ORIGINAL

14-013

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:	The University of Chicago Medical Center
Street Address:	5841 South Maryland Avenue
City and Zip Code:	Chicago 60637-1470
County: Cook	Health Service Area HSA 6 Health Planning Area: A-3

Applicant /Co-Applicant Identification

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

Exact Legal Name:	The University of Chicago Medical Center
Address:	5841 South Maryland Avenue
Name of Registered Agent:	John Satalic
Name of Chief Executive Officer:	Sharon O'Keefe
CEO Address:	5841 South Maryland Avenue
Telephone Number:	(773) 702-6240

Type of Ownership of Applicant/Co-Applicant

- [X] Non-profit Corporation
- [ ] For-profit Corporation
- [ ] Limited Liability Company
- [ ] Partnership
- [ ] Governmental
- [ ] 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)

Name:	John R. Beberman
Title:	Director, Capital Budget and Control
Company Name:	The University of Chicago Medical Center
Address:	14216 South Meadowview Court, Orland Park, IL 60462-2350
Telephone Number:	(773) 702-1246
E-mail Address:	john.beberman@uchospitals.edu
Fax Number:	(773) 702-8148

Additional Contact

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

Name:	Joe Ourth
Title:	Attorney
Company Name:	Arnstein & Lehr LLP
Address:	120 S. Riverside Plaza, Suite 1200, Chicago, IL 60606
Telephone Number:	(312) 876-7100
E-mail Address:	jourth@arnstein.com
Fax Number:	(312) 876-0288

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:	John R. Beberman
Title:	Director, Capital Budget and Control
Company Name:	The University of Chicago Medical Center
Address:	14216 South Meadowview Court, Orland Park, IL 60462-2350
Telephone Number:	(773) 702-1246
E-mail Address:	john.beberman@uchospitals.edu
Fax Number:	(773) 702-8148

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	The University of Chicago Medical Center
Address of Site Owner:	5841 South Maryland Avenue, Chicago, IL 60637

Street Address or Legal Description of Site:

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:	The University of Chicago Medical Center
Address:	5841 South Maryland Avenue, Chicago, IL 60637

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

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

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

Organizational Relationships

Provide (for each 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:

X Substantive

☐ Non-substantive

This project is considered Substantive because it proposes the addition of 12 ICU beds.

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.

On May 20, 2008, the Review Board granted permit #07-153 to the University of Chicago Medical Center ("UCMC") to construct a new hospital pavilion, the Center for Care and Discovery ("CCD"), which houses 180 medical-surgical beds, 60 ICU beds, general surgical rooms, a GI Procedure, Unit, Interventional Radiology and other support services. At the time the CCD opened, many functions were transferred from the existing adult, adult care hospital on campus, Mitchell Hospital ("Mitchell"), but several functions remained. Additionally, the third and fourth floors of the CCD were left as shelled space for future use. Because UCMC's urban campus has limited available land for new construction, UCMC determined it was prudent to reserve space in the CCD for future use, but not to build out that space until needed and when further resources were available. UCMC committed to returning to the Review Board for a permit to build out this shelled space.

On August 13, 2013, the Review Board granted UCMC permit #13-025 to recommission 38 medical-surgical beds in its existing adult, acute care hospital, Mitchell Hospital ("Mitchell") because average utilization over the previous four years had grown five times faster than the anticipated 1.2% annual growth rate. This was an interim step to address immediate capacity constraints, and UCMC is in the process of closing out this project in compliance with its permit.

UCMC now proposes to convert the shelled space on the third and fourth floors of the CCD to inpatient floors (the "Project") and returns to the Review Board for this purpose.

Medical-surgical beds will remain at the current licensed number of 338. The purpose of the current Project is to accommodate high utilization of inpatient beds, including ICU beds, to create clinical efficiencies by consolidating most adult clinical operations into one building, and to further modernize UCMC's facilities.

The build out would consist of 221,395 square feet for both clinical and non-clinical space. The total cost for the Project is expected to be $123,504,716 and will be funded with cash and securities.

The Project is classified as "substantive" based upon definitions in the Planning Act and is expected to be completed by September 30, 2017.

THE UNIVERSITY OF
CHICAGO
MEDICINE

Sharon O'Keefe
President

MC 1000 S-115
5841 South Maryland Avenue
Chicago, Illinois 60637-1470
phone (773) 702-8908
fax (773) 702-1897
sharon.okeefe@uchospitals.edu

April 15, 2014

Ms. Kathy J. Olson, Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson, 2nd Floor
Springfield, Illinois 62761

Re: University of Chicago Medical Center ("UCMC", the "Medical Center")
New Hospital Shelled Space Development Project (the "Project")
Application for Permit

Dear Chairwoman Olson:

We are pleased to submit our application to the Review Board to convert two floors of shelled space in our new hospital pavilion, the Center for Care & Discovery (the "CCD"), to inpatient floors.

These floors were shelled as part of our recently completed new hospital pavilion project, with the future intent to serve as clinical space. At the time the CCD opened, many functions were transferred from the existing adult, acute care hospital on campus – Mitchell Hospital ("Mitchell") – but several functions remained. This Project is the third in a sequence of capital projects to enable the University of Chicago Medical Center ("UCMC" or "Medical Center") to gradually shift the clinical core of the Medical Center from Mitchell to the CCD, while simultaneously accommodating growth, all in the context of dynamic health care regulation and reform.

Specifically, this Project would include the relocation of 122 medical-surgical beds and 32 ICU beds from Mitchell Hospital to the CCD, the addition of 12 ICU beds, and the creation of two ambulatory observation bed units with a total of 46 beds. The Project would, thereby, concentrate the clinical operations for the most acutely ill patients in the CCD, alongside the ancillary diagnostic and treatment modalities required for their medical care, and it is a key part of our incremental and deliberate approach to improving our overall clinical efficiency and to modernizing our medical campus.

Our medical-surgical beds would remain at their current licensed number of 338.

Completion of Project for Hospital Pavilion

On May 20, 2008, the Review Board granted us a permit for project #07-153 to construct a new hospital pavilion – our Center for Care and Discovery ("CCD"). The CCD currently houses 180 of our 338 medical-surgical beds, 60 ICU beds and other clinical and support services. The CCD was not meant to be a complete replacement hospital for Mitchell, but the cornerstone of a comprehensive plan to accommodate future growth and to allow for the gradual transition of the majority of our clinical functions, including those for our most acutely ill patients, from Mitchell to the CCD. The CCD pavilion opened February 23, 2013, and we are in the process of closing out that project in compliance with our permit.

Completion of Project for Medical Surgical Bed Recommissioning

On August 13, 2013, the Review Board granted us a permit for project #13-025 to recommission 38 medical-surgical beds in Mitchell Hospital. When we filed our CCD permit application in 2007, we forecast a utilization growth rate of 1.2% annually. Instead, our actual utilization grew by an average of 6.3% over the last four years. Within four days of opening on February 23, 2013, the medical-surgical beds in the CCD, along with the remainder of medical-surgical beds in Mitchell, were essentially full. Reactivating these beds in Mitchell was an intermediate step and provided a low-cost means to quickly alleviate our capacity constraints while developing the longer term solution that we now propose. In this way, UCMC has been able to meet the growing demand for medical-surgical beds in its community while we seek to enhance the delivery of essential medical services for the future. We are in the process of closing out that project in compliance with our permit.

Description of Current Project

For UCMC to maintain its exceptional standards of patient care and to uphold its ongoing commitment to a healthy community well into the future, we need to convert the shelled space in the CCD to two (2) inpatient floors. This Project would relocate 122 medical-surgical beds and 32 ICU beds from Mitchell Hospital to the CCD, increase our ICU beds by 12, and expand our ambulatory observation beds from 15 to 46.

Relocation of Existing Beds. Mitchell Hospital was completed in 1983. While the Mitchell building is still sufficient for high quality inpatient care, it is located remotely from the CCD and prevents full integration of patient care for patients requiring high intensity clinical resources. With this build out, we seek to maximize the full potential of our new hospital by relocating as many medical-surgical as possible and all ICU beds from Mitchell Hospital, which will help to concentrate the delivery of adult medical care for our most acutely ill patients in a modern, patient-centered, healing

environment. This Project would enable us to locate 92% of UCMC's adult beds in the CCD, excluding obstetric beds, which means that more patients will be in close proximity to the advanced diagnostic, treatment and ancillary services available in the CCD. The Project would thereby obviate long patient transports from Mitchell and the need for clinical staff to attend to their patients over a wide area. Additionally, the Project would provide important clinical adjacencies that will reduce redundancy and the inefficiency of operating in two separate buildings. From a patient's perspective, the inpatient rooms in the CCD are spacious enough to comfortably house families and visitors, numerous pieces of equipment and the number of providers who all work at the bedside in a teaching hospital. With a smaller clinical footprint in Mitchell, UCMC can afford to improve and to modernize the remaining hospital space according to standards comparable to the CCD and to provide all of its patients with the accommodations expected from a modern hospital.

Addition of ICU Beds. With this Project, we are also proposing to expand our licensed number of ICU beds by 12 to handle heavy patient use in this bed category, which would bring our total number of licensed ICU beds to 126. In the past two years, UCMC's ICU beds have had average occupancy rates in excess of the State standard of 60%. For calendar year 2013, our adult ICU beds have had an average occupancy rate of 72%, with an overall occupancy rate of 68% for both pediatric and adult ICU beds. Now, we reach 80% of our licensed ICU bed capacity on 89% of the days, a utilization level that well exceeds both the State standard and optimal clinical efficiency. As an academic medical center with tertiary and quaternary care, community hospitals regularly rely on UCMC to provide intensive care services to their high acuity patients. During peak periods of high volume, we are compelled to either delay access to care for these patients or to deny transfers when ICU beds are not available. Intensive Care beds also persist as an underserved category of service in our current Planning Area A-03, and we seek to mitigate this deficiency and to better serve our community with an increase of 12 ICU beds.

Addition of Observation Beds. In order to keep pace with industry standards, a growing trend to provide appropriate medical care in an ambulatory setting and changes in federal law, we are proposing to move UCMC's observation bed inventory from Mitchell to the CCD, to increase the number of observation beds from 15 to 46, and to operate the observation beds in units. Currently, when running at peak periods of occupancy, UCMC lacks the flexibility to cohort observation patients and to concentrate the resources to care for them, which creates unnecessary inefficiencies and may detract from the patient experience. Additionally, over the past thirty (30) years, hospitals have seen a tremendous change in the mix of acute care, intensive care and observation care, delivered in their facilities. It is now an accepted industry standard that a hospital's observation beds should total approximately 15% of its medical-surgical bed inventory. Moreover, in August 2013, the Centers for Medicare and Medicaid Services announced a new standard for determining whether a patient is admitted as an inpatient to a hospital or

is there for observation, a standard whose application has already materially increased the need for observation beds for hospitals, including UCMC.

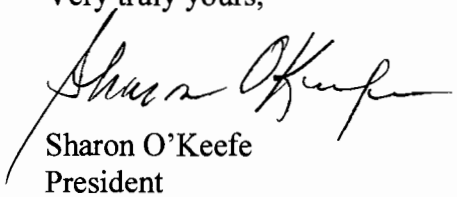
The Project is Practical, Prudent, and Timely

Our capacity constraints and need for modern facilities come at a precarious time in health care delivery in Chicago's south side, which has seen its hospital inventory contract by more than half over the past 25 years. UCMC is a valuable resource on the South Side of Chicago, and we want to remain viable in an era of health care reform in order to continue to serve our patients who depend on us.

The request to build out the shelled space in the CCD is part of a multi-year plan to more fully deploy the space available in our new hospital; to transform or, as appropriate, transition from, existing space in a manner that is cost effective and least disruptive to the delivery of patient care; and to best match the use of our medical campus to existing demand for health care within the community. The development of the shelled space in the CCD is a prudent next step, and the benefits to the community are greater now than if we delay action.

We are pleased to submit our application for the development of the shelled space in our CCD to the Review Board and look forward to working with you to fulfill our mission.

Very truly yours,



Sharon O'Keefe
President

Project Costs and Sources of Funds

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

Project Costs and Sources of Funds			
USE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts	**$61,925,370**	**$26,440,662**	**$88,366,370**
Modernization Contracts			
Contingencies	**4,335,048**	**1,850,952**	**6,186,000**
Architectural/Engineering Fees	**4,025,301**	**1,718,699**	**5,744,000**
Consulting and Other Fees	**1,026,713**	**438,380**	**1,465,093**
Movable or Other Equipment (not in construction contracts)	**19,668,503**	**379,750**	**20,048,253**
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized	**1,187,828**	**507,172**	**1,695,000**
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	**$92,169,102**	**$31,335,614**	**$123,504,716**
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	**$92,169,102**	**$31,335,614**	**$123,504,716**
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	**$92,169,102**	**$31,335,614**	**$123,504,716**

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: $ N/A
Fair Market Value: $ N/A

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

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

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

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): September 30,2017

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

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

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

State Agency Submittals

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

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.**

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS ATTACHMENT-9, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization

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

FACILITY NAME: The University of Chicago Medical Center		**CITY:** Chicago			
REPORTING PERIOD DATES:		**From:** 1/1/2013	**to:** 12/31/2013		
Category of Service	**Authorized Beds**	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	338	14,529	94,869	0	338
Obstetrics	46	2,029	6,364	0	46
Pediatrics	60	2,961	14,788	0	60
Intensive Care	114	5,925	28,433	12	126
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care	47	727	13,965	0	47
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	605	26,171	158,419	12	617

CERTIFICATION

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

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

This Application for Permit is filed on the behalf of THE UNIVERSITY OF CHICAGO 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

Sharon O'Keefe
PRINTED NAME

President UCMC
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10th day of April 2014

Signature of Notary

Seal "OFFICIAL SEAL" CASSANDRA COLE NOTARY PUBLIC, STATE OF ILLINOIS MY COMMISSION EXPIRES 8/3/2017

SIGNATURE

Jennifer A. Hill
PRINTED NAME

Secretary UCMC
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 10th day of April 2014

Signature of Notary

Seal "OFFICIAL SEAL" CASSANDRA COLE NOTARY PUBLIC, STATE OF ILLINOIS MY COMMISSION EXPIRES 8/3/2017

*Insert EXACT legal name of the applicant

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

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

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

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

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

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

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:

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.

SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing establishment, expansion or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion and modernization). After identifying the applicable review criteria for each category of service involved , read the criteria and provide the required information, AS APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

A. Criterion 1110.530 - Medical/Surgical, Obstetric, Pediatric and Intensive Care

1. Applicants proposing to establish, expand and/or modernize Medical/Surgical, Obstetric, Pediatric and/or Intensive Care categories of service must submit the following information:

2. Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
X **Medical/Surgical**	**338**	**338**
☐ **Obstetric**		
☐ **Pediatric**		
X **Intensive Care**	**114**	**126**

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.530(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.530(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.530(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.530(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.530(b)(5) - Planning Area Need - Service Accessibility	X		
1110.530(c)(1) - Unnecessary Duplication of Services	X		
1110.530(c)(2) - Maldistribution	X	X	
1110.530(c)(3) - Impact of Project on Other Area Providers	X		
1110.530(d)(1) - Deteriorated Facilities			X

APPLICABLE REVIEW CRITERIA		Establish	Expand	Modernize
1110.530(d)(2) -	Documentation			X
1110.530(d)(3) -	Documentation Related to Cited Problems			X
1110.530(d)(4) -	Occupancy			X
110.530(e) -	Staffing Availability	X	X	
1110.530(f) -	Performance Requirements	X	X	X
1110.530(g) -	Assurances	X	X	X

APPEND DOCUMENTATION AS ATTACHMENT-20, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

O. 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
☐ **Observation Beds**	**15**	**46**
☐		
☐		

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-34, 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): Applicant has an A or better rating.

- **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:**

$123,504,716	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;
_____	d)	Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	e)	Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent;
_____	f)	Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
_____	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$123,504,716	**TOTAL FUNDS AVAILABLE**	

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

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver **Univ. of Chicago Medical Center bond rating is A or better**

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

2. Variance

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

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

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

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

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

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

B. Conditions of Debt Financing

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).

2.

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

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

* Include the percentage (%) of space for circulation

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-39, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XI. Safety Net Impact Statement

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

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.

2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.

3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

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

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.

2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.

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

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

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**Year**	**Year**	**Year**
Inpatient			
Outpatient			
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 40, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

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

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

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

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

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Section I, Type of Ownership of Applicant/Co-Applicant

Attachment 1

The University of Chicago Medical Center is an Illinois not-for-profit corporation, incorporated on October 1, 1986. A copy of UCMC's Good Standing Certificate dated April 9, 2014 is attached.

File Number 5439-757-7

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

THE UNIVERSITY OF CHICAGO MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON OCTOBER 01, 1986, 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.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 9TH *day of* APRIL *A.D.* 2014 .

Jesse White

SECRETARY OF STATE

Authentication #: 1409901572

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

Attachment - 1

Section I, Site Ownership

Attachment 2

A copy of that certain New Hospital Pavilion Lease Agreement between The University of Chicago ("Lessor") and The University of Chicago Medical Center ("Lessee") dated as of August 20, 2009 related to the property commonly known as The Center for Care and Discovery ("CCD") showing that UCMC has ownership of the site is attached.

This instrument was prepared by
and after recording return to:

Robert Rush
University of Chicago
Office of Legal Counsel
5801 S. Ellis Avenue, Suite 619
Chicago, Illinois 60637

SPACE ABOVE THIS LINE FOR RECORDER'S USE.

NEW HOSPITAL PAVILION LEASE AGREEMENT

THIS LEASE AGREEMENT dated as of August 20, 2009 (herein, together with all supplements and amendments hereto made or entered into at any time hereafter, referred to as this "Lease") is made by and between THE UNIVERSITY OF CHICAGO (the "Lessor"), an Illinois not-for-profit corporation, and THE UNIVERSITY OF CHICAGO MEDICAL CENTER (the "Lessee"), an Illinois not-for-profit corporation, who hereby mutually covenant and agree as follows:

ARTICLE I

DEFINITIONS

1.1 "Affiliation Agreement." Affiliation Agreement shall mean the Affiliation Agreement dated October 1, 1986 entered into between Lessor and Lessee, as the same may be amended, modified or supplemented from time to time.

1.2 "Default Interest Rate." Default Interest Rate shall mean the Corporate Base Rate as posted by JPMorgan Chase Bank, N.A., or its successor, each day.

1.3 "Improvements." Improvements shall mean, at any time, all buildings and any other improvements comprising or located on the premises.

1.4 "Loan Agreement." Loan Agreement shall mean, collectively: (i) the Loan Agreement dated as of August 1, 2009 between the Lessee and the Illinois Finance Authority, as successor to the Illinois Health Facilities Authority or its successor, if any (the "Authority") related to the Illinois Finance Authority Revenue Bonds, Series 2009C (The University of Chicago Medical Center), (ii) the Loan Agreement dated as of August 1, 2009 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2009D (The University of Chicago Medical Center) (the "Series 2009D Bonds") and any Credit Facility Agreement (as defined in the Loan Agreement) for the Series 2009D Bonds or any subseries thereof, which is initially the Reimbursement Agreement dated as of August 1, 2009 between the Lessee and Bank of America, N.A., and (iii) the Loan Agreement dated as of August 1, 2009 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2009E (The University of Chicago Medical Center) (the "Series 2009E Bonds") and any

Credit Facility Agreement (as defined in such Loan Agreement) for the Series 2009E Bonds or any subseries thereof, which is initially the Reimbursement Agreement dated as of August 1, 2009 between the Lessee and JPMorgan Chase Bank, National Association, and, in the case of each of the foregoing clauses, as such agreements may from time to time be amended in accordance with the terms thereof.

1.5 "Premises." Premises shall mean the real property set forth in the legal description contained in EXHIBIT A, together with all buildings, appurtenances and fixtures located thereon.

ARTICLE II

DEMISE

2.1 Lease of Property. Upon the terms and conditions hereinafter set forth and in consideration of the payment of the rent hereinafter set forth and of the performance by Lessor and Lessee of each and every one of the covenants and agreements hereinafter contained to be kept and performed by each of them, Lessor does hereby lease, let and demise unto Lessee, and Lessee does hereby lease of and from Lessor the Premises.

ARTICLE III

TITLE, CONDITION AND USE OF THE LEASED PREMISES

3.1 Title and Condition.

(a) Except for the express warranty set out in Section 3.1 (b), the Premises are demised and let in their condition as in effect at the commencement of the lease term relating thereto, "as is," and without any representation or warranty by Lessor of any kind as to any matter whatsoever express or implied (including, without limitation, the physical condition thereof).

(b) Lessor represents and warrants that, as of the date of this Lease, Lessor is the fee owner of the Premises and holds title to such land and Improvements as, and subject to the qualifications and exceptions, shown on the Commitments for Title Insurance (the "Title Reports") prepared by Chicago Title Insurance Company, copies of which have been furnished to Lessor and Lessee, as they may be subsequently revised with the agreement of the parties.

(c) LESSOR HAS NOT MADE AN INSPECTION OF THE PREMISES OR OF ANY PROPERTY, FIXTURE, EQUIPMENT OR OTHER ITEM CONSTITUTING A PORTION THEREOF, AND LESSOR MAKES NO WARRANTY OR REPRESENTATION, EXPRESS OR IMPLIED OR OTHERWISE, WITH RESPECT TO THE SAME OR THE LOCATION, USE, DESCRIPTION, DESIGN, MERCHANTABILITY, FITNESS FOR USE FOR ANY PARTICULAR PURPOSE, CONDITION OR DURABILITY THEREOF, OR AS TO THE QUALITY OF THE MATERIAL OR WORKMANSHIP THEREIN, OR OTHERWISE. THE PREMISES ARE BEING LEASED "AS IS." ALL WARRANTIES ARE EXPRESSLY WAIVED BY LESSEE. THE PROVISIONS

OF THIS SECTION 3.1 ARE INTENDED TO BE A COMPLETE EXCLUSION AND NEGATION OF ANY AND ALL WARRANTIES (EXCEPT ONLY THE EXPRESS WARRANTY CONTAINED IN SECTION 3.1.(b)) BY LESSOR, EXPRESS OR IMPLIED, WITH RESPECT TO THE PREMISES AND ALL PROPERTY, FIXTURES, EQUIPMENT AND OTHER ITEMS CONSTITUTING A PORTION THEREOF.

3.2 Use of Premises. Lessee shall manage and operate the facilities on the Premises in a manner consistent with the Affiliation Agreement. The Premises, and every part thereof, shall be used and occupied only for the purpose of building and operating a not-for-profit hospital and related outpatient clinics which is supportive of the Lessor's academic and research mission. Lessee may operate certain facilities incidental to the operation of the health care facility such as a cafeteria and a hospital gift shop, unless prohibited from so doing pursuant to Sections 3.3 and 3.4 below.

3.3 Certain Uses Prohibited. Except to the extent that such violation will not materially adversely affect the business or financial position or ability to operate of either Lessee or Lessor, Lessee shall not use or occupy the Premises, or any part thereof, or permit the Premises, or any part thereof, to be used or occupied: contrary to any statute, law, rule, order, ordinance, requirement, regulation, covenant, condition or restriction of record applicable thereto; or in any manner which would violate any certificate of occupancy affecting the same, or which would cause major damage to the improvements. Lessee shall not use or occupy the Premises for any unlawful purpose, or in any manner which would cause, maintain or permit any nuisance or anything against public policy in or about the Premises or any part thereof. Except as necessary for Lessee to conduct its ordinary business as contemplated under this Lease, Lessee will not keep or use on the Premises or any part thereof any inflammable or explosive liquids or materials. Lessee will not commit or suffer to be committed any waste in, upon or about the Premises, or any part thereof. Lessee shall not permit persons under its control to engage in any unlawful activity in or about the Premises, and shall endeavor to prohibit any activity from being conducted on the Premises which is prohibited by the Affiliation Agreement.

3.4 Prohibition of Use. If the use or occupancy of the Premises, or any part thereof, should at any time during the term of this Lease be prohibited by law or by ordinance or other governmental regulation, or prevented by injunction, this Lease shall not be thereby terminated, nor shall Lessee be entitled by reason thereof to surrender the premises, nor shall the respective obligations of the parties hereto be otherwise affected.

3.5 Requirement of Continued Use. Lessee shall continuously during all of the Lease Term conduct and carry on the uses permitted by Section 3.2 hereof in the premises in a high quality and reputable manner. The provisions of this Section 3.5 obligating the Lessee to occupy and use the Premises at all times shall not apply when Lessee is prevented from doing so by strikes, lockouts or other causes and acts of God beyond the reasonable control of Lessee.

