrower hereby agrees with the Bank and acknowledges to the Bank, the following:

- (a) As of the date hereof, the Bank
 - (i) does not represent that the presumptions or opinions in the Appraisal are relevant or accurate;
 - (ii) does not represent that the appraisal has been or has not been approved by the Bank;
 - (iii) does not represent that the Bank endorses or does not endorse the opinions set forth in the Appraisal and;
 - (iv) is transmitting the Appraisal to the Borrower without representation or warranty.
- (b) The Borrower will hold the Appraisal in confidence and will not distribute it to any other person or entity, except its employees, agents, attorneys, consultants, or unless compelled by law or judicial proceedings, without the Bank's prior written consent.
- (c) The Borrower will indemnify and hold the Bank harmless from and against, and reimburse it for, any and all claims, demands, liabilities, losses, damages, causes of action, judgments, penalties, costs and expenses of every kind, known or unknown, which may be imposed upon, asserted against, or incurred or paid by the Bank at any time and from time to time, resulting from, in connection with, or arising out of any transaction, act, omission, event or circumstance in any way connected with the content or accuracy of the Appraisal, the Borrower's use of the Appraisal, and subsequent use of the Appraisal by any third party to whom the Borrower provides the Appraisal.
- (d) The Borrower hereby waives any and all present and future claims, actions, causes of action, defenses and/or counterclaims which it may now or hereafter assert against the Bank in connection with the content or accuracy of the Appraisal, the Borrower's use of the Appraisal, and subsequent use of the Appraisal by any third party to whom the Borrower provides the Appraisal.

For purposes of this Agreement, the term "Bank" shall include, without limitation, its present, former and future officers, directors, associates, agents, parents, subsidiaries, affiliates, successors and assigns.

EXECUTED this 17th day of October, 2011.

BORROWER:

By: [Signature]
Name: Michael V. Paccetti
Title: CFO

Attachment 2-Exhibit 2

Lease Between DuPage Medical Group, Ltd. and Rush University Medical Center

Note: Some portions of this lease have been redacted. The portions redacted are those that provide specific terms regarding monetary compensation (either rental fees or interest rates). This information is considered proprietary and confidential. Furthermore, this information is not necessary for the purpose intended by inclusion of this document in the CON submission, i.e. demonstrating DuPage Medical Group's ownership of the property on which this project is located.

LEASE

This lease (the "Lease") made and entered into as of October 12, 2011, constitutes an Agreement by and between DuPage Medical Group, LTD (the "Landlord"), and Rush University Medical Center, an Illinois not-for-profit corporation located at 1653 West Congress Parkway, Chicago, IL 60612 (the "Tenant").

WHEREAS, Landlord, Tenant, Rush System for Health and Rush Health are parties to that certain Affiliation Agreement dated October 12, 2011, (the "Affiliation Agreement") pursuant to which the parties have agreed to collaborate to provide accessible, high quality, cost-effective health care services to promote the general public health and improve the health status of citizens living in the communities serviced by Landlord and Tenant;

WHEREAS, Landlord and Tenant are parties to that certain Master Clinical Collaboration Agreement (the "Master Collaboration Agreement") pursuant to which the parties set forth the framework for their various clinical collaborations, and the terms of which are specifically incorporated herein by reference; and

WHEREAS, Landlord and Tenant are parties to a Cancer Center Collaboration Agreement pursuant to which the parties set forth the framework for collaboration in the development of a cancer treatment center (the "Cancer Center"), and the terms of which are specifically incorporated herein by reference; and

WHEREAS, Landlord intends to construct and own a building located at 430 Warrenville Road in Lisle, Illinois (the "Medical Office Building" or "M.O.B") in which the Cancer Center will be located;

WHEREAS, Tenant intends to lease space in the M.O.B. from Landlord to provide on-site medical oncologists and surgeons and other health care professionals to support Landlord and Tenant patients by providing comprehensive cancer treatment, including oncologic infusion services (the "Infusion Services"); and

WHEREAS, the Infusion Services will be provided in designated space within the Cancer Center (the "Infusion Center") and the Infusion Center will be established as a satellite location of Tenant, pursuant to rules and regulations applicable to Provider Based Clinics.

WHEREAS, Tenant desires to lease from Landlord, and Landlord desires to lease to Tenant the Infusion Center.

IN CONSIDERATION of the mutual covenants and agreements set forth herein, the parties hereto agree as follows:

ARTICLE I – The Demise

- 1.1 **The Leased Premises:** Landlord hereby leases to the Tenant that certain space known as the Infusion Center being Suite 200 (the "Premises"), comprising approximately 12,927 rentable square feet of the Medical Office Building located at 430 Warrenville Road, Lisle, Illinois 60532. The Medical Office Building and surrounding land are collectively referred to as the "Real Property." The floor plan of the Premises is depicted on Exhibit A, attached hereto and made a part hereof. The Premises comprises 14.55% of the Medical Office Building.

- 1.2 Use of Premises: The Premises shall at all times during the Term be used and occupied by Tenant, its sublessees, assignees, agents and employees only as medical offices for licensed physicians ("Physicians") to engage in the private practice of medicine solely limited to the provision of chemotherapy and infusion medical services and other related activities solely incidental thereto; except the provision or operation of ancillary medical care services and facilities described in paragraph 24 of the Rules and Regulations (Exhibit B). Nothing in this Section 1.2 or elsewhere in this Lease requires or shall require any Physician or any person associated with a Physician to refer any patient to or order or purchase any item of service from Tenant, Landlord or any of their affiliates.

The medical practice ("Practice") conducted upon the Premises shall at all times be conducted under the supervision and authority of a Physician.

Tenant shall act in accordance with and not violate any restrictions or covenants of record affecting the Premises or the M.O.B. Landlord shall inform Tenant in writing of any such restrictions or covenants. Tenant shall not use or occupy the Premises in violation of law or of the certificate of occupancy issued to the M.O.B. of which the Premises are a part, and shall immediately discontinue any use of the Premises which is declared by any governmental authority having jurisdiction to be a violation of any law, code, governmental regulation or a violation of said certificate of occupancy. Tenant shall comply with any direction of any governmental authority having jurisdiction which shall, by reason of the nature of Tenant's use or occupancy of the Premises, impose any duty upon Tenant with respect to the use or occupancy thereof.

Tenant shall not do nor permit to be done anything in the Premises which will invalidate or increase the cost of any casualty and extended coverage insurance policy covering the M.O.B. and/or property located therein, and shall comply with all rules, orders, regulations and requirements of the appropriate Fire Rating Bureau or any other organization performing a similar function. Tenant shall promptly upon demand reimburse Landlord for any additional premium charged for such policy by reason of Tenant's failure to comply with the provisions of this paragraph. Tenant shall not do or permit anything to be done in, on or about the Premises which would in any way unreasonably obstruct or interfere with the rights of other tenants or occupants of the M.O.B., or use or allow the Premises to be used for any unlawful purpose, nor shall Tenant maintain or permit any nuisance or commit or suffer to be committed any waste in, on or about the Premises.

1.3 Exclusivity:

(a) During the Term, as defined herein, Landlord hereby agrees that it shall not lease any space in the Medical Office Building to (i) a provider of oncologic infusion services, (ii) a provider of any services which are competitive with those services provided under the Master Collaboration Agreement, or (iii) any hospital, health system, academic medical center or "Affiliate" thereof, as defined herein.

(b) During the Term Landlord hereby agrees that neither it nor any of its Affiliates shall develop, acquire, lease to or from or invest in new or existing oncologic infusion services within its Service Area except for expansions of oncologic infusion services developed with Tenant.

(c) Definitions: "Affiliate" shall mean, with respect to any Person, (i) any Person directly or indirectly controlling, controlled by or under common control with such Person; (ii) any Person owning or controlling, directly or indirectly, five percent (5%) or more of the outstanding voting securities, equity interests, or membership interests (including such interests in a not-for-profit organization), of such Person; (iii) any officer, director, shareholder, member, manager or partner of such Person; (iv) any company in which such Person is an officer, director, member, manager or partner. "Person" shall mean any individual, partnership, corporation, trust, limited liability company, association, joint venture, investment fund, joint stock company, organization, business, trust or any other entity or organization, including a government or any department, agency or political subdivision thereof. "Service Area" shall mean (i) Cook, DuPage and Will Counties in Illinois and (ii) within a 15 mile radius of any cancer treatment center sites established between Landlord and Tenant outside of such counties.

(d) If any court of competent jurisdiction shall at any time deem any particular restrictive covenant contained in this Section 1.3 unreasonable, the other provisions of this Section 1.3 shall nevertheless stand, the duration of the exclusivity (i.e. the "Term") shall be deemed to be the longest period permissible by law under the circumstances and the Service Area shall be deemed to comprise the largest territory permissible by law under the circumstances, as determined by the court in each case.

(e) If the event the Cancer Collaboration Agreement between the Landlord and Tenant is terminated for any reason, the parties shall, within six (6) months of the termination of the Cancer Collaboration Agreement, meet and confer in good faith to determine whether this Lease should also be terminated and the terms of any such termination. Any decision to terminate the Lease must be agreed to by both Landlord and Tenant.

- 1.4 Environmental Matters Tenant shall not cause the release or disposal of any hazardous substances, wastes or materials, or any medical, special or infectious wastes, on or about the Premises or the M.O.B. of which they are a part if such release or disposal is in violation of applicable laws and Tenant shall be solely responsible for and shall promptly pay the cost of removing all such hazardous substances, wastes and materials and any medical special and infectious waste from the Premises, which removal shall be in accordance with all applicable governmental requirements. Hazardous substances, wastes or materials shall include those which are defined in the Comprehensive Environmental Response, Compensation and Liability Act of 1980, the Clean Air Act; the Resource Conservation and Recovery Act of 1976 and; the Toxic Substances Control Act (including any amendments or extensions thereof and any rules, regulations, standards or guidelines issued pursuant to any such laws); and medical, special or infectious wastes, including those which are defined pursuant to the medical waste regulations which have been promulgated by the state in which the Premises are located, and as further set forth in any state or local laws and ordinances, and their corresponding regulations. Tenant shall comply with all reasonable rules and policies set by Landlord for all tenants in the M.O.B. and with all federal, state and local laws, regulations and ordinances which govern the use, storage, handling and disposal of hazardous substances, wastes or materials and medical, special or infectious wastes. Tenant shall indemnify, defend and hold Landlord harmless from and against any claims or liability arising out of or connected with Tenant's failure to comply with the terms of this Section 1.4, which indemnity shall survive the expiration or earlier termination of this Lease.

- 1.5 Condition of the Premises: Except as provided in Section 2.4, Tenant's taking possession shall be conclusive evidence as against Tenant that the Premises were in good order and satisfactory condition when Tenant took possession, subject to punch list items and latent defects. No promise of Landlord to alter, remodel, repair, or improve the Premises or the M.O.B. and no representation respecting the condition of the Premises or the M.O.B. have been made by Landlord to Tenant, other than as contained herein and made a part hereof, including but not limited to, the Work Letter attached hereto as Exhibit C. This Lease does not grant any rights to light or air over or about the Land.
- 1.6 The Term: The Premises hereby are leased for an initial term of five (5) years ("Initial Term"), commencing on a date not later than thirty (30) days following the date on which a certificate of occupancy for the Premises (the "C/O") is issued by the Village of Lisle to permit Tenant to take occupancy of the Premises for its intended use (the "Commencement Date"). The Initial Term of this Lease (the "Term") shall end with respect to all of the Premises on the last day of the calendar month that is five (5) years after the Commencement Date, unless sooner terminated or extended as provided herein. Tenant acknowledges that the Landlord will be entering into various agreements, expending funds and otherwise taking various actions in reliance upon Tenant's covenants, agreements, representations, warranties and acknowledgements contained in this Lease. Landlord agrees to provide Tenant with periodic updates on construction and the projected Commencement Date. Landlord shall also provide Tenant with a letter memorializing the Commencement Date and termination date upon receipt of the C/O. In addition, prior to the Commencement Date, Landlord shall grant Tenant access to the Premises so that Tenant may make certain approved improvements to the Premises ("Tenant-Made Improvements") so long as such access or work by Tenant does not interfere with Landlord's Work as provided in Section 13.9. The timing of Tenant's access shall be addressed in the construction schedule.
- 1.7 Option to Extend: Tenant shall have the option to extend the Term of this Lease for two (2) periods of five (5) years (the "Renewal Terms") (the Initial Term and each Renewal Term collectively referred to as the "Term"). Such option shall be exercised by Tenant giving Landlord written notice thereof at least six months prior to the date on which the then Renewal Term will commence. Tenant may exercise such option only if it is not in default under this Lease beyond the expiration of applicable cure periods at the time of such exercise. In the event of such exercise, all of the terms of this Lease (except this Section 1.7) shall continue in effect during such Renewal Terms.
- 1.8 In the event Landlord shall be unable to give possession of the Premises on or before December 31, 2012 (the "Delivery Deadline") because the construction of the M.O.B. or the Premises has not been sufficiently completed to make the Premises ready for occupancy as determined by Landlord and Tenant, Landlord shall not be subject to any claims, damages, or liability for the failure to give possession on said date. Under such circumstances, the rent reserved and covenanted to be paid herein shall not commence until the possession of the Premises is given or the Premises are tendered to Tenant, consistent with paragraph 1.5, and failure to give possession on or before the Delivery Deadline shall in no way affect the validity of this Lease or the obligations of Tenant hereunder. If Landlord fails to deliver possession of the Premises to Tenant within 120 days after the Delivery Deadline through no fault or delay caused by Tenant, Landlord shall reimburse Tenant for any reasonable expenses incurred by Tenant due to such delivery delay and if

Landlord fails to deliver possession of the Premises within 180 days after the Delivery Deadline through not fault or delay caused by Tenant, Tenant may terminate this Lease by notifying Landlord in writing within thirty (30) days thereafter, in which event this Lease shall terminate on the date the notice is deemed to be given as provided herein and any monies paid to Landlord shall be returned to Tenant.

- 1.9 Parking: Landlord shall provide parking for the joint use of all of the tenants in the M.O.B. and the Landlord and their agents, employees, patients, and invitees during the Term hereof. Parking spaces for Tenant's use are described in the Parking Plan, attached hereto as Exhibit D. In the event it becomes the prevailing practice to charge a parking fee for parking elsewhere on the property, Landlord shall not charge Tenant a similar parking fee.

- 1.10 Rules and Regulations: Tenant shall observe such rules and regulations described in Exhibit B attached hereto and any amendments or supplements thereto made by Landlord (the "Rules and Regulations"). The Rules and Regulations shall be made part of any sublease of the Premises. The Landlord reserves the right from time to time to make reasonable modifications to the Rules and Regulations which shall be consistent with the terms of this Lease. Notice of amendments and supplements to the Rules and Regulations, if any, shall be given to Tenant and Tenant shall comply with and observe all the Rules and Regulations. However, no such amendments or supplements to the Rules and Regulations shall materially alter Tenant's ability to use the Premises or the cost of Tenant's obligations hereunder, or the ability of patients to access or utilize the Premises. Material failure to keep and observe the Rules and Regulations shall constitute a breach of the terms of this Lease in the manner as if the same were contained herein as covenants. Any change in the Rules and Regulations, whether by amendment or supplement, shall not be deemed or considered as amendments to this Lease.

1.11 Assignment and Subletting:

A. Without the prior written consent of Landlord which shall not be unreasonably withheld, Tenant may not sublease, assign, mortgage, pledge, hypothecate or otherwise transfer or permit the transfer of this Lease or the interest of Tenant in this Lease, in whole or in part, by operation of law or otherwise. If Tenant desires to enter into any sublease or assignment of the Premises, Tenant shall deliver written notice thereof to Landlord, together with financial and other information sufficient for Landlord to make an informed judgment with respect to such proposed subtenant or assignee and a copy of the proposed sublease or assignment agreement at least 60 days prior to the commencement date of the term of the proposed sublease or assignment. Any approved sublease or assignment shall be expressly subject to the terms and conditions and use stated in this Lease, and Tenant shall pay Landlord on the first day of each month during the term of any sublease, one-half (1/2) of the excess of all rent and other consideration due from the subtenant or assignee for such month over that portion of the Base Rent and Rent Adjustments due under this Lease for said month which is allocable to the space sublet or assigned.

B. In the event of any approved sublease or assignment, Tenant shall not be released or discharged from any liability, whether past, present or future, under this Lease. Anything contained herein to the contrary notwithstanding, Tenant may assign or sublet all or part of the Premises for the same Use stipulated in Paragraph 1.2 to an Affiliate without Landlord's consent, but with notice to Landlord ("Permitted Transfer"). For purposes hereof an Affiliate shall mean an entity which either controls, is controlled by or is under common control with Tenant.

C. Anything contained herein to the contrary notwithstanding, in the event the Premises are sublet or assigned and the subtenant or assignee becomes owned by a health system competitor, either directly or indirectly, of Landlord, the Sublease or Assignment shall become null and void 60 days after such event in which case with no liability to Landlord and Tenant shall be responsible to recapture possession of the Premises from such subtenant or assignee. Any sublease or assignment shall contain a statement that such subtenant or assignee acknowledges this Paragraph 1.11EC and agrees to be bound by the same.

ARTICLE II - The Rental

- 2.1 **Base Rent:** Commencing on the Commencement Date, Tenant shall pay to Landlord as "Base Rent" (the "Rent Commencement Date") the annual sum of [REDACTED] for each rentable square foot of the Premises during the first year of the Term of this Lease payable in monthly in the amount of [REDACTED]. Commencing with the second year of the Term of this Lease, and each year thereafter throughout the Term of this Lease (including any renewal term) the Base Rent shall be increased by an amount equal to [REDACTED] of the then prevailing Base Rent.
- 2.2 **Manner and Time of Payment:** All Base Rent shall be paid, in legal tender at the time of payment, in monthly installments as above provided, in advance, on the first day of each month during the Term at the offices of Landlord, Attention: DuPage Medical Group, 1100 31st Street, Suite 300, Downers Grove, Illinois 60515 or at such other place as Landlord may designate in writing, without any set-off or deduction or further demand whatsoever, except as otherwise provided in this Lease. If the Term shall begin on any day except the first day or shall end on any day except the last day of a calendar month, the rent for the initial fractional period shall be paid on the first day of the Term, and the rent for any fractional period at the end of the Term shall be paid together with the last full month's rent. The Base Rent due for any period of less than one calendar month shall be computed and paid on the basis of a prorated fraction of the monthly installment. This covenant to pay rent shall be independent of any other covenant set forth in this Lease.
- 2.3 **Additional Rent:** In addition to and at the time of payment of the Base Rent, Tenant shall pay to the Landlord Operating Expense Deposits pursuant to Article III. All other charges, costs and sums required to be paid by Tenant to Landlord under this Lease shall be deemed additional rent ("Additional Rent") and together with Base Rent and Operating Expense Deposits shall hereinafter be collectively called "Rent."
- 2.4 **Construction of Tenant Improvements:** Landlord and Tenant, as applicable, shall cause to have constructed certain initial tenant improvements to the Premises as set forth in the Work Letter attached hereto as Exhibit C and made a part hereof (the "Tenant Improvements"). Landlord shall arrange and provide all tenant improvements set forth in Exhibit C. The costs of the tenant improvements set forth in Exhibit C-1 shall be costs of Landlord. The costs of the tenant improvements set forth in Exhibit C-2 (and for any additional costs incurred due to changes thereto requested by Tenant) shall be costs of Tenant. Landlord shall ensure that the tenant improvements set forth on Exhibit C-2 are delivered in accordance with the construction specifications provided by Tenant, as reasonably agreed to by Landlord.

- 2.5 Covenant of Quiet Enjoyment: Upon payment by Tenant of the rents and all other charges provided for under this Lease, and upon the observance and performance of all covenants, terms and conditions on Tenant's part to be observed and performed pursuant to this Lease, Tenant shall, at all times during the Term hereof, subject to the terms, covenants and conditions of this Lease, peaceably and quietly hold and enjoy the Premises, without any interruption or disturbance from Landlord or any other person or persons claiming by, through or under Landlord, subject to the terms and conditions of this Lease.

ARTICLE III – Services and Operating Expenses

- 3.1 General Services. Landlord shall provide the following services: (a) heat and air conditioning in the Premises, Monday through Friday from 6:00 a.m. to 8:00 p.m. and Saturdays from 6:00 a.m. to 12:00 p.m., excluding national holidays, to the extent necessary for the comfortable occupancy of the Premises (subject to all applicable voluntary and mandatory regulations and laws) under normal business office operations. Wherever Tenant requests in writing supplementary air-conditioning units within the Premises or whenever heat generating machines or equipment are used by Tenant in the Premises, which heat generating machines or equipment affect the temperature otherwise maintained by the air-cooling system, as mutually determined by Landlord and Tenant, Landlord shall install supplementary air conditioning units in the Premises and any mutually agreed to expense of such units and the installation thereof shall be paid by Tenant. The expense resulting from the operations and maintenance of the supplementary air conditioning system shall be paid by Tenant to Landlord as additional Rent at rates fixed by Landlord. (b) hot and cold water for use in lavatories Landlord installs for use in common with other tenants and hot and cold service shall be available to the Premises supplied from the municipal mains drawn through a line, meter and fixtures installed within the Premises by Tenant or as part of the Tenant Improvements with Landlord's consent. Tenant shall pay Landlord as additional Monthly Base Rent, at rates fixed by Landlord, charges for all water furnished to the Premises. (c) customary cleaning and janitorial services in the Premises consistent with the cleaning specifications set forth in Exhibit E-1, Monday through Friday, excluding national holidays. (d) automatic passenger elevator service in common with other tenants of the Building and freight elevator service subject to scheduling by Landlord. (e) window washing a minimum of two times per year. The term national holidays as used herein shall also include other holidays recognized by the Landlord and the janitor and other unions servicing the Building in accordance with their contracts.
- 3.2 Electricity: Landlord shall furnish electricity to the entire M.O.B. and to the Premises through separate meters. Landlord shall provide a demarcation point on the same floor as the Premises and Tenant shall have a control panel sufficient for data and telephone access. Landlord shall select, furnish and install all lamps, bulbs, ballast and starters used in the Premises unless Landlord is unable to respond in a timely manner to Tenant's request for replacement lamps, bulbs, ballasts and starters. Landlord shall not charge Tenant for lamps, bulbs, ballast and starters, or installation thereof, in excess of Landlord's cost thereof.
- 3.3 Termination of Additional Services for Non-Payment: In the event that by agreement with Tenant, Landlord furnishes extra or additional services to be paid for by Tenant, Tenant's failure to pay for such services within forty-five (45) days without further notice from Landlord, shall constitute a default hereunder and allow Landlord to discontinue such services and terminate any agreement for such services. The money due for such extra or

additional services shall be deemed additional rental due hereunder and the same shall be subject to all of the provisions pertaining to the payment of rental.

- 3.4 Interruption of Service: No interruption in, or temporary stoppage of, any of the aforesaid services caused by strikes, lockouts, labor controversies, accidents, inability to obtain fuel, supplies, materials, parts, or equipment or other causes beyond the reasonable control of Landlord shall be deemed an eviction or disturbance of Tenant's use and possession, or render Landlord liable for damages, by abatement of rent or otherwise, or relieve Tenant from any obligation herein set forth unless the same makes the Premises unusable for more than two consecutive days in which case all Rents shall abate for each day after the two days that the Premises is unusable. Tenant hereby releases all claims against Landlord for damages for interruption or stoppage of any of said services caused by the events or circumstances above unless caused by Landlord's failure to remedy a known problem, gross negligence or willful conduct. Landlord shall make all reasonable efforts to minimize the time of interruptions of any of the services provided to Tenant under the terms of this Lease and shall, in the event such interruption of services shall tend to make the Premises unusable for the ordinary purposes for which they are intended, use the utmost diligence including, without limitation, the use of overtime labor services so as to minimize such interruptions, provided that Landlord shall not be required to use or cause to be used overtime labor services in connection with the initial construction of the M.O.B. and improvements thereto. In the event Landlord is unable to cure the interruption of services which interruption is due to circumstances over which Landlord has control as opposed to circumstances over which Landlord has no ability to control, within thirty (30) days of initial interruption of services, Tenant may terminate this Lease upon written notice to Landlord within 10 days after the end of said thirty (30) day period.
- 3.5 Maintenance of Structural and Common Areas: Landlord shall keep the structural and common areas of the M.O.B. including without limitation, the heating and air conditioning systems and equipment, elevators, exterior, roof, entrances, hallways, stairways, corridors and parking areas in a good, safe, clean and well-maintained condition and in material compliance with all applicable laws, codes and ordinances, and shall furnish reasonable security to the common areas of the M.O.B. during non-office hours.
- 3.6 Right of Self-Help. If Landlord fails to provide any of the services that Landlord has agreed to provide to Tenant pursuant to this Lease and such failure continues for a period of five (5) business days following Tenant's written notice to Landlord of such failure, then Tenant shall have the right to unilaterally arrange for such services and shall withhold from rental payments due to Landlord an amount equal to the Tenant's cost of such services.
- 3.7 For the purposes of this Article III, the following words and phrases shall have the following meanings:
- A. "Operating Expense Deposit" means that sum estimated from time to time by the Landlord to be Tenant's proportionate share of the operating expenses attributed to any calendar year.
- B. "Operating Expenses" shall mean all costs, expenses and disbursements of every kind and nature which Landlord shall pay or become obligated to pay in connection with the management, operation, maintenance, and repair of the Real Property and of the

personal property, fixtures, machinery, equipment, systems and apparatus located in or used in connection with the Real Property, including without limitation:

The costs of common area electricity; water; fuel; heating; lighting; air conditioning; window cleaning; interior and exterior landscaping; snow removal; janitorial services; insurance (including fire, extended coverage, liability, workman's compensation, elevator or any other insurance) carried in good faith by the Landlord and applicable to the Real Property; painting; uniforms; customary management fees; supplies; sundries; sale or use tax on supplies or services; cost of wages and salaries of all persons engaged in the operation, maintenance and repair of the Real Property and so called "fringe benefits" (including but not limited to social security taxes, unemployment insurance taxes, cost for providing coverage for disability benefits, costs for any pensions, hospitalization, welfare and retirement plans, vacation or severance pay, or other similar or like expense incurred under the provisions of any collective bargaining agreement, or any costs or expenses which the Landlord pays or incurs to provide benefits to employees so engaged in the operation maintenance and repair of the Real Property); current amortization of capital improvements reasonably necessary for the operation and maintenance of the M.O.B.; replacements that do not constitute a capital expense under generally accepted accounting principles and current amortization of replacements that would constitute a capital expense under generally accepted accounting principles; the charges of any independent contractor, who under a contract with the Landlord, or its representatives, does any of the work of operating, maintaining or repairing of the Real Property; legal and accounting expenses or any other expense or charge, similar or dissimilar, whether or not heretofore mentioned, which in accordance with generally accepted management principles would be considered as an expense of maintaining, operating or repairing the Real Property or any personal property therein and Taxes as hereinafter defined.

Operating expenses shall not include the following: costs of improvement of the Premises and the premises of other tenants of the M.O.B.; charges for depreciation of the M.O.B.; interest and principal payments on mortgages and other financing costs; ground lease related payments; real estate brokerage and leasing commissions; expenses incurred in enforcing obligations of other tenants of the M.O.B.; any expenditures for which Landlord has been reimbursed (other than pursuant to rent adjustment and escalation provisions provided in leases); costs (including legal and other professional fees) of negotiating leases and capital improvements to the M.O.B. (except as provided above); costs of repairs or restoration necessitated by fire or other casualty or any condemnation; costs of any electric current furnished to areas of the M.O.B. occupied by tenants or purposes other than operation of M.O.B. equipment or machinery or the lighting of toilets, shaftways or M.O.B. machinery or fan rooms; compensation paid in respect of officers and executives of Landlord above the level of building manager; any cost stated in Operating Expense representing an amount paid to a Landlord-related corporation or entity which is in excess of the amount which would be paid in absence of such relationship; advertising and promotional expenses of the Building and any artwork or similar decoration in common areas; costs of correcting defects in the construction of the M.O.B. or in the M.O.B. equipment, except for conditions (not occasioned by construction or equipment defects) resulting from ordinary wear and tear shall not be deemed defects for the purpose of this category; costs of any repair made by Landlord to remedy damage caused by, or resulting from, the negligence or willful act or omissions of Landlord, its agents, servants, contractors or employees; costs of any additions to the Building; expenses incurred by Landlord in connection with the transfer or disposition of the Real Property or Building or any ground, underlying or overriding lease, including, without limitation, transfer, deed and

gains taxes. If any Real Property expense, though paid in one year relates to more than one calendar year, at the option of the Landlord, such expense may be proportionately allocated among such calendar years. Additionally, there shall be deducted from Operating Expenses all amounts received by Landlord through proceeds of insurance or condemnation awards to the extent they are compensation for, or reimbursement of, sums previously included in Operating Expenses hereunder.

"Taxes" shall mean all federal, state and local governmental taxes, assessments and charges (including transit or transit district taxes or assessments and the Illinois Personal Property Replacement Income Tax), of every kind or nature, whether general, special, ordinary or extraordinary, which Landlord shall pay or become obligated to pay because of or in connection with the ownership, leasing, management, control or operation of the Real Property, or of the personal property, fixtures, machinery, equipment, systems and apparatus located therein or used in connection therewith (including any rental or similar taxes levied in lieu of or in addition to general real and/or personal property taxes). For purposes hereof, Taxes for any year shall be Taxes which are due for payment or paid in that year, rather than Taxes which are assessed or become a lien during such year. There shall be included in Taxes for any year the amount of all fees, costs and expenses (including reasonable attorneys' fees) paid by Landlord during such year in seeking or obtaining any refund or reduction of Taxes. Taxes in any year shall be reduced by the net amount of any tax refund received by Landlord during such year. If a special assessment payable in installments is levied against the Real Property, Taxes for any year shall include only the installment of such assessment and any interest payable or paid during such year. Taxes shall not include any federal or state inheritance, general income, gift or estate taxes, franchise taxes, except that if a change occurs in the method of taxation resulting in whole or in part in the substitution of any such taxes, or any other assessment, for any Taxes as above defined, such substituted taxes or assessments shall be included in the Taxes and provided further, that the Illinois Personal Property Replacement Income Tax shall be included in Taxes.

- 3.8 Payment of Operating Expenses. Tenant shall pay to Landlord, as additional rent, Tenant's Proportionate Share of the Operating Expenses attributable to each calendar year during the Term as a Rent Adjustment for such calendar year. Tenant shall deposit with Landlord on the first day of each month during the Lease Term commencing with the first month in which the payment of rent commences as an Operating Expense Deposit, the sum of [REDACTED] of Tenant's estimated share of the Operating Expenses attributable to the current calendar year. The Operating Expense Deposit shall be credited against Tenant's share of the Operating Expenses due for that calendar year. During the last complete calendar year or during any partial calendar year in which the Lease terminates, Landlord may include in the Operating Expense Deposit its best estimate of Operating Expenses which may not be finally determined until after the termination of this Lease.

3.9 Statement of Landlord.

As soon as feasible after the expiration of each calendar year of this Lease, but in no event more than 365 days after the end of the applicable calendar year, Landlord will furnish Tenant a statement showing the following:

- (i) Operating Expenses for the then completed Calendar Year;

(ii) Tenant's Proportionate Share of said Operating Expenses, less credit for the Operating Expense Deposits if any; and

(iii) The amount of the new Operating Expense Deposit.

Tenant shall pay to Landlord the amount due in accordance with said statement within thirty (30) days after receipt of such statement, and the new Operating Expense Deposits shall be paid as provided in Section 3.7. No interest or penalties shall accrue on any amounts which Landlord is obligated to credit to Tenant by reason of any overdeposit. Any credit due Tenant shall be applied to Tenant's Operating Expense Deposits for the new calendar year.

3.10 Books and Records. Landlord shall maintain books and records showing Operating Expenses in accordance with sound accounting and management practices. The Tenant or its representative shall have the right to examine the Landlord's books and records on site or request copies of such books and records with respect to the items in the foregoing statement of Operating Expenses during normal business hours at any time within thirty (30) days following the furnishing by the Landlord to the Tenant of such statement. Unless the Tenant shall take written exception to any item within thirty (30) days after the furnishing of the foregoing statement, such statement shall be considered as final and accepted by the Tenant. Any amount due to the Landlord as shown on any such statement, whether or not written exception is taken thereto, shall be paid by the Tenant within thirty (30) days after the Landlord shall have submitted the statement, without prejudice to any such written exception.

ARTICLE IV - Rights Reserved by Landlord

4.1 Specific Rights Reserved by Landlord: Landlord reserves the following rights, exercisable without notice (except as provided below) and without liability to Tenant for damage or injury to property, person or business and without effecting an eviction, constructive or actual, or disturbance of Tenant's use or possession or giving rise to any claim for setoff or abatement of rent;

(a) **Name:** To change the M.O.B.'s name. In the event of a change in the M.O.B.'s name, Landlord shall notify Tenant in writing of such change not less than 60 days prior to such change; provided, however, that Landlord shall not change the name of M.O.B. to include the name of any hospital or health system other than Rush University Medical Center, without the consent of Tenant.

(b) **Signs:** To install, affix and maintain any and all signs and directories on the exterior and interior of the M.O.B. other than Tenant's exterior and interior signs. Anything contained in the Rules and Regulations to the contrary notwithstanding, Landlord hereby agrees that any Tenant signage, other than signage on the Building interior Directory, for which Landlord must first give prior written approval, which approval shall not be unreasonably withheld or delayed, as to size, location and installation method may include the Rush University Medical Center name and logo. Tenant shall submit drawings for the proposed signs and such other documentation as Landlord may request showing the proposed sign, sign materials, locations and means of installation for Landlord's review as part of the approval process. Landlord shall review such submission and provide notice to Tenant within ten (10) days of Tenant's submission (the "Notice Deadline"). Landlord's failure to object to the proposed signage on or prior to the Notice Deadline shall be deemed Landlord's approval thereof. Any exterior signage must also conform with all applicable

municipal laws. Tenant shall pay the cost of any signage for the Premises. Landlord hereby agrees that there will be no external signage or branding on the M.O.B for any tenant other than Landlord and Tenant, without Tenant's written consent.

- (c) Window Coverage: To designate and approve, prior to installation, all types of window shades, blinds, drapes, awnings, window ventilators and other similar equipment, and to control all internal lighting that may be visible from the exterior of the M.O.B.
- (d) Access: To show the Premises at reasonable hours, provided that Landlord shall provide Tenant with not less than 24 hour advance written notice to show the Premises and provided such showing does not interrupt or interfere with Tenant's business in the Premises.
- (e) Keys: At the commencement of the Lease, Landlord shall provide a set of keys to Tenant for the M.O.B. and the Premises. If additional sets are required, Landlord shall provide the same to Tenant, at Tenant's cost. Landlord shall retain at all times (except for keys to Tenant's safe and drug closets), and to use in appropriate instances, keys to all doors within and into the Premises. No locks shall be changed, except by Landlord and at Tenant's cost, and in the event of such change, Landlord shall retain a key to each lock so changed.
- (f) Alterations: To decorate or to make repairs, alterations, additions, or improvements, whether structural or otherwise, in or about the M.O.B., or any part thereof other than in the Premises, and for such purposes to enter upon the Premises, and, during the continuance of any of said work, to temporarily close doors, entryways, public spaces and corridors in the M.O.B. and to interrupt or temporarily suspend M.O.B. services and facilities, provided that Landlord shall diligently avoid interruption in Tenant's enjoyment of and access to the Premises to the extent reasonably possible. If such alterations do make the Premises unusable. Tenant's rent shall abate for each day the Premises is unusable.
- (g) Title: To have and retain a paramount title to the Premises free and clear of any act of Tenant.

- 4.2 Tenant Shall Not Interfere With Reserved Rights: Tenant shall not attempt to exercise any of the rights specifically reserved by Landlord or interfere in any way with the exercise of those rights by Landlord.

ARTICLE V - Landlord's Security

- 5.1 Security Deposit. As security for the full and prompt performance by Tenant of all of Tenant's obligations hereunder, Tenant has previously paid to Landlord the sum of [REDACTED] (the "Security Deposit"). Said sum maybe applied by Landlord for the purpose of curing any defaults of Tenant under this Lease in addition to any other rights and remedies available to Landlord. If Tenant has not defaulted hereunder or if Landlord has not applied the Security Deposit to said default during the first twelve (12) months after the payment of Rent commences, then the Security Deposit or any portion thereof not so applied by Landlord shall be refunded to Tenant . The Security Deposit cannot be applied against any monthly installment of rent unless expressly so elected by Landlord. The

Landlord may commingle the Security Deposit with any of its other funds. Upon request by Landlord, Tenant shall provide Landlord with a letter of net worth signed by an officer of Rush.

ARTICLE VI - Damages or Losses

- 6.1 **Waiver of Claims Against Landlord:** Except for the negligent or willful acts or omissions by Landlord or its agents, contractors or employees or from Landlord's failure to satisfy its obligations under this Lease, Tenant agrees, to the extent not expressly prohibited by law, that Landlord, its agents, employees and servants shall not be liable for, and Tenant waives all claims for, injury to person or damage to property sustained by Tenant in or on the M.O.B. or the Premises, resulting directly or indirectly from any existing or future condition, defect, matter or thing in the Premises, the M.O.B. or any part thereof or from equipment or appurtenances becoming out of repair or from accident, or from any occurrence or act, or omission of any tenant or occupant of the M.O.B., or of any other person. This Section 6.1 shall apply especially, but not exclusively, to damage caused as aforesaid or by the flooding of basements or other areas or by refrigerators, sprinkling devices, air conditioning apparatus, water, snow, frost, steam, excessive heat or cold, falling plaster, broken glass, sewage, gas, odors, or noise, or the bursting or leaking of pipes, plumbing fixtures, windows, walls or ceilings and shall apply equally whether any such damage results from the act or omission of other tenants or occupants in the M.O.B. or any other persons other than Landlord or its agents or employees, and whether such damage be caused by or result from any thing or circumstance whether of a like or wholly different nature. Tenant shall be solely responsible to Landlord and to other tenants in the M.O.B. to the extent proceeds are not available under Landlord's insurance coverage for any claims for injury to person or damage to property caused by the gross negligent or willful act or omission of Tenant, its agents, employees or servants provided that in no event shall Tenant be liable for any amount in excess of the insurance proceeds available to Tenant.
- 6.2 **Repair of Damages by Landlord:** If any damage to the Premises or the M.O.B. or any part thereof results from any negligent or willful act or omission of Tenant, its agents, employees or invitees, Landlord may, at Landlord's option, repair such damage and to the extent proceeds are not available under Landlord's insurance coverage. Tenant shall, upon demand by Landlord, reimburse Landlord forthwith for all costs of making such repairs, and the amount of such costs shall be deemed additional rent hereunder provided that in no event shall Tenant be liable for any amount in excess of the insurance proceeds available to Tenant.
- 6.3 **Tenant is Responsible for Tenant's Property:** Except for the negligent or willful acts or omissions by Landlord or its agents, contractors, or employees, all property in the M.O.B. or on the Premises belonging to Tenant, its agents, employees or invitees, or to any occupant of the Premises shall be at the risk of Tenant or such other person only, and Landlord shall not be liable for damage thereto or theft, misappropriation or loss thereof.
- 6.4 **Hold Harmless:** Except for the negligent or willful acts or omissions by Landlord or its agents, contractor or employees, from Landlord's failure to satisfy its obligations under this Lease, Tenant shall be liable for injuries to all persons and for damage to, or theft, misappropriation or loss of all property occurring in or about the Premises, (including, without limitation, medical malpractice claims relating thereto) due to any negligent or willful act or omission of Tenant, its agents, employees or invitees provided that in no

event shall Tenant be liable for any amount in excess of the insurance proceeds available to Tenant.

- 6.5 Damage by Fire or Other Casualty: If any part of the Premises or the M.O.B. is rendered untenantable by fire or other casualty Landlord may elect within sixty (60) days (the "Notice Date") of the date of the fire or casualty (the "Casualty Date") by notice to Tenant (a) to terminate this Lease as of the Casualty Date or (b) to repair, restore or rehabilitate the M.O.B. or the Premises at Landlord's expense, which repairs must commence within thirty (30) days of the Notice Date and which must be completed within no more than one hundred and eighty (180) days from the Casualty Date (the "Repair Deadline"), in which event this Lease shall not terminate but rent shall be abated on a per diem basis while the Premises are untenantable. If Landlord elects to repair, restore or rehabilitate the M.O.B. or the Premises, said work shall be undertaken and prosecuted with all due diligence and speed. If Landlord elects to repair, restore or rehabilitate the M.O.B. or the Premises and, in cases not due to act or neglect of the Tenant, does not substantially complete the work by the Repair Deadline, except as to Tenant so long as such delay is due to no action of Tenant, either party can terminate this Lease as of the date of such fire or casualty by notice to the other party not later than thirty (30) days after the Repair Deadline. In the event of termination of the Lease pursuant to this Article, rent shall be apportioned on a per diem basis and paid to the Casualty Date. Landlord shall elect clause (b) unless the damage is substantial or there is less than 1 year remaining in the term of this Lease.

6.6 Insurance:

- (a) Tenant shall, throughout the term of this Lease and at Tenant's expense, carry and keep in full force and effect through its self-insurance policy (i) malpractice insurance for Tenant and all professional staff employed or contracted by Tenant, in such amounts as required by Tenant for staff privileges from time to time; (ii) commercial general liability insurance, including contractual liability coverage, with respect to the Premises, which policy or policies (A) shall have limits of [REDACTED] per occurrence Personal Injury and [REDACTED] Property Damage, or [REDACTED] per occurrence Personal Injury and Property Damage Combined Single Limit; (B) name Landlord as additional insured when permissible; (C) shall contain a clause that the insurance carrier will not cancel or materially change the insurance without first giving the Landlord thirty (30) days prior written notice; and (iii) fire, theft, and extended perils insurance covering Tenant's own property.
 - (b) Tenant shall obtain and deliver to Landlord prior to commencement of the Term hereof, and shall maintain with Landlord at all times during such Term, current certificates evidencing full compliance with the provisions of this Section 6.6.
 - (c) Landlord shall maintain at all times during the Term, insurance protecting the M.O.B. against risks of fire and extended coverage and shall carry public liability insurance in amounts then reasonable and customary for owners of multi-story office buildings similar to the M.O.B.
- 6.7 Waiver of Subrogation: Landlord and Tenant hereto waive any right of subrogation against the other under any insurance policy insofar as they are able under such policies issued by their respective carriers.

ARTICLE VII - Access to the Premises

- 7.1 **Surrender Upon Termination of Lease:** Upon any termination of this Lease, by expiration, lapse of time or otherwise, or upon any termination of Tenant's right to possession of the Premises:
- (a) **Vacate Immediately:** Tenant shall immediately vacate the Premises and surrender the Premises in good order, condition and repair, reasonable wear and tear excepted.
 - (b) **Keys:** Tenant shall surrender all keys of the Premises to Landlord.
 - (c) **License to Enter:** Tenant grants to Landlord full authority and license to enter the Premises and take possession thereof.
 - (d) **Ownership of Certain Items:** All non-removable additions, partitions, hardware, light fixtures, fixtures and improvements, specifically excluding moveable furniture, trade fixtures, medical/other equipment and personal property belonging to Tenant, in or upon the Premises, whether placed there by Tenant or Landlord, shall be Landlord's property and shall remain upon the Premises, all without compensation, allowance or credit to Tenant.
 - (e) **Property Abandoned:** All trade fixtures, movable furniture, equipment and other personal property not removed from the Premises prior to the expiration of the Term shall be conclusively presumed to have been abandoned by Tenant, and title thereto shall pass to Landlord under this Lease as by a bill of sale, without further payment or credit by Landlord to Tenant, and Landlord may remove the same, and Tenant shall pay the cost of such removal to Landlord upon demand, provided that Tenant shall not be obligated to pay such cost of removal unless Landlord has notified Tenant of Landlord's intention to remove at Tenant's expense no later than the last of (i) five business days after Tenant requests this information from Landlord, or (ii) five business days after the termination of Tenant's right to possession of the Premises.
- 7.2 **Payment During Hold-Over:** Tenant shall pay Landlord for each day Tenant retains possession of the Premises or any part thereof, after termination of the Term by expiration of time or otherwise, [REDACTED] of the amount of the daily Rent for the last period prior to the date of such termination and also pay all out of pocket damages sustained by Landlord by reason of such retention. Nothing in this Article contained, however, shall be construed as a waiver of Landlord's right of re-entry or any other right nor give Tenant any right to holdover.
- 7.3 **Access to the Premises During Lease:** Tenant shall permit Landlord at any time to inspect, erect, use and maintain, pipes, ducts, conduits and similar devices in and through the Premises, and to make any necessary repairs or alterations. Landlord shall be allowed to take all material into and upon the Premises that may be required therefor without the same constituting an eviction of Tenant in whole or in part and the rent reserved shall in no way abate while said repairs and maintenance are being made by reason of loss or interruption of business of Tenant or otherwise. If Tenant shall not be personally present to open and

permit an entry into the Premises, at any time, when for any reason an entry therein shall be necessary or permissible, Landlord or Landlord's agents may enter the same by a master key, or may forcibly enter the same, without rendering Landlord or such agents liable therefor (if during such entry Landlord or Landlord's agents shall accord reasonable care to Tenant's property), and without in any manner affecting the obligations and covenants of this Lease. Nothing contained in this Section, however, shall be deemed or construed to impose upon Landlord any obligations, responsibility or liability whatsoever, for the care, supervision or repair of the M.O.B. or any part thereof. Landlord shall also have the right at any time, without the same constituting an actual or constructive eviction and without incurring any liability to Tenant therefor, to change the arrangement and location of entrances, passageways, doors, doorways, elevators, stairs, toilets or other public parts of the M.O.B. Landlord agrees to diligently perform any such work so as to minimize any interference with Tenant's operations. Other than instances of an emergency nature, Landlord agrees to give Tenant not less than 48 hours notice of any work to be performed with the Premises.

ARTICLE VIII - Eminent Domain

- 8.1 **Taking of the Premises:** In the event that the whole or any substantial part of the Premises shall be lawfully condemned or taken in any manner for any public or quasi-public use, this Lease shall forthwith cease and terminate on the date of the taking of possession by the condemning authority and Landlord shall be entitled to receive the entire award for the Premises without any payment to Tenant, provided that Tenant shall be entitled to pursue and receive any award granted specifically to Tenant by the court for the taking of Tenant's leasehold estate and/or property not in derogation of the award Landlord would otherwise receive.
- 8.2 **Taking of the M.O.B.:** In the event that a part of the M.O.B. other than the Premises shall be so condemned or taken and, if in the opinion of the Landlord or Tenant, the M.O.B. should be restored in such a way as to alter the Premises materially, Landlord or Tenant, may terminate this lease without compensation to lessee by notifying the other party of such termination within sixty (60) days following the date of the taking of possession by the condemning authority, such termination to be effective on the date specified in the notice of termination which in no event shall be less than sixty (60) days of such notice, and after the giving the Base Rent and any other amounts payable hereunder shall be apportioned as of such termination date.
- 8.3 **Waiver of Claim Against Landlord:** In the event this Lease shall be terminated under the provisions of this Article, Tenant shall have no claim against Landlord for the value of any unexpired term.

ARTICLE IX - Estoppel Certificate

Tenant agrees that from time to time, upon not less than ten (10) business days prior written request by Landlord, Tenant will deliver to Landlord a statement in writing certifying (a) that this Lease is unmodified and in full force and effect (or if there have been modifications that the Lease as modified is in full force and effect and stating the modifications); (b) the dates to which the rent and other charges have been paid; and (c) that to the knowledge of the person signing the

statement on Tenant's behalf, Landlord is not in default under any provision of this Lease or, if in default, the nature thereof in detail.

ARTICLE X - Rights and Remedies of Landlord

- 10.1 **In Addition to Other Rights:** All rights and remedies given to Landlord in this Lease shall be cumulative and shall be in addition to all other rights and remedies allowed Landlord by law or equity.
- 10.2 **Bankruptcy:** If any voluntary or involuntary petition or similar pleading under any section or sections of any bankruptcy act shall be filed by or against Tenant (and if involuntary, is not dismissed within 90 days), or any voluntary or involuntary proceeding in any court or tribunal shall be instituted to declare Tenant insolvent or unable to pay Tenant's debts (and if involuntary, is not dismissed within 90 days), or Tenant makes an assignment for the benefit of its creditors, or a trustee or receiver is appointed for Tenant or for any substantial part of Tenant's property, then and in any such event, Landlord may, if lessor so elects but not otherwise, and with thirty (30) days notice of such election, and with or without entry or other action by Landlord, forthwith terminate this Lease, and, notwithstanding any other provision of this Lease, Landlord shall upon such termination be entitled to recover such damages as Landlord may have or will suffer as a result of such termination.
- 10.3 **Default in Payment or Performance:** If (i) Tenant defaults in the payment when due of Base Rent, Additional Rent or any other payment to be made by Tenant hereunder and Tenant fails to cure such default within ten (10) business days following Tenant's receipt of written notice thereof from Landlord (all of such payments to be treated as Additional Rent hereunder); or (ii) Tenant defaults in the performance or observance of any other provision of this Lease and Tenant fails to cure such default within thirty (30) days following Tenant's receipt of written notice thereof from Landlord; provided that if such default can be cured, and Tenant has commenced cure within such 30 day period, Tenant may have up to an additional 60 days to fully cure such default so long as Tenant diligently pursues such cure; or (iii) the leasehold interest of Tenant be levied upon under execution or attached by process of law; then and in any such event, Landlord if it so elects, with notice or demand, forthwith, either may terminate Tenant's right to possession without terminating this Lease, or may terminate this Lease and exercise all rights and remedies of Landlord to collect amounts due from Tenant as permitted by Law.
- 10.4 **License to Enter:** Upon any termination of this Lease, whether by lapse of time or otherwise, or upon any termination of Tenant's right of possession without termination of the Lease, Tenant shall surrender possession and vacate the Premises immediately, and deliver possession thereof to Landlord, and hereby grants to Landlord full and free license to enter into and upon the Premises in such event with process of law and to repossess the Premises and to expel or remove from possession Tenant and any others who may be occupying or within the Premises and to remove any and all property therefrom, without being deemed in any manner guilty of trespass, eviction, forcible entry or detainer, or conversion of property, and without relinquishing Landlord's rights to rent or any other right given to Landlord hereunder or by operation of law.
- 10.5 **Termination of Right to Possession Only:** If Tenant abandons or vacates the Premises or if Landlord has the right to elect, and does elect, under the foregoing provisions to terminate

Tenant's right to possession only, Landlord may enter into the Premises, remove Tenant's signs and other evidences of tenancy, and take and hold possession thereof as in Section 10.4 provided, without such entry and possession terminating the Lease or releasing Tenant. Landlord shall not be required to accept any tenant offered by Tenant or to observe any instructions given by Tenant about such reletting. In any such case, Landlord may make repairs, alterations and additions in or to the Premises, and redecorate the same to the extent reasonably necessary or desirable, and Tenant shall, upon demand, pay the cost thereof, together with Landlord's expenses of the reletting. If the consideration collected by Landlord upon any such reletting for Tenant's account is not sufficient to pay the full amount of the Base Rent for the Term, together with the cost of repairs, alterations, additions, redecorating and Landlord's expenses, Tenant shall pay to Landlord the amount of each deficiency upon demand and, if the consideration so collected from any such reletting is more than sufficient to pay said full amount of the Base Rent and any Additional Rent, together with the costs and expenses of Landlord, Landlord, at the end of the Term, shall account for the surplus to Tenant. Notwithstanding anything contained herein to the contrary, if Tenant abandons the Premises Landlord shall be obligated to mitigate Landlord's damages by exercising reasonable diligence to procure a new tenant for the Premises; provided, however, that such obligation to mitigate shall not toll or otherwise limit Landlord's right to exercise its rights and remedies under this Lease.

- 10.6 Costs of Enforcement and Litigation. In the event that either party shall file suit to enforce any of the provisions of this Lease, each party shall pay its own costs, charges and expenses, including attorneys' fees and court costs and experts .
- 10.7 Injunctive Relief. If Tenant violates any of the terms and provisions of this Lease, or defaults in any of its obligations hereunder, other than the payment of Base Rent or other sums payable hereunder, such violation may be restrained or such obligation enforced by injunction, which remedy shall be in addition to all other rights and remedies available to Landlord.

ARTICLE XI - Subordination

- 11.1 Mortgage: Landlord may encumber the Land or the M.O.B. with a mortgage or mortgages or otherwise bind the M.O.B. as security for the payment of existing or future obligations of Landlord. At the option of Landlord, Tenant's tenancy hereunder is and shall always be subject and subordinate to any such mortgage, trust deed, deed of trust or other lien voluntarily created or granted by Landlord, provided that Tenant's possession of the Premises shall not be disturbed unless Tenant is in default under any of the terms of this Lease beyond the expiration of all applicable cure periods under this Lease, or Landlord would otherwise have the right to dispossess Tenant. Tenant agrees to execute and deliver upon demand such further instrument or instruments in a form reasonably acceptable to Tenant so subordinating this Lease to any such liens or encumbrances as shall be desired by Landlord, Landlord's mortgagee, or their respective successors and assigns. Landlord agrees that upon the written request of Tenant, Landlord shall request the holder of any such mortgage to grant Tenant a "nondisturbance agreement" in the form usually provided by such holder and reasonably acceptable to Tenant.
- 11.2 Attornment: In the event of a foreclosure of any such mortgage or other lien, or other transfer of the M.O.B. in lieu thereof, Tenant shall attorn to the mortgagee or lien holder or their respective successors in interest upon demand.

11.3 Modification of This Lease: Intentionally deleted.

ARTICLE X11 – Notices

12.1 Notices to Tenant: All notices shall be in writing. They shall be effectively served by to the following address or such other address as a party may so direct:

If to Tenant: Rush University Medical Center
1725 West Harrison Street
Suite 364
Chicago, IL 60612
Attn: CEO

With a copies to: Office of Legal Affairs
Rush University Medical Center
1700 West Van Buren Street, Suite 301
Chicago, IL 60612
Attn: General Counsel

and

Leasing and Tenant Relations
Rush University Medical Center
1725 West Harrison, Suite 229
Chicago, IL 60612

If to Landlord: Chief Operating Officer
DuPage Medical Group
1100 31st Street – Suite 300
Downers Grove, IL 60515

With copy to: Murray J. Lewison
Johnson and Colmar
2201 Waukegan Road – Suite 260
Bannockburn, IL 60015

in any one of the following manners:

- (a) By hand delivery to Tenant (including without limitation delivery by messenger or courier, with evidence of receipt) ,
- (b) When delivered by overnight carrier; or
- (c) By forwarding through Certified or Registered Mail, postage prepaid, return receipt requested, in which case two business days after the time of mailing shall be the time of notice.

ARTICLE XIII Miscellaneous

- 13.1 Receipt of Money: No receipt of money by Landlord from Tenant after the termination of this Lease or after the commencement of any suit, or after final judgment for possession of the Premises shall reinstate, continue or extend the Term or affect any such notice, demand or suit.
- 13.2 Real Estate Broker: Tenant represents and warrants to Landlord that Tenant has dealt directly with Landlord (and only with Landlord) in connection with this Lease, and that no broker has negotiated or participated in the negotiations of this Lease or submitted or showed the Premises or is entitled to any commission in connection therewith. No recognition of such brokerage herein shall in anywise be construed by any judge or court as in anywise vesting in said broker any right to participate in the rents as such or give said broker any lien or charge upon the rents growing due hereunder at any time.
- 13.3 No Waivers By Implication: No waiver of any default of Tenant hereunder shall be implied from any omission by Landlord to take any action on account of such default if such default persists or be repeated, and no express waiver shall affect any default other than the default specified in the express waiver and that only for the time and to the extent therein stated.
- 13.4 Severability: The invalidity or unenforceability of any provision hereof shall not affect or impair any other provision.
- 13.5 No Options to Lease: Submission of this instrument for examination does not constitute a reservation of or option for the Premises. The instrument becomes effective as a Lease upon execution and delivery by both Landlord and Tenant.
- 13.6 Interest on Unpaid Amounts: All amounts, other than Base Rent and Additional Rent payable as provided for herein, owed by Tenant to Landlord hereunder shall be paid no later than thirty (30) days from the date of receipt of Landlord's statements of account therefor and such amounts of Base Rent, Additional Rent and all amounts for Tenant Chargeable Services shall bear interest at the rate of [REDACTED] computed daily from the due date of each obligation.
- 13.7 Captions: The captions contained in this Lease are for convenience only and are not intended to limit or define the scope or effect of any provisions of this Lease.
- 13.8 Binding on Successors: Subject to Section 1.11 of this Lease, each provision hereof shall extend to and shall, as the case may require, bind and inure to the benefit of Landlord and Tenant and their respective heirs, legal representatives, successors and assigns.
- 13.9 Occupancy Other Than During Term: It is hereby agreed that, except for the access granted to Tenant under this Lease or as expressly agreed otherwise in writing, any use or occupancy of the Premises by Tenant other than during the Term hereof shall be subject to all of the provisions of this Lease, provided, however, that Tenant shall not be required to pay Base Rent and Additional Rent during such non-term use or occupancy. In the event Landlord in delivering possession of the Premises on a turnkey basis, Landlord shall give Tenant access to the Premises at least 30 days prior to the Commencement Date so that Tenant may complete Tenant Made Improvements so long as Tenant's installations do not interfere with Landlord's Work.