3.6 Agreements Affecting the Premises. Lessee shall keep, observe, perform and comply with all covenants, conditions and restrictions in any endowments or instruments of gift or bequest which affect the Premises.

3.7 Lessor's Right to Terminate Lessee's Occupancy Upon Abandonment. If Lessee should, for any reason other than a major renovation of the Premises or other than any of the reasons set out in the last sentence of Section 3.5, at any time cease to occupy or use for the uses permitted by Section 3.2 hereof for any period exceeding 90 consecutive days (or for any 90 days within any 120-day period) all or substantially all of any building which comprises part of the Premises, then Lessor has the right (but no obligation), upon written notice to Lessee, to terminate this Lease with respect to such Abandoned Premises (the "Abandoned Premises"), and by such notice to Lessee, such Abandoned Premises shall automatically cease to be a part of the Premises and shall permanently revert to the Lessor, and thereafter, Lessee shall have no rights or obligations with respect to the Abandoned Premises; provided, however, that until receipt of Lessor's notice pursuant to this Section 3.7, Lessee shall have full liability for all obligations under this Lease with respect to the Abandoned Premises.

Further, should Lessee fail to substantially complete construction (so as to permit building occupancy) of the NHP (as defined in Article VII hereof) within forty-eight (48) months of signing this Lease, this Lease shall be terminated and possession of the premises, including all improvements located thereon shall be surrendered by Lessee and delivered to Lessor.

ARTICLE IV

TERM

4.1 Lease Term. The term of this Lease (the "Lease Term") shall commence on date hereof. The Lease Term shall end upon the earliest of the following events: (a) the termination of the Affiliation Agreement or any extensions thereof; (b) the expiration of the Affiliation Agreement as a result of an exercise of the election not to renew for additional 10 year terms; (c) Lessor's assumption of Lessee's obligations under Lessee's loan agreements with the Authority pursuant to Section 18.2 of the Lease between the Lessor and Lessee dated as of June 30, 1987, as may be amended from time to time (the "1987 Lease"), Section 16.3 of the Center for Advanced Medicine and Pritzker Building Lease Agreement between Lessor and Lessee dated as of June 21, 1993, as may be amended from time to time (the "DCAM Lease"), or Section 16.3 of the Comer Children's Hospital Lease Agreement dated as of June 29, 2001, between Lessor and Lessee dated as of June 21, 1993, as may be amended from time to time (the "Comer Lease"); (d) termination of this Lease otherwise in accordance with its terms.

4.2 Possession. At any time during the Lease Term, Lessee shall have the right (subject to the terms and conditions of this Lease) to enter upon, occupy, possess and peaceably and quietly have, hold and enjoy the Premises, provided that (a) Lessor shall retain the right to enter upon the Premises at any time in order to make inspections or to exercise any other rights of Lessor hereunder and further provided that except in the case of emergency, any entry by Lessor pursuant to this Section 4.2 shall not unreasonably interfere with Lessee's use of the Premises; and (b) Lessor shall retain the right to enter upon and occupy certain portions of Parcel 3 of the Premises in order to install and maintain conduits for utility services (including but not limited to gas, water, sewer, electricity and telecommunications services) through and under the Premises, provided that no such access, use or occupancy shall materially interfere with or materially impair the Lessee's operation of the Premises.

ARTICLE V

RENT

5.1 Basic Rent. Lessee covenants to pay Lessor rent ("Basic Rent") for the Premises for the entire Lease Term in the amount of $10.00, all due and payable on August 20, 2009.

5.2 Additional Rent.

(a) Lessee covenants to pay and discharge when the same shall become due or payable, as additional rent hereunder, all of the following (collectively, "Impositions"): each and every cost, tax, assessment and other expense on or with respect to the Premises or any part thereof, or for the payment of which Lessor or Lessee is liable pursuant to any provision of this Lease or by reason of any rights or interest of Lessor or Lessee in this Lease, or any portion thereof or relating to the Premises or any portion thereof, or the operation, maintenance, insurance, alteration, repair, rebuilding, possession, use or occupancy of the Premises or any portion thereof, or by reason of or in any manner connected with or relating to this Lease, or for any other reason whether similar or dissimilar to the foregoing, foreseen or unforeseen, together with every fine, penalty, interest and cost which may be added for nonpayment or late payment thereof; provided, however, that nothing herein shall require Lessee to pay any franchise, transfer, Federal net income, Federal profits, single business or other taxes of Lessor determined on the basis of Lessor's income or revenue, unless such tax is in lieu of or a substitute for any other tax or assessment upon or with respect to the Premises, which if such other tax or assessment were in effect, would be payable by Lessee hereunder.

(b) Lessee covenants to pay, as additional rent hereunder, all amounts, charges or costs required to be paid by Lessee under this Lease, all in accordance with the provisions of this Lease. All such additional rent, together with all Impositions are sometimes referred to collectively herein as "Additional Rent" and all Additional Rent and Basic Rent are sometimes referred to collectively herein as "Rent."

(c) In the event of any failure by Lessee timely and fully to pay any Rent when due or to discharge any of the foregoing, Lessor shall have all rights, powers and remedies provided herein, by law, or otherwise, and in addition thereto the right (but without any obligation) to pay and to perform any and all of Lessee's obligations and covenants under this Lease and to receive on demand from Lessee repayment thereof, with interest at the Default Interest Rate.

5.3 Net Lease. This is intended to be a completely "net" lease to Lessor, and the Rent and all other sums payable hereunder by Lessee shall be paid without demand, and without set-off, counterclaim, abatement, suspension, credit, deduction, deferment, defense, diminution or reduction of any kind or for any reason.

ARTICLE VI

IMPOSITIONS AND OTHER LIENS

6.1 Payment by Lessee.

(a) At Lessee's request, Lessor will apply for real estate tax exemptions for those portions of the Premises which are not exempt from such taxes and will charge the expenses of obtaining the exemption to the Lessee.

(b) Lessee shall cooperate with Lessor in filing or causing to be filed any documentation required to retain the Premises' status as exempt from real estate taxes and shall pay prior to delinquency, as additional rent for the Premises, its share (based on a reasonable allocation thereof determined by Lessor and acceptable to Lessee as between the Premises and any other property on which such taxes or impositions were levied, assessed, or charged, but if the parties cannot agree, the amount allocated to Lessee shall be based on Lessee's proportionate share of the square footage of the premises covered by such taxes or Impositions) of any and all taxes and assessments (general and special), and water rates and other Impositions (ordinary and extraordinary), of every kind and nature whatsoever, which are levied, assessed, charged or imposed upon or with respect to the Premises, or any part thereof, or which become payable during the Lease Term, or any ad valorem taxes assessed thereon or on or in connection with any personal property used in connection therewith which Lessor shall be required to pay, becoming due and payable during or with respect to the term of this Lease.

(c) Lessee shall also be responsible for and shall pay prior to delinquency any and all taxes, whether or not customary or now within the contemplation of the parties hereto and regardless of whether imposed upon Lessor or Lessee: (i) levied against, upon, measured by or reasonably attributable to any and all equipment, furniture, fixtures and other personal property located in or upon the Premises; (ii) upon or with respect to the possession, leasing, operation, management, maintenance, alteration, repair, use or occupancy by Lessee of the Premises or any portion thereof; or (iii) upon this transaction. If, at any time during the term, any of the foregoing taxes are included with any tax bills to Lessor or upon or relating to the Premises, then Lessee shall promptly upon notice by Lessor reimburse Lessor for any and all such taxes and such tax or assessment shall for purposes of this Lease be deemed to be taxes or assessments under this Section 6.1 payable by Lessee; provided, however, that if such taxes are included in a bill which also covers property owned by Lessor or property other than the Premises or property other than that within or upon the Premises, Lessee shall pay its share of such tax or assessment based on a reasonable allocation proposed by Lessor and acceptable to Lessee, but if the parties cannot agree, the amount allocated to Lessee shall be based on Lessee's proportionate share of the square footage of the premises covered by such tax or assessment; and provided further, that if the activity of one of the parties alone has resulted in the imposition of the tax or assessment, then that party shall pay the full cost of such tax or assessment.

(d) If under applicable law any Imposition may at the option of the taxpayer be paid in installments, Lessee may exercise such option, as long as Lessee pays all finance charges, installment payment fees or charges, and similar amounts.

(e) There shall be excluded from Impositions all Federal or state income taxes, Federal or state excess profit taxes, franchise, capital stock and Federal or state estate or inheritance taxes imposed upon Lessor except insofar as the same may be included within the definition of Additional Rent under Section 5.2.

6.2 Alternative Taxes.

(a) If at any time during the term of this Lease the method of taxation prevailing at the commencement of the Lease Term hereof shall be altered so that any new tax, assessment, levy, imposition or charge, or any part thereof, shall be measured or be based in whole or in part upon the Lease or Premises, or the Rent, or other income therefrom and shall be imposed upon the Lessor, then all such taxes, assessments, levies, impositions or charges, or the part thereof reasonably allocated by Lessor to this Lease or the Premises, to the extent that they are so measured or based, shall be deemed to be included within the term Impositions for the purposes hereof, to the extent that such Impositions would be payable if the Premises were the only property of Lessor subject to such Impositions, and Lessee shall pay and discharge the same as herein provided in respect of the payment of Impositions.

(b) Without limiting the generality of the preceding Section 6.2(a), if at any time during the Lease Term a tax, excise, assessment or imposition on rents or income or the privilege of leasing (as lessor or as lessee) real or personal property or other tax however described (a "Rent Tax") is levied or assessed by any governmental unit or taxing authority, on account of the rents payable or receivable hereunder or the interest of Lessor under this Lease or the privilege of leasing (as lessor or as lessee) real or personal property or otherwise, then Lessee agrees to reimburse Lessor on account thereof for the full amount thereof reasonably allocated by Lessor to this Lease or the Premises.

6.3 Evidence of Payment. Lessee shall deliver to Lessor receipts showing the payments of all Impositions and other taxes payable by Lessee hereunder, within thirty days after the earlier to occur of the payment or due date thereof.

6.4 Lessor's Right to Pay Impositions on Behalf of Lessee. In the event Lessee shall fail for any reason to make any of the payments required by this Article VI before the same become past due, then Lessor may, at its option, pay the same. The amounts so paid, including reasonable attorneys fees and expenses which are reasonably incurred because of, or in connection with, such payments, together with interest on all of such amounts from the respective dates of payment at the Default Interest Rate, shall be deemed Additional Rent hereunder and shall be paid promptly by Lessee to Lessor. The election of Lessor to make such payments shall not waive the default thus committed by Lessee.

6.5 Encumbering Title. Lessee shall not do or suffer to be done any act or omission which shall in any way encumber (or result in the encumbrance of) the title of Lessor in and to the Premises, nor shall the interest or estate of Lessor in the Premises be in any way subject to

any mortgage, claim by way of lien or encumbrance, whether by operation of law or by virtue of any express or implied contract by or of Lessee.

6.6 Liens. Lessee shall not permit the Premises to remain subject to any mechanics', laborers', materialmen's or similar lien on account of labor, service or material furnished to, or claimed to have been furnished to, or for the benefit of Lessee or the Premises, except if payment for such labor, service or material is not yet due under the contract in question and except to the extent such lien is being contested in accordance with the terms of Section 6.7 hereof.

6.7 Permitted Contests. Lessee shall not be required to pay any Imposition, or to remove any lien, charge or encumbrance required to be removed under Sections 6.5 and 6.6 hereof, or to comply with any law, ordinance, rule, order, decree, decision, regulation or requirement referred to in Section 3.3 hereof, so long as Lessee shall, in good faith and at its sole cost and expense, be actively contesting the amount or validity thereof, in an appropriate manner and by appropriate legal proceedings which shall operate during the pendency thereof to prevent the sale, estate or interest therein, and provided, that no such contest shall subject Lessor to the risk of any loss or liability. Lessee will indemnify, defend and save Lessor harmless from and against any and all losses, judgments, decrees, liabilities, claims and costs (including, without limitation, attorneys' fees and expenses in connection therewith) which may relate to or result from any such contest.

6.8 Notice. Lessor shall promptly deliver to Lessee any notice, bill, assessment or other documentation received by Lessor requiring payment of any tax, imposition or other payment required by this Article VI.

ARTICLE VII

CONSTRUCTION OF NEW HOSPITAL PAVILION

Lessor and Lessee understand that Lessee anticipates building the New Hospital Pavilion (the "NHP") on the Premises. The NHP will be a 10 floor, approximately 1,200,000 square foot medical pavilion for specialty care, with 52 operating rooms and 240 inpatient beds, as well as diagnostic imaging and procedure suites.

ARTICLE VIII

INSURANCE

8.1 Maintenance of Insurance. The parties shall procure, and maintain in effect at all times, insurance policies or self-insurance covering the Premises, and the operations conducted thereon, against casualties, contingencies and risks (including but not limited to public liability and employee dishonesty) in amounts not less than customary in the case of corporations engaged in the same or similar activities and similarly situated and adequate to protect the Premises and operations.

Any insurance procured and maintained pursuant to this Article VIII may be obtained jointly by Lessor and Lessee or separately by either party. To the extent insurance is obtained

jointly or by Lessor, Lessor shall allocate, on an equitable basis consistent with past practice or acceptable to Lessee, the cost of such policies or self-insurance as between Lessor and Lessee, and Lessee shall pay to Lessor, as Additional Rent, the portion of the cost of such policies or self-insurance so allocated to Lessee by Lessor. To the extent Lessee procures and maintains insurance policies covering the Premises, the entire cost and expense of such policies shall be paid by Lessee and considered to be Additional Rent.

All policies of insurance carried pursuant to this Section shall be maintained in such form and with such companies as shall be approved by Lessor. For those policies procured and maintained by Lessee individually, Lessee agrees to deliver to and keep deposited with Lessor all such policies and renewals thereof, with premiums prepaid, and with loss payable clauses satisfactory to Lessor, and non-cancellation clauses providing for not less than 30 days' written notice to Lessor attached thereto. For those policies procured and maintained by Lessor individually, Lessor agrees to furnish certificates or other documents reasonably required to show such insurance to Lessee or to other interested parties as requested by Lessee.

8.2 Mutual Waiver of Subrogation Rights. Whenever (a) any loss, cost, damage or expense resulting from fire, explosion or any other casualty or occurrence is incurred by either of the parties to this Lease in connection with the Premises, and (b) such party is then covered in whole or in part by insurance with respect to such loss, cost, damage or expense, then the party so insured (or hereby required so to insure) hereby releases the other party from any liability it may have on account of such loss, cost, damage or expense to the extent of any amount recovered by reason of such insurance (or which could have been recovered had such insurance been carried as so required) and waives any right of subrogation which might otherwise exist in or accrue to any person on account thereof, provided that such release of liability and waiver of the right of subrogation shall not be operative in any case where the effect thereof is to invalidate such insurance coverage or increase the costs thereof (provided that in the case of increased cost the other party shall have the right, within thirty days following written notice, to pay such increased cost, thereupon keeping such release and waiver in full force and effect).

ARTICLE IX

MAINTENANCE AND ALTERATIONS

9.1 Maintenance. Lessee shall, at its sole cost and expense, at all times keep and maintain the entire Premises (specifically including, without limitation, for each building, the exterior, the interior, the heating, ventilating and air conditioning equipment and system, the building systems, the structure and the roof) in good condition and repair, and in a safe, secure, clean and sanitary condition and, except to the extent that failure to do so will not materially adversely affect Lessee's financial position or its ability to operate its business, in full compliance with all building, fire, health and other applicable laws, codes, ordinances, rules and regulations and conforming to all requirements of any governmental authority having jurisdiction over the Premises. As used herein, each and every obligation of Lessee to keep, maintain and repair shall include, without limitation, all ordinary and extraordinary structural and nonstructural repairs and replacements. Notwithstanding the foregoing, if unanticipated major structural repairs are required within the last five years of the lease

term, the parties will attempt to negotiate a reasonable sharing of the cost of such repairs. All repairs, replacements and restoration to any exterior portion of any building, or to any structural portion of any building, shall be done in a manner that has been approved in advance by Lessor. If Lessee does not promptly make such repairs and replacements, Lessor may, but need not, make such repairs and replacements and the amount paid by Lessor for such repairs and replacements shall be deemed Additional Rent reserved under this Lease due and payable upon demand. Lessor may (but shall not be required to) enter the Premises at all reasonable times to make such repairs or alterations as Lessor shall reasonably deem necessary or appropriate for the preservation of the Premises.

9.2 Alterations.

(a) Lessee shall consult with Lessor's Facilities Services department from time to time and apprise them of modifications, alterations, or additions to space or demolishing facilities within the Premises ("Alterations"), and Lessee shall not make any major alterations that have a substantial effect on the nature of activities on the Premises, without the consent of Lessor, which shall not be unreasonably withheld. Lessee shall review plans for such alterations with the Lessor's Facilities Services department to confirm that they conform to reasonable, established architectural criteria for the University campus.

(b) Lessee shall, subject to the right to contest as set forth in Section 6.7 hereof, at Lessee's expense, make such repairs and alterations, if any, on the Premises as are expressly required by any governmental authority or which may be made necessary by the act or neglect of Lessee, its employee's agents or contractors, or any persons, firm or corporation, claiming by, through or under Lessee; provided, however, that to the fullest extent permitted by applicable law or governmental order, all such work shall be done pursuant to the notice, review and approval provisions set forth in Section 9.2 (a).

(c) Any Alterations, repairs and replacements performed or made by Lessee shall be performed or made in a good, workmanlike manner with good quality, new materials, in accordance with all applicable laws and ordinances, and lien-free.

(d) Upon completion of any such work by or on behalf of Lessee, Lessee shall provide Lessor with access to such documents as Lessor may reasonably require (including, without limitation, a certificate of occupancy, if such certificates are then issued by the appropriate governmental agency or agencies with respect to projects or work of the type so performed by or on behalf of Lessee, an architect's certificate of completion, and sworn contractors' and subcontractors' statements and supporting final lien waivers) evidencing completion of the work in compliance with applicable laws (and, if relevant, with plans and specifications approved by Lessor) and payment in full for such work, and "as built" working drawings.

9.3 Title to Alterations. All improvements and Alterations installed pursuant to this Lease shall be deemed part of the Premises and the property of Lessor (subject only to Lessee's rights hereunder during the Lease Term); provided, however, that upon expiration of this Lease, Lessee may remove from the Premises, in accordance with the provisions of Section 15.2 hereof, any trade fixtures and personal property which are owned by Lessee.

9.4 Signs. The parties shall agree upon the detailed plans and specifications for any exterior signs on or about the Premises.

ARTICLE X

ASSIGNMENT AND SUBLETTING

10.1 Consent Required.

(a) Lessee shall not, without Lessor's prior written consent (which Lessor may withhold in Lessor's sole discretion): (i) assign, sell, transfer, convey, pledge, encumber or mortgage this Lease or any interest herein or hereunder; (ii) allow or permit to occur or exist any assignment, sale, transfer, conveyance, pledge, encumbrance or mortgage of, or lien upon or security interest in, this Lease or any part of Lessee's interest herein or hereunder, whether by operation of law or otherwise; (iii) sublet, or cause or permit to occur or exist any subletting of, the Premises or any part thereof; or (iv) permit the use or occupancy of the Premises or any part thereof by anyone other than Lessee, provided however, that if this Lease is assigned to any person or entity pursuant to the provisions of the United States Bankruptcy Code, 11 U.S.C. 101 et seq. (the "Bankruptcy Code"), any and all monies and other consideration of any kind whatsoever payable or otherwise to be delivered in connection with such assignment shall be paid or delivered to Lessor, shall be and remain the exclusive property of Lessor and shall not constitute property of Lessee or of the estate of Lessee within the meaning of the Bankruptcy Code. Any and all monies or other consideration constituting Lessor's property under the preceding sentence not paid or delivered to Lessor shall be received and held in trust for the benefit of Lessor and shall be promptly paid to or turned over to the Lessor. It is understood that, by sublease or other agreement between the parties, Lessee may make available for occupancy by Lessor certain portions of the Premises for specified periods of time under arrangements for payment of maintenance costs and other services furnished by Lessee to Lessor.

(b) No assignment or subletting, whether or not permitted hereunder, shall relieve Lessee of any of Lessee's obligations, covenants, or agreements hereunder and Lessee shall continue to be liable as a principal and not as a guarantor or surety, to the same extent as though no assignment or subletting had been made. Any person or entity to whom this Lease is assigned or to whom a sublease is made pursuant to the provisions of the United States Bankruptcy Code shall be deemed without further act or deed to have personally assumed, and agreed personally to be liable for, all of the obligations of the Lessee arising under this Lease on and after the date of such assignment or sublease. Any such assignee or sublessee shall, upon demand, execute and deliver to Lessor an instrument expressly confirming such assumption.

ARTICLE XI

UTILITIES

11.1 Utilities. The cost of all utility services to the Premises, including but not limited to gas, water, sewer, electricity and telephone, shall be paid or reimbursed by Lessee; provided, however, that Lessor shall provide (and Lessee agrees to accept and pay for), steam heat and telecommunications and paging services to Lessee in accordance with and on the terms and conditions set out in a separate agreement between Lessor and Lessee. Whenever and wherever reasonably requested by Lessor, Lessee shall, at its expense, install and maintain separate meters for utilities servicing the Improvements. Where utilities are not separately metered, and any utility bill relates to both the Premises and to space which is not part of the Premises, Lessee shall pay its share of such utilities based upon the share thereof reasonably allocated to Lessee by Lessor and acceptable to Lessee, but if the parties cannot agree, the amount allocated to Lessee shall be based on Lessee's proportionate share of the premises served by such utilities. Provided, however, that to the extent, if any, that the Operating Agreement provides for the amount or number of payments by Lessee for or with respect to utility services, those provisions shall govern and control over any inconsistent provisions in this section.

ARTICLE XII

INDEMNITY AND WAIVER

12.1 Indemnity. Lessee will protect, indemnify and save harmless Lessor and Lessor's agents from and against all liabilities, obligations, claims, damages, penalties, causes of action, judgments, costs and expenses (including without limitation, attorneys' fees and expenses) imposed upon or incurred by or asserted against Lessor by reason of: (a) any failure on the part of the Lessee to perform or comply with any of the terms or provisions of this Lease to be performed by Lessee; or (b) performance of any labor or services or the furnishing of any materials or other property at the request of and on behalf of Lessee or any other person (except only Lessor) in respect of the Premises or any part thereof. In case any action, suit or proceeding is brought against Lessor or Lessor's trustees, officers, agents, or employees by reason of any such occurrence, Lessee will, at Lessor's election and Lessee's expense, resist and defend such action, suit or proceeding, or cause the same to be resisted and defended, and Lessor shall also have the right to defend and resist the same by its own attorneys. Lessee will not settle or compromise any such matter without Lessor's written consent. Upon demand, Lessee shall reimburse Lessor for any cost incurred as a result of or in connection with any such action, suit or proceeding.

12.2 Waiver of Certain Claims. Lessee waives all claims it may have against Lessor and Lessor's trustees, officers, agents, or employees for damage or injury to person or property sustained by Lessee or any persons claiming through Lessee or by any occupant, patient, visitor, invitee or licensee of Lessee or the Premises, or any part thereof, or by any other person, occurring at, upon, within or about, or resulting from the condition of, any part of the Premises or resulting directly or indirectly from any act or omission of Lessee to the fullest extent permitted by law; provided, however, that nothing contained herein shall relieve Lessor from liability for its own negligence or willful misconduct. The foregoing waiver shall include, without limitation, damage or injury caused by water, snow, frost, steam, excessive heat or cold, sewage, gas, odors or noise, or caused by bursting or leaking of pipes or plumbing fixtures or unsafe conditions, and shall apply equally whether any such damage or injury results from the act or omission of Lessee or of any other person and whether such damage be caused by or result from any thing or circumstance whether of a like nature or of

a wholly different nature. All personal property belonging to Lessee or any other person other than Lessor that is in or on any part of the Premises shall be there at the risk of Lessee or of such other person only, and Lessor shall not be liable for any damage thereto or for the theft or misappropriation thereof.

12.3 Lessor's Indemnity. Lessor will protect, indemnify and save harmless Lessee's agents from and against all liabilities, obligations, claims, damages, penalties, causes of action, judgments, costs and expenses (including without limitation, attorneys' fees and expenses) imposed upon or incurred by or asserted against Lessee by reason of any failure on the part of Lessor to perform or comply with any of the terms or provisions of this Lease to be performed by Lessor. In case any action, suit or proceeding is brought against Lessee or Lessee's trustees, officers, agents, or employees by reason of any such occurrence, Lessor will, at Lessee's election and Lessor's expense, resist and defend such action, suit or proceeding, or cause the same to be resisted and defended, and Lessee shall also have the right to defend and resist the same by its own attorneys. Lessor will not settle or compromise any such matter without Lessee's written consent. Upon demand, Lessor shall reimburse Lessee for any cost incurred as a result of or in connection with any such action, suit or proceeding.

ARTICLE XIII

INSPECTION

13.1 Inspection. Lessor and Lessor's agents may enter the Premises at any time for the purpose of inspecting the same, or of making repairs which Lessee has failed for any reason to make in accordance with the covenants and agreements of this Lease, and also for the purpose of showing the Premises to persons interested in the programs and activities carried on thereat; provided, however, that except in the case of emergency or if necessary to correct any unsafe or unsound condition, any entry by Lessor pursuant to this Section 13.1 shall not unreasonably interfere with Lessee's use of the Premises.

ARTICLE XIV

LESSEE'S COVENANTS

14.1 Covenants. Lessee hereby covenants and agrees that:

(a) Lessee shall: permit access by the Lessor to, and allow the Lessor to copy and make extracts from, the books and records of the Lessee at any time; and permit the Lessor to inspect the properties and operations of the Lessee at any time.

(b) Lessee shall not enter into any agreement containing any provision which would be violated or breached by the performance of any of its obligations hereunder or under any instrument or document delivered or to be delivered by it hereunder or in connection herewith.

ARTICLE XV

SURRENDER

15.1 Surrender. Upon termination of this Lease for any reason, Lessee will at once surrender and deliver up the Premises to Lessor in good condition and repair, reasonable wear and tear excepted. Lessee shall deliver to Lessor keys to all doors on the Premises. All hardware, fixtures (other than trade fixtures), and improvements, in or upon the Premises, shall become Lessor's property and shall remain upon the Premises upon any termination of this Lease, without compensation, allowance or credit to Lessee.

15.2 Removal of Lessee's Property. Upon the termination of this Lease, if Lessee is not in default hereunder, Lessee may remove Lessee's trade fixtures, personal property and equipment; provided, however, that Lessee shall repair any injury or damage to the Premises which may result from such removal. Any of Lessee's furniture, machinery, trade fixtures and other items of personal property which Lessee fails to remove from the Premises by the end of the Lease Term may, at Lessor's option, be removed by Lessor and delivered to any other place of business of Lessee or any warehouse, and Lessee shall pay the reasonable cost of such removal (including the repair of any injury or damage to the Premises resulting from such removal), delivery and warehousing to Lessor on demand, with interest at the Default Interest Rate from the tenth day after the demand until paid in full; or Lessor may treat such property as having been conveyed to Lessor with the Lease as a Bill of Sale, without further payment or credit by Lessor to Lessee.

15.3 Holding Over. Any holding over of the Premises by Lessee after the expiration of this Lease shall operate and be construed to be a tenancy from month to month only. During any such extended term of this Lease, all of the provisions hereof (including without limitation, those obligating Lessee to pay all Additional Rent) shall govern and apply, except that Lessee shall pay Base Rent to Lessor for such period at the rate of $100,000.00 per month. Nothing contained in this Section 15.3 shall be construed to give Lessee the right to hold over after the expiration of this Lease, and Lessor may exercise any and all remedies at law or in equity to recover possession of the Premises.

ARTICLE XVI

DEFAULTS AND REMEDIES

16.1 Defaults. Lessee agrees that the occurrence of any one or more of the following events shall constitute an Event of Default for all purposes of this Lease:

(i) Lessee fails to pay, within 30 days after written notice to Lessee that the same is due and payable, any amount of Rent (including, without limitation, Additional Rent) due hereunder;

(ii) Lessee fails to pay, within 30 days after written notice to Lessee that the same is due and payable, any other amount or charge required to be paid by Lessee hereunder;

(iii) Lessee fails in any material respect to keep, observe or perform any of the other covenants or agreements herein contained to be kept, observed and performed by Lessee, and Lessee fails to completely and fully cure such default within 30 days after notice thereof in writing to Lessee; provided, however, that if such matter

cannot be cured within 30 days, then no Event of Default shall be deemed to have occurred with respect thereto so long as cure is commenced immediately and Lessee diligently proceeds to complete cure within a reasonable period of time, and provided further, that no cure period whatsoever shall apply with respect to a hazardous or emergency condition;

(iv) Lessee shall become insolvent or shall admit in writing its inability to pay its debts, or shall make a general assignment for the benefit of creditors;

(v) Lessee shall file, institute or commence any case, proceeding or other action seeking reorganization, arrangement, adjustment, liquidation, dissolution or composition of it or its debts under any law relating to bankruptcy, insolvency, reorganization or relief of debtors, or seeking appointment of a receiver, trustee, custodian or other similar official for it or for all or any substantial part of its property;

(vi) Lessee shall take any corporate or other action to authorize any of the actions set forth above in either of the preceding paragraphs (iv) or (v);

(vii) Any case, proceeding or other action against the Lessee or any of its property shall be filed, instituted or commenced seeking to have an order for relief entered against it as debtor, or seeking reorganization, arrangement, adjustment, liquidation, dissolution or composition of it or its debts under any law relating to bankruptcy, insolvency, reorganization or relief of debtors, or seeking appointment of a receiver, trustee, custodian or other similar official for it or for all or any substantial part of its property, and such case, proceeding or other action results in the entry of an order for relief against it which is not fully stayed within 30 days after the entry thereof or remains undismissed for a period of 60 days;

(viii) All or any material part of the interest or estate of Lessee under this Lease is levied upon under execution or is attached under process of law;

(ix) An Event of Default shall have occurred under the 1987 Lease, the DCAM Lease or the Comer Lease.

16.2 Remedies. Upon the occurrence of any one or more Events of Default, Lessor may, in its discretion, pursue any and all rights and remedies specified in this Lease or available at law or in equity (including, without limitation, an action for damages and for injunctive relief) and may also, in Lessor's discretion, terminate this Lease. Upon termination of this Lease, Lessee shall surrender possession, vacate the Premises immediately and deliver possession thereof to Lessor, and hereby grants to Lessor the full and free right, without demand or notice of any kind to Lessee, to enter into and upon the Premises in such event with or without process of law and to repossess the Premises as the Lessor's former estate and to expel or remove the Lessee and any others who may be occupying or may be within the Premises without being deemed in any manner guilty of trespass, eviction, or forcible entry or detainer, without incurring any liability for any damage resulting therefrom and without relinquishing the Lessor's rights to rent or any other right given to the Lessor hereunder or by operation of law. Upon termination of this Lease, Lessor shall be entitled to recover as damages all Rent (including, without limitation, Additional Rent) and other sums due and payable by Lessee on the date of termination or for or with respect to the period ending on

the effective date of such termination, plus interest at the Default Interest Rate, plus the cost of performing any other covenants or obligations Lessee should have performed on or before the effective date of such termination. Lessor may relet all or any part of the Premises and none of the rents or other amounts received by Lessor as a result of any such reletting shall reduce, or be a credit or offset against, the damages and other amounts required to be paid by Lessee to Lessor hereunder with respect to such termination or otherwise, except as required by law.

16.3 Assumption of Loan Agreement Obligations. Notwithstanding anything else contained in this Lease including, without limitation, the provisions of Sections 3.7, 4.1 and 16.2 hereof, the Lessor or the Lessee shall not be entitled to terminate this Lease for any reason or to exercise its option not to renew the Affiliation Agreement for an additional ten year term upon completion of its initial term unless prior to or concurrently with the termination of the Lease or end of the Lease Term under Section 4.1 hereof as a result of such non-renewal, the Lessor shall have assumed and agreed to perform the obligations of the Lessee under the Loan Agreement in the manner and to the extent provided in the Loan Agreement.

16.4 Lessee's Waiver of Statutory Rights. In the event of any termination of the term of this Lease or any repossession of the Premises pursuant to this Article XVI, Lessee, to the fullest extent permitted by law, waives (a) any notice of re-entry, (b) any right of redemption, re-entry or repossession, and (c) the benefits of any laws now or hereafter in force exempting property from liability for rent or for debt.

16.5 Remedies Cumulative. No right or remedy of Lessor shall be considered to exclude or suspend any other remedy. All rights and remedies of the Lessor shall be cumulative and shall be in addition to every other remedy. Every such power, right and remedy may be exercised from time to time, together or successively, and so often as Lessor chooses.

16.6 No Waiver. No delay or omission of Lessor to exercise any right, remedy or power shall impair any such right, remedy or power or be construed to be a waiver thereof or of any default or any acquiescence therein. No waiver of any breach of any of the covenants of this Lease shall be a waiver of any other breach or waiver, acquiescence in or consent to any further or succeeding breach of the same covenant. The acceptance by Lessor of any payment of Rent or other charges hereunder after the termination of this Lease shall not restore this Lease or Lessee's right to possession hereunder, but rather shall be construed only as a payment on account, and not in satisfaction, of damages due from Lessee to Lessor.

ARTICLE XVII

MISCELLANEOUS

17.1 Lessor's Right to Cure. Lessor may, but shall not be obligated to, cure any default by Lessee or failure of Lessee to perform any of its obligations hereunder, including Lessee's failure to pay Impositions, obtain or maintain appropriate insurance, make repairs or satisfy lien claims; and whenever Lessor so elects, all costs and expenses paid by Lessor in curing such default or failure, including (without limitation) reasonable attorneys' fees and interest at the Default Interest Rate from the date expended by Lessor until Lessor is repaid in full, shall be so much Additional Rent due on demand.

17.2 Amendments Must Be In Writing. This Lease may not be amended, nor may any obligation, right or remedy hereunder be waived or released, except by and to the extent expressly provided in a written instrument duly signed and delivered by the party against whom the same is sought to be enforced; and no act, omission, or waiver, acquiescence or forgiveness, by Lessor as to any default in or failure of performance, either in whole or in part, by Lessee of any of the covenants, terms or conditions of this Lease shall be deemed to be a waiver by Lessor of the right to performance by Lessee of each and every one of the terms and conditions hereof thereafter to be performed in the same manner and to the same extent as the same are herein covenanted to be performed by Lessee.

17.3 Notices. All notices to or demands upon Lessor or Lessee desired or required to be given under this Lease shall be in writing, and shall be deemed to have been duly and sufficiently given on the first to occur of (i) actual delivery, (ii) the next business day following mailing by U.S. Express Mail or any other overnight delivery service, or (iii) the third business day after a copy thereof has been mailed by United States certified mail in an envelope properly stamped and addressed as follows:

If to Lessor:	The President The University of Chicago 5801 South Ellis Avenue Chicago, Illinois 60637
with a copy to:	The General Counsel The University of Chicago 5801 South Ellis Avenue Chicago, Illinois 60637
If to Lessee:	The President The University of Chicago Medical Center 5841 South Maryland Avenue Chicago, Illinois 60637
with a copy to:	The General Counsel The University of Chicago Medical Center 5841 South Maryland Avenue Chicago, Illinois 60637

or at such address in the City of Chicago as either party may designate, in a notice duly given to the other party, as its address for the receipt of notices hereunder.

17.4 Relationship of Parties. Nothing contained herein shall be deemed or construed by the parties hereto or by any other person as creating the relationship of principal and agent, or of partnership or joint venture, or any other relationship other than that of landlord and tenant, by the parties hereto.

17.5 Attorneys' Fees. In the event that either party retains an attorney to enforce this Lease or any term, covenant or condition hereunder or to collect any Rent or any other amount due or payable under this Lease or to recover possession of the Premises, or files any action or

proceeding under or relating to this Lease, the non-prevailing party shall pay the prevailing party's reasonable attorneys' fees and court costs incurred in connection therewith.

17.6 No Brokers. Lessor and Lessee each represents and warrants to the other that it has dealt with no broker in connection with this transaction. Each party hereto agrees to indemnify and hold the other harmless from and against any and all damage, liability, loss, expense and claims arising from the incorrectness of this warranty.

17.7 Entire Agreement. This Lease (including any Exhibits hereto, which are made a part hereof), the agreement concerning the provision of steam described in Section 11.1 hereof, and any other agreement specifically identified or described in this Lease, contains all of the understandings and agreements between the parties hereto with respect to the Premises and the subject matter hereof.

17.8 Applicable Law. This Lease shall be governed by, and construed and enforced in accordance with, the laws of the State of Illinois.

17.9 Covenants Binding on Successors; No Third Party Beneficiaries. All of the covenants, agreements, conditions and undertakings contained in this Lease shall extend and inure to the benefit of, and be binding upon, the parties hereto and their respective successors and assigns; provided, however, that this sentence shall not be construed as restricting or limiting in any way the provisions of Article X hereof, which shall govern and control over any inconsistent provisions of this Section 17.9. No person, firm, corporation, entity, or governmental authority other than the parties hereto and their respective successors and assigns shall have or may enforce any right, benefit, claim or privilege under or as a result of this Lease or any covenants, agreement, condition or undertaking in this Lease, it being the express intention of the parties that there not be any third party beneficiaries of this Lease or any provision hereof. Notwithstanding the other provisions of this Section 17.9, the other parties to the Loan Agreement (as that term may be amended from time to time) and their respective successors and assigns, so long as the Loan Agreement is in effect and amounts are payable thereunder, shall be third party beneficiaries solely with respect to the provisions of Section 16.3 hereof.

[Signature page follows.]

IN WITNESS WHEREOF, Lessor and Lessee have executed and delivered this Lease as of the day and year first above written, pursuant to proper authority duly granted.

Lessor:

ATTEST:

By: _____

Its: Assistant Secretary

THE UNIVERSITY OF CHICAGO

_____

By: Nimalan ~~Chinniah~~

Its: Vice President and
Chief Financial Officer

Lessee:

ATTEST:

By: _____

Its: Secretary

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

By: _____

Its: Corp Assistant

ATTEST:

By: _____

Its: Assistant General Counsel

Attachment - 2

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

I, Tambra A. Black, a Notary Public in and for the said County in the State aforesaid, do hereby certify that Nimalan Chinniah and Russell Herron, personally known to me to be the same persons whose names are, respectively, Vice President and CFO and Assistant Secretary of THE UNIVERSITY OF CHICAGO, an Illinois not for profit corporation, subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that they, being thereunto duly authorized, signed, sealed with the seal of said corporation, and delivered the said instrument as the free and voluntary act of said corporation and as their own free and voluntary act, for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this 1st day of August, 2009.

(SEAL) OFFICIAL SEAL
TAMBRA A BLACK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:07/30/10

Tambra A Black
Notary Public in and for Cook County, Illinois

My Commission Expires: July 30, 2010

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

I, Wanda H. Wideman, a Notary Public in and for the said County in the State aforesaid, do hereby certify that Benjamin D. Gibson, William D. Frazier and Carolyn S. Wilson, personally known to me to be the same persons whose names are, respectively, Secretary, Asst. Gen. Counsel and CFO, Associate Dean of THE UNIVERSITY OF CHICAGO MEDICAL CENTER, an Illinois not for profit corporation, subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that they, being thereunto duly authorized, signed, sealed with the seal of said corporation, and delivered the said instrument as the free and voluntary act of said corporation and as their own free and voluntary act, for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this 15th day of August, 2009.

(SEAL) "OFFICIAL SEAL"
WANDA H. WIDEMAN
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 8/4/2010

Wanda H. Wideman
Notary Public in and for Cook County, Illinois

My Commission Expires: 8/4/2010

NEW HOSPITAL PAVILION LEASE AGREEMENT

EXHIBIT A

THE PREMISES

PARCEL 3

ALL THAT PART OF SOUTH MARYLAND AVENUE LYING WEST OF THE WEST LINE OF LOTS 26 TO 32, BOTH INCLUSIVE, IN BLOCK 11 IN (MC KICHAN AND MASON) SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14, EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS, LYING WEST OF THE WEST LINE OF LOTS 1 TO 10, BOTH INCLUSIVE, IN HAROLD P. WILBER'S RESUBDIVISION OF LOT 32 (EXCEPT THE SOUTH 6 FEET THEREOF) AND ALL OF LOTS 33 TO 41, BOTH INCLUSIVE, AND LOT 42 (EXCEPT THE NORTH 11 FEET THEREOF) IN BLOCK 11 IN MC KICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14 AFORESAID, LYING WEST OF THE WEST LINE OF LOTS 1 TO 8, BOTH INCLUSIVE, IN HAROLD P. WILBER'S RESUBDIVISION OF THE NORTH 11 FEET OF LOT 42 AND ALL OF LOTS 43, 44, 45, 46, 47, 48, 49 AND 50 IN BLOCK 11 IN MASON AND MC KICHAN'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14 AFORESAID, LYING EAST OF THE EAST LINE OF LOTS 1 TO 25, BOTH INCLUSIVE, IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID, LYING SOUTH OF A LINE DRAWN FROM THE NORTHWEST CORNER OF LOT 1 IN HAROLD P. WILBER'S RESUBDIVISION OF THE NORTH 11 FEET OF LOT 42 AFORESAID TO THE NORTHEAST CORNER OF LOT 1 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID AND LYING NORTH OF A LINE DRAWN FROM THE SOUTHWEST CORNER OF LOT 26 IN BLOCK 11 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID TO THE SOUTHEAST CORNER OF LOT 25 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID,

ALSO

THE WEST 8.00 FEET OF SOUTH MARYLAND AVENUE, AS WIDENED, LYING BETWEEN THE SOUTH LINE OF EAST 57TH STREET AND THE NORTH LINE OF EAST 58TH STREET, BY PLAT OF DEDICATION APPROVED BY THE CITY COUNCIL OF THE CITY OF CHICAGO, APRIL 13, 1994 AND RECORDED MAY 2, 1994 IN THE OFFICE OF THE RECORDER OF DEEDS OF COOK COUNTY, ILLINOIS AS DOCUMENT NUMBER 94393401 AND BEING DESCRIBED ON SAID RECORDED PLAT OF DEDICATION AS: THE EAST 8.00 FEET OF BLOCK 12 IN MC KICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS, LYING SOUTH OF THE NORTH LINE OF LOT 1 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID AND LYING NORTH OF THE SOUTH LINE OF LOT 25 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID, SAID PART OF PUBLIC STREET AS HEREIN VACATED BEING FURTHER DESCRIBED AS SOUTH MARYLAND AVENUE, AS WIDENED, LYING BETWEEN THE SOUTH LINE OF EAST 57TH STREET AND THE NORTH LINE OF EAST 58TH STREET;

EXCEPTING THEREFROM ALL THAT PART LYING NORTH OF A LINE 180.16 FEET SOUTH OF AND PARALLEL WITH THE SOUTH LINE OF EAST 57TH STREET AFORESAID, IN COOK COUNTY, ILLINOIS.

CONTAINING 27,560 SQUARE FEET (0.63277 ACRES) OF LAND, MORE OR LESS.

PARCEL 5

THAT PART OF BLOCK 12 TOGETHER WITH THAT PART OF THE NORTH SOUTH 16.00 FOOT WIDE ALLEY LYING WITHIN SAID BLOCK 12, IN McKICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, LYING NORTH OF A LINE DESCRIBED AS FOLLOWS:

BEGINNING AT THE INTERSECTION OF THE WEST LINE OF BLOCK 12 AFORESAID, BEING ALSO THE EAST LINE OF SOUTH COTTAGE GROVE AVENUE, WITH A LINE 177.33 FEET SOUTH OF AND PARALLEL WITH THE NORTH LINE OF SAID BLOCK 12;

THENCE EAST ALONG SAID PARALLEL LINE, 151.03 FEET; THENCE SOUTH, PERPENDICULAR TO THE LAST DESCRIBED LINE, 7.91 FEET; THENCE EAST, PERPENDICULAR TO THE LAST DESCRIBED LINE, 30.50 FEET; THENCE NORTH, PERPENDICULAR TO THE LAST DESCRIBED LINE, 3.03 FEET; THENCE EAST, PERPENDICULAR TO THE LAST DESCRIBED LINE, 41.33 FEET; THENCE SOUTH, PERPENDICULAR TO THE LAST DESCRIBED LINE, 0.73 FEET; THENCE EAST, PERPENDICULAR TO THE LAST DESCRIBED LINE, 21.85 FEET; THENCE NORTH, PERPENDICULAR TO THE LAST DESCRIBED LINE, 2.77 FEET TO A LINE 180.16 FEET SOUTH OF AND PARALLEL WITH THE NORTH LINE OF BLOCK 12 AFORESAID; THENCE EAST ALONG SAID PARALLEL LINE, 8.55 FEET TO THE EAST LINE OF SAID BLOCK 12 AND THE POINT OF TERMINOUS OF SAID LINE; IN COOK COUNTY, ILLINOIS.

CONTAINING 45,498 SQUARE FEET (1.0445 ACRES) OF LAND, MORE OR LESS.

PARCEL 6

ALL THAT PART OF SOUTH MARYLAND AVENUE LYING WEST OF THE WEST LINE OF LOTS 26 TO 32, BOTH INCLUSIVE, IN BLOCK 11 IN (MC KICHAN AND MASON) SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14, EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS, LYING WEST OF THE WEST LINE OF LOTS 1 TO 10, BOTH INCLUSIVE, IN HAROLD P. WILBER'S RESUBDIVISION OF LOT 32 (EXCEPT THE SOUTH 6 FEET THEREOF) AND ALL OF LOTS 33 TO 41, BOTH INCLUSIVE, AND LOT 42 (EXCEPT THE NORTH 11 FEET THEREOF) IN BLOCK 11 IN MC KICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14 AFORESAID, LYING WEST OF THE WEST LINE OF LOTS 1 TO 8, BOTH INCLUSIVE, IN HAROLD P. WILBER'S RESUBDIVISION OF THE NORTH 11 FEET OF LOT 42 AND ALL OF LOTS 43, 44, 45, 46, 47, 48, 49 AND 50 IN BLOCK 11 IN MASON AND MC KICHAN'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14 AFORESAID, LYING EAST OF THE EAST LINE OF LOTS 1 TO 25, BOTH INCLUSIVE, IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID, LYING SOUTH OF A LINE DRAWN FROM THE NORTHWEST CORNER OF LOT 1 IN HAROLD P. WILBER'S RESUBDIVISION OF THE NORTH 11 FEET OF LOT 42 AFORESAID TO THE NORTHEAST CORNER OF LOT 1 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID AND LYING NORTH OF A LINE DRAWN FROM THE SOUTHWEST CORNER OF LOT 26 IN BLOCK 11 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID TO THE SOUTHEAST CORNER OF LOT 25 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID,

ALSO

THE WEST 8.00 FEET OF SOUTH MARYLAND AVENUE, AS WIDENED, LYING BETWEEN THE SOUTH LINE OF EAST 57TH STREET AND THE NORTH LINE OF EAST 58TH STREET, BY PLAT OF DEDICATION APPROVED BY THE CITY COUNCIL OF THE CITY OF CHICAGO, APRIL 13, 1994 AND RECORDED MAY 2, 1994 IN THE OFFICE OF THE RECORDER OF DEEDS OF COOK COUNTY, ILLINOIS AS DOCUMENT NUMBER 94393401 AND BEING DESCRIBED ON SAID RECORDED PLAT OF DEDICATION AS: THE EAST 8.00 FEET OF BLOCK 12 IN MC KICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS, LYING SOUTH OF THE NORTH LINE OF LOT 1 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID AND LYING NORTH OF THE SOUTH LINE OF LOT 25 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID, SAID PART OF PUBLIC STREET AS HEREIN VACATED BEING FURTHER DESCRIBED AS SOUTH MARYLAND AVENUE, AS WIDENED, LYING BETWEEN THE SOUTH LINE OF EAST 57TH STREET AND THE NORTH LINE OF EAST 58TH STREET;

EXCEPTING THEREFROM ALL THAT PART LYING SOUTH OF A LINE 180.16 FEET SOUTH OF AND PARALLEL WITH THE SOUTH LINE OF EAST 57TH STREET AFORESAID, IN COOK COUNTY, ILLINOIS.

CONTAINING 11,891 SQUARE FEET (0.2730 ACRES) OF LAND, MORE OR LESS.