13.10 Entire Agreement: This Lease contains the entire agreement of the parties and there are, and were, no verbal representations, understandings, stipulations, agreements or promises pertaining to this Lease that are not incorporated in this Lease. This Lease supersedes and replaces the Letter of Intent, if any, previously entered into between Landlord and Tenant which agreement shall be of no further force and effect after full execution and delivery hereof. This Lease may not be altered, waived, amended or extended except by an instrument in writing, signed by both Landlord and Tenant.

[Signature page follows.]

IN WITNESS WHEREOF, Landlord and Tenant have hereunto executed this lease as of the day and year first above written.

LANDLORD:

DuPage Medical Group, Ltd.

By: 

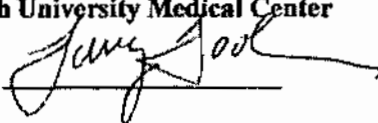
Name: Dennis Fine

Title: Chief Operating Officer

Date: 10/12/11

TENANT:

Rush University Medical Center

By: 

Name: Larry J. Goodman, M.D.

Title: Chief Executive Officer

Date: 10-12-11

SECTION I – IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Operating Identity/Licensee

This particular subsection of the application is not applicable as the Medical Office Building itself is not subject to licensure, nor are any of the services provided at the location. The various medical services will either be provided by licensed physicians or, in the case of the Chemotherapy and Infusion Medical Services provided by Rush University Medical Center, a hospital off-site location, is outside of Illinois Hospital licensure jurisdiction. According to the Hospital Licensing Act (210 ILCS 85) off-campus locations do not fall within the definition of "hospital." Therefore, there is no licensee for this project.

Upon advice of the IHFSRB staff, however, the applicants have included the relevant information. As such, this Attachment includes:

- Illinois Certificate of Good Standing for DuPage Medical Group, Ltd.
- Illinois Certificate of Good Standing for Rush University Medical Center

The shares of DuPage Medical Group, Ltd. are held in equal amounts by over 200 Physician shareholders. Therefore, there is no person with 5% interest or greater in that corporation.



To all to whom these Presents Shall Come, Greeting:

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

DU PAGE MEDICAL GROUP, LTD., A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JULY 22, 1968, 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 IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1212401698

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 3RD
day of MAY A.D. 2012*

Jesse White

SECRETARY OF STATE

File Number 0200-214-1



To all to whom these Presents Shall Come, Greeting:

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

RUSH UNIVERSITY MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON JULY 21, 1883, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1134800458

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 15TH
day of DECEMBER A.D. 2011*

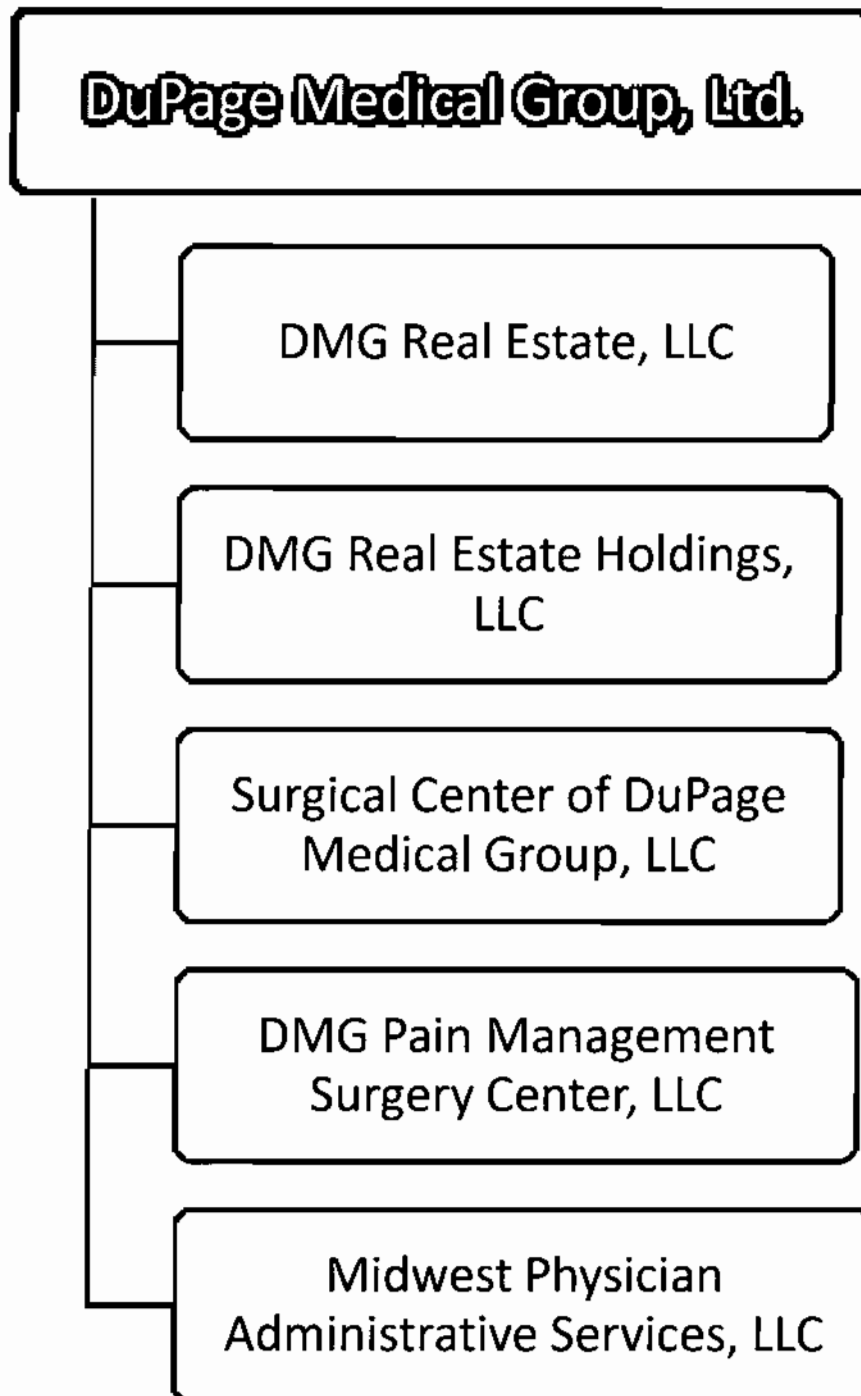
Jesse White

SECRETARY OF STATE

SECTION I – IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Organizational Relationships

Organizational Chart for DuPage Medical Group, Ltd.



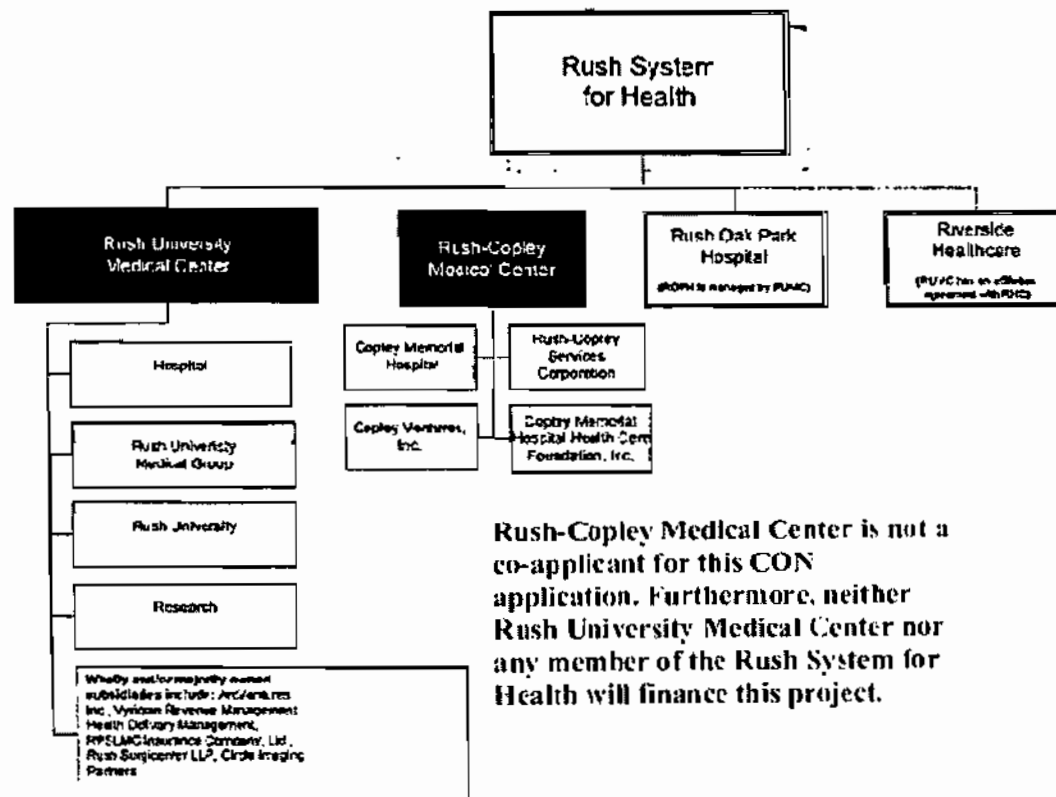
Explanation of DuPage Medical Group, Ltd. Organizational Chart

DuPage Medical Group, Ltd. wholly owns all subsidiary LLCs listed above. Those of particular note include:

- DMG Real Estate, LLC is the owner of the site at 430 Warrenville Rd., Lisle, IL 60532.
- Surgical Center of DuPage Medical Group, LLC is the legal name for the applicant that received a CON to open an Ambulatory Surgical Treatment Center in Lombard. (See Attachment 11).
- DMG Pain Management Surgery Center, LLC is the legal name for the applicant that received a CON to open an Ambulatory Surgical Treatment Center in Naperville. (See Attachment 11).

Organizational Chart for Rush System for Health

Rush System for Health Organizational Chart



Rush-Copley Medical Center is not a co-applicant for this CON application. Furthermore, neither Rush University Medical Center nor any member of the Rush System for Health will finance this project.

Dark boxes indicate members of the obligated group.

Explanation of Rush University Medical Center Organizational Chart

The organizational chart above is for Rush System for Health, a not-for-profit Illinois corporation and includes Rush University Medical Center, which is the co-applicant. Rush System for Health does not have any of the following rights or powers with respect to RUMC:

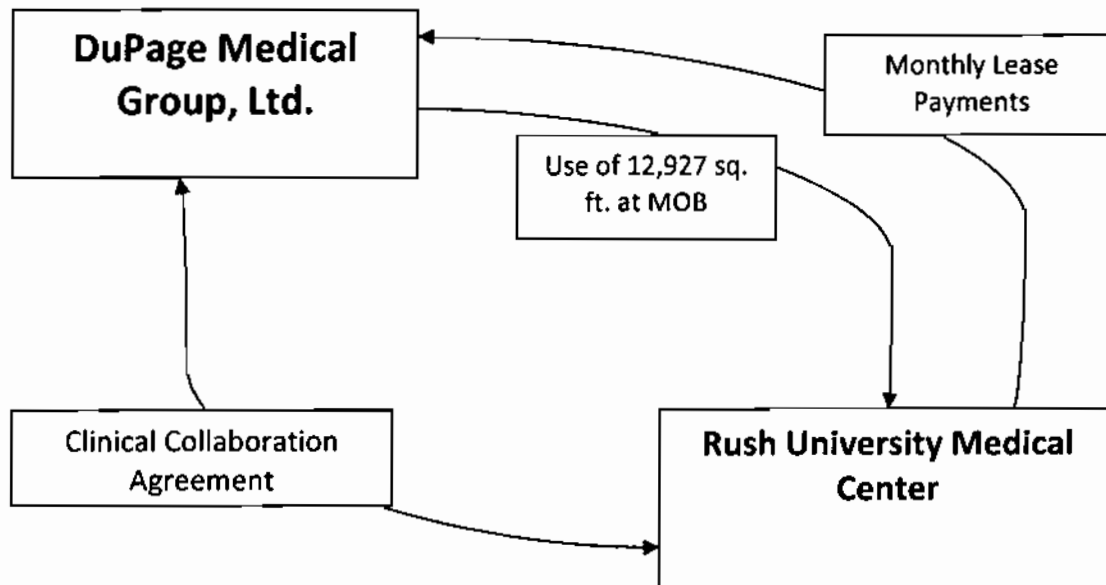
- approve and remove a controlling portion of an organization
- approve the use of funds or assets
- approve, amend, or modify the by-laws or other rules of governance

Furthermore, it should be noted that:

- Rush Oak Park Hospital is operated by RUMC.
- Riverside Healthcare has an affiliation with RUMC.
- Neither Rush System for Health, Rush-Copley Medical Center, Rush Oak Park Hospital, or Riverside Healthcare meets the test for co-applicancy.

Structure of Relationship between DMG and Rush

DuPage Medical Group, Ltd. and Rush University Medical Center have entered into a landlord-tenant relationship with respect to a portion of DMG Medical Office Building in Lisle. (See Attachment 2 for a copy of the lease). They have also entered into a Clinical Collaboration Agreement, which is designed to break down operational and clinical barriers between DMG and Rush physicians in order to maximize beneficial patient outcomes. This agreement is entirely separate from the DuPage Medical Group MOB.



SECTION I – IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Flood Plain Requirements

This project complies with Illinois Executive Order #2005-5 in that the building under construction is not located in a flood plain.

Please find included with this Attachment:

- A statement attesting that the project complies with the requirements of Illinois Executive Order #2005-5
- A Flood Plain map generated using FEMA's flood map generator for 430 Warrenville Rd. Lisle, IL 60532

May 25, 2012

Dale Galassie, Chairman
Illinois Health Facilities and Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

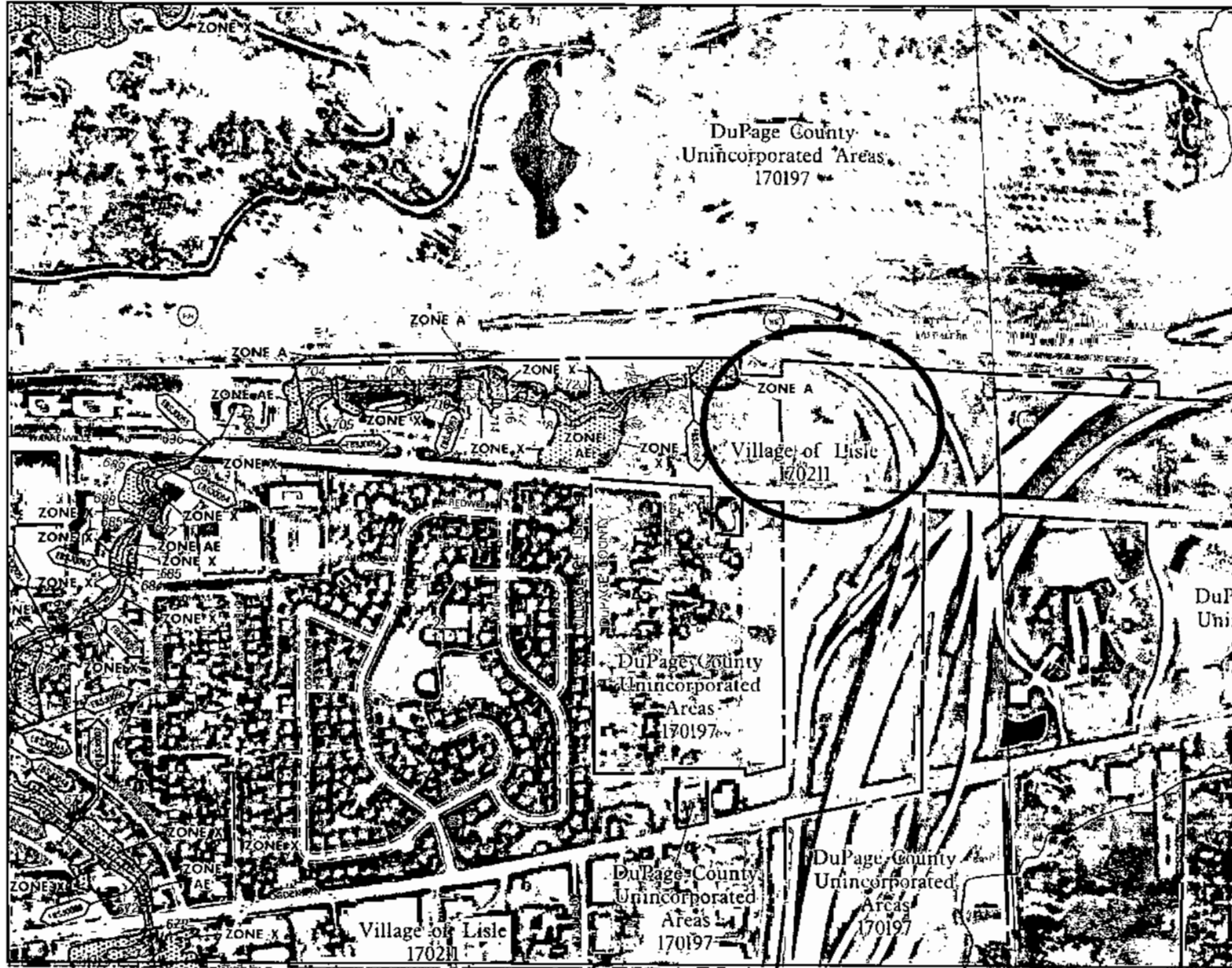
Dear Chairman Galassie,

I hereby certify and attest that the Medical Office Building owned by DuPage Medical Group at 430 Warrenville Rd. in Lisle, IL is not located in a special flood hazard area.

Sincerely,



Dennis Fine, COO
DuPage Medical Group



MAP SCALE 1" = 500'

250 0 500 1000 FEET

NFP

PANEL 0803H

FIRM
FLOOD INSURANCE RATE MAP
DuPAGE COUNTY,
ILLINOIS
AND INCORPORATED AREAS

PANEL 0803 OF 1008
(SEE MAP INDEX FOR FIRM PANEL LAYOUT)

CONTAINS	NUMBER	PANEL	SHEET
CONTAINS ABOVE, ALIAS OF	170197	0803	1
DUPAGE COUNTY	170197	0803	1
LISLE VILLAGE OF	170211	0803	1

Map Number 17043C0803H
EFFECTIVE DATE
DECEMBER 15, 2004

Federal Emergency Management Agency

This is an official copy of a portion of the above referenced Flood map. It was extracted using FIRM On-Line. This map does not reflect changes or amendments which may have been made subsequent to the date on the 15th block. For the latest product information about National Flood Insurance Program Flood maps, check the FEMA Flood Map Store at www.msc.fema.gov.

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SECTION I – IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Historic Resources Act Preservation Requirements

Please find included here a copy of a letter from Anne Haaker, Deputy State Historic Preservation Officer, that no significant historical, architectural, or archeological resources are located within the project area.



Illinois Historic Preservation Agency

1 Old State Capitol Plaza • Springfield, Illinois 62701-1512 • www.illinois-history.gov

DuPage County
Lisle

PLEASE REFER TO: IHPA LOG #003050412

430 Warrenville Road
Section:2-Township:38N-Range:10E
IHFSRB
New construction, DMG Medical Office Building

May 10, 2012

Matthew Dunne
Murer Consultants, Inc.
58 North Chicago Street, 7th Floor
Joliet, IL 60432

Dear Mr. Dunne:

The Illinois Historic Preservation Agency is required by the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420, as amended, 17 IAC 4180) to review all state funded, permitted or licensed undertakings for their effect on cultural resources. Pursuant to this, we have received information regarding the referenced project for our comment.

Our staff has reviewed the specifications under the state law and assessed the impact of the project as submitted by your office. We have determined, based on the available information, that no significant historic, architectural or archaeological resources are located within the proposed project area.

According to the information you have provided concerning your proposed project, apparently there is no federal involvement in your project. However, please note that the state law is less restrictive than the federal cultural resource laws concerning archaeology. If your project will use federal loans or grants, need federal agency permits, use federal property, or involve assistance from a federal agency, then your project must be reviewed under the National Historic Preservation Act of 1966, as amended. Please notify us immediately if such is the case.

This clearance remains in effect for two (2) years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the IL Human Skeletal Remains Protection Act (20 ILCS 3440).

Please retain this letter in your files as evidence of compliance with the Illinois State Agency Historic Resources Preservation Act.

Sincerely,

Anne E. Haaker

Anne E. Haaker
Deputy State Historic
Preservation Officer

SECTION I – IDENTIFICATION, GENERAL INFORMATION AND CERTIFICATION

Project Cost and Source of Funds

USE OF FUNDS

Table 1: Use of Funds

USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$7,868.54	\$12,471.46	\$20,340.00
Site Survey and Soil Investigation	\$23,501.16	\$37,248.84	\$60,750.00
Site Preparation	\$198,020.60	\$313,858.40	\$511,879.00
Off Site Work			\$0
New Construction Contracts	\$10,461,790.01	\$16,581,711.99	\$27,043,502.00 (Includes linac build-out)
Modernization Contracts			N/A
Contingencies	\$235,165.59	\$372,732.41	\$607,898.00
Architectural/Engineering Fees	\$722,988.61	\$1,145,921.39	\$1,868,910.00
Consulting and Other Fees	\$415,610.84	\$658,734.23	\$1,074,345.07
Movable or Other Equipment (not in construction contracts)	\$2,862,172.00	\$0.00	\$2,862,172.00
Bond Issuance Expense (project related)			N/A
Net Interest Expense During Construction (project related)	\$85,107.09	\$134,892.91	\$220,000.00 (Interest Reserve)
Fair Market Value of Leased Space or Equipment			N/A
Other Costs to Be Capitalized	\$1,138,457.01	\$2,089,725.99	\$3,408,183.00
Acquisition of Building or Other Property (excluding land)	\$696,330.75	\$1,103,669.25	\$1,800,000.00
TOTAL USES OF FUNDS	\$16,562,456.31	\$21,714,655.76	\$39,477,979.07

Table 2: Preplanning Costs Itemized

Item	Total Cost
Feasibility and Planning Work	\$15,440
Other Engineering Due Diligence	\$4,900
TOTAL	\$20,340

Table 3: Site Survey and Soil Investigation Itemized

Item	Total Cost
Soils Report (Architect and Engineer)	\$7,250
Alta Survey (Architect and Engineer)	\$3,500
Survey and Layout (Leopardo Construction)	\$50,000
TOTAL	\$60,750

Table 4: Consulting and Other Fees Itemized

Item	Total Cost
Construction Management Fee	\$300,000
Permits and Other Fees	\$750,000
Construction Consultant Front End	\$4,000
Construction Consultant Monthly	\$9,600
Bank of America Appraisal Fee	\$6,500
Wheaton Bank and Trust Co. Appraisal Fee	\$350
Bank of America Environmental Review Fee	\$360
Survey	\$3,535.07
TOTAL	\$1,074,345.07

Table 5: Movable or Other Equipment Itemized

Item	Total Cost
Linear Accelerator (Purchase Price)	\$2,862,172
TOTAL	\$2,862,172

Table 6: Acquisition of Building or Other Property Itemized

Item	Total Cost
Furniture and Fixtures	\$1,500,000
IT, Phones & Infrastructure	\$300,000
TOTAL	\$1,800,000

Table 7: Other Costs to be Capitalized Itemized

Item	Total Cost
Land Acquisition	\$3,267,178
Loan Fee	\$77,000
Bank Attorney	\$40,000
Title Company and Recording	\$15,905
Escrow Agent Draw and Wire Fee (12 months)	\$8,100
TOTAL	\$3,408,183

SOURCE OF FUNDS

Table 8: Source of Funds

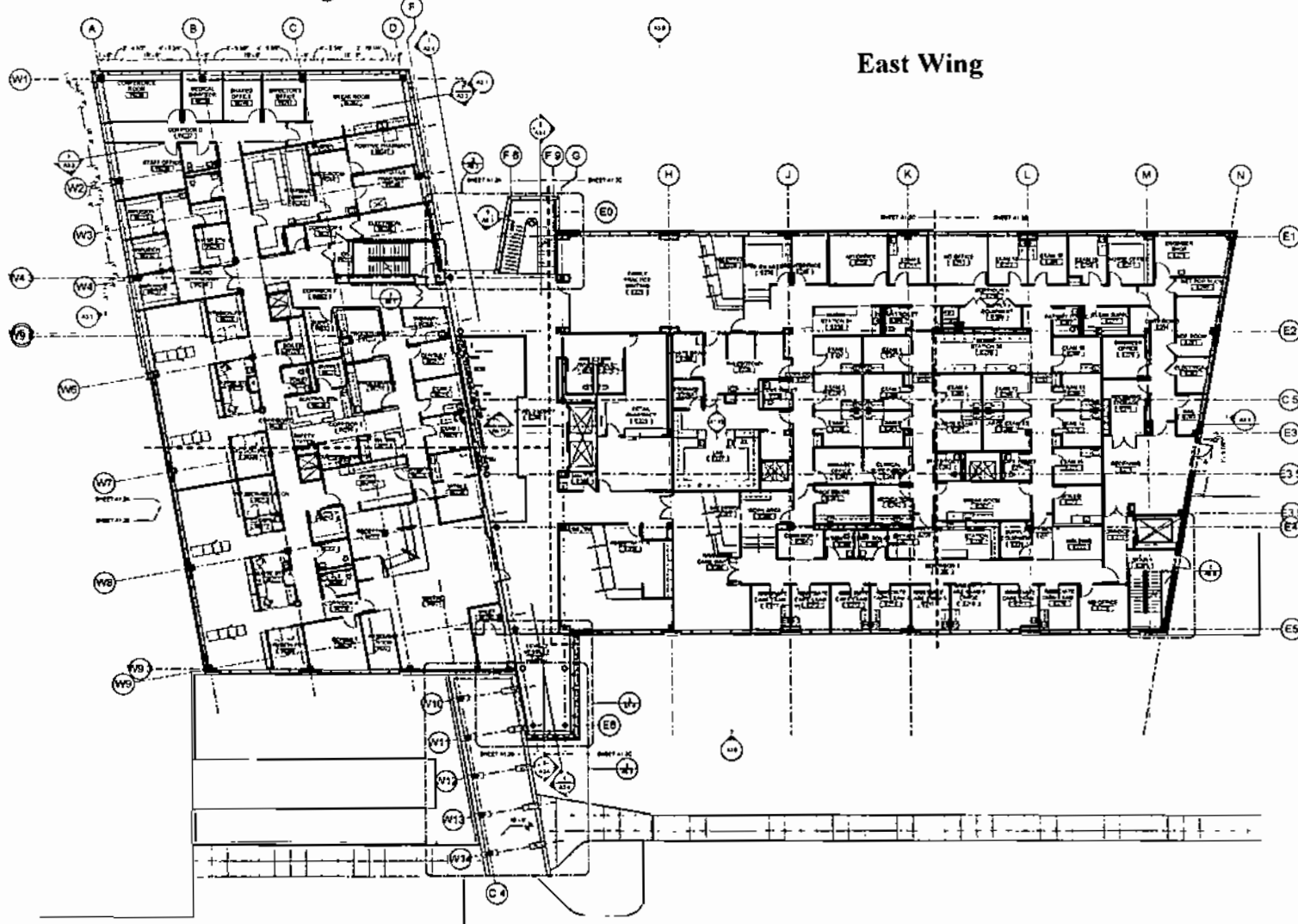
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$6,761,363.48	\$10,716,615.59	\$17,477,979.07
Pledges			N/A
Gifts and Bequests			N/A
Bond Issues (project related)			N/A
Mortgages	\$8,510,709.16	\$13,489,290.84	\$22,000,000.00
Leases (Fair market value)			N/A
Governmental Appropriations			N/A
Grants			N/A
Other Funds and Sources			N/A
TOTAL SOURCES OF FUNDS	\$15,272,072.64	\$24,205,906.43	\$39,477,979.07

SECTION I – IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Project Status and Completion Schedules

Please find included with this attachment a copy of the final working architectural drawings for the DuPage Medical Group's Medical Office Building at 430 Warrenville Rd. Lisle, IL 60532.

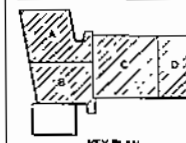
East Wing



PLAN NOTES

- [illegible]

KEYNOTES ©

[illegible]

- | | | |
|----|------------|----------------------------------|
| 4. | 30-75-2251 | Issued for Strategic Development |
| 3. | 30-75-2251 | Issued for Strategic Development |
| 2. | 30-75-2251 | Issued for Strategic Development |
| 1. | 30-75-2251 | Issued for Strategic Development |
- Title: _____
 Date: _____
 Issue: _____
- 
- [EVEN MORE BOUNDERS AROMATICS]
- 700 South Center Ave. #300 Chicago IL 60607
 (773) 462-1234 F
 (773) 462-1234 F
- © 1997 All rights reserved.

**Lisle Medical Office
Building
DuPage Medical Group**

450 Wapenerville Road, Suite 1000 • 90552

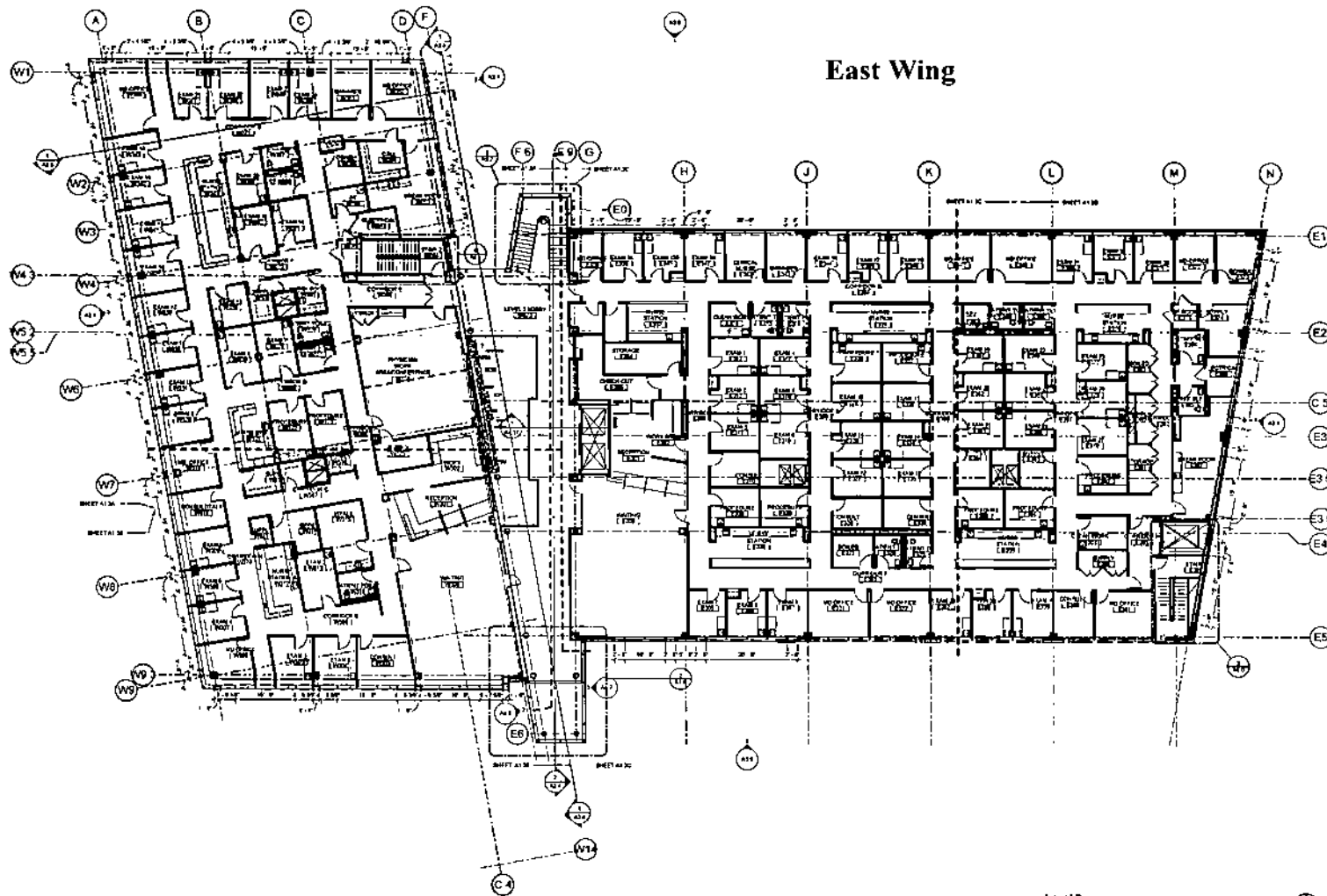
Level 2 - Overall Floor Plan

A1.2

11024

West Wing

East Wing

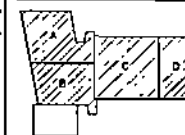


LEGEND

PLAN NOTES

1. ALL PARTITIONS TO BE TYPE I U.N.D. PER TO SHEET 305 FOR PARTITION TYPE.
2. ALL CONCRETE DOORS TO BE TYPE I U.N.D. PER TO SHEET 305 FOR PARTITION TYPE.
3. ALL STEEL COLUMNS TO BE TYPE I U.N.D. PER TO SHEET 305 FOR PARTITION TYPE.
4. PARTITION TO BE COATED ON EXTERIOR OF WINDOW SILLING PER 305 FOR PARTITION TYPE.
5. RATED ASSEMBLIES SHALL BE SPACED IN SAFETY FLOOR TO MAINTAIN ASSEMBLY RATED TO LIFT SAFETY ASSEMBLY FOR SETBACK OF SAFETY PARTITION.
6. ALL CORRIDORS ARE TO FACE OF SHIFTER PARTITION 305.
7. SEE FINISH SCHEDULE ON 31 FINISH SHEET FOR FINISHES. FINISHES SHALL BE TYPE I U.N.D. PER TO SHEET 305 FOR PARTITION TYPE.
8. REFER TO 31 FINISH SHEET FOR FINISHES.
9. REFER TO 31 FINISH SHEET FOR FINISHES.
10. REFER TO 31 FINISH SHEET FOR FINISHES.
11. REFER TO 31 FINISH SHEET FOR FINISHES.
12. A SURVEY OF ALL FLOOR SURFACES SHALL BE MADE PRIOR TO INSTALLATION OF FINISHES. FINISHES SHALL BE TYPE I U.N.D. PER TO SHEET 305 FOR PARTITION TYPE.
13. REFER TO 31 FINISH SHEET FOR FINISHES.
14. PROVIDE ACCESS PANELS TO ALL RATED PARTITIONS AND RATED PARTITIONS SHALL BE TYPE I U.N.D. PER TO SHEET 305 FOR PARTITION TYPE.
15. PROVIDE ACCESS PANELS TO ALL RATED PARTITIONS AND RATED PARTITIONS SHALL BE TYPE I U.N.D. PER TO SHEET 305 FOR PARTITION TYPE.

KEYNOTES



KEY PLAN

1 REFER TO SHEET 305 FOR FINISHES

10/10/2011 Issued by Design Development
10/10/2011 Issued by Design Development
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10/10/2011 Issued by Design Development
10/10/2011 Issued by Design Development
10/10/2011 Issued by Design Development
10/10/2011 Issued by Design Development
10/10/2011 Issued by Design Development
10/10/2011 Issued by Design Development
10/10/2011 Issued by Design Development

Liste Medical Office
Building
DuPage Medical Group
400 Westmoreland Road, Suite 1000, Naperville, IL 60563
Level 3 - Overall Floor Plan

A1.3

11024

Architect & Title

SECTION I – IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

Cost Space Requirements

Dept./Area	Cost	Gross Sq. Ft.		Amount of Proposed Total Gross Sq. Ft. That Is			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Imaging	\$5,908,569.86	N/A	14,138	14,138	N/A	N/A	N/A
Chemo and Infusion Medical Services (Rush Univ. Med. Center)	\$5,402,467.29	N/A	12,927	12,927	N/A	N/A	N/A
Radiation Oncology (excluding linear accelerator)	\$2,363,344.36	N/A	5,655	5,655	N/A	N/A	N/A
Linear Accelerator	\$3,490,784.95*	N/A	965	965	N/A	N/A	N/A
Total Clinical	\$17,165,166.46	N/A	33,685	33,685	N/A	N/A	N/A
NON REVIEWABLE							
Common Space, Atrium	\$5,324,316.03	N/A	12,740	12,740	N/A	N/A	N/A
Primary Care, Immediate Care, Retail Pharmacy, and Lab	\$5,570,471.61	N/A	13,329	13,329	N/A	N/A	N/A
Physician Office (General)	\$6,516,645.20	N/A	15,593	15,593	N/A	N/A	N/A
Physician Offices (Oncology)	\$4,901,379.78	N/A	11,728	11,728	N/A	N/A	N/A
Total Non-clinical	\$22,312,812.61	N/A	53,390	53,390	N/A	N/A	N/A
TOTAL	\$39,477,979.07	N/A	87,075	87,075	N/A	N/A	N/A

*The cost for the 965 sq. ft. devoted to the linear accelerator includes (1) the premium build-out cost of \$225,319 and (2) the purchase price of \$2,862,172.

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

Criterion 1110.230 – Background, Purpose of the Project and Alternatives

BACKGROUND OF THE APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.

DMG Medical Group, Ltd. owns and operates the following health care facilities, both of which are Ambulatory Surgical Treatment Centers:

- DMG Surgical Center in Lombard
- DMG Center for Pain Management in Naperville

See Attachment 11-Exhibit 1 for all relevant licensing and/or certification for these facilities

Rush University Medical Center owns and operates the following health care facilities:

- Rush University Medical Center in Chicago
- Rush Oak Park Hospital in Oak Park

See Attachment 11-Exhibit 2 for all relevant licensing and/or certification for these facilities

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.

There have been no adverse actions taken against any facility owned or operated by DuPage Medical Group, Ltd. during the three years prior to the filing of this application. See Attachment 11-Exhibit 3 for a statement of certification.

There have been no adverse actions taken against any facility owned or operated by Rush University Medical Center during the three years prior to the filing of this application. See Attachment 11-Exhibit 4 for a statement of certification.

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.**

Attachment 11-Exhibit 3 includes authorization from DuPage Medical Group, Ltd. certifying that there have been no adverse actions against its facilities listed above and permitting HFSRB and IDPH access to any documents necessary to verify the information submitted in this application. Attachment 11-Exhibit 4 also includes authorization from Rush University Medical Center to the same effect.

Note: Rush University Medical Center had previously filed a CON application on January 31, 2012 (Project 12-011) to modernize the atrium and Kellogg buildings as its location on 1650 West Harrison and 1753 West Congress Parkway. Per 77 Ill. Adm. Code §1110.230(a)(4), RUMC has used information included in that application to fulfill the relevant information requirements. RUMC has also included an attestation certifying that no changes have occurred regarding the information previously provided. See Attachment 11-Exhibit 5.

Attachment 11-Exhibit 1
Accreditation and Licensure for DMG's
Health Care Facilities



ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

May 8, 2012

Organization #: 68951 Accreditation Expires: May 1, 2015

Organization: DuPage Medical Group Surgical Center, LLC dba Surgical Center of DuPage Medical Group

Address: 2725 South Technology Drive

City, State, Zip: Lombard, IL 60148-5675

Decision Recipient: Dawn Dormitorio Survey Chair: James Hansen, BS, MA

Survey Contact: Dawn Dormitorio Survey Team Members: Kasia Rossi, RN, MSN, MBA-HCA, LHRM, CASC
Leah Peters

Survey Dates: April 16-17, 2012 Accreditation Renewal Code: ef42fefe68951

Complimentary Study Participation code: 68951FREEIQ1

It is a pleasure to inform you that the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) Accreditation Committee has awarded **DuPage Medical Group Surgical Center, LLC dba Surgical Center of DuPage Medical Group**, a three-year term of accreditation.

Granting accreditation reflects confidence, based on evidence from this recent survey that you meet, and will continue to demonstrate throughout the accreditation term, the attributes of an accreditable organization as reflected in the standards found in the *Accreditation Handbook for Ambulatory Health Care*. The dedication and effort necessary for an organization to be accredited is substantial and the compliance with those standards implies a commitment to continual self-evaluation and continuous improvement.

Members of your organization should take time to review your Survey Report, which may arrive separately:

- Any standard marked "PC" (Partially Compliant) or "NC" (Non-Compliant) must be corrected promptly. Subsequent surveys by the AAAHC will seek evidence that deficiencies from this survey were addressed without delay.
- The Summary Table provides an overview of compliance for each chapter applicable to the organization. Emphasis for attention should be given to chapters marked "PC" (Partially Compliant) or "NC" (Non-Compliant).
- As a guide to the ongoing process of self-evaluation, periodically review the Survey Report to ensure the organization's ongoing compliance with the standards throughout the term of accreditation.
- Statements in the "Consultative Comments" sections of the report represent the educational component of the survey. Such comments may provide suggested approaches for correcting identified deficiencies.

AAAHC policies and procedures and standards are revised on an annual basis, such revisions become effective March 1 each year. Accredited organizations are required to maintain their operations in compliance with the current AAAHC standards and policies. Therefore, the organization is encouraged to visit the AAAHC website, www.aaahc.org, for information pertaining to any revisions to AAAHC policies and procedures and standards.

We hope the survey has been beneficial to your organization in identifying its strengths and opportunities to improve. AAAHC trusts that you will continue to find the accreditation experience meaningful, not only from the benefit of having carefully reviewed your own operation, but also from the recognition brought forth by your participation in this survey process.

In order to ensure continuation of accreditation, your organization should submit an application for survey approximately five months prior to your accreditation expiration. According to our Accreditation Handbook, *Currently-accredited organizations must complete and submit the Application for Survey, supporting documentation, and application fee for their subsequent full accreditation survey (referred to as a re-accreditation survey). Please visit www.aaahc.org to complete the Application for Survey and for further information. After review of an organization's completed Application for Survey and supporting documentation, the AAAHC will*

Organization #: 68951 Accreditation Expires: May 1, 2015
Organization: DuPage Medical Group Surgical Center, LLC dba Surgical Center of DuPage
Medical Group

May 8, 2012

Page 2

contact the organization to establish survey dates. To prevent a lapse in accreditation, an organization should ensure that all documentation is submitted to the AAAHC at least five (5) months prior to its accreditation expiration date. In states where accreditation is mandated by law, an organization should submit the completed Application for Survey and other required documentation a minimum of six (6) months prior to its accreditation expiration date.

For submission of an application for survey, your organization will need the "accreditation renewal code" located underneath the accreditation expiration date.

You will notice that you have a "complimentary study participation code" at the top of this letter. You may use this to register for one of the AAAHC Institute for Quality Improvement's studies. Please visit www.aaahc.org/institute for additional information or contact Michelle Chappell, at 847-324-7747 or mchappell@aaahc.org.

If you have any questions or comments about any portion of the accreditation process, please contact the AAAHC Accreditation Services department at (847) 853-6060.



ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

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ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

November 23, 2011

Organization #:	95139	Accreditation Effective Date:	November 22, 2011
		Recommended Medicare Deemed Status:	Yes
		Accreditation Expiration Date:	November 22, 2012
Organization:	DMG Pain Management Surgery Center		
Address:	2940 Rollingridge Road, Suite 200		
City, State, Zip:	Naperville, IL 60564-4226		
Decision Recipient:	Kristina Sharkey	Survey Chair:	Patti Spears, RN
Survey Contact:	Kristina Sharkey	Survey Team Member:	Mary Shea, RN, BS, CNOR, CRNFA
Special cc:	CMS CO - Baltimore CMS RO V - Chicago		
CMS Certification Number (CCN):	Initial	Type of Survey:	Early Option Survey/Initial Medicare Deemed Status
Survey Dates:	November 14-15, 2011	Correction Method:	Plan of Correction Self-Attestation Document Review
		Correction Timeframe:	November 2011 to November 2011

It is a pleasure to inform you that the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) Accreditation Committee has awarded DMG Pain Management Surgery Center a one-year term of full accreditation, based on participation in the Early Option Survey Program.

The Centers for Medicare and Medicaid Services (CMS) requires that ambulatory surgery centers (ASC) demonstrate compliance with the Medicare Conditions for Coverage (CfC) to be eligible for Medicare deemed status. As an ASC that had an AAAHC/Medicare deemed status survey, your ASC has demonstrated its compliance with the AAAHC standards and all CfCs; however, standard-level deficiencies were identified. Your ASC has submitted an acceptable Plan of Correction (POC) and is recommended for participation in the Medicare deemed status program at the accreditation effective date referenced above. CMS has the authority to determine the effective date for participation in Medicare deemed status. CMS will identify the effective date for Medicare certification and participation in deemed status based on its final determination of your 855B application for Medicare certification.

Granting accreditation reflects confidence, based on evidence from this recent survey that you meet, and will continue to demonstrate throughout the accreditation term, the attributes of an accreditable organization as reflected in the standards found in the *Accreditation Handbook for Ambulatory Health Care*. The dedication and effort necessary for an organization to be accredited is substantial and the compliance with those standards implies a commitment to continual self-evaluation and continuous improvement.

Members of your organization should take time to review the enclosed Survey Report:

- Any standard marked "PC" (Partially Compliant) or "NC" (Non-Compliant) must be corrected promptly. Subsequent surveys by the AAAHC will seek evidence that deficiencies from this survey were addressed without delay.
- The Summary Table provides an overview of compliance for each chapter applicable to the organization. Emphasis for attention should be given to chapters marked "PC" (Partially Compliant) or "NC" (Non-Compliant).
- As a guide to the ongoing process of self-evaluation, periodically review the Survey Report to ensure the organization's ongoing compliance with the standards throughout the term of accreditation.

AAAHC policies and procedures and standards are revised on an annual basis, such revisions become effective March 1 each year. Accredited organizations are required to maintain their operations in compliance with the current AAAHC standards and policies. Therefore, the organization is encouraged to visit the AAAHC website, www.aaahc.org, for information pertaining to any revisions to AAAHC policies and procedures and standards.

Organization #:
Organization:
November 23, 2011
Page 2

95139

DMG Pain Management Surgery Center

Accreditation Expiration Date: November 22, 2012

We hope the survey has been beneficial to your organization in identifying its strengths and opportunities to improve. AAAHC trusts that you will continue to find the accreditation experience meaningful, not only from the benefit of having carefully reviewed your own operation, but also from the recognition brought forth by your participation in this survey process.

If you have any questions or comments about any portion of the accreditation process, please contact the AAAHC Accreditation Services department at (847) 853-6060.



ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

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Attachment 11- Exhibit 1

State of Illinois 2051147

Department of Public Health

LICENSE, PERMIT, CERTIFICATE, OR REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations pertaining to the practice of the profession or activity in the field herein.

LAMON I. ARNOLD, M.D.

DIPLCICP

ISSUED BY THE BOARD OF
THE JUNE 1, 2012
DEPARTMENT OF PUBLIC HEALTH

EXPIRATION DATE	TYPE OF LICENSE	EXPIRATION DATE
09/19/12	SGCL	7003023

FULL LICENSE

ARNOLD SURGICAL TREAT CENTER

EFFECTIVE: 09/20/11

BUSINESS ADDRESS

ONE SURGICAL CENTER, LLC

2725 S. TECHNOLOGY DRIVE

LEMAY

IL 60146

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

91



State of Illinois

Department of Public Health

1406929

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DANON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	ID NUMBER
09/06/12	BGBD	7003162

FULL LICENSE
AMBULATORY SURGICAL TRMT CTR

EFFECTIVE: 09/07/11

BUSINESS ADDRESS

DMG Pain Management Surgery Center, LLC
2490 Rollingridge Ste 200
Naperville, IL 60564

OFFICE COPY

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

← **DISPLAY THIS PART IN A CONSPICUOUS PLACE**

↓ **REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION**

State of Illinois

Department of Public Health

1406929

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

DMG Pain Management Surgery Center, LLC

EXPIRATION DATE	CATEGORY	ID NUMBER
09/06/12	BGBD	7003162

FULL LICENSE
AMBULATORY SURGICAL TRMT CTR

EFFECTIVE: 09/07/11

DMG Pain Management Surgery Center, LLC
2490 Rollingridge Ste 200
Naperville, IL 60564

Attachment 11-Exhibit 2
Documentation of Licensure and Accreditation
of Health Care Facilities Owned and Operated
by Rush University Medical Center

CITY OF CHICAGO	
LICENSE CERTIFICATE	
NON-TRANSFERABLE	
BY THE AUTHORITY OF THE CITY OF CHICAGO, THE FOLLOWING SPECIFIED LICENSE IS HEREBY GRANTED TO	
NAME	RUSH UNIVERSITY MEDICAL CENTER
ADDRESS	RUSH UNIVERSITY MEDICAL CENTER 1653 W. CONGRESS PKWY., Floor 900 III, Apt./Suite 364 CHICAGO, IL 60612
LICENSE NO.	11181
CODE	1375
FEE	\$**2,200.00
LICENSE	Hospital
Beds Max.	
PRINTED ON	09/10/2010
	\$**2,200.00
THIS LICENSE IS ISSUED AND ACCEPTED SUBJECT TO THE REPRESENTATIONS MADE ON THE APPLICATION THEREFOR, AND MAY BE SUSPENDED OR REVOKED FOR CAUSE AS PROVIDED BY LAW. LICENSEE SHALL OBLIGE AND COMPLY WITH ALL LAWS, ORDINANCES, RULES AND REGULATIONS OF THE UNITED STATES GOVERNMENT, STATE OF ILLINOIS, COUNTY OF COOK, CITY OF CHICAGO AND ALL AGENCIES THEREOF.	
WITNESS THE HAND OF THE MAYOR OF SAID CITY AND THE CORPORATE SEAL THEREOF	
THIS	15 DAY OF SEPTEMBER, 2010
EXPIRATION DATE:	September 15, 2012
ATTEST:	
 <i>Richard M. Daley</i> MAYOR	<i>Miguel del Valle</i> CITY CLERK
ACCOUNT NO. 62954 SITE: 2	
TRANS ID	
THIS LICENSE MUST BE POSTED IN A CONSPICUOUS PLACE UPON THE LICENSED PREMISES.	

State of Illinois 2065072
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

CRAIG CONOVER, M.D.
ACTING DIRECTOR

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

12/31/12	6680	0001917
----------	------	---------

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/12

BUSINESS ADDRESS

RUSH UNIVERSITY MEDICAL CENTER
1653 WEST CONGRESS PARKWAY
CHICAGO, ILL. 60612

This form of this license has a colored background. Printed by Authority of the State of Illinois - 4927

← **DISPLAY THIS PART IN A CONSPICUOUS PLACE**

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 2065072
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

RUSH UNIVERSITY MEDICAL CENTER

12/31/12	6680	0001917
----------	------	---------

FULL LICENSE
GENERAL HOSPITAL
EFFECTIVE: 01/01/12

11/08/11
RUSH-PRESBYTERIAN-ST. LUKE'S MEDIC
1653 WEST CONGRESS PARKWAY
CHICAGO ILL 60612

FEE RECEIPT NO.

Rush University Medical Center

Chicago, IL

has been Accredited by



The Joint Commission

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

November 14, 2009

Accreditation is customarily valid for up to 39 months.

David L. Nahreid
David L. Nahreid, M.D.
Chairman of the Board

Organization ID: 17797
Prior/Reprint Date: 1/18/10

Mark Chassin
Mark Chassin, M.D.
President

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



AMAK





November 18, 2010

Larry J. Goodman
President and Chief Executive Officer
Rush University Medical Center
1653 West Congress Parkway
Chicago, Illinois 60612

Joint Commission ID#: 7297
Certification Activity: Intra-Cycle
Certification Activity Due: 11/01/2010
Program: Disease-Specific Care
Certification-Primary Stroke Center

Dear Dr. Goodman:

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

The Joint Commission is continuing to grant your organization a Passed Certification decision for all services reviewed under the applicable manual noted below:

• Disease-Specific Care Certification Manual

Please visit www.jointcommission.org for information related to your certified sites.

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

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

Sincerely,

Ann Scott Blouin RN, Ph.D.

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

www.jointcommission.org

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

CITY OF CHICAGO

LICENSE CERTIFICATE

NON-TRANSFERABLE

BY THE AUTHORITY OF THE CITY OF CHICAGO, THE FOLLOWING SPECIFIED LICENSE IS HEREBY GRANTED TO

NAME: RUSH UNIVERSITY MEDICAL CENTER

RUSH CHILDREN'S SERVICES
1753 W. CONGRESS PKWY.
CHICAGO, IL 60612

LICENSE NO: 23452
LICENSE: Hospital

CODE: 1375

FEE: \$2,200.00

Beds MAX:

PRINTED ON: 09/10/2010

\$2,200.00

THIS LICENSE IS ISSUED AND ACCEPTED SUBJECT TO THE REPRESENTATIONS MADE ON THE APPLICATION THEREFOR, AND MAY BE SUSPENDED OR REVOKED FOR CAUSE AS PROVIDED BY LAW. LICENSEE SHALL OBSERVE AND COMPLY WITH ALL LAWS, ORDINANCES, RULES AND REGULATIONS OF THE UNITED STATES GOVERNMENT, STATE OF ILLINOIS, COUNTY OF COOK, CITY OF CHICAGO AND ALL AGENCIES THEREOF.

WITNESS THE HAND OF THE MAYOR OF SAID CITY AND THE CORPORATE SEAL THEREOF
THIS 15 DAY OF SEPTEMBER, 2010

EXPIRATION DATE: September 15, 2012

ATTEST:



Richard M. Daley
MAYOR

Miguel del Valle
CITY CLERK



ACCOUNT NO: 62954 SITE: 5
TRANS NO:

THIS LICENSE MUST BE POSTED IN A CONSPICUOUS PLACE UPON THE LICENSED PREMISES.



State of Illinois 2035986
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	ID NUMBER
06/30/12	BGBD	0001750
FULL LICENSE GENERAL HOSPITAL EFFECTIVE: 07/01/11		

BUSINESS ADDRESS

RUSH OAK PARK HOSPITAL, INC.
520 SOUTH MAPLE AVENUE

OAK PARK IL 60304

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

Rush Oak Park Hospital, Inc.
Oak Park, IL

has been Accredited by



The Joint Commission

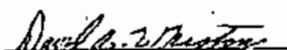
Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

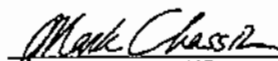
This award excludes skilled nursing and nursing home services.

August 14, 2010

Accreditation is customarily valid for up to 39 months.


David A. Whitson, D.D.S.
Chairman of the Board

Organization ID #: 7398
Print/Reprint Date:


Mark Chasin, M.D.
President

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



This reproduction of the original accreditation certificate has been issued for use in regulatory/payer agency verification of accreditation by The Joint Commission. Please consult Quality Check on The Joint Commission's website to confirm the organization's current accreditation status and for a listing of the organization's locations of care.



License #

3472

Business License

Permission is hereby granted to conduct business in
Oak Park subject to applicable Village Ordinances.

Acc# 3188
Rush Oak Park Hospital
520 S Maple Ave
Oak Park, IL 60304

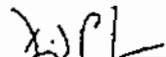
Inspection: Sign/awning
Inspection: Sign/awning (additional)
Medical: Hospital
Merchandise: Newspaper Stands

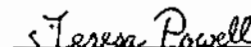
October 12, 2011

Date Issued

December 31, 2012

Expiration Date


Village President


Village Clerk

NON-TRANSFERABLE MUST BE POSTED IN A VISABLE LOCATION

The person, firm or corporation named above is hereby granted a license to engage in, carry on or conduct in the Village of Oak Park, Illinois the business, trade, calling, profession, occupation or occupation described, for the period indicated. The issuance of this Oak Park Business License does not constitute Village approval of any violation of law or regulation of the Village of Oak Park.

May 25, 2012

Mr. Dale Galassie, Chairman
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Chairman Galassie,

In keeping with 77 Ill. Adm. Code §1110.230(a) (Background of Applicant - Information Requirements), please find this letter of certification and authorization.

Specifically, this letter certifies that none of the health care facilities owned or operated by DuPage Medical Group, Ltd., to wit DMG Surgical Center in Lombard and DMG Center for Pain Management in Naperville, have had any adverse actions taken against them in the three (3) years prior to the filing of this application.

Furthermore, DuPage Medical Group, Ltd. authorizes, on behalf of DMG Surgical Center and DMG Center for Pain Management, the Health Facilities and Services Review Board and the Illinois Department of Public Health to access to any documents necessary to verify the information submitted, including, but not limited to: official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations.

Sincerely,



Dennis Fine, COO
DuPage Medical Group Ltd.

May 25, 2012

Mr. Dale Galassie, Chairman
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Chairman Galassie,

In keeping with 77 Ill. Adm. Code §1110.230(a) (Background of Applicant – Information Requirements), please find this letter of certification and authorization.

Specifically, this letter certifies that none of the health care facilities owned or operated by DuPage Medical Group, Ltd., to wit DMG Surgical Center in Lombard and DMG Center for Pain Management in Naperville, have had any adverse actions taken against them in the three (3) years prior to the filing of this application.