PARCEL 7

LOTS 1 THROUGH 8, BOTH INCLUSIVE, IN HAROLD P. WILBUR'S RESUBDIVISION RECORDED JULY 6TH, 1910 UNDER DOCUMENT NUMBER 4589769 AND LOTS 1 THROUGH 10, BOTH INCLUSIVE, IN HAROLD P. WILBER'S RESUBDIVISION RECORDED JULY 6TH, 1911 UNDER DOCUMENT NUMBER 4788108 AND ALSO LOTS 1 THROUGH 31, BOTH INCLUSIVE, AND THE SOUTH 6.00 FEET OF LOT 32 LYING SOUTH OF THE SOUTH LINE OF SAID HAROLD P. WILBUR'S RESUBDIVISION RECORDED JULY 6TH, 1911 UNDER DOCUMENT NUMBER 4788108 TOGETHER WITH THE NORTH SOUTH 16.00 FOOT WIDE ALLEY ALL LYING WITHIN BLOCK 11 IN McKICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN,

EXCEPTING THEREFROM ALL THAT PART LYING SOUTH OF A LINE 180.16 FEET SOUTH OF AND PARALLEL WITH THE NORTH LINE OF BLOCK 11 AFORESAID, BEING ALSO THE SOUTH LINE OF EAST 57TH STREET, IN COOK COUNTY, ILLINOIS.

CONTAINING 45,627 SQUARE FEET (1.0474 ACRES) OF LAND, MORE OR LESS.

This instrument was prepared by
and after recording return to:

Elizabeth F. Weber
Katten Muchin Rosenman LLP
525 West Monroe Street
Chicago, Illinois 60661-3693

SPACE ABOVE THIS LINE FOR RECORDER'S USE.

FIRST AMENDMENT
to
NEW HOSPITAL PAVILION LEASE AGREEMENT

This First Amendment (the "First Amendment") supplementing and amending that certain Lease Agreement dated as of August 20, 2009, between The University of Chicago (the "Lessor") and The University of Chicago Medical Center (the "Lessee"), relating to the real property described in the Exhibit attached hereto, shall become effective on the date of issuance of the Series 2010 Bonds (as defined below). The original Lease Agreement as amended is referred to herein as the "Lease".

The parties recognize that it is necessary to amend the Lease in order to enable Lessee to borrow funds from the Illinois Finance Authority (which will obtain such funds through the issuance of the Series 2010 Bonds) in order to finance certain borrowings of the Lessee and pay related costs. The parties therefore agree as follows:

1. Section 1.4 of the Lease is amended in its entirety to read as follows:

1.4 "Loan Agreement." Loan Agreement means, collectively, (i) the Loan Agreement dated as of August 1, 2009 between the Lessee and the Authority related to the Illinois Finance Authority Revenue Bonds, Series 2009C (The University of Chicago Medical Center) (the "Series 2009C Bonds"), (ii) the Loan Agreement dated as of August 1, 2009 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2009D (The University of Chicago Medical Center) (the "Series 2009D Bonds") and any Credit Facility Agreement (as defined in such Loan Agreement) for the Series 2009D Bonds or any subseries thereof, which is initially the Reimbursement Agreement dated as of August 1, 2009 between the Lessee and Bank of America, N.A., (iii) the Loan Agreement dated as of August 1, 2009 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2009E (The University of Chicago Medical Center) (the "Series 2009E Bonds" and, together with the Series 2009C Bonds and the Series 2009D Bonds, the "Series 2009CDE Bonds") and any Credit Facility Agreement (as defined in such Loan Agreement) for the Series 2009E Bonds or any subseries thereof, which is initially the Reimbursement Agreement dated as of August 1, 2009 between the Lessee and JPMorgan Chase Bank, National Association, (iv) the Loan Agreement dated as of November 1, 2010 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2010A (The University of Chicago Medical Center) (the "Series 2010A Bonds") and any Credit Facility

Agreement (as defined in the Loan Agreement) for the Series 2010A Bonds or any subseries thereof, which is initially the Reimbursement Agreement dated as of November 1, 2010 between the Lessee and Bank of America, N.A. and (v) the Loan Agreement dated as of November 1, 2010 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2010B (The University of Chicago Medical Center) (the "Series 2010B Bonds" and, together with the Series 2010A Bonds, the "Series 2010 Bonds") and any Credit Facility Agreement (as defined in the Loan Agreement) for the Series 2010B Bonds or any subseries thereof, which is initially the Letter of Credit Reimbursement Agreement dated as of November 1, 2010 between the Lessee and Wells Fargo Bank, National Association, and, in the case of each of the foregoing clauses, as any of such agreements may from time to time be amended in accordance with the terms thereof."

2. All other provisions of the Lease shall remain in full force and effect.

3. This First Amendment may be executed in two or more counterparts, each of which shall be deemed an original and all of which, taken together, shall constitute and be taken as one and the same instrument.

IN WITNESS WHEREOF, Lessor and Lessee have executed and delivered this First Amendment to Lease Agreement as of November 9, 2010 pursuant to proper authority duly granted.

Lessor:

ATTEST:

THE UNIVERSITY OF CHICAGO

By: _____
Name: Russell J. Herron
Its: Assistant Secretary

By: _____
Name: Nimalan ~~Chinniah~~
Its: Vice President and Chief Financial Officer

Lessee:

ATTEST:

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

By: _____
Name: Jennifer A. Hill
Its: Secretary

By: _____
Name: Lawrence J. Furnstahl
Its: Chief Financial and Strategy Officer

IN WITNESS WHEREOF, Lessor and Lessee have executed and delivered this First Amendment to Lease Agreement as of November 9, 2010 pursuant to proper authority duly granted.

Lessor:

ATTEST:

THE UNIVERSITY OF CHICAGO

By: _____
Name: Russell J. Herron
Its: Assistant Secretary

By: _____
Name: Nimalan Chinniah
Its: Vice President and Chief Financial Officer

Lessee:

ATTEST:

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

By: _____
Name: Jennifer A. Hill
Its: Secretary

By: _____
Name: Lawrence J. Burnstahl
Its: Chief Financial and Strategy Officer

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

I, Tambra A. Black, a Notary Public in and for the said County in the State aforesaid, do hereby certify that Nimalan Chinniah and Russell J. Herron, personally known to me to be the same persons whose names are, respectively, Vice President and CFO and Assistant Secretary of THE UNIVERSITY OF CHICAGO, an Illinois not for profit corporation, subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that they, being thereunto duly authorized, signed, sealed with the seal of said corporation, and delivered the said instrument as the free and voluntary act of said corporation and as their own free and voluntary act, for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this 5th day of November, 2010.

(SEAL) OFFICIAL SEAL
TAMBRA A BLACK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:07/30/14

Tambra A. Black
Notary Public in and for Cook County, Illinois

My Commission Expires: 7/30/14

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

I, _____, a Notary Public in and for the said County in the State aforesaid, do hereby certify that Lawrence J. Furnstahl and Jennifer A. Hill, personally known to me to be the same persons whose names are, respectively, Chief Financial and Strategy Officer and Secretary of THE UNIVERSITY OF CHICAGO MEDICAL CENTER, an Illinois not for profit corporation, subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that they, being thereunto duly authorized, signed, sealed with the seal of said corporation, and delivered the said instrument as the free and voluntary act of said corporation and as their own free and voluntary act, for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this ____ day of November, 2010.

(SEAL)

_____
Notary Public in and for Cook County, Illinois

My Commission Expires:

60835009v3

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

I, _____, a Notary Public in and for the said County in the State aforesaid, do hereby certify that Nimalan Chinniah and Russell J. Herron, personally known to me to be the same persons whose names are, respectively, Vice President and CFO and Assistant Secretary of THE UNIVERSITY OF CHICAGO, an Illinois not for profit corporation, subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that they, being thereunto duly authorized, signed, sealed with the seal of said corporation, and delivered the said instrument as the free and voluntary act of said corporation and as their own free and voluntary act, for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this ____ day of November, 2010.

(SEAL)

_____
Notary Public in and for Cook County, Illinois

My Commission Expires:

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

I, Cathy A. Zorba, a Notary Public in and for the said County in the State aforesaid, do hereby certify that Lawrence J. Furnstahl and Jennifer A. Hill, personally known to me to be the same persons whose names are, respectively, Chief Financial and Strategy Officer and Secretary of THE UNIVERSITY OF CHICAGO MEDICAL CENTER, an Illinois not for profit corporation, subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that they, being thereunto duly authorized, signed, sealed with the seal of said corporation, and delivered the said instrument as the free and voluntary act of said corporation and as their own free and voluntary act, for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this 5 day of November, 2010.

"OFFICIAL SEAL"
CATHY A. ZORBA
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 8/3/2013

(SEAL)

Cathy A. Zorba
Notary Public in and for Cook County, Illinois

My Commission Expires: 8/3/2013

60835009v3

Attachment - 2

This instrument was prepared by
and after recording return to:

Elizabeth F. Weber
Katten Muchin Rosenman LLP
525 West Monroe Street
Chicago, Illinois 60661-3693

SPACE ABOVE THIS LINE FOR RECORDER'S USE.

SECOND AMENDMENT
to
NEW HOSPITAL PAVILION LEASE AGREEMENT

This Second Amendment (the "Second Amendment") supplementing and amending that certain Lease Agreement dated as of August 20, 2009, between The University of Chicago (the "Lessor") and The University of Chicago Medical Center (the "Lessee"), relating to the real property described in the Exhibit attached hereto, as heretofore amended by the First Amendment dated as of November 9, 2010, shall become effective on the date of issuance of the Series 2011 Bonds (as defined below). The original Lease Agreement as amended is referred to herein as the "Lease".

The parties recognize that it is necessary to amend the Lease in order to enable Lessee to borrow funds from the Illinois Finance Authority (which will obtain such funds through the issuance of the Series 2011 Bonds) in order to finance certain borrowings of the Lessee and pay related costs. The parties therefore agree as follows:

1. Section 1.4 of the Lease is amended in its entirety to read as follows:

1.4 "Loan Agreement." Loan Agreement means, collectively, (i) the Loan Agreement dated as of August 1, 2009 between the Lessee and the Authority related to the Illinois Finance Authority Revenue Bonds, Series 2009C (The University of Chicago Medical Center) (the "Series 2009C Bonds"), (ii) the Loan Agreement dated as of August 1, 2009 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2009D (The University of Chicago Medical Center) (the "Series 2009D Bonds") and any Credit Facility Agreement (as defined in such Loan Agreement) for the Series 2009D Bonds or any subseries thereof, which is initially the Reimbursement Agreement dated as of August 1, 2009 between the Lessee and Bank of America, N.A., (iii) the Loan Agreement dated as of August 1, 2009 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2009E (The University of Chicago Medical Center) (the "Series 2009E Bonds" and, together with the Series 2009C Bonds and the Series 2009D Bonds, the "Series 2009CDE Bonds") and any Credit Facility Agreement (as defined in such Loan Agreement) for the Series 2009E Bonds or any subseries thereof, which is initially the Reimbursement Agreement dated as of August 1, 2009 between the Lessee and JPMorgan Chase Bank, National Association, (iv) the Loan Agreement dated as of November 1, 2010 between the Lessee and the Authority related to the Illinois

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Finance Authority Variable Rate Demand Revenue Bonds, Series 2010A (The University of Chicago Medical Center) (the "Series 2010A Bonds") and any Credit Facility Agreement (as defined in the Loan Agreement) for the Series 2010A Bonds or any subseries thereof, which is initially the Reimbursement Agreement dated as of November 1, 2010 between the Lessee and Bank of America, N.A., (v) the Loan Agreement dated as of November 1, 2010 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2010B (The University of Chicago Medical Center) (the "Series 2010B Bonds" and, together with the Series 2010A Bonds, the "Series 2010 Bonds") and any Credit Facility Agreement (as defined in the Loan Agreement) for the Series 2010B Bonds or any subseries thereof, which is initially the Letter of Credit Reimbursement Agreement dated as of November 1, 2010 between the Lessee and Wells Fargo Bank, National Association, (vi) the Loan Agreement dated as of May 1, 2011 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2011A (The University of Chicago Medical Center) (the "Series 2011A Bonds") and any Credit Facility Agreement (as defined in the Loan Agreement) for the Series 2011A Bonds or any subseries thereof, which is initially the Reimbursement Agreement dated as of May 1, 2011 between the Lessee and Bank of America, N.A., (vii) the Loan Agreement dated as of May 1, 2011 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2011B (The University of Chicago Medical Center) (the "Series 2011B Bonds") and any Credit Facility Agreement (as defined in the Loan Agreement) for the Series 2011B Bonds or any subseries thereof, which is initially the Letter of Credit Reimbursement Agreement dated as of May 1, 2011 between the Lessee and Wells Fargo Bank, National Association, and, (viii) the Loan Agreement dated as of May 1, 2011 between the Lessee and the Authority related to the Illinois Finance Authority Revenue Bonds, Series 2011C (The University of Chicago Medical Center) (the "Series 2011C Bonds" and, together with the Series 2011A Bonds and the Series 2011B Bonds, the "Series 2011 Bonds," and, in the case of each of the foregoing clauses, as any of such agreements may from time to time be amended in accordance with the terms thereof."

2. All other provisions of the Lease shall remain in full force and effect.

3. This Second Amendment may be executed in two or more counterparts, each of which shall be deemed an original and all of which, taken together, shall constitute and be taken as one and the same instrument.

IN WITNESS WHEREOF, Lessor and Lessee have executed and delivered this Second Amendment to Lease Agreement as of May 20, 2011 pursuant to proper authority duly granted.

Lessor:

ATTEST:

THE UNIVERSITY OF CHICAGO

By: _____
Name: Russell J. Herron
Its: Assistant Secretary

By: _____
Name: Nimalan Chinniah
Its: Vice President for Administration and Chief Financial Officer

Lessee:

ATTEST:

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

By: _____
Name: Jennifer A. Hill
Its: Secretary

By: _____
Name: Kenneth J. Sharigian
Its: Interim Chief Financial Officer

IN WITNESS WHEREOF, Lessor and Lessee have executed and delivered this Second Amendment to Lease Agreement as of May 20, 2011 pursuant to proper authority duly granted.

Lessor:

ATTEST:

THE UNIVERSITY OF CHICAGO

By: _____
Name: Russell J. Herron
Its: Assistant Secretary

By: _____
Name: Nimalan Chinniah
Its: Vice President for Administration and Chief Financial Officer

Lessee:

ATTEST:

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

By: Jennifer A. Hill
Name: Jennifer A. Hill
Its: Secretary

By: _____
Name: Kenneth J. Sharigian
Its: Interim Chief Financial Officer

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

I, Tambra A Black, a Notary Public in and for the said County in the State aforesaid, do hereby certify that Nimalan Chinniah and Russell J. Herron, personally known to me to be the same persons whose names are, respectively, Vice President for Administration and CFO and Assistant Secretary of THE UNIVERSITY OF CHICAGO, an Illinois not for profit corporation, subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that they, being thereunto duly authorized, signed, sealed with the seal of said corporation, and delivered the said instrument as the free and voluntary act of said corporation and as their own free and voluntary act, for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this 17th day of May, 2011.

(SEAL) OFFICIAL SEAL
TAMBRA A BLACK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:07/30/14

Tambra A Black
Notary Public in and for Cook County, Illinois

My Commission Expires: 7/30/2014

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

I, _____, a Notary Public in and for the said County in the State aforesaid, do hereby certify that Kenneth J. Sharigian and Jennifer A. Hill, personally known to me to be the same persons whose names are, respectively, Interim Chief Financial Officer and Secretary of THE UNIVERSITY OF CHICAGO MEDICAL CENTER, an Illinois not for profit corporation, subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that they, being thereunto duly authorized, signed, sealed with the seal of said corporation, and delivered the said instrument as the free and voluntary act of said corporation and as their own free and voluntary act, for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this ____ day of May, 2011.

(SEAL)

_____
Notary Public in and for Cook County, Illinois

My Commission Expires:

Attachment - 2

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

I, _____, a Notary Public in and for the said County in the State aforesaid, do hereby certify that Nimalan Chinniah and Russell J. Herron, personally known to me to be the same persons whose names are, respectively, Vice President for Administration and CFO and Assistant Secretary of THE UNIVERSITY OF CHICAGO, an Illinois not for profit corporation, subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that they, being thereunto duly authorized, signed, sealed with the seal of said corporation, and delivered the said instrument as the free and voluntary act of said corporation and as their own free and voluntary act, for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this ____ day of May, 2011.

(SEAL)

_____
Notary Public in and for Cook County, Illinois

My Commission Expires:

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

I, Colette Louise Gurin, a Notary Public in and for the said County in the State aforesaid, do hereby certify that Kenneth J. Sharigian and Jennifer A. Hill, personally known to me to be the same persons whose names are, respectively, Interim Chief Financial Officer and Secretary of THE UNIVERSITY OF CHICAGO MEDICAL CENTER, an Illinois not for profit corporation, subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that they, being thereunto duly authorized, signed, sealed with the seal of said corporation, and delivered the said instrument as the free and voluntary act of said corporation and as their own free and voluntary act, for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this 17th day of May, 2011.

(SEAL)

OFFICIAL SEAL
COLETTE LOUISE GURIN
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 9-17-2012

Colette Louise Gurin
Notary Public in and for Cook County, Illinois

My Commission Expires:

NEW HOSPITAL PAVILION LEASE AGREEMENT

EXHIBIT A

THE PREMISES

PARCEL 3

ALL THAT PART OF SOUTH MARYLAND AVENUE LYING WEST OF THE WEST LINE OF LOTS 26 TO 32, BOTH INCLUSIVE, IN BLOCK 11 IN (MC KICHAN AND MASON) SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14, EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS, LYING WEST OF THE WEST LINE OF LOTS 1 TO 10, BOTH INCLUSIVE, IN HAROLD P. WILBER'S RESUBDIVISION OF LOT 32 (EXCEPT THE SOUTH 6 FEET THEREOF) AND ALL OF LOTS 33 TO 41, BOTH INCLUSIVE, AND LOT 42 (EXCEPT THE NORTH 11 FEET THEREOF) IN BLOCK 11 IN MC KICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14 AFORESAID, LYING WEST OF THE WEST LINE OF LOTS 1 TO 8, BOTH INCLUSIVE, IN HAROLD P. WILBER'S RESUBDIVISION OF THE NORTH 11 FEET OF LOT 42 AND ALL OF LOTS 43, 44, 45, 46, 47, 48, 49 AND 50 IN BLOCK 11 IN MASON AND MC KICHAN'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14 AFORESAID, LYING EAST OF THE EAST LINE OF LOTS 1 TO 25, BOTH INCLUSIVE, IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID, LYING SOUTH OF A LINE DRAWN FROM THE NORTHWEST CORNER OF LOT 1 IN HAROLD P. WILBER'S RESUBDIVISION OF THE NORTH 11 FEET OF LOT 42 AFORESAID TO THE NORTHEAST CORNER OF LOT 1 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID AND LYING NORTH OF A LINE DRAWN FROM THE SOUTHWEST CORNER OF LOT 26 IN BLOCK 11 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID TO THE SOUTHEAST CORNER OF LOT 25 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID,

ALSO

THE WEST 8.00 FEET OF SOUTH MARYLAND AVENUE, AS WIDENED, LYING BETWEEN THE SOUTH LINE OF EAST 57TH STREET AND THE NORTH LINE OF EAST 58TH STREET, BY PLAT OF DEDICATION APPROVED BY THE CITY COUNCIL OF THE CITY OF CHICAGO, APRIL 13, 1994 AND RECORDED MAY 2, 1994 IN THE OFFICE OF THE RECORDER OF DEEDS OF COOK COUNTY, ILLINOIS AS DOCUMENT NUMBER 94393401 AND BEING DESCRIBED ON SAID RECORDED PLAT OF DEDICATION AS: THE EAST 8.00 FEET OF BLOCK 12 IN MC KICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS, LYING SOUTH OF THE NORTH LINE OF LOT 1 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID AND LYING NORTH OF THE SOUTH LINE OF LOT 25 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID, SAID PART OF PUBLIC STREET AS HEREIN VACATED BEING FURTHER DESCRIBED AS SOUTH MARYLAND AVENUE, AS WIDENED, LYING BETWEEN THE SOUTH LINE OF EAST 57TH STREET AND THE NORTH LINE OF EAST 58TH STREET;

EXCEPTING THEREFROM ALL THAT PART LYING NORTH OF A LINE 180.16 FEET SOUTH OF AND PARALLEL WITH THE SOUTH LINE OF EAST 57TH STREET AFORESAID, IN COOK COUNTY, ILLINOIS.

CONTAINING 27,560 SQUARE FEET (0.63277 ACRES) OF LAND, MORE OR LESS.

PARCEL 3

THAT PART OF BLOCK 12 TOGETHER WITH THAT PART OF THE NORTH SOUTH 16.00 FOOT WIDE ALLEY LYING WITHIN SAID BLOCK 12, IN McKICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, LYING NORTH OF A LINE DESCRIBED AS FOLLOWS:

BEGINNING AT THE INTERSECTION OF THE WEST LINE OF BLOCK 12 AFORESAID, BEING ALSO THE EAST LINE OF SOUTH COTTAGE GROVE AVENUE, WITH A LINE 177.33 FEET SOUTH OF AND PARALLEL WITH THE NORTH LINE OF SAID BLOCK 12;

THENCE EAST ALONG SAID PARALLEL LINE, 151.03 FEET; THENCE SOUTH, PERPENDICULAR TO THE LAST DESCRIBED LINE, 7.91 FEET; THENCE EAST, PERPENDICULAR TO THE LAST DESCRIBED LINE, 30.50 FEET; THENCE NORTH, PERPENDICULAR TO THE LAST DESCRIBED LINE, 3.03 FEET; THENCE EAST, PERPENDICULAR TO THE LAST DESCRIBED LINE, 41.33 FEET; THENCE SOUTH, PERPENDICULAR TO THE LAST DESCRIBED LINE, 0.73 FEET; THENCE EAST, PERPENDICULAR TO THE LAST DESCRIBED LINE, 21.85 FEET; THENCE NORTH, PERPENDICULAR TO THE LAST DESCRIBED LINE, 2.77 FEET TO A LINE 180.16 FEET SOUTH OF AND PARALLEL WITH THE NORTH LINE OF BLOCK 12 AFORESAID; THENCE EAST ALONG SAID PARALLEL LINE, 8.35 FEET TO THE EAST LINE OF SAID BLOCK 12 AND THE POINT OF TERMINOUS OF SAID LINE, IN COOK COUNTY, ILLINOIS.

CONTAINING 45,498 SQUARE FEET (1.0445 ACRES) OF LAND, MORE OR LESS.

PARCEL 6

ALL THAT PART OF SOUTH MARYLAND AVENUE LYING WEST OF THE WEST LINE OF LOTS 26 TO 32, BOTH INCLUSIVE, IN BLOCK 11 IN (MC KICHAN AND MASON) SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14, EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS, LYING WEST OF THE WEST LINE OF LOTS 1 TO 10, BOTH INCLUSIVE, IN HAROLD P. WILBER'S RESUBDIVISION OF LOT 32 (EXCEPT THE SOUTH 6 FEET THEREOF) AND ALL OF LOTS 33 TO 41, BOTH INCLUSIVE, AND LOT 42 (EXCEPT THE NORTH 11 FEET THEREOF) IN BLOCK 11 IN MC KICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14 AFORESAID, LYING WEST OF THE WEST LINE OF LOTS 1 TO 8, BOTH INCLUSIVE, IN HAROLD P. WILBER'S RESUBDIVISION OF THE NORTH 11 FEET OF LOT 42 AND ALL OF LOTS 43, 44, 45, 46, 47, 48, 49 AND 50 IN BLOCK 11 IN MASON AND MC KICHAN'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14 AFORESAID, LYING EAST OF THE EAST LINE OF LOTS 1 TO 25, BOTH INCLUSIVE, IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID, LYING SOUTH OF A LINE DRAWN FROM THE NORTHWEST CORNER OF LOT 1 IN HAROLD P. WILBER'S RESUBDIVISION OF THE NORTH 11 FEET OF LOT 42 AFORESAID TO THE NORTHEAST CORNER OF LOT 1 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID AND LYING NORTH OF A LINE DRAWN FROM THE SOUTHWEST CORNER OF LOT 26 IN BLOCK 11 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID TO THE SOUTHEAST CORNER OF LOT 25 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID,

ALSO

THE WEST 8.00 FEET OF SOUTH MARYLAND AVENUE, AS WIDENED, LYING BETWEEN THE SOUTH LINE OF EAST 57TH STREET AND THE NORTH LINE OF EAST 58TH STREET, BY PLAT OF DEDICATION APPROVED BY THE CITY COUNCIL OF THE CITY OF CHICAGO, APRIL 13, 1994 AND RECORDED MAY 2, 1994 IN THE OFFICE OF THE RECORDER OF DEEDS OF COOK COUNTY, ILLINOIS AS DOCUMENT NUMBER 94339401 AND BEING DESCRIBED ON SAID RECORDED PLAT OF DEDICATION AS: THE EAST 8.00 FEET OF BLOCK 12 IN MC KICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS, LYING SOUTH OF THE NORTH LINE OF LOT 1 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID AND LYING NORTH OF THE SOUTH LINE OF LOT 25 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID. SAID PART OF PUBLIC STREET AS HEREIN VACATED BEING FURTHER DESCRIBED AS SOUTH MARYLAND AVENUE, AS WIDENED, LYING BETWEEN THE SOUTH LINE OF EAST 57TH STREET AND THE NORTH LINE OF EAST 58TH STREET;

EXCEPTING THEREFROM ALL THAT PART LYING SOUTH OF A LINE 180.16 FEET SOUTH OF AND PARALLEL WITH THE SOUTH LINE OF EAST 57TH STREET AFORESAID, IN COOK COUNTY, ILLINOIS.

CONTAINING 11,891 SQUARE FEET (0.2730 ACRES) OF LAND, MORE OR LESS.

PARCEL 7

LOTS 1 THROUGH 8, BOTH INCLUSIVE, IN HAROLD P. WILBUR'S RESUBDIVISION RECORDED JULY 6TH, 1910 UNDER DOCUMENT NUMBER 4589769 AND LOTS 1 THROUGH 10, BOTH INCLUSIVE, IN HAROLD P. WILBER'S RESUBDIVISION RECORDED JULY 6TH, 1911 UNDER DOCUMENT NUMBER 4788108 AND ALSO LOTS 1 THROUGH 31, BOTH INCLUSIVE, AND THE SOUTH 6.00 FEET OF LOT 32 LYING SOUTH OF THE SOUTH LINE OF SAID HAROLD P. WILBUR'S RESUBDIVISION RECORDED JULY 6TH, 1911 UNDER DOCUMENT NUMBER 4788108 TOGETHER WITH THE NORTH SOUTH 16.00 FOOT WIDE ALLEY ALL LYING WITHIN BLOCK 11 IN McKICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN.

EXCEPTING THEREFROM ALL THAT PART LYING SOUTH OF A LINE 180.16 FEET SOUTH OF AND PARALLEL WITH THE NORTH LINE OF BLOCK 11 AFORESAID, BEING ALSO THE SOUTH LINE OF EAST 57TH STREET, IN COOK COUNTY, ILLINOIS.

CONTAINING 45,627 SQUARE FEET (1.0474 ACRES) OF LAND, MORE OR LESS.

This instrument was prepared by
and after recording return to:

Elizabeth F. Weber
Katten Muchin Rosenman LLP
525 West Monroe Street
Chicago, Illinois 60661-3693

SPACE ABOVE THIS LINE FOR RECORDER'S USE.

THIRD AMENDMENT
to
NEW HOSPITAL PAVILION LEASE AGREEMENT

This Third Amendment (the "Third Amendment") supplementing and amending that certain Lease Agreement dated as of August 20, 2009, between The University of Chicago (the "Lessor") and The University of Chicago Medical Center (the "Lessee"), relating to the real property described in the Exhibit attached hereto, as heretofore amended by the First Amendment dated as of November 9, 2010 and the Second Amendment dated as of May 20, 2011, shall become effective on the date of issuance of the Series 2013A Bonds (as defined below). The original Lease Agreement as amended is referred to herein as the "Lease".

The parties recognize that it is necessary to amend the Lease in order to enable Lessee to borrow funds from the Illinois Finance Authority (which will obtain such funds through the issuance of the Series 2013A Bonds) in order to pay or reimburse the Lessee for certain capital expenditures and related costs. The parties therefore agree as follows:

1. Section 1.4 of the Lease is amended in its entirety to read as follows:

1.4 "Loan Agreement." Loan Agreement means, collectively, (i) the Loan Agreement dated as of August 1, 2009 between the Lessee and the Authority related to the Illinois Finance Authority Revenue Bonds, Series 2009C (The University of Chicago Medical Center) (the "Series 2009C Bonds"), (ii) the Loan Agreement dated as of August 1, 2009 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2009D (The University of Chicago Medical Center) (the "Series 2009D Bonds") and any Credit Facility Agreement (as defined in such Loan Agreement) for the Series 2009D Bonds or any subseries thereof, which is initially the Reimbursement Agreement dated as of August 1, 2009 between the Lessee and Bank of America, N.A., (iii) the Loan Agreement dated as of August 1, 2009 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2009E (The University of Chicago Medical Center) (the "Series 2009E Bonds" and, together with the Series 2009C Bonds and the Series 2009D Bonds, the "Series 2009CDE Bonds") and any Credit Facility Agreement (as defined in such Loan Agreement) for the Series 2009E Bonds or any subseries thereof, which is initially the Reimbursement Agreement dated as of August 1, 2009 between the Lessee and JPMorgan Chase Bank, National Association, (iv) the Loan Agreement dated as of November 1, 2010 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2010A (The University

of Chicago Medical Center) (the "Series 2010A Bonds") and any Credit Facility Agreement (as defined in such Loan Agreement) for the Series 2010A Bonds or any subseries thereof, which is initially the Reimbursement Agreement dated as of November 1, 2010 between the Lessee and Bank of America, N.A., (v) the Loan Agreement dated as of November 1, 2010 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2010B (The University of Chicago Medical Center) (the "Series 2010B Bonds" and, together with the Series 2010A Bonds, the "Series 2010 Bonds") and any Credit Facility Agreement (as defined in such Loan Agreement) for the Series 2010B Bonds or any subseries thereof, which is initially the Letter of Credit Reimbursement Agreement dated as of November 1, 2010 between the Lessee and Wells Fargo Bank, National Association, (vi) the Loan Agreement dated as of May 1, 2011 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2011A (The University of Chicago Medical Center) (the "Series 2011A Bonds") and any Credit Facility Agreement (as defined in such Loan Agreement) for the Series 2011A Bonds or any subseries thereof, which is initially the Reimbursement Agreement dated as of May 1, 2011 between the Lessee and Bank of America, N.A., (vii) the Loan Agreement dated as of May 1, 2011 between the Lessee and the Authority related to the Illinois Finance Authority Variable Rate Demand Revenue Bonds, Series 2011B (The University of Chicago Medical Center) (the "Series 2011B Bonds") and any Credit Facility Agreement (as defined in such Loan Agreement) for the Series 2011B Bonds or any subseries thereof, which is initially the Letter of Credit Reimbursement Agreement dated as of May 1, 2011 between the Lessee and Wells Fargo Bank, National Association, (viii) the Loan Agreement dated as of May 1, 2011 between the Lessee and the Authority related to the Illinois Finance Authority Revenue Bonds, Series 2011C (The University of Chicago Medical Center) (the "Series 2011C Bonds" and, together with the Series 2011A Bonds and the Series 2011B Bonds, the "Series 2011 Bonds") and (ix) the Bond Purchase and Loan Agreement dated as of January 1, 2013 among the Lessee, the Authority and Bank of America, N.A. related to the Illinois Finance Authority Revenue Bonds, Series 2013A (The University of Chicago Medical Center) (the "Series 2013A Bonds") and any Continuing Covenant Agreement (as defined in such Bond Purchase and Loan Agreement) for the Series 2013A Bonds or any subseries thereof, which is initially the Continuing Covenant Agreement dated as of January 1, 2013 between the Lessee and Bank of America, N.A., or its successors and assignees, and, in the case of each of the foregoing clauses, as any of such agreements may from time to time be amended in accordance with the terms thereof."

2. All other provisions of the Lease shall remain in full force and effect.

3. This Third Amendment may be executed in two or more counterparts, each of which shall be deemed an original and all of which, taken together, shall constitute and be taken as one and the same instrument.

IN WITNESS WHEREOF, Lessor and Lessee have executed and delivered this Third Amendment to Lease Agreement as of January 24, 2013 pursuant to proper authority duly granted.

Lessor:

ATTEST:

THE UNIVERSITY OF CHICAGO

By: _____
Name: Russell J. Herron
Its: Assistant Secretary

By: _____
Name: Nimalan Chinniah
Its: Executive Vice President for Administration and Chief Financial Officer

Lessee:

ATTEST:

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

By: _____
Name: Jennifer A. Hill
Its: Secretary

By: _____
Name: James M. Watson
Its: Chief Financial Officer

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

I, Tambra A. Black, a Notary Public in and for the said County in the State aforesaid, do hereby certify that Nimalan Chinniah and Russell J. Herron, personally known to me to be the same persons whose names are, respectively, Executive Vice President for Administration and Chief Financial Officer and Assistant Secretary of THE UNIVERSITY OF CHICAGO, an Illinois not for profit corporation, subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that they, being thereunto duly authorized, signed, sealed with the seal of said corporation, and delivered the said instrument as the free and voluntary act of said corporation and as their own free and voluntary act, for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this 23rd day of January, 2013.

(SEAL) OFFICIAL SEAL
TAMBRA A BLACK
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:07/30/14

Tambra A. Black
Notary Public in and for Cook County, Illinois

My Commission Expires: 7/30/14

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

I, _____, a Notary Public in and for the said County in the State aforesaid, do hereby certify that James M. Watson and Jennifer A. Hill, personally known to me to be the same persons whose names are, respectively, Chief Financial Officer and Secretary of THE UNIVERSITY OF CHICAGO MEDICAL CENTER, an Illinois not for profit corporation, subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that they, being thereunto duly authorized, signed, sealed with the seal of said corporation, and delivered the said instrument as the free and voluntary act of said corporation and as their own free and voluntary act, for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this ____ day of January, 2013.

(SEAL)

_____
Notary Public in and for Cook County, Illinois

My Commission Expires:

Attachment - 2

IN WITNESS WHEREOF, Lessor and Lessee have executed and delivered this Third Amendment to Lease Agreement as of January 24, 2013 pursuant to proper authority duly granted.

Lessor:

ATTEST:

THE UNIVERSITY OF CHICAGO

By: _____
Name: Russell J. Herron
Its: Assistant Secretary

By: _____
Name: Nimalan Chinniah
Its: Executive Vice President for Administration and Chief Financial Officer

Lessee:

ATTEST:

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

By: _____
Name: Jennifer A. Hill
Its: Secretary

By: _____
Name: James M. Watson
Its: Chief Financial Officer

Attachment - 2

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

I, _____, a Notary Public in and for the said County in the State aforesaid, do hereby certify that Nimalan Chinniah and Russell J. Herron, personally known to me to be the same persons whose names are, respectively, Executive Vice President for Administration and Chief Financial Officer and Assistant Secretary of THE UNIVERSITY OF CHICAGO, an Illinois not for profit corporation, subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that they, being thereunto duly authorized, signed, sealed with the seal of said corporation, and delivered the said instrument as the free and voluntary act of said corporation and as their own free and voluntary act, for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this ____ day of January, 2013.

(SEAL)

_____
Notary Public in and for Cook County, Illinois

My Commission Expires:

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

I, Wanda H. Wideman, a Notary Public in and for the said County in the State aforesaid, do hereby certify that James M. Watson and Jennifer A. Hill, personally known to me to be the same persons whose names are, respectively, Chief Financial Officer and Secretary of THE UNIVERSITY OF CHICAGO MEDICAL CENTER, an Illinois not for profit corporation, subscribed to the foregoing instrument, appeared before me this day in person and severally acknowledged that they, being thereunto duly authorized, signed, sealed with the seal of said corporation, and delivered the said instrument as the free and voluntary act of said corporation and as their own free and voluntary act, for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this 23rd day of January, 2013.

(SEAL)

"OFFICIAL SEAL"
WANDA H. WIDEMAN
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 8/4/2014

Wanda H. Wideman
Notary Public in and for Cook County, Illinois

My Commission Expires: August 4, 2014

Attachment - 2

NEW HOSPITAL PAVILION LEASE AGREEMENT

EXHIBIT A

THE PREMISES

PARCEL 3

ALL THAT PART OF SOUTH MARYLAND AVENUE LYING WEST OF THE WEST LINE OF LOTS 26 TO 32, BOTH INCLUSIVE, IN BLOCK 11 IN (MC KICHAN AND MASON) SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14, EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS, LYING WEST OF THE WEST LINE OF LOTS 1 TO 10, BOTH INCLUSIVE, IN HAROLD P. WILBER'S RESUBDIVISION OF LOT 32 (EXCEPT THE SOUTH 6 FEET THEREOF) AND ALL OF LOTS 33 TO 41, BOTH INCLUSIVE, AND LOT 42 (EXCEPT THE NORTH 11 FEET THEREOF) IN BLOCK 11 IN MC KICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14 AFORESAID, LYING WEST OF THE WEST LINE OF LOTS 1 TO 8, BOTH INCLUSIVE, IN HAROLD P. WILBER'S RESUBDIVISION OF THE NORTH 11 FEET OF LOT 42 AND ALL OF LOTS 43, 44, 45, 46, 47, 48, 49 AND 50 IN BLOCK 11 IN MASON AND MC KICHAN'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14 AFORESAID, LYING EAST OF THE EAST LINE OF LOTS 1 TO 25, BOTH INCLUSIVE, IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID, LYING SOUTH OF A LINE DRAWN FROM THE NORTHWEST CORNER OF LOT 1 IN HAROLD P. WILBER'S RESUBDIVISION OF THE NORTH 11 FEET OF LOT 42 AFORESAID TO THE NORTHEAST CORNER OF LOT 1 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID AND LYING NORTH OF A LINE DRAWN FROM THE SOUTHWEST CORNER OF LOT 26 IN BLOCK 11 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID TO THE SOUTHEAST CORNER OF LOT 25 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID,

ALSO

THE WEST 8.00 FEET OF SOUTH MARYLAND AVENUE, AS WIDENED, LYING BETWEEN THE SOUTH LINE OF EAST 57TH STREET AND THE NORTH LINE OF EAST 58TH STREET, BY PLAT OF DEDICATION APPROVED BY THE CITY COUNCIL OF THE CITY OF CHICAGO, APRIL 13, 1994 AND RECORDED MAY 2, 1994 IN THE OFFICE OF THE RECORDER OF DEEDS OF COOK COUNTY, ILLINOIS AS DOCUMENT NUMBER 94393401 AND BEING DESCRIBED ON SAID RECORDED PLAT OF DEDICATION AS: THE EAST 8.00 FEET OF BLOCK 12 IN MC KICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS, LYING SOUTH OF THE NORTH LINE OF LOT 1 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID AND LYING NORTH OF THE SOUTH LINE OF LOT 25 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID, SAID PART OF PUBLIC STREET AS HEREIN VACATED BEING FURTHER DESCRIBED AS SOUTH MARYLAND AVENUE, AS WIDENED, LYING BETWEEN THE SOUTH LINE OF EAST 57TH STREET AND THE NORTH LINE OF EAST 58TH STREET;

EXCEPTING THEREFROM ALL THAT PART LYING NORTH OF A LINE 180.16 FEET SOUTH OF AND PARALLEL WITH THE SOUTH LINE OF EAST 57TH STREET AFORESAID, IN COOK COUNTY, ILLINOIS.

CONTAINING 27,560 SQUARE FEET (0.63277 ACRES) OF LAND, MORE OR LESS.

PARCEL 5

THAT PART OF BLOCK 12 TOGETHER WITH THAT PART OF THE NORTH SOUTH 16.00 FOOT WIDE ALLEY LYING WITHIN SAID BLOCK 12, IN McKICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, LYING NORTH OF A LINE DESCRIBED AS FOLLOWS:

BEGINNING AT THE INTERSECTION OF THE WEST LINE OF BLOCK 12 AFORESAID, BEING ALSO THE EAST LINE OF SOUTH COTTAGE GROVE AVENUE, WITH A LINE 177.33 FEET SOUTH OF AND PARALLEL WITH THE NORTH LINE OF SAID BLOCK 12;

THENCE EAST ALONG SAID PARALLEL LINE, 151.03 FEET; THENCE SOUTH, PERPENDICULAR TO THE LAST DESCRIBED LINE, 7.91 FEET; THENCE EAST, PERPENDICULAR TO THE LAST DESCRIBED LINE, 30.50 FEET; THENCE NORTH, PERPENDICULAR TO THE LAST DESCRIBED LINE, 3.03 FEET; THENCE EAST, PERPENDICULAR TO THE LAST DESCRIBED LINE, 41.33 FEET; THENCE SOUTH, PERPENDICULAR TO THE LAST DESCRIBED LINE, 0.73 FEET; THENCE EAST, PERPENDICULAR TO THE LAST DESCRIBED LINE, 21.85 FEET; THENCE NORTH, PERPENDICULAR TO THE LAST DESCRIBED LINE, 2.77 FEET TO A LINE 180.16 FEET SOUTH OF AND PARALLEL WITH THE NORTH LINE OF BLOCK 12 AFORESAID; THENCE EAST ALONG SAID PARALLEL LINE, 8.55 FEET TO THE EAST LINE OF SAID BLOCK 12 AND THE POINT OF TERMINOUS OF SAID LINE; IN COOK COUNTY, ILLINOIS.

CONTAINING 45,498 SQUARE FEET (1.0445 ACRES) OF LAND, MORE OR LESS.

PARCEL 6

ALL THAT PART OF SOUTH MARYLAND AVENUE LYING WEST OF THE WEST LINE OF LOTS 26 TO 32, BOTH INCLUSIVE, IN BLOCK 11 IN (MC KICHAN AND MASON) SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14, EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS, LYING WEST OF THE WEST LINE OF LOTS 1 TO 10, BOTH INCLUSIVE, IN HAROLD P. WILBER'S RESUBDIVISION OF LOT 32 (EXCEPT THE SOUTH 6 FEET THEREOF) AND ALL OF LOTS 33 TO 41, BOTH INCLUSIVE, AND LOT 42 (EXCEPT THE NORTH 11 FEET THEREOF) IN BLOCK 11 IN MC KICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14 AFORESAID, LYING WEST OF THE WEST LINE OF LOTS 1 TO 8, BOTH INCLUSIVE, IN HAROLD P. WILBER'S RESUBDIVISION OF THE NORTH 11 FEET OF LOT 42 AND ALL OF LOTS 43, 44, 45, 46, 47, 48, 49 AND 50 IN BLOCK 11 IN MASON AND MC KICHAN'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14 AFORESAID, LYING EAST OF THE EAST LINE OF LOTS 1 TO 25, BOTH INCLUSIVE, IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID, LYING SOUTH OF A LINE DRAWN FROM THE NORTHWEST CORNER OF LOT 1 IN HAROLD P. WILBER'S RESUBDIVISION OF THE NORTH 11 FEET OF LOT 42 AFORESAID TO THE NORTHEAST CORNER OF LOT 1 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID AND LYING NORTH OF A LINE DRAWN FROM THE SOUTHWEST CORNER OF LOT 26 IN BLOCK 11 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID TO THE SOUTHEAST CORNER OF LOT 25 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID,

ALSO

THE WEST 8.00 FEET OF SOUTH MARYLAND AVENUE, AS WIDENED, LYING BETWEEN THE SOUTH LINE OF EAST 57TH STREET AND THE NORTH LINE OF EAST 58TH STREET, BY PLAT OF DEDICATION APPROVED BY THE CITY COUNCIL OF THE CITY OF CHICAGO, APRIL 13, 1994 AND RECORDED MAY 2, 1994 IN THE OFFICE OF THE RECORDER OF DEEDS OF COOK COUNTY, ILLINOIS AS DOCUMENT NUMBER 94393401 AND BEING DESCRIBED ON SAID RECORDED PLAT OF DEDICATION AS: THE EAST 8.00 FEET OF BLOCK 12 IN MC KICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, IN COOK COUNTY, ILLINOIS, LYING SOUTH OF THE NORTH LINE OF LOT 1 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID AND LYING NORTH OF THE SOUTH LINE OF LOT 25 IN BLOCK 12 IN (MC KICHAN AND MASON) SUBDIVISION AFORESAID, SAID PART OF PUBLIC STREET AS HEREIN VACATED BEING FURTHER DESCRIBED AS SOUTH MARYLAND AVENUE, AS WIDENED, LYING BETWEEN THE SOUTH LINE OF EAST 57TH STREET AND THE NORTH LINE OF EAST 58TH STREET;

EXCEPTING THEREFROM ALL THAT PART LYING SOUTH OF A LINE 180.16 FEET SOUTH OF AND PARALLEL WITH THE SOUTH LINE OF EAST 57TH STREET AFORESAID, IN COOK COUNTY, ILLINOIS.

CONTAINING 11,891 SQUARE FEET (0.2730 ACRES) OF LAND, MORE OR LESS.

PARCEL 7

LOTS 1 THROUGH 8, BOTH INCLUSIVE, IN HAROLD P. WILBUR'S RESUBDIVISION RECORDED JULY 6TH, 1910 UNDER DOCUMENT NUMBER 4589769 AND LOTS 1 THROUGH 10, BOTH INCLUSIVE, IN HAROLD P. WILBER'S RESUBDIVISION RECORDED JULY 6TH, 1911 UNDER DOCUMENT NUMBER 4788108 AND ALSO LOTS 1 THROUGH 31, BOTH INCLUSIVE, AND THE SOUTH 6.00 FEET OF LOT 32 LYING SOUTH OF THE SOUTH LINE OF SAID HAROLD P. WILBUR'S RESUBDIVISION RECORDED JULY 6TH, 1911 UNDER DOCUMENT NUMBER 4788108 TOGETHER WITH THE NORTH SOUTH 16.00 FOOT WIDE ALLEY ALL LYING WITHIN BLOCK 11 IN McKICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN.

EXCEPTING THEREFROM ALL THAT PART LYING SOUTH OF A LINE 180.16 FEET SOUTH OF AND PARALLEL WITH THE NORTH LINE OF BLOCK 11 AFORESAID, BEING ALSO THE SOUTH LINE OF EAST 57TH STREET, IN COOK COUNTY, ILLINOIS.

CONTAINING 45,627 SQUARE FEET (1.0474 ACRES) OF LAND, MORE OR LESS.

File Number 5439-757-7

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

THE UNIVERSITY OF CHICAGO MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON OCTOBER 01, 1986, 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.

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 9TH *day of* APRIL *A.D.* 2014 .

Jesse White

SECRETARY OF STATE

Authentication #: 1409901572

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

Attachment - 3

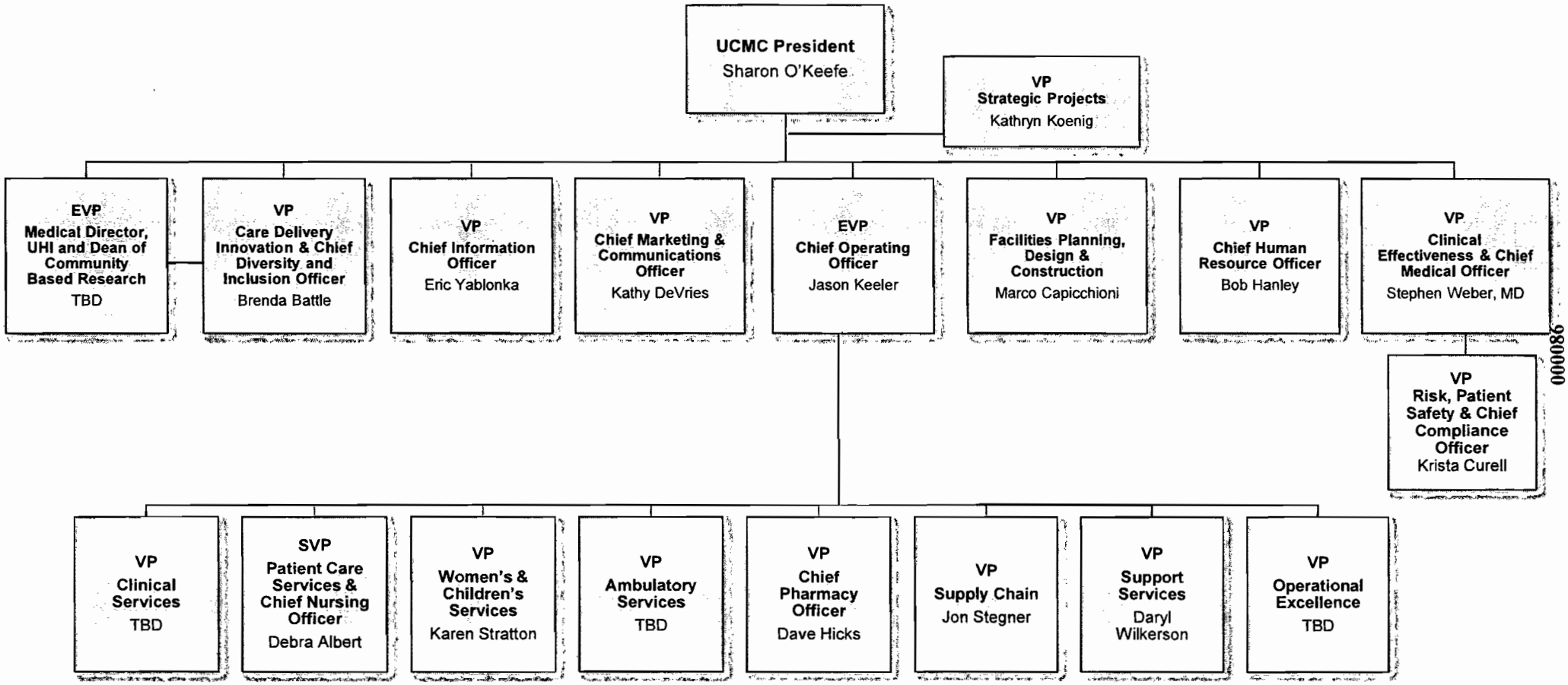
Section I, Organizational Relationships

Attachment 4

A copy of UCMC's Senior Management Team organizational chart is attached. There are no other subsidiary corporate entities.