Furthermore, DuPage Medical Group, Ltd. authorizes, on behalf of DMG Surgical Center and DMG Center for Pain Management, the Health Facilities and Services Review Board and the Illinois Department of Public Health to access to any documents necessary to verify the information submitted, including, but not limited to: official records of IDPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations.

Sincerely,



Dennis Fine, COO
DuPage Medical Group Ltd.

Professional Building
1725 W. Harrison St.
Suite 364
Chicago, IL 60612

Tel: 312.942.8801
Fax: 312.942.2055
peter_butler@rush.edu



Peter W. Butler
Rush University Medical Center
President and Chief Operating Officer
Rush University
Chairman, Department of Health Systems
Management

April 24, 2012

Mr. Dale Galassie, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761

Dear Mr. Galassie:

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

1. Rush University Medical Center and Rush Oak Park Hospital do not have any adverse actions against any facility owned or operated by the applicant during the last three (3) year period prior to the filing of this application, and
2. Rush University Medical Center and Rush Oak Park Hospital authorize the State Board and Agency access to information in order to verify documentation or information submitted in response to the requirements of Criterion 1110.230.a or to obtain documentation or information which the State Board or Agency finds pertinent to this application.

Sincerely,

A handwritten signature in black ink that reads "Peter W. Butler".

Peter W. Butler

cc: Mike Constantino, Supervisor of Project Review

Professional Building
1725 W. Harrison St.
Suite 364
Chicago, IL 60612

Tel: 312.942.8801
Fax: 312.942.2055
peter_butler@rush.edu



Peter W. Butler
Rush University Medical Center
President and Chief Operating Officer
Rush University
Chairman, Department of Health Systems
Management

April 24, 2012

Mr. Dale Galassie, Chairman
Illinois Health Facilities and Services Review Board
525 West Jefferson, 2nd Floor
Springfield, Illinois 62761

Dear Mr. Galassie:

In January 2012, Rush University Medical Center ("Rush" or "RUMC") submitted a Certificate of Need application for modernization of selected portions of the Atrium and Kellogg buildings. With an expedited review, Rush received approval for Permit #12-011 on April 17, 2012.

In accordance with 77 Ill. Admin Code 1110.230(a)(4), Rush is submitting this letter attesting that the information previously provided in the January 2012 application (#12-011), will be used in this application and that, except for the immediate corrections and update listed below, there are currently no changes to this information.

- State Staff requested clarification of numbers of recovery stations on pages 81 and 88, copies enclosed dated February 9, 2012; and
- Moody's rating update of Rush dated February 28, 2012.

Rush will submit amendments to the information submitted in application #12-011, as needed, to update and/or clarify data.

Sincerely,

A handwritten signature in black ink that reads "Peter W. Butler".

Peter W. Butler

cc: Courtney Avery, Administrator, IHFSRB
Mike Constantino, Supervisor of Project Review
Anne Murphy, General Counsel, Rush University Medical Center

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

Criterion 1110.230 – Background, Purpose of the Project and Alternatives

PURPOSE OF THE PROJECT

Improving Health Care in DuPage County

The Need for Complex, Specialized Care in the Western Suburbs

DuPage Medical Group (DMG) serves the residents of DuPage County, Illinois, which is co-terminous with Health Planning Area 05. It does have several locations outside that area, but this project is intended primarily to serve patients in DuPage County.

Incidences of cancer are on the rise in the United States as the population ages. Sixty-five (65) is the age at which one's risk of cancer increases, and 10,000 people are turning 65 every day.¹ According to the calculations of the applicants, demand for cancer treatment in DuPage County will grow by roughly 3% per year for the foreseeable future, when overall growth and the aging of the population are taken into consideration.

As is detailed in Attachment 37 of this submission, the applicants expect roughly 4,900 new cancer cases in 2013. Therefore, there is a high demand for the type of services that will be provided at this MOB. Furthermore, this demand will only increase in the coming years.

The purpose of this project is to provide the community with high-level, standardized, comprehensive, and coordinated care. In providing these services, the co-applicants will bring a higher level of care to the community than is presently available. It will do so by providing the following:

- Integrated and coordinated approach to treatment
- Comprehensive care in a central location within the community
- Patient-centered, personalized care, including support and guidance
- The latest radiation therapy equipment, which will minimize side-effects, reduce treatment times, and lower costs

Case Studies: The Scope and Purpose of the Clinical Collaboration Agreement

DMG and Rush University Medical Center (Rush) entered into a clinical collaboration agreement in October 2011 after years of discussion and planning.² The primary purpose of this agreement is to break down operational and clinical barriers in order to maximize beneficial patient outcomes and patient access. Both DMG and Rush have provided demonstrative cases studies illustrating how the clinical collaboration agreement currently operates and is intended to operate in the future. These case studies

¹ Boomers Hit New Self-Absorption Milestone: Age 65. *New York Times*, December 10, 2010.

² See Attachment 12-Exhibit 1.

were formulated with the assistance of physicians from both organizations and incorporate the experiences and understandings of those physicians.³

From the perspective of these physicians, this agreement is, first and foremost, a relationship that was conceptualized prior to the construction of DMG's Medical Office Building, the subject of this Certificate of Need application. As discussed by the physicians, the clinical collaboration between DMG and Rush has been undertaken, at its core, in the spirit of cooperation and coordination between and among physicians. The agreement is intended to open more direct lines of communication between physicians in order to streamline operations and improve the patient care process. Furthermore, this agreement will bring high level, specialized services to the area, thus improving patient outcomes. All of the physicians interviewed for this case study offered examples from their own practices of how the agreement is accomplishing this goal:

First, this clinical collaboration agreement allows DMG patients, through increased communication with Rush University Medical Center physicians, access to specialized and high-level tertiary services provided by academic physicians. For instance, the streamlining of communication has already enabled Dr. Nemivant (DMG) to send some of his patients to an "outstanding" thoracic surgeon at Rush. This access would be more difficult without the facilitation process provided by the clinical collaboration agreement.

Dr. Merrick (DMG) explained that patients sometimes need a university level of care not available in the community. This is especially important in instances where, as is the case with Dr. Hoscheit's (DMG) pancreatic cancer patients, it is not uncommon to have a diagnostic option in the community but no therapeutic option. In fact, this lack of a therapeutic option in the community forces many patients who live in the suburbs to go to Rush or other facilities in the City of Chicago for treatment. Indeed, there is a substantial outmigration of cancer patients from DuPage County to receive treatment in Chicago.

This access to specialized care is in keeping with the philosophy and culture shared by DMG and Rush. As explained by Dr. Bonomi (Rush), both organizations want to provide super-specialized and comprehensive patient care. This collaboration agreement is a vehicle for doing so.

Second, this agreement allows easier dialogue among specialists, for example, between Dr. Nemivant and an oncologist from Rush to whom he often refers lung cancer patients. Thus not only does this agreement allow patients easier access to specialized academic medicine, it also allows the primary care or attending physician from DMG expedited interface with Rush specialists which can then be integrated into the patient's plan of treatment.

It is necessary to minimize the barriers to communication where patients receive initial treatment at a university-level facility in Chicago but then receive most of their follow up treatments closer to their home in the suburbs. This is common in the practices of the physicians interviewed. This collaboration agreement is intended to foster communication in these situations. Per Dr. Merrick, complex cases require direct communication between physicians and this agreement is a vehicle bringing that about.

Shared medical records are an example of how this agreement will enhance communication between physicians. As explained by Dr. Merrick, unified medical records are of an enormous value to patients

³ Please see Attachment 12-Exhibit 2 for the biographical information of the physicians interviewed for these case studies.

given the many subtleties of complex care. This ability to share clinical information will also allow physicians to make better decisions that are based on structured and coherent medical records, rather than on the memory of patients.

Third, the agreement will also facilitate access for DMG patients to clinical trials conducted by Rush. Sometimes patients need access to clinical trials when other therapies have proved insufficient. This agreement creates an entry point for patients to participate in these trials and allows Rush to more easily identify patients appropriate for the clinical trials. Also, as explained by Dr. Bonomi, Rush will establish the infrastructure for patients living in DuPage County to participate in the clinical trials in their own community, rather than requiring them to travel into Chicago.

According to Dr. Bonomi (Rush), the preponderance of patients served under this collaboration agreement are those being, and who will be, referred from DMG. Some patients will be seeking a tertiary opinion from Rush. Others will not be referred from either organization but will enter into treatment because of the quality of care provided under the framework of this agreement. Some of this is happening already, and the applicants anticipate seeing growth because of the improved access to specialized, expert care.

As these case studies demonstrate, the clinical collaboration agreement has a broad-ranging purpose that is not inherently linked with the DuPage Medical Office Building. Indeed, it is building on pre-existing relationships between physicians from both groups and would or could have occurred regardless of the construction of DuPage Medical Group's MOB in Lisle.

Market Area

As stated above, this project is intended to serve primarily the residents of DuPage County (the Primary Market Service Area). However, it is expected that patients living in Cook, Will, and Kane County will also visit this location. This is for two reasons. First, most patients at this MOB will be referred from physicians located at other DMG locations, and DMG has locations in DuPage, Cook, Will, and Kane County. Second, it is anticipated that patients will also be referred by Rush or by other providers as word spreads of the high quality services provided at the MOB. It is likely that some of these will come from outside of DuPage County (the Secondary Market Service Area).

The MOB will be located at 430 Warrenville Rd. in Lisle, IL. Given where DMG locations are concentrated, the most appropriate border for the service area encompasses the following cities/towns:

- to the North: Bloomingdale
- to the West: Warrenville
- to the South: Naperville/Woodridge
- to the East: Hinsdale

See Attachment 12-Exhibit 3 for a map showing DMG's locations as well as the planned Market Service Area.

Existing Problems

DuPage Medical Group is undertaking this project because it has identified several issues that, in the aggregate, make it difficult to provide its patients with the highest quality care. They are as follows:

Fragmentation of Care

In DuPage County, cancer care is, for the most part, fragmented, meaning patients receiving treatment tend to go to several different providers who often have trouble coordinating with one another. Often, physicians have to rely on patients as a source of information regarding treatments they have received from other providers. This is less than optimal. Furthermore, lack of a standardized medical record means that even when physicians are able to coordinate on a patient's course of treatment they are often relying on incomplete information.

Care is at its best when delivered by highly specialized professionals working in close cooperation. Therefore, this piecemeal delivery of care inevitably affects quality. Also, DMG physicians are forced to outsource many of their treatments and are therefore not in a position to provide the necessary oversight so as to ensure the highest standard of care.

Lack of a Treatment Option

If DMG wishes to ensure that its patients receive coordinated and comprehensive care of the highest quality, it must have the ability to provide radiation therapy. Indeed, without such capability DMG could not provide care that is either coordinated or comprehensive since radiation therapy is such an integral part of cancer treatment.

Currently, DMG has no such treatment option, as it does not own or operate a linear accelerator. It has a diagnostic capability but must outsource nearly all treatments. This is particularly problematic because radiation therapy is involved in the vast majority of cancer treatments. Also, because DMG does not operate any linear accelerators, it is not in a position to oversee and ensure the proper administration of doses of radiation. Misadministration of radiation therapy, which does occur if the therapy is not done properly, can have serious side-effects.

Convenience

Due to the fragmentation of cancer care in DuPage County and the lack of a reliable treatment option, many DMG patients travel to Chicago for care. This is very inconvenient, as it forces patients to shuttle between the city and their community (where their support network is located) for follow-up appointments and further treatment.

Lack of University-Level Care

For some patients, a higher level of care is necessary to treat their cancer. It is also common for patients to seek a second opinion, often at a university-level facility. Furthermore, university medical centers are where the most accomplished specialists are and where most clinical trials are conducted. This helps explain why so many patients from the community feel compelled to travel into Chicago for diagnosis and treatment, despite the obvious inconvenience.

Addressing the Existing Problems

Fragmentation of Care

This project addresses the fragmentation of care by bringing all cancer diagnoses and treatments under one roof. The use of a single location, along with the fact that physicians are from the same group will minimize barriers to communication and help patients receive more coordinated care. This will be especially beneficial for the more complicated cases, where physician coordination is at a premium. For example, patients will have a unified electronic medical record to which all DMG physicians will, as necessary, have access. This will help ensure that physicians have all the information they need and that nothing is missed. This problem will also be addressed through the clinical collaboration agreements as explained above, although that agreement is independent of this project.

The clinical collaboration also addresses the fragmentation of care. It should be noted, however, that the agreement is wholly independent of this project.

Lack of a Treatment Option

Through the purchase of a linear accelerator, this project will provide patients a readily available treatment option that will allow DMG to offer more comprehensive and coordinated care. It will also enable DMG to ensure treatment is of the highest quality as it will no longer have to outsource treatments.

The applicants prepared a case study as to the role of linear accelerators in the provision of radiation therapy. This case study was prepared with the assistance of Dr. Brian Moran of DMG, a renowned specialist in radiation therapy.⁴ As explained by Dr. Moran, linear accelerators are an integral part of the current standard of care for radiation therapy. This particular type of equipment uses microwave technology to accelerate electrons, which are in turn used to generate high energy x-rays. These beams are then shaped to conform to the patient's tumor so as to concentrate high doses on that tumor and minimize radiation on other parts of the body.

Linear accelerators are by far the most commonly used device for external beam radiation treatments. Dr. Moran estimates that around 95% of all radiation therapy done in the United States utilizes a linear accelerator. There are several reasons for this, the principal one being that it is as effective in shrinking tumors as any other method of treatment.

The specific type of linear accelerator proposed is the RapidArc, the newest version of the most commonly accepted standard of care modality for radiation therapy able to perform treatments much more efficiently than earlier models. Per Dr. Moran, it is able to generate four times the radiation per unit time compared with earlier models. It also allows a greater focus of radiation on the tumor, thus minimizing radiation to healthy tissue. Indeed, it is on par with proton-beam therapy in this regard but at a significantly reduced cost.

This linear accelerator is part of DuPage Medical Groups' MOB project in order to improve the quality of care. Having a linear accelerator means that DMG physicians will no longer have to outsource treatments, but will instead be in a position to ensure the necessary quality of care. It will also benefit

⁴ Dr. Moran's biographical sketch is included in Attachment 12-Exhibit 2.

patients and third-party payers as it will help deliver better care more efficiently and thus more cost-effectively. In this regard, it should be noted that the applicants project at least 7,688 treatments in the first year of utilization; this is well above the established standards.

Dr. Moran is firmly supportive of this goal and endorses the acquisition of the linear accelerator. This support should be given great weight not only because of his professional credentials, but also because he is himself a cancer survivor, and thus has a personal commitment to delivering the highest quality of care.

Convenience

By building this MOB in DuPage County, patients in the community will have easier access to comprehensive, high-quality diagnosis and treatment provided in a coordinated manner. This will mean fewer trips into Chicago for patients. It also means that treatment will be provided in one location within the community rather than at various physician offices located throughout the area. Also, the planned site for this MOB is conveniently located, with easy access via I-88, I-355, and US Route 34.

Lack of University-Level Care

The level of coordination and comprehensiveness is usually only available at university-level institutions. This project will bring that higher standard of care into the community. It will provide a facility for diagnosis and treatment and will also enable physicians to more easily coordinate their efforts, thus improving patient outcomes.

As previously described in the section on Improving Health Care in DuPage County, DMG has entered into a clinical collaboration agreement with Rush University Medical Center. This agreement will enhance access to university-level care for patients in the community but is not dependent on the MOB to exist. The MOB will, however, facilitate and enhance optimal utilization under the agreement.

Attachment 12-Exhibit 1

Clinical Collaboration Agreement Between DuPage Medical Group, Ltd. and Rush University Medical Center

Note: Some portions of this clinical collaboration agreement have been redacted. The portions redacted are those that provide specific terms regarding monetary compensation. This information is considered proprietary and confidential. Furthermore, this information is not necessary for the purpose intended by inclusion of this document in the CON submission, i.e. understanding the scope and character of the clinical collaboration agreement.



Attachment 12-Exhibit 1
Clinical Collaboration Agreement Between
DMG and RUMC

AFFILIATION AGREEMENT

THIS AFFILIATION AGREEMENT (the "Agreement") is effective the 12th day of October, 2011 ("Effective Date"), by and between Rush University Medical Center, a tax-exempt, Illinois not-for-profit corporation ("RUMC"), Rush Health, a taxable Illinois not-for-profit corporation ("Rush Health" and together with RUMC, "Rush") and DuPage Medical Group, Ltd., an Illinois corporation ("DMG"). Rush and DMG may each be referred to as a "party" and collectively as "parties" to this Agreement.

RECITALS

WHEREAS, the health care industry has experienced significant growth in revenues and expenses, changes in federal and state government regulatory and reimbursement programs, shifts in demographics and demand, rapid technological enhancements, and other economic changes which have encouraged collaboration between and among health care providers to share resources and provide additional and cost-effective services and facilities to the communities they serve;

WHEREAS, RUMC is a tax-exempt, not-for-profit medical center engaged in research, education, and patient care, which also owns and operates a University with four colleges, a hospital and various clinical sites in the greater metropolitan Chicago, Illinois area to provide a full spectrum of health care services;

WHEREAS, Rush Health is a clinically integrated network of physicians and hospitals working together to improve health through high quality, efficient health care services covering the spectrum of patient care;

WHEREAS, DMG is a multi-specialty medical group comprised of approximately 300 physicians who provide a broad range of physician services to patients in the Western suburbs of Chicago, Illinois;

WHEREAS, DMG and Rush desire to collaborate to provide accessible, high quality, cost-effective health care services to promote the general public health and improve the health status of citizens living in the communities serviced by DMG and Rush;

WHEREAS, DMG and Rush desire to enter into this Agreement that will, to a significant and meaningful extent, allow each party to retain their separate identities and independence while collaborating in appropriate ways to foster a provision of a broad spectrum of health care services; and

WHEREAS, DMG and Rush consider it to be in their best interests to enter into a formal affiliation on the terms and conditions set forth in this Affiliation Agreement.

NOW, THEREFORE, in consideration of the mutual promises and covenants herein contained and intending to be legally bound hereby, the parties agree as follows:

1. Affiliation.

1.1. Affiliation Goals. DMG and Rush desire to affiliate in order to provide accessible, high quality, cost-effective health care services to promote general public health and improve the health status of citizens living in the communities serviced by DMG and Rush pursuant to the terms of this Agreement.

1.2. New Clinical Services. For any clinical services which require a model of care similar those which have been developed by DMG and Rush under this Agreement, DMG or its Affiliates, as defined herein, will not seek to develop any such clinical services or models of care outside this Agreement without the express prior written consent of Rush.

1.3. Definitions.

1.3.1. "Affiliate" shall mean, with respect to any Person, (i) any Person directly or indirectly controlling, controlled by or under common control with such Person; (ii) any Person owning or controlling, directly or indirectly, five percent (5%) or more of the outstanding voting securities, equity interests, or membership interests (including such interests in a not-for-profit organization), of such Person; (iii) any officer, director, shareholder, member, manager or partner of such Person; (iv) any company in which such Person is an officer, director, member, manager or partner.

1.3.2. "Person" shall mean any individual, partnership, corporation, trust, limited liability company, association, joint venture, investment fund, joint stock company, organization, business, trust or any other entity or organization, including a government or any department, agency or political subdivision thereof.

2. Clinical Collaboration. Rush and DMG have determined that it is in the best interest of their patients to offer medical services in a coordinated fashion. In furtherance of this goal, Rush and DMG shall enter into a Master Clinical Collaboration Agreement, attached hereto as Schedule 2, which shall be amended from time to time to include sub-agreements, attached as exhibits thereto, which will expand the clinical collaboration to include additional service lines.

3. Academic Relationship. RUMC and DMG shall jointly seek to develop mutually beneficial opportunities for DMG physicians to work collaboratively with RUMC physicians and participate in RUMC academic activities. Such activities may include faculty appointments, training of medical residents and fellows, clinical trials, continuing medical education and physician and nursing recruitment. RUMC and DMG shall enter into an Academic Agreement setting forth the terms of this relationship, attached hereto as Schedule 3.

4. Clinical Integration and Managed Care.

4.1. Rush and DMG hereby agree that the collaboration set forth in this Agreement is intended to create clinical integration.

4.2. As clinically integrated entities, Rush Health shall, on behalf of themselves and RUMC and DMG, explore the feasibility of pursuing opportunities to negotiate reimbursement methodologies and rates with third party payors for the provision of inpatient, outpatient or professional health services to the payors' beneficiaries.

5. Term.

5.1. Initial Term. The initial term of this Agreement shall commence on the Effective Date and shall continue for a period of ten (10) years ("Initial Term"), unless earlier terminated in accordance with the terms hereof.

5.2. Renewal Terms. THIS AGREEMENT SHALL AUTOMATICALLY RENEW FOR ADDITIONAL five (5) year PERIODS (each a "Renewal Term") (the Initial Term and each Renewal Term collectively referred to as the "Term") ON THE SAME TERMS AND CONDITIONS AS ARE THEN IN EFFECT UNTIL AND UNLESS TERMINATED IN ACCORDANCE WITH THE TERMS HEREOF.

6. Termination.

6.1. Termination by Mutual Agreement. This Agreement may be terminated, in whole or in part, at any time upon the mutual agreement of the parties.

6.2. Termination Without Cause. At the end of the Initial Term or any Renewal Term hereof, either party may terminate this Agreement without cause upon one hundred eighty (180) days written notice to the other party prior to the end of the applicable Term.

6.3. Termination for Cause. RUMC or DMG may terminate this Agreement immediately upon written notice to the other party, if:

6.3.1. The other party has materially breached this Agreement. However, if the breach is capable of being cured within sixty (60) days, then this right shall not be exercised unless the breaching party has been given written notice of the breach and has failed to cure such breach within sixty (60) days of receiving notice. This cure period shall be shortened if a shorter period is needed to protect patients' health or safety or if required by the Illinois Department of Public Health, the Centers for Medicare and Medicaid Services, the Joint Commission, or any other entity by which RUMC or DMG must be licensed or certified in order to conduct regular operations;

6.3.2. The other party fails to maintain insurance as required by this Agreement;

6.3.3. The other party's license or certification required for its continued operation is suspended or terminated;

6.3.4. The other party is convicted of a crime, or is suspended or excluded from any federal health care program, including the Medicare and/or Medicaid

programs, or State of Illinois health care program, or is debarred by the federal or State government; or

6.3.5. The other party voluntarily initiates bankruptcy proceedings or becomes unable to pay its liabilities as and when they become due, or involuntary bankruptcy proceedings are commenced against the other party and are not dismissed within ninety (90) days.

6.4. Termination for Sale of Practice. If DMG merges with, is subject to a change in control whereby fifty percent (50%) or more of its capital stock is sold or otherwise transferred in any twelve (12) month period, fifty percent (50%) or more of its physician employees terminate their employment within any twelve (12) month period, or all or substantially all of its fixed assets and equipment are acquired by a hospital, health system, academic medical center or any Affiliate thereof, Rush shall have the right to immediately terminate this Agreement and any of the agreements attached as Schedules hereto upon written notice.

6.5. Termination for Sale of RUMC. If RUMC merges with or its assets are acquired by a hospital, health system, academic medical center or any Affiliate thereof, DMG shall have the right to immediately terminate this Agreement and any of the agreements attached as Schedules hereto upon written notice.

6.6. Termination Due to Legislative or Administrative Changes. In the event that there shall be a change in applicable health care law or the interpretation thereof, including, without limitation, Medicare or Medicaid, statutes, regulations, court decisions or general instructions, (or the application thereof), the adoption of new legislation or regulations applicable to this Agreement, the implementation of a change in payment methodology in any material third party payor reimbursement system, or the initiation of an enforcement action with respect to any applicable health care law (each of which are referred to herein as a "Regulatory Risk"), the Agreement and any of the agreements attached as Schedules hereto may be terminated as set forth herein. The existence of a Regulatory Risk shall be determined by a nationally recognized health care regulatory or tax counsel (for purposes of this Section, hereinafter referred to as "Counsel") and should be set forth in writing and presented to the other party, who then shall retain its own Counsel to (a) review the written opinion, (2) perform its own independent analysis, and (3) issue its own written opinion concerning the alleged Regulatory Risk. If Counsel for each party agrees that a Regulatory Risk is present, then both parties shall diligently and in good faith attempt to negotiate a restructuring of the Agreement and any of the agreements attached as Schedules hereto so as to alleviate such Regulatory Risk. If respective Counsel diverges on the presence of a Regulatory Risk, they shall then select a third, independent Counsel to (1) review the divergent written opinions; (2) perform its own independent analysis; and (3) issue a written opinion concerning the alleged Regulatory Risk. If the third, independent Counsel determines that no Regulatory Risk is present, then the Agreement shall continue to remain in full force and effect. If, however, a Regulatory Risk is deemed present by the third, independent Counsel, then both parties shall diligently and in good faith attempt to negotiate a restructuring of the Agreement and any of the agreements attached as Schedules hereto so as to alleviate such Regulatory Risk.

7. Coordination of Care.

7.1. Independent Professional Judgment. Rush and DMG hereby acknowledge that no party hereto has, nor do they exercise any, control or direction over the specific methods by which the other party provides professional services and practices medicine. Nothing contained in this Agreement requires referrals to particular health care facilities, interferes with patients' choice for medical treatment, or interferes with any physicians' independent medical judgment. Each party shall retain the right to refer patients to appropriate physicians and providers based on the independent medical judgment of the referring physician and any restrictions imposed by such patient's managed care plan. Each party's patients will retain the right to select a health care provider of their choice, subject to any restrictions imposed by managed care plans in which they may participate.

7.2. Right to Bill and Collect for Services. Unless otherwise agreed by the parties, each party or its designee, solely, shall bill for all professional services rendered by its physicians and its other healthcare professionals. Any and all fees received in connection with such billed services shall belong to the billing party and, if erroneously received by another party to this Agreement, shall immediately be assigned to or endorsed promptly to the appropriate party.

7.3. Health Information Technology. RUMC and DMG shall develop electronic health and related information exchanges, including the development of an integrated patient medical record system and shall enter into a Health Information Technology Agreement, which is attached hereto as Schedule 7.3.

7.4. Managed Care. The parties recognize the importance of working with payors of health care services in care coordination, quality improvement, and cost containment efforts and will enter into a managed care agreement, which is attached hereto as Schedule 7.4.

7.5. Ancillary Arrangements. The parties anticipate that additional agreements between the parties may become necessary to further the goals of collaboration, outreach and clinical integration and to deliver necessary medical services to their patients. The parties shall record the terms of any such ancillary arrangements and attach them hereto as Schedule 7.5.

8. Covenants.

8.1. Confidentiality. Except as necessary in this Agreement's performance, or as authorized in writing by a party or by law, the parties (and their employees, agents, and contractors) shall not disclose to any Person, institution, entity, company, or any other party, any proprietary business information directly or indirectly related to a party that another party (or its employees, agents, and contractors) receives under this Agreement, or about which it otherwise is aware. The parties (and their employees, agents, and contractors) also agree not to disclose, except to each other, another party's proprietary information, professional secrets or other information obtained under this Agreement, unless a party receives prior written authorization to do so from another party or as authorized by law. Nothing contained herein shall be construed to prohibit any Department of Health and Human Services ("DHHS") or

other appropriate government official from obtaining, reviewing, and auditing any information, record, data, and data elements to which he/she or his/her agency lawfully is entitled. In addition, nothing contained herein shall restrict a party from disclosing any information to its attorneys, accountants and other third party advisors and consultants, or pursuant to any subpoena or order of a court or an administrative or governmental agency, or in connection with any litigation relating to this Agreement. Unless otherwise prohibited by law, if a party receives a request from a third party (including, but not limited to DHHS) to disclose the confidential information of the other party, the disclosing party shall, as soon as practical, provide the other party with notice of such request in order to provide the other party with an opportunity to review and/or challenge such disclosure.

8.2. Non-Solicitation. RUMC and DMG hereby acknowledge that each party has invested valuable and significant resources in the development of its employees, including recruitment, training, supervision and management. In recognition thereof, neither party, nor any Affiliates of such party, shall, during the term of this Agreement and for one (1) year thereafter, employ, recruit, affiliate or in any way contract, directly or indirectly or in any manner whatsoever, with an employee of the other party, or such party's Affiliates, who provides services pursuant to this Agreement and any attachments hereto, without such other party's express written consent, provided, however, that no party will be precluded from hiring any employee of the other party who responds to any public notice or advertisement of an employment opportunity.

8.3. Remedies and Enforcement. RUMC and DMG each acknowledge that the other party has expended considerable time, effort, and cost in relation to this Agreement and that a violation of the provisions set forth in this Section 8 will result in irreparable damage, and that the dollar amount of such damage is difficult to ascertain with any degree of certainty. Thus, the parties agree that injunctive or other equitable relief (including injunctions pending trial on the merits) shall be available, without the necessity of any party posting a bond.

8.4. Notification of Obligations. The parties shall use commercially reasonable efforts to ensure that their respective employees, agents, and contractors are aware of and shall comply with the aforementioned obligations.

9. Dispute Resolution.

9.1. The parties shall first attempt to resolve any dispute arising under this Agreement by informal discussions between the parties' chief executive officers or their designees, subject to good cause exceptions, including, but not limited to, disputes determined by either party to require immediate relief (i.e. the health, welfare, and/or safety of patients is threatened). Any dispute which has failed to be resolved by informal discussions between the parties within a reasonable period of time after the commencement of such discussions (not to exceed thirty (30) days) and which does not require immediate relief may, at the request of either party, be referred to mediation.

9.2. The mediator will be selected jointly by the parties, or, if the parties are unable to agree on a mediator, in accordance with the Alternative Dispute Resolution procedures of the American Health Lawyers Association, Washington, D.C. ("AHLA"). The goal of the

mediation generally, and the specific task of the mediator, will be to preserve the substance of the collaboration to the extent reasonably possible.

9.3. The parties will work in good faith with the mediator for a period of thirty (30) days (which may be extended by the mediator for an additional thirty (30) days if the mediator believes such an extension would be desirable) in an effort to reach a mutually satisfactory solution. If the mediation is unsuccessful, the dispute may be resolved through any other means available. Each party will bear its own fees, costs and expenses in mediation, including attorney costs. The general costs and expenses of the mediation, such as facility rental fees and the costs and expenses of the mediator and the AHLA, will be borne equally by the parties.

10. **Insurance.** Rush and DMG shall each ensure that it, and any physician providing services on its behalf, shall be afforded profound liability protection, at such party's expense, through a self-insurance program or a commercial insurer with limits of not less than [REDACTED] per occurrence and [REDACTED] annual aggregate. Any party may request proof of insurance from one or more of the other parties. Parties requested to provide proof of insurance shall comply with the request within ten (10) business days of their receipt of the request. The insurance obligations contained herein shall survive the termination of this Agreement.

11. **Patient Referrals.** RUMC and DMG agree that (i) each party may be considered a current or potential source of patient referrals to the other; (ii) any remuneration exchanged between the parties is consistent with fair market value; and (iii) any remuneration exchanged between the parties reflects fair market value and does not take into account the volume or value of referrals or business that may otherwise be generated between the parties for which payment may be made in whole or in part under Medicare, Medicaid or other federal health care programs. RUMC and DMG hereby acknowledge and agree that it is not a purpose of this Agreement or any of the transactions contemplated herein to exert influence in any manner over the reason or judgment of any party with respect to the referral of patients or business of any nature whatsoever. It is the intent of the parties hereto that any referrals that may be made directly or indirectly by either party to the other, shall be based solely upon the medical judgment and discretion of a patient's physician while acting in the best interests of the patient.

12. **Regulatory Compliance.**

12.1. **Exclusions.** During the term of this Agreement, each party shall notify the other party of any exclusion of either party or its Affiliates from participation in any federal health care program, as defined under 42 U.S.C. §1320a-7b (f), for the provision of items or services for which payment may be made under such federal health care programs ("Exclusion") within five (5) business days of learning of any such Exclusion or any basis therefore. The non-excluded party shall have the right to immediately terminate this Agreement and any and all other agreements between the parties, upon learning of any Exclusion or any reasonable basis therefore against the other, its Affiliates and/or any employee, contractor or agent engaged by any of them to provide items or services.

12.2. Medicare Access to Books and Records. In the event, and only in the event, that Section 952 of P.L. 96-499 (42 U.S.C. Section 1395x(v)(1)(I)) is applicable to this Agreement, the parties agree as follows: (i) until the expiration of four (4) years after the termination of this Agreement, the parties shall make available, upon written request by the Secretary of the DHHS or upon request by the Comptroller General of the United States, or any of their duly authorized representatives, this Agreement, and books, documents and records of either party that are necessary to certify the nature and extent of the costs incurred pursuant to this Agreement; (ii) if either party carries out any of the duties of this Agreement or other contract between the parties through a subcontract, with a value or cost of \$10,000 or more over a twelve-month period, with a related organization, such subcontract shall contain a clause to the effect that until the expiration of four (4) years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request to the Secretary of the DHHS or upon request to the Comptroller General of the United States, or any of their duly authorized representatives, the subcontract, and books, documents and records of such organization that are necessary to verify the nature and extent of the costs incurred pursuant to such subcontract; and (iii) unless prohibited by the party making such request each party shall notify the other party immediately of the nature and scope of any request for access to books and records described above and shall provide copies of any books, records or documents to the other party prior to the provision of same to any governmental agent to give such party an opportunity to lawfully oppose such production of documents if such party believes such opposition is warranted. In addition, each party shall indemnify and hold the other party harmless from any liability arising out of any refusal by such party to grant access to books and records as required above. Nothing herein shall be deemed to be a waiver of any applicable privilege (such as attorney client privilege) by either party as the case may be.

13. Compliance with Applicable Law.

13.1. This Agreement shall be governed and construed in accordance with the laws of the State of Illinois, as well as all applicable Federal laws, regulations, and policies, including, but not limited to all applicable State and local laws, ordinances, and codes, including all licensing standards and applicable accreditation standards.

13.2. DMG and RUMC hereby each certify that it has not been debarred or suspended from participation in the Medicaid and/or Medicare programs or any other Federally-funded contracts.

13.3. Simultaneously with the execution hereof, the parties agree to execute and abide by the Business Associate Agreement, attached hereto as Schedule 13.3.

14. Marketing and Co-Branding. The parties agree to work cooperatively in marketing and co-branding the affiliation between the parties and to perform the marketing and co-branding activities. Within sixty (60) days of the Effective Date, which period may be extended upon mutual agreement of Rush and DMG, the parties shall determine the marketing and cobranding activities to be performed and shall include same set forth on Schedule 14, attached hereto. DMG acknowledges and agrees that it shall not use the name or logo of or make reference in any way to "Rush University Medical Center," "Rush" or any of its Affiliates or subsidiaries thereof

(including but not limited to the Rush System for Health and Rush Health) or employees, without the express prior written authorized approval of RUMC. Rush acknowledges and agrees that it shall not use the name or logo of or make reference in any way to "DuPage Medical Group", without the express written authorized approval of DMG.

15. The Parties' Relationship. Rush and DMG shall remain separate and independent entities. None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create, any relationship between or among the parties other than that of independent contractors. Except as otherwise provided, neither of the parties shall be construed to be the agent, partner, co-venturer, employee or representative of the other party or make a party liable for another party's expenses or obligations except as herein described. Each party in performing its respective duties and obligations hereunder at all times is acting and performing as an independent contractor with respect to each other and at no time shall one party's trustees, members, employees, directors, managers, partners, representatives or agents hold themselves out as or be considered another party's members, employees, partners, managers, trustees, directors, representatives or agents.

16. Consequences of Termination or Expiration of Agreement. Upon any termination of this Agreement in accordance with any provision hereof, or upon expiration of this Agreement at the end of the Initial Term or any Renewal Term, the obligations provided for under Sections 8 and 9 are intended to survive and shall survive any termination or expiration of this Agreement. The parties hereto shall work collaboratively to terminate all ancillary agreements and to provide for an effective transition of any services provided thereunder.

17. Notices. All notices required to be given under this Agreement shall be in writing, and delivered in person or sent by telecopy, overnight courier or certified mail, return receipt requested, postage prepaid, to the following addresses:

For RUMC: President and Chief Executive Officer
Rush University Medical Center
1725 W. Harrison, Suite 364
Chicago, IL 60612

and

General Counsel
Rush University Medical Center
1700 W. Van Buren, Suite 301
Chicago, IL 60612

With a copy to:

McGuireWoods LLP
77 W. Wacker Drive Suite 4100
Chicago, IL 60601
Attn: James B. Riley, Jr.

For Rush Health:

Brent J. Estes
President and Chief Executive Officer, Rush Health
1645 West Jackson Blvd.
Suite 501
Chicago, IL 60612

For DMG:

DuPage Medical Group
Attention: COO
1100 W. 31st Street, Suite 300
Downers Grove, IL 60515

The foregoing addresses may be changed and/or additional persons may be added thereto by notifying the other party hereto in writing and in the manner hereinafter set forth.

18. **Waivers.** The waiver by any party of any breach of any term, covenant or condition contained herein shall not be deemed to be a waiver of any subsequent breach of the same or any other term, covenant or condition contained herein. The subsequent acceptance of performance or payment of compensation hereunder by a party shall not be deemed to be a waiver of any preceding breach by the other party of any term, covenant or condition of this Agreement regardless of such party's knowledge of such preceding breach at the time of acceptance of such performance.

19. **No Inducement to Refer.** Nothing contained in this Agreement shall require DMG or any DMG physician owner or employee to admit or refer any patients to Rush. The parties enter into this Agreement with the intent of conducting their relationship in full compliance with applicable federal, state and local law, including the Medicare/Medicaid Anti-fraud and Abuse Amendments and Physician Ownership and Referral Act (commonly known as the Stark Law). Notwithstanding any unanticipated effect of any of the provisions herein, neither party will intentionally conduct itself under the terms of this Agreement in a manner to constitute a violation of these provisions.

20. **Non-Discrimination.** All parties hereto will comply with all applicable laws, rules, regulations and executive orders pertaining to non-discrimination on the basis of race, creed, color, national origin, age, sex, veteran status, handicapped status and such other classification or classifications which may from time to time be protected by law.

21. **Severability.** The provisions of this Agreement shall be deemed severable. If any provision of this Agreement shall be deemed invalid, illegal or unenforceable in any respect, such determination shall affect only the specific provision and shall not affect the remaining terms of this Agreement which shall remain in full force and effect and binding upon the parties hereto.

22. **Successors and Assigns.** This Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective transferees, successors and assigns.

23. **No Third Party Beneficiaries.** Nothing in this Agreement is intended to or shall create any right or remedies for any third party.

24. **Assignment.** Neither party shall have the right to assign, delegate or transfer this Agreement, or its rights and obligations hereunder, without the express prior written consent of the other party. Such consent shall not be unreasonably withheld. Notwithstanding the foregoing, upon the sale of all or substantially all of the fixed assets and equipment of DMG, this Agreement shall be assigned to the purchaser of such assets and equipment, subject to Rush's termination right set forth in Section 6.4.

25. **Amendments.** Any amendment to this Agreement shall be in writing and signed by the parties. Except for the specific provision of this Agreement which thereby may be amended, this Agreement shall remain in full force and effect after such amendment.

26. **Entire Agreement.** This Agreement represents the complete understanding of the parties with regard to the subject matter. This Agreement supersedes any prior agreements or understandings between the parties, whether oral or written, relating to the subject matter of this Agreement. No such prior agreements or understandings may be enforced by either party nor may they be employed for interpretation purposes in any dispute involving this Agreement.

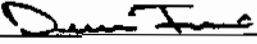
27. **Governing Law.** This Agreement shall be governed and construed in accordance with the laws of Illinois, as well as all applicable Federal, State and local laws, regulations and policies. The parties agree that all suits, actions or other proceedings primarily arising out of or from this Agreement shall be subject to litigation in the United States District Court, Northern District, Eastern Division of Illinois or the Cook County circuit courts.

28. **Counterparts.** This Agreement may be executed in counterparts, all of which when taken together shall constitute a single original.

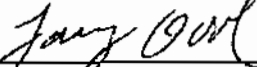
[Signature Page Immediately Follows]

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives as of the Effective Date.

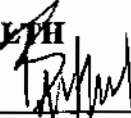
DUPAGE MEDICAL GROUP, LTD

By: 
Name: Dennis Fine
Title: Chief Operating Officer
Date: 10-12-11

RUSH UNIVERSITY MEDICAL CENTER

By: 
Name: Larry J. Goodman, M.D.
Title: President and Chief Executive Officer
Date: 10-12-11

RUSH HEALTH

By: 
Name: Brent Estes
Title: President and Chief Executive Officer
Date: 10-12-11

SCHEDULE 2 TO THE AFFILIATION AGREEMENT
MASTER CLINICAL COLLABORATION AGREEMENT
(see attached)

Schedule 2

23

Attachment 12- Exhibit 1

[Handwritten mark]

MASTER CLINICAL COLLABORATION AGREEMENT

THIS MASTER CLINICAL COLLABORATION AGREEMENT (the "**Agreement**") is effective the 12th day of October, 2011, by and between Rush University Medical Center, a tax-exempt, Illinois not-for-profit corporation ("**RUMC**") and DuPage Medical Group, Ltd., an Illinois corporation ("**DMG**"). RUMC and DMG may each be referred to as a "party" and collectively as "parties" to this Agreement.

WHEREAS, DMG, RUMC and Rush Health are parties to that certain Affiliation Agreement dated October 12, 2011 (the "**Affiliation Agreement**") pursuant to which the parties have agreed to collaborate to provide accessible, high quality, cost-effective health care services to promote the general public health and improve the health status of citizens living in the communities serviced by DMG and Rush; and

WHEREAS, DMG and RUMC desire to define specific clinical disciplines and service lines in which RUMC and DMG will work together to develop and implement new and/or enhanced service capabilities to serve patients in the western and southwestern suburbs of the Chicago metropolitan area.

NOW, THEREFORE, in consideration of the mutual promises and covenants herein contained and intending to be legally bound hereby, the parties agree as follows:

1. Scope of Clinical Collaboration.

1.1. The parties acknowledge and agree that the following clinical disciplines and service lines constitute the initial listing of clinical areas of mutual interest to the parties:

- i. Hematology/Oncology services, including but not limited to, oncologic infusion services and related professional services provided by RUMC's department of hematology/oncology, as well as related surgical subspecialty areas;

1.2. The parties agree the above listing of clinical specialties and service lines may be modified at any time by the mutual agreement of the parties and that indicating mutual interest does not constitute a binding commitment on any party to commit time or resources to actually providing related services. The parties will execute a specific sub-agreement, which will be attached as an Exhibit hereto, for each collaboration in a specific clinical area the parties desire to implement.

1.3. Each sub-agreement between the parties shall be specific to the clinical discipline and/or service line contemplated and will address all applicable considerations, including:

- Overall intended structure, scope of services to be provided, and roles and responsibilities of the parties;
- Governance and leadership, including but not limited to establishment of any necessary advisory committees, clinical protocols and standards of care, and

operational considerations;

- Necessary infrastructure and personnel, including staff, equipment purchases, and leasehold improvements;
- Operational expectations, including those related to billing and customer service;
- Managed care considerations;
- Marketing and branding; and
- Term and termination

2. Term.

2.1. Initial Term. The initial term of this Agreement shall commence on the Effective Date and shall continue for a period of ten (10) years ("Initial Term"), unless earlier terminated in accordance with the terms hereof.

2.2. Renewal Terms. THIS AGREEMENT SHALL AUTOMATICALLY RENEW FOR ADDITIONAL five (5) year PERIODS (each a "Renewal Term") (the Initial Term and each Renewal Term collectively referred to as the "Term") ON THE SAME TERMS AND CONDITIONS AS ARE THEN IN EFFECT UNTIL AND UNLESS TERMINATED IN ACCORDANCE WITH THE TERMS HEREOF.

3. Termination. This Agreement may be terminated for the reasons set forth in Section 6 of the Affiliation Agreement as though this Agreement is the "Agreement" referenced therein. In addition, this Agreement will automatically terminate upon termination of the Affiliation Agreement.

4. Consumer Choice. DMG or its Affiliates will not implement agreements or processes which limit or prohibit patients who require clinical services of a nature similar to those outlined in this Agreement from receiving such services from Rush; nor shall DMG or its physicians or Affiliates engage in activities which directly or indirectly steer patients who require clinical services similar to those outlined in this Agreement to receive such services from other non-DMG providers.

5. Incorporation and Conflict. The terms and conditions of the Affiliation Agreement are hereby specifically incorporated into this Agreement by reference with this Agreement being deemed the "Agreement" referenced in the Affiliation Agreement. In the event any provision of this Agreement conflicts with the Affiliation Agreement, this Agreement shall be deemed to supersede the Affiliation Agreement with respect to such conflicting provision.

[Signature Page Immediately Follows]

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives as of the Effective Date.

DUPAGE MEDICAL GROUP, LTD

By: 
Name: Dennis Fine
Title: Chief Operating Officer
Date: 10/12/14

RUSH UNIVESITY MEDICAL CENTER

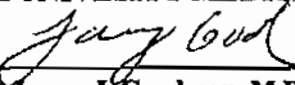
By: 
Name: Larry J. Goodman, M.D.
Title: Chief Executive Officer
Date: 10-12-11

EXHIBIT A TO THE MASTER CLINICAL COLLABORATION AGREEMENT

CANCER CENTER COLLABORATION

THIS CANCER CENTER COLLABORATION AGREEMENT (the "Agreement") is effective the 12th day of October, 2011, by and between Rush University Medical Center, a tax-exempt, Illinois not-for-profit corporation ("RUMC") and DuPage Medical Group, Ltd., an Illinois corporation ("DMG"). RUMC and DMG may each be referred to as a "party" and collectively as "parties" to this Agreement.

WHEREAS, DMG, RUMC and Rush Health are parties to that certain Affiliation Agreement dated October 12, 2011 (the "Affiliation Agreement") pursuant to which the parties have agreed to collaborate to provide accessible, high quality, cost-effective health care services to promote the general public health and improve the health status of citizens living in the communities serviced by DMG and RUMC;

WHEREAS, DMG and RUMC are parties to that certain Master Clinical Collaboration Agreement (the "Master Collaboration Agreement") pursuant to which the parties set forth the framework for their various clinical collaborations, and the terms of which are specifically incorporated herein by reference; and

WHEREAS, DMG and RUMC desire to collaborate in the development of a cancer treatment center (the "Cancer Center") on the terms and conditions contained herein;

WHEREAS, DMG intends to construct and own a building located at 430 Warrenville Road in Lisle, Illinois (the "Building") in which the Cancer Center will be located;

WHEREAS, RUMC intends to lease space in the Building from DMG.

NOW, THEREFORE, in consideration of the mutual promises and covenants herein contained and intending to be legally bound hereby, the parties agree as follows:

1. Cancer Center Services.

1.1. RUMC Services. RUMC will provide on-site medical oncologists and surgeons and other health care professionals to support RUMC and DMG patients by providing comprehensive cancer treatment, including oncologic infusion services (the "Infusion Services"). The Infusion Services shall be provided in designated space within the Cancer Center (the "Infusion Center"). The Infusion Center will be established as a satellite location of RUMC, pursuant to rules and regulations applicable to Provider Based Clinics.

1.2. DMG Services. DMG will provide on-site medical oncologists, physicians, other health care professionals, radiation oncology, and diagnostic and ancillary services at the Cancer Center to support RUMC and DMG patients by providing comprehensive cancer treatment.

1.3. Lease. DMG and RUMC shall enter into a lease agreement, which will be attached hereto as Attachment 1, pursuant to which RUMC will lease space in the Building to for physician services and the Infusion Center (the "Lease").

2. Clinical Collaboration for Cancer Center Services.

2.1 Cancer Center Services. The parties shall collaborate to provide services at the Cancer Center as set forth on Attachment 2.

2.2 Definitions.

2.2.1 "Affiliate" shall mean, with respect to any Person, (i) any Person directly or indirectly controlling, controlled by or under common control with such Person; (ii) any Person owning or controlling, directly or indirectly, five percent (5%) or more of the outstanding voting securities, equity interests, or membership interests (including such interests in a not-for-profit organization), of such Person; (iii) any officer, director, shareholder, member, manager or partner of such Person; (iv) any company in which such Person is an officer, director, member, manager or partner.

2.2.2 "Person" shall mean any individual, partnership, corporation, trust, limited liability company, association, joint venture, investment fund, joint stock company, organization, business, trust or any other entity or organization, including a government or any department, agency or political subdivision thereof.

2.2.3 "Service Area" shall mean (i) Cook, DuPage and Will Counties in Illinois and (ii) within a 15 mile radius of any cancer treatment center sites established between DMG and Rush outside of such counties.

2.2 Exclusivity. During the term of this Agreement (the "Exclusivity Period"), DMG hereby agrees that neither it nor any of its Affiliates shall develop, acquire, lease to or from or invest in new or existing oncologic infusion services within its Service Area except for expansions of oncologic infusion services developed with Rush under this Agreement. If any court of competent jurisdiction shall at any time deem any particular restrictive covenant contained in this Section 2 unreasonable, the other provisions of this Section 2 shall nevertheless stand, the Exclusivity Period herein shall be deemed to be the longest period permissible by law under the circumstances and the Service Area shall be deemed to comprise the largest territory permissible by law under the circumstances, as determined by the court in each case.

3. Term.

3.1. Initial Term. The initial term of this Agreement shall commence on the Effective Date and shall continue for a period of ten (10) years ("Initial Term"), unless earlier terminated in accordance with the terms hereof.

3.2. Renewal Terms. THIS AGREEMENT SHALL AUTOMATICALLY RENEW FOR ADDITIONAL five (5) year PERIODS (each a "Renewal Term") (the Initial Term and each Renewal Term collectively referred to as the "Term") ON THE SAME TERMS AND CONDITIONS AS ARE THEN IN EFFECT UNTIL AND UNLESS TERMINATED IN ACCORDANCE WITH THE TERMS HEREOF.

4. Termination. The terms and conditions of the Affiliation Agreement and are hereby specifically incorporated into this Agreement by reference with this Agreement being deemed the "Agreement" referenced in the Affiliation Agreement and shall automatically terminate upon termination of the Affiliation Agreement. In addition, this Agreement may also be terminated by RUMC:

4.1. Upon notice to DMG within thirty (30) days of either of the following events (i) failure to commence construction (i.e., commence site preparation) of the Building on or before December 31, 2011 or (ii) failure to complete (i.e., obtain a certificate of occupancy) the Building within 180 days of the December 31, 2012 delivery deadline set forth in the Lease, through no fault or delay caused by the Tenant.

4.2. Upon termination of the Lease for any reason.

5. Incorporation and Conflict. The terms and conditions of the Affiliation Agreement and the Master Collaboration Agreement are hereby specifically incorporated into this Agreement by reference with this Agreement being deemed the "Agreement" referenced therein. In the event any provision of this Agreement conflicts with the Affiliation Agreement or the Master Collaboration Agreement, this Agreement shall be deemed to supersede the Affiliation Agreement and the Master Collaboration Agreement with respect to such conflicting provision.

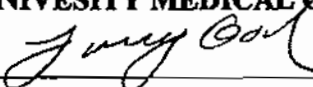
[Signature Page Immediately Follows]

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives as of the Effective Date.

DUPAGE MEDICAL GROUP, LTD

By: 
Name: Dennis Fine
Title: Chief Operating Officer
Date: 10/12/11

RUSH UNIVERSITY MEDICAL CENTER

By: 
Name: Larry J. Goodman, M.D.
Title: Chief Executive Officer
Date: 10-12-11

Attachment 1 to the Cancer Center Collaboration Agreement

SPACE LEASE AGREEMENT
(see attached)

Schedule 2
Exhibit A
Attachment 1

Attachment 12- Exhibit 1

Attachment 2 to the Cancer Center Collaboration Agreement

CLINICAL COLLABORATION FOR CANCER CENTER SERVICES

1. RUMC shall provide Infusion Services.
2. DMG shall provide on-site radiation oncology, and diagnostic and ancillary services.
3. The parties shall collaborate in the provision of other cancer treatment-related physician services as agreed to by the parties in good faith.
4. The parties will mutually select a Medical Director for the Cancer Center, who shall be a physician employed by RUMC. The cost of the compensation (salary and any benefits) for the Medical Director of the Cancer Center shall be paid as follows: [REDACTED]
5. Within sixty (60) days of execution of this Agreement, DMG will select two (2) DMG physicians to be formally charged to provide additional administrative services which will further the mutual intent of the parties under this Agreement related to: (i) developing health information technology coordination with RUMC and (ii) advancing the quality improvement agenda/clinical integration activities of the affiliation. RUMC shall provide DMG with an annual, fair market value rate of [REDACTED] for each physician's services. RUMC and DMG will prepare annual objectives for DMG and the physicians appointed pursuant to this arrangement and the parties will meet at least quarterly to review progress relative to the agreed upon activities.
6. The parties will mutually select an Administrator for the Cancer Center. The cost of the Administrator's compensation (salary and benefits) shall be [REDACTED]
7. The parties will work in good faith to further define the scope of the clinical collaboration for cancer center services and shall amend this Attachment 2 to reflect same. The parties shall make such amendment on or before the receipt of the Certificate of Occupancy for the Building.

SCHEDULE 3 TO THE AFFILIATION AGREEMENT

ACADEMIC AGREEMENT

THIS ACADEMIC AGREEMENT (the "Agreement") is effective the 12th day of October, 2011, by and between Rush University Medical Center, a tax-exempt, Illinois not-for-profit corporation ("RUMC") and DuPage Medical Group, Ltd., an Illinois corporation ("DMG"). RUMC and DMG may each be referred to as a "party" and collectively as "parties" to this Agreement.

WHEREAS, DMG, RUMC and Rush Health are parties to that certain Affiliation Agreement dated October 12, 2011 (the "Affiliation Agreement") pursuant to which the parties have agreed to collaborate to provide accessible, high quality, cost-effective health care services to promote the general public health and improve the health status of citizens living in the communities serviced by DMG and Rush; and

WHEREAS, RUMC operates the Rush Medical College, which sponsors and participates in various clinical educational programs for the training of its students, residents and health care professionals; and

WHEREAS, RUMC, the Rush Medical College and DMG desires to work collaboratively to develop mutually beneficial opportunities for DMG physicians to work with RUMC physicians and participate in RUMC academic activities.

NOW, THEREFORE, in consideration of the mutual promises and covenants herein contained and intending to be legally bound hereby, the parties agree as follows:

1. **Scope of Academic Relationship.** RUMC and DMG hereby agree to utilize best efforts to develop mutually beneficial opportunities for DMG physicians to work collaboratively with RUMC physicians and participate in RUMC academic activities. Such activities may include faculty appointments, training of medical residents and fellows, clinical trials, continuing medical education and physician and nursing recruitment. The parties shall commence good faith negotiations on the various components of the academic relationship within one hundred twenty (120) of the execution hereof and will work diligently and in good faith to define the scope of their academic relationship and shall, within twelve (12) months of the execution hereof, amend this Agreement to reflect same.

2. **Term.**

2.1. **Initial Term.** The initial term of this Agreement shall commence on the Effective Date and shall continue for a period of ten (10) years ("Initial Term"), unless earlier terminated in accordance with the terms hereof.

2.2. **Renewal Terms.** THIS AGREEMENT SHALL AUTOMATICALLY RENEW FOR ADDITIONAL five (5) year PERIODS (each a "Renewal Term") (the Initial Term and each Renewal Term collectively referred to as the "Term") ON THE SAME TERMS AND

CONDITIONS AS ARE THEN IN EFFECT UNTIL AND UNLESS TERMINATED IN ACCORDANCE WITH THE TERMS HEREOF.

3. **Termination**. This Agreement may be terminated for the reasons set forth in Section 6 of the Affiliation Agreement as though this Agreement is the "Agreement" referenced therein. In addition, this Agreement will automatically terminate upon termination of the Affiliation Agreement.

4. **Incorporation and Conflict**. The terms and conditions of the Affiliation Agreement are hereby specifically incorporated into this Agreement by reference with this Agreement being deemed the "Agreement" referenced in the Affiliation Agreement. In the event any provision of this Agreement conflicts with the Affiliation Agreement, this Agreement shall be deemed to supersede the Affiliation Agreement with respect to such conflicting provision.

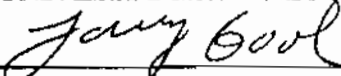
[Signature Page Immediately Follows]

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives as of the Effective Date.

DUPAGE MEDICAL GROUP, LTD

By: 
Name: Dennis Fine
Title: Chief Operating Officer
Date: 10/12/11

RUSH UNIVERSITY MEDICAL CENTER

By: 
Name: Larry J. Goodman, M.D.
Title: Chief Executive Officer
Date: 10/12/11

SCHEDULE 7.3 TO THE AFFILIATION AGREEMENT

HEALTH INFORMATION TECHNOLOGY AGREEMENT

THIS HEALTH INFORMATION TECHNOLOGY AGREEMENT (the "**Agreement**") is effective the 12th day of October, 2011, by and between Rush University Medical Center, a tax-exempt, Illinois not-for-profit corporation ("**RUMC**") and DuPage Medical Group, Ltd., an Illinois corporation ("**DMG**"). RUMC and DMG may each be referred to as a "**party**" and collectively as "**parties**" to this Agreement.