Attachment – 4

Operational Focus
2014 UCMC Senior Management Team



980000

Section I, Flood Plain Requirement

Attachment 5

A flood plan attestation, attesting that the site of the Project is not located in a flood plain and that the Project complies with the Flood Plain Rules under Illinois Executive Order #2005-5, is attached.

Section I, Flood Plain Requirement

Attachment 5

UCMC attests, by signature of the applicant on this application, that the site of the Project is not located in a flood plain and that the Project complies with the Flood Plain Rules under Illinois Executive Order #2005-5, is attached.

// Make spelling changes

Cook County Map Panels

Effective Flood Insurance Rate Maps for Cook County may be viewed and/or downloaded at the FEMA Map Service Center

... even more!

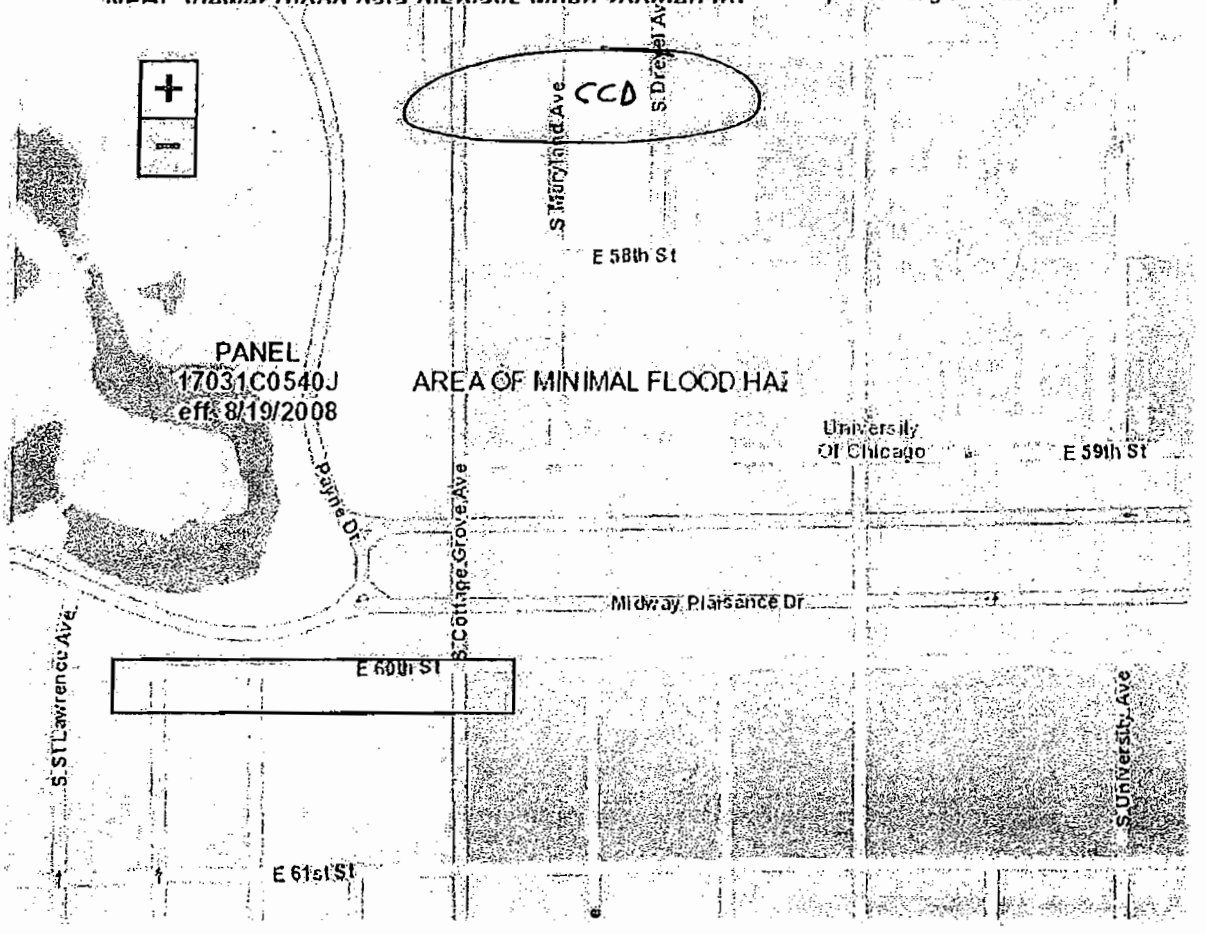
Below are links to resources pertaining to Cook County

- Chicago River Watershed Discovery
- Des Plaines Watershed Discovery
- Lower Fox Watershed Discovery
- Upper Fox Watershed Discovery
- Unmapped Special Flood Hazard Areas (SFHA) (pdf)
- Destined for DFIRMs - stream studies becoming flood maps
- Effective DFIRMs Map Search on FEMA's Map Service Center
- FEMA's National Flood Hazard Layer (NFHL) download

NFHL Viewer (flood data displays when zoomed in)

What is a DFIRM?

The DFIRM Database is a digital version of the FEMA flood insurance rate map that is designed for use with digital mapping and analysis software.



A sample DFIRM showing areas of greater flood risk

ATTACHMENT 5

STATE OF ILLINOIS

EXECUTIVE DEPARTMENT

SPRINGFIELD, ILLINOIS

2006-05

CONSTRUCTION ACTIVITIES IN SPECIAL FLOOD HAZARD AREAS

WHEREAS, the State of Illinois has programs for the construction of buildings, facilities, roads, and other development projects and annually acquires and disposes of lands in floodplains; and

WHEREAS, federal financial assistance for the acquisition or construction of insurable structures in all Special Flood Hazard Areas requires State participation in the National Flood Insurance Program; and

WHEREAS, the Federal Emergency Management Agency has promulgated and adopted regulations governing eligibility of State governments to participate in the National Flood Insurance Program (44 C.F.R. 59-79), as presently enacted or hereafter amended, which requires that State development activities comply with specified minimum floodplain regulation criteria; and

WHEREAS, the Presidential Interagency Floodplain Management Review Committee has published recommendations to strengthen Executive Orders and State floodplain management activities;

NOW THEREFORE, by virtue of the authority vested in me as Governor of the State of Illinois, it is hereby ordered as follows:

ATTACHMENT 5

2. All State Agencies engaged in any development within a Special Flood Hazard Area shall undertake such development in accordance with the following:

   A. All development shall comply with all requirements of the National Flood Insurance Program (44 C.F.R. 59-79) and with all requirements of 92 Illinois Administrative Code Part 700 or 92 Illinois Administrative Code Part 708, whichever is applicable.

   B. In addition to the requirements set forth in preceding Section A, the following additional requirements shall apply where applicable:

      1. All new Critical Facilities shall be located outside of the floodplain. Where this is not practicable, Critical Facilities shall be developed with the lowest floor elevation equal to or greater than the 500-year frequency flood elevation or structurally dry floodproofed to at least the 500-year frequency flood elevation.

      2. All new buildings shall be developed with the lowest floor elevation equal to or greater than the Flood Protection Elevation or structurally dry floodproofed to at least the Flood Protection Elevation.

      3. Modifications, additions, repairs or replacement of existing structures may be allowed so long as the new development does not increase the floor area of the existing structure by more than twenty (20) percent or increase the market value of the structure by fifty (50) percent, and does not obstruct flood flows. Floodproofing activities are permitted and encouraged, but must comply with the requirements noted above.

3. State Agencies which administer grants or loans for financing development within Special Flood Hazard Areas shall take all steps within their authority to ensure that such development meets the requirements of this Order.

4. State Agencies responsible for regulating or permitting development within Special Flood Hazard Areas shall take all steps within their authority to ensure that such development meets the requirements of this Order.

5. State Agencies engaged in planning programs or programs for the promotion of development shall inform participants in their programs of the existence and location of Special Flood Hazard Areas and of any State or local floodplain requirements in effect in such areas. Such State Agencies shall ensure that proposed development within Special Flood Hazard Areas would meet the requirements of this Order.

6. The Office of Water Resources shall provide available flood hazard information to assist State Agencies in carrying out the responsibilities established by this Order. State Agencies which obtain new flood elevation, floodway, or encroachment data developed in conjunction with development or other activities covered by this Order shall submit such data to the Office of Water Resources for their review. If such flood hazard information is used in determining design features or location of any State development, it must first be approved by the Office of Water Resources.

1. For purpose of this Order:

A. "Critical Facility" means any facility which is critical to the health and welfare of the population and, if flooded, would create an added dimension to the disaster. Damage to these critical facilities can impact the delivery of vital services, can cause greater damage to other sectors of the community, or can put special populations at risk. The determination of Critical Facility will be made by each agency.

Examples of critical facilities where flood protection should be required include:
Emergency Services Facilities (such as fire and police stations)
Schools
Hospitals
Retirement homes and senior care facilities
Major roads and bridges
Critical utility sites (telephone switching stations or electrical transformers)
Hazardous material storage facilities (chemicals, petrochemicals, hazardous or toxic substances)

Examples of critical facilities where flood protection is recommended include:
Sewage treatment plants
Water treatment plants
Pumping stations

B. "Development" or "Developed" means the placement or erection of structures (including manufactured homes) or earthworks; land filling, excavation or other alteration of the ground surface; installation of public utilities; channel modification; storage of materials or any other activity undertaken to modify the existing physical features of a floodplain.

C. "Flood Protection Elevation" means one foot above the applicable base flood or 100-year frequency flood elevation.

D. "Office of Water Resources" means the Illinois Department of Natural Resources, Office of Water Resources.

E. "Special Flood Hazard Area" or "Floodplain" means an area subject to inundation by the base or 100-year frequency flood and shown as such on the most current Flood Insurance Rate Map published by the Federal Emergency Management Agency.

F. "State Agencies" means any department, commission, board or agency under the jurisdiction of the Governor; any board, commission, agency or authority which has a majority of its members appointed by the Governor; and the Governor's Office.

7. State Agencies shall work with the Office of Water Resources to establish procedures of such Agencies for effectively carrying out this Order.

8. **Effective Date.** This Order supersedes and replaces Executive Order Number 4 (1979) and shall take effect on the first day of.

Rod R. Blagojevich, Governor

Issued by Governor: March 7, 2006
Filed with Secretary of State: March 7, 2006

ATTACHMENT 5

Section I, Historic Resources Preservation Act Requirements

Attachment 6

Attached is a letter from the Illinois Historic Preservation Agency dated March 7, 2014 noting that the Project meets the Secretary of the Interior's "Standard for Rehabilitation and Guidelines for Rehabilitation of Historic Buildings" and will not result in any adverse effect.

Illinois Historic
Preservation Agency

1 Old State Capitol Plaza, Springfield, IL 62701-1512

FAX (217) 524-7525
www.illinoishistory.gov

Cook County
Chicago
Build-Out of 2 Floors of the Center for Care and Discovery
5700 S. Maryland Ave.
IHPA Log #008022114

March 7, 2014

John R. Beberman
The University of Chicago Hospitals
Capital Budget and Control
MC 0953
850 E. 58th St.
Chicago, IL 60637-1459

Dear Mr. Beberman:

We have reviewed the information provided for the above referenced project. This property is located within the Hyde Park – Kenwood Historic District, which was listed on the National Register of Historic Places on February 14, 1979. In our opinion the project meets The Secretary of the Interior's "Standards for Rehabilitation and Guidelines for Rehabilitation of Historic Buildings" and we concur in a finding of no adverse effect.

Carrying out the project in accordance with these plans constitutes compliance with the Illinois State Agency Resources Preservation Act.

If you have any questions, please contact me at 217/785-5027.

Sincerely,

Anne E. Haaker

Anne E. Haaker
Deputy State Historic
Preservation Officer

Section I, Project Costs and Source of Funds

Attachment 7

		Total	Clinical	Non-Clinical
New Construction				
Base Construction	82,546,370			
Distributed Antenna System	1,600,000			
Build Out Elevators (2)	2,400,000			
Telecom/IT Built-In Equip.	400,000			
Get Well Network	400,000			
Plant Shutdowns	660,000			
Security Devices	120,000			
Interior Signage	220,000			
Lock Cylinders, Keys	20,000			
		$88,366,370	$57,874,494	$30,491,876
Contingencies		6,186,000	4,051,447	2,134,553
Architectural/Engineering Fees		5,744,000	3,761,964	1,982,036
Consulting and Other Fees				
Elevator Consultant	40,000			
Legal	5,000			
Program Manager	800,000			
Equipment Planner	250,000			
CON Consultant	45,000			
CON Fee	100,000			
Permit Expeditor	12,000			
City Permit Fees	173,093			
IDPH Review Fees	40,000			
		1,465,093	959,545	505,548
Movable and Other Equipment				
medical-surgical Units	4,755,578			
Intensive Care Units	2,736,029			
Observation Units	3,051,099			
Other Clinical	5,898,511			
Furnishings	3,365,086			
Non-Clinical	379,750			
		20,048,253	19,668,503	379,750
Other Costs to be Capitalized				
Environmental Services	440,000			
Movers	440,000			
Art Work	15,000			
Capitalized Staff Salaries	800,000			
		1,695,000	1,110,120	584,880
Total Costs		$123,504,716	$87,426,073	$36,078,643

Section I, Cost Space Requirements

Attachment 9

Department/Area	Cost	Gross Square Feet		Amount of Proposed Total GSF That Is:			
		Existing	Proposed	New Constr.	Modern.	As Is	Vacated Space
Reviewable:							
medical-surgical Patient	$56,733,061	192,913	235,201	94,460		140,741	52,172
ICU Patient Units	15,349,893	81,948	77,446	20,964		56,482	25,466
Observation Patient Units	20,086,148	9,761	29,576	29,576		0	9,761
Total Reviewable	$92,169,102	284,622	342,223	145,000	0	197,223	87,399
Nonreviewable:							
Mechanical, Other Support	$31,335,614	1,483,352	1,559,747	76,395		1,483,352	
Total Nonreviewable	$31,335,614			76,395	0	1,483,352	
Grand Total	$123,504,716	2,052,596	2,244,193	221,395	0	1,877,798	174,798

Section III, Background of Applicant

Attachment 11

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

   UCMC's full general hospital license #2132869, effective July 1, 2013, issued by the Illinois Department of Public Health, is attached. UCMC's most recent accreditation letter from the Joint Commission, dated July 12, 2013, is attached.

2. **A certified listing of any adverse action taken against any facility owned and/or operated by applicant during the three years prior to the filing of the application.**

   There have been no adverse actions taken against UCMC within the prior three years. A letter attesting to this fact is attached.

3. **Authorization permitting HFSRB and DPH access to 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.**

   A letter granting the Review Board and the Illinois Department of Public Health access to information to verify information in the application is attached.

State of Illinois 2132869
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

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

LA MAR HASBROUCK, MD, MPH
DIRECTOR

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/14	8680	0003697

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/01/13

BUSINESS ADDRESS

THE UNIVERSITY OF CHICAGO MEDICAL CENTER
5841 SOUTH MARYLAND
MC 1112
CHICAGO IL 60637

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 2132869
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

THE UNIVERSITY OF CHICAGO MEDICAL CEN

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/14	8680	0003697

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/01/13

05/04/13

THE UNIVERSITY OF CHICAGO MEDICAL
5841 SOUTH MARYLAND
MC 1112
CHICAGO IL 60637

FEE RECEIPT NO.

Attachment – 11

The Joint Commission

July 12, 2013

Sharon O'keefe
President
University of Chicago Medical Center
5841 South Maryland Avenue
Chicago, IL 60637

Joint Commission ID #: 7315
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 07/11/2013

Dear Ms. O'keefe:

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

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

- Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning March 23, 2013. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

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

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

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

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

Attachment – 11

THE UNIVERSITY OF CHICAGO MEDICINE

Sharon O'Keefe
President

MC 1000 S-115
5841 South Maryland Avenue
Chicago, Illinois 60637-1470
phone (773) 702-8908
fax (773) 702-1897
sharon.okeefe@uchospitals.edu

April 15, 2014

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: University of Chicago Medical Center Permit Application – No Adverse Action

Dear Ms. Avery:

Please be advised that no disciplinary action relative to "Adverse Action" as defined under Section 1110.230(a)(1) of the Review Board Rules has been adjudicated against The University of Chicago Medical Center, or against any health care facility owned or operated by it, directly or indirectly, within three (3) years preceding the filing of the permit application.

Sincerely,

The University of Chicago Medical Center

Sharon O'Keefe
President

Notarization:
Subscribed and sworn to before me
This 10th day of April, 2014

Signature of Notary Public

Seal

"OFFICIAL SEAL"
CASSANDRA COLE
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 8/3/2017

Attachment – 11

THE UNIVERSITY OF CHICAGO MEDICINE

Sharon O'Keefe
President

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April 15, 2014

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: University of Chicago Medical Center Permit Application – Access to Information

Dear Ms. Avery:

I hereby authorize the State Board and State Agency access to information from any licensing/certification agency in order to verify any and all documentation or information submitted in relation to this permit application. I further authorize the Illinois Department of Public Health to obtain any additional documentation or information that said agency deems necessary for the review of the application as it pertains to Section 1110.230(a)(3)(C) of the Review Board Rules.

Sincerely,

The University of Chicago Medical Center

Sharon O'Keefe
President

Notarization:
Subscribed and sworn to before me
This 10th day of April, 2014

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Attachment - 11

Section III, Purpose of Project

Attachment 12

Overview of Purpose

The University of Chicago Medical Center ("UCMC") proposes to convert two floors of shelled space in its new hospital pavilion, the Center for Care & Discovery (the "CCD"), to inpatient floors (the "Project").

The Project has three components in which UCMC proposes to: (1) relocate 122 medical-surgical beds, all 32 of its ICU beds, and 15 observation beds from Mitchell Hospital ("Mitchell") to the CCD; (2) expand its licensed number of ICU beds by 12 to handle heavy patient use in this bed category, which would bring total number of licensed ICU beds to 126; and (3) increase the number of observation beds from 15 to 46, and operate the observation beds in units. UCMC's medical-surgical beds would remain at the current licensed number of 338.

1. **Document that the project will provide health care services that improve the health care or well-being of the market area population to be served.**

   As the sole academic medical center on the South Side of Chicago and closest tertiary hospital for the surrounding community hospitals, part of our mission at UCMC is to provide superior health care in a compassionate manner, ever mindful of each patient's dignity and individuality. To accomplish this mission, we rely upon the skills and expertise of all who work together to advance medical innovation, service the health needs of the community and further the knowledge of those dedicated to caring for patients.

   UCMC is a nationally recognized leader in patient care, research and medical education. Renowned for treating some of the most complex medical cases, we bring the very latest medical treatments to patients in Chicago's South Side community and we continue to invest in the capital resources necessary to maintain this effort. We routinely rank among the top providers of Medicaid services in Illinois.

   Over the past several years, we have experienced sustained, high demand for our medical-surgical and ICU bed categories. We now need to more fully deploy the space available in the CCD in order to create clinical and operational efficiencies and to allow patients to receive care in the most technologically advanced facilities available. Currently, there is also a calculated deficiency of ICU beds in Planning Area A-03. These capacity constraints come at a precarious time in health care delivery on Chicago's South Side, which has seen its hospital inventory contract by more than half over the past 25 years. UCMC is a valuable resource on the South Side of Chicago, and wants to remain viable in an era of health care reform in order to continue to serve patients who depend on us.

2. **Define the planning area or market area, or other, per the applicant's definition.**

As a major national academic medical center, UCMC essentially has two market areas. First, it serves much of the South Side of the City of Chicago, primarily in Planning Area A-03. In addition, for its highly specialized tertiary and quaternary services, UCMC serves much of the metropolitan area, the state and the Midwest, and international patients. These service areas are more precisely delineated in Attachment 20.

3. **Identify the existing problems or issues that need to be addressed, as applicable and appropriate for the project.**

A. **Need to Create Clinical Efficiencies**

UCMC proposes to maximize the full potential of its new hospital and create clinical efficiencies by relocating 122 of its medical-surgical beds and all 32 of its ICU beds from Mitchell to the CCD.

Mitchell Hospital was completed over 30 years ago. While the Mitchell building is adequate for high quality patient care, it is located remotely from the CCD and prevents full integration of patient care for patients requiring high intensity clinical resources. With this build out we seek to maximize the full potential of the CCD by relocating as many medical-surgical beds as possible (122) and all ICU beds (32) from Mitchell. This Project would enable us to locate 92% of UCMC's adult beds in the CCD, excluding obstetric beds, which means that more patients will be in close proximity to the advanced diagnostic, treatment and ancillary services available in the CCD. The Project would thereby obviate most long patient transports from Mitchell to the CCD, which average 20 minutes and several elevator rides, and the need for clinical staff to attend to their patients over a wide area. Additionally, the Project would provide important clinical adjacencies that will reduce redundancy and the inefficiency of operating in two separate buildings.

From a patient's perspective, the inpatient rooms in the CCD are sized to comfortably accommodate families and visitors, numerous pieces of equipment and the numerous providers who all work at the bedside in a teaching hospital. Longer term, by moving a majority of clinical operations to the CCD, we will minimize the square footage in the Mitchell building that would need to be maintained as a hospital, a cost prohibitive undertaking given its age and design. With a smaller clinical footprint in Mitchell, we could afford to improve and modernize the remaining hospital space according to standards comparable to the CCD and to provide all of our patients with access to the latest clinical technology and the amenities that they demand from a modern hospital.

The Project would also enable us to better accommodate continued strong demand for medical-surgical volume at UCMC, which has increased 6.3% annually in the past four years, especially as the demand for UCMC's sub-specialized services continues to grow. We forecast continued growth in medical-surgical days, which is driven, in relevant part, by key physician recruits in our Department of Medicine and Department of Orthopedic and Rehabilitation Medicine, an increased number of both operating rooms and GI procedure suites, and improvement in the throughput and efficiency of our use of beds.

Unlike other hospitals in our service area, UCMC has no reserve capacity to accommodate growth in inpatient utilization or even peak census periods. The lack of capacity creates numerous issues that directly bear upon our ability to provide patient care.

B. **Current Shortage of ICU Beds**

UCMC proposes expanding its licensed ICU beds by 12 to handle heavy patient use in this bed category, which would increase licensed ICU beds to 126.

In the past two years, UCMC's ICU beds have had average occupancy rates in excess of the State standard of 60%. For calendar year 2013, our adult ICU beds had an average occupancy rate of 72%, with an overall occupancy rate of 68% for both pediatric and adult ICU beds. We currently reach 80% of our licensed ICU bed capacity at some time during the day on 89% of days, a utilization level that well exceeds both the State standard and optimal clinical efficiency. As an academic medical center with tertiary and quaternary care, community hospitals regularly rely on UCMC to provide intensive care services to their high acuity patients. During peak periods of high volume, we are compelled to either delay access to care for these patients or to deny transfers when ICU beds are not available.

ICU beds also persist as an underserved category of service in our Planning Area A-03, and we seek to mitigate this deficiency to better serve our community with an increase of 12 ICU beds.