WHEREAS, DMG, RUMC and Rush Health are parties to that certain Affiliation Agreement dated October 12, 2011 (the "**Affiliation Agreement**") pursuant to which the parties have agreed to collaborate to provide accessible, high quality, cost-effective health care services to promote the general public health and improve the health status of citizens living in the communities serviced by DMG and Rush; and

WHEREAS, RUMC and DMG desires to work collaboratively to develop mutually agreeable health information technology utilization strategies, including but not limited to electronic health and related information exchanges and the development of an integrated patient medical record system.

NOW, THEREFORE, in consideration of the mutual promises and covenants herein contained and intending to be legally bound hereby, the parties agree as follows:

1. **Scope of Relationship.** RUMC and DMG hereby agree to utilize best efforts to develop mutually agreeable health information technology utilization strategies, including but not limited to electronic health and related information exchanges and the development of an integrated patient medical record system. The parties shall commence good faith discussions to develop this strategy within one hundred twenty (120) of the execution hereof and shall work diligently and in good faith to negotiate the specific terms and conditions of the health and related information exchange and shall, within twelve (12) months of the execution hereof, amend this Agreement to reflect same.

2. **Term.**

2.1. **Initial Term.** The initial term of this Agreement shall commence on the Effective Date and shall continue for a period of ten (10) years ("**Initial Term**"), unless earlier terminated in accordance with the terms hereof.

2.2. **Renewal Terms.** THIS AGREEMENT SHALL AUTOMATICALLY RENEW FOR ADDITIONAL five (5) year PERIODS (each a "**Renewal Term**") (the Initial Term and each Renewal Term collectively referred to as the "**Term**") ON THE SAME TERMS AND CONDITIONS AS ARE THEN IN EFFECT UNTIL AND UNLESS TERMINATED IN ACCORDANCE WITH THE TERMS HEREOF.

3. **Termination.** This Agreement may be terminated for the reasons set forth in Section 6 of the Affiliation Agreement as though this Agreement is the "Agreement" referenced therein. In

addition, this Agreement will automatically terminate upon termination of the Affiliation Agreement.

4. **Incorporation and Conflict.** The terms and conditions of the Affiliation Agreement are hereby specifically incorporated into this Agreement by reference with this Agreement being deemed the "Agreement" referenced in the Affiliation Agreement. In the event any provision of this Agreement conflicts with the Affiliation Agreement, this Agreement shall be deemed to supersede the Affiliation Agreement with respect to such conflicting provision.

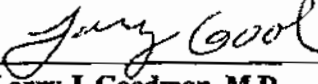
[Signature Page Immediately Follows]

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives as of the Effective Date.

DUPAGE MEDICAL GROUP, LTD

By: 
Name: Dennis Fine
Title: Chief Operating Officer
Date: 10/12/11

RUSH UNIVERSITY MEDICAL CENTER

By: 
Name: Larry J. Goodman, M.D.
Title: Chief Executive Officer
Date: 10/12/11

SCHEDULE 7.4 TO THE AFFILIATION AGREEMENT

**MANAGED CARE AGREEMENT
(See Attached)**

SCHEDULE 7.5 TO THE AFFILIATION AGREEMENT

ANCILLARY AGREEMENTS

(see attached)

SCHEDULE 13.4 TO THE AFFILIATION AGREEMENT

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (the "Agreement") is entered into by and between Rush University Medical Center, a tax-exempt, Illinois not-for-profit corporation ("RUMC"), Rush Health, a taxable Illinois not-for-profit corporation ("Rush Health" and together with RUMC, "Rush") and DuPage Medical Group, Ltd., an Illinois corporation ("Company"). Rush and DMG may each be referred to as a "party" and collectively as "parties" to this Agreement.

WHEREAS, this Agreement establishes the terms of the relationship between Rush and Company on the use, exchange, and storage of confidential health information;

WHEREAS, each party provides certain services to the other, and in connection with the provision of said services, each party discloses to the other certain Protected Health Information ("PHI," (as defined in 45 C.F.R. §16.4.501) that is subject to the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (the "Act"), the privacy standards adopted by the U.S. Department of Health and Human Services ("DHHS") as they may be amended from time to time, 45 C.F.R. parts 160 and 164, subparts A and E (the "Privacy Rule"), the security standards adopted by DHHS as they may be amended from time to time, 45 C.F.R. parts 160, 162, and 164, subpart C (the "Security Rule"), and the Privacy provisions (Subtitle D) of the Health Information Technology for Economic Clinical Health Act, Division A, Title XIII of Pub. L. 111-5, and its implementing regulations (the "HITECH Act"). (the Act, Privacy Rule, the Security Rule, and the HITECH Act are collectively referred to as "HIPAA" for purposes of this Agreement;

WHEREAS, each party is a "Covered Entity" as that term is defined in the HIPAA implementing regulations, 45 C.F.R. Part 160 and Part 164, Subparts A and E, the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule"); and as that term is defined in the HIPAA implementing regulations, 45 C.F.R. Part 164, Subpart C, the Security Standards for the Protection of Electronic Protected Health Information ("Security Rule");

WHEREAS, each party, as a recipient of PHI from the other, is a "Business Associate" as that term is defined in the Privacy Rule and the Security Rule;

WHEREAS, pursuant to the Privacy Rule and the Security Rule, all Business Associates of Covered Entities must agree in writing to certain mandatory provisions regarding the use and disclosure of PHI; and

WHEREAS, the purpose of this Agreement is to comply with the requirements of the Privacy Rule and the Security Rule, including, but not limited to, the Business Associates contract requirements at 45 C.F.R. 164.314 (a).

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. **Definitions.** Unless otherwise provided in this Agreement, capitalized terms have the same meanings as set forth in HIPAA.

2. **Scope of Use and Disclosure of Protected Health Information.**

2.1. Each party shall be permitted to use and disclose PHI that is disclosed to it (the "Receiving Party") by the other (the "Disclosing Party") as necessary to perform in accordance with the Disclosing Party's established policies, procedures and requirements.

2.2. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Agreement or required by law, the Receiving Party may:

2.2.1. use the PHI in its possession for its proper management and administration and to fulfill any of its legal responsibilities;

2.2.2. de-identify any and all PHI created or received under this agreement; provided, that the de-identification conforms to the requirements of HIPAA.

2.3. Each party shall implement and maintain the administrative, physical and technical safeguards required by HIPAA to protect the confidentiality, integrity and availability of electronic PHI and to ensure that PHI disclosed by and between the parties is not used or disclosed by a party, or by any subcontractors, affiliates, or associates of the party, except as provided in this Agreement;

2.4. Each party shall promptly report to the other party any use or disclosure of PHI of which the party becomes aware that is not provided for or permitted by this Agreement or under HIPAA. Each party agrees to report to the other party the aggregate number of unsuccessful, unauthorized attempts to RUMC, use, disclose, modify or destroy electronic versions of the other party's PHI or interfere with systems operations in an Information System containing the other party's PHI, of which the party becomes aware, provided that: (a) such reports will be provided only as frequently as the parties mutually agree, but no more than once per month; and, (b) if the definition of "Security Incident" is amended under the Security Rule to remove the requirement for reporting "unsuccessful" attempts to use, disclose, modify or destroy electronic PHI, this Section 2.4 shall no longer apply as of the effective date of such amendment.

3. **Obligations of Receiving Party in connection with its use and disclosure of PHI.** The Receiving Party agrees that it will:

3.1. Use or further disclose PHI only as permitted or required by this Agreement and as required by law;

3.2. To the extent practicable, mitigate any harmful effect that is known to Receiving Party of a use or disclosure of PHI by the Receiving Party in violation of this Agreement;

3.3. Report to the Disclosing Party any use or disclosure of PHI not provided for by this Agreement of which the Receiving Party becomes aware;

3.4. Require contractors or agents to whom the Receiving Party provides PHI to agree to the same restrictions and conditions that apply to the Receiving Party pursuant to this Agreement;

3.5. Make available to the Secretary of Health and Human Services, the Receiving Party's internal practices, books and records relating to the use and disclosure of PHI for purposes of determining the Disclosing Party's compliance with HIPAA, subject to any applicable legal privileges;

3.6. Within fifteen (15) days of receiving a request from the Disclosing Party, make available the information necessary for the Disclosing Party to make an accounting of disclosures of PHI about an individual;

3.7. Within ten (10) days of receiving a written request from the Disclosing Party, make available PHI necessary for the Disclosing Party to respond to individuals' requests for Access to PHI about them that is not in the possession of the Receiving Party, in the event that the PHI in the Receiving Party's possession constitutes a Designated Record Set;

3.8. Within fifteen (15) days of receiving a written request from the Disclosing Party incorporate any amendments or corrections to the PHI in accordance with HIPAA in the event that the PHI in the Receiving Party's possession constitutes a Designated Record Set;

3.9. Not make any disclosure of PHI that the Disclosing Party would be prohibited from making.

4. Obligations of the Disclosing Party. The Disclosing Party agrees that it:

4.1. Has included, and will include, in the Disclosing Party's Notice of Privacy Practices required by HIPAA that the Disclosing Party may disclose PHI for health care operations purposes;

4.2. Has obtained, and will obtain, from Individuals consents, authorizations and other permissions necessary or required by laws applicable to the Disclosing Party for the Receiving Party and the Disclosing Party to fulfill their obligations under this Agreement;

4.3. Will promptly notify the Receiving Party in writing of any restrictions on the use and disclosure of PHI about Individuals that the Disclosing Party has agreed to that may affect the Receiving Party's ability to perform its obligations under the underlying Agreement;

4.4. Will promptly notify the Receiving Party in writing of any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes or revocation may affect the Receiving Party's ability to perform its obligations under the underlying Agreement.

5. Termination.

5.1. Termination for Breach. The Disclosing Party may terminate this Agreement if the Disclosing Party determines that the Receiving Party has breached a material term of this Agreement. However, if the breach is capable of being cured within thirty (30) days, then this right shall not be exercised unless the breaching party has been given written notice of the breach and has failed to cure such breach within thirty (30) days of receiving notice. This cure period shall be shortened if a shorter period is needed to protect patients' health or safety or if required by the Illinois Department of Public Health, the Centers for Medicare and Medicaid Services, the Joint Commission, or any other entity by which RUMC or DMG must be licensed or certified in order to conduct regular operations. In the event the Receiving Party fails to cure the breach to the satisfaction of the Disclosing Party, the Disclosing Party may immediately thereafter terminate this Agreement.

5.2. Effect of Termination.

5.2.1. Termination of this Agreement will result in termination of the operations between the Disclosing Party and the Receiving Party.

5.2.2. Upon termination of this Agreement, the Receiving Party will return all PHI received from the Disclosing Party or created or received by the Receiving Party on behalf of the Disclosing Party that the Receiving Party still maintains and retain no copies of such PHI.

6. Amendment. The Receiving Party and the Disclosing Party agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the Disclosing Party to comply with the requirements of the Privacy and Security Rule.

7. Survival. The obligations of the Receiving Party under Section 5.2.2 of this Agreement shall survive any termination of this agreement.

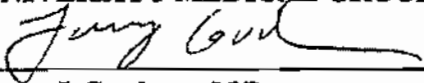
8. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

IN WITNESS WHEREOF, the parties hereto have executed this BUSINESS ASSOCIATE AGREEMENT as of the day and year first written above.

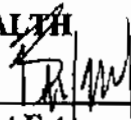
DUPAGE MEDICAL GROUP, LTD.

By: 
Name: Dennis Fine
Title: Chief Operating Officer
Date: 10/12/11

RUSH UNIVERSITY MEDICAL GROUP

By: 
Name: Larry J. Goodman, M.D.
Title: Chief Executive Officer
Date: 10/12/11

RUSH HEALTH

By: 
Name: Brent Estes
Title: President and Chief Executive Officer
Date: 10/12/11

SCHEDULE 15 TO THE AFFILIATION AGREEMENT

MARKETING AND CO-BRANDING ACTIVITIES

1. Representatives of Rush and DMG will meet no less frequently than annually to develop an the marketing/co-branding/communications plan for the following year.
2. The plan will address the following marketing strategies:
 - i. Rush and DMG websites;
 - ii. Utilizing social media (e.g., Twitter and Facebook)
 - iii. Press releases;
 - iv. Direct to consumer advertising;
 - v. Internal marketing efforts; and
 - vi. Marketing of the new building/cancer center. The campaign to publicize and market the new building and the cancer center will commence no later than 90 days prior to opening.
3. As part of the annual marking plan development, the parties will agree on cost-sharing and funding responsibility for the approved marketing strategies.

\\Rush-DMG Affiliation Agreement #29571429 (v.21).doc

Attachment 12-Exhibit 2

Physician Biographical Sketches

The following physicians were interviewed for the case studies on the clinical collaboration agreement:

From DuPage Medical Group –

Dr. Ravi Nemivant is a board-certified specialist in pulmonary medicine, critical care, and sleep medicine. He has received numerous teaching awards and has been published in medical journals. Dr. Nemivant received his medical degree in 1998 from Rush Medical College in Chicago where he was elected to the Alpha Omega Honor Society. He has completed a residency in internal medicine at Chicago's Rush Presbyterian-St. Luke's Medical Center where he was intern and resident of the year and also named Chief Resident. He went on to complete fellowship training in Pulmonary & Critical Care Medicine at Loyola University Medical Center and Hines Veterans Administration Medical Center in Maywood from 2002-2005.

Dr. Paul Merrick is a board-certified urologist in practice at the DuPage Medical Group since 1994. He received his medical degree from Rush Medical College in Chicago where he also completed his residency. He has a busy practice encompassing all types of urologic disease with particular focus on care for cancer patients, voiding dysfunction, and kidney stones. Dr. Merrick performs numerous evaluations and treatments, including surgery, brachytherapy, and other minimally invasive treatments.

Dr. Donald Hoscheit is a board-certified gastroenterologist specializing in diseases and disorders of the digestive tract with a particular emphasis on endoscopic surgery, colon cancer detection and screening, colitis, Crohn's disease, and peptic ulcer disease. He received his medical degree in 1982 from Loyola University Stritch School of Medicine and completed his internship, residency and fellowship at the Loyola University Medical Center in Maywood. Dr. Hoscheit has also been elected a fellow of the American College of Gastroenterology.

From Rush University Medical Center –

Dr. Philip Bonomi is a board-certified specialist in internal medicine and medical oncology, with a particular expertise in lung cancer and mesothelioma. He received his medical degree from the University of Illinois College of Medicine at Chicago and completed his residency at the Geisinger Medical Center, which recently received the 2012 Thomson Reuters 100 Top Hospitals National Benchmarks Award. Dr. Bonomi went on to complete a fellowship at Rush University Medical Center, where he now holds a professorship. He is also a prolific writer whose work has been published in numerous medical journals.

The following physician was interviewed for the case study on the linear accelerator:

From DuPage Medical Group –

Dr. Brian Moran is a renowned specialist in radiation oncology. He is a prolific speaker and author on the subject and has been certified by the American Board of Radiology. Dr. Moran has also held numerous positions, both in an academic as well as an administrative capacity, and is currently the Medical Director of the Prostate Cancer Foundation of Chicago. He received his medical degree from the Loyola Stritch School of Medicine and completed his residency in radiation oncology at Loyola-Hines University Medical Center. Over the course of his career, Dr. Moran has received numerous honors, including the Resident Teaching Award at Lutheran General Hospital. Based on these qualifications and achievements, DuPage Medical Group had decided to put Dr. Moran in charge of its radiation therapy program.

Attachment 12-Exhibit 3 Planned Market Service Area

[Home](#)

[About Us](#)

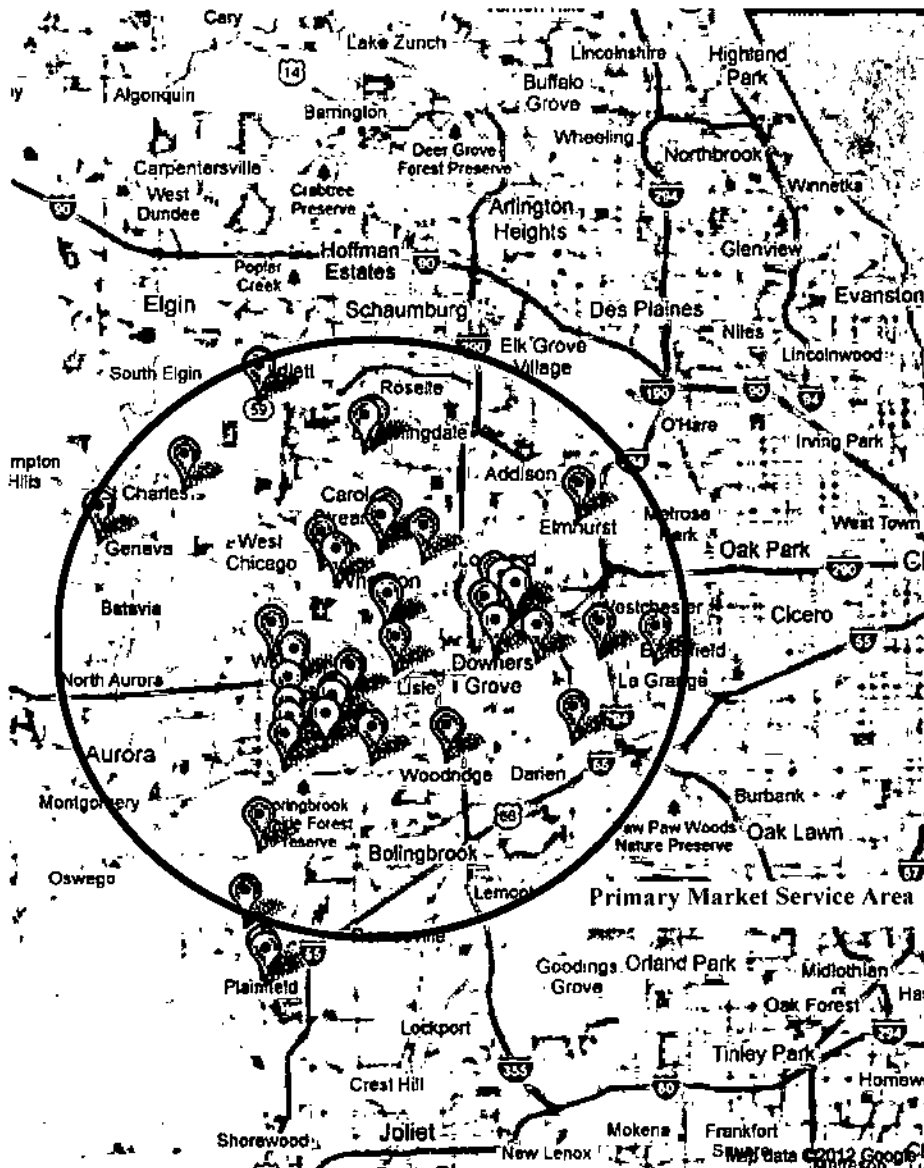
[Specialties & Locations](#)

[For Patients](#)

[For Physicians](#)

[DMG News](#)

DuPage Medical Group Locations



Bartlett
 -- 1124 Stearns Road
 -- 1130 Stearns Road

Bloomington
Stratford
Stratford North

Carol Stream
Belmont Lane

Downers Grove
Butterfield Road
Highland Avenue
Highland Avenue Tower 2

Elmhurst
Geneva
Glen Ellyn

Hinsdale
N. Elm Street
Belleza Skin Care Institute in Hinsdale

LaGrange
Lisle

Lombard
Highland Avenue
Surgical Center
West Suburban Podiatrics

Naperville
Belleza Skin Care Institute in Naperville
Edward Medical Physician Center
 -- 100 Spalding Drive
 -- 120 Spalding Drive
Bay Scott Circle
CityGate Lane
Hobson Road
Martin Ave
Qaden Avenue
Rickert Drive
River North Medical Center
RollingRidge Road
S. Washington Street
Three Farms Avenue

Oak Brook
127th Street
Naperville Road
West Riverwalk Court

St. Charles
 Warrenville
Institute of Aesthetic Surgery

Westmont
 Wheaton
Belleza Skin Care Institute Wheaton
County Farm Road
Danada
Main St.
Town Square

Willowbrook
Winfield
Woodridge

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

Criterion 1110.230 – Background, Purpose of the Project and Alternatives

ALTERNATIVES

As is explained below, DMG decided on the proposed project after considering several alternatives. These alternatives included: (1) maintain status quo; (2) provide the planned services at existing facilities; and (3) proceed without leasing space to Rush University Medical Center. Each was rejected for various reasons.

Alternative #1 – Maintain Status Quo

The status quo was determined to be untenable given DuPage Medical Group's growth related to numbers and specialties of physicians. This Medical office Building will provide more than 50,000 sq. ft. of office space for primary as well as specialty medicine.

Furthermore the 87,000 sq. ft. of medical office space will integrate physicians within a single environment addressing the growing demand for integrated health care. The MOB will be utilized to respond to community need for easier access to complex and tertiary care. As discussed in more detail in Attachment 37, cancer cases in particular are projected to grow significantly as the population ages. Furthermore, many patients in the community already travel to Chicago in order to receive treatment. This is especially true for patients requiring a university level of care.

Therefore, continuing under the status quo would fail to address the remaining needs of patients and their physicians in several ways:

- First, it limits DMG's ability to provide clinical and office space to its group physician multi-specialty group.
- Second, it would mean that area residents would continue to have limited access to integrated, university-level tertiary care in their community.
- Third, it would perpetuate a situation whereby patients are forced to travel outside of their community to receive care, which has negative effects on both patient convenience and coordination of care.

Alternative #2 – Use Space at Existing Facilities

The applicants rejected the idea of using space at existing facilities because it does not meet their goals for coordinating and ensuring the quality of care. The primary reason that DMG is constructing this Medical Office Building is to ensure that its patients receive integrated, high-quality care. Presently, DMG must outsource treatments for many of its patients, including those requiring radiation therapy. This has several drawbacks.

The main problem is that this outsourcing often causes care to be delivered in a piecemeal way. For example, when a patient is referred to a specialist, there are often problems in coordination between

the specialist and the primary care physician. This means that the primary care physician will often not have all the relevant information regarding a patient, e.g. complete medical records. This fragmentation also leads to a variation in the quality of care. A uniform and high standard of care is especially important in radiation therapy where misadministration of therapy can have serious and lasting side effects.

It is only through the construction of this Medical Office Building that DMG can ensure its patients receive coordinated care at the highest standard. It will allow DMG physicians to have patients at an integrated, DMG-directed facility, thus minimizing barriers to communication between physicians tasked with coordinating care. Furthermore, having a linear accelerator located on the premises will mean that DMG physicians no longer will be forced to outsource radiation therapy treatments and can ensure that those treatments are delivered according to their standards and protocols.

This MOB is designed to offer care that is both coordinated and also comprehensive. DMG intends to provide to patients in the community, a location where they can receive complex as well as primary care treatments in one, convenient location. It is for this reason that a smaller building, providing a lesser scope of services was deemed inappropriate. If one of the services, e.g. radiation therapy or physician office space, was not incorporated into the MOB, the project would not serve the goal of providing patients in the community with a convenient location for receiving comprehensive, state of the art care.

Another reason, in addition to the benefits described above, that DMG decided to build a centrally-located MOB is that it is more cost effective in the long run. Providing these services at many different locations is subject to inherent inefficiencies, e.g. duplication of costs, confusion for patients, and ineffective communication between physicians. This MOB will help streamline the provision of care to such an extent that, even after the cost of land acquisition and construction are taken into account, it has definite financial advantages compared to the status quo.

It should be noted that the benefits of care coordination, a central location, and an on-site radiation therapy capability are specific to the MOB. These advantages are not to be confused with those provided by the clinical collaboration agreement, which is separate and distinct from this MOB. (See Attachment 12 for case studies describing implementation of the clinical collaboration agreement between DMG and Rush).

For all of the foregoing reasons, DMG decided that construction of a Medical Office Building was the best option, both from a patient care as well as a financial perspective.

Alternative #3 – Do Not Lease Space to Rush University Medical Center

DuPage Medical Group considered constructing a Medical Office Building in which no space was leased to other parties. While this option was viable from a clinical and financial perspective, it was not optimal. Therefore, DMG decided to proceed with the project in its current form, i.e. with a portion of the building leased to Rush University Medical Center for the purpose of providing Chemotherapy and Infusion Medical Services.

From a financial perspective, the lease between DMG and Rush is beneficial in that it diversifies the sources of revenue. However, this has only a minor impact given that Rush will lease only a limited portion of the building (15% of the total space) and given that DMG is already in a very strong financial position.

Regarding the clinical aspects of this project, if DMG was to use the space to be leased by Rush to (1) provide Chemotherapy and Infusion Medical Services itself or (2) provide other services, it could do so and still achieve the project's intended purpose of providing complex and specialized care in the western suburbs of Chicago. Furthermore, the clinical collaboration agreement DMG has signed with Rush has always been considered by both applicants to be wholly independent of the DMG MOB. Therefore, the benefits in patient care derived from that agreement would not have been affected had DMG opted not to lease space in the building to Rush.

However, when DMG assessed the existing health care needs in the western suburbs and how to address those needs, it wanted to find the best solution. Leasing space to Rush to provide Chemotherapy and Infusion Medical Services helps optimize the care provided by (1) increasing the scope of treatment available at the MOB and (2) providing specialization of care from university-affiliated physicians.

In summation, this project includes, as one of its aspects, a lease by Rush University Medical Center for a portion of the MOB to provide Chemotherapy and Infusion Medical Services because such an arrangement was deemed by DMG to be a means of optimizing the project, both from a financial as well as a clinical perspective. This was determined to be preferable to an alternative scenario, in which Rush leased no space at the MOB. While this alternative would have been acceptable, it would not have been optimal. Therefore, it was not chosen.

SECTION IV – PROJECT SCOPE, UTILIZATION, AND UNFINISHED SHELL SPACE

SIZE OF PROJECT

Upon completion, the DuPage Medical Group Medical Office Building will have a total square footage of 87,075 sq. ft. All of this space is necessary, and the vast majority of it will be for the direct treatment of patients, either in physician offices or other diagnostic/treatment areas. There is sufficient common/shared space for the operation of the building. However, there is little non-clinical space such as a gift shop or a cafeteria as this was deemed not necessary given the location's use as a Medical Office Building.

Unlike a hospital, where many spaces can be used by several different departments, some areas of the building, e.g. waiting rooms, are dedicated to particular services. For example, Radiation Oncology will have its own waiting area, as will the physician offices. This means more square footage is necessary than would otherwise be the case.

Each area, along with its location and square footage are included in the table below.

Area	Location in Building	Square Footage
Radiation Oncology Note: Excludes linear accelerator	1 st Floor, West Wing	5,655
Linear Accelerator	1 st Floor, West Wing	965
Chemotherapy and Infusion Medical Services Note: Provided by RUMC	2 nd Floor, West Wing	12,927
Physician Offices: Oncology	3 rd Floor, West Wing	11,728
Imaging Note: No major medical equipment	1 st Floor, East Wing	14,138
Primary, Specialty, and Immediate Care; Retail Pharmacy, Lab	2 nd Floor, East Wing	13,329
Physician Offices	3 rd Floor, East Wing	15,593
Atrium/Common Space	Throughout Building	12,740
TOTAL		87,075

Radiation Therapy (Linear Accelerator)

The only explicit state standard with regard to size is for radiation therapy, specifically the linear accelerator. This standard is 2,400 dgsf/accelerator.¹ So, where there is only one linear accelerator for the project, as is the case here, the maximum allowed departmental gross square footage to house and support that linear accelerator is 2,400 dgsf. As is shown in the table above, there are only 965 sq. ft. devoted to the linear accelerator, thus coming under the maximum allowable space of 2,400 dgsf. The space for radiation oncology (5,655 sq. ft.) will not be used solely to support the use of the linear

¹ See Section 1110 Appendix B.

accelerator. Rather, that space will serve other, additional needs including examinations, conferencing, and offices. It is therefore not included in the calculation.

Service	Proposed DGSG	State Standard	Difference	Met Standard?
Radiation Therapy (Linear Accelerator)	965 dgsf	2,400 dgsf maximum	1,435 dgsf under the maximum	Yes

Chemotherapy and Infusion Medical Services

Rush University Medical Center (RUMC) plans to lease space on the second floor of the DMG medical office building to house a provider-based chemotherapy infusion center. The infusion center will be organized and function as an outpatient location of Rush. RUMC will also timeshare space on the third floor of the building for clinic space in which Rush physicians will evaluate and manage patients and also conduct research and engage in education.

In keeping with the precedent of other, comparable CON applications that involved Chemotherapy or Infusion Medical Services,² the applicants have not included here an explanation of how the square footage devoted to those services meets the state standard. As in those previous CON applications by other providers, there is no established standard for Chemotherapy or Infusion Medical Services. For this reason, the applicants have included here the total square footage devoted to those services without reference to any standard.

Service	Proposed DGSG	State Standard	Difference	Met Standard?
Infusion Therapy (Chemotherapy) and Oncology Clinic	12,927 bgsf	No Standard	N/A	N/A

In order to lease the appropriate amount of space, Rush first determined the current and projected need for infusion therapy services in the target market (the process for which is detailed in Attachment 15). Rush then converted the treatment volume into square footage requirements for the infusion therapy center. Finally, Rush determined the number of non-clinical space (e.g. offices, support space) that would be needed to support the number of new cancer cases with infusion-treatable cancer and translated that into square footage. The infusion therapy space and the non-clinical space were added together to arrive at the total need for square footage for that service.

² See Application for Project 11-108 (page 45), Delnor Comprehensive Cancer Center, Received November 23, 2011, Approved February 8, 2012; Application for Project 10-049 (page 94), The University of Chicago Cancer Center at Silver Cross Hospital, Received July 26, 2010, Approved October 26, 2010.

SECTION IV – PROJECT SCOPE, UTILIZATION, AND UNFINISHED SHELL SPACE

PROJECT SERVICES UTILIZATION

Per the applicable rules (confirmed in conversations with Board staff members), an application involving Clinical Service Areas need only include utilization standards for which the IHFSRB has established targets. This project includes two specific clinical service areas: (1) Radiation Therapy including a linear accelerator and (2) Chemotherapy and Infusion Medical Services. The former has established standards found in Section 1110, Appendix B. The latter, which will be provided by RUMC in the space it is leasing from DMG does not have any state established utilization targets. Per the request of the Board staff, the applicants have included the methodology used to determine utilization of the Chemotherapy and Infusion Medical Services to be provided by RUMC.

Radiation Therapy (Linear Accelerator)

To estimate the number of treatments for the linear accelerator, the applicants first estimated the number of patients that would receive radiation therapy treatment at the MOB. This figure was put at 250-300 new cancer patients referred from DMG in the first year, with possibly another 50 from other places in the community. As a conservative estimate, therefore, the applicants assumed 250 new patients in Year 1 with an additional 50 by Year 2.

Based on the experience of Dr. Brian Moran, a renowned radiation therapy specialist who will be tasked with leading DMG's radiation therapy program,¹ about 70% of those patients will require curative therapy and about 30% will require palliative therapy. Curative therapies require 35-40 treatments while palliative therapies require 10-20 treatments.

Applying these assumptions, DMG used a weighted formula to determine the number of treatments for the linear accelerator in the first and second years of operation. Even using a conservative estimate of 250 patients in the first year, the linear accelerator will easily exceed the utilization standards.

Table 1: Conservative Estimate (250 Patients in Year 1)

UTILIZATION FOR LINEAR ACCELERATOR					
	DEPT./ SERVICE AREA	HISTORICAL UTILIZATION	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1	Linear Accelerator	N/A	7,688 Treatments	7,500 Treatments	YES
YEAR 2*	Linear Accelerator	N/A	9,225 Treatments	7,500 Treatments	YES

*Assumes 50 additional patients in Year 2

¹ See Attachment 12-Exhibit 1 for Dr. Moran's biographical sketch.

Table 2: Most Likely Estimate (300 Patients in Year 1)

UTILIZATION FOR LINEAR ACCELERATOR					
	DEPT./ SERVICE AREA	HISTORICAL UTILIZATION	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1	Linear Accelerator	N/A	9,225 Treatments	7,500 Treatments	YES
YEAR 2*	Linear Accelerator	N/A	10,763 Treatments	7,500 Treatments	YES

Note: DMG perceptions significantly exceed state utilization standards for linear accelerators.

Chemotherapy and Infusion Medical Services

Unlike other Clinical Service Areas, there are no established utilization standards for Chemotherapy and Infusion Medical Services. For this reason and in keeping with the instructions of the Board staff, the applicants have not referenced any specific utilization numbers for these services but have described below the methodology used to determine what level of Chemotherapy and Infusion Medical Services would be provided in the space leased by RUMC.

To determine the level of services for this particular Clinical Service Area, Rush relied on the current patient populations (served by itself as well as DMG) in the local market, local demographic information, published incidence rates of new cancer cases in an Illinois population, and the number of new cancer cases that are treatable with this modality. Based on the number of new cancer cases, Rush determined the number of treatments that would be generated. Throughout the needs development process, Rush also drew on its extensive experience in delivering cancer infusion therapy services in other outpatient settings.

Rush used the following methodology to project the number of infusion therapy treatments that could be expected at the new center:

1. Rush estimated the potential market size for the proposed infusion therapy center based on two factors. First, Rush determined the number of new cancer cases that currently travel to Rush's Chicago campus from the greater Lisle area and assumed that a portion of these patients would elect to receive their care at the new MOB because of greater convenience and the assurance that they would receive the same quality of care that they receive at the downtown campus. To this already aligned population, RUMC added the number of existing DMG cancer patients that would be most likely to use the new facility. Together, the already aligned patients from Rush and DMG represent the initial target population of the infusion therapy service.
2. Rush identified the infusion therapy treatable cancers; these include cancers of the breast, skin and lungs as well as of the gastrointestinal, gynecological, genitourinary, and hematological (lymphoma, leukemia, multiple myeloma) systems. By applying Illinois rates of patients treated by chemotherapy by site,² Rush calculated the current number of chemotherapy-treatable new

² See American College of Surgeons Commission on Cancer, National Cancer Database.

cancer cases in the target population. Using the Advisory Board Company's growth rates, Rush projected the number of new cancer cases out to 2022, or 10 years from the present.

3. Next, Rush determined the annual number of infusion therapy treatments in the target population. The number of new treatable cancer cases was multiplied by the average number of treatments per case to arrive at a total number of annual treatments that could be expected at the new center.

Rush University Medical Center believes that there are a significant number of patients within the health planning area that would benefit from accessible and reliable delivery of chemotherapy and infusion services on an outpatient basis.

SECTION I – PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Unfinished/Shell Space

This project will not involve the use of unfinished/shell space and so this criterion is not applicable.

SECTION IV – PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 – Project Scope, Utilization, and Unfinished/Shell Space

UNFINISHED/SHELL SPACE

This project does not involve any unfinished or shell space. Therefore, the applicants have not included an assurance that existing shell space will be used as it is not pertinent.

SECTION VII – SERVICE SPECIFIC REVIEW CRITERIA

Subsection R: Criterion 1110.3030 – Clinical Service Areas Other than Categories of Service

Need Determination

The only Clinical Service Areas that will be provided at the DuPage Medical Group MOB which fall within CON requirements are (1) Radiation Therapy and (2) Chemotherapy and Infusion Medical Services, both of which are inherently focused on cancer. Other services provided at the MOB, e.g. primary care, are not Clinical Service Areas for which need must be demonstrated. As such, this information contained herein focuses on incidence of cancer and the demand for cancer treatment services, even though that is not the totality of what will be provided at the MOB.

Service to the Planning Area Residents

Using an average cancer rates from the Illinois State Cancer Registry the applicants were able to **project 4,855 new cancer patients in DuPage County in the coming year (2013).**

This calculation is based on the following:

- Male and Female cancer incidence rates per 100,000 people. These rates were based on the latest available data from the Illinois State Cancer Registry and represent an average of the years 2004-2008. The rate for males thus calculated is 537.7. The rate for females thus calculated is 437.8. Attachment 37-Exhibit 1.
- US Census data regarding the population of DuPage County. The 2010 Census puts this figure at 916,924. Using the County's total growth rate from 2000-2010 (1.4%), we then applied a comparable annual growth rate to arrive at a population estimate for the County for 2012 and 2013 respectively.
- The aging US population. It is estimated that 10,000 people turn 65 every day in the United States.¹ As people age they become more susceptible to cancer. Indeed cancer incidence rates based on age often use 65 years of age as a demarcation. Given this fact, some estimate that the incidence of cancer may rise by more than 30% by 2020. Attachment 37-Exhibit 2. This required an increase in the annual growth rate in new cancer cases to 2.75%.

	Male	Female	Total
2012 Population (est.)	449,922	468,286	918,208
2013 Population (est.)	450,552	468,942	919,493
Cancer Rates/100,000	537.7	437.8	N/A
Projected New Cancer Patients (2012)	2,554	2,164	4,719
Projected New Cancer Patients (2013)	2,628	2,227	4,855

¹ Boomers Hit New Self-Absorption Milestone: Age 65. *New York Times*, December 10, 2010.

Also, it should be noted that this project will primarily provide care to the residents of the planning area in which the proposed service will be located; that is HPA 05 (DuPage County). However, it is anticipated that many patients will come from Cook, Will, and Kane County. This is due to two factors. First, DMG has locations in these counties and some of the patients at these locations will naturally be referred for treatment at the MOB. Second, the applicants plan to offer a higher quality of medical care than is currently available in the community, and so it is inevitable some patients from outside the community will also want to take advantage of the quality of care that will be available.

Service Demand

Radiation Therapy (Linear Accelerator)

Based on the experience of radiation oncology specialists from DMG, **at least two thirds of all cancer patients require radiation therapy**. Since 95% of all radiation therapy involves a linear accelerator, these patients will need to be treated using the linear accelerator included as part of this project. This is particularly true given the fact that the type of linear accelerator being installed, the RapidArc, is the most up-to-date version of the most commonly accepted standard of care modality for radiation therapy.

So, based on the estimates of the number of new cancer patients, there will be **3,253 patients requiring Radiation Therapy in HPA 05 by 2013**. DuPage Medical Group projects that it will treat at least 250 cancer patients with radiation therapy in the first year of operation for its MOB. It is anticipated that this could increase by another 50 cases as word spreads in the community of the high standard of services offered at the MOB.

Chemotherapy and Infusion Medical Services

Based on its experience, Rush University Medical Center estimates that at least 45% of all cancer cases will require chemotherapy infusion. Based on the estimates of the number of new cancer patients, this means that **there will be 2,185 patients requiring Chemotherapy and Infusion Medical Services in HPA 05 by 2013**.

Impact on Other Providers

Radiation Therapy (Linear Accelerator)

There are currently seven (7) linear accelerators operating within Health Planning Area 5. See Attachment 37-Exhibit 3. These machines are located at the following hospitals.

Hospital	Number of Linear Accelerators
Edward Hospital	3
Advocate Good Samaritan Hospital	2
Adventist Hinsdale Hospital	1
Elmhurst Memorial Hospital	1
TOTAL	7

A map showing the geographic location of these hospitals is included in Attachment 37-Exhibit 4.

Methodology for Determining Linear Accelerator Utilization by Other Providers

After the number of linear accelerators at each facility had been determined, the applicants then used different methodologies to determine the utilization of those linear accelerators. The methodology used was the one that was most appropriate and accurate based on the scope of information available. The methodologies used were as follows:

Methodology A:

Where more recent utilization information was available, that information was used. If none was available, the applicants used the figures for therapies/treatments in each hospital's 2010 Hospital Profile.

Methodology B:

Because the Utilization Standards in Section 1110, Appendix B are based on treatments, the data for hospitals containing courses of treatment were, when necessary, converted to show the number of treatments.

There are multiple treatments for each course of treatment for radiation therapy. So, hospitals with a very low figure in the "Therapies/Treatments" column are clearly reporting courses of treatment rather than treatments. For example, Edward Hospital listed only 750 "Therapies/Treatments" despite the fact that it has three (3) linear accelerators. It is, therefore, clearly reporting courses of treatment rather than treatments.

For hospitals where the only utilization data available is for courses of treatment, the applicants applied the following formula:

$$\text{Number of treatments} = (\# \text{ of courses of treatment} \times 37.5 \times 0.70) + (\# \text{ of courses of treatment} \times 15 \times 0.30)$$

This formula reflects the experience of Dr. Brian Moran, a renowned specialist in radiation oncology and takes into account the difference between curative care and palliative care. It assumes that for all courses of treatment 70% will constitute curative care and 30% will constitute palliative care (hence the weighting of factors). It also assumes, based on Dr. Moran's experience that:

- For curative care each course of treatment will involve 35-40 treatments (37.5 is used in the equation above as it is in the middle of this range).
- For palliative care each course of treatment will involve 10-20 treatments (15 is used in the equation above as it is in the middle of this range).

Note: This is the same formula the applicants used to project utilization for the linear accelerator included in this project.

Methodology C:

For Hospitals where it was clear that survey data listed number of treatments rather than courses of treatment, a conservative 1.4% annual growth rate² was applied to the relevant figure to generate an estimated number of treatments for each hospital in 2012.

The results of this analysis are as follows:

Hospital	Methodology Used	Determined Number of Treatments (2012)	Number of Linear Accelerators Allowed	Number of Linear Accelerators in Use
Edward Hospital	B	23,062	4	3
Advocate Good Samaritan Hospital	C	7,764	2	2
Adventist Hinsdale Hospital	C	5,213	1	1
Elmhurst Memorial Hospital*	A	7,607	2	1
TOTAL			9	7

* See Attachment 37-Exhibit 5

Analysis of Impact on Other Providers with Linear Accelerators

This analysis shows that linear accelerators in Health Planning Area 05 are being used at or near capacity. Indeed some hospitals would, based on the State standards, be warranted in adding additional machines. Therefore, this project will not lower the utilization of other area providers below the utilization standards.

It should also be noted that, although DMG will significantly exceed the utilization standards, it will provide radiation therapy to a very small percentage of the cancer patients in the Health Planning Area. Even based on the most conservative estimate of the total cancer patient population and the most optimistic estimate of the number of patients receiving radiation therapy treatment at the Medical Office Building, DMG will treat only about 10% of all patients requiring the use of a linear accelerator.

This can hardly affect the utilization of other providers. This is particularly true given that:

- there will be an overall increase in the number of patients requiring radiation therapy; and
- many of the patients to be treated at this MOB currently travel into Chicago for treatment and therefore will not use the other facilities even if this project does not go forward.

Chemotherapy and Infusion Medical Services

As there are no established utilization standards for Chemotherapy and Infusion Medical Services, it is not possible to show that the proposed project will not (A) lower the utilization of other area providers below the utilization standards specified in Section 1110, Appendix B or (B) lower, to a further extent,

² 1.4% reflects DuPage County's overall population growth rate from 2000-2010 according to the US Census Bureau.

the utilization of other area providers that are currently operating below the utilization standards. As such, the criterion found in Section 1110.3030(b)(3) is inapplicable.

It should be noted, however, that this project is unlikely to affect the utilization of Chemotherapy and Infusion Medical Services for other providers. Most of the patients who will receive this service in the space to be leased by RUMC would, in the absence of the new MOB, travel to RUMC's downtown facility. This project merely allows them to receive the same service closer to home.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Pat Quinn, Governor

Cancer in Illinois

Statistics


[< Home](#) [< Statistics](#)

Illinois Specific Statistics

Cancer Incidence Data

[State by Race](#) | [State by Ethnicity](#) | [By County](#) | [By ZIP Code](#)

Five-Year Cancer Incidence Counts and Age-adjusted Rates per 100,000 (US 2000 Std) with 95 percent Confidence Interval

[Technical Notes](#)

Select Years	Select County	Select Cancer Site	Select Race
2004-2008 1999 - 2003 1994 - 1998 1989 - 1993	Cook Crawford Cumberland DeKalb DeWitt Douglas DuPage	All Cancers Combined Oral Cavity & Pharynx Esophagus Stomach Colon & Rectum Liver Pancreas	All races White Black
			Records per page 25 Go

Cancer Incidence Data '2004-2008'

Year	Race	County	sites	Male Count	Male Rate	Male Lower CI	Male Upper CI	Female Count	Female Rate	Female Lower CI	Female Upper CI
2004-2008	1 All Races	DuPage	99 All Cancers Combined	10364	537.7	527.1	548.6	10680	437.8	429.4	446.4

Records 1 to 1 of 1

 Source: Illinois Department of Public Health, Illinois State Cancer Registry,
 Public Dataset as of November 2010.

Data last updated: 11/21/2011 1:19:54 PM

Cancer Mortality Data

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 Attachment 37-Exhibit 1
 Cancer Incidence Data,
 DuPage County

ARTICLE

Projections of the Cost of Cancer Care in the United States: 2010–2020

Angela B. Mariotto, K. Robin Yabroff, Yongwu Shao, Eric J. Feuer, Martin L. Brown

Manuscript received January 14, 2010; revised November 4, 2010; accepted November 5, 2010.

Correspondence to: Angela B. Mariotto, PhD, Surveillance Research Program, Division of Cancer Control and Population Sciences, National Cancer Institute, Ste 504, MSC 8317, 6116 Executive Blvd, MSC 7344, Bethesda, MD 20892-7344 (e-mail: mariotta@mail.nih.gov).

- Background** Current estimates of the costs of cancer care in the United States are based on data from 2003 and earlier. However, incidence, survival, and practice patterns have been changing for the majority of cancers.
- Methods** Cancer prevalence was estimated and projected by phase of care (initial year following diagnosis, continuing, and last year of life) and tumor site for 13 cancers in men and 16 cancers in women through 2020. Cancer prevalence was calculated from cancer incidence and survival models estimated from Surveillance, Epidemiology, and End Results (SEER) Program data. Annualized net costs were estimated from recent SEER–Medicare linkage data, which included claims through 2006 among beneficiaries aged 65 years and older with a cancer diagnosis. Control subjects without cancer were identified from a 5% random sample of all Medicare beneficiaries residing in the SEER areas to adjust for expenditures not related to cancer. All cost estimates were adjusted to 2010 dollars. Different scenarios for assumptions about future trends in incidence, survival, and cost were assessed with sensitivity analysis.
- Results** Assuming constant incidence, survival, and cost, we projected 13.8 and 18.1 million cancer survivors in 2010 and 2020, respectively, with associated costs of cancer care of 124.57 and 157.77 billion 2010 US dollars. This 27% increase in medical costs reflects US population changes only. The largest increases were in the continuing phase of care for prostate cancer (42%) and female breast cancer (32%). Projections of current trends in incidence (declining) and survival (increasing) had small effects on 2020 estimates. However, if costs of care increase annually by 2% in the initial and last year of life phases of care, the total cost in 2020 is projected to be \$173 billion, which represents a 39% increase from 2010.
- Conclusions** The national cost of cancer care is substantial and expected to increase because of population changes alone. Our findings have implications for policy makers in planning and allocation of resources.
- J Natl Cancer Inst 2011;103:117–128

Rapid scientific progress in oncology during the 1990s led to new tools for diagnosis and the development of novel targeted therapies. During the same period, incidence declined and survival improved for many cancers (1). The average cost of treating the most common cancers increased as well (2). With more expensive targeted treatments adopted as standards of care, the costs of cancer care are expected to escalate more rapidly in the near future. The US Bureau of Census projects that the population aged 65 years and older is expected to increase from 40 million in 2009 to 70 million in 2030 (3). Because cancer incidence is highest in the elderly, the impact of these population changes on cancer prevalence may exceed the impact of declining cancer incidence rates for some cancers. As a result, both the number of cancer survivors and cancer expenditures are likely to increase in the future.

Previous estimates of national expenditures for cancer care have mostly been based on older data for incidence, patterns of care, and survival and on inflation adjusted with general medical care

inflation adjusters (4). For example, the estimate of the direct costs of “neoplasms” of \$99 billion in 2009 is based on broadly defined self-reported disease categories from 1995 and inflated to 2009 dollars (5). This national estimate does not reflect current cancer incidence, patterns of care, and survival. Furthermore, escalation in the costs of cancer chemotherapy has been greater than general medical care inflation (4,6), suggesting that the use of general medical care inflation adjusters might underestimate the cost of cancer care.

The purpose of this study was to estimate and project the national medical cost of cancer care through the year 2020 separately for 13 cancers in men and 16 cancers in women using the most recent available US population projections and cancer incidence, survival, and cost of care data. We used methods developed specifically for estimating and projecting cancer prevalence by phase of care, including the initial phase following diagnosis, the last year of life phase, and the continuing phase between the initial

CONTEXTS AND CAVEATS

Prior knowledge

The costs of cancer care are expected to rise with increased cancer incidence in an aging population, along with advances in diagnostic technology and novel targeted treatments.

Study design

Data on incidence and survival from the Surveillance, Epidemiology, and End Results (SEER) database linked to Medicare records were used to estimate the costs at initial, continuing, and final phases of cancer care for 13 cancers in men and 16 in women. Different models of incidence, survival, and cost increases were used to project total cost of care through 2020 in the United States.

Contribution

Changes in the US population alone are projected to result in a cost increase of 27% by 2020. However, if costs in the initial and final phases of care increase by 2% annually, the total cost of care in 2020 is projected to be \$173 billion an increase of 39% from 2010.

Implications

Expanding costs of cancer care due to increases in an aging population are inevitable, but the costs of new treatments and diagnostic technologies could potentially be managed to ensure access to quality care for all patients.

Limitations

The estimates of cancer prevalence were based on data from SEER-9 areas, which do not cover the entire United States. The estimates were also based on first tumor diagnosed and may not be applicable to patients with multiple tumors. The presence of other diseases in addition to cancer was not included in the analysis.

From the Editors

and last year of life phases (7). We projected the costs of cancer care through the year 2020 using US population projections and scenarios with varying assumptions about trends in incidence, survival, and cost. To our knowledge, the estimated national cost of cancer care has not been previously projected dynamically. These data may be particularly useful for policy makers in understanding and anticipating the future burden of cancer care in the United States

Methods

Overview

Estimates and projections of the medical cost of cancer care through the year 2020 were calculated by combining cancer prevalence with average annual costs of cancer care by phase of care and tumor site for 13 cancers in men and 16 cancers in women. We also estimated and projected cost for all cancer sites combined. Cancer incidence, survival, practice patterns, and costs of care have changed in the past decades (1,2), but the degree to which these changes will continue in the future is unclear. Because of the uncertainty surrounding future trends in incidence, survival, and costs of care, we evaluated multiple scenarios with varying assumptions, including 1) constant current incidence, survival, and cost,

the base case scenario; 2) recent incidence trends only; 3) recent survival trends only; 4) recent incidence and survival trends; and 5) recent incidence, survival, and cost trends. In all of the sensitivity analysis scenarios, we assumed a dynamic population increase as projected by the US Bureau of the Census and used the most recently available data to estimate incidence, survival, and cost of cancer care.

Data Sources

Incidence, survival, all-cause mortality, and population data from 1975 through 2005 were obtained from the Surveillance, Epidemiology, and End Results (SEER) program. The SEER registries collected every occurrence of a primary incident cancer, month and year of diagnosis, cancer site, stage, histology, and vital status, with cause of death for patients who died in geographically defined areas. Cancer incidence and survival were obtained by cancer site, sex, and year and age at diagnosis.

Population projections were obtained from the National Interim Projections of the US population from 2006 through 2020 from the US Census Bureau Web site (3). These population projections are based on assumptions about future births, deaths, and international migration. Other cause mortality in the years 2006–2020 were obtained from the Berkeley Mortality cohort life tables (8). These life table projections incorporate observed trends in life expectancy in the past century. Life tables and related documentation are available at <http://www.demog.berkeley.edu/~bmd/states.html>.

The cost of cancer care was estimated from Medicare claims data linked to the SEER data (SEER–Medicare) among beneficiaries aged 65 years and older with a cancer diagnosis (9). Control subjects without cancer were identified from a 5% random sample of all Medicare beneficiaries residing in SEER areas. A more detailed description of the linked SEER–Medicare data is available at <http://healthservices.cancer.gov/seermedicare/>.

Phase of Care Definitions

We defined phase of care using three distinct clinically relevant periods or phases, including the initial period following diagnosis, the last year of life, and the period in between the initial and last year of life. The initial period was defined as the first 12 months following diagnosis, the last year of life was the final 12 months of life, and the continuing phase included all the months in-between. However, not all cancer patients contribute months of observation to all phases of care. For patients who survived less than 24 months after diagnosis, months of survival were assigned to the last year of life phase, and the remaining months of observation were allocated to the initial phase, with no allocation to the continuing phase of care. For patients who survived less than 12 months after diagnosis, those months between diagnosis and death were allocated to the last year of life.

Estimates and Projections of Cancer Prevalence

Cancer patients were classified by the site of their first diagnosis between 1975 and 2005 into one of the following 17 cancer sites: bladder, brain and other nervous system, female breast, cervix, colorectal, corpus uteri, esophagus, head and neck, kidney and renal pelvis, leukemia, lymphoma, lung, melanoma of the skin,

ovary, pancreas, prostate and stomach. Nonmalignant cervical cancer and benign brain and other nervous system tumors were excluded; other nonmalignant tumors were included. All cancer sites combined were modeled as a single site and included only the first primary tumor between 1975 and 2005.

Cancer prevalence was estimated using a statistical method that projects prevalence from cancer incidence, cancer survival, and mortality for other causes of death (ie, prevalence incidence approach model [PIAMOD]) (7,10). Prevalence was estimated separately by tumor site for 13 cancer sites in men and 16 cancer sites in women. To estimate the prevalence of the remaining cancer sites, we calculated the difference between the prevalence of all cancer sites combined and the sum of the site-specific prevalence separately for men and women. Because PIAMOD can only provide results for closed age classes, and populations are reported with an age class of 85 years or older, prevalence for this age class was obtained by applying prevalence proportions of the 80–84 year age class to the population aged 85 years or older. For further details on the PIAMOD method, refer to Mariotto et al (7).

Cancer prevalence for years beyond the last year of data, 2005, was projected assuming different scenarios of future incidence and survival trends. In all of the sensitivity analysis scenarios, we assumed dynamic population trends, as estimated by the US Bureau of Census. We evaluated five prevalence scenarios: 1) constant current incidence, survival, and cost, the base case scenario; 2) recent incidence trends only; 3) recent survival trends only; 4) recent incidence and survival trends; and 5) recent incidence, survival, and cost trends.

The base case scenario assumes that future incidence and survival rates are constant and were based on rates from the most recent data period, 2003–2005, for each cancer site. For the incidence trends scenario, we projected the tumor and site-specific incidence trends estimated in years 1996–2005 into the future for years 2006–2020. In mathematical terms, the estimated annual percent change was calculated for each cancer site and sex by fitting a regression line to the natural logarithm of the age-adjusted rates I in years 1996 through 2005, $\ln(I) = \alpha + \beta y$, where α and β were coefficients to be estimated and y is calendar year. The annual percent change was calculated as $100(e^{\hat{\beta}} - 1)$, where $\hat{\beta}$ is the estimate of β . Let $I(2003-2005, a)$ be the average incidence rate at age a at years 2003–2005. For each single age a , the SEER incidence rates were projected to years $y = 2006, \dots, 2020$ by applying the estimate annual percent change to the baseline incidence rate, that is $I(y, a) = I(2003-2005, a)e^{\hat{\beta}(y-2005)}$. The national number of incident cancer patients by age and year were calculated by multiplying the SEER age and year incidence rates by the respective US populations for each tumor site and sex.

For the survival trends scenario, linear survival trends were estimated by fitting a parametric mixture cure survival model to the SEER data by tumor site, sex, and age group (11). This type of model assumes that a hypothetical fraction of the patients will not die of cancer and will experience the same mortality risk as the general population, whereas the complementary fraction will die of cancer, and their survival time follows a Weibull distribution (12). The cumulative probability of surviving t years from diagnosis, for people diagnosed at year y and at the age class a is given by

$$S_c(y, t) = \{c_c + (1 - c_c) \exp[-((\lambda_c t)^{\gamma_c})]\}^{\exp(\delta_c(y - y_0))},$$

where c_c is the cure fraction, the proportion of patients who at diagnosis will eventually not die of their cancer, λ_c and γ_c are, respectively, the scale and shape parameters of the Weibull survival distribution of patients not cured, and $\exp(\delta_c)$ represents the relative risk (RR) of cancer death for being diagnosed 1 year later than an arbitrary reference year y_0 (eg, 1985). Survival parameters were estimated for each cancer site, sex, and age group (0–44, 45–54, 55–64, 65–74, and 75–84 years). The use of a parametric survival model allows survival extrapolation beyond the range of the empirical data. The constant survival trend scenario assumes future survival as equal to the most recent year of data 2005, whereas the linear trend scenario extrapolates survival using the period trend parameter δ_c . The survival model and the prevalence method are described in greater detail elsewhere (7). The incidence and survival trends scenario combined both recent incidence and recent survival trends.

Estimates and Projections of the Cost of Cancer Care

We updated previously published direct medical cost estimates by phase of care (13) using the most recently available linked SEER-Medicare data from all registries (SEER-17), which included cancer patients diagnosed through the year 2005. We used all Medicare claims files and standard methods of estimating mean annualized net costs of care with these data (13,14) as described below. Patients with a cancer diagnosis in SEER between 1975 and 2005 and aged 65 years and older during 2001–2006, the observation period, were selected for the cohort. Cancer patients with a prior cancer diagnosis or identified through a death certificate or autopsy were excluded. Months of observation in which patients received coverage through managed care or were covered through fee-for-service and without both Medicare part A and part B were excluded because these data would not completely capture costs of care received during this period. Months of observation and costs were assigned to the initial, continuing, and last year of life phases of care. A total of 390 683 cancer patients were included in the initial phase of care, 926 793 in the continuing phase of care, and 475 750 in the last year of life phase of care. Cancer patients in the last year of life were also classified by cause of death on the death certificate as cancer vs all other causes.

Noncancer control subjects were randomly assigned a “pseudo-diagnosis date” that corresponded to the date of diagnosis of one of the pool of cancer patients. Control subjects were frequency matched to cancer patients by sex, 5-year age group (65–69, 70–74, 75–79, and ≥ 80 years), and SEER area strata in up to a 5:1 ratio. For the initial and continuing phases of care, costs for cancer patients were compared with costs for “continuing control subjects” that included data from the pseudo-diagnosis date through 1 year before the date of death. To reflect costs associated with cancer care in the last year of life, cancer patients who died of cancer were matched to continuing control subjects, whereas cancer patients who died of other causes (eg, accident) were matched to control subjects in their last year of life. As with cancer patients, average monthly estimates of cost of care were calculated for each

phase of care for control subjects. A total of 1 648 138 control subjects were included in the initial phase of care, 2 141 794 in the continuing phase of care, and 1 662 486 in the last year of life phase of care.

We used payments to reflect costs and estimated Medicare part A (inpatient services) and part B (outpatient services) separately. Monthly costs were estimated for cancer patients and control subjects by phase of care. Net monthly medical costs were calculated as differences in costs for cancer patients and control subjects by tumor site and phase of care. Mean annualized net costs were calculated by multiplying the net monthly costs by 12 months by tumor site and phase of care. We added adjustments for patient deductibles and coinsurance expenses separately for Medicare parts A and B. The Medicare Prospective Payment System adjuster and the Medicare Economic Index were used to adjust for inflation in Medicare part A and part B, respectively. The Medical Geographic Adjustment Factor and the Geographic Practice Cost Index were used to adjust for cost difference across different SEER locations for part A and part B costs, respectively (15).

Patterns of care have been reported to be more aggressive for younger cancer patients compared with elderly cancer patients in many health-care settings (16). In addition, because the prevalence of comorbid conditions and levels of medical care increase with age, health-care spending also typically increases with age (17). To extrapolate net cost estimates from the patient population aged 65 years and older to the population aged 65 years and younger, we used ratios of the relationship between costs in the elderly to those in younger patients in the initial and last year of life phases of care from published studies conducted in managed care settings (18). We used ratios of 1.2 and 1.5 to adjust the annual net medical cost for those younger than 65 years treated in the initial and last year of life, respectively. Costs in the continuing phase of care were assumed to be the same. All costs are reported in 2010 US dollars. National estimates of costs of care were calculated by combining the mean net costs of cancer care with US prevalence estimates by age, sex, and cancer site.

In the base case scenario, we assumed that recent cancer costs remained constant through the year 2020. In addition to evaluating scenarios with varying assumptions about incidence and survival, in the cost trends scenario, we also evaluated different assumptions about costs. For example, the introduction of more effective, but dramatically more expensive treatments (6,19), will likely affect cancer costs in the future. However, the patterns of diffusion of these therapies are unknown. To reflect this uncertainty, we evaluated three cost trends scenarios: 1) overall cost increase of 2% annually, 2) recent trends in which costs increased by 2% annually in the initial and last year of life phases, and 3) escalating costs in which costs increased by 5% annually in the initial and last year of life phases.

Results

Recent and Projected Incidence

For most of the cancer sites, incidence has been decreasing, and we estimated a negative annual percent change (Table 1) during the period 1996–2005. The largest decreases in men were for lung,

Table 1. Incidence and survival trends used in the incidence and survival trend scenario*

Site	APC in age-adjusted incidence rates		RR of cancer death for being diagnosed one year later†	
	Women	Men	Women	Men
All sites	−0.46	−0.68	0.982	0.959
Bladder	−1.28	−1.36	0.982	0.974
Brain	0.18	−0.89	0.987	0.987
Breast	−1.05	—	0.935	—
Cervix	−3.95	—	0.997	—
Colorectal	−1.78	−2.22	0.978	0.974
Esophagus	−1.57	0.00	0.980	0.971
Head and neck	−1.59	−1.66	0.995	0.993
Kidney	2.36	1.83	0.974	0.977
Leukemia	−0.64	−0.69	0.993	0.988
Lung	−0.81	−2.72	0.994	0.994
Lymphoma	0.19	−0.63	0.978	0.977
Melanoma	3.09	2.09	0.915	0.905
Ovary	−4.71	—	0.976	—
Pancreas	−0.24	0.02	0.988	0.989
Prostate	—	−0.70	—	0.889
Stomach	−1.75	−2.24	0.985	0.988
Uterus	−0.88	—	0.991	—

* Incidence trends were modeled using estimated annual percent change (APC) in age-adjusted cancer incidence rates 1996–2005. Survival trends were modeled for men and women diagnosed in age groups 0–44, 45–54, 55–64, and 65–74 years. RR = relative risk.

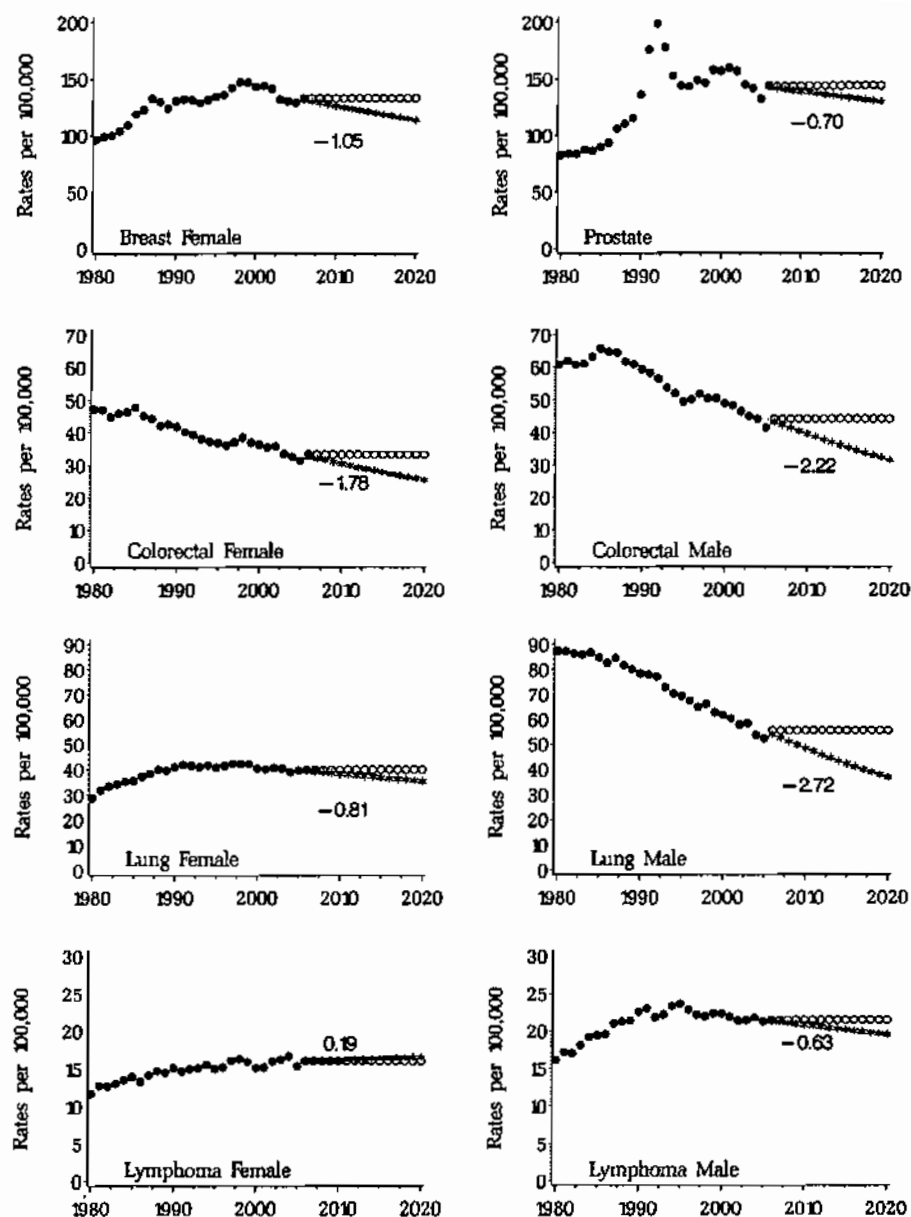
† Trends were summarized using estimated relative risk of cancer death for patients diagnosed in a given year compared with patients diagnosed in the previous year. Results were similar by age groups; estimates are presented for the 65–74 age group.

stomach, and colorectal cancers, respectively, −2.72, −2.24, and −2.22 annual percent change in age-adjusted rates. More dramatic decreases were observed for women for ovarian and cervical cancer, −4.71 and −3.95, respectively, annual percent change in age-adjusted rates. Incidence of kidney cancer and melanoma has been increasing in both men and women, and incidence of lymphoma and brain cancer has been increasing in women (Table 1). Among the five major cancer sites, the largest decreases in incidence were observed for lung and colorectal cancers in men, −2.72 and −2.22, respectively, annual percent change in age-adjusted incidence rates (Figure 1; Similar figures for more cancer sites are available at <http://costprojections.cancer.gov>).

Recent and Projected Survival

Survival has been improving for almost all cancer sites. Survival trends are summarized by the estimated relative risk, which represents the risk of dying of cancer for patients diagnosed in a given year compared with patients diagnosed in the previous year. The largest improvements in survival were for prostate cancer in men, where the risk of dying of cancer death for patients diagnosed in a given year compared with patients diagnosed in the previous year was 89% smaller (ie, RR = 0.89), followed by melanoma (RR = 0.91 in men and RR = 0.92 in women), and female breast cancer (RR = 0.94) (Table 1). For bladder, cervix, and uterus, a flat or slight decline (younger age groups) in survival trend was estimated (data not shown). The observed and modeled 5-, 10-, and 15-year relative survival trends for the major cancer sites for people diagnosed

Figure 1. Observed age-adjusted incidence (solid circles) and projected age-adjusted incidence under the assumption of future constant incidence (open circles) and continuing incidence trend (asterisks). The number represents the estimated annual percent change from 1996 through 2005.



between the ages of 65 and 74 years showed the largest increases in survival for prostate cancer in men and breast cancer in women (Figure 2).

Cancer Prevalence. In the year 2010, we estimated that a total of 13 772 000 cancer survivors will be alive, with 42% younger than 65 years and the remaining 58% aged 65 years and older (Table 2). Under the base case scenario, holding incidence and survival constant, the number of cancer survivors in 2020 will increase by 31% to approximately 18 071 000. The largest increase between 2010 and 2020 (42%) was projected for the population aged 65 years and older (Table 2) because of the aging of the US population. The largest proportion of cancer survivors were in the continuing phase of care, representing 86% of all cancer survivors in 2010 and 2020. Female breast (3 461 000), prostate (2 311 000), colorectal (1 216 000), and melanoma (1 225 000) were the sites with the largest number of survivors in 2010 (Table 2). These sites

were also projected to have the largest number of survivors in the year 2020. For most of the cancer sites, 2020 cancer prevalence projections were robust under the different incidence and survival assumptions (Table 3). For all cancers, the 2020 projections under the base case, incidence trend, survival trend, and incidence and survival trend scenarios were very similar, with approximately 18 million survivors (Table 3).

Estimates of the Medical Costs Associated With Cancer Care

The average annualized net costs of care were highest in the last year of life phase of care for patients dying from cancer for all cancer sites (Table 4). The average annualized net costs of care were more variable in the initial phase of care. Brain, pancreas, ovary, esophagus, and stomach cancers had the largest annualized initial cost, and melanoma, prostate, and breast cancers had the lowest annualized initial cost (Table 4).

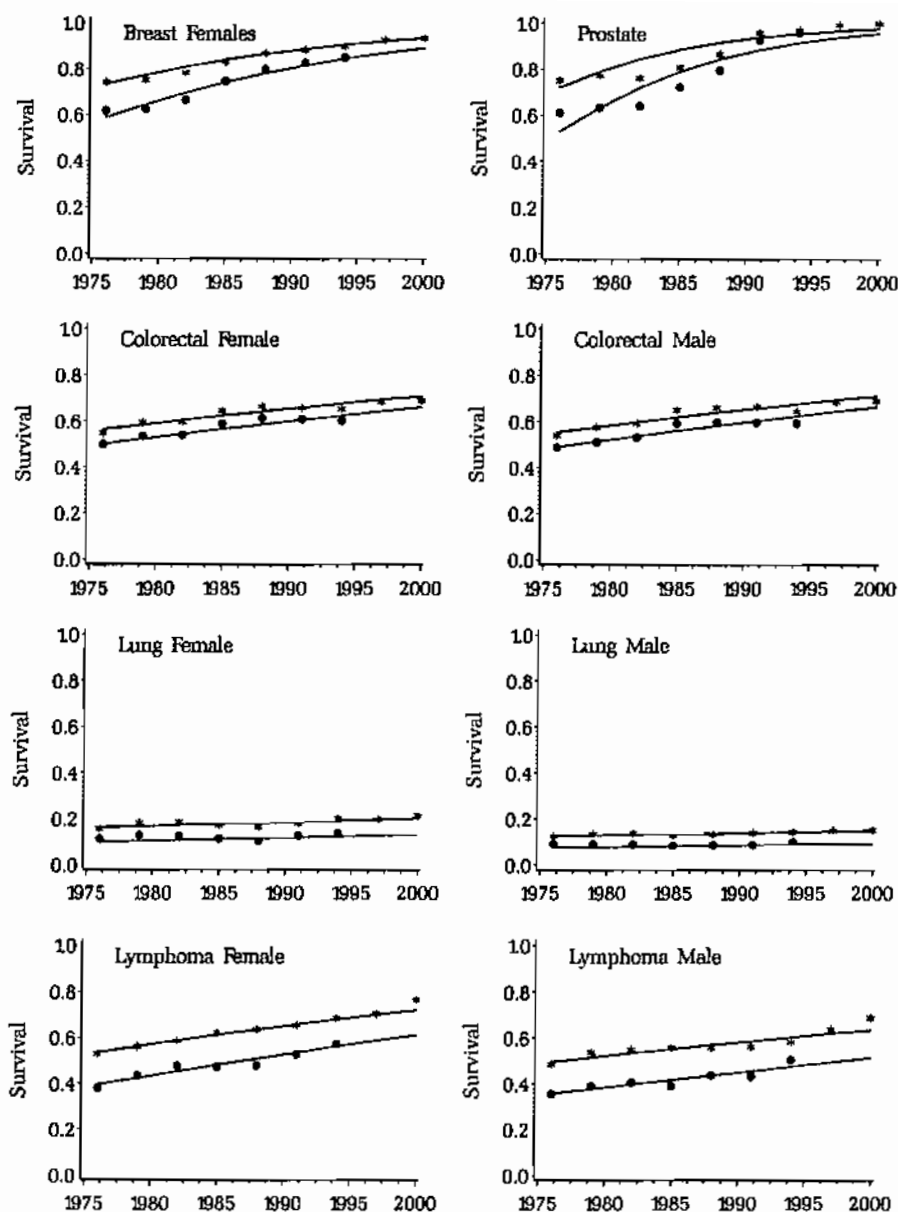


Figure 2. Fit of the survival model to observed data. Observed (solid circles [10-year] and asterisks [5-year]) and modeled (solid line [5-year] and dashed line [10-year]) relative survival trends for the major cancer sites for people diagnosed between the ages of 65 and 74 years.

Under the base case scenario, the national cost of cancer care in 2010 was estimated to be \$124.57 billion (Table 5). Female breast was the cancer site with the highest cost in 2010 (\$16.50 billion) followed by colorectal (\$14.14 billion), lymphoma (\$12.14 billion), lung (\$12.12 billion), and prostate (\$11.85 billion). Under the base case scenario, costs in 2020 were estimated to be \$157.77 billion, representing a 27% increase from 2010. Assuming constant costs, the scenario with the highest national cost estimate in 2020 was the continuing survival trend only scenario (\$165.21 billion), and the lowest national cost estimate in 2020 was the continuing incidence trends only scenario (\$147.57 billion). The continuing incidence trend scenario represents a smaller increase in costs from 2010, compared with the base scenario, because incidence trends have been decreasing for most of the cancer sites. The exceptions are cancer of the kidney and melanoma, for which incidence increased. If the incidence of cervical and ovarian cancers

continues to decrease, care costs for these cancer sites in 2020 will remain the same or decrease compared with 2010. Under the assumption of continuing survival improvement, costs will increase compared with the base scenario. However, the impact of survival on cancer prevalence was smaller than that of incidence (Table 5). If we assume a 2% annual increase in the average costs of care in the initial and last year of life phases, the cost of cancer care is estimated to be \$172.77 billion, representing a 39% increase. Costs of cancer care in 2020 were estimated to be \$207 billion under the assumption of 5% increase in the costs in the initial and last year phases of care (escalating costs), representing a 66% increase from 2010.

National expenditures in 2020 by phases of care for the five major cancer sites—breast, colorectal, prostate, lung, and lymphoma—were partitioned into the estimated expenditure in 2010 and the additional expenditure under the base case scenario

Table 2. United States cancer prevalence estimates for 2010 and 2020*

Site	No. of people in thousands								
	Initial		Continuing		Last year		All phases		All ages
	<65	≥65	<65	≥65	<65	≥65	<65	≥65	
Bladder									
2010	15	29	117	312	4	38	135	379	514
2020	16	39	123	399	4	47	144	485	629
Brain and ONS									
2010	7	3	103	14	9	3	118	20	139
2020	7	4	123	25	11	5	142	35	176
Female breast									
2010	141	92	1320	1735	32	141	1493	1068	3461
2020	148	120	1496	2538	36	200	1680	2858	4538
Cervix									
2010	7	2	140	119	5	9	152	130	281
2020	7	3	128	125	5	9	139	137	276
Colorectal									
2010	41	65	286	724	16	84	343	873	1216
2020	48	82	338	926	19	104	405	1112	1517
Esophagus									
2010	3	4	9	13	2	4	14	21	35
2020	3	5	11	22	2	6	17	33	50
Head and neck									
2010	14	10	110	122	7	18	132	150	283
2020	16	12	124	156	8	23	149	191	340
Kidney									
2010	14	12	123	136	5	17	142	166	308
2020	16	17	151	211	6	25	173	254	426
Leukemia									
2010	10	11	148	72	8	13	166	97	263
2020	10	14	182	105	10	19	202	138	340
Lung									
2010	28	52	64	171	13	46	105	269	374
2020	31	68	69	217	14	59	113	343	457
Lymphoma									
2010	26	22	333	212	15	31	374	265	639
2020	27	29	369	323	17	47	413	399	812
Melanoma									
2010	53	30	629	466	10	38	691	534	1225
2020	55	42	753	788	12	63	820	893	1714
Ovary									
2010	8	7	108	91	7	16	124	114	238
2020	8	9	108	127	8	22	125	158	282
Pancreas									
2010	5	9	7	3	3	3	15	16	30
2020	6	12	9	7	3	5	17	23	40
Prostate									
2010	87	126	387	1546	10	154	484	1827	2311
2020	108	175	510	2243	13	215	631	2633	3265
Stomach									
2010	4	6	18	37	2	6	24	50	74
2020	5	8	22	49	3	8	29	64	93
Uterus									
2010	20	16	156	360	3	31	179	407	586
2020	23	20	177	413	3	34	204	468	672
All sites									
2010	528	552	5066	6725	178	723	5772	8000	13772
2020	583	724	5902	9645	209	1008	6694	11377	18071

* The estimated number of individuals with a previous cancer diagnosis in the initial year after diagnosis, continuing and last year of life phases of care by age (<65 and ≥65 years), and year was estimated using a method that calculates prevalence from projected incidence and survival models (7,10). ONS = other nervous system tumors.

projected for 2020 (Figure 3). Differences were due only to the aging and growth of the US population. Colorectal cancer was the site with the highest cost in the initial phase of care and lung cancer had the highest cost in the last year of life phase of care.

Prostate and female breast cancers had the highest cost in the continuing phase. The highest increases in medical cost of care in 2020 were projected for female breast (32%) and prostate (42%) cancer patients in the continuing phase (Figure 3).

Table 3. United States cancer prevalence estimates for 2010 and projections for 2020 under different scenario assumptions*

Site	Number of cancer survivors				
	2010	2020			
	Base	Base, No. (% change)	Trend incidence, No. (% change)	Trend survival, No. (% change)	Trend incidence and survival, No. (% change)
Bladder	514 000	629 000 (22)	576 000 (12)	640 000 (14)	587 000 (14)
Brain	139 000	176 000 (27)	174 000 (25)	185 000 (31)	182 000 (31)
Breast	3 461 000	4 538 000 (31)	4 275 000 (24)	4 597 000 (25)	4 329 000 (25)
Cervix	281 000	276 000 (-2)	245 000 (-13)	277 000 (-13)	245 000 (-13)
Colorectal	1 216 000	1 517 000 (25)	1 327 000 (9)	1 575 000 (13)	1 376 000 (13)
Esophagus	35 000	50 000 (43)	48 000 (37)	62 000 (71)	60 000 (71)
Head and neck	283 000	340 000 (20)	308 000 (9)	346 000 (11)	313 000 (11)
Kidney	308 000	426 000 (38)	487 000 (58)	446 000 (66)	511 000 (66)
Leukemia	263 000	340 000 (29)	328 000 (25)	356 000 (30)	342 000 (30)
Lung	374 000	457 000 (22)	392 000 (5)	481 000 (10)	412 000 (10)
Lymphoma	639 000	812 000 (27)	803 000 (26)	841 000 (30)	831 000 (30)
Melanoma	1 225 000	1 714 000 (40)	1 971 000 (61)	1 724 000 (62)	1 983 000 (62)
Ovary	238 000	282 000 (18)	232 000 (-3)	296 000 (11)	241 000 (1)
Pancreas	30 000	40 000 (33)	40 000 (33)	50 000 (67)	50 000 (67)
Prostate	2 311 000	3 265 000 (41)	3 108 000 (34)	3 291 000 (36)	3 132 000 (36)
Stomach	74 000	93 000 (26)	80 000 (8)	103 000 (19)	88 000 (19)
Uterus	586 000	672 000 (15)	638 000 (9)	667 000 (8)	634 000 (8)
All sites	13 772 000	18 071 000 (31)	17 465 000 (27)	18 878 000 (32)	18 229 000 (32)

* Scenarios: base, incidence trend, survival trend, and incidence and survival trend. Percent change from 2010 base estimate. The 2020 estimates under the base scenario represent prevalence estimates under the assumption of flat incidence and survival trends but dynamic changes in the US population. Incidence trend and survival trend scenarios represent prevalence projections under the assumptions that survival and incidence trends will continue as observed in the last years of data. Incidence trends represent changes due to prevention and risk factor prevalence. Survival trends represent changes in early detection and treatment.

Discussion

We used the most recently available cancer incidence, survival, and medical cost of care data in the United States to estimate and project the national costs of cancer care through the year 2020. In our base case model using constant cancer incidence, survival, and cost of care, we estimated that the national costs of cancer care in 2010 will be approximately \$124.57 billion. We projected national costs to increase to \$157.77 billion in 2020 under the base case scenario (constant incidence, survival, and cost), a 27% increase. Because we used dynamic assumptions of aging and growing of the US population (3) for all projections, this increase in costs over time in the base case scenario reflects growth and aging in the population only. The largest increase in cost projected for 2020 was in the continuing care phase for female breast and prostate cancers (Figure 3). This increase in the number of breast and prostate cancer survivors has important implications for the demand for medical oncologists (20), as well as the interaction between primary care and oncology for coordination of surveillance care. Our findings will be particularly useful for policy makers for planning and allocation of resources.

We also evaluated a variety of sensitivity analysis scenarios reflecting different assumptions about future trends in incidence, survival, and costs of care. Projections using different assumptions of survival and incidence trends were robust and show that changes in incidence and/or survival have a smaller impact on estimates compared with the aging and growth of the US population. The 2020 predicted costs of cancer care under the assumptions of 1) continuing trends (decreasing incidence and increasing survival) and 2) constant incidence and survival were very similar, 154.70 and 157.77 billion US 2010 dollars, respectively. These estimates

represent increases of 27% and 24%, respectively, in cost compared with 2010. In both of these scenarios, we assumed that currently developed cancer control technologies and their current costs will continue as in the past. It is likely that new tools for diagnosis, treatment, and follow-up of cancer patients will be developed and will be more expensive. Assuming recent incidence and survival trends, a 2% increase in annual costs of care in the initial and last year of life phases will result in a 39% increase in costs over the 10 years and a cost estimate of \$173 billion in 2020. With expected increases in use of targeted chemotherapies, increases in the cost of a course of treatment are expected to escalate more rapidly. A 5% increase in the annual costs of care in the initial and last year of life phases yields a projected \$207 billion in 2020, a 66% increase from 2010. However, trends in costs associated with the use of targeted chemotherapies might be mitigated somewhat through the use of genomic based prognostic markers.

Our estimates of the national cost of cancer care in the year 2010 are higher than those reported elsewhere (5), even after accounting for differences in the base year used for inflation adjustment. Important differences include our use of the most recent incidence, survival, and cost of care data, identification of cancer patients from registry rather than self-report, use of dynamic population estimates and projections, and detailed methods for estimating cancer prevalence. In particular, our cost estimates were based on Medicare claims through the year 2006, reflecting the use of targeted therapies in this population. In addition, we used a phase of care framework to measure the trajectory of cancer care from diagnosis to death to classify cancer survivors and estimate the cost of care for distinct periods. Costs of care for cancer patients who die of their disease follows a "U-shaped" curve, with

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	3	3	346	76	1708	141	1849	4.9	1.9
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	16	16	1564	3704	3808	6202	10010	2.4	1.7
Gastroenterology	0	0	0	0	0	0	0	0	0	0.0	0.0
Neurology	0	0	0	0	700	165	2946	258	3204	4.2	1.6
OB/Gynecology	0	0	0	0	365	1440	963	2320	3283	2.6	1.6
Oral/Maxillofacial	0	0	0	0	15	48	48	99	147	3.2	2.1
Ophthalmology	0	0	0	0	5	178	11	314	325	2.2	1.8
Orthopedic	0	0	0	0	1280	2089	3484	4256	7740	2.7	2.0
Otolaryngology	0	0	0	0	19	1119	30	1245	1275	1.6	1.1
Plastic Surgery	0	0	0	0	40	241	117	657	774	2.9	2.7
Podiatry	0	0	0	0	0	0	0	0	0	0.0	0.0
Thoracic	0	0	0	0	102	0	317	0	317	3.1	0.0
Urology	0	0	0	0	80	173	355	313	668	4.4	1.8
Totals	0	0	19	19	4516	9233	13787	15805	29592	3.1	1.7

SURGICAL RECOVERY STATIONS

Stage 1 Recovery Stations

16

Stage 2 Recovery Stations

31

Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	6	6	1223	7338	917	5504	6421	0.7	0.8
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	1	1	218	489	356	730	1086	1.6	1.5
Multipurpose Non-Dedicated Rooms											
Minor Procedures	0	0	2	2	15	581	14	631	645	0.9	1.1
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+Nondedicated labs):	6
Cath Labs used for Angiography procedures	1
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	1

Emergency/Trauma Care

Certified Trauma Center	Yes
Level of Trauma Service	Level 1 Not Applicable
Operating Rooms Dedicated for Trauma Care	1
Number of Trauma Visits:	1,122
Patients Admitted from Trauma	1,015
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	46
Persons Treated by Emergency Services:	63,282
Patients Admitted from Emergency:	9,478
Total ED Visits (Emergency+Trauma):	64,404

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	3,911
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	2,276
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	670
EP Catheterizations (15+)	965

Cardiac Surgery Data

Total Cardiac Surgery Cases:	233
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	233
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	151

Outpatient Service Data

Total Outpatient Visits	485,150
Outpatient Visits at the Hospital/ Campus:	339,805
Outpatient Visits Offsite/off campus	145,545

Diagnostic/Interventional Equipment

Examinations

Radiation Equipment

Therapie:

	Own	Contract	Inpatient	Outpt	Contract		Owned	Contract	Treatments
General Radiography/Fluoroscopy	40	0	29,032	85,364	0	Lithotripsy	0	0	0
Nuclear Medicine	10	0	1,648	6,339	0	Linear Accelerator	3	0	750
Mammography	9	0	0	53,154	0	Image Guided Rad Therapy	0	0	774
Ultrasound	40	0	11,528	54,497	5,388	Intensity Modulated Rad Thrapy	0	0	720
Angiography	0	2				High Dose Brachytherapy	1	0	25
Diagnostic Angiography			5,582	2,158	0	Proton Beam Therapy	0	0	0
Interventional Angiography			0	0	0	Gamma Knife	0	0	0
Positron Emission Tomography (PET)	1	0	4	793	0	Cyber knife	0	0	0
Computerized Axial Tomography (CAT)	12	0	11,275	47,925	550				
Magnetic Resonance Imaging	5	0	2,650	11,917	0				

Source: 2010 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

Surgery and Operating Room Utilization

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	2	2	374	1	1625	3	1628	4.3	3.0
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	10	10	1122	1150	4269	2192	6461	3.8	1.9
Gastroenterology	0	0	0	0	14	0	29	0	29	2.1	0.0
Neurology	0	0	0	0	135	12	581	36	617	4.3	3.0
OB/Gynecology	0	0	0	0	316	653	729	1005	1734	2.3	1.5
Oral/Maxillofacial	0	0	0	0	12	9	25	13	38	2.1	1.4
Ophthalmology	0	0	0	0	3	10	5	11	16	1.7	1.1
Orthopedic	0	0	0	0	1787	1285	6149	3743	9892	3.4	3.0
Otolaryngology	0	0	0	0	73	292	143	637	780	2.0	2.2
Plastic Surgery	0	0	0	0	176	709	461	1436	1897	2.6	2.0
Podiatry	0	0	0	0	104	108	159	248	407	1.5	2.3
Thoracic	0	0	0	0	32	6	132	18	150	4.1	3.0
Urology	0	0	1	1	320	429	591	690	1281	1.8	1.6
Totals	0	0	13	13	4468	4644	14898	10032	24930	3.3	2.2

SURGICAL RECOVERY STATIONS	Stage 1 Recovery Stations	18	Stage 2 Recovery Stations	21
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Dedicated and Non-Dedicated Procedure Room Utilization

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	6	6	1666	5075	1537	3814	5351	0.9	0.8
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	1	1	0	660	0	330	330	0.0	0.5
Cystoscopy	0	0	1	1	252	342	291	381	672	1.2	1.1
Multipurpose Non-Dedicated Rooms											
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+NonDedicated labs):	3
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	0

Emergency/Trauma Care

Certified Trauma Center	No	
Level of Trauma Service	Level 1 Adult	Level 2 Not Applicable
Operating Rooms Dedicated for Trauma Care	0	
Number of Trauma Visits:	864	
Patients Admitted from Trauma	514	
Emergency Service Type:	Comprehensive	
Number of Emergency Room Stations	29	
Persons Treated by Emergency Services:	44,869	
Patients Admitted from Emergency:	14,765	
Total ED Visits (Emergency+Trauma):	45,733	

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	3,362
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	2,049
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	419
EP Catheterizations (15+)	894

Cardiac Surgery Data

Total Cardiac Surgery Cases:	199
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	199
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	116

Outpatient Service Data

Total Outpatient Visits	177,633
Outpatient Visits at the Hospital/ Campus:	155,487
Outpatient Visits Offsite/off campus	22,146

Diagnostic/Interventional Equipment

Examinations

Radiation Equipment

Therapie:

Diagnostic/Interventional Equipment						Therapeutic Equipment			
	Own	Contract	Inpatient	Outpt	Contract		Owned	Contract	Treatments
General Radiography/Fluoroscopy	24	0	31,821	43,291	0	Lithotripsy	0	0	0
Nuclear Medicine	3	0	1,620	3,063	0	Linear Accelerator	2	0	0
Mammography	7	0	33	19,443	0	Image Guided Rad Therapy	0	0	4967
Ultrasound	13	0	7,034	14,566	0	Intensity Modulated Rad Thrpy	0	0	2584
Angiography	3	0				High Dose Brachytherapy	1	0	212
Diagnostic Angiography			0	0	0	Proton Beam Therapy	0	0	0
Interventional Angiography			29149	28994	0	Gamma Knife	0	0	0
Positron Emission Tomography (PET)	0	1	0	0	456	Cyber knife	0	0	0
Computerized Axial Tomography (CAT)	6	0	14,147	21,169	0				
Magnetic Resonance Imaging	3	0	2,864	5,168	0				

Source: 2010 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

Surgery and Operating Room Utilization											
Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	1	1	196	22	1043	53	1096	5.3	2.4
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	2	2	593	697	1882	1604	3486	3.2	2.3
Gastroenterology	0	0	0	0	13	4	25	8	33	1.9	2.0
Neurology	0	0	0	0	338	123	1122	317	1439	3.3	2.6
OB/Gynecology	0	0	2	2	414	1044	1490	2403	3893	3.6	2.3
Oral/Maxillofacial	0	0	0	0	47	120	201	343	544	4.3	2.9
Ophthalmology	0	0	0	0	8	68	18	156	174	2.3	2.3
Orthopedic	0	0	4	4	1042	600	3490	1658	5148	3.3	2.8
Otolaryngology	0	0	2	2	118	788	438	1954	2392	3.7	2.5
Plastic Surgery	0	0	0	0	29	93	90	332	422	3.1	3.6
Podiatry	0	0	0	0	16	54	46	189	215	2.9	3.1
Thoracic	0	0	0	0	14	1	57	3	60	4.1	3.0
Urology	0	0	1	1	240	366	889	782	1671	3.7	2.1
Totals	0	0	12	12	3068	3980	10791	9782	20573	3.5	2.5

SURGICAL RECOVERY STATIONS Stage 1 Recovery Stations 16 Stage 2 Recovery Stations 27

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours		
Gastrointestinal	0	0	4	4	817	3886	938	4404	5342	1.1	1.1
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	1	1	15	696	13	633	646	0.9	0.9
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
Ambulatory Care	0	2	0	2	0	300	0	522	522	0.0	1.7
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+NonDedicated Labs):	3
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	1

Emergency/Trauma Care

Certified Trauma Center	Yes
Level of Trauma Service	Level 1 Not Applicable
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	403
Patients Admitted from Trauma	287
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	24
Persons Treated by Emergency Services:	25,955
Patients Admitted from Emergency:	6,113
Total ED Visits (Emergency+Trauma):	26,358

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	1,664
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	635
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	236
EP Catheterizations (15+)	793

Cardiac Surgery Data

Total Cardiac Surgery Cases:	103
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	103
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	79

Outpatient Service Data

Total Outpatient Visits	262,727
Outpatient Visits at the Hospital/ Campus:	198,240
Outpatient Visits Offsite/off campus	64,487

Diagnostic/Interventional Equipment	Examinations					Radiation Equipment			Therapeutic Treatments
	Own	Contract	Inpatient	Outpt	Contract	Owned	Contract		
General Radiography/Fluoroscopy	20	0	20,668	21,457	0	Lithotripsy	3	2	34
Nuclear Medicine	4	0	1,228	1,977	0	Linear Accelerator	1	0	5,070
Mammography	1	0	1	108	0	Image Guided Rad Therapy	0	0	33
Ultrasound	17	0	3,845	7,794	0	Intensity Modulated Rad Thpy	0	0	37
Angiography	2	0				High Dose Brachytherapy	0	0	0
Diagnostic Angiography			1,855	2,172	0	Proton Beam Therapy	0	0	0
Interventional Angiography			1813	1019	0	Gamma Knife	0	0	0
Positron Emission Tomography (PET)	0	0	0	0	0	Cyber knife	0	1	5
Computerized Axial Tomography (CAT)	2	0	6,781	12,225	0				
Magnetic Resonance Imaging	1	0	1,358	2,558	0				

Source: 2010 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

Surgical Specialty	Operating Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Cardiovascular	0	0	2	2	461	91	2385	244	2629	5.2	2.7
Dermatology	0	0	0	0	0	0	0	0	0	0.0	0.0
General	0	0	10	10	1060	1454	3049	2903	5952	2.9	2.0
Gastroenterology	0	0	0	0	25	4	40	8	48	1.6	2.0
Neurology	0	0	0	0	183	19	806	49	855	4.4	2.6
OB/Gynecology	0	0	0	0	239	582	691	937	1628	2.9	1.6
Oral/Maxillofacial	0	0	0	0	4	10	10	21	31	2.5	2.1
Ophthalmology	0	0	0	0	3	284	6	545	551	2.0	1.9
Orthopedic	0	0	0	0	1005	1414	3298	2872	6170	3.3	2.0
Otolaryngology	0	0	0	0	41	712	94	1067	1161	2.3	1.5
Plastic Surgery	0	0	0	0	17	529	69	1204	1273	4.1	2.3
Podiatry	0	0	0	0	14	4	26	8	34	1.9	2.0
Thoracic	0	0	0	0	6	1	13	2	15	2.2	2.0
Urology	0	0	2	2	177	474	384	720	1104	2.2	1.5
Totals	0	0	14	14	3235	5578	10871	10580	21451	3.4	1.9

SURGICAL RECOVERY STATIONS

Stage 1 Recovery Stations

20

Stage 2 Recovery Stations

23

Procedure Type	Procedure Rooms				Surgical Cases		Surgical Hours			Hours per Case	
	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	Total Hours	Inpatient	Outpatient
Gastrointestinal	0	0	5	5	1234	6020	1049	5117	6166	0.9	0.9
Laser Eye Procedures	0	0	0	0	0	0	0	0	0	0.0	0.0
Pain Management	0	0	0	0	0	0	0	0	0	0.0	0.0
Cystoscopy	0	0	0	0	0	0	0	0	0	0.0	0.0
Multipurpose Non-Dedicated Rooms											
C-Section	2	0	0	2	299	0	545	0	545	1.8	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0
	0	0	0	0	0	0	0	0	0	0.0	0.0

Cardiac Catheterization Labs

Total Cath Labs (Dedicated+NonDedicated labs):	3
Cath Labs used for Angiography procedures	0
Dedicated Diagnostic Catheterization Labs	0
Dedicated Interventional Catheterization Labs	0
Dedicated EP Catheterization Labs	1

Emergency/Trauma Care

Certified Trauma Center	Yes
Level of Trauma Service	Level 1 Not Applicable
Operating Rooms Dedicated for Trauma Care	0
Number of Trauma Visits:	5,536
Patients Admitted from Trauma	602
Emergency Service Type:	Comprehensive
Number of Emergency Room Stations	28
Persons Treated by Emergency Services:	39,716
Patients Admitted from Emergency:	8,183
Total ED Visits (Emergency+Trauma):	45,252

Cardiac Catheterization Utilization

Total Cardiac Cath Procedures:	2,397
Diagnostic Catheterizations (0-14)	0
Diagnostic Catheterizations (15+)	1,105
Interventional Catheterizations (0-14):	0
Interventional Catheterization (15+)	472
EP Catheterizations (15+)	820

Cardiac Surgery Data

Total Cardiac Surgery Cases:	186
Pediatric (0 - 14 Years):	0
Adult (15 Years and Older):	186
Coronary Artery Bypass Grafts (CABGs) performed of total Cardiac Cases :	133

Outpatient Service Data

Total Outpatient Visits	400,326
Outpatient Visits at the Hospital/ Campus:	225,514
Outpatient Visits Offsite/off campus	174,812

Diagnostic/Interventional Equipment

Examinations

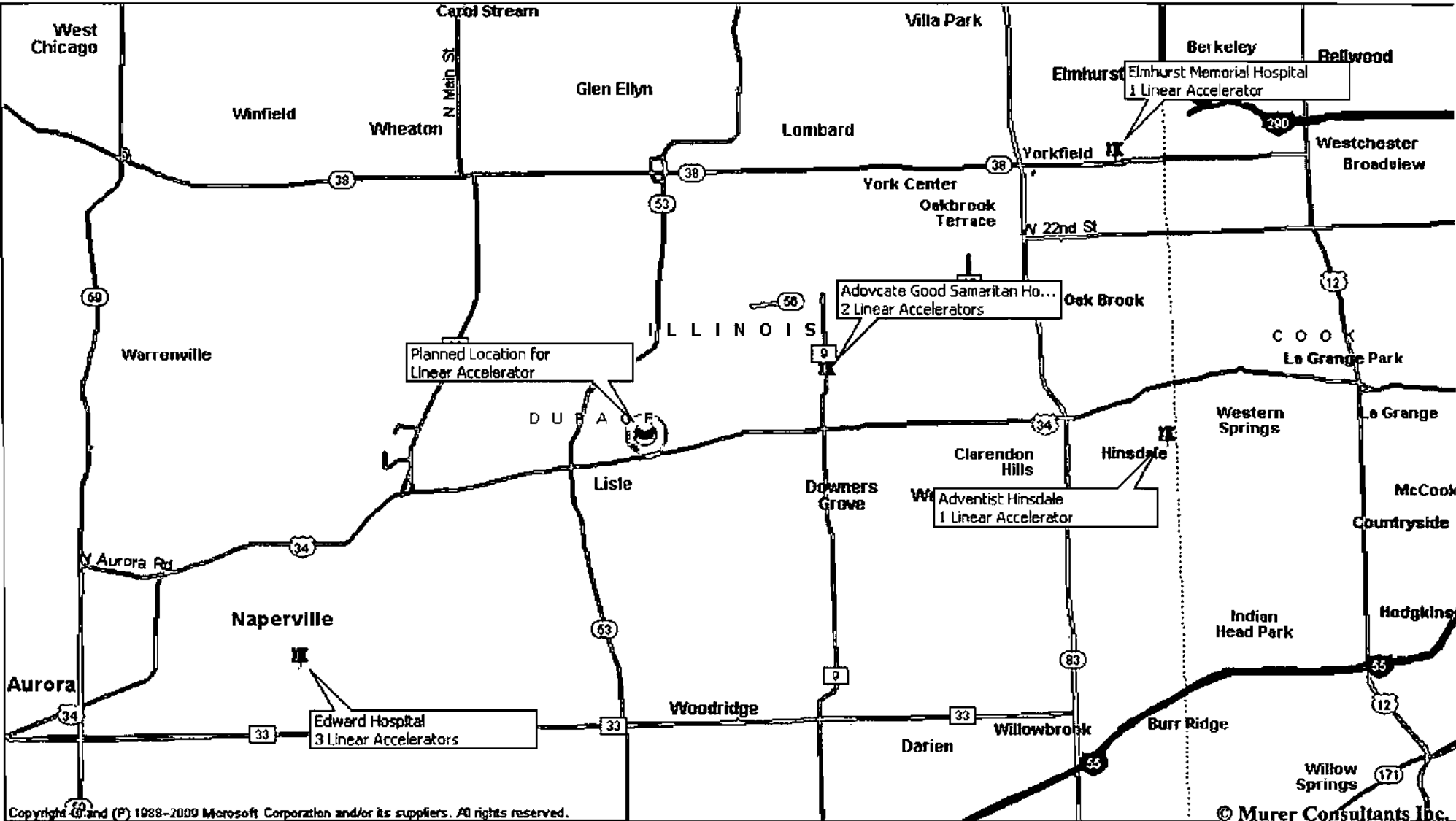
Radiation Equipment

Therapeutic

	Own		Contract		Inpatient	Outpt	Contract		Owned		Contract	Treatments
General Radiography/Fluoroscopy	8	0	26,547	31,788	0				Lithotripsy	0	0	0
Nuclear Medicine	6	0	1,436	3,356	0				Linear Accelerator	1	0	245
Mammography	3	0	21	6,828	0				Image Guided Rad Therapy	0	0	202
Ultrasound	4	0	4,699	8,606	0				Intensity Modulated Rad Thrpy	0	0	88
Angiography	1	0							High Dose Brachytherapy	0	0	0
Diagnostic Angiography			289	259	0				Proton Beam Therapy	0	0	0
Interventional Angiography			568	318	0				Gamma Knife	0	0	0
Positron Emission Tomography (PET)	0	1	0	0	317				Cyber knife	0	1	260
Computerized Axial Tomography (CAT)	2	0	9,286	13,428	0							
Magnetic Resonance Imaging	1	0	1,572	2,412	0							

Source: 2010 Annual Hospital Questionnaire, Illinois Department of Public Health, Health Systems Development.

**Attachment 37-Exhibit 4
Health Planning Area 05
DuPage County- Linear Accelerators**



Attachment 37-Exhibit 5
Linear Accelerator Utilization Information for
Elmhurst Memorial Hospital

Dept./ Service	Historical Utilization (Patient Days) (TREATMENTS) ETC.	PROJECTED UTILIZATION		STATE STANDARD	MET STANDARD?
		YEAR 1	YEAR 2		
Radiation Ther.	6,502 (2011)	7,313	7,607	7,500+	yes

Note: Elmhurst Memorial Hospital has historically provided radiation therapy utilization data on its IDPH Annual Hospital Questionnaires as "courses of treatment", as directed. The IHFSRB's utilization standard, as identified in Appendix B to Section 1110 refers to "treatments". A technical assistance conference was held on January 11, 2012 with IHFSRB staff, and recorded consistent with IHFSRB requirements. During that conference, IHFSRB staff acknowledged that "treatments" were a more accurate measurement of utilization than treatment courses.

Note: This information is taken from Elmhurst Memorial Hospital's CON Application (Project 12-019), submitted March 2, 2012.

SECTION VIII – AVAILABILITY OF FUNDS

Availability of Funds

See Attachment 39-Exhibit 1 for the relevant sections of the loan agreement used to finance a portion of this project. This documentation includes the loan term sheet as well as pages from the loan agreement itself. It demonstrates the loan amount of \$22,000,000. The balance of the project costs (\$17,477,979.07) will be funded with cash. All financing for this project comes from DuPage Medical Group, Ltd.

Bond Rating Information for Rush University Medical Center

Rush University Medical Center, which is a co-applicant, has not in any way participated in the financing of this project and will merely rent out, as a tenant, a portion of the space at DMG's Medical Office Building. Information as to RUMC's bond rating is included in this application per the advice of the CON staff. Please see Attachment 39-Exhibit 2, which includes:

- Moody's Investors Service rating from February 28, 2012 assigning RUMC a Bond Rating of "A2";
- Fitch Ratings from July 1, 2011 assigning RUMC a Bond Rating of "A-"; and
- Standard and Poor's Research rating from December 17, 2011 assigning RUMC a Bond Rating of "A-".

Attachment 39-Exhibit 1

Term Sheet and Construction Loan

Note: Some portions of the Term Sheet have been redacted. The portions redacted are those that provide specific terms regarding interest rates or fees. This information is considered proprietary and confidential. Furthermore, this information is not necessary for the purpose intended by inclusion of this document in the CON submission, i.e. demonstrating the loan amount and thus confirming the availability of funds.

Attachment 39-Exhibit 1
Term Sheet and Construction Loan



TERM SHEET PROPOSAL
DMG Real Estate, LLC
October 17, 2011

This Term Sheet Proposal is presented for discussion purposes only, and replaces the Proposal dated August 3, 2011. It is not a commitment to lend by Bank of America or any of its affiliates. Bank of America may withdraw or amend it at any time in its sole discretion. If Bank of America does extend a loan commitment, the actual terms and conditions (including pricing and financial covenants) will be subject to completion of due diligence, Bank of America's credit and documentation standards, necessary credit approval, market conditions and other considerations determined by Bank of America in its sole discretion.

BORROWER: DMG Real Estate, LLC (the "Borrower").

ADMINISTRATIVE AGENT & ARRANGER: Bank of America, N.A. (the "Administrative Agent," "Arranger" or "BANA") will act as sole and exclusive administrative agent and arranger.

LENDERS: A syndicate of financial institutions (including BANA), arranged by the Administrative Agent and acceptable to the Borrower and BANA.

GUARANTOR: Unlimited guaranty of payment of Du Page Medical Group, Ltd. ("DMG")

CREDIT FACILITY: Construction-to-Permanent Term Loan Facility ("Credit Facility") consisting of an initial Construction Loan ("Construction Loan") and a subsequent permanent Term Loan ("Term Loan").

CREDIT FACILITY AMOUNT: The lesser of:
(i) \$22,000,000; or
(ii) 70% of the Fair Market Value of the Property, as evidenced by a satisfactory as-completed appraisal performed by the Bank.

BANA SHARE/ PARTICIPATION: BANA will hold up to \$11,220,000 or 51% of the Credit Facility.

On a best efforts basis, BANA will pursue a participation(s) in the facility for up to \$10,780,000 or 49% of the Credit Facility.

"BEST EFFORTS" SYNDICATION BANA will use its best efforts to form a syndicate of financial institutions ("Lenders") for the Credit Facility, based on the indicative terms and conditions contained herein. This Proposal represents our current view of where a transaction such as this would clear the market, but are subject to change.

The Borrower agrees to actively assist BANA in achieving a successful syndication of the Facility. To assist BANA in its syndication efforts, the Borrower agrees to: (i) provide, and cause its advisors to provide, BANA and each other Lender that becomes part of the syndicate of financial institutions upon request with all information reasonably deemed necessary by BANA to complete the syndicate; (ii) assist BANA upon reasonable request in the preparation of marketing materials to be used in connection with the syndication of the Facility; and (iii) otherwise assist BANA in its syndication efforts, including making available officers and advisors of the Borrower/Guarantor and its affiliates and subsidiaries from time to time to attend and make presentations regarding the business and prospects of the Borrower/Guarantor and at a meeting or meetings of prospective syndicate members.

MARKET FLEX

The Borrower will cooperate with BANA's recommendations to change the structure or terms (including pricing) of the Credit Facility, if BANA determines that such changes will be necessary in order to ensure a successful syndication of an optimal credit structure of the Credit Facility. Such change to structure, terms or amount may occur before or after initial close of the Credit Facility. If the Borrower withholds consent, BANA or the Borrower may terminate any commitments that may have been issued and any further discussions or efforts with respect to the Credit Facility. The Borrower shall remain liable for all costs actually incurred during the negotiation, preparation, execution and syndication of the Credit Facility whether or not such Credit Facility closes.

**CLEAR MARKET
PROVISION:**

From the date of acceptance of this Proposal and continuing until execution and delivery of the Credit Facility, there shall be no competing offering, placement or arrangement of any debt securities or bank financing by or on behalf of the Borrower/Guarantor. The Borrower will immediately notify BANA if any such transaction is contemplated.

PURPOSE:

The proceeds of the Credit Facility shall be used for the construction and permanent financing of an approximate 100,000 sq. ft. medical office building in Lisle, IL (the "Property").

MATURITY:

- Construction Loan: 12 months from Closing Date
- Term Loan: 5 years from Term Loan Conversion.

CLOSING DATE:

Targeted December 31, 2011

INTEREST RATE:

- Construction Loan: [REDACTED]
- Term Loan: LIBOR [REDACTED]

The [REDACTED] shall be renewed upon the expiration of the initial interest period for a like tenor, or other tenor as agreed to by the Bank, and the rate adjusted to the applicable [REDACTED] in effect at the time of such renewal.

**INTEREST
CALCULATION**

All calculations of interest and fees shall be made on the basis of actual number of days elapsed in a 360-day year.

**INTEREST RATE
PROTECTION**

The Borrower shall enter into interest protection agreements acceptable to BANA for up to 50% of the principal amount of the Credit Facility for a term no less than 3 years, within 60 days of Term Loan Conversion. The terms of such interest rate swap shall be governed by the standard ISDA Master Agreement and related documentation.

UPFRONT FEE:

[REDACTED] payable at closing to Lenders based on their pro rata share.

ARRANGER FEE:

[REDACTED] payable at closing to Arranger.

AGENCY FEE:

[REDACTED] payable annually to Administrative Agent.

**CONSTRUCTION LOAN
DISBURSEMENTS:**

The Borrower may request disbursements up to the Credit Facility Amount. Conditions to each disbursement will be usual and customary for transactions of this type, including, without limitation: (i) all representations and warranties are true and correct as of the date of each loan, and (ii) no event of default has occurred or is continuing under the Credit Facility or would result from such loan.

Conditions applicable to construction disbursements include, but are not limited to, the following:

- The Credit Facility shall be subject to the receipt, review, and acceptance of the plans and specs of the proposed project by BANA's Commercial Banking Construction ("CBC") Division and an outside consultant hired by the Bank to perform a Front End Plan and Cost Review. This cost is paid by the Borrower. The Bank shall provide a checklist of all construction related documents and permits required for closing.
- The Credit Facility shall be further subject to approval of the contractor and the contract for the proposed project by BANA's CBC Division.
- Construction costs and disbursements shall be administered by BANA's CBC Division during the construction phase.
- Each Construction Loan disbursement will be evidenced by a monthly inspection plus a cost review by BANA's construction monitoring consultant, which will be paid for by the Borrower.
- The Borrower's equity in the construction draws shall be determined based on formation of current equity in the Property and formal credit approval, and either:
 - (i) Shared with each draw; or
 - (ii) Lump sum upfront

**TERM LOAN
CONVERSION:**

The Construction Loan shall convert to a Term Loan ("Term Loan Conversion"), subject to satisfaction of usual and customary conditions for transactions of this type, including but not limited to:

- Final Construction Loan disbursement
- Construction completion on the Property
- Confirmation of waiver of all mechanic's lien claims
- Delivery of ALTA Loan policy
- Delivery of permanent insurance
- Delivery of certificate of occupancy
- Execution of all applicable Property leases
- Confirmation that no judgments or tax liens exist on either the Property or the Borrower.

REPAYMENT:

The Credit Facility shall be subject to monthly interest payments.

The Term Loan shall be subject to equal monthly installments of principal based on a 20-year amortization schedule.

PREPAYMENTS:

The Borrower may prepay any variable rate loan under the Credit Facility in whole or in part at any time without penalty, except for reimbursement of BANA's breakage and redeployment costs in the case of prepayment of LIBOR based borrowings.

**REAL ESTATE
COLLATERAL:**

A first priority mortgage on real property commonly known as 430 Warrenville Road located in Lisle, Du Page County, Illinois. Any existing leases on the real property shall not contain any right to purchase the property or any right of first refusal unless such rights are subordinated to BANA's lien in a manner satisfactory to the Bank. At BANA's request, Borrower shall provide the Bank with a complete copy of any existing lease on the real property.

Such lien on the real property shall be subject to such terms and conditions as the Bank may reasonably impose including, but not limited to, a loan to value ratio not to exceed 70%, an appraisal (to be ordered by Bank of America), instrument survey, title insurance (with all required endorsements) and environmental Phase I survey (to be completed by Borrower), all of which shall be acceptable to Bank of America and its counsel.

The foregoing security shall also secure any liabilities of Borrower to the Bank arising under any interest rate swap/foreign currency swap or other hedging arrangement.

**CONDITIONS
PRECEDENT:**

The closing (and the initial funding) of the Credit Facility will be subject to satisfaction of the conditions precedent deemed appropriate for transactions of this type including, but not limited to, the following:

- (i) The negotiation, execution and delivery of definitive documentation for the Credit Facility satisfactory to Bank of America, which shall include, without being limited to satisfactory opinions of counsel to the Borrower and Guarantor and such other customary closing documents as Bank of America shall reasonably request.
- (ii) There shall not have occurred a material adverse change in the business, assets, liabilities (actual or contingent), operations, condition (financial or otherwise) or prospects of the Borrower and Guarantor taken as a whole or in the facts and information regarding such entities as represented to date.
- (iii) The absence of any action, suit, investigation or proceeding pending or threatened in any court or before any arbitrator or governmental authority that purports (a) to materially and adversely affect the Borrower or Guarantor, or (b) to affect any transaction contemplated hereby or the ability of the Borrower or the Guarantor to perform their respective obligations under the documentation for the Credit Facility.
- (iv) Additional due diligence on the Property consistent with transactions of this type, including, but not limited to, as-completed appraisal of the Property, environmental due diligence, evidence of all required insurance, satisfactory title insurance, and review of the construction and architect contracts and documents by BANA's CBC Division and the outside consultant hired by the Bank.
- (v) Payment of all fees and expenses then due and payable.
- (vi) Receipt of items as listed on Exhibit A.

RELATIONSHIP:

DMG shall maintain BANA as its principal depository bank, including for the maintenance of business, cash management, operating and administrative deposit accounts.