UCMC is a safety-net provider for patients and even other safety-net hospitals in Planning Area A-03, but we cannot keep pace with current demand. Hospitals in our primary service area, including Ingalls Memorial, St. Bernard, Mercy, Jackson Park, Roseland Community, Holy Cross, South Shore, Little Company of Mary, Advocate Trinity, MetroSouth Medical Center, and Provident Cook County rely on UCMC's specialized expertise. The need for ICU beds and the analogous resources is among the top ten requests for transfers of inpatients from outside hospitals. In the past year, more than one in five requests for medical ICU services from nearby hospitals could not be accommodated because of capacity constraints.

Additional beds are also required for UCMC to accommodate anticipated growth in key programs. For 2013 – 2014, we have recruited or plan to recruit surgeons for

whom the majority of patients are expected to require intensive care beds. The surgeons are in specialties including orthopedics, cardiovascular surgery, neurosurgery, general surgery, plastic and reconstructive surgery, as well as urological surgery.

C. **Increased Demand for Observation Beds**

UCMC proposes to relocate all of UCMC's observation bed inventory from Mitchell to the CCD, to increase the number of observation beds from 15 to 46, and to operate the observation beds in units.

In order to keep pace with industry standards, a growing trend to provide appropriate medical care in an ambulatory setting and changes in federal law, we seek to move our observation beds from Mitchell to the CCD, to increase the number of observation beds from 15 to 46, and to operate the observation beds in units. Currently, when operating at peak occupancy, we lack the flexibility to cohort observation patients and to concentrate the resources to care for them, which creates unnecessary inefficiencies and may detract from the patient experience. Additionally, over the past thirty (30) years, hospitals have seen a tremendous change in the mix of acute care, intensive care and observation care, delivered in their facilities. It is now an accepted industry standard that a hospital's observation beds should total approximately 15% of its medical-surgical bed inventory.

Moreover, effective October 1, 2013, the Centers for Medicare and Medicaid Services ("CMS") implemented a new rule, the "Two Midnight Rule," for determining whether a patient is admitted as an inpatient to a hospital or is there for observation, a standard whose application has already materially increased the need for observation beds for hospitals, including UCMC. Under this new rule, a patient who occupies a bed for fewer than two consecutive midnights is considered to be in observation status and not an inpatient. In the three months following the effective date of the new rule, we saw our number of observation patients nearly double for Medicare patients.

D. **Cite the sources of the information provided as documentation**.

UCMC undertakes ongoing internal utilization studies and the source of this information includes those reports and other information reported to EMS, IDFPR and IDPH.

E. **Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.**

The Project will address the previously referenced issues as well as the population's health status and well-being as follows:

1. **Project Creates Clinical Efficiencies in both CCD and Mitchell**

   The proposed development of two inpatient floors in the CCD will enable UCMC to locate 92% of its adult beds, excluding obstetrics beds, in the CCD, which means that more patients will be in close proximity to the advanced diagnostic, treatment and ancillary services available in the CCD. This would obviate long patient transports from Mitchell to the CCD, which average 20 minutes and several elevator rides, and the need for clinical staff to round on their patients over a wide area. Additionally, the Project would reduce the redundancy and the inefficiency of operating large-scale clinical operations in two separate buildings.

2. **Project Resolves Current Shortage of ICU Beds**

   One component of the Project adds 12 ICU beds, which helps alleviate the high rate at which our current ICU beds are being utilized and the overall shortage of ICU beds in Planning Area A-03. The additional ICU beds will improve access to UCMC not only for patients in the community and other community hospitals, but also by patients already at UCMC whose conditions merit more intensive inpatient resources. The additional ICU beds are also necessary so that newly recruited surgeons can schedule and perform medically necessary surgeries for their patients with the assurance that an appropriate bed will be available post-operatively.

3. **Project Resolves Shortage of Observation Beds and Streamlines the Delivery of Observation Care**

   Effective October 1, 2013, CMS revised its definition of observation beds, which has caused a dramatic increase in utilization of observation beds for Medicare patients. Similarly, because UCMC has expanded the number of GI procedure rooms in the CCD, many of which are same-day procedures, there is an increased need for observation beds by patients undergoing such procedures. The proposed new observation units in the CCD – two units of 23 beds, one on each of the third and fourth floors – would also enhance the quality of care in this setting by centralizing the nursing resources necessary for such stays as well as creating cost-saving efficiencies. The observation units would operate in close proximity to the medical-surgical and ICU unit

on these floors, which would allow patients to benefit from skilled staff in such units and cross coverage as necessary.

4. **Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals as appropriate.**

   This Project would relocate 122 medical-surgical beds and all 32 of UCMC's ICU beds from Mitchell to the CCD, add 12 ICU beds, and create two ambulatory observation bed units with a total of 46 beds.

   UCMC's prevailing objectives are two-fold: access and sustainability. Specifically, the goals of the Project are:

   - To concentrate clinical operations for the most acutely ill patients in the CCD, alongside the ancillary diagnostic and treatment modalities required for their medical care, and to improve clinical efficiency throughout UCMC's medical campus.

   - To decrease the number of specialized and high acuity patients transfers from area community hospitals that must be declined because of the unavailability of on open bed.

   - To meet increased demand for observation beds because of changes in both clinical practice and applicable law, as well as to streamline the delivery of medical care to patients in observation beds.

These goals can be achieved within the timeframe for Project completion.

Section III, Alternatives

Attachment 13

1. **Alternative Options**

A. **Consider Projects of Greater or Lesser Scope and Cost**

The reason for the proposed project is to locate as many medical-surgical and ICU beds as possible into the newly constructed CCD. A project of lesser scope would mean that we would not fully utilize the two currently shelled floors in the CCD, not making the best use of our most modern, efficient, and desirable building. A larger project enabling the move of even more beds out of Mitchell is not feasible because the CCD cannot accommodate all the beds. The only other shelled space available is located on the third floor of the Comer Center for Children and Specialty Services, with 25,000 square feet of undeveloped space. This building is currently used for UCMC's Pediatric Emergency Department, Pediatric Specialty Clinics, and Pediatric Special Procedures. We are considering locating UCMC's Labor & Delivery services to this space as we combine the operations of Women's and Children's Services. Thus, this space may not be available. Because of the available space in the CCD, neither option is feasible, but if it were the cost of the larger or smaller options would likely be more or less than the estimated $124 million for the proposed option.

B. **Pursue a Joint Venture with Other Providers**

The majority of our patients reside in Planning Area A-03 (South Chicago). While there are community hospitals in Planning Area A-03 with underutilized beds, these facilities do not offer the specialty services and intensity of care that UCMC does. Only ICU beds are being added. Using case mix index (CMI) data from 2012 discharges Planning Area (see attached), our case mix index, a measure of the complexity of patients treated, was 1.8987. This is 69% higher than the weighted average CMI of the other Planning Area A-03 hospitals of 1.1254. Assuming these hospitals could provide the tertiary and quaternary services we do, there likely would be renovation and equipment costs as these hospitals bring beds on line that might have been mothballed. We estimate this cost at $57 million.

C. **Utilize Other Academic Medical Centers**

There are other academic medical centers providing excellent quaternary and tertiary care in the Chicago Metropolitan area, however, UCMC's the only academic medical center located in Planning Area A-03. Most of our patients reside in this area and many have a history of receiving care at our hospital. We believe these patients prefer receiving their care at UCMC and would not want to go elsewhere, outside their community.

We are not increasing the number of medical-surgical beds. If UCMC were to forfeit the capacity reflected in the 212 beds the Project involves it would reduce the scale of our operations by 30%. The average bed size of the other academic medical centers in the Chicagoland area is 672 beds. Nationally, UCMC's peer institutions typically range from 800 to 1,100 beds. Were UCMC to refer patients and consequently the need for these beds elsewhere, we would drop to 441 beds, which is a scale that is inefficient and problematic in terms of maintaining the viability and vitality of our enterprise and the 'bench strength' of our faculty. (The departure of one key faculty member could 'gut' a smaller service.) The size of our hospital is also important for teaching resident physicians and medical students. A smaller facility would be less able to provide the broad and deep range of services we offer. Further, we believe that in several service areas, we deliver care that is superior to that found elsewhere in our region.

D. **Renovate Mitchell**

An on-site alternative considered was renovating patient units in Mitchell. Presently we occupy 4 of the original 6 ICU's and 8 of medical-surgical units at Mitchell. In order to renovate these areas to provide the most modern inpatient areas possible, it would require gutting the existing floors, replacing all infrastructure, while staging the renovations in multiple phases since there are 12 active patient units there presently. The cost would be $116 million. However, total available space is only 155,000 dgsf compared to 221,000 dgsf in the CCD, or 70% as much space. Assuming that patient room size would be constrained at this rate, the dgsf per medical-surgical room would be 493 and for ICU's it would be 458, both of which are below the low range of the State standards of 500 and 600 dgsf per bed respectively.

The problem with re-using a building constructed in the early 1980's is that the expectation for patient room size has changed. Mitchell had a combination of private rooms and double occupancy rooms which, while acceptable for that era, is not what patients and families desire today. Investing $116 million in a 31 year-old building versus $124 million in a new building is makes more sense economically. Instead, using the former Mitchell building for less intensive purposes (e.g., offices, meeting rooms and storage) makes more sense than spending large sums trying to modernize this building for high intensity uses.

E. **Relocate Beds to the CCD**

The proposed option was selected because it consolidates 100% of adult ICU and 92% of medical-surgical beds in the new CCD. This is critical for optimal clinical operations due to the many difficulties of operating between two buildings that are a 20 minute walk and several elevator rides apart. It will allow us to make the fullest use of our newest and most modern building, reaping the maximum benefit from this

substantial investment. The cost is $124 million, but achieves the most benefits of the options considered.

2. Comparison of Alternatives

A chart comparing the alternatives UCMC considered is attached.

ATTACHMENT 13

Alternatives to the Proposed Project
Cost/Benefit Analysis

Alternative	Costs	Benefits/Limitations
1. Project of greater or lesser scope	Project cost greater or less than $124 million	Benefits: - larger could empty Mitchell Hospital - smaller would cost less Limitations: - larger does not fit in CCD - smaller does not fully use CCD space
2. Joint venture with A-03 hospitals	Cost of upgrading patient units $57 million	Benefits: - Lower cost - Increase occupancy of underused beds Limitations: - Specialty services may not be available. - Staff expertise might be insufficient.
3. Refer patients to other academic medical centers in Chicago area	Cost of upgrading patient units $57 million	Benefits: - Possibly lower costs - Increase occupancy of underused beds Limitations: - South Chicago patients might not wish to be referred elsewhere - Would effectively reduce UCMC from 617 to 441 beds, too small to support programs and remain viable.
4. Renovate Mitchell Hospital	Cost of renovation $116 million	Benefits: - Slightly lower cost - Would leave CCD 3,4 open for other uses. Limitations: - Disruptive to active patient units in Mitchell - Less space available in Mitchell than CCD so room size would be below State minimum standards - Would not consolidate most adult inpatient service in CCD making operation more difficult and less efficient
5. Relocate Beds to CCD shelled Floors 3 and 4	Cost of renovation $124 million	Benefits: - Substantially consolidates inpatient services in new CCD - Makes full use of most modern and desirable space avaialble. - Achieves best balance of cost and benefits

ATTACHMENT 13

CASE MIX INDEX
A-3 PLANNING AREA

A-3 Planning Area	FY12 Discharges (excl normal newborns)	Case Mix Index	Index x Disch.	Non-UCMC Discharges	Wtd. Avg. Non-UCMC
UNIVERSITY OF CHICAGO MEDICAL CENTER	24,006	1.8987			
MERCY HOSPITAL & MEDICAL CENTER - CHICAGO	14,674	1.2788	18765.1112		
ADVOCATE TRINITY HOSPITAL - CHICAGO	11,389	1.2378	14097.3042		
HOLY CROSS HOSPITAL	9,950	1.2085	12024.575		
SOUTH SHORE HOSPITAL	4,283	1.0923	4678.3209		
ROSELAND COMMUNITY HOSPITAL	4,971	0.9802	4872.5742		
ST BERNARD HOSPITAL & HEALTH CARE CENTER	8,499	0.9797	8326.4703		
JACKSON PARK HOSPITAL	9,576	0.9428	9028.2528		
PROVIDENT HOSPITAL OF COOK COUNTY	1,527	0.7933	1211.3691		
			73003.9777	64,869	1.1254

Conclusion: UCMC CMI is 69% greater than weighted avg. for the other A-3 hospitals. 69%

Section IV, Project Size

Attachment 14

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
Medical/Surgical Beds	705	500 - 660	45 dgsf/bed	No
ICU Beds	655	600 - 685	(30) dgsf/bed	Yes
Observation Beds		NA		NA

1) **Proposed Space is Necessary and Not Excessive**

This Project maximizes the new, modern CCD and relocates as many of the inpatient beds as possible from Mitchell to the CCD. It is operationally difficult to have adult inpatient services in two buildings, with a 20 minute patient transport time and two elevator rides. When the CCD was built, the 3rd and 4th floors were left empty, in part to allow the advantage of having significant space to address future needs. Admittedly, the large investment the CCD project entailed ($730 million) was a consideration in delaying the complete build-out.

The Project proposes to place 134 medical-surgical beds, 32 ICU beds, and 46 observation beds on the 3rd and 4th floors of the CCD. We presently operate 8 medical-surgical units, 4 ICUs, and 1 observation unit in Mitchell. After the Project, there will be no ICUs and no observation beds in Mitchell and only 28 medical-surgical beds for less acute patients and two units of 46 obstetrics beds. The 4th, 5th, and 6th floors of Mitchell will be vacated and converted to non-clinical faculty and related staff offices for UCMC's Biological Sciences Division for academic use only (no clinical).

A copy of the detailed space program is attached.

The design of the 3rd and 4th floors of the CCD is fairly straightforward, consisting entirely of patient beds – medical-surgical, ICU, and observation. Having observation patients situated near the nursing staff caring for the acute and intensive patients, since these nurses have special skills relating to the type of observation these patients are undergoing. To maximize the number of patient beds we can place on these floors, we have designed the medical-surgical and ICU rooms sizes somewhat smaller than on the other CCD patient unit floors. Where we had 80 beds per floor previously, we will now have 83, in addition to 5 observation beds along the exterior wall. There will also be 18 observation beds in the center core of each floor, whereas with the upper floors, there are offices, meeting rooms, and work rooms in the center. Because these rooms will not have external windows, under the IDPH architectural standards they could not be converted to medical-surgical beds in the future. Seven years ago when the CCD was designed, the need for observation beds was less urgent. Because the medical-surgical beds are now

mostly full with acute patients and a recent change in CMS' definition of an inpatient stay versus observation, there is greater demand for observation beds.

The design of the medical-surgical and ICU rooms is much the same as on the other floors. Room sizes are mostly predetermined by structural members, mechanical and electrical risers, and window mullions that reflect the original design on the upper patient floors. Each room will have a shower, handicapped accessible bathroom, and clinical circulation space around the patient bed. There is a family zone alongside the exterior windows, with a couch that folds into a bed for overnight stays. There are 44 isolation rooms on the two floors for the 24 medical-surgical and ICU units. There will be work alcoves outside each room in which a nurse can sit and enter information on a computer, while being able to observe the patient through a window. The alcoves are spacious enough to accommodate the large teams of nurses, medical students, residents, and attending physicians who 'round' on the patients. While these teams will also enter the room while the patient is being examined and interviewed, they are able to consult outside of the room. This is less intrusive for the patient, who can feel overwhelmed by the large groups of clinicians that are common in academic medical centers. The patient is also spared the noise from the corridor if their door is closed and enjoys a high level of privacy.

The design intent was to place as many beds as possible on these floors, while maintaining the standards of family-friendly space in each room, and affording a quiet and private setting for patient comfort and healing. Because of the desire to locate as many beds as possible on the shelled floors, we achieved efficient use of space. On each floor, there are 2 family/visitor restrooms outside of the patient room, 2 family lounges, and 2 family consult rooms. Each floor has 6 conference rooms, 2 staff locker rooms, 2 staff lounges, 2 staff restrooms, 4 resident work rooms, and 4 on-call rooms. The Project also includes some work on the 2nd floor in mechanical areas, adding infrastructure to serve these additional floors. The detailed space program is found in Attachment 14.

2) <u>Justification of Discrepancy in Square Footage</u>

The average dgsf per ICU bed is 655, which is within the State's standard range of 500 to 660. However, the medical-surgical units exceed the State's upper standard of 660 with an average area of 705 dgsf per bed. Two factors contribute to this variance.

There are 22 isolation rooms planned for the 12 units on the 3rd floor and 18 for the 8 units on the 4th Floor. Ordinarily, there is 1 isolation room on each unit, but we planned for more isolation rooms to make our beds more flexible and to handle surges of patients requiring isolation. As we are one of a limited number of hospitals providing very specialized cancer care and offering organ transplant, we must have open isolation beds to accommodate transfer requests from community hospitals that do not provide these services. If there were 1 isolation room for every unit, the total would be 20. Thus of the 40 that are planned, 20 are additional. At 86.4 dgsf each represent 13 dgsf for each of the 134 medical-surgical beds.

Nurse alcoves exterior to the patient rooms require, at a minimum, 22 dgsf per room. Many hospitals are designed for charting within the room, often with a computer on wheels that can be brought in, or a desktop computer accessible by the nurse within the room. To improve patient privacy and reduce noise in the patient room, we prefer to have nurses do charting outside the room, with a window into the room for observing the patient in a less intrusive way.

Finally, our patient rooms will each have a shower in the bathroom. While this is not required, we think this is a priority for patients and occasionally rooming-in family members. This adds 17 dgsf per room.

The extra isolation rooms contribute 13 dgsf per bed, the charting alcoves 22 dgsf per bed, and the showers 17 dgsf per room, for a total of 52 dgsf, which accounts for the square footage by which we exceed the State standard.

DETAIL

	Quant	Net Area	Net Area	Sub Total Net Area Med/Surg	Sub Total Net Area Observation	Sub Total Net Area Non Clinical Support	Sub Total Net Area ICU	Unit Sub Total Net Area	Total Units per Floor	Total Net Area per Floor
THIRD FLOOR LEVEL										
Corner Medical-Surgical Care Unit- (8) Beds				3,774	0	0	0	3,774	4	15,096
Private Patient Room	8	288	2,304							
Isolation Ante Room	2	60	120							
Patient Toilet	8	55	440							
Staff Alcove	8	15	120							
Staff Toilet	1	55	55							
Clean & Medications	1	200	200							
Nourishment	1	65	65							
Staff Workstation	1	270	270							
Staff Work Room	1	160	160							
PPE/Linen	4	10	40							
Medical-Surgical Unit- (8) Beds				3,774	0	0	0	3,774	3	11,322
Private Patient Room	8	288	2,304							
Isolation Ante Room	2	60	120							
Patient Toilet	8	55	440							
Staff Alcove	8	15	120							
Staff Toilet	1	55	55							
Clean & Medications	1	200	200							
Nourishment	1	65	65							
Staff Workstation	1	270	270							
Staff Work Room	1	160	160							
PPE/Linen	4	10	40							
Medical-Surgical @ DCAM- (6) Beds				3,203	0	0	0	3,203	1	3,203
Private Medical-Surgical Patient Room	6	288	1,728							
Medical- Surgical Patient Toilet	6	55	330							
Isolation Ante Room	2	60	120							
Staff Alcove-Med/Surg	6	15	90							
Staff Toilet	1	55	55							
Clean & Medications	1	250	250							
Staff Workstation	1	270	270							
Staff Work Room	1	160	160							
Equipment Storage	1	200	200							
Observation @ DCAM- (2) Beds				0	765	0	0	765	1	765
Private Observation Patient Room	2	275	550							
Observation Patient Toilet	2	40	80							
Staff Alcove-Observation	2	15	30							
Nourishment	1	65	65							
PPE/Linen	4	10	40							
Medical-Surgical - (6) Beds				2,998	0	0	0	2,998	1	2,998
Private Med-Surg Patient Room	6	288	1,728							
Med-Surg Patient Bath	6	55	330							
Isolation Ante Room	2	60	120							
Staff Alcove-Med/Surg	3	15	45							
Staff Toilet	1	55	55							
Staff Workstation	1	270	270							
Clean & Medications	1	250	250							
Equipment Storage	1	200	200							
Observation Unit - (4) Beds				0	1,780	0	0	1,780	1	1,780
Private Observation Patient Room	4	275	1,100							
Observation Patient Toilet	4	40	160							
Staff Alcove-Observation	3	15	45							
Staff Work Room	1	160	160							
PPE/Linen	5	10	50							
Nourishment	1	65	65							
Soiled Utility	1	150	150							
Equipment Alcoves	1	50	50							
Medical-Surgical @ DCAM- (3) Beds				1,719	0	0	0	1,719	1	1,719
Private Med-Surg Patient Room	3	288	864							
Med-Surg Patient Bath	3	55	165							
Isolation Ante Room	2	60	120							
Staff Alcove-Med/Surg	3	15	45							
Staff Toilet	1	55	55							
Staff Workstation	1	270	270							
Equipment Storage	1	200	200							
Observation Unit @ DCAM- (7) Beds				0	2,925	0	0	2,925	1	2,925
Private Observation Patient Room	7	275	1,925							
Observation Patient Toilet	7	40	280							
Staff Alcove-Observation	3	15	45							
Staff Work Room	1	160	160							
PPE/Linen	5	10	50							
Clean & Medications	1	200	200							
Nourishment	1	65	65							
Soiled Utility	1	150	150							
Equipment Alcoves	1	50	50							
Medical-Surgical - (6) Beds				2,928	0	0	0	2,928	2	5,856
Private Med-Surg Patient Room	6	288	1,728							

ATTACHMENT 14

	Quant	Net Area	Net Area	Sub Total Net Area Med/Surg	Sub Total Net Area Observation	Sub Total Net Area Non Clinical Support	Sub Total Net Area ICU	Unit Sub Total Net Area	Total Units per Floor	Total Net Area per Floor
Med-Surg Patient Bath	6	55	330							
Isolation Ante Room	2	50	100							
Staff Alcove-Med Surg	3	15	45							
Staff Toilet	1	55	55							
Staff Workstation	1	270	270							
Clean & Medications	1	200	200							
Equipment Storage	1	200	200							
				0	2,095	0	0	2,095	2	4,190
Observation Unit- (5) Beds										
Private Observation Patient Room	5	275	1,375							
Observation Patient Toilet	5	40	200							
Staff Alcove-Observation	3	15	45							
Staff Work Room	1	160	160							
PPE/Linen	5	10	50							
Nourishment	1	65	65							
Soiled Utility	1	150	150							
Equipment Alcoves	1	50	50							
				0	0	1,055	0	1,055	4	4,220
Non Clinical Shared Staff & Support for Med-Surg & Observation										
Soiled Utility	1	200	200							
Janitor Closet	1	55	55							
Linen Chute Room	1	150	150							
Trash Chute Room	1	150	150							
Equipment Storage	2	200	400							
Equipment Alcoves	2	50	100							
				0	0	475	0	475	4	1,900
Non Clinical Shared Public Areas for Med-Surg & Observation										
Family Lounge	1	300	300							
Family Consult	1	120	120							
Family Toilet	1	55	55							
				0	0	205	0	205	4	820
Non Clinical Shared Public Areas for Med-Surg & Observation										
Visitor Toilet	1	55	55							
Family Lounge/Consult	1	150	150							
				0	0	380	0	380	4	1,520
Non Clinical Shared Staff & Support for Med-Surg & Observation										
Janitor Closet	2	40	80							
Linen Chute Room	1	150	150							
Trash Chute Room	1	150	150							
				0	0	8,800	0	8,800	1	8,800
Non Clinical Staff & Support Areas										
Elevator Lobbies	2	600	1,200							
Freight Elevator Lobbies	2	450	900							
Resident Rooms	4	300	1,200							
Lockers/Toilets	2	900	1,800							
Conference Rooms	6	300	1,800							
Staff Lounges	2	300	600							
Control	2	400	800							
On-Call Rooms	4	110	440							
On Call Bath	1	60	60							
				0	0	1,000	0	1,000	1	1,000
Other Public Areas										
Public Elevator Lobbies	2	500	1,000							
										68,114
TOTAL THIRD FLOOR NET AREAS										1.50
Grossing Factor										102,000
THIRD FLOOR GROSS AREA										
THIRD FLOOR TOTAL NUMBER OF BEDS										
FOURTH FLOOR LEVEL										
				0	0	0	3,774	3,774	3	11,322
Corner Intensive Care Unit- (8) Beds										
Private Patient Room	8	288	2,304							
Isolation Ante Room	2	60	120							
Patient Toilet	8	55	440							
Staff Alcove	8	15	120							
Staff Toilet	1	55	55							
Clean & Medications	1	200	200							
Nourishment	1	65	65							
Staff Workstation	1	270	270							
Staff Work Room	1	160	160							
PPE/Linen	4	10	40							
				0	0	0	4,124	4,124	1	4,124
Corner Intensive Care Unit- (8) Beds- Burn Unit										
Private Patient Room	8	288	2,304							
Isolation Ante Room	2	60	120							
Patient Toilet	8	55	440							
Staff Alcove	8	15	120							
Staff Toilet	1	55	55							
Clean & Medications	1	200	200							
Nourishment	1	65	65							
Staff Workstation	1	270	270							
Staff Work Room	1	160	160							
Burn Therapy Room	1	200	200							
Burn Unit Support Room	1	150	150							
PPE/Linen	4	10	40							