**REPRESENTATIONS
AND WARRANTIES:**

Usual and customary for transactions of this type, to include, without limitation: (i) due organization, valid existence and good standing (ii) due authorization/enforceability; (iii) correctness of specified financial statements and no material adverse change; (iv) binding effect and enforceability of loan documents; (v) no liens or encumbrances other than as disclosed to Bank of America; (vi) compliance with environmental laws; (vii) no material litigation; (viii) payment of taxes.

COVENANTS:

Usual and customary for transactions of this type, to include, without limitation: (i) due organization, valid existence and good standing (ii) due authorization/enforceability; (iii) correctness of specified financial statements and no material adverse change; (iv) binding effect and enforceability of loan documents; (v) no liens or encumbrances other than as disclosed to Bank of America; (vi) compliance with environmental laws; (vii) no material litigation; and (viii) payment of taxes.

The Borrower may be required to obtain a payment and performance bond for the general contractor, subject to BANA's review of the contractor's AIA Statement of Qualifications and financial statements.

**FINANCIAL
COVENANTS:**

Financial covenants of the Borrower will include:

- Minimum Debt Service Coverage Ratio ("DSCR") of 1.20x, measured quarterly and calculated on a three-months basis.

DSCR shall be defined as the ratio of (a) Cash Flow to (b) the sum of scheduled principal and interest payments on all long-term debt.

"Cash Flow" is defined as (a) net income, after income tax, (b) less income or plus loss from discontinued operations and extraordinary items, (c) plus depreciation, amortization and other non-cash charges, (d) plus interest expense on all obligations, and (e) minus dividends, withdrawals, and other distributions.

Financial covenants of the Guarantor will include:

Financial covenants and definitions for the Guarantor will be consistent with those contained in the Loan Agreement between BANA and DMG dated 12/31/2010, as follows:

- Minimum Tangible Net Worth of \$40,000,000 + 50% of net income after 12/31/2009, tested quarterly on a year-to-date basis.
- Minimum Debt Service Coverage Ratio of 1.50x, tested quarterly on a trailing 12-months basis.
- Maximum Senior Debt/EBITDA of 3.50x, tested quarterly on LTM basis
- Minimum Fixed Charge Coverage of 1.10x, tested quarterly on a trailing 12-months basis.

- Maximum unfunded capital expenditures in any fiscal year, tested quarterly on a year-to-date basis, of:
 - \$15,000,000 for fiscal year ended 12/31/2011
 - \$20,000,000 for fiscal years ended 12/31/2012 and thereafter
- Maximum aggregate rental payments under operating leases in any fiscal year, tested quarterly on a year-to-date basis, of:
 - \$25,000,000 for fiscal year ended 12/31/2011
 - \$30,000,000 for fiscal years ended 12/31/2012 and thereafter

**REPORTING
REQUIREMENTS:**

Financial reporting from the Borrower will include:

Prior to Term Loan Conversion:

- Project reporting as required by BANA's CBC Division.
- Copy of any executed lease(s) on the Property, as well as any future amendments and/or modifications

After Term Loan conversion:

- Quarterly financial statements of the Borrower within 45 days of quarter end (including the fourth fiscal quarter of each year), certified and dated by the Borrower's authorized financial officer
- Annual rent roll for the Borrower and the Property within 45 days of year end

Financial reporting from the Guarantor will include:

Financial reporting for the Guarantor will be consistent with that outlined in the Loan Agreement between BANA and DMG dated 12/31/2010, as follows:

- Annual audited consolidated financial statements within 120 days of FYE, certified and dated by DMG authorized financial officer
- Quarterly consolidated financial statements within 45 days of quarter end (including the fourth fiscal quarter of each year), certified and dated by DMG authorized financial officer
- Annual consolidated budget within 60 days of commencement of each fiscal year, certified by CFO
- Quarterly compliance certificate within 45 days of each quarter end, signed by authorized financial officer showing calculations of financial covenants
- Monthly summary A/R aging by payor class, within 30 days of month end

In addition, reporting will include the following:

- Any other information from the Guarantor and/or Borrower as the Bank shall reasonably request.

EVENTS OF DEFAULT:	Usual and customary in transactions of this type, to include without limitation: (i) nonpayment of principal, interest, fees or other amounts; (ii) violation of covenants; (iii) inaccuracy of representations and warranties; (iv) cross-default to other material agreements and indebtedness; (v) bankruptcy and other insolvency events; (vi) creditor or forfeiture proceedings; (vii) actual or asserted invalidity of any loan documentation or security interests; (viii) material events affecting guarantor; (ix) change in control and (x) material adverse change.
GOVERNING LAW/ARBITRATION:	State of Illinois. Any dispute arising out of or related to this letter or the final loan documentation shall be determined by binding arbitration in accordance with the Federal Arbitration Act. All arbitration proceedings shall be conducted through the American Arbitration Association (an independent, alternative dispute resolution service).
EXPENSES:	Borrower will pay all reasonable costs and expenses associated with the preparation, due diligence, administration and enforcement of all documentation executed in connection with the Credit Facility, whether or not the loan closes, including, without limitation: • BANA's attorneys' fees (including the allocated cost of internal counsel), estimated at [REDACTED] • Applicable construction-related administration fees, including but not limited to: appraisal(s), cost analysis, site inspection, title, environmental review, flood certification and, if applicable, contractor payment and performance bond.
CREDIT PROCESS TIMEFRAME:	The credit process will take 15 business days from the point at which BANA is officially awarded the transaction and has in its possession all materials necessary to undertake a full credit analysis.
EXPIRATION OF TERMS AND CONDITIONS	Unless rescinded earlier, consideration of a financing based on the terms and conditions presented in this term sheet shall automatically expire 30 days from the date hereof. BANA reserves the right to terminate, reduce or otherwise amend its commitment if the subject transaction is not closed within 90 days of the receipt of a signed term sheet

This Term Sheet Proposal contains confidential and proprietary loan structuring and pricing information. Except for disclosure on a confidential basis to your accountants, attorneys and other professional advisors retained by you in connection with the credit facilities contained in this Term Sheet Proposal or as may be required by law, the contents of the Term Sheet Proposal may not be disclosed in whole or in part to any other person or entity without our prior written consent, provided that nothing herein shall restrict disclosure of information relating to the tax structure or tax treatment of the proposed credit facilities.

**AGREEMENT BY THE
BORROWER:**

The Borrower hereby agrees to engage BANA to provide the Credit Facility which is the subject hereof, pursuant to the terms and conditions stated herein.

Please evidence your acceptance of the foregoing by signing and returning a copy of the document to BANA.

Accepted and Agreed to:

By:  Date: 10/17/2011

Exhibit A

- Satisfactory ALTA Survey – Signed, sealed and certified to Lender, Title Company and Borrower
- Detailed project construction cost breakdown from the contractor including an itemization and schedule of disbursements
- Sets of detailed construction plans and specifications for all architectural, structural, mechanical, plumbing, electrical, site development (on and off-site) and other work for or in connection with the Improvements which have been approved by the municipality
- Fully executed copies of Borrowers' construction, architectural and engineering contracts regarding the Improvements
- Project description of improvements
- Construction schedule (provided by the contractor – usually a bar chart)
- Architect and/or Engineer list of permits required and site development permit status data
- Insurance – Fire, all-risk replacement cost coverage, builder's risk, Contractor's liability, Borrower Liability and flood insurance if project is in a flood zone
- Satisfactory Soil Report with recommendations
- Satisfactory Environmental information
- Zoning and concurrency letter
- Utility availability letters (should also state that capacity is available and appropriate for this project)
- Title commitment
- True and correct copies of valid building permit for the Improvements and all other applicable permits, licenses and approvals necessary for construction.
- Performance and Payment bonds (Unconditional) for each original construction contractor (and any material subcontractor as required by Lender) naming Lender as an additional obligee and in amount, form and content, and issued by sureties, satisfactory to Lender and in compliance with applicable law.

The above list is provided for informational purposes only.

A more detailed and all inclusive listing of the construction requirements will be included in the Construction Loan Agreement and related loan documentation.

Borrower Indemnification Letter

On this 17th day of October, 2011, DMG Real Estate, LLC (the "Borrower") wishes to induce Bank of America, (the "Bank") to waive its right to retain sole possession of the appraisal report (the "Appraisal"), prepared by CB Richard Ellis (the "Appraiser") with respect to the property consisting of DuPage Medical MOB as of the date of the Appraisal, and located at 1807 S. Highland Ave., Lombard, DuPage County, IL (collectively the "Property").

In consideration of the Bank's agreement to deliver a copy of the Appraisal to the Borrower, the Borrower hereby agrees with the Bank and acknowledges to the Bank, the following:

- (a) As of the date hereof, the Bank
 - (i) does not represent that the presumptions or opinions in the Appraisal are relevant or accurate;
 - (ii) does not represent that the appraisal has been or has not been approved by the Bank;
 - (iii) does not represent that the Bank endorses or does not endorse the opinions set forth in the Appraisal and;
 - (iv) is transmitting the Appraisal to the Borrower without representation or warranty.
- (b) The Borrower will hold the Appraisal in confidence and will not distribute it to any other person or entity, except its employees, agents, attorneys, consultants, or unless compelled by law or judicial proceedings, without the Bank's prior written consent.
- (c) The Borrower will indemnify and hold the Bank harmless from and against, and reimburse it for, any and all claims, demands, liabilities, losses, damages, causes of action, judgments, penalties, costs and expenses of every kind, known or unknown, which may be imposed upon, asserted against, or incurred or paid by the Bank at any time and from time to time, resulting from, in connection with, or arising out of any transaction, act, omission, event or circumstance in any way connected with the content or accuracy of the Appraisal, the Borrower's use of the Appraisal, and subsequent use of the Appraisal by any third party to whom the Borrower provides the Appraisal.
- (d) The Borrower hereby waives any and all present and future claims, actions, causes of action, defenses and/or counterclaims which it may now or hereafter assert against the Bank in connection with the content or accuracy of the Appraisal, the Borrower's use of the Appraisal, and subsequent use of the Appraisal by any third party to whom the Borrower provides the Appraisal.

For purposes of this Agreement, the term "Bank" shall include, without limitation, its present, former and future officers, directors, associates, agents, parents, subsidiaries, affiliates, successors and assigns.

EXECUTED this 17th day of October, 2011.

BORROWER:

By: [Signature]

Name: Michael V. Paccetti

Title: CFO

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03-30-12

CONSTRUCTION LOAN AGREEMENT

by and between

DMG Real Estate, LLC,
an Illinois limited liability company,
as Borrower,

and

Bank of America, N.A.,
a national banking association,
as Administrative Agent,

and

Bank of America, N.A.,
a national banking association,
as Lender,

and

Each Other Lender From Time to Time
Party Hereto

with respect to
DuPage Medical Group Oncology Institute
430 Warrenville Road, Lisle, Illinois

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Construction Loan Agreement

This Construction Loan Agreement (this "Agreement") is made as of the 30th day of March, 2012, by and among DMG Real Estate, LLC, an Illinois limited liability company ("Borrower"), Bank of America, N.A., a national banking association, as Administrative Agent ("Administrative Agent"), and Bank of America, N.A., a national banking association, as Lender each other Lender from time to time a party hereto (individually, a "Lender" and collectively, "Lenders").

Recitals

Lenders have severally agreed to make Pro Rata Shares of a loan to Borrower on the terms and conditions set forth in this Agreement and in the other documents evidencing and securing the loan, to finance certain costs related to the construction and development of improvements on real property in which Borrower has acquired or is acquiring an interest. Such real property is legally described in the Mortgage (as defined in Section 1.1 of this Agreement), and is commonly known as 430 Warrenville Road, Lisle, Illinois. Such improvements consist of an approximately 100,000 square foot medical office building.

Now, therefore, in consideration of the premises, and in further consideration of the mutual covenants and agreements herein set forth, the parties covenant and agree as follows:

Agreements

Article I

General Information.

Section 1.1 Defined Terms.

Unless the context otherwise specifies or requires, the following terms shall have the meanings herein specified, such definitions to be applicable equally to the singular and the plural forms of such terms and to all genders:

"Accounts Payable List" means a written summary from Borrower of all accounts paid or payable for soft costs associated with the applicable draw request identifying each such account and the invoice amount due, and shall be in form and substance acceptable to Administrative Agent. For purposes of this definition, "soft costs" includes costs and expenses of development other than those attributable to the construction of the physical Improvements, including but not limited to architect's fees, consulting fees, management fees, abatement expenses, legal fees, testing and inspection fees, connection charges, and other similar fees and expenses.

"Act" means the USA Patriot Act (Title III of Pub. L. 107-56 (signed into law October 26, 2001)).

"Adjusted LIBOR Rate" means the quotient obtained by dividing (i) the applicable London Interbank Offered Rate by (ii) 1.00 minus the LIBOR Reserve Percentage, where,

whether or not applicable to any Lender, in respect of "Eurocurrency liabilities" (or in respect of any other category of liabilities which includes deposits by reference to which the interest rate on principal of the Loan and the Notes is determined), whether or not any Lender has any Eurocurrency liabilities. The LIBOR Rate shall be adjusted automatically as of the effective date of each change in the LIBOR Reserve Percentage.

"Lien" means, with respect to any Covenant Party, any interest granted by such Covenant Party in any real or personal property, asset or other right owned or being purchased or acquired by such Covenant Party which secures payment or performance of any obligation and shall include any mortgage, lien, encumbrance, charge or other security interest of any kind, whether arising by contract, as a matter of law, by judicial process or otherwise.

"Loan" means the loan from Lenders to Borrower, the repayment obligations in connection with which are evidenced by the Notes.

"Loan Amount" means Twenty Two Million and No/100 Dollars (\$22,000,000) (which does not exceed 70% of the "as completed" appraised value of the Property as determined in an appraisal obtained by and acceptable to Administrative Agent).

"Loan Documents" means this Agreement, the Notes, the Mortgage, the Environmental Agreement, the Guaranty, any Swap Contract, and any and all other documents which Borrower, Guarantor or any other party or parties have executed and delivered, or may hereafter execute and deliver, to evidence, secure or guarantee the Obligations, or any part thereof, as the same may from time to time be extended, amended, restated, supplemented or otherwise modified.

"London Banking Day" means a day on which dealings in dollar deposits are conducted by and between banks in the London interbank eurodollar market.

"London Interbank Offered Rate" means, with respect to any applicable Interest Period, the rate per annum equal to the British Bankers' Association LIBOR Rate ("BBA LIBOR"), as published by Reuters (or other commercially available source providing quotations of BBA LIBOR as selected by Administrative Agent from time to time) at approximately 11:00 a.m. London time two London Business Days before the commencement of the Interest Period, for deposits in U.S. Dollars (for delivery on the first day of such Interest Period) with a term equivalent to such Interest Period. If such rate is not available at such time for any reason, then the rate for that Interest Period will be determined by such alternate method as reasonably selected by Administrative Agent.

"Long Term Debt" means any Debt that matures more than one year after the date of determination or matures within one year from such date but is renewable or extendible, at the option of the debtor, to a date more than one year after such date or arises under a revolving credit or similar agreement that obligates the lender or lenders to extend credit during a period of more than one year after such date, including the current portion of all such Debt.

"Major Lease" means each of the Leases between Borrower as landlord and the Major Tenants as tenant.

IN WITNESS WHEREOF, Borrower, Administrative Agent and the Lenders named below have caused this Agreement to be executed as of the date first above written.

DMG REAL ESTATE, LLC

By 
Michael Kasper, General Manager

BANK OF AMERICA, N.A., as Administrative Agent

By _____
Printed Name: _____
Title: _____

BANK OF AMERICA, N.A., as a Lender

By _____
Christie Davis, Senior Vice President

WHEATON BANK & TRUST CO., an Illinois banking corporation, as a Lender

By _____
Pamela Sharar-Stoppel
Executive Vice President

CONSTRUCTION LOAN AGREEMENT
SIGNATURE PAGE

Attachment 39- Exhibit 1

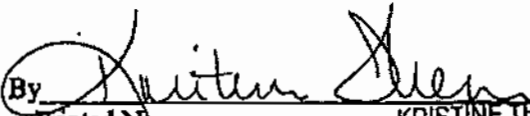
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IN WITNESS WHEREOF, Borrower, Administrative Agent and the Lenders named below have caused this Agreement to be executed as of the date first above written.

DMG REAL ESTATE, LLC

By _____
Michael Kasper, General Manager

BANK OF AMERICA, N.A., as Administrative Agent

By  _____
Printed Name: KRISTINE THENNES.
Title: Vice President

BANK OF AMERICA, N.A., as a Lender

By _____
Christie Davis, Senior Vice President

WHEATON BANK & TRUST CO., an Illinois banking corporation, as a Lender

By _____
Pamela Sharar-Stoppel
Executive Vice President

IN WITNESS WHEREOF, Borrower, Administrative Agent and the Lenders named below have caused this Agreement to be executed as of the date first above written.

DMG REAL ESTATE, LLC

By _____
Michael Kasper, General Manager

BANK OF AMERICA, N.A., as Administrative Agent

By _____
Printed Name: _____
Title: _____

BANK OF AMERICA, N.A., as a Lender

By Christie Davis
Christie Davis, Senior Vice President

WHEATON BANK & TRUST CO., an Illinois banking corporation, as a Lender

By _____
Pamela Sharar-Stoppel
Executive Vice President

CONSTRUCTION LOAN AGREEMENT
SIGNATURE PAGE

Attachment 39- Exhibit 1

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IN WITNESS WHEREOF, Borrower, Administrative Agent and the Lenders named below have caused this Agreement to be executed as of the date first above written.

DMG REAL ESTATE, LLC

By _____
Michael Kasper, General Manager

BANK OF AMERICA, N.A., as Administrative Agent

By _____
Printed Name: _____
Title: _____

BANK OF AMERICA, N.A., as a Lender

By _____
Christie Davis, Senior Vice President

WHEATON BANK & TRUST CO., an Illinois banking corporation, as a Lender

By _____
Pamela Sharar-Stoppel
Executive Vice President

CONSTRUCTION LOAN AGREEMENT
SIGNATURE PAGE

Attachment 39- Exhibit 1

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Attachment 39-Exhibit 2
Rush University Medical Center Bond
Rating

MOODY'S INVESTORS SERVICE

Rating Update: MOODY'S AFFIRMS RUSH UNIVERSITY MEDICAL CENTER OBLIGATED GROUP'S (IL) A2 LONG-TERM AND UNENHANCED BOND RATINGS; OUTLOOK REMAINS STABLE

Global Credit Research - 28 Feb 2012

AFFIRMATION AFFECTS APPROXIMATELY \$558 MILLION OF RATED DEBT OUTSTANDING

ILLINOIS FINANCE AUTHORITY
Hospitals & Health Service Providers
IL

Opinion

NEW YORK, February 28, 2012 --Moody's Investors Service has affirmed Rush University Medical Center Obligated Group's (RUMC Obligated Group) A2 long-term and unenhanced bond ratings. This action affects approximately \$558 million of revenue bonds issued through the Illinois Finance Authority (see Rated Debt section). The outlook remains stable.

RATINGS RATIONALE

SUMMARY RATING RATIONALE: The affirmation of the A2 rating and stable outlook reflects RUMC Obligated Group's continued favorable operating performance in fiscal year (FY) 2011 and interim FY 2012, maintenance of adequate debt coverage and balance sheet ratios, and the fact that RUMC is beyond construction risks after the January 2012 opening of the new patient tower at the flagship campus. The System faces challenge with an above average Medicaid share of business in a state with a challenged budget.

STRENGTHS

*Sizeable academic medical center (AMC) with broad array of tertiary and quaternary services (the RUMC flagship had a Medicare case mix index of 1.93 in FY 2011).

*Impressive operating improvement since FY 2004 (11.8% operating cash flow margin in FY 2011).

*Improved cash on hand with 145 days at fiscal year end (FYE) 2011. While this remains below the A2 median (188 days cash on hand), we note that RUMC Obligated Group has significant restricted investments, which bolster the balance sheet strength (at FYE 2011, the System had \$488 million of restricted investments outstanding).

*The System is beyond most construction risks with the January 2012 opening the new patient tower at the RUMC flagship.

CHALLENGES

*Very competitive healthcare market in the Chicago area, with five AMCs (including RUMC) plus other sizeable health system and large community hospitals.

*Medicaid as a percentage of gross revenues has increased from 15.1% in FY 2008 to 18.5% in FY 2011, which is of particular concern given the challenges of the State of Illinois budget (the state has been delaying Medicaid payments to healthcare providers).

*Underfunded defined benefit pension plan with an 84% pension funded ratio compared to a projected benefit obligation of \$797 million at FYE 2011, plus the System has operating leases outstanding. Effective December 31, 2011, the remaining employees were moved to a cash balance pension plan (most RUMC employees were moved to the cash balance plan in 2004).

DETAILED CREDIT DISCUSSION

LEGAL SECURITY: The bonds are secured by a gross revenue pledge and a mortgage pledge of the RUMC Obligated Group including Rush University Medical Center (RUMC) and Rush-Copley Medical Center (Copley). Rush North Shore Medical Center (North Shore) withdrew from the Obligated Group on December 31, 2008. Violating rate covenant of 1.1 times requires hiring of consultant. Additional debt test: (1) debt-to-capitalization of no more than 69% in FY 2008 (decreasing by 1 percentage point each year until 65% in FY 2012); or (2) historical pro-forma debt service coverage greater than 1.25 times; or (3) historical debt service coverage greater than 1.1 times and projected debt service coverage greater than 1.1 times.

INTEREST RATE DERIVATIVES: The RUMC Obligated Group entered into fixed payor swaps with Morgan Stanley Capital

Services, Inc. and Citibank, N.A. with a combined notional amount of \$96.8 million that expire in November 2035. Under the agreements, the RUMC Obligated Group pays a fixed interest rate of 3.945% and receives 68% of LIBOR. \$50 million of the interest rate swaps hedge the interest rate on the Series 2008A variable rate demand bonds (VRDB) issued in December 2008. As a result of prior variable rate debt restructurings, the remaining \$46.8 million notional amount is not hedging a particular variable rate bond series. The total net termination value of the swaps at audited FYE June 30, 2011 was a negative \$14.5 million to RUMC Obligated Group. According to management, the net termination value of the swaps as of December 31, 2011 was a negative \$23.8 million. Management notes the System has a collateral posting threshold of negative \$25 million (the swaps have bilateral posting requirements for RUMC and the counterparties, based on the same posting scale).

RECENT DEVELOPMENTS/RESULTS

RUMC (30,259 admissions in FY 2011) is the System's flagship hospital and is one of five AMCs in the Chicago market. Other academic medical centers in the market include: University of Illinois Health Services (rated A1); Northwestern Memorial Hospital (rated Aa2); Loyola University Health System (now a member of Aa2 rated Trinity Health Credit Group); and The University of Chicago Medical Center (rated Aa3). In addition to the competing AMCs, RUMC faces competition from a number of sizeable acute care systems in the market, notably market share leader Aa2 rated Advocate Health Care Network and Baa1 rated Resurrection Health Care. Northwestern Memorial is the largest single hospital in the Chicago area. RUMC shares a state-designated medical district campus with University of Illinois Health Services, John H. Stroger Jr. Hospital of Cook County, and Jesse Brown VA Medical Center.

In addition to the RUMC flagship hospital, the RUMC Obligated Group includes 12,985 admission Copley in Aurora, IL. Effective December 31, 2008, Rush North Shore withdrew from the Obligated Group and joined Aa2 rated NorthShore University Health System. RUMC, through a joint venture with a third-party, operates and manages 4,383 admission Rush Oak Park Hospital (ROPH) in Oak Park, IL. Other non-obligated system affiliates include A2 rated Riverside Health System in Kankakee, IL.

The RUMC Obligated Group's operating performance generally has improved in recent years, which we view as a key credit positive. In audited FY 2011 (June 30 year end), the RUMC Obligated Group recorded adjusted operating income of \$68.3 million (3.9 % operating margin) and adjusted operating cash flow of \$205.0 million (11.8% operating cash flow margin). This is an improvement over audited FY 2010, when the RUMC Obligated Group recorded adjusted operating income of \$45.0 million (2.7% margin) and operating cash flow of \$174.6 million (10.4% margin). Audited results have been adjusted to reclassify the portion of investment income included in operating revenue to non-operating and to include capitalized interest as an interest expense. FY 2010 is adjusted further to add \$18.0 million to operating expenses to account for a favorable one-time IRS settlement related to a FICA tax refund on medical residents. Since FY 2005, RUMC Obligated Group has maintained profitable operating results.

Factors contributing to continued good operating results for the RUMC Obligated Group in FY 2011 include: (a) focus on productivity improvements to offset revenue pressures that included a layoff of approximately 200 full-time equivalents in FY 2011 (FY 2011 results include approximately \$5 million of severance costs) (management notes that labor costs as a percent of net revenue decreased from 36.2% in FY 2010 to 35.3% in FY 2011); (b) reduced supply costs (management notes that medical supply expenses per adjusted discharge decreased 5.2% in FY 2011); (c) reduced malpractice expenses; and (d) favorable prior year cost report settlements and non-recurring adjustments increased from \$2.2 million in FY 2010 to \$12.6 million in FY 2011, although FY 2010 was lower than in prior years (\$7.6 million in FY 2008 and \$14.2 million in FY 2009).

Looking forward, management expects RUMC Obligated Group's operating cash flow margin to be in-line with or better than FY 2011. To maintain these margins despite Medicare and Medicaid reimbursement pressures will necessitate management to continue to identify significant expense savings in the coming years. Through six months FY 2012 the System's operating margins remain favorable (2.7% operating margin and 10.7% operating cash flow margin), although lag results through six months FY 2011 (4.2% operating margin and 12.1% operating cash flow margin). Operating revenues decreased 0.1% in the first half of FY 2012 compared to FY 2011 due to a 0.4% decline in inpatient admissions and a 17.3% decline in observation stays. Management notes further that while outpatient surgeries continue to increase, inpatient surgeries are down due to a change in mix of services and a push to lower cost settings, and that the System incurred some ramp up in costs to staff up and supply the new patient tower at the RUMC flagship leading up to the January 2012 opening. Management reports that activity at the flagship is up since the new tower opened without a change in payor mix.

The RUMC Obligated Group's Moody's adjusted debt ratios are adequate at the A2 rating level. Based on FY 2011 results, adjusted debt-to-cash flow measures 3.3 times (A2 median is 3.3 times), adjusted maximum annual debt service (MADS) coverage measures 4.5 times (A2 median is 4.8 times), and debt-to-total operating revenues measures 39% (A2 median is 36%).

The RUMC Obligated Group's unrestricted liquidity position improved modestly in FY 2011. Absolute unrestricted cash and investments increased to \$626 million at FYE 2011 from \$605 million at FYE 2010. As a result, Moody's adjusted cash on hand improved slightly to 145 days at FYE 2011 from 143 days at FYE 2010, but remains below the median (A2 median is 188 days). Similarly, cash-to-debt improved to a still somewhat modest 93% at FYE 2011 from 88% at FYE 2010. Monthly cash-to-demand debt measured a very strong 1,251% at FYE 2011 due to a very low variable debt load. According to management, at FYE 2011 RUMC Obligated Group's unrestricted cash and investments were allocated among approximately 88.3% cash and fixed income securities, 11.4% equities, and 0.3% other investments, and 100% of unrestricted cash and investments could be liquidated

within one month. When we reviewed RUMC in November 2010, due to expected equity contributions to the System's capital spending plans, management had projected cash on hand to decrease to approximately 120 days at FYE 2011. Due to the equity contributions and investment losses, the RUMC's Obligated Group's adjusted cash on hand decreased to 129 days at December 31, 2011.

In January 2012 the System opened the new patient tower at the RUMC flagship campus (on schedule). With the opening of the new tower (as well as other key projects such as the opening of a new freestanding emergency department for Copley in Yorkville, IL), capital spending plans are manageable in the coming years. Between FY 2013 and FY 2016, the System has approximately \$394 million of capital plans, which translates to an average capital spending ratio of approximately 0.8 times. Key projects in the coming years include modernization of the RUMC flagship's Atrium tower (floors 5, 7, 8, and 9) and construction of a new cancer center as part of a new affiliation with the DuPage Medical Group (an investment that is expected to open in early calendar year 2013).

In December 2011, the RUMC Obligated Group refunded its Series 1998A fixed rate bonds with a \$56 million variable rate private placement with JPMorgan Chase Bank with a 14 year term. The System has no material new money debt plans through FY 2017.

Outlook

The stable outlook reflects RUMC Obligated Group's continued favorable operating performance in FY 2011 and interim FY 2012, maintenance of adequate debt coverage and balance sheet ratios, and the fact that RUMC is beyond construction risks after the January 2012 opening of the new patient tower at the flagship campus.

WHAT COULD MAKE THE RATING GO UP

Continued cash flow growth and significantly improved debt and balance sheet ratios

WHAT COULD MAKE THE RATING GO DOWN

Sustained weakening of operating results leading to thinner debt coverage and liquidity ratios; material market share loss; unexpected increase in debt without commensurate increase in cash flow generation

KEY INDICATORS

Assumptions & Adjustments:

- Based on Rush University Medical Center Obligated Group consolidated financial statements
- First number reflects audited FY 2010 for the year ended June 30, 2010
- Second number reflects audited FY 2011 for the year ended June 30, 2011
- Interest expense adjusted to include capitalized interest
- FY 2010 adjusted to add \$18.0 million to operating expense to account for a favorable one-time IRS settlement related to FICA tax on medical residents
- Investment returns reclassified from operating revenue to non-operating revenue and smoothed at 6%
- *Inpatient admissions: 48,693; 47,627
- *Total operating revenues: \$1.68 billion; \$1.73 billion
- *Moody's-adjusted net revenues available for debt service: \$221.5 million; \$250.5 million
- *Total debt outstanding: \$687 million; \$674 million
- *Maximum annual debt service (MADS): \$55.1 million; \$55.1 million
- *MADS Coverage with reported investment income: 3.54 times; 4.16 times
- *Moody's-adjusted MADS Coverage with normalized investment income: 4.02 times; 4.54 times
- *Debt-to-cash flow: 3.86 times; 3.28 times
- *Days cash on hand: 143 days; 145 days
- *Cash-to-debt: 88.0%; 92.8%
- *Total comprehensive debt (factoring operating leases and underfunded defined benefit pension plan): \$1,026 million; \$917

million

*Adjusted cash-to-comprehensive debt: 58.9%; 68.2%

*Operating margin: 2.7%; 3.9%

*Operating cash flow margin: 10.4%; 11.8%

RATED DEBT

Issued through Illinois Finance Authority (debt outstanding as of June 30, 2011):

-Series 2009C&D Fixed Rate Hospital Revenue Bonds (\$200.0 million outstanding), rated A2

-Series 2009A&B Fixed Rate Hospital Revenue Bonds (\$211.6 million outstanding), rated A2

-Series 2008A VRDB Hospital Revenue Bonds (\$50.0 million outstanding), supported by a direct-pay LOC from Northern Trust Company and rated Aa1/VMIG1 (reflecting Moody's approach to rating jointly supported transactions) (the LOC expires in February 2015), A2 underlying rating

-Series 2006B Fixed Rate Hospital Revenue Bonds (\$96.8 million outstanding), insured by National Public Finance Guarantee Corp (MBIA), A2 unenhanced rating

CONTACTS

Obligor: John Mordach, CFO, (312) 942-5600; Patricia O'Neil, Chief Investment Officer, (312) 942-5647

Financial Advisor: Errol Brick, Public Financial Management, (212) 949-6656

Underwriter: Bruce Gurley, Morgan Stanley, (312) 706-4267

PRINCIPAL METHODOLOGY USED

The principal methodology used in this rating was Not-for-Profit Hospitals and Health Systems published in January 2008. Please see the Credit Policy page on www.moody.com for a copy of this methodology.

REGULATORY DISCLOSURES

Although this credit rating has been issued in a non-EU country which has not been recognized as endorsable at this date, this credit rating is deemed "EU qualified by extension" and may still be used by financial institutions for regulatory purposes until 30 April 2012. Further information on the EU endorsement status and on the Moody's office that has issued a particular Credit Rating is available on www.moody.com.

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Information sources used to prepare the credit rating are the following: parties involved in the ratings, parties not involved in the ratings, public information, confidential and proprietary Moody's Investors Service information, and confidential and proprietary Moody's Analytics information.

Moody's considers the quality of information available on the rated entity, obligation or credit satisfactory for the purposes of issuing a rating.

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Analysts

Mark Pascaris
Lead Analyst
Public Finance Group
Moody's Investors Service

Lisa Goldstein
Backup Analyst
Public Finance Group
Moody's Investors Service

Contacts

Journalists: (212) 553-0376
Research Clients: (212) 553-1653

Moody's Investors Service, Inc.
250 Greenwich Street
New York, NY 10007
USA

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FitchRatings

FITCH AFFIRMS RUSH UNIVERSITY MEDICAL CENTER OBLIGATED GROUP (IL) REVS AT 'A-'; OUTLOOK TO POSITIVE

Fitch Ratings-Chicago-11 July 2011: As part of its ongoing surveillance efforts, Fitch Ratings has affirmed the 'A-' rating on the following approximately \$618.9 million of debt issued by the Illinois Finance Authority or the Illinois Health Facilities Authority on behalf of Rush University Medical Center Obligated Group (Rush):

- Series 2009D revenue bonds;
- Series 2009C revenue bonds;
- Series 2009B revenue bonds;
- Series 2009A revenue bonds;
- Series 2008A variable rate demand revenue bonds;
- Series 2006B revenue bonds;
- Series 1998A revenue bonds.

The Rating Outlook is revised to Positive from Stable.

RATING RATIONALE:

- The Outlook revision to Positive reflects Rush's continued strong operating performance in a competitive market and near completion of its new hospital, which is on time and within budget.
- Rush's operating and operating EBITDA margins have exceeded Fitch's 'A' category medians in each of the last four fiscal years.
- Rush's leverage position is moderate with a conservative debt portfolio (92% fixed rate).
- Rush has strong physician alignment across an integrated platform.
- Credit concerns include execution risk associated with the opening of the new facility located on Rush's Chicago campus, an expected decline in liquidity metrics as capital spending remains high through fiscal 2012 to finish the campus transformation project and a competitive service area.

WHAT COULD TRIGGER AN UPGRADE:

- Successful completion and transition to the new facility with minimal operational impact.
- Maintenance of strong operating cash flow to offset the expected decline in liquidity.

SECURITY:

Debt payments are secured by a pledge of the gross revenues of the obligated group and a mortgage on certain property of the obligated group.

CREDIT SUMMARY:

The rating affirmation at 'A-' is based upon Rush's consistently strong operating performance since fiscal 2007, moderate leverage and strong alignment with physicians across an integrated platform.

Rush's operating and operating EBITDA margins have averaged 5.3% and 11.6%, respectively, between fiscal 2007 and fiscal 2010, exceeding Fitch's 2010 'A' category medians of 3% and 10%. Rush's strong operating performance continued through the nine-month interim period ending March 31, 2011 (the interim period) with operating and operating EBITDA margins of 5.7% and 12.4%, respectively. Management's 2012 budget includes operating and operating EBITDA margins of 3.4% and 11.3%. Rush receives approximately \$50 million of supplemental funds per year including disproportionate share payments and Medicaid provider tax funds.

Rush's moderate leverage metrics are enhanced by a conservative debt portfolio, with 92% fixed rate debt. Debt to capitalization increased from 35% in fiscal 2008 to 52% in fiscal 2010 but moderated to 45.1% as of March 31, 2011 relative to Fitch's 'A' category median of 42.1%. Strong cash flow generation further mitigates the moderate leverage levels with debt to EBITDA of 2.4

times (x) as of March 31, 2011 which compares favorably to Fitch's 'A' category median of 3.8x. Coverage of maximum annual debt service (MADS) by EBITDA was a solid 4.3x in fiscal 2010 and 4.6x in the interim period.

Credit concerns include execution risk associated with the opening of the new facility located on Rush's Chicago campus, an expected decline in liquidity metrics and a competitive service area. At March 31, 2011 Rush's unrestricted cash and investments totaled \$642.1 million reflecting a sharp improvement from \$514.4 million as of fiscal year-end 2009. Liquidity metrics have improved. However days cash on hand (158.8), cushion ratio (11.7x) and cash to long term debt (104.3%) are light relative to the respective 'A' category medians of 183.8, 14.4x and 105.5%. Moreover, Rush projects that days cash will decrease to 124 days in fiscal 2012 due to the completion of the new facility.

The new facility is set to open in January 2012 and is on time and on budget. The combination of the strength of Rush's clinical programs with the new facility should provide a boost to operations in the competitive Chicago-area marketplace.

Rush spent over \$729 million between fiscal 2008 and March 31, 2011 on the estimated \$1 billion Campus Transformation Plan. Capital expenditures are forecasted to equal \$285 million in fiscal 2011, \$215 million in fiscal 2012 (of which \$53 million is carryover from fiscal 2011) and subsequently decrease to \$105 million per year thereafter. Liquidity is expected to rebound after fiscal 2012 due to strong operating performance.

The Positive Outlook reflects Fitch's expectation of upward rating movement if Rush maintains its strong operating performance while successfully transitioning operations to the new facility.

Rush consists of three acute care hospitals including Rush University Medical Center, located in Chicago, IL; Rush Oak Park Hospital, located in Oak Park, Illinois; and Rush-Copley Medical Center, located in Aurora, Illinois. The three hospitals operate 985 staffed beds. Rush also operates a medical university, research facilities, a physician group practice with over 400 employed physicians, and a rehabilitation/skilled nursing facility. In fiscal 2010, the Obligated Group reported total revenues of \$1.69 billion. Rush's disclosure practices are among the best in Fitch's health care portfolio with quarterly and annual disclosure consisting of balance sheet, income statements and cash flow statements, utilization statistics and a management discussion and analysis.

Contact:

Primary Analyst
Adam Kates
Director
+1-312-368-3180
Fitch, Inc.
70 West Madison Street
Chicago, IL

Secondary Analyst
Jim LeBuhn
Senior Director
+1-312-368-2059

Committee Chairperson
Emily Wong
Senior Director
+1-212-908-0651

Media Relations: Cindy Stoller, New York, Tel: +1 212 908 0526, Email: cindy.stoller@fitchratings.com.

Additional information is available at 'www.fitchratings.com'.

Applicable Criteria and Related Research:

--'Revenue-Supported Rating Criteria', dated Oct. 8, 2010;

--'Nonprofit Hospitals and Health Systems Rating Criteria', dated Dec. 29, 2009.

Applicable Criteria and Related Research:

Revenue-Supported Rating Criteria

http://www.fitchratings.com/creditedesk/reports/report_frame.cfm?rpt_id=637130

Nonprofit Hospitals and Health Systems Rating Criteria

http://www.fitchratings.com/creditedesk/reports/report_frame.cfm?rpt_id=493186

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October 17, 2011

**Illinois Finance Authority
Rush University Medical Center
Obligated Group; Joint Criteria;
System**

Primary Credit Analyst:

Suzie Desai, Chicago (1) 312-233-7046; suzie_desai@standardandpoors.com

Secondary Contact:

Brian T. Williamson, Chicago (1) 312-233-7009; brian_williamson@standardandpoors.com

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Illinois Finance Authority Rush University Medical Center Obligated Group; Joint Criteria; System

Credit Profile

Illinois Fin Auth, Illinois

Rush Univ Med Ctr Obligated Grp, Illinois

Illinois Finance Authority (Rush University Medical Center Obligated Group)

Long Term Rating	A-/Positive	Outlook Revised
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Illinois Finance Authority (Rush University Medical Center Obligated Group) (MBA) (National)

Unenhanced Rating	A-(SPUR)/Positive	Outlook Revised
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Illinois Fin Auth (Rush University Medical Center Obligated Group) Hosp VRDO ser 2008

Long Term Rating	AAA/A-1+	Affirmed
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Unenhanced Rating	A-(SPUR)/Positive	Outlook Revised
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Many issues are enhanced by bond insurance

Rationale

Standard & Poor's Ratings Services revised its outlook to positive and affirmed the 'A-' long-term rating on Illinois Finance Authority's \$411.6 million series 2009A through 2009D fixed-rate hospital revenue bonds. Standard & Poor's also revised its outlook to positive and affirmed the 'A-' underlying rating (SPUR) on the authority's \$30 million series 2008A and \$96.75 million series 2006B revenue bonds, all issued for the Rush University Medical Center Obligated Group (Rush). At the same time, Standard & Poor's affirmed its 'AAA/A-1+' dual rating on the authority's series 2008A variable-rate demand bonds (VRDBs), also issued for Rush.

The 'AAA/A-1+' dual rating on the series 2008A VRDBs is based on our joint criteria, with the long-term component of the rating based jointly on the Northern Trust Bank (AA) and Rush long-term ratings. The 'A-1+' short-term component of the rating is based on the Northern Trust short-term rating. The letter of credit expires December 2013.

The positive outlook reflects near completion of Rush University Medical Center's (RUMC) new patient tower (to open early in calendar 2012) and Rush's robust operating performance, which has helped to maintain a fairly stable balance sheet despite RUMC's recent period of major construction.

The 'A-' rating reflects the strength of RUMC, the obligated group's flagship hospital, as an academic medical center with well-defined market recognition despite concerns about competition. The rating also reflects RUMC's large net patient revenue base and robust operating income during the past five years. While capital spending will remain steady during the next few years, the opening of the new patient tower, Rush's largest project, is expected to open in early calendar 2012 and eliminates a major risk that has been part of Rush's profile for the past several years.

The 'A-' and positive outlook also reflect Rush's:

- Continued strong market recognition as an academic medical center with broad clinical services, extensive

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education and research capabilities, and a solid market position in several key service lines in the competitive Chicago-area market;

- Track record of solid financial operations and cash flow, with unaudited fiscal 2011 results showing a strong operating margin of 5.6%, a solid EBITDA margin of 13.6%, and very good maximum annual debt service coverage of 4.2x; and
- Large net patient revenue base of \$1.5 billion from serving two distinct market areas with modest inpatient growth offset by steady outpatient growth in recent years.

Credit risks, in our view, include Rush's:

- Final cash outlay for RUMC's new patient tower project in 2012 and ability to absorb the higher expense base at the same time that inpatient volume growth has slowed and the state Medicaid program is experiencing some pressure;
- Adequate, 137 days' cash on hand as of June 30, 2011 (with a minimum threshold of 115 during the next few years); and
- Location in the highly competitive Chicago service area, with RUMC in close proximity to three other hospitals in its immediate service area and with several other area academic medical centers and hospitals or health systems providing strong competition for key services.

The bonds secured under the master trust indenture are secured by Rush's gross revenues and mortgages on the main hospital facilities' property, plant, and equipment. Rush's total long-term debt, including capital leases, other financing arrangements, and guarantees, is \$658 million, with most of this debt to be secured under the master trust indenture.

Rush's largest single project during the past few years has been the construction of a new patient tower at RUMC (\$637 million). The new patient tower, which has been funded through bond proceeds, capital campaign contributions, governmental funding, and operating cash flow, is scheduled to open in mid-fiscal 2012. While Rush's capital expenditures will remain high at \$238 million in 2012, capital spending should decrease thereafter but still remain steady at around \$100 million annually as RUMC completes remaining renovations at its existing facilities through 2016. Moreover, the completion of and successful move into the new patient tower will eliminate a significant risk that has been part of Rush's profile for the past few years. In addition, some flexibility in the future capital spending plans should allow Rush to strengthen its currently light balance sheet profile should operations come under any unforeseen pressure away from currently strong levels. In recent years, RUMC and the smaller Rush-Copley Medical Center have generated strong operations, supported partially by the Illinois Provider Tax (IPT), but also through a very strong focus on strengthening key service lines as well as on operations and expense controls.

John Mordach is the new full-time Chief Financial Officer (CFO) at Rush and filled that position, which has been open since last summer, in early calendar 2011. He's held several senior finance positions including CFO at several hospitals and was most recently the CFO at Loyola University Health System in Maywood, Ill., (a neighboring suburb of Chicago).

Rush is party to two interest-rate swaps with a total notional amount of \$96.75 million. Standard & Poor's has assigned Rush a Debt Derivative Profile (DDP) overall score of '1.5' on a four-point scale, with '1' representing minimal risk. The overall score of '1.5' reflects our view that Rush's swap portfolio poses a very low risk.

Outlook

The positive outlook reflects Rush's near completion of its major capital project at the same time that operations have remained strong and Rush has maintained its solid market position. If Rush is able to grow its balance sheet after final payments have been made for the new patient tower and absorb the higher expense base while continuing to make operating improvements as planned, Standard & Poor's could raise the ratings in the next year or two. Standard & Poor's could revise the outlook back to stable if the balance sheet shows limited growth with liquidity remaining at or near current levels. However, if operations experience sustained declines after the opening of the patient tower and margins remain below median levels, or operational liquidity levels decline and remain below Rush's floor of 115 days, the rating could be revised downward. Rush does not expect to issue any new-money debt during the next two years.

Operational Profile

The Rush health system consists of two medical centers in distinct service areas in the Chicago area:

- RUMC: A 664-staffed bed facility just west of downtown Chicago that also operates the 128-staffed-bed Rush Oak Park Hospital (ROPH) in the neighboring suburb of Oak Park; and
- Rush-Copley Medical Center (RCMC): Located in Aurora, Ill., a far-southwest suburb of Chicago, it serves as the parent holding company for Copley Memorial Hospital Inc. (a 210-staffed bed facility), Copley Ventures Inc., Rush-Copley Foundation, and Rush-Copley Medical Group NFP, all of which are Rush members.

Rush's operations include employed physicians as well as significant research and educational components such as Rush University, a health sciences university that includes Rush Medical College, College of Nursing, College of Health Sciences, and the Graduate College. Rush was created to diversify the revenue base that supports debt service, maximize debt capacity for the system, and generally strengthen overall creditworthiness. Although Rush is involved in some joint activities, the entities operate independently in terms of day-to-day activities and service delivery. However, management is focusing on how to strengthen collaboration clinically across its organizations and affiliates. RUMC's board exerts certain governance controls on the other entities' boards, which hold certain reserve powers through majority board representation. In 2011, Rush's admissions were down 2.5% relative to the prior year to 43,885; however, year-over-year outpatient volumes increased slightly by 0.5% to 442,088 and outpatient surgeries increased 2.6% to 29,664.

While RCMC generates positive operating income, RUMC -- Rush's largest component -- has helped Rush generate its strong financial performance in recent years. RUMC, which accounted for 89% of Rush's total assets, 83% of total revenues, and 85% of operating income as of fiscal year-end June 30, 2011, is in the Illinois Medical District with three other hospitals. It competes with four Chicago-area academic medical centers: Northwestern Memorial Hospital (AA+); University of Chicago Hospitals and Health System (AA-); Loyola University Health System; and University of Illinois Medical Center (A), as well as other suburban hospitals and systems. RUMC has well-known programs in orthopedics, neurology, neurosurgery, geriatrics, and kidney disease; and has generally maintained its 2.7% market share. The immediate service area and larger Chicago area remain competitive.

Admissions have flattened, similar to other markets and hospitals, although RUMC has continued to experience good outpatient growth through focus on certain key service lines and physician recruitment. Fiscal 2011 inpatient

acute case admissions were down 1.4% from the prior year to 27,568. However, in fiscal 2011 adjusted admissions at RUMC rose 1.6% to 49,143 with total surgeries stable at 26,329. RUMC has made slight gains more than the past few years in its market share to 2.7% in a very fragmented market. ROPH, which operates in a service area near RUMC, has become more closely integrated with RUMC's strategy and Rush has focused on strengthening certain key service lines across RUMC and ROPH. After a strong uptick in 2010, admissions at ROPH decreased slightly by 1% to 3,740 in 2011 but are still higher than 2009 levels.

RCMC is in a far-southwest Chicago suburb that has experienced favorable population growth, although recent economic challenges have negatively affected volumes in that market in addition to slowing growth. RCMC admissions were down 5.2% from the prior year to 12,577 in 2011. RCMC, however, maintains the leading market share, which has been growing, but decreased slightly in 2011 and is at 38.8%. Total adjusted discharges are up 3%, and surgeries increased about 1%, in fiscal 2011.

Finances: Positive Operating Income Trends In Recent Years

During the past five years, Rush has generated solid operating performance, with operating margins averaging 5.0% and operating cash flow margins averaging a healthy 11.9%. More specifically, unaudited fiscal 2011 generated \$98.1 million (5.6% margin) of operating income, as compared with \$89.4 million (5.3% margin) in fiscal 2010 (included in fiscal 2010-2011 operating income is the \$23.0 million annual net payment from the IPT program that is approved through June 30, 2014). In addition to the solid outpatient volumes and the net payment from the IPT, management has made a concerted effort to manage its expenses and will continue efforts to do so during the next several years. Unaudited excess income of \$114.4 million (6.5% margin) in fiscal 2011 was on par with the audited \$101.6 million (6.0% margin) generated in fiscal 2010 due to the improvements from the investment markets. (We note that excess income excludes any gains or realized losses on discontinued operations, unrealized gains and losses on investments, changes in the fair value of interest-rate swaps as well as any gains/losses on sales, and losses on the extinguishment of debt.) Rush generated healthy 4.2x and 3.9x MADS coverage in fiscals 2011 and 2010, respectively.

According to its most recent plan from 2010, future operating and excess income margins should remain close to 2% and more than 5%, respectively, with EBITDA at 10%-12% to fund capital plans and begin to re-strengthen the balance sheet. Although management has operated within these targets for the past few years, the larger expense base, the general softness of the overall economy, and potentially lighter investment income required Rush to focus on core operations and key service-line enhancements. Management is updating its long-range financing plan to identify additional opportunities to strengthen its finances beyond current forecasts. Management is targeting an operating income of about \$61.6 million in fiscal 2012, down from fiscal 2011 as the new patient tower is scheduled to open in mid-fiscal 2012.

Rush's balance sheet has remained relatively stable during the past year, despite increased spending for capital projects out of cash flow. However, balance sheet metrics could ease during the next year as management relies entirely on its own operating cash flow to complete and open its patient tower in 2012. Additionally, the state is experiencing some pressure and may delay payments to Rush as the year continues; Rush has a total of \$150 million in two lines of credits as a back up to help manage any excess pressure related to receivables. As mentioned above, the largest single project in Rush's capital plans is the new patient tower, which totals \$637 million; to date, Rush has spent about \$437 million on that project. There are other smaller projects scheduled to be completed during the

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SECTION IX – FINANCIAL VIABILITY

Financial Viability Waiver for Rush University Medical Center

As detailed on page 50 of the application and in Attachment 39, this project is being wholly financed by DuPage Medical Group, Ltd. through cash and debt. Rush University Medical Center, which is a co-applicant, has not in any way participated in the financing of this project and will merely rent out, as a tenant, a portion of the space at DMG's Medical Office Building.

Information as to RUMC's bond rating is included in this application per the advice of the CON staff. Please see Attachment 40-Exhibit 1.

**Attachment 40-Exhibit 1
Rush University Medical Center Bond
Rating**

MOODY'S INVESTORS SERVICE

Rating Update: MOODY'S AFFIRMS RUSH UNIVERSITY MEDICAL CENTER OBLIGATED GROUP'S (IL) A2 LONG-TERM AND UNENHANCED BOND RATINGS; OUTLOOK REMAINS STABLE

Global Credit Research - 28 Feb 2012

AFFIRMATION AFFECTS APPROXIMATELY \$558 MILLION OF RATED DEBT OUTSTANDING

ILLINOIS FINANCE AUTHORITY
Hospitals & Health Service Providers
IL

Opinion

NEW YORK, February 28, 2012 --Moody's Investors Service has affirmed Rush University Medical Center Obligated Group's (RUMC Obligated Group) A2 long-term and unenhanced bond ratings. This action affects approximately \$558 million of revenue bonds issued through the Illinois Finance Authority (see Rated Debt section). The outlook remains stable.

RATINGS RATIONALE

SUMMARY RATING RATIONALE: The affirmation of the A2 rating and stable outlook reflects RUMC Obligated Group's continued favorable operating performance in fiscal year (FY) 2011 and interim FY 2012, maintenance of adequate debt coverage and balance sheet ratios, and the fact that RUMC is beyond construction risks after the January 2012 opening of the new patient tower at the flagship campus. The System faces challenge with an above average Medicaid share of business in a state with a challenged budget.

STRENGTHS

*Sizeable academic medical center (AMC) with broad array of tertiary and quaternary services (the RUMC flagship had a Medicare case mix index of 1.93 in FY 2011).

*Impressive operating improvement since FY 2004 (11.8% operating cash flow margin in FY 2011).

*Improved cash on hand with 145 days at fiscal year end (FYE) 2011. While this remains below the A2 median (188 days cash on hand), we note that RUMC Obligated Group has significant restricted investments, which bolster the balance sheet strength (at FYE 2011, the System had \$488 million of restricted investments outstanding).

*The System is beyond most construction risks with the January 2012 opening the new patient tower at the RUMC flagship.

CHALLENGES

*Very competitive healthcare market in the Chicago area, with five AMCs (including RUMC) plus other sizeable health system and large community hospitals.

*Medicaid as a percentage of gross revenues has increased from 15.1% in FY 2008 to 18.5% in FY 2011, which is of particular concern given the challenges of the State of Illinois budget (the state has been delaying Medicaid payments to healthcare providers).

*Underfunded defined benefit pension plan with an 84% pension funded ratio compared to a projected benefit obligation of \$797 million at FYE 2011, plus the System has operating leases outstanding. Effective December 31, 2011, the remaining employees were moved to a cash balance pension plan (most RUMC employees were moved to the cash balance plan in 2004).

DETAILED CREDIT DISCUSSION

LEGAL SECURITY: The bonds are secured by a gross revenue pledge and a mortgage pledge of the RUMC Obligated Group including Rush University Medical Center (RUMC) and Rush-Copley Medical Center (Copley). Rush North Shore Medical Center (North Shore) withdrew from the Obligated Group on December 31, 2008. Violating rate covenant of 1.1 times requires hiring of consultant. Additional debt test: (1) debt-to-capitalization of no more than 69% in FY 2008 (decreasing by 1 percentage point each year until 65% in FY 2012); or (2) historical pro-forma debt service coverage greater than 1.25 times; or (3) historical debt service coverage greater than 1.1 times and projected debt service coverage greater than 1.1 times.

INTEREST RATE DERIVATIVES: The RUMC Obligated Group entered into fixed payor swaps with Morgan Stanley Capital

Services, Inc. and Citibank, N.A. with a combined notional amount of \$96.8 million that expire in November 2035. Under the agreements, the RUMC Obligated Group pays a fixed interest rate of 3.945% and receives 68% of LIBOR. \$50 million of the interest rate swaps hedge the interest rate on the Series 2008A variable rate demand bonds (VRDB) issued in December 2008. As a result of prior variable rate debt restructurings, the remaining \$46.8 million notional amount is not hedging a particular variable rate bond series. The total net termination value of the swaps at audited FYE June 30, 2011 was a negative \$14.5 million to RUMC Obligated Group. According to management, the net termination value of the swaps as of December 31, 2011 was a negative \$23.8 million. Management notes the System has a collateral posting threshold of negative \$25 million (the swaps have bilateral posting requirements for RUMC and the counterparties, based on the same posting scale).

RECENT DEVELOPMENTS/RESULTS

RUMC (30,259 admissions in FY 2011) is the System's flagship hospital and is one of five AMCs in the Chicago market. Other academic medical centers in the market include: University of Illinois Health Services (rated A1); Northwestern Memorial Hospital (rated Aa2); Loyola University Health System (now a member of Aa2 rated Trinity Health Credit Group); and The University of Chicago Medical Center (rated Aa3). In addition to the competing AMCs, RUMC faces competition from a number of sizeable acute care systems in the market, notably market share leader Aa2 rated Advocate Health Care Network and Baa1 rated Resurrection Health Care. Northwestern Memorial is the largest single hospital in the Chicago area. RUMC shares a state-designated medical district campus with University of Illinois Health Services, John H. Stroger Jr. Hospital of Cook County, and Jesse Brown VA Medical Center.

In addition to the RUMC flagship hospital, the RUMC Obligated Group includes 12,985 admission Copley in Aurora, IL. Effective December 31, 2008, Rush North Shore withdrew from the Obligated Group and joined Aa2 rated NorthShore University Health System. RUMC, through a joint venture with a third-party, operates and manages 4,383 admission Rush Oak Park Hospital (ROPH) in Oak Park, IL. Other non-obligated system affiliates include A2 rated Riverside Health System in Kankakee, IL.

The RUMC Obligated Group's operating performance generally has improved in recent years, which we view as a key credit positive. In audited FY 2011 (June 30 year end), the RUMC Obligated Group recorded adjusted operating income of \$68.3 million (3.9 % operating margin) and adjusted operating cash flow of \$205.0 million (11.8% operating cash flow margin). This is an improvement over audited FY 2010, when the RUMC Obligated Group recorded adjusted operating income of \$45.0 million (2.7% margin) and operating cash flow of \$174.6 million (10.4% margin). Audited results have been adjusted to reclassify the portion of investment income included in operating revenue to non-operating and to include capitalized interest as an interest expense. FY 2010 is adjusted further to add \$18.0 million to operating expenses to account for a favorable one-time IRS settlement related to a FICA tax refund on medical residents. Since FY 2005, RUMC Obligated Group has maintained profitable operating results.

Factors contributing to continued good operating results for the RUMC Obligated Group in FY 2011 include: (a) focus on productivity improvements to offset revenue pressures that included a layoff of approximately 200 full-time equivalents in FY 2011 (FY 2011 results include approximately \$5 million of severance costs) (management notes that labor costs as a percent of net revenue decreased from 36.2% in FY 2010 to 35.3% in FY 2011); (b) reduced supply costs (management notes that medical supply expenses per adjusted discharge decreased 5.2% in FY 2011); (c) reduced malpractice expenses; and (d) favorable prior year cost report settlements and non-recurring adjustments increased from \$2.2 million in FY 2010 to \$12.6 million in FY 2011, although FY 2010 was lower than in prior years (\$7.6 million in FY 2008 and \$14.2 million in FY 2009).

Looking forward, management expects RUMC Obligated Group's operating cash flow margin to be in-line with or better than FY 2011. To maintain these margins despite Medicare and Medicaid reimbursement pressures will necessitate management to continue to identify significant expense savings in the coming years. Through six months FY 2012 the System's operating margins remain favorable (2.7% operating margin and 10.7% operating cash flow margin), although lag results through six months FY 2011 (4.2% operating margin and 12.1% operating cash flow margin). Operating revenues decreased 0.1% in the first half of FY 2012 compared to FY 2011 due to a 0.4% decline in inpatient admissions and a 17.3% decline in observation stays. Management notes further that while outpatient surgeries continue to increase, inpatient surgeries are down due to a change in mix of services and a push to lower cost settings, and that the System incurred some ramp up in costs to staff up and supply the new patient tower at the RUMC flagship leading up to the January 2012 opening. Management reports that activity at the flagship is up since the new tower opened without a change in payor mix.

The RUMC Obligated Group's Moody's adjusted debt ratios are adequate at the A2 rating level. Based on FY 2011 results, adjusted debt-to-cash flow measures 3.3 times (A2 median is 3.3 times), adjusted maximum annual debt service (MADS) coverage measures 4.5 times (A2 median is 4.8 times), and debt-to-total operating revenues measures 39% (A2 median is 36%).

The RUMC Obligated Group's unrestricted liquidity position improved modestly in FY 2011. Absolute unrestricted cash and investments increased to \$626 million at FYE 2011 from \$605 million at FYE 2010. As a result, Moody's adjusted cash on hand improved slightly to 145 days at FYE 2011 from 143 days at FYE 2010, but remains below the median (A2 median is 188 days). Similarly, cash-to-debt improved to a still somewhat modest 93% at FYE 2011 from 88% at FYE 2010. Monthly cash-to-demand debt measured a very strong 1,251% at FYE 2011 due to a very low variable debt load. According to management, at FYE 2011 RUMC Obligated Group's unrestricted cash and investments were allocated among approximately 88.3% cash and fixed income securities, 11.4% equities, and 0.3% other investments, and 100% of unrestricted cash and investments could be liquidated

within one month. When we reviewed RUMC in November 2010, due to expected equity contributions to the System's capital spending plans, management had projected cash on hand to decrease to approximately 120 days at FYE 2011. Due to the equity contributions and investment losses, the RUMC's Obligated Group's adjusted cash on hand decreased to 129 days at December 31, 2011.

In January 2012 the System opened the new patient tower at the RUMC flagship campus (on schedule). With the opening of the new tower (as well as other key projects such as the opening of a new freestanding emergency department for Copley in Yorkville, IL), capital spending plans are manageable in the coming years. Between FY 2013 and FY 2016, the System has approximately \$394 million of capital plans, which translates to an average capital spending ratio of approximately 0.8 times. Key projects in the coming years include modernization of the RUMC flagship's Atrium tower (floors 5, 7, 8, and 9) and construction of a new cancer center as part of a new affiliation with the DuPage Medical Group (an investment that is expected to open in early calendar year 2013).

In December 2011, the RUMC Obligated Group refunded its Series 1998A fixed rate bonds with a \$56 million variable rate private placement with JPMorgan Chase Bank with a 14 year term. The System has no material new money debt plans through FY 2017.

Outlook

The stable outlook reflects RUMC Obligated Group's continued favorable operating performance in FY 2011 and interim FY 2012, maintenance of adequate debt coverage and balance sheet ratios, and the fact that RUMC is beyond construction risks after the January 2012 opening of the new patient tower at the flagship campus.

WHAT COULD MAKE THE RATING GO UP

Continued cash flow growth and significantly improved debt and balance sheet ratios

WHAT COULD MAKE THE RATING GO DOWN

Sustained weakening of operating results leading to thinner debt coverage and liquidity ratios; material market share loss; unexpected increase in debt without commensurate increase in cash flow generation

KEY INDICATORS

Assumptions & Adjustments:

- Based on Rush University Medical Center Obligated Group consolidated financial statements
- First number reflects audited FY 2010 for the year ended June 30, 2010
- Second number reflects audited FY 2011 for the year ended June 30, 2011
- Interest expense adjusted to include capitalized interest
- FY 2010 adjusted to add \$18.0 million to operating expense to account for a favorable one-time IRS settlement related to FICA tax on medical residents
- Investment returns reclassified from operating revenue to non-operating revenue and smoothed at 6%
- *Inpatient admissions: 48,693; 47,627
- *Total operating revenues: \$1.68 billion; \$1.73 billion
- *Moody's-adjusted net revenues available for debt service: \$221.5 million; \$250.5 million
- *Total debt outstanding: \$687 million; \$674 million
- *Maximum annual debt service (MADS): \$55.1 million; \$55.1 million
- *MADS Coverage with reported investment income: 3.54 times; 4.16 times
- *Moody's-adjusted MADS Coverage with normalized investment income: 4.02 times; 4.54 times
- *Debt-to-cash flow: 3.86 times; 3.28 times
- *Days cash on hand: 143 days; 145 days
- *Cash-to-debt: 88.0%; 92.8%
- *Total comprehensive debt (factoring operating leases and underfunded defined benefit pension plan): \$1,026 million; \$917

million

*Adjusted cash-to-comprehensive debt: 58.9%; 68.2%

*Operating margin: 2.7%; 3.9%

*Operating cash flow margin: 10.4%; 11.8%

RATED DEBT

Issued through Illinois Finance Authority (debt outstanding as of June 30, 2011):

-Series 2009C&D Fixed Rate Hospital Revenue Bonds (\$200.0 million outstanding), rated A2

-Series 2009A&B Fixed Rate Hospital Revenue Bonds (\$211.6 million outstanding), rated A2

-Series 2008A VRDB Hospital Revenue Bonds (\$50.0 million outstanding), supported by a direct-pay LOC from Northern Trust Company and rated Aa1/VMIG1 (reflecting Moody's approach to rating jointly supported transactions) (the LOC expires in February 2015), A2 underlying rating

-Series 2006B Fixed Rate Hospital Revenue Bonds (\$96.8 million outstanding), insured by National Public Finance Guarantee Corp (MBIA), A2 unenhanced rating

CONTACTS

Obligor: John Mordach, CFO, (312) 942-5600; Patricia O'Neil, Chief Investment Officer, (312) 942-5647

Financial Advisor: Errol Brick, Public Financial Management, (212) 949-6656

Underwriter: Bruce Gurley, Morgan Stanley, (312) 706-4267

PRINCIPAL METHODOLOGY USED

The principal methodology used in this rating was Not-for-Profit Hospitals and Health Systems published in January 2008. Please see the Credit Policy page on www.moodys.com for a copy of this methodology.

REGULATORY DISCLOSURES

Although this credit rating has been issued in a non-EU country which has not been recognized as endorsable at this date, this credit rating is deemed "EU qualified by extension" and may still be used by financial institutions for regulatory purposes until 30 April 2012. Further information on the EU endorsement status and on the Moody's office that has issued a particular Credit Rating is available on www.moodys.com.

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Analysts

Mark Pascaris
Lead Analyst
Public Finance Group
Moody's Investors Service

Lisa Goldstein
Backup Analyst
Public Finance Group
Moody's Investors Service

Contacts

Journalists: (212) 553-0376
Research Clients: (212) 553-1653

Moody's Investors Service, Inc.
250 Greenwich Street
New York, NY 10007
USA

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FitchRatings

FITCH AFFIRMS RUSH UNIVERSITY MEDICAL CENTER OBLIGATED GROUP (IL) REVS AT 'A-'; OUTLOOK TO POSITIVE

Fitch Ratings-Chicago-11 July 2011: As part of its ongoing surveillance efforts, Fitch Ratings has affirmed the 'A-' rating on the following approximately \$618.9 million of debt issued by the Illinois Finance Authority or the Illinois Health Facilities Authority on behalf of Rush University Medical Center Obligated Group (Rush):

- Series 2009D revenue bonds;
- Series 2009C revenue bonds;
- Series 2009B revenue bonds;
- Series 2009A revenue bonds;
- Series 2008A variable rate demand revenue bonds;
- Series 2006B revenue bonds;
- Series 1998A revenue bonds.

The Rating Outlook is revised to Positive from Stable.

RATING RATIONALE:

- The Outlook revision to Positive reflects Rush's continued strong operating performance in a competitive market and near completion of its new hospital, which is on time and within budget.
- Rush's operating and operating EBITDA margins have exceeded Fitch's 'A' category medians in each of the last four fiscal years.
- Rush's leverage position is moderate with a conservative debt portfolio (92% fixed rate).
- Rush has strong physician alignment across an integrated platform.
- Credit concerns include execution risk associated with the opening of the new facility located on Rush's Chicago campus, an expected decline in liquidity metrics as capital spending remains high through fiscal 2012 to finish the campus transformation project and a competitive service area.

WHAT COULD TRIGGER AN UPGRADE:

- Successful completion and transition to the new facility with minimal operational impact.
- Maintenance of strong operating cash flow to offset the expected decline in liquidity.

SECURITY:

Debt payments are secured by a pledge of the gross revenues of the obligated group and a mortgage on certain property of the obligated group.

CREDIT SUMMARY:

The rating affirmation at 'A-' is based upon Rush's consistently strong operating performance since fiscal 2007, moderate leverage and strong alignment with physicians across an integrated platform.

Rush's operating and operating EBITDA margins have averaged 5.3% and 11.6%, respectively, between fiscal 2007 and fiscal 2010, exceeding Fitch's 2010 'A' category medians of 3% and 10%. Rush's strong operating performance continued through the nine-month interim period ending March 31, 2011 (the interim period) with operating and operating EBITDA margins of 5.7% and 12.4%, respectively. Management's 2012 budget includes operating and operating EBITDA margins of 3.4% and 11.3%. Rush receives approximately \$50 million of supplemental funds per year including disproportionate share payments and Medicaid provider tax funds.

Rush's moderate leverage metrics are enhanced by a conservative debt portfolio, with 92% fixed rate debt. Debt to capitalization increased from 35% in fiscal 2008 to 52% in fiscal 2010 but moderated to 45.1% as of March 31, 2011 relative to Fitch's 'A' category median of 42.1%. Strong cash flow generation further mitigates the moderate leverage levels with debt to EBITDA of 2.4

times (x) as of March 31, 2011 which compares favorably to Fitch's 'A' category median of 3.8x. Coverage of maximum annual debt service (MADS) by EBITDA was a solid 4.3x in fiscal 2010 and 4.6x in the interim period.

Credit concerns include execution risk associated with the opening of the new facility located on Rush's Chicago campus, an expected decline in liquidity metrics and a competitive service area. At March 31, 2011 Rush's unrestricted cash and investments totaled \$642.1 million reflecting a sharp improvement from \$314.4 million as of fiscal year-end 2009. Liquidity metrics have improved. However days cash on hand (158.8), cushion ratio (11.7x) and cash to long term debt (104.3%) are light relative to the respective 'A' category medians of 183.8, 14.4x and 105.5%. Moreover, Rush projects that days cash will decrease to 124 days in fiscal 2012 due to the completion of the new facility.

The new facility is set to open in January 2012 and is on time and on budget. The combination of the strength of Rush's clinical programs with the new facility should provide a boost to operations in the competitive Chicago-area marketplace.

Rush spent over \$729 million between fiscal 2008 and March 31, 2011 on the estimated \$1 billion Campus Transformation Plan. Capital expenditures are forecasted to equal \$285 million in fiscal 2011, \$215 million in fiscal 2012 (of which \$53 million is carryover from fiscal 2011) and subsequently decrease to \$105 million per year thereafter. Liquidity is expected to rebound after fiscal 2012 due to strong operating performance.

The Positive Outlook reflects Fitch's expectation of upward rating movement if Rush maintains its strong operating performance while successfully transitioning operations to the new facility.

Rush consists of three acute care hospitals including Rush University Medical Center, located in Chicago, IL; Rush Oak Park Hospital, located in Oak Park, Illinois; and Rush-Copley Medical Center, located in Aurora, Illinois. The three hospitals operate 985 staffed beds. Rush also operates a medical university, research facilities, a physician group practice with over 400 employed physicians, and a rehabilitation/skilled nursing facility. In fiscal 2010, the Obligated Group reported total revenues of \$1.69 billion. Rush's disclosure practices are among the best in Fitch's health care portfolio with quarterly and annual disclosure consisting of balance sheet, income statements and cash flow statements, utilization statistics and a management discussion and analysis.

Contact:

Primary Analyst
Adam Kates
Director
+1-312-368-3180
Fitch, Inc.
70 West Madison Street
Chicago, IL

Secondary Analyst
Jim LeBuhn
Senior Director
+1-312-368-2059

Committee Chairperson
Emily Wong
Senior Director
+1-212-908-0651

Media Relations: Cindy Stoller, New York, Tel: +1 212 908 0526, Email: cindy.stoller@fitchratings.com

Additional information is available at 'www.fitchratings.com'.

Applicable Criteria and Related Research:

--'Revenue-Supported Rating Criteria', dated Oct. 8, 2010;

--'Nonprofit Hospitals and Health Systems Rating Criteria', dated Dec. 29, 2009.

Applicable Criteria and Related Research:

Revenue-Supported Rating Criteria

http://www.fitchratings.com/creditedesk/reports/report_frame.cfm?rpt_id=637130

Nonprofit Hospitals and Health Systems Rating Criteria

http://www.fitchratings.com/creditedesk/reports/report_frame.cfm?rpt_id=493186

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October 17, 2011

**Illinois Finance Authority
Rush University Medical Center
Obligated Group; Joint Criteria;
System**

Primary Credit Analyst:
Surie Desai, Chicago (1) 312-233-7046; surie_desai@standardandpoors.com

Secondary Contact:
Brian T. Williamson, Chicago (1) 312-233-7009; brian_williamson@standardandpoors.com

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Illinois Finance Authority Rush University Medical Center Obligated Group; Joint Criteria; System

Credit Profile

Illinois Fin Auth, Illinois

Rush Univ Med Ctr Obligated Grp, Illinois

Illinois Finance Authority (Rush University Medical Center Obligated Group)

Long-Term Rating	A-/Positive	Outlook Revised
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Illinois Finance Authority (Rush University Medical Center Obligated Group) (MBA) (National)

Unenhanced Rating	A-(SPUR)/Positive	Outlook Revised
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Illinois Fin Auth (Rush University Medical Center Obligated Group) Hosp VRDB ser 2008

Long-Term Rating	AAA/A-1+	Affirmed
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Unenhanced Rating	A-(SPUR)/Positive	Outlook Revised
-------------------	-------------------	-----------------

Many issues are enhanced by bond insurance.

Rationale

Standard & Poor's Ratings Services revised its outlook to positive and affirmed the 'A-' long-term rating on Illinois Finance Authority's \$411.6 million series 2009A through 2009D fixed-rate hospital revenue bonds. Standard & Poor's also revised its outlook to positive and affirmed the 'A-' underlying rating (SPUR) on the authority's \$30 million series 2008A and \$96.73 million series 2006B revenue bonds, all issued for the Rush University Medical Center Obligated Group (Rush). At the same time, Standard & Poor's affirmed its 'AAA/A-1+' dual rating on the authority's series 2005A variable-rate demand bonds (VRDBs), also issued for Rush.

The 'AAA/A-1+' dual rating on the series 2005A VRDBs is based on our joint criteria, with the long-term component of the rating based jointly on the Northern Trust Bank (AA) and Rush long-term ratings. The 'A-1+' short-term component of the rating is based on the Northern Trust short-term rating. The letter of credit expires December 2013.

The positive outlook reflects near completion of Rush University Medical Center's (RUMC) new patient tower (to open early in calendar 2012) and Rush's robust operating performance, which has helped to maintain a fairly stable balance sheet despite RUMC's recent period of major construction.

The 'A-' rating reflects the strength of RUMC, the obligated group's flagship hospital, as an academic medical center with well-defined market recognition despite concerns about competition. The rating also reflects RUMC's large net patient revenue base and robust operating income during the past five years. While capital spending will remain steady during the next few years, the opening of the new patient tower, Rush's largest project, is expected to open in early calendar 2012 and eliminates a major risk that has been part of Rush's profile for the past several years.

The 'A-' and positive outlook also reflect Rush's:

- Continued strong market recognition as an academic medical center with broad clinical services, extensive

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SP-11-1013-NA001-1

education and research capabilities, and a solid market position in several key service lines in the competitive Chicago-area market;

- Track record of solid financial operations and cash flow, with unaudited fiscal 2011 results showing a strong operating margin of 5.6%, a solid EBIDA margin of 13.6%, and very good maximum annual debt service coverage of 4.2x; and
- Large net patient revenue base of \$1.5 billion from serving two distinct market areas with modest inpatient growth offset by steady outpatient growth in recent years.

Credit risks, in our view, include Rush's:

- Final cash outlay for RUMC's new patient tower project in 2012 and ability to absorb the higher expense base at the same time that inpatient volume growth has slowed and the state Medicaid program is experiencing some pressure;
- Adequate, 137 days' cash on hand as of June 30, 2011 (with a minimum threshold of 115 during the next few years); and
- Location in the highly competitive Chicago service area, with RUMC in close proximity to three other hospitals in its immediate service area and with several other area academic medical centers and hospitals or health systems providing strong competition for key services.

The bonds secured under the master trust indenture are secured by Rush's gross revenues and mortgages on the main hospital facilities' property, plant, and equipment. Rush's total long-term debt, including capital leases, other financing arrangements, and guarantees, is \$638 million, with most of this debt to be secured under the master trust indenture.

Rush's largest single project during the past few years has been the construction of a new patient tower at RUMC (\$637 million). The new patient tower, which has been funded through bond proceeds, capital campaign contributions, governmental funding, and operating cash flow, is scheduled to open in mid-fiscal 2012. While Rush's capital expenditures will remain high at \$238 million in 2012, capital spending should decrease thereafter but still remain steady at around \$100 million annually as RUMC completes remaining renovations at its existing facilities through 2016. Moreover, the completion of and successful move into the new patient tower will eliminate a significant risk that has been part of Rush's profile for the past few years. In addition, some flexibility in the future capital spending plans should allow Rush to strengthen its currently tight balance sheet profile should operations come under any unforeseen pressure away from currently strong levels. In recent years, RUMC and the smaller Rush-Copley Medical Center have generated strong operations, supported partially by the Illinois Provider Tax (IPT), but also through a very strong focus on strengthening key service lines as well as on operations and expense controls.

John Mordach is the new full-time Chief Financial Officer (CFO) at Rush and filled that position, which has been open since last summer, in early calendar 2011. He's held several senior finance positions including CFO at several hospitals and was most recently the CFO at Loyola University Health System in Maywood, Ill., (a neighboring suburb of Chicago).

Rush is party to two interest-rate swaps with a total notional amount of \$96.75 million. Standard & Poor's has assigned Rush a Debt Derivative Profile (DDP) overall score of '1.5' on a four-point scale, with '1' representing minimal risk. The overall score of '1.5' reflects our view that Rush's swap portfolio poses a very low risk.

Outlook

The positive outlook reflects Rush's near completion of its major capital project at the same time that operations have remained strong and Rush has maintained its solid market position. If Rush is able to grow its balance sheet after final payments have been made for the new patient tower and absorb the higher expense base while continuing to make operating improvements as planned, Standard & Poor's could raise the ratings in the next year or two. Standard & Poor's could revise the outlook back to stable if the balance sheet shows limited growth with liquidity remaining at or near current levels. However, if operations experience sustained declines after the opening of the patient tower and margins remain below median levels, or operational liquidity levels decline and remain below Rush's floor of 115 days, the rating could be revised downward. Rush does not expect to issue any new-money debt during the next two years.

Operational Profile

The Rush health system consists of two medical centers in distinct service areas in the Chicago area:

- RUMC: A 664-staffed bed facility just west of downtown Chicago that also operates the 128-staffed-bed Rush Oak Park Hospital (ROPH) in the neighboring suburb of Oak Park; and
- Rush-Copley Medical Center (RCMC): Located in Aurora, Ill., a far-southwest suburb of Chicago, it serves as the parent holding company for Copley Memorial Hospital Inc. (a 210-staffed bed facility), Copley Ventures Inc., Rush-Copley Foundation, and Rush-Copley Medical Group NFP, all of which are Rush members.

Rush's operations include employed physicians as well as significant research and educational components such as Rush University, a health sciences university that includes Rush Medical College, College of Nursing, College of Health Sciences, and the Graduate College. Rush was created to diversify the revenue base that supports debt service, maximize debt capacity for the system, and generally strengthen overall creditworthiness. Although Rush is involved in some joint activities, the entities operate independently in terms of day-to-day activities and service delivery. However, management is focusing on how to strengthen collaboration clinically across its organizations and affiliates. RUMC's board exerts certain governance controls on the other entities' boards, which hold certain reserve powers through majority board representation. In 2011, Rush's admissions were down 2.5% relative to the prior year to 43,885; however, year-over-year outpatient volumes increased slightly by 0.5% to 442,088 and outpatient surgeries increased 2.6% to 29,664.

While RCMC generates positive operating income, RUMC – Rush's largest component – has helped Rush generate its strong financial performance in recent years. RUMC, which accounted for 89% of Rush's total assets, 83% of total revenues, and 85% of operating income as of fiscal year-end June 30, 2011, is in the Illinois Medical District with three other hospitals. It competes with four Chicago-area academic medical centers: Northwestern Memorial Hospital (AA+); University of Chicago Hospitals and Health System (AA-); Loyola University Health System; and University of Illinois Medical Center (A), as well as other suburban hospitals and systems. RUMC has well-known programs in orthopedics, neurology, neurosurgery, geriatrics, and kidney disease; and has generally maintained its 2.7% market share. The immediate service area and larger Chicago area remain competitive.

Admissions have flattened, similar to other markets and hospitals, although RUMC has continued to experience good outpatient growth through focus on certain key service lines and physician recruitment. Fiscal 2011 inpatient

acute care admissions were down 1.4% from the prior year to 27,568. However, in fiscal 2011 adjusted admissions at RUMC rose 1.6% to 49,143 with total surgeries stable at 26,329. RUMC has made slight gains more than the past few years in its market share to 2.7% in a very fragmented market. ROPH, which operates in a service area near RUMC, has become more closely integrated with RUMC's strategy and Rush has focused on strengthening certain key service lines across RUMC and ROPH. After a strong uptick in 2010, admissions at ROPH decreased slightly by 1% to 3,740 in 2011 but are still higher than 2009 levels.

RCMC is in a far-southwest Chicago suburb that has experienced favorable population growth, although recent economic challenges have negatively affected volumes in that market in addition to slowing growth. RCMC admissions were down 5.2% from the prior year to 12,577 in 2011. RCMC, however, maintains the leading market share, which has been growing, but decreased slightly in 2011 and is at 38.8%. Total adjusted discharges are up 3%, and surgeries increased about 1%, in fiscal 2011.

Finances: Positive Operating Income Trends In Recent Years

During the past five years, Rush has generated solid operating performance, with operating margins averaging 5.0% and operating cash flow margins averaging a healthy 11.9%. More specifically, unaudited fiscal 2011 generated \$98.1 million (5.6% margin) of operating income, as compared with \$89.4 million (5.3% margin) in fiscal 2010 (included in fiscal 2010-2011 operating income is the \$23.0 million annual net payment from the IPT program that is approved through June 30, 2014). In addition to the solid outpatient volumes and the net payment from the IPT, management has made a concerted effort to manage its expenses and will continue efforts to do so during the next several years. Unaudited excess income of \$114.4 million (6.5% margin) in fiscal 2011 was on par with the audited \$101.6 million (6.0% margin) generated in fiscal 2010 due to the improvements from the investment markets. (We note that excess income excludes any gains or realized losses on discontinued operations, unrealized gains and losses on investments, changes in the fair value of interest-rate swaps as well as any gains/losses on sales, and losses on the extinguishment of debt.) Rush generated healthy 4.2x and 3.9x MADS coverage in fiscal 2011 and 2010, respectively.

According to its most recent plan from 2010, future operating and excess income margins should remain close to 2% and more than 5%, respectively, with EBITDA at 10%-12% to fund capital plans and begin to re-strengthen the balance sheet. Although management has operated within these targets for the past few years, the larger expense base, the general softness of the overall economy, and potentially lighter investment income required Rush to focus on core operations and key service-line enhancements. Management is updating its long-range financing plan to identify additional opportunities to strengthen its finances beyond current forecasts. Management is targeting an operating income of about \$61.6 million in fiscal 2012, down from fiscal 2011 as the new patient tower is scheduled to open in mid-fiscal 2012.

Rush's balance sheet has remained relatively stable during the past year, despite increased spending for capital projects out of cash flow. However, balance sheet metrics could ease during the next year as management relies entirely on its own operating cash flow to complete and open its patient tower in 2012. Additionally, the state is experiencing some pressure and may delay payments to Rush as the year continues; Rush has a total of \$150 million in two lines of credits as a back up to help manage any excess pressure related to receivables. As mentioned above, the largest single project in Rush's capital plans is the new patient tower, which totals \$637 million; to date, Rush has spent about \$437 million on that project. There are other smaller projects scheduled to be completed during the

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SECTION IX – FINANCIAL VIABILITY

Criterion 1120.130 – Financial Viability

Please find in the tables below viability ratios for DuPage Medical Group, Ltd. The ratios contained therein are calculated in accordance with the requirements of Section 1120, Appendix A and are based on the information contained in DuPage Medical Group, Ltd.'s consolidated financial statements for the years 2009-2011. The relevant portions of which are included at Attachment 41-Exhibit 1.

Choice of Standards

The applicant or co-applicant that is responsible for funding the project must provide viability ratios. The standards for these ratios are contained in Section 1120, APPENDIX A. This appendix lists the standards for the various viability ratios based on type of provider. Thus, hospitals, long-term care facilities, ESRD facilities, and ASTCs all have different standards that take into account the type of provider they are. There are, however, no standards that directly applicable to this project.

This project involves a Medical Office Building owned and operated by a physician group. It is clearly not a long-term care or ESRD facility, nor is it an ASTC. It is equally clear that the applicant responsible for funding the project, DuPage Medical Group, Ltd., is not a hospital, nor is the MOB itself a hospital. Rush University Medical Center is a hospital, but, as is clearly documented throughout this application, it will not provide or guarantee any funding for this project.

The applicants wish to note that they were advised by CON staff to apply the viability ratio standards for hospitals to this project, which are stricter than the standards for other types of facilities. Applying hospital standards would seem particularly onerous in this case given the difference in financial goals and structures between a hospital and a physician group.

For example, hospitals attempt to generate large amounts of net income, often to pay for large capital costs. Physician groups, on the other hand, try to generate income for the individual physician members, rather than the group itself. Indeed, if the group (as distinct from the physicians) holds a large amount of cash, it can be seen as deviating from its business model. Furthermore, all of the provider types for which standards are available (hospital, ESRD, long-term care, and ASTC) are those that generate *facility* fees. The services provided under this project, however, will by and large generate *professional* fees for physician services.

Therefore, applying hospital standards for viability ratios to a physician group means applying standards that appear not to be for their intended purposes.

Meeting the Standards

Despite their apparent inapplicability, the applicants used, per the direction of the Board staff, the hospital viability ratio standards for this application. To judge whether or not those standards have been met, the applicants used the viability ratios not only for DuPage Medical Group, Ltd. but also for DMG Real Estate, LLC (the LLC). The LLC is fully owned by DuPage Medical Group, Ltd.,¹ which is an applicant for this submission. This was done because the building will be owned and operated by the LLC, and the

¹ See Attachment 4.

construction loan agreement was entered into by the LLC, with DuPage Medical Group, Ltd. acting as guarantor.² Therefore, it was deemed proper and in keeping with the relevant instructions on page 51 of the application to include both organizations in these calculations.

Viability Ratio Calculations: Current Ratio

Organization	Standard	2009	2010	2011	Met Standard?
DMG Real Estate, LLC	≥2.0	11.48	1.60	8.47	Yes
DuPage Medical Group, Ltd.	≥2.0	0.896827	0.872996	0.959426	No

As this table demonstrates DMG Real Estate, LLC is able to meet the hospital standard for the Current Ratio.

Viability Ratio Calculations: Net Margin Percentage

Organization	Standard	2009	2010	2011	Met Standard?
DMG Real Estate, LLC	≥5%	46.3%	47.8%	50.5%	Yes
DuPage Medical Group, Ltd.	≥5%	3.8%	4.1%	3.4%	No

As this table demonstrates DMG Real Estate, LLC is able to meet the hospital standard for Net Margin Percentage

Viability Ratio Calculations: Percent Debt to Total Capitalization

Organization	Standard	2009	2010	2011	Met Standard?
DMG Real Estate, LLC	≤50%	79.8%	66.7%	67.3%	No
DuPage Medical Group, Ltd.	≤50%	41.3%	28.5%	31.5%	Yes

As this table demonstrates DuPage Medical Group, Ltd. is able to meet the hospital standard for Percent Debt to Total Capitalization.

Viability Ratio Calculations: Projected Debt Service Coverage

Organization	Standard	2009	2010	2011	Met Standard?
DMG Real Estate, LLC	≥2.5	1.8	1.9	1.3	No
DuPage Medical Group, Ltd.	≥2.5	3.1	6.2	5.2	Yes

As this table demonstrates DuPage Medical Group, Ltd. is able to meet the hospital standard for Projected Debt Service Coverage.

² See Attachment 39-Exhibit 1.

Viability Ratio Calculations: Days Cash on Hand

Organization	Standard	2009	2010	2011	Met Standard?
DMG Real Estate, LLC	≥75 days	18.99	28.17	38.16	No
DuPage Medical Group, Ltd.	≥75 days	4.60	11.27	18.78	No

Although neither DMG organization meets this particular standard it should be noted that Days Cash on Hand is a particularly poor measure of the financial viability of a physician practice group, such as DuPage Medical Group, Ltd. This is because DMG's business model is designed to generate income for its physician members through professional fees, rather than itself. Therefore, there is little comparison with providers that generate a facility fee. Also, DMG's business model requires it to apportion excess cash to physician shareholders after necessary expenses have been paid.

Viability Ratio Calculations: Cushion Ratio

Organization	Standard	2009	2010	2011	Met Standard?
DMG Real Estate, LLC	≥7.0	4.64	7.89	7.74	Yes
DuPage Medical Group, Ltd.	≥7.0	0.63	3.07	5.12	No

As this table demonstrates DMG Real Estate, LLC is able to meet the hospital standard for the Cushion Ratio.

Note: Rush University Medical Center has an A Bond Rating. See Attachment 40. Therefore, it is not necessary to include any viability ratios for RUMC here.

**Attachment 41-Exhibit1
Consolidated Financial Statements of
DuPage Medical Group, Ltd. from
2009-2011**

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CONSOLIDATED FINANCIAL STATEMENTS

**DuPage Medical Group, Ltd. and Subsidiaries
Years Ended December 31, 2011 and 2010
With Report of Independent Auditors**

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

Attachment 41-Exhibit 1

DuPage Medical Group, Ltd. and Subsidiaries

Consolidated Financial Statements

Years Ended December 31, 2011 and 2010

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PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

Report of Independent Auditors

The Board of Directors
DuPage Medical Group, Ltd. and Subsidiaries

We have audited the accompanying consolidated balance sheets of DuPage Medical Group, Ltd. and Subsidiaries (collectively, the Group) as of December 31, 2011 and 2010, and the related consolidated statements of operations, changes in stockholders' equity, and cash flows for the years then ended. These financial statements are the responsibility of the Group's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Group's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Group's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of DuPage Medical Group, Ltd. and Subsidiaries at December 31, 2011 and 2010, and the consolidated results of their operations and their cash flows for the years then ended, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 2 to the consolidated financial statements, in 2011, the Group adopted authoritative guidance issued by the Financial Accounting Standards Board related to accounting for medical malpractice and similar liabilities and their related anticipated insurance recoveries.

April 19, 2012

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

1202-1328218

Attachment 41-Exhibit 1

DuPage Medical Group, Ltd. and Subsidiaries

Consolidated Balance Sheets

	December 31	
	2011	2010
Assets		
Current assets:		
Cash	\$ 18,725,173	\$ 10,407,596
Patient accounts receivable, less allowances for uncollectible accounts of \$3,966,000 in 2011 and \$3,188,000 in 2010	28,468,250	25,350,256
Reinsurance receivable	2,056,736	3,502,124
Inventory	2,291,613	2,442,106
Prepaid expenses and other	5,394,210	6,651,700
Current portion of professional liabilities insurance receivable	6,236,864	5,516,002
Deferred income tax, net	618,284	444,700
Total current assets	63,791,130	54,314,484
Property and equipment, net	113,796,775	107,551,607
Goodwill	3,606,430	3,606,430
Professional liabilities insurance receivable	16,763,136	16,483,998
Deferred income tax, net	2,455,323	—
Deferred compensation and other	1,539,722	1,557,070
Total assets	\$ 201,952,516	\$ 183,513,589
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable	\$ 7,518,207	\$ 6,719,754
Accrued expenses	9,532,954	2,673,294
Accrued payroll and benefits	15,894,429	14,896,588
Due to third-party payor	7,343,714	5,474,271
Medical claims payable	3,140,021	3,000,000
Current portion of professional liabilities	6,236,864	5,516,002
Current maturities of long-term debt	1,702,203	12,525,093
Payable to physicians	15,120,490	11,411,217
Total current liabilities	66,488,882	62,216,219
Noncurrent liabilities:		
Long-term debt, less current maturities	32,471,163	25,305,413
Fair value of interest rate swaps	2,003,772	1,618,937
Deferred compensation	934,987	1,018,804
Deferred income tax, net	—	991,274
Professional liabilities	29,563,136	28,983,998
Total liabilities	131,461,940	120,134,645
Stockholders' equity:		
Common stock (\$1 par value; 500,000 shares authorized 250,000 and 235,000 shares issued and outstanding at December 31, 2011 and 2010, respectively)	250,000	235,000
Additional paid-in capital	2,900,000	2,750,000
Noncontrolling interest	1,089,208	1,018,149
Retained earnings	66,251,368	59,375,795
Total stockholders' equity	70,490,576	63,378,944
Total liabilities and stockholders' equity	\$ 201,952,516	\$ 183,513,589

See notes to consolidated financial statements.

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

1202-1328218

Attachment 41-Exhibit I

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DuPage Medical Group, Ltd. and Subsidiaries

Consolidated Statements of Operations

	Year Ended December 31	
	2011	2010
Revenues:		
Net patient service revenue	\$ 287,258,730	\$ 261,579,606
Capitation revenue	93,978,264	94,433,682
Other revenue	7,991,503	6,981,588
Total revenue	389,228,497	362,994,876
Expenses:		
Physician salaries, wages, and benefits	129,289,535	117,921,844
Nonphysician salaries, wages, and benefits	102,307,769	98,150,032
Medical claims	18,393,298	16,801,585
Rent and utilities	34,399,757	32,782,908
Medical supplies and other	47,696,034	41,891,170
Professional fees and purchased services	16,285,377	14,558,706
Insurance	5,358,758	5,309,406
Provision for uncollectible accounts	8,732,156	8,010,157
Interest	1,385,414	1,545,488
Depreciation	11,961,358	11,174,309
Total expenses	375,809,456	348,145,605
Other losses:		
Change in fair value of interest rate swaps	(384,835)	(537,367)
Income before income taxes	13,034,206	14,311,904
Provision for income taxes	5,585,706	4,106,439
Consolidated net income	7,448,500	10,205,465
Less net income attributed to noncontrolling interest	(572,927)	(501,868)
Net income attributed to the Group	\$ 6,875,573	\$ 9,703,597

See notes to consolidated financial statements.

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Consolidated Statements of Changes in Stockholders' Equity

Years Ended December 31, 2011 and 2010

	Common Stock	Additional Paid-In Capital	Retained Earnings	Noncontrolling Interest	Total Stockholders' Equity
Balance at January 1, 2010	\$ 217,000	\$ 2,570,000	\$ 49,672,198	\$ 943,272	\$ 53,402,470
Net income	-	-	9,703,597	-	9,703,597
Noncontrolling interest net income	-	-	-	501,868	501,868
Partnership distribution	-	-	-	(426,991)	(426,991)
Purchase of common stock	(5,000)	(50,000)	-	-	(55,000)
Issuance of common stock	23,000	230,000	-	-	253,000
Balance at December 31, 2010	235,000	2,750,000	59,375,795	1,018,149	63,378,944
Net income	-	-	6,875,573	-	6,875,573
Noncontrolling interest net income	-	-	-	572,927	572,927
Partnership distribution	-	-	-	(501,868)	(501,868)
Purchase of common stock	(8,000)	(80,000)	-	-	(88,000)
Issuance of common stock	23,000	230,000	-	-	253,000
Balance at December 31, 2011	<u>\$ 250,000</u>	<u>\$ 2,900,000</u>	<u>\$ 66,251,368</u>	<u>\$ 1,089,208</u>	<u>\$ 70,490,576</u>

See notes to consolidated financial statements.

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Consolidated Statements of Cash Flows

	Year Ended December 31	
	2011	2010
Operating activities		
Net income attributed to the Group	\$ 6,875,573	\$ 9,703,597
Net income attributed to the noncontrolling interest	572,927	501,868
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation	11,961,358	11,174,309
Net (gain) loss on sales of property and equipment	(2,123)	27,507
Change in fair value of interest rate swap	384,835	537,367
Deferred income taxes	(3,620,181)	(1,488,060)
Provision for uncollectible accounts	8,732,156	8,010,157
Changes in operating assets and liabilities:		
Patient accounts receivable	(11,850,150)	(8,830,752)
Reinsurance receivable	1,445,388	(2,573,389)
Prepaid expenses and other	1,257,490	(36,192)
Inventory	150,493	(731,065)
Due to third-party payor	1,869,443	84,962
Accounts payable, accrued expenses, and other current liabilities	8,655,954	3,459,300
Medical claims payable	140,021	(623,000)
Payable to physicians	3,709,273	2,725,949
Other noncurrent assets and liabilities	233,531	67,836
Cash provided by operating activities	30,515,988	22,010,394
Investing activities		
Purchases of property and equipment	(18,204,403)	(11,777,583)
Net cash used in investing activities	(18,204,403)	(11,777,583)
Financing activities		
Distributions to noncontrolling interest	(501,868)	(426,991)
Payments of debt and capital lease obligations	(3,657,140)	(3,394,052)
Purchase of common stock	(88,000)	(55,000)
Proceeds from issuance of stock	253,000	253,000
Net cash used in financing activities	(3,994,008)	(3,623,043)
Net increase in cash	8,317,577	6,609,768
Cash at beginning of year	10,407,596	3,797,828
Cash at end of year	\$ 18,725,173	\$ 10,407,596

See notes to consolidated financial statements.

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements

December 31, 2011

1. Organization and Basis of Presentation

DuPage Medical Group, Ltd. (the Group) is a multi-specialty physician practice that provides a broad range of outpatient services. The main office is in Glen Ellyn, Illinois, with 42 satellite offices throughout the western suburbs of Chicago, predominantly DuPage County, Illinois. The Group was incorporated as a medical corporation in the state of Illinois in July 1968 and is a for-profit, taxable corporation. The Group has 321 physicians, of which 250 are shareholders, at December 31, 2011.

Included in the Group's consolidated financial statements are all wholly owned and controlled subsidiaries. The Group's subsidiary corporations are DMG Real Estate, LLC (LLC); DMG Real Estate Holdings, LLC (REH); DMG Surgery Center, LLC (Surgery Center); and DMG Pain Management Surgery Center, LLC (Pain ASC).

LLC owns and operates medical office buildings in DuPage County.

The Surgery Center was formed in 2002 as a surgery center operation. Effective December 1, 2005, the Surgery Center amended and restated its operating agreement and sold a 12.5% ownership interest to a minority shareholder.

REH was formed in 2004 to acquire land and construct a surgery center facility.

Pain ASC was formed in 2009 as a pain management surgery center. Operations began October 2011.

Illinois Health Partners (IHP), a joint venture owed 50% by the Group and 50% by Edward Health Ventures, was formed in 2011. Operations began January 2012 by combining managed care operations for the Group and Naperville Health Care Association, Edward Health Ventures, previously PHO.

All significant intercompany balances have been eliminated in consolidation.

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

2. Summary of Significant Accounting Policies (continued)

Goodwill

Goodwill is assessed for impairment on an annual basis through the comparison of the fair value of the respective reporting unit with its carrying value. Fair value is determined primarily based upon valuation studies performed by the Group, which consider discounted cash flows, physician compensation, and future earnings. Valuation analysis requires significant judgments and estimates to be made by management. Changes in market conditions, among other factors, may have an impact on these estimates, which may require future adjustments to the carrying value of goodwill.

Due to Third-Party Payor

Due to third-party payor represents the liability for funds received by the Surgery Center that are to be paid back to Blue Cross/Blue Shield as of December 31, 2011 and 2010. Blue Cross/Blue Shield pays the Surgery Center invoices at gross amounts and invoices the Surgery Center for the difference between the gross charges and the contracted rate.

Medical Claims Payable

Medical claims payable represents the estimated liability for claims expenses reported but not paid and for claims incurred but not reported to the Group for the years ended December 31, 2011 and 2010. Liabilities for unpaid claims and claims incurred but not reported are actuarially determined. The estimates used in determining the liabilities are subject to the effects of trends in claim severity and frequency. Although considerable variability is inherent in such estimates, management believes that the liabilities for unpaid claims are adequate. The estimates are continually reviewed and adjusted as necessary as experience develops or new information becomes known; such adjustments are included in current operations.

Noncontrolling Interest

The Group's noncontrolling interest in the consolidated statements of operations represents the noncontrolling shareholder's share of the Surgery Center's operations. The noncontrolling interest in the consolidated balance sheets reflects the original investment by a noncontrolling shareholder in the Surgery Center subsidiary, along with the noncontrolling interest's share of the Surgery Center's subsequent operations.

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

2. Summary of Significant Accounting Policies (continued)

Asset Impairment

The Group considers whether indicators of impairment are present and performs the necessary tests to determine if the carrying value of an asset is appropriate. Impairment write-downs are recognized in operating expenses at the time the impairment is identified. There was no impairment of long-lived assets in 2011 and 2010.

Payable to Physicians

Payable to physicians represents the amount of calculated compensation based upon the shareholder compensation formula that has not been paid as of the end of a given reporting period. These amounts are calculated and distributed to individual physicians on a monthly basis.

General and Professional Liability

The provision for self-insured general and professional liability claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported. The estimated insurance receivable for professional liability claims represents the receivable for reported claims that are at or below the insurance coverage limits.

Net Patient Service Revenue

The Group has agreements with third-party payors that provide for payments to the Group at amounts different from its established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated adjustments under reimbursement agreements. Those adjustments are accrued on an estimated basis and are adjusted in future periods.

Capitation Revenue

The Group has agreements with various health maintenance organizations (HMOs) under which the Group provides or arranges for medical care to members of HMOs in return for a monthly payment per member (capitation revenue).

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

2. Summary of Significant Accounting Policies (continued)

Reinsurance

The Group's capitation agreements include reinsurance arrangements, which limit the Group's expenses on individual patients. Under the terms of the agreements, the Group will be reimbursed a portion of the cost incurred for each patient's annual physician services in excess of a deductible outlined in each agreement. Amounts reimbursable from reinsurance contracts are recorded as reinsurance receivable as outlined in each agreement. Amounts received under reinsurance agreements related to claims paid to external parties are included as a reduction in medical claims expense. Amounts reimbursed related to services provided by the Group are reflected in capitation revenue.

Community Services Provided

The Group provides care to patients who meet certain criteria without charge or at amounts less than established rates. Community services provided by the Group are excluded from net patient service revenue.

The forgone charges related to community services provided by the Group to the DuPage Community Clinic amounted to approximately \$2,843,000 and \$2,442,000 for the years ended December 31, 2011 and 2010, respectively.

Derivative Instruments

Derivative instruments, specifically interest rate swaps, are reported in the consolidated balance sheets at their respective fair values. The change in the fair value of those derivative instruments is reflected in net income.

Reclassifications

Certain amounts in the 2010 consolidated financial statements have been reclassified to conform to the 2011 presentation. These reclassifications had no impact on stockholders' equity or net income.

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

2. Summary of Significant Accounting Policies (continued)

New Accounting Pronouncements

In August 2010, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries*. The provisions of ASU 2010-24 are intended to address the current diversity in practice related to health care entities for medical malpractice claims and similar liabilities and their related anticipated insurance recoveries. ASU 2010-24 clarifies that a health care entity should not net insurance recoveries against a related claim liability. Additionally, the amount of the claim liability should be determined without consideration of insurance recoveries. This new guidance was effective for fiscal years beginning after December 15, 2010, with early application permitted. The Group adopted ASU 2010-24 for year ended December 31, 2011 (see Note 11).

In July 2011, the FASB issued ASU 2011-07, *Presentation and Disclosure for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities*. The guidance requires certain health care entities to reclassify in the statement of operations the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenues (net of contractual allowances and discounts). Additionally, the guidance requires enhanced disclosures about policies for recognizing revenue, assessing bad debts, and qualitative and quantitative information about the changes in the allowance for uncollectible accounts. The guidance is effective for the Group for the reporting period beginning on January 1, 2012, with early adoption permitted. The Group is evaluating the impact of this guidance on the consolidated financial statements.

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

3. Net Patient Service and Capitation Revenue

Net patient service and capitation revenue represents amounts received and the estimated net realizable amounts due from patients and third-party payors for services rendered. The Group provides certain medical care services to members of various HMOs. For these patients, the Group recognizes prepaid capitation revenue each month during the period in which the Group is obligated to provide medical care services, which is typically one year. Under the terms of these capitation agreements, the Group is obligated to provide specified medically necessary services to covered HMO members without regard to the underlying standard charges or actual costs of such services. These arrangements include the Group's assumption of financial responsibility for the appropriate and effective utilization of hospital and other health care resources. Capitation received under these agreements was approximately \$94,000,000 and \$94,400,000 for the years ended December 31, 2011 and 2010, respectively. Estimates for incurred but not reported claims expenses, included in medical claims payable, have been provided for based upon the Group's historical claims experience. During 2011 and 2010, changes in estimates relating to prior years' medical claims payable liability increased net income by approximately \$442,000 and \$1,348,000, respectively.

The Group has entered into reinsurance arrangements to provide reinsurance coverage for patients in which the Group received capitation. The agreements provide protection to the Group for a percentage of losses that exceed the \$15,000 and \$14,000 deductible per member per year for the years ended December 31, 2011 and 2010, respectively.

Provisions have been made in the consolidated financial statements for contractual adjustments, representing the difference between the standard charges for services and estimated payments to be received from third-party payors. The Group's concentration of credit risk related to the accounts receivable is limited due to the diversity of patients and payors.

The mix of receivables from patients and third-party payors at December 31 consisted of the following:

	2011	2010
Medicare	11%	16%
Medicaid	2	2
Managed care	27	24
Blue Cross/Blue Shield	24	22
Private pay and other	36	36
	100%	100%

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

3. Net Patient Service and Capitation Revenue (continued)

The Group grants credit without collateral from its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of net patient service revenue from patients and third-party payors at December 31 was as follows:

	2011	2010
Medicare	22%	20%
Medicaid	1	1
Managed care	31	31
Blue Cross/Blue Shield	41	42
Private pay and other	5	6
	<u>100%</u>	<u>100%</u>

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

4. Property and Equipment

Property and equipment consist of the following at December 31:

	2011	2010
Land	\$ 13,140,482	\$ 13,140,482
Land improvements	5,434,067	5,434,067
Buildings	58,878,167	58,505,937
Equipment	108,027,187	95,512,247
	<u>185,479,903</u>	<u>172,592,733</u>
Accumulated depreciation	(78,798,205)	(66,982,521)
	<u>106,681,698</u>	<u>105,610,212</u>
Construction-in-process	7,115,077	1,941,395
	<u>\$ 113,796,775</u>	<u>\$ 107,551,607</u>

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

5. Long-Term Debt

Long-term debt consists of the following at December 31:

	2011	2010
Stratford mortgage payable to bank	\$ —	\$ 1,906,884
Lombard mortgage payable to bank	8,867,952	9,358,346
Rickert mortgage payable to bank – purchase	4,141,200	4,338,400
Rickert mortgage payable to bank – construction	3,016,872	3,157,737
430 Pennsylvania mortgage payable to bank	18,017,109	18,836,068
Capital lease obligations	130,233	233,071
	<u>34,173,366</u>	<u>37,830,506</u>
Current maturities	(1,702,203)	(12,525,093)
	<u>\$ 32,471,163</u>	<u>\$ 25,305,413</u>

The carrying value of the debt approximates the fair value of the debt at December 31, 2011.

Proceeds from the Stratford mortgage loan were used to finance the purchase of DMG-RE properties during 1999, pay certain fees and expenses associated with the acquisition, and retain sufficient working capital. The mortgage loan was due in monthly principal payments of \$11,713 plus interest. The balance of \$1,801,470 was paid in full on October 4, 2011. The interest rate was variable with an average rate of 1.84% for 2011 and 2.05% for 2010.

Proceeds from the Lombard mortgage loan were used to finance the construction of the building at 1801 S. Highland Ave. in Lombard. The mortgage loan is collateralized with the building, which has a net book value of \$16,900,000. The mortgage loan is due in monthly principal payments of \$40,866 plus interest with a maturity date of October 2016. The original maturity date for this loan was October 2011. The mortgage loan was refinanced during 2011 to extend the maturity date. The interest rate is variable with an average rate of 1.90% for 2011 and 2.07% for 2010.

Proceeds from the Rickert mortgage loan were used to purchase the land at 808 Rickert in Naperville. The mortgage loan is collateralized with the property, which has a net book value of \$9,600,000. The mortgage is due in monthly principal payments of \$16,433 plus interest with a maturity date of July 2017. The interest rate is variable with an average rate of 1.40% for 2011 and 1.44% for 2010.

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

5. Long-Term Debt (continued)

Proceeds from the Rickert mortgage loan were used to finance the construction and build-out of the building at 808 Rickert in Naperville. The mortgage loan is collateralized with the building, which has a net book value of \$9,600,000. The mortgage loan is due in monthly principal payments of \$11,739 plus interest with a maturity date of May 2018. The interest rate is variable with an average rate of 1.40% for 2011 and 1.44% for 2010.

Proceeds from the 430 Pennsylvania mortgage loan were used to finance the construction of the building at 430 Pennsylvania Avenue. in Glen Ellyn. The construction loan outstanding at December 31, 2007, was converted into this mortgage loan during 2008. The mortgage loan is collateralized with the building, which has a net book value of \$24,500,000. The mortgage loan is due in monthly principal payments of \$68,247 plus interest with a maturity date of June 2015. The interest rate is variable with an average rate of 1.75% for 2011 and 1.79% for 2010.

At December 31, 2011 and 2010, the Group had a line of credit with a bank totaling \$10,500,000. The Group may advance from the line of credit at a rate equal to 61.35% of the Group's eligible accounts receivable balances. The Group repaid the outstanding balance on the line of credit in 2010. There was no amount outstanding on the line of credit at December 31, 2011 and 2010. The line of credit's maturity is December 31, 2012.

At December 31, 2011, the Group had one letter of credit in the amount of \$2,431,762 related to the construction of the medical building, which reduces the amount available for borrowing on the line of credit to \$8,068,238. At December 31, 2011, none of the amount appropriated for letter of credit was withdrawn. At December 31, 2010, the Group did not have a letter of credit.

Maturities of long-term debt, excluding capital lease obligations, for each of the next five years ending December 31 are as follows:

2012	\$ 1,647,419
2013	1,647,419
2014	1,647,419
2015	16,388,690
2016	7,244,443

Interest paid during the years ended December 31, 2011 and 2010, amounted to approximately \$633,000 and \$735,000, respectively.

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

6. Interest Rate and Basis Swaps

The Group has various derivative instruments to manage the exposure on interest rates and the Group's interest expense. Through the use of derivative financial instruments, the Group is exposed to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of the derivative contract is positive, the counterparty owes the Group, which creates credit risk to the Group. When the fair value of the derivative contract is negative, the Group owes the counterparty, and there is no credit risk to the Group at that point in time. The Group minimizes the credit risk in derivative instruments by entering into transactions that require the counterparty to post collateral for the benefit of the fair value of the derivative contract. Market risk is the adverse effect on the value of the financial instrument that results from a change in interest rates. Swap management is meant to be long term in nature, and any modifications to the program are reviewed for the long-term costs and benefits. Management also mitigates risk through periodic reviews of its derivative position in the context of its total blended cost of capital.

The Group entered into an interest rate swap in which a counterparty agreed to make variable payments based upon a market interest rate. The interest rate swap effectively fixed the total interest rate paid on the DMG-RE mortgage of \$5,417,190 at 6.07%. The swap ended in October 2011. The fair value of the interest rate swap was \$(128,384) at December 31, 2010, and was reported in noncurrent liabilities in the accompanying consolidated balance sheet. The change in the fair value of the interest rate swap is included in the consolidated statement of operations.

In 2007, the Group entered into a second interest rate swap in which a counterparty agreed to make variable payments based upon a market interest rate. The interest rate swap effectively fixed the total interest rate paid on the DMG LLC mortgage of \$4,930,000 at 6.785%. The fair value of the interest rate swap was \$(862,892) and \$(717,823) at December 31, 2011 and 2010, respectively, and is reported in noncurrent liabilities in the accompanying consolidated balance sheets, and the change in the fair value of the interest rate swap is included in the consolidated statements of operations.

In 2008, the Group entered into a third interest rate swap in which a counterparty agreed to make variable payments based upon a market interest rate. The interest rate swap effectively fixed the total interest rate paid on the DMG LLC mortgage of \$3,521,640 at 6.03%. The fair value of the interest rate swap was \$(558,982) and \$(403,767) at December 31, 2011 and 2010, respectively, and is reported in noncurrent liabilities in the accompanying consolidated balance sheets, and the change in the fair value of the interest rate swap is included in the consolidated statements of operations.

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

6. Interest Rate and Basis Swaps (continued)

In 2009, the Group entered into a fourth interest rate swap in which a counterparty agreed to make variable payments based upon a market interest rate. The interest rate swap effectively fixed the total interest rate paid on the DMG LLC mortgage of \$10,202,870 at 4.30%. The fair value of the interest rate swap was \$(581,898) and \$(368,963) at December 31, 2011 and 2010, respectively, and is reported in noncurrent liabilities in the accompanying consolidated balance sheets, and the change in the fair value of the interest rate swap is included in the consolidated statements of operations.

The following is a summary of the outstanding interest rate swaps as of December 31, 2011:

<u>Origination Date</u>	<u>Notional Amounts</u>	<u>Swap Position</u>	<u>Maturity Date</u>
07/25/07	\$ 4,141,200	Pay fixed	07/13/17
06/20/08	3,016,872	Pay fixed	05/31/18
01/05/09	9,008,560	Pay fixed	06/30/15
Net position	<u>\$ 16,166,632</u>		

The fair value of derivative instruments not designated as hedging instruments at December 31 is as follows:

<u>Type of Derivative</u>	<u>Liability Derivatives</u>		
	<u>Balance Sheet Location</u>	<u>2011</u>	<u>2010</u>
Interest rate contracts	Noncurrent liabilities	<u>\$ 2,003,772</u>	<u>\$ 1,618,937</u>

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

6. Interest Rate and Basis Swaps (continued)

The effects of the derivative instruments not designated as hedging instruments on the consolidated statements of operations for the years ended December 31 are as follows:

Type of Derivative	Classification of Loss Recognized in Consolidated Net Income	Amount of Loss Recognized in Consolidated Net Income	
		2011	2010
Interest rate contracts	Interest expense	\$ 752,467	\$ 810,409
	Change in fair value of interest rate swaps	\$ 384,835	\$ 537,367

7. Leases

The Group leases certain office space and equipment under various noncancelable operating leases. These leases contain various terms and typically provide for renewal at prevailing market rates. Rental expense for operating leases amounted to approximately \$13,198,000 and \$12,160,000 for the years ended December 31, 2011 and 2010, respectively.

Future minimum lease payments under noncancelable capital and operating leases, having an initial term of more than one year at December 31, 2011, are as follows:

	Capital Leases	Operating Leases
2012	\$ 57,409	\$ 5,588,087
2013	26,916	3,202,841
2014	26,916	993,976
2015	24,672	207,780
Total minimum lease payments	135,913	9,992,684
Interest	(5,419)	—
Present value of minimum lease payments	\$ 130,494	\$ 9,992,684

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

7. Leases (continued)

Included in equipment are assets under capital leases, which aggregated \$6,632,600 with accumulated depreciation of \$6,255,900 at December 31, 2011. The Group entered into three new capital lease arrangements for 2010, totaling \$158,175. There were no capital lease arrangements entered into for 2011.

8. Employee Benefit and Retirement Plans

The Group maintains and contributes to a defined-contribution plan covering substantially all employees and physicians. The employer contributions under the plan consist of an elective profit-sharing contribution and a 401(k) matching contribution. Contribution expense under this plan, which is included in both physician salaries, wages, and benefits and nonphysician salaries, wages, and benefits, was approximately \$8,715,000 and \$8,353,000 for the years ended December 31, 2011 and 2010, respectively.

9. Related-Party Transactions

During 2011 and 2010, the Group purchased and retired the stock of certain physicians who departed from the organization in the amount of \$88,000 and \$55,000, respectively.

The Group leases medical office space from two different physician-owned partnerships or trusts. The total rental expense related to these leases amounted to approximately \$269,500 and \$237,000 for the years ended December 31, 2011 and 2010, respectively.

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

10. Income Taxes

As a personal service corporation, the Group uses the cash basis method of accounting to prepare its income tax filings. The use of the cash basis method of accounting for tax return reporting purposes results in a difference between financial statement accrual basis income and the Group's cash basis taxable income as reported on its tax returns.

The Group has deferred income taxes due to temporary differences between financial reporting and tax reporting for certain assets and liabilities. Significant components of the Group's deferred tax assets and liabilities as of December 31 are as follows:

	2011	2010
Deferred tax assets:		
Difference in accrual and cash basis book income	\$ 8,415,990	\$ 4,917,890
Professional liability	515,189	534,615
Deferred compensation	384,981	404,923
Accrued expenses	270,176	63,782
Total deferred tax assets	9,586,336	5,921,210
Deferred tax liabilities:		
Depreciation	(5,207,434)	(5,234,328)
Amortization	(1,268,422)	(1,209,451)
Prepaid expenses	(9,438)	(11,200)
Other liabilities	(27,435)	(12,805)
Total deferred tax liabilities	(6,512,729)	(6,467,784)
Net deferred tax asset (liability)	\$ 3,073,607	\$ (546,574)

Provisions for income taxes for the years ended December 31 consist of the following:

	2011	2010
Current:		
Federal	\$ 7,165,660	\$ 4,541,550
State	2,040,227	1,052,949
	9,205,887	5,594,499
Deferred	(3,620,181)	(1,488,060)
Total provision for income taxes	\$ 5,585,706	\$ 4,106,439

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

10. Income Taxes (continued)

The effective income tax rate varies from the prevailing corporate income tax rate of 35% primarily due to state taxes. The Group paid approximately \$4,750,000 and \$3,950,000 of income taxes during 2011 and 2010, respectively.

11. Professional Liability Insurance

Effective August 15, 2011, the Group purchased professional liability insurance, on a claims-made basis, with annual limits of \$2,000,000 for three orthopedic spine surgeons, \$1,000,000 for all other physicians per occurrence, and \$250,000,000 in the aggregate for the Group.

Effective August 15, 2010, the Group purchased professional liability insurance, on a claims-made basis, with annual limits of \$2,000,000 for three orthopedic spine surgeons, \$1,000,000 for all other physicians per occurrence, and \$235,000,000 in the aggregate for the Group.

Effective August 15, 2009, the Group purchased professional liability insurance, on a claims-made basis, with annual limits of \$2,000,000 for three orthopedic spine surgeons, \$1,000,000 for all other physicians per occurrence, and \$235,000,000 in the aggregate for the Group.

The Group has provided for losses in excess of insurance coverage. Estimated liabilities related to losses in excess of insurance coverage amounted to approximately \$3,800,000 at December 31, 2011 and 2010.

Management is not aware of any factors that would cause insurance expense to vary materially from the amounts provided. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during 2011 and prior, but reported subsequently, may not be insured. Estimated reserves for incurred but not reported claims expenses have been provided for based on the Group's historical claims experience and amounted to approximately \$9,000,000 and \$8,700,000 at December 31, 2011 and 2010, respectively.

Effective January 1, 2011, the Group adopted ASU 2010-24. As a result of this adoption, the Group recognized professional liabilities insurance receivable and increased its professional liabilities by \$23,000,000 as of December 31, 2011. The guidance allows for but does not require retrospective adoption of the amendment; however, management opted to adopt retrospectively resulting to the recognition of professional liabilities insurance receivable and increase in professional liabilities amounting to \$22,000,000 as of December 31, 2010. This represents the liability for known claims within the insurance coverage limits.

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

12. Fair Value Disclosures

The Group evaluates the carrying amounts of significant classes of financial instruments in the consolidated balance sheets for disclosure of fair values for which it is practicable. The carrying amounts of cash and cash equivalents, patient accounts receivable, other current assets, accounts payable, and accrued expenses approximate fair value because of the short-term nature of those instruments.

The Group adopted Accounting Standards Codification (ASC) 820, *Fair Value Measurement*, which establishes a three-level valuation hierarchy for disclosure of fair value measurements. The valuation hierarchy is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

- Level 1 – Inputs to the valuation methodology are quoted prices (unadjusted) for identical assets or liabilities in active markets.
- Level 2 – Inputs to the valuation methodology include quoted prices for similar assets or liabilities in active markets and inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial instruments.
- Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement of the assets or liabilities.

The following table presents financial assets and liabilities measured at fair value on a recurring basis as of December 31, 2011, by ASC 820 valuation hierarchy.

	Level 1	Level 2	Level 3	Total Fair Value
Assets				
Investments held for deferred compensation	\$ 934,987	\$ –	\$ –	\$ 934,987
Liabilities				
Interest rate swaps	\$ –	\$ 2,003,772	\$ –	\$ 2,003,772

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

12. Fair Value Disclosures (continued)

The following table presents financial assets and liabilities measured at fair value on a recurring basis as of December 31, 2010, by ASC 820 valuation hierarchy.

	Level 1	Level 2	Level 3	Total Fair Value
Assets				
Investments held for deferred compensation	\$ 1,018,804	\$ —	\$ —	\$ 1,018,804
Liabilities				
Interest rate swaps	\$ —	\$ 1,618,937	\$ —	\$ 1,618,937

Investments held for deferred compensation— The investments in deferred compensation primarily consist of mutual fund investments and common stock for which identical quotes exist on active exchanges. These securities are classified as Level 1.

Interest rate swaps— Derivative financial instruments consist solely of interest rate swap agreements with interest rate terms that are observable based upon forward interest rate curves and are therefore considered Level 2 inputs.

The credit risk adjustment related to the fair value of the swap agreements was an increase in value in total of \$55,324 and \$46,197 at December 31, 2011 and 2010, respectively.

13. Commitments and Contingencies

The Group is a defendant in various lawsuits arising in the ordinary course of business. Although the outcome of these lawsuits cannot be predicted with certainty, management believes the ultimate disposition of such matters will not have a material effect on the Group's consolidated financial condition or operations.

In 2011, the Group entered into a construction contract related to the Lisle medical building. A construction contract was signed on June 1, 2011 in the amount of \$28,000,000. As of December 31, 2011, \$3,400,000 of construction had been completed on this contract, leaving a remaining commitment of \$24,600,000.

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

14. Subsequent Events

The Group evaluated subsequent events and transactions occurring subsequent to December 31, 2011 through April 19, 2012, the date the consolidated financial statements were available to be issued. On March 30, 2012, the Group entered into a construction loan agreement with Bank of America and Win Trust Bank to provide financing for the Lisle medical building.

The amount of the construction loan is \$22,000,000 with an expiration date of March 30, 2013, at which time the construction loan will convert to a permanent loan. The permanent loan will mature on March 30, 2018. The interest rate on the loan is equal to the LIBOR rate. To date, no draws have been requested on this loan.

PRELIMINARY AND TENTATIVE FOR DISCUSSION ONLY

1202-1328218

Attachment 41-Exhibit I

CONSOLIDATED FINANCIAL STATEMENTS

DuPage Medical Group, Ltd. and Subsidiaries
Years Ended December 31, 2010 and 2009
With Report of Independent Auditors

Ernst & Young LLP

 **ERNST & YOUNG**

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DuPage Medical Group, Ltd. and Subsidiaries

Consolidated Financial Statements

Years Ended December 31, 2010 and 2009

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ERNST & YOUNG

Ernst & Young LLP
155 North Wacker Drive
Chicago, IL 60606-1787
Tel: +1 312 879 2000
Fax: +1 312 879 4000
www.ey.com

Report of Independent Auditors

The Board of Directors
DuPage Medical Group, Ltd. and Subsidiaries

We have audited the accompanying consolidated balance sheets of DuPage Medical Group, Ltd. and Subsidiaries (Group) as of December 31, 2010 and 2009, and the related consolidated statements of operations, changes in stockholders' equity, and cash flows for the years then ended. These financial statements are the responsibility of the Group's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Group's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Group's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of DuPage Medical Group, Ltd. and Subsidiaries at December 31, 2010 and 2009, and the consolidated results of their operations and their cash flows for the years then ended, in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

April 21, 2011

DuPage Medical Group, Ltd. and Subsidiaries

Consolidated Balance Sheets

	December 31	
	2010	2009
Assets		
Current assets:		
Cash and cash equivalents	\$ 10,407,596	\$ 3,797,828
Patient accounts receivable, less allowances for uncollectible accounts of \$3,188,000 in 2010 and \$3,241,000 in 2009	25,350,256	24,529,661
Reinsurance receivable	3,502,124	928,735
Inventory	2,442,106	1,711,041
Prepaid expenses and other	6,651,700	6,615,508
Total current assets	48,353,782	37,582,773
Property and equipment, net	107,551,607	106,817,665
Goodwill	3,606,430	3,606,430
Deferred compensation and other	1,557,070	1,574,890
Total assets	<u>\$ 161,068,889</u>	<u>\$ 149,581,758</u>
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable	\$ 6,719,754	\$ 4,451,703
Accrued expenses	2,673,294	3,231,860
Accrued payroll and benefits	14,896,588	13,146,773
Due to third-party payor	5,474,271	5,389,309
Medical claims payable	3,000,000	3,623,000
Borrowings under line-of-credit agreement	—	1,500,000
Current maturities of long-term debt	12,525,093	1,878,454
Payable to physicians	11,411,217	8,685,268
Total current liabilities	56,700,217	41,906,367
Noncurrent liabilities:		
Long-term debt, less current maturities	25,305,413	37,687,929
Fair value of interest rate swaps	1,618,937	1,081,570
Deferred compensation	1,018,804	1,193,464
Deferred income tax, net	546,574	2,034,634
Professional liabilities	12,500,000	12,275,324
Total liabilities	97,689,945	96,179,288
Stockholders' equity:		
Common stock (\$1 par value; \$500,000 and \$230,000 authorized shares at December 31, 2010 and 2009, respectively; 235,000 and 217,000 shares issued and outstanding at December 31, 2010 and 2009, respectively)	235,000	217,000
Additional paid-in capital	2,750,000	2,570,000
Noncontrolling interest	1,018,149	943,272
Retained earnings	59,375,795	49,672,198
Total stockholders' equity	63,378,944	53,402,470
Total liabilities and stockholders' equity	<u>\$ 161,068,889</u>	<u>\$ 149,581,758</u>

See notes to consolidated financial statements.

DuPage Medical Group, Ltd. and Subsidiaries

Consolidated Statements of Operations

	Year Ended December 31	
	2010	2009
Revenues:		
Net patient service revenue	\$ 261,579,606	\$ 236,316,995
Capitation revenue	94,433,682	86,300,394
Other revenue	6,981,588	5,267,362
Total revenue	362,994,876	327,884,751
Expenses:		
Physician salaries, wages, and benefits	117,921,844	102,660,582
Nonphysician salaries, wages, and benefits	98,150,032	91,200,096
Medical claims	16,801,585	17,513,646
Rent and utilities	32,782,908	31,140,075
Medical supplies and other	41,891,170	36,302,002
Professional fees and purchased services	14,558,706	12,607,305
Insurance	5,309,406	5,178,579
Provision for uncollectible accounts	8,010,157	6,360,749
Interest	1,545,488	1,743,557
Depreciation	11,174,309	10,785,110
Total expenses	348,145,605	315,491,701
Other gains and (losses):		
Change in fair value of interest rate swaps	(537,367)	741,153
Total other gains and losses	(537,367)	741,153
Income before income taxes	14,311,904	13,134,203
Provision for income taxes	4,106,439	5,080,943
Consolidated net income	10,205,465	8,053,260
Less net income attributed to noncontrolling interest	(501,868)	(345,033)
Net income attributed to the Group	\$ 9,703,597	\$ 7,708,227

See notes to consolidated financial statements.

DuPage Medical Group, Ltd. and Subsidiaries

Consolidated Statements of Changes in Stockholders' Equity

	Common Stock	Additional Paid-In Capital	Retained Earnings	Noncontrolling Interest	Total Stockholders' Equity
Balance at January 1, 2009	\$ 195,000	\$ 2,350,000	\$ 41,963,971	\$ 681,958	\$ 45,190,929
Net income	-	-	7,708,227	-	7,708,227
Noncontrolling interest net income	-	-	-	345,033	345,033
Partnership distribution	-	-	-	(83,719)	(83,719)
Purchase of common stock	(2,000)	(20,000)	-	-	(22,000)
Issuance of common stock	24,000	240,000	-	-	264,000
Balance at December 31, 2009	217,000	2,570,000	49,672,198	943,272	53,402,470
Net income	-	-	9,703,597	-	9,703,597
Noncontrolling interest net income	-	-	-	501,868	501,868
Partnership distribution	-	-	-	(426,991)	(426,991)
Purchase of common stock	(5,000)	(50,000)	-	-	(55,000)
Issuance of common stock	23,000	230,000	-	-	253,000
Balance at December 31, 2010	<u>\$ 235,000</u>	<u>\$ 2,750,000</u>	<u>\$ 59,375,795</u>	<u>\$ 1,018,149</u>	<u>\$ 63,378,944</u>

See notes to consolidated financial statements.

DuPage Medical Group, Ltd. and Subsidiaries

Consolidated Statements of Cash Flows

	Year Ended December 31	
	2010	2009
Operating activities		
Net income attributed to the Group	\$ 9,703,597	\$ 7,708,227
Net income attributed to the noncontrolling interest	501,868	345,033
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation	11,174,309	10,785,110
Net loss on sales of property and equipment	27,507	77,540
Change in fair value of interest rate swap	537,367	(741,153)
Deferred income taxes	(1,488,060)	3,618,994
Provision for uncollectible accounts	8,010,157	6,360,749
Changes in operating assets and liabilities:		
Patient accounts receivable	(8,830,752)	(7,582,368)
Reinsurance receivable	(2,573,389)	87,808
Prepaid expenses and other	(36,192)	(2,082,482)
Inventory	(731,065)	129,701
Due to third-party payors	84,962	984,224
Accounts payable, accrued, and other current liabilities	3,459,300	(1,689,810)
Medical claims payable	(623,000)	(287,843)
Payable to physicians	2,725,949	1,484,858
Other noncurrent assets and liabilities	67,836	355,609
Cash provided by operating activities	22,010,394	19,554,197
Investing activities		
Purchases of property and equipment	(11,777,583)	(11,716,741)
Net cash used in investing activities	(11,777,583)	(11,716,741)
Financing activities		
Distributions to noncontrolling interest	(426,991)	(83,719)
Payments of debt and capital lease obligations	(3,394,052)	(5,987,710)
Purchase of common stock	(55,000)	(22,000)
Proceeds from issuance of stock	253,000	264,000
Net cash used in financing activities	(3,623,043)	(5,829,429)
Net increase in cash	6,609,768	2,008,027
Cash and cash equivalents at beginning of year	3,797,828	1,789,801
Cash and cash equivalents at end of year	<u>\$ 10,407,596</u>	<u>\$ 3,797,828</u>

See notes to consolidated financial statements.

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements

Years Ended December 31, 2010 and 2009

1. Organization and Basis of Presentation

DuPage Medical Group, Ltd. (the Group) is a multi-specialty physician practice that provides a broad range of outpatient services. The main office is in Glen Ellyn, Illinois, with 41 satellite offices throughout the western suburbs of Chicago, predominantly DuPage County, Illinois. The Group was incorporated as a medical corporation in the state of Illinois in July 1968 and is a for-profit, taxable corporation. The Group has 301 physicians, of which 235 are shareholders, at December 31, 2010.

Included in the Group's consolidated financial statements are all wholly owned and controlled subsidiaries. The Group's subsidiary corporations are DMG Real Estate, LLC (LLC), DMG Real Estate Holdings, LLC (REH), DMG Surgery Center, LLC (Surgery Center), and DMG Pain Management Surgery Center, LLC (Pain ASC).

LLC owns and operates medical office buildings in DuPage County.

The Surgery Center was formed in 2002 as a surgery center operation. Effective December 1, 2005, the Surgery Center amended and restated its operating agreement and sold a 12.5% ownership interest to a minority shareholder.

REH was formed in 2004 to acquire land and construct a surgery center facility.

Pain ASC was formed in 2009 as a pain management surgery center. Operations will begin in 2011.

All significant intercompany balances have been eliminated in consolidation.

2. Summary of Significant Accounting Policies

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Although estimates are considered to be fairly stated at the time that the estimates are made, actual results could differ from those estimates.

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

2. Summary of Significant Accounting Policies (continued)

Cash and Cash Equivalents

Cash and cash equivalents include currency on-hand, demand deposits with banks or other financial institutions, and short-term investments with maturities of 90 days or less from the date of purchase.

Patient Accounts Receivable

Patient accounts receivable are stated at net realizable value. The Group maintains allowances for uncollectible accounts for estimated losses resulting from a payor's inability to make payments on accounts. The Group evaluates the collectibility of its accounts receivable based upon the length of time the receivable is outstanding and the anticipated future uncollectible amounts based on historical experience. Accounts are written off when collection efforts have been exhausted.

Inventories

Inventories, consisting primarily of pharmaceuticals, are valued at the lower of cost or market, with cost determined using the first-in, first-out method.

Property and Equipment

Property and equipment are stated at cost. Provisions for depreciation of property and equipment are computed using the straight-line method based upon the estimated useful lives of the related assets, ranging from 10 to 40 years for land improvements and buildings and two to seven years for equipment. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation expense in the accompanying consolidated financial statements. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets.

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

2. Summary of Significant Accounting Policies (continued)

Goodwill

Goodwill is assessed for impairment on an annual basis through the comparison of the fair value of the respective reporting unit with its carrying value. Fair value is determined primarily based upon valuation studies performed by the Group, which consider discounted cash flows, physician compensation, and future earnings. Valuation analysis requires significant judgments and estimates to be made by management. Changes in market conditions, among other factors, may have an impact on these estimates, which may require future adjustments to the carrying value of goodwill.

Due to Third-Party Payor

Due to third-party payor represents the liability for funds received by the Surgery Center that are to be paid back to Blue Cross/Blue Shield as of December 31, 2010 and 2009. Blue Cross/Blue Shield pays the Surgery Center invoices at gross amounts and invoices the Surgery Center for the difference between the gross charges and the contracted rate.

Medical Claims Payable

Medical claims payable represents the estimated liability for claims expenses reported but not paid and for claims incurred but not reported to the Group for the years ended December 31, 2010 and 2009. Liabilities for unpaid claims and claims incurred but not reported are actuarially determined. The estimates used in determining the liabilities are subject to the effects of trends in claim severity and frequency. Although considerable variability is inherent in such estimates, management believes that the liabilities for unpaid claims are adequate. The estimates are continually reviewed and adjusted as necessary as experience develops or new information becomes known; such adjustments are included in current operations.

Noncontrolling Interest

The Group's noncontrolling interest in the consolidated statements of operations represents the noncontrolling shareholder's share of the Surgery Center's operations. The noncontrolling interest in the consolidated balance sheets reflects the original investment by a noncontrolling shareholder in the Surgery Center subsidiary, along with the noncontrolling interest's share of the Surgery Center's subsequent operations.

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

2. Summary of Significant Accounting Policies (continued)

Asset Impairment

The Group considers whether indicators of impairment are present and performs the necessary tests to determine if the carrying value of an asset is appropriate. Impairment write-downs are recognized in operating expenses at the time the impairment is identified. There was no impairment of long-lived assets in 2010 and 2009.

Payable to Physicians

Payable to physicians represents the amount of calculated compensation based upon the shareholder compensation formula that has not been paid as of the end of a given reporting period. These amounts are calculated and distributed to individual physicians on a monthly basis.

General and Professional Liability

The provision for self-insured general and professional liability claims includes estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Net Patient Service Revenue

The Group has agreements with third-party payors that provide for payments to the Group at amounts different from its established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated adjustments under reimbursement agreements. Those adjustments are accrued on an estimated basis, and are adjusted in future periods.

Capitation Revenue

The Group has agreements with various health maintenance organizations (HMO) under which the Group provides or arranges for medical care to members of the organizations in return for a monthly payment per member (capitation revenue).

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

2. Summary of Significant Accounting Policies (continued)

Reinsurance

The Group's capitation agreements include reinsurance arrangements, which limit the Group's expenses on individual patients. Under the terms of the agreements, the Group will be reimbursed a portion of the cost incurred for each patient's annual physician services in excess of a deductible outlined in each agreement. Amounts reimbursable from reinsurance contracts are recorded as reinsurance receivable as outlined in each agreement. Amounts received under reinsurance agreements related to claims paid to external parties are included as a reduction in medical claims expense. Amounts reimbursed related to services provided by the Group are reflected in capitation revenue.

Community Services Provided

The Group provides care to patients who meet certain criteria without charge or at amounts less than established rates. Community services provided by the Group are excluded from net patient service revenue.

The forgone charges related to community services provided by the Group to the DuPage Community Clinic amounted to \$2,442,000 and \$2,302,000 for the years ended December 31, 2010 and 2009, respectively.

Derivative Instruments

Derivative instruments, specifically interest rate swaps, are reported in the consolidated balance sheets at their respective fair values. The change in the fair value of those derivative instruments is reflected in net income.

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

2. Summary of Significant Accounting Policies (continued)

New Accounting Pronouncements

In August 2010, the Financial Accounting Standards Board (FASB) issued ASU No. 2010-24, *Presentation of Insurance Claims and Related Insurance Recoveries*. The provisions of ASU 2010-24 are intended to address the current diversity in practice related to health care entities for medical malpractice claims and similar liabilities and their related anticipated insurance recoveries. ASU 2010-24 clarifies that a health care entity should not net insurance recoveries against a related claim liability. Additionally, the amount of the claim liability should be determined without consideration of insurance recoveries. This new guidance is effective for fiscal years beginning after December 15, 2010, with early application permitted. The Group is currently evaluating the impact to the consolidated financial statement disclosures.

3. Net Patient Service and Capitation Revenue

Net patient service and capitation revenue represents amounts received and the estimated net realizable amounts due from patients and third-party payors for services rendered. The Group provides certain medical care services to members of various HMOs. For these patients, the Group recognizes prepaid capitation revenue each month during the period in which the Group is obligated to provide medical care services, which is typically one year. Under the terms of these capitation agreements, the Group is obligated to provide specified medically necessary services to covered HMO members without regard to the underlying standard charges or actual costs of such services. These arrangements include the Group's assumption of financial responsibility for the appropriate and effective utilization of hospital and other healthcare resources. Capitation received under these agreements was \$94,400,000 and \$86,300,000 for the years ended December 31, 2010 and 2009, respectively. Estimates for incurred but not reported claims expenses, included in medical claims payable, have been provided for based upon the Group's historical claims experience. During 2010 and 2009, changes in estimates relating to prior years' medical claims payable liability increased net income by approximately \$1,348,000 and \$944,000, respectively.

The Group has entered into reinsurance arrangements to provide reinsurance coverage for patients in which the Group received capitation. The agreements provide protection to the Group for a percentage of losses that exceed the \$14,000 and \$13,000 deductible per member per year for the years ended December 31, 2010 and 2009, respectively.

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

3. Net Patient Service and Capitation Revenue (continued)

Provisions have been made in the consolidated financial statements for contractual adjustments, representing the difference between the standard charges for services and estimated payments to be received from third-party payors. The Group's concentration of credit risk related to the accounts receivable is limited due to the diversity of patients and payors.

The mix of receivables from patients and third-party payors at December 31 consisted of the following:

	2010	2009
Medicare	16%	12%
Medicaid	2	2
Managed care	24	29
Blue Cross/Blue Shield	22	20
Private pay and other	36	37
	<u>100%</u>	<u>100%</u>

The Group grants credit without collateral from its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of net patient service revenue from patients and third-party payors at December 31 was as follows:

	2010	2009
Medicare	20%	18%
Medicaid	1	1
Managed care	31	34
Blue Cross/Blue Shield	42	40
Private pay and other	6	7
	<u>100%</u>	<u>100%</u>

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

4. Property and Equipment

Property and equipment consist of the following at December 31:

	2010	2009
Land	\$ 13,140,482	\$ 13,140,482
Land improvements	5,434,067	5,424,302
Buildings	58,505,937	58,328,848
Equipment	95,512,247	85,261,286
	<u>172,592,733</u>	<u>162,154,918</u>
Accumulated depreciation	(66,982,521)	(55,979,884)
	<u>105,610,212</u>	<u>106,175,034</u>
Construction-in-process	1,941,395	642,631
	<u>\$ 107,551,607</u>	<u>\$ 106,817,665</u>

5. Long-Term Debt

Long-term debt consists of the following at December 31:

	2010	2009
Stratford mortgage payable to bank	\$ 1,906,884	\$ 2,047,436
Lombard mortgage payable to bank	9,358,346	9,848,740
Rickert mortgage payable to bank – purchase	4,338,400	4,535,600
Rickert mortgage payable to bank – construction	3,157,737	3,298,603
430 Pennsylvania mortgage payable to bank	18,836,068	19,655,028
Capital lease obligations	233,071	180,976
	<u>37,830,506</u>	<u>39,566,383</u>
Current maturities	(12,525,093)	(1,878,454)
	<u>\$ 25,305,413</u>	<u>\$ 37,687,929</u>

The carrying value of the debt approximates the fair value of the debt at December 31, 2010.

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

5. Long-Term Debt (continued)

Proceeds from the Stratford mortgage loan were used to finance the purchase of DMG-RE properties during 1999, pay certain fees and expenses associated with the acquisition, and retain sufficient working capital. The mortgage loan is due in monthly principal payments of \$11,713 plus interest with a maturity date of October 2011. The interest rate is variable with an average rate of 2.05% for 2010, and 2.42% for 2009.

Proceeds from the Lombard mortgage loan were used to finance the construction of the building at 1801 S. Highland Ave. in Lombard. The mortgage loan is collateralized with the building, which has a net book value of \$16,900,000. The mortgage loan is due in monthly principal payments of \$40,866 plus interest with a maturity date of October 2011. The interest rate is variable with an average rate of 2.07% for 2010, and 2.13% for 2009.

Proceeds from the Rickert mortgage loan were used to purchase the land at 808 Rickert in Naperville. The mortgage loan is collateralized with the property, which has a net book value of \$9,600,000. The mortgage is due in monthly principal payments of \$16,433 plus interest with a maturity date of July 2017. Payments commenced in January 2008. The interest rate is variable with an average rate of 1.44% for 2010, and 1.53% for 2009.

Proceeds from the Rickert mortgage loan were used to finance the construction and buildout of the building at 808 Rickert in Naperville. The mortgage loan is collateralized with the building, which has a net book value of \$9,600,000. The mortgage loan is due in monthly principal payments of \$11,739 plus interest with a maturity date of May 2018. The interest rate is variable with an average rate of 1.44% for 2010, and 2.64% for 2009.

Proceeds from the 430 Pennsylvania mortgage loan were used to finance the construction of the building at 430 Pennsylvania Ave. in Glen Ellyn. The construction loan outstanding at December 31, 2007, was converted into this mortgage loan during 2008. The mortgage loan is collateralized with the building, which has a net book value of \$24,500,000. The mortgage loan is due in monthly principal payments of \$68,247 plus interest, which started in January 2009 with a maturity date of June 2015. The interest rate is variable with an average rate of 1.79% for 2010, and 2.04% for 2009.

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

5. Long-Term Debt (continued)

At December 31, 2010 and 2009, the Group had a line of credit with a bank totaling \$10,500,000. The Group may advance from the line of credit at a rate equal to 61.35% of the Group's eligible accounts receivable balances. The Group repaid the outstanding balance on the line of credit in 2010. There was no amount outstanding on the line of credit at December 31, 2010. The amount outstanding on the line of credit as of December 31, 2009 was \$1,500,000. The interest rate is variable with an average rate of 4.01% paid monthly. The line of credit expired on November 30, 2010. On April 21, 2011, the Group signed a loan agreement with the bank to extend the line of credit through December 31, 2012. The loan agreement was dated effective December 31, 2010, but will be executed on April 29, 2011.

At December 31, 2010, the Group did not have a letter of credit. At December 31, 2009, the Group had one letter of credit in the amount of \$280,000. No amounts were drawn on the letter of credit.

Maturities of long-term debt, excluding capital lease obligations, for each of the next five years ending December 31 are as follows:

2011	\$ 12,422,255
2012	1,157,025
2013	1,157,025
2014	1,157,025
2015	15,898,296

Interest paid during the years ended December 31, 2010 and 2009, amounted to \$735,000 and \$909,000, respectively.

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

6. Interest Rate and Basis Swaps

The Group has various derivative instruments to manage the exposure on interest rates and the Group's interest expense. Through the use of derivative financial instruments, the Group is exposed to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of the derivative contract is positive, the counterparty owes the Group, which creates credit risk to the Group. When the fair value of the derivative contract is negative, the Group owes the counterparty, and there is no credit risk to the Group at that point in time. The Group minimizes the credit risk in derivative instruments by entering into transactions that require the counterparty to post collateral for the benefit of the fair value of the derivative contract. Market risk is the adverse effect on the value of the financial instrument that results from a change in interest rates. Swap management is meant to be long-term in nature, and any modifications to the program are reviewed for the long-term costs and benefits. Management also mitigates risk through periodic reviews of its derivative position in the context of its total blended cost of capital.

The Group entered into an interest rate swap in which a counterparty agreed to make variable payments based upon a market interest rate. The interest rate swap effectively fixed the total interest rate paid on the DMG-RE mortgage of \$5,417,190 at 6.07%. The fair value of the interest rate swap was \$(128,384) and \$(227,815) at December 31, 2010 and 2009, respectively, and is reported in noncurrent liabilities in the accompanying consolidated balance sheets. The change in the fair value of the interest rate swap is included in the consolidated statements of operations.

In 2007, the Group entered into a second interest rate swap in which a counterparty agreed to make variable payments based upon a market interest rate. The interest rate swap effectively fixed the total interest rate paid on the DMG LLC mortgage of \$4,930,000 at 6.785%. The fair value of the interest rate swap was \$(717,823) and \$(585,087) at December 31, 2010 and 2009, respectively, and is reported in noncurrent liabilities in the accompanying consolidated balance sheets, and the change in the fair value of the interest rate swap is included in the consolidated statements of operations.

In 2008, the Group entered into a third interest rate swap in which a counterparty agreed to make variable payments based upon a market interest rate. The interest rate swap effectively fixed the total interest rate paid on the DMG LLC mortgage of \$3,521,640 at 6.03%. The fair value of the interest rate swap was \$(403,767) and \$(284,656) at December 31, 2010 and 2009, respectively, and is reported in noncurrent liabilities in the accompanying consolidated balance sheets, and the change in the fair value of the interest rate swap is included in the consolidated statements of operations.

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

6. Interest Rate and Basis Swaps (continued)

In 2009, the Group entered into a fourth interest rate swap in which a counterparty agreed to make variable payments based upon a market interest rate. The interest rate swap effectively fixed the total interest rate paid on the DMG LLC mortgage of \$10,202,870 at 4.30%. The fair value of the interest rate swap was \$(368,963) and \$15,988 at December 31, 2010 and 2009, respectively, and is reported net in noncurrent liabilities in the accompanying consolidated balance sheet, and the change in the fair value of the interest rate swap is included in the consolidated statement of operations.

The following is a summary of the outstanding interest rate swaps as of December 31, 2010:

<u>Origination Date</u>	<u>Notional Amounts</u>	<u>Swap Position</u>	<u>Maturity Date</u>
11/23/04	\$ 3,995,503	Pay Fixed	10/31/11
07/25/07	4,338,400	Pay Fixed	07/13/17
06/20/08	3,157,737	Pay Fixed	05/31/18
01/05/09	9,418,034	Pay Fixed	06/30/15
Net position	<u>\$ 20,909,674</u>		

The fair value of derivative instruments not designated as hedging instruments at December 31 is as follows:

<u>Type of Derivative</u>	<u>Liability Derivatives</u>		
	<u>Balance Sheet Location</u>	<u>2010</u>	<u>2009</u>
Interest rate contracts	Noncurrent liabilities	<u>\$ 1,618,937</u>	<u>\$ 1,081,570</u>

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

6. Interest Rate and Basis Swaps (continued)

The effects of the derivative instruments not designated as hedging instruments on the consolidated statements of operations for the years ended December 31 are as follows:

Type of Derivative	Classification of (Gain) Loss Recognized in Consolidated Net Income	Amount of Loss (Gain) Recognized in Consolidated Net Income	
		2010	2009
Interest rate contracts	Interest expense	\$ 810,409	\$ 834,865
	Change in fair value of interest rate swaps	\$ 537,367	\$ (741,153)

7. Leases

The Group leases certain office space and equipment under various noncancelable operating leases. These leases contain various terms and typically provide for renewal at prevailing market rates. Rental expense for operating leases amounted to \$12,160,000 and \$11,506,000 for the years ended December 31, 2010 and 2009, respectively.

Future minimum lease payments under noncancelable capital and operating leases, having an initial term of more than one year at December 31, 2010, are as follows:

	Capital Leases	Operating Leases
2011	\$ 109,213	\$ 6,487,353
2012	57,409	4,819,103
2013	26,916	2,725,682
2014	26,916	907,584
2015	24,672	1,115,363
Total minimum lease payments	245,126	16,055,085
Interest	(12,056)	—
Present value of minimum lease payments	\$ 233,070	\$ 16,055,085

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

7. Leases (continued)

Included in equipment are assets under capital leases, which aggregated \$6,751,982 with accumulated depreciation of \$6,194,023 at December 31, 2010. The Group entered into three new capital lease arrangements for 2010, totaling \$158,175. There were capital lease arrangements entered into 2009, totaling \$186,776.

8. Employee Benefit and Retirement Plans

The Group maintains and contributes to a defined-contribution plan covering substantially all employees and physicians. The employer contributions under the plan are comprised of an elective profit sharing contribution and a 401(k) matching contribution. Contribution expense under this plan, which is included in both physician salaries, wages, and benefits, and nonphysician salaries, wages, and benefits was approximately \$8,353,000 and \$7,723,000 for the years ended December 31, 2010 and 2009, respectively.

9. Related-Party Transactions

During 2010 and 2009, the Group purchased and retired the stock of certain physicians who departed from the organization in the amount of \$55,000 and \$22,000, respectively.

The Group leases medical office space from two different physician-owned partnerships or trusts. The total rental expense related to these leases amounted to approximately \$237,000 and \$225,000 for the years ended December 31, 2010 and 2009, respectively.

10. Income Taxes

As a personal service corporation, the Group uses the cash basis method of accounting to prepare its income tax filings. The use of the cash basis method of accounting for tax return reporting purposes results in a difference between financial statement accrual basis income and the Group's cash basis taxable income as reported on its tax returns.

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DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

10. Income Taxes (continued)

The Group has deferred income taxes due to temporary differences between financial reporting and tax reporting for certain assets and liabilities. Significant components of the Group's deferred tax assets and liabilities as of December 31 are as follows:

	2010	2009
Deferred tax assets:		
Difference in accrual and cash basis book income	\$ 4,917,890	\$ 3,684,760
Professional liability	534,615	546,173
Deferred compensation	404,923	474,342
Accrued expenses	63,782	(164,480)
Total deferred tax assets	5,921,210	4,540,795
Deferred tax liabilities:		
Depreciation	(5,234,328)	(5,344,346)
Amortization	(1,209,451)	(1,194,533)
Prepaid expenses	(11,200)	(10,723)
Other liabilities	(12,805)	(25,827)
Total deferred tax liabilities	(6,467,784)	(6,575,429)
Net deferred tax liability	\$ (546,574)	\$ (2,034,634)

Provisions for income taxes consist of the following:

	2010	2009
Current:		
Federal	\$ 4,541,550	\$ 1,030,927
State	1,052,949	431,022
	5,594,499	1,461,949
Deferred	(1,488,060)	3,618,994
Total provision for income taxes	\$ 4,106,439	\$ 5,080,943

The effective income tax rate varies from the prevailing corporate income tax rate of 35% primarily due to state taxes. The Group paid \$3,950,000 and \$2,000,000 of income taxes during 2010 and 2009, respectively.

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

11. Professional Liability Insurance

Effective August 15, 2010, the Group purchased professional liability insurance, on a claims-made basis, with annual limits of \$2,000,000 for three orthopedic spine surgeons, \$1,000,000 for all other physicians per occurrence, and \$235,000,000 in the aggregate for the Group.

Effective August 15, 2009, the Group purchased professional liability insurance, on a claims-made basis, with annual limits of \$2,000,000 for three orthopedic spine surgeons, \$1,000,000 for all other physicians per occurrence, and \$235,000,000 in the aggregate for the Group.

Effective August 15, 2008, the Group purchased professional liability insurance, on a claims-made basis, with annual limits of \$2,000,000 for three orthopedic spine surgeons, \$1,000,000 for all other physicians per occurrence, and \$190,000,000 in the aggregate for the Group.

The Group has provided for losses in excess of insurance coverage and for losses resulting from the liquidation of the Group's previous insurance carrier. Estimated liabilities related to losses in excess of insurance coverage amounted to approximately \$3,800,000 at December 31, 2010 and 2009.

Management is not aware of any factors that would cause insurance expense to vary materially from the amounts provided. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during 2010 and prior, but reported subsequently, may not be insured. Estimated reserves for incurred but not reported claims expenses have been provided for based on the Group's historical claims experience and amounted to approximately \$8,700,000 and \$8,475,000 at December 31, 2010 and 2009, respectively.

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

12. Fair Value Disclosures

The Group evaluates the carrying amounts of significant classes of financial instruments in the consolidated balance sheets for disclosure of fair values for which it is practicable. The carrying amounts of cash and cash equivalents, patient accounts receivable, other current assets, accounts payable, and accrued expenses approximate fair value because of the short-term nature of those instruments.

The Group adopted Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements*, which establishes a three-level valuation hierarchy for disclosure of fair value measurements. The valuation hierarchy is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

- Level 1 – Inputs to the valuation methodology are quoted prices (unadjusted) for identical assets or liabilities in active markets.
- Level 2 – Inputs to the valuation methodology include quoted prices for similar assets or liabilities in active markets, and inputs that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the financial instruments.
- Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement of the assets or liabilities.

The following table presents financial assets and liabilities measured at fair value on a recurring basis as of December 31, 2010, by ASC Topic 820 valuation hierarchy.

	Level 1	Level 2	Level 3	Total Fair Value
Assets				
Investment held for deferred compensation	\$ 1,018,804	\$ –	\$ –	\$ 1,018,804
Liabilities				
Interest rate swaps	\$ –	\$ 1,618,937	\$ –	\$ 1,618,937

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

12. Fair Value Disclosures (continued)

The following table presents financial assets and liabilities measured at fair value on a recurring basis as of December 31, 2009, by ASC Topic 820 valuation hierarchy.

	Level 1	Level 2	Level 3	Total Fair Value
Assets				
Investment held for deferred compensation	\$ 1,193,464	\$ -	\$ -	\$ 1,193,464
Liabilities				
Interest rate swaps	\$ -	\$ 1,081,570	\$ -	\$ 1,081,570

Investments held for deferred compensation – The investments in deferred compensation are comprised of mutual fund investments for which identical quotes exist on active exchanges. These securities are classified as Level 1.

Interest rate swaps – Derivative financial instruments consist solely of interest rate swap agreements with interest rate terms that are observable based upon forward interest rate curves and are therefore considered Level 2 inputs.

The credit risk adjustment related to the fair value of the four swap agreements was an increase in value in total of \$46,197 and \$12,305 at December 31, 2010 and 2009, respectively.

13. Commitments and Contingencies

The Group is a defendant in various lawsuits arising in the ordinary course of business. Although the outcome of these lawsuits cannot be predicted with certainty, management believes the ultimate disposition of such matters will not have a material effect on the Group's consolidated financial condition or operations.

14. Subsequent Events

The Group evaluated subsequent events and transactions occurring subsequent to December 31, 2010 through April 21, 2011, the date the financial statements were available to be issued. During this period, there were no subsequent events requiring recognition or disclosure in the consolidated financial statements.

Ernst & Young LLP

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Attachment 41-Exhibit 2
Consolidated Financial Statements of
DMG Real Estate, LLC
From 2009 – 2011

Please Note: The consolidated financial statements included in Attachment 41-Exhibit 2 are those for both DMG Real Estate, LLC and DMG Real Estate Holdings, LLC. They are the figures upon which the viability ratios, discussed in Attachment 41, are based.

**DuPage Medical Group
Consolidated Income Statement (LLC & REH)
For Fiscal Years 2009-2011**

	2009	2010	2011
Revenues			
Property Rental Revenue	6,302,872	6,293,240	6,135,170
Operating Revenue	-	27,717	126,674
Total Revenue	<u>6,302,872</u>	<u>6,320,957</u>	<u>6,261,844</u>
Operating Expenses			
Depreciation Expense	1,714,812	1,731,431	1,739,775
Consulting Expense	30,045	30,207	-
Legal Expense	5,700	28,837	-
Licensing	609	1,184	-
Interest Expense - Loans	797,242	696,332	607,517
Interest Expense - Swap	834,865	810,409	752,467
Total Operating Expenses	<u>3,383,273</u>	<u>3,298,400</u>	<u>3,099,760</u>
Net Operating Income	<u>2,919,599</u>	<u>3,022,557</u>	<u>3,162,084</u>

**DuPage Medical Group
Consolidated Balance Sheet (LLC & REH)
For Fiscal Years 2009-2011**

	2009	2010	2011
Assets			
Current Assets:			
Notes Receivable - Current Portion	(22,331,508)	(20,072,936)	(23,385,212)
Other Assets:			
Property & Equipment	71,401,543	70,316,325	74,252,108
Total Assets	49,070,035	50,243,389	50,866,896
Liabilities & Shareholder's Equity			
Current Liabilities			
Accrued Expenses	158,011	96,779	1,112,504
Debts Payable - Current Portion	1,787,971	12,422,255	1,647,419
Non-Current Liabilities			
Debts Payable - LT Portion	37,597,436	25,175,181	32,395,714
Total Liabilities	39,543,417	37,694,215	35,155,637
Shareholder's Equity			
Partner's Equity	1,700,000	1,700,000	1,700,000
Investor Investment	(68,000)	(68,000)	(68,000)
Retained Earnings	7,894,617	10,917,174	14,079,258
Total Shareholder's Equity	9,526,617	12,549,174	15,711,258
Total Liabilities & Shareholders Equity	49,070,035	50,243,389	50,866,896

SECTION X – ECONOMIC FEASIBILITY

Criterion 1110.140 – Economic Feasibility

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.

See Attachment 42-Exhibit 1 for a signed, notarized statement from a representative of DMG that (1) 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 and (2) that the selected form of debt financing for the project will be at the lowest net cost available.

B. Conditions of Debt Financing

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.

See Attachment 42-Exhibit 1 for a signed, notarized statement from a representative of DMG that (1) 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 and (2) that the selected form of debt financing for the project will be at the lowest net cost available.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department	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)	
Imaging	\$291	N/A	14,138		N/A	N/A	\$4,114,158	N/A	\$4,114,158
Primary Care, etc. *	\$291	N/A	13,329		N/A	N/A	\$3,878,739	N/A	\$3,878,739
Phys. Off. (Gen.) *	\$291	N/A	15,593		N/A	N/A	\$4,537,563	N/A	\$4,537,563
Rad. Onc.	\$291	N/A	5,655		N/A	N/A	\$1,645,605	N/A	\$1,645,605
Linear Accelerator	\$524	N/A	965		N/A	N/A	\$505,660	N/A	\$505,660
Chemo & Infusion	\$291	N/A	12,927		N/A	N/A	\$3,761,757	N/A	\$3,761,757
Phys. Off. (Onc.) *	\$291	N/A	11,728		N/A	N/A	\$3,412,848	N/A	\$3,412,848
Contingency	Included above	N/A	N/A		N/A	N/A	Included in Total	N/A	Included in Total
TOTALS		N/A	74,335		N/A	N/A	\$21,856,330	N/A	\$21,856,330
*Considered non-clinical									

See Attachment 42-Exhibit 2 for documentation as to the cost/square foot for the building as a whole and the premium cost/square foot for the buildout necessary to house the linear accelerator.

D. Projected Operating Costs

The projected direct annual operating costs are delineated in the table below:

OPERATING COSTS	
Annual Principal Payments (25 Years)	\$911,173.12
Average Interest at 7%	\$797,276.48
Estimated Real Estate Taxes	\$500,000.00
Building Operating Expenses	\$918,750.00
TOTAL	\$3,127,200.58

Total Patient Visits = 86,700

Operating Cost/Visit = \$36.07

E. Total Effect of the Project on Capital Costs

CAPITAL COSTS	
Furniture & Fixtures	\$700,000
IT, Phones & Infrastructure	\$400,000
TOTAL	\$1,100,000

Total Patient Visits = 86,700

Capital Cost/Visit = \$12.69

May 25, 2012

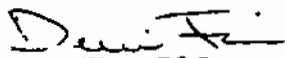
Dale Galassie, Chairman
Illinois Health Facilities and
Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chairman Galassie,

I hereby attest that, for the DuPage Medical Group Medical Office Building project, borrowing is less costly than the liquidation of existing investments and that the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

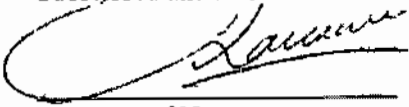
Furthermore, I certify that, as this project will require debt financing, the selected form of debt financing will be at the lowest net cost available.

Respectfully,


Dennis Fine, COO
DuPage Medical Group

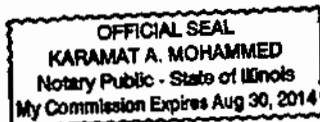
Notarization:

Subscribed and sworn to before me this 25th day of MAY, 2012.



Signature of Notary
STATE: ILLINOIS
COUNTY: DUPAGE.

SEAL



Attachment 42-Exhibit 2
Cost/Square Foot Documentation



CONSTRUCTION

DESIGN - BUILD

DEVELOPMENT

January 25, 2012

Mr. Dennis Fine
DuPage Medical Group
1100 West 31st Street
Suite 300
Downers Grove, Illinois 60515

RE: LCI #11-3423
DuPage Medical Group Oncology Institute
Linear Accelerator Premium Cost

Dear Dennis:

As you have requested, we have analyzed the cost to build Linear Accelerator room #W121 and compared this cost against the average construction cost for the rest of the building.

There is a premium of approximately \$225,319 to build Linear Accelerator room #W121 as compared to the average cost of building other spaces within the building.

A cost summary is attached for your reference.

Please call with any questions.

Respectfully,

Leopardo Construction

Michael Mastin
Project Manager

Attachment 42-Exhibit 2



Linear
Accelerator
W121
965 s.f.

DIVISION 1	
GC/GR	\$12,750
DIVISION 2 - Earthwork	
02000 Excavation/Backfill	\$16,402
DIVISION 3 - Concrete	
03300 Concrete Placement	\$248,520
DIVISION 6 - Wood & Plastics	
06100 Carpentry	\$3,885
06400 Millwork/Plastic Laminates	\$21,905
DIVISION 7 - Thermal & Moisture Protection	
07111 Waterproofing	\$12,995
DIVISION 8 - Doors & Windows	
08110 Metal Doors & Frames	N/A
08811 Miscellaneous Glazing	N/A
08300 LINAC Doors	\$33,947
DIVISION 9 - Finishes	
09006 Plaster	\$15,300
09252 Metal Stud & Drywall	\$25,124
09310 Hard Tile	N/A
09560 Resilient Tile Flooring & Base	\$6,038
09695 Floor Preparation - Misc.	\$481
09510 Acoustical Ceilings	\$2,752
09900 Painting & Wall	\$5,432
DIVISION 10 - Special	
10190 Hospital Cubicle	N/A
10260 Wall & Corner Guards	N/A
10800 Toilet Accessories	N/A
DIVISION 12 - Furnishings	
12530 Window Treatment	N/A
DIVISION 15 - Mechanical	
15300 Fire Protection	\$2,550
15400 Plumbing	\$5,457
15500 H.V.A.C.	\$34,660
DIVISION 16 - Electrical	
16001 Electrical-Building	\$32,032
TRADE SUB-TOTAL	\$480,247
Liability Insurance	\$4,620
Contingency	\$10,360
Contractor's Fee	\$10,567
Linac #W121 SUB-TOTAL	\$505,795
Cost/SF for Linac #W121	\$524
Average Cost/SF for Remainder of Building	\$291
Premium Cost/SF for Linac #W121	\$233
Total Premium for Linac #W121	\$225,319

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SECTION XII – CHARITY CARE INFORMATION

The tables below contain the relevant charity care information for DuPage Medical Group, Ltd. and Rush University Medical Center, respectively.

Charity Care Information for DuPage Medical Group, Ltd.

DuPage Medical Group, Ltd. reports charity care on a consolidated basis. Therefore, the information in the table below is for DuPage Medical Group, Ltd. as a whole.

CONSOLIDATED CHARITY CARE INFORMATION FOR DMG			
	FY 2009 (in thousands)	FY 2010 (in thousands)	FY 2011 (in thousands)
Net Patient Revenue	\$236,317	\$261,580	\$287,259
Amount of Charity Care (charges)	\$2,302	\$2,442	\$2,843
Cost of Charity Care	\$1,236	\$1,368	\$1,461
Ratio of Charity Care to Net Patient Revenue	0.005	0.005	0.005

For documentation as to DMG's charity care, please see Attachment 44-Exhibit 1 which comes from DMG's consolidated financial statements for the years ending December 31, 2011, 2010, and 2009 respectively. Note these financial statements contain only the amount of charity care charges. The cost of charity care was for 2009 - \$1,236,000; 2010 - \$1,368,000; and 2011 - \$1,461,000, respectively.

Charity Care Information for Rush University Medical Center

Information pertaining to Rush University Medical Center's charity care is included here as RUMC is considered a co-applicant. To fulfill this requirement, the applicants have included information pertaining to RUMC's charity care as submitted in a CON application earlier this year.¹ This is allowed under 77 Ill. Adm. Code §1110.230(a)(4), which states:

"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."

Included below is all charity care information as submitted in that previous application, including for (1) Rush University Medical Center; (2) Rush Oak Park Hospital and (3) the consolidated statements for Rush University Medical Center and Rush Oak Park Hospital. However, only Rush University Medical Center is considered a co-applicant for this project.

¹ Project 12-011 the application for which was received by the Board on January 31, 2012.

CHARITY CARE INFORMATION FOR RUMC			
	FY 2009 (in thousands)	FY 2010 (in thousands)	FY 2011 (in thousands)
Net Patient Revenue	\$1,038,134	\$1,079,553	\$1,118,958
Amount of Charity Care (charges)	\$53,737	\$59,180	\$65,788
Cost of Charity Care	\$15,339	\$16,756	\$18,124
Ratio of Charity Care to Net Patient Revenue	1.5%	1.67%	1.67%

CHARITY CARE INFORMATION FOR RUSH OAK PARK HOSPITAL			
	FY 2009 (in thousands)	FY 2010 (in thousands)	FY 2011 (in thousands)
Net Patient Revenue	\$98,827	\$103,911	\$102,497
Amount of Charity Care (charges)	\$3,393	\$3,264	\$3,684
Cost of Charity Care	\$705	\$889	\$1,000
Ratio of Charity Care to Net Patient Revenue	0.77%	0.97%	1.0%

CONSOLIDATED CHARITY CARE INFORMATION FOR RUSH SYSTEM FOR HEALTH			
	FY 2009 (in thousands)	FY 2010 (in thousands)	FY 2011 (in thousands)
Amount of Charity Care Charges	\$57,130	\$62,444	\$69,472
Cost of Charity Care	\$16,044	\$17,645	\$19,124
Net Patient Revenue	\$1,136,961	\$1,183,464	\$1,221,455
Ratio of Charity Care to Net Patient Revenue	1.4%	1.5%	1.6%

For documentation that this data has been previously submitted to the Board, please see Attachment 44-Exhibit 2, which comes from the application for Project 12-011, submitted January 31, 2012.

ATTACHMENT 44-EXHIBIT 1
Note: From the 2011 and 2010 Consolidated Financial
Statements of DuPage Medical Group, Ltd.

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

2. Summary of Significant Accounting Policies (continued)

Reinsurance

The Group's capitation agreements include reinsurance arrangements, which limit the Group's expenses on individual patients. Under the terms of the agreements, the Group will be reimbursed a portion of the cost incurred for each patient's annual physician services in excess of a deductible outlined in each agreement. Amounts reimbursable from reinsurance contracts are recorded as reinsurance receivable as outlined in each agreement. Amounts received under reinsurance agreements related to claims paid to external parties are included as a reduction in medical claims expense. Amounts reimbursed related to services provided by the Group are reflected in capitation revenue.

Community Services Provided

The Group provides care to patients who meet certain criteria without charge or at amounts less than established rates. Community services provided by the Group are excluded from net patient service revenue.

The forgone charges related to community services provided by the Group to the DuPage Community Clinic amounted to approximately \$2,843,000 and \$2,442,000 for the years ended December 31, 2011 and 2010, respectively.

Derivative Instruments

Derivative instruments, specifically interest rate swaps, are reported in the consolidated balance sheets at their respective fair values. The change in the fair value of those derivative instruments is reflected in net income.

Reclassifications

Certain amounts in the 2010 consolidated financial statements have been reclassified to conform to the 2011 presentation. These reclassifications had no impact on stockholders' equity or net income.

ATTACHMENT 44-EXHIBIT 1
Note: From the 2010 and 2009 Consolidated Financial
Statements of DuPage Medical Group, Ltd.

DuPage Medical Group, Ltd. and Subsidiaries

Notes to Consolidated Financial Statements (continued)

2. Summary of Significant Accounting Policies (continued)

Reinsurance

The Group's capitation agreements include reinsurance arrangements, which limit the Group's expenses on individual patients. Under the terms of the agreements, the Group will be reimbursed a portion of the cost incurred for each patient's annual physician services in excess of a deductible outlined in each agreement. Amounts reimbursable from reinsurance contracts are recorded as reinsurance receivable as outlined in each agreement. Amounts received under reinsurance agreements related to claims paid to external parties are included as a reduction in medical claims expense. Amounts reimbursed related to services provided by the Group are reflected in capitation revenue.

Community Services Provided

The Group provides care to patients who meet certain criteria without charge or at amounts less than established rates. Community services provided by the Group are excluded from net patient service revenue.

The forgone charges related to community services provided by the Group to the DuPage Community Clinic amounted to \$2,442,000 and \$2,302,000 for the years ended December 31, 2010 and 2009, respectively.

Derivative Instruments

Derivative instruments, specifically interest rate swaps, are reported in the consolidated balance sheets at their respective fair values. The change in the fair value of those derivative instruments is reflected in net income.

ATTACHMENT 44-EXHIBIT 2
Note: From RUMC's CON Application for
Project 12-011, Received 1/31/2012 (page 270)

Rush University Medical Center

RUMC CHARITY CARE			
	FY 2011 (in thousands)	FY 2010 (in thousands)	FY 2009 (in thousands)
Net Patient Revenue	1,118,958	1,079,553	1,038,134
Amount of Charity Care (charges)	65,788	59,180	53,737
Cost of Charity Care	18,124	16,756	15,339
Ratio of Charity Care to Net Patient Revenue	1.67%	1.67%	1.5%

Source: RUMC Records

Rush Oak Park Hospital

ROPH CHARITY CARE			
	FY 2011 (in thousands)	FY 2010 (in thousands)	FY 2009 (in thousands)
Net Patient Revenue	102,497	103,911	98,827
Amount of Charity Care (charges)	3,684	3,264	3,393
Cost of Charity Care	1,000	889	705
Ratio of Charity Care to Net Patient Revenue	1.0%	0.97%	0.77%

Source: RUMC Records

Consolidated

CONSOLIDATED CHARITY CARE			
	FY 2011 (in thousands)	FY 2010 (in thousands)	FY 2009 (in thousands)
CONSOLIDATED			
Amount of Charity Care Charges	69,472	62,444	57,130
Cost of Charity Care	19,124	17,645	16,044
Net Patient Revenue	1,221,455	1,183,464	1,136,961
Ratio	1.6%	1.5%	1.4%

Source: RUMC Audited Financial Statements

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

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