ATTACHMENT 14

Section IV. Size of Project

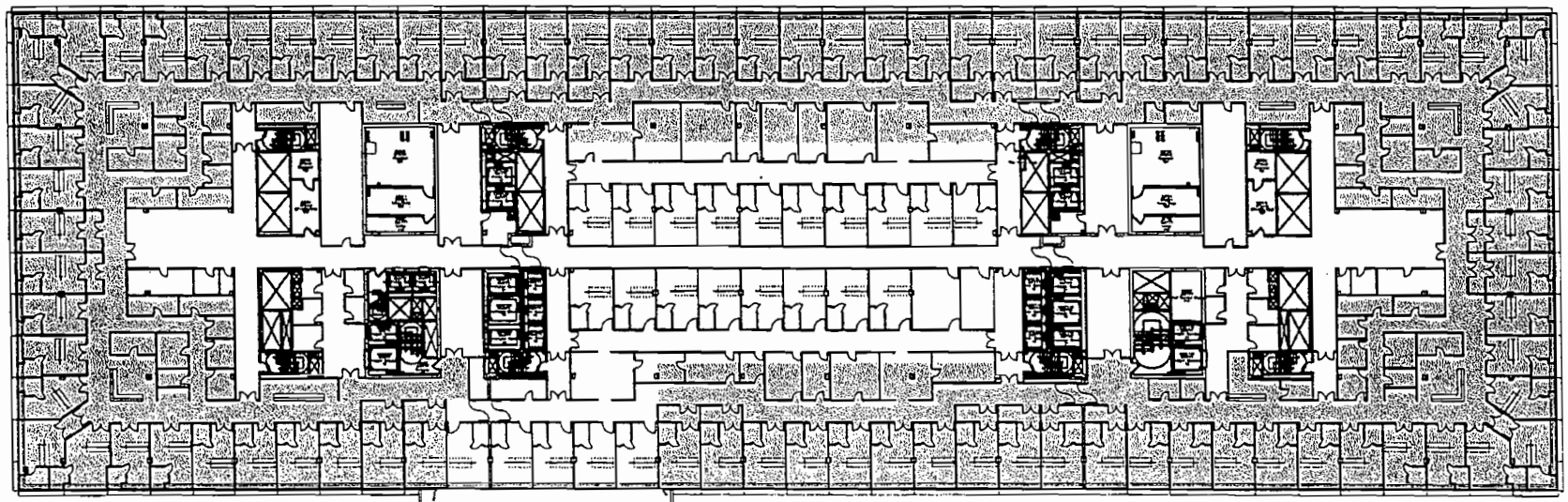
	Quant	Net Area	Net Area	Sub Total Net Area Med/Surg	Sub Total Net Area Observation	Sub Total Net Area Non Clinical Support	Sub Total Net Area ICU	Unit Sub Total Net Area	Total Units per Floor	Total Net Area per Floor
Medical-Surgical Unit- (8) Beds				4,074	0	0	0	4,074	3	12,222
Private Patient Room	8	288	2,304							
Isolation Ante Room	2	60	120							
Patient Toilet	8	55	440							
Staff Alcove	8	15	120							
Staff Toilet	1	55	55							
Clean & Medications	1	250	250							
Nourishment	1	65	65							
Staff Workstation	1	270	270							
Staff Work Room	1	160	160							
Equipment Storage	1	250	250							
PPE/Linen	4	10	40							
Medical-Surgical @ DCAM- (6) Beds				3,253	0	0	0	3,253	1	3,253
Private Medical-Surgical Patient Room	6	288	1,728							
Medical- Surgical Patient Toilet	6	55	330							
Isolation Ante Room	2	60	120							
Staff Alcove-Med/Surg	6	15	90							
Staff Toilet	1	55	55							
Clean & Medications	1	250	250							
Staff Workstation	1	270	270							
Staff Work Room	1	160	160							
Equipment Storage	1	250	250							
Observation Unit @ DCAM- (2) Beds				0	765	0	0	765	1	765
Private Observation Patient Room	2	275	550							
Observation Patient Toilet	2	40	80							
Staff Alcove-Observation	2	15	30							
Nourishment	1	65	65							
PPE/Linen	4	10	40							
Medical-Surgical - (6) Beds				2,948	0	0	0	2,948	1	2,948
Private Med-Surg Patient Room	6	288	1,728							
Med-Surg Patient Bath	6	55	330							
Isolation Ante Room	2	60	120							
Staff Alcove-Med/Surg	3	15	45							
Staff Toilet	1	55	55							
Staff Workstation	1	270	270							
Clean & Medications	1	200	200							
Equipment Storage	1	200	200							
Observation Unit- (4) Beds				0	1,780	0	0	1,780	1	1,780
Private Observation Patient Room	4	275	1,100							
Observation Patient Toilet	4	40	160							
Staff Alcove-Observation	3	15	45							
Staff Work Room	1	160	160							
PPE/Linen	5	10	50							
Nourishment	1	65	65							
Soiled Utility	1	150	150							
Equipment Alcoves	1	50	50							
Medical-Surgical @ DCAM- (3) Beds				1,719	0	0	0	1,719	1	1,719
Private Med-Surg Patient Room	3	288	864							
Med-Surg Patient Bath	3	55	165							
Isolation Ante Room	2	60	120							
Staff Alcove-Med/Surg	3	15	45							
Staff Toilet	1	55	55							
Staff Workstation	1	270	270							
Equipment Storage	1	200	200							
Observation Unit @ DCAM- (7) Beds				0	2,925	0	0	2,925	1	2,925
Private Observation Patient Room	7	275	1,925							
Observation Patient Toilet	7	40	280							
Staff Alcove-Observation	3	15	45							
Staff Work Room	1	160	160							
PPE/Linen	5	10	50							
Clean & Medications	1	200	200							
Nourishment	1	65	65							
Soiled Utility	1	150	150							
Equipment Alcoves	1	50	50							
Medical-Surgical - (6) Beds				2,948	0	0	0	2,948	2	5,896
Private Med-Surg Patient Room	6	288	1,728							
Med-Surg Patient Bath	6	55	330							
Isolation Ante Room	2	60	120							
Staff Alcove-Med Surg	3	15	45							
Staff Toilet	1	55	55							
Staff Workstation	1	270	270							
Clean & Medications	1	200	200							
Equipment Storage	1	200	200							
Observation Unit- (5) Beds				0	2,095	0	0	2,095	2	4,190
Private Observation Patient Room	5	275	1,375							
Observation Patient Toilet	5	40	200							
Staff Alcove-Observation	3	15	45							
Staff Work Room	1	160	160							

ATTACHMENT 14

Section IV. Size of Project

	Quant	Net Area	Net Area	Sub Total Net Area Med/Surg	Sub Total Net Area Observation	Sub Total Net Area Non Clinical Support	Sub Total Net Area ICU	Unit Sub Total Net Area	Total Units per Floor	Total Net Area per Floor
PPE/Linen	5	10	50							
Nourishment	1	65	65							
Soiled Utility	1	150	150							
Equipment Alcoves	1	50	50							
Non Clinical Shared Staff & Support for ICU & Med-Surg				0	0	1,055	0	1,055	4	4,220
Soiled Utility	1	200	200							
Janitor Closet	1	55	55							
Linen Chute Room	1	150	150							
Trash Chute Room	1	150	150							
Equipment Storage	2	200	400							
Equipment Alcoves	2	50	100							
Non Clinical Shared Public Areas for ICU & Med-Surg				0	0	475	0	475	4	1,900
Family Lounge	1	300	300							
Family Consult	1	120	120							
Family Toilet	1	55	55							
Non Clinical Shared Public Areas for Med-Surg & Observation				0	0	205	0	205	4	820
Visitor Toilet	1	55	55							
Family Lounge/Consult	1	150	150							
Non Clinical Shared Staff & Support for Med-Surg & Observation				0	0	410	0	410	4	1,640
Janitor Closet	2	55	110							
Linen Chute Room	1	150	150							
Trash Chute Room	1	150	150							
Non Clinical Staff & Support Areas				0	0	8,800	0	8,800	1	8,800
Elevator Lobbies	2	600	1,200							
Freight Elevator Lobbies	2	450	900							
Resident Rooms	4	300	1,200							
Lockers/Toilets	2	900	1,800							
Conference Rooms	6	300	1,800							
Staff Lounges	2	300	600							
Control	2	400	800							
On-Call Rooms	4	110	440							
On Call Bath	1	60	60							
Other Public Areas				0	0	1,000	0	1,000	1	1,000
Public Elevator Lobbies	2	500	1,000							
TOTAL FOURTH FLOOR NET AREAS										69,524
Grossing Factor										1.47
FOURTH FLOOR GROSS AREA										102,000

ATTACHMENT 14



THIRD FLOOR

MEDICAL/SURGICAL UNIT

Kahn

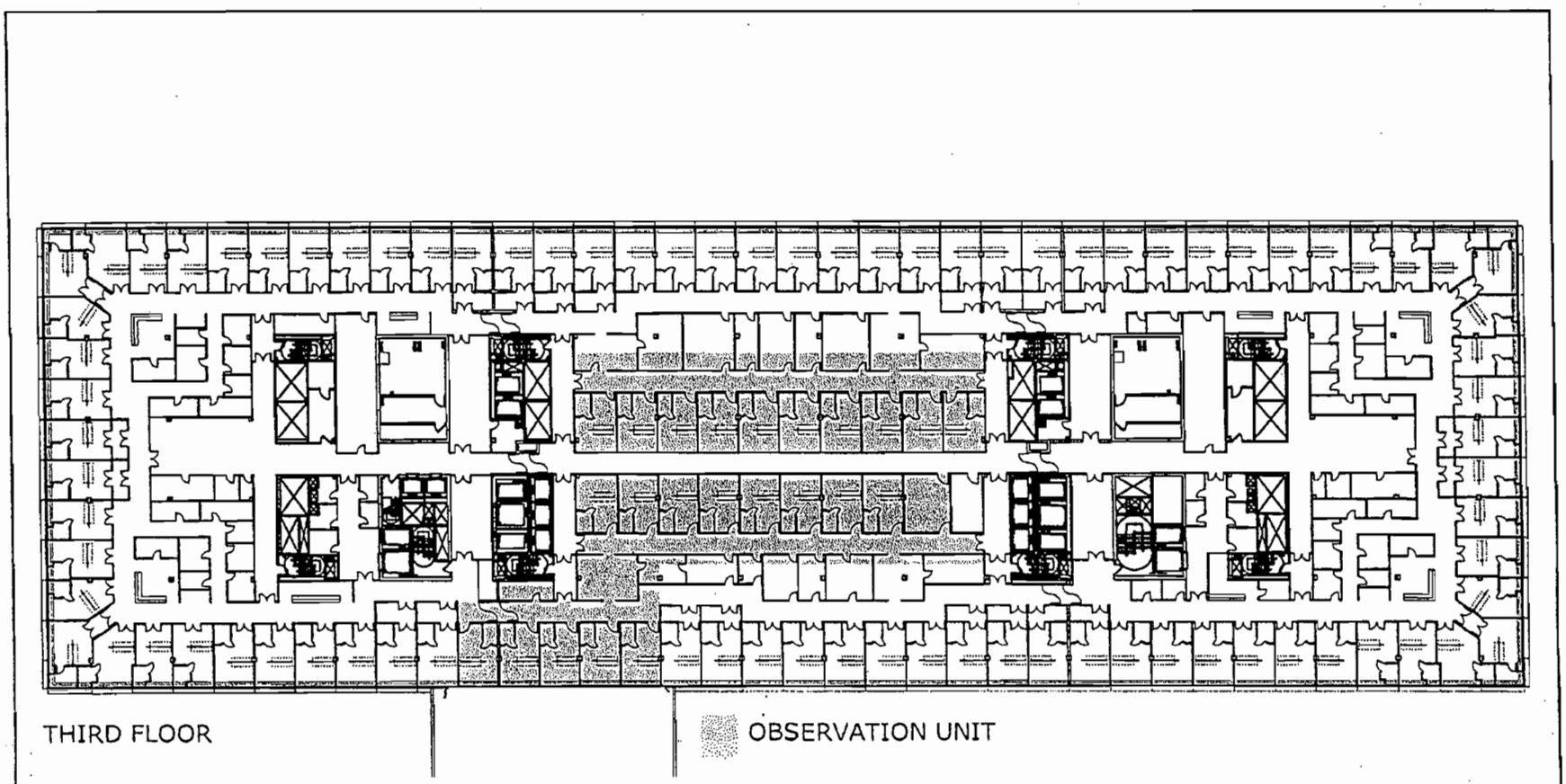
Albert Kahn Building
7430 Second Ave.
Detroit, Michigan 48202

0' 1' 2'

1" = 1'

UNIVERSITY OF CHICAGO BIOLOGY AND MEDICINE	ABS: Center for Care and Discovery	
	PLAN	NORTH ↑
OFFICE OF SPACE PLANNING AND REAL ESTATE MANAGEMENT	DATE 03/14/2014	FLOOR 03

Attachment 14



Kahn
Albert Kahn Building
7430 Second Ave.
Detroit, Michigan 48202

0' 1' 2'
1" = 1'

UNIVERSITY OF CHICAGO
BIOLOGY AND MEDICINE

OFFICE OF SPACE PLANNING
AND REAL ESTATE MANAGEMENT

A05: Center for Care and Discovery

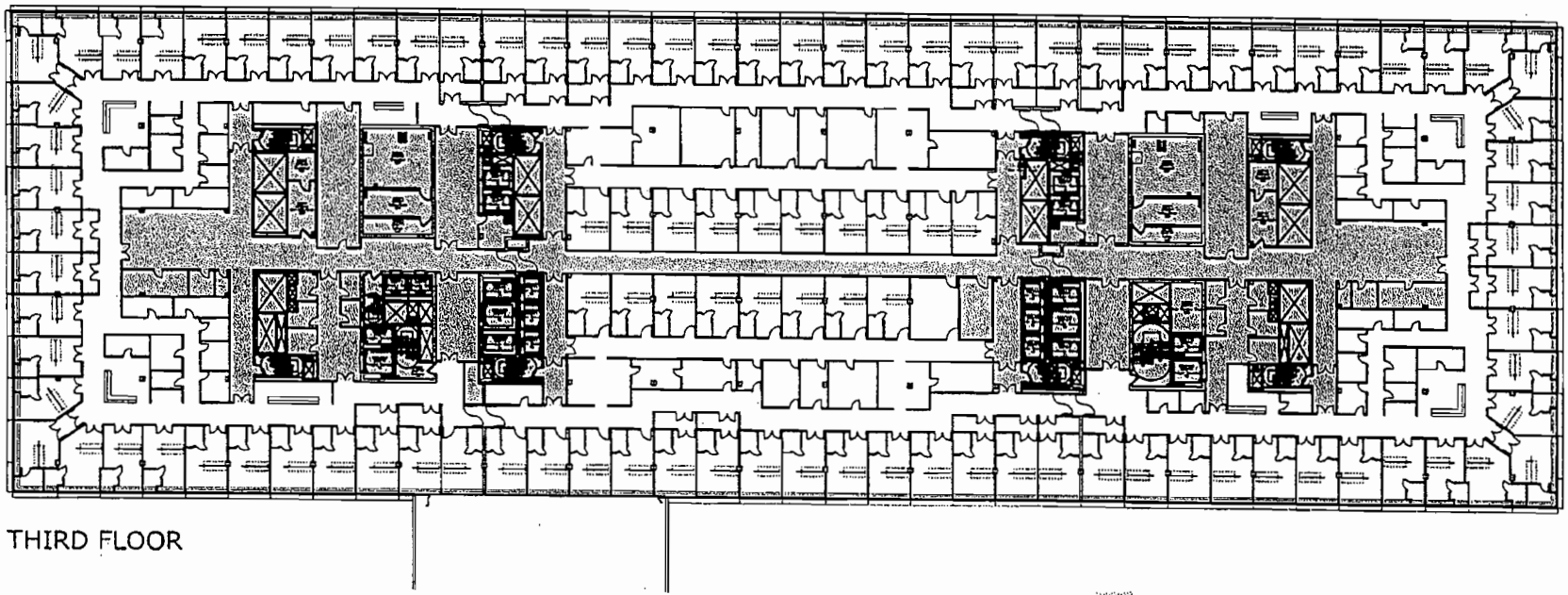
PLAN | NORTH

DATE 03/14/2014 | FLOOR 03

000122

ATTACHMENT 14

Attachment 14



THIRD FLOOR

NON CLINICAL SUPPORTS AREAS

Kahn

Albert Kahn Building
7430 Second Ave.
Detroit, Michigan 48202

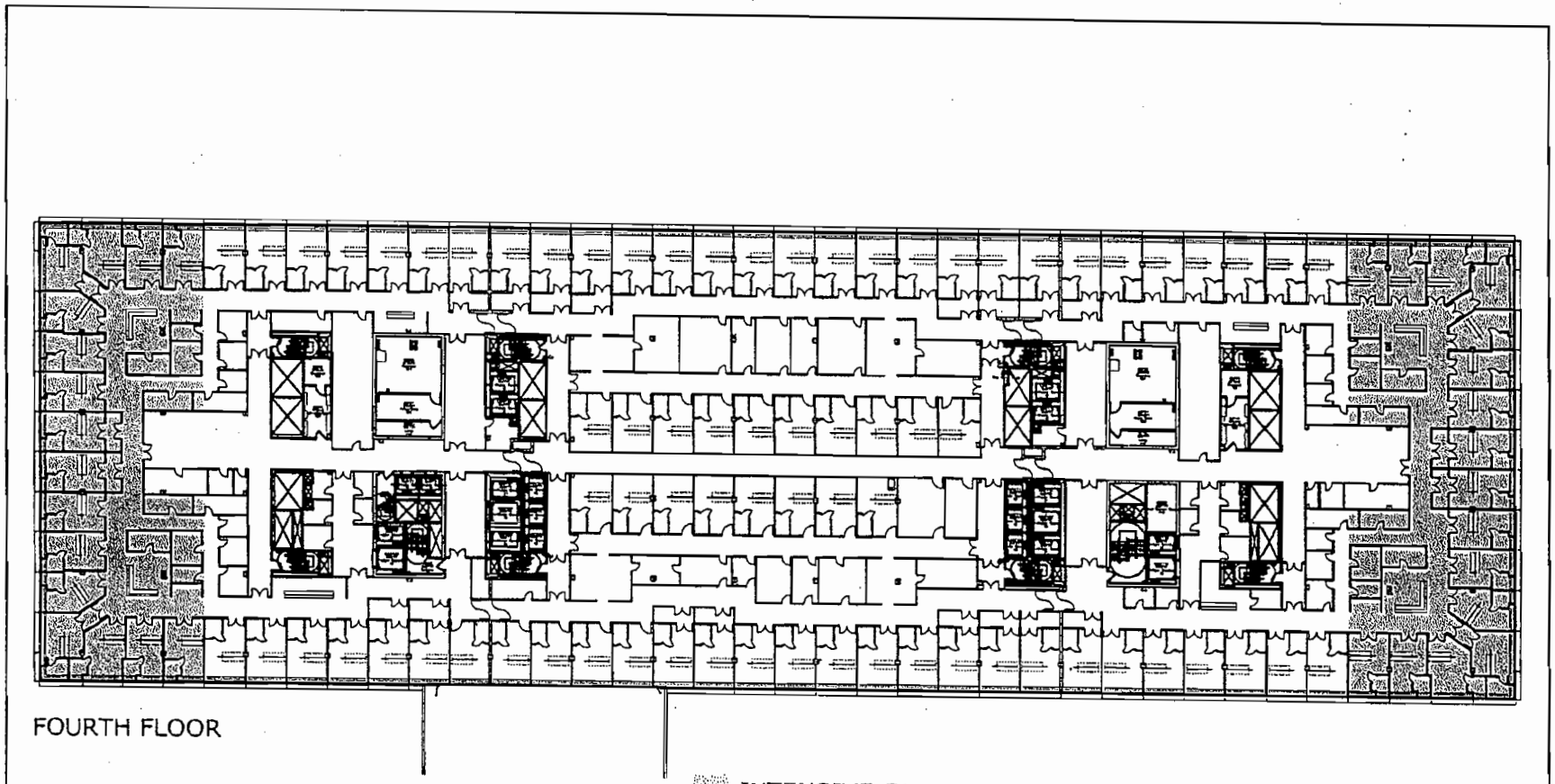
0' 1' 2'
1" = 1'

UNIVERSITY OF CHICAGO BIOLOGY AND MEDICINE	A95: Center for Care and Discovery	
PLAN	NORTH ↑	
OFFICE OF SPACE PLANNING AND REAL ESTATE MANAGEMENT	DATE 03/07/2014	FLOOR 03

Attachment 14

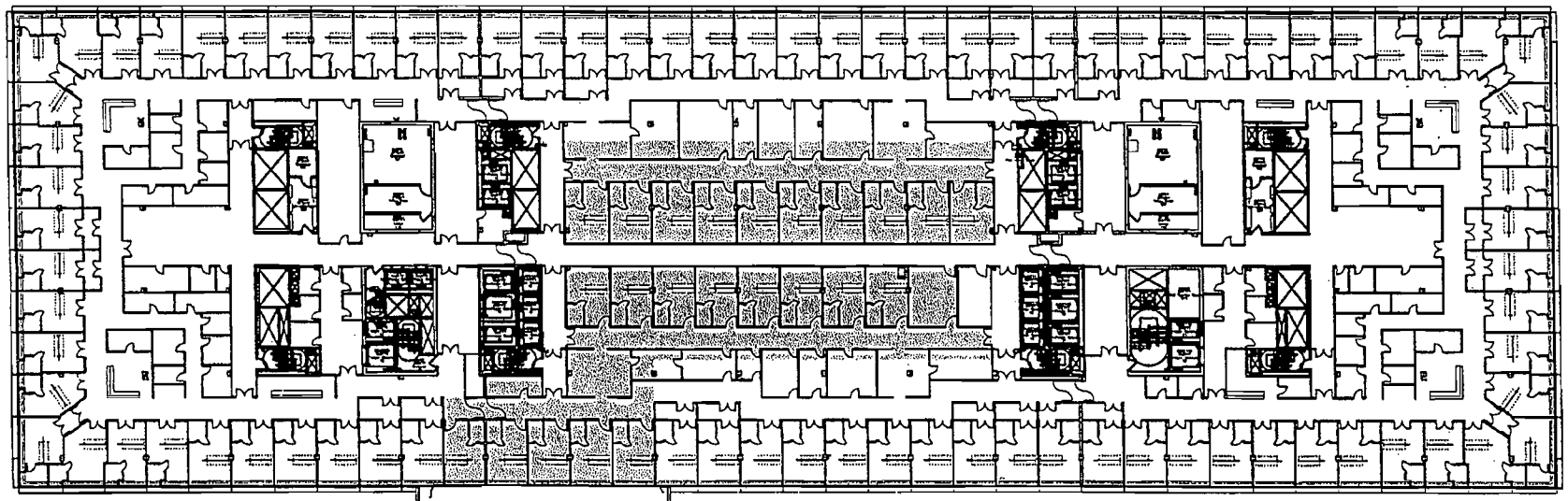
000123

ATTACHMENT 14



Attachment 14

ATTACHMENT 14



FOURTH FLOOR

OBSERVATION UNIT

Kahn

Albert Kahn Building
7430 Second Ave.
Detroit, Michigan 48202

0' 1' 2'

1" = 1'

UNIVERSITY OF CHICAGO BIOLOGY AND MEDICINE

ABS: Center for Care and Discovery

PLAN

NORTH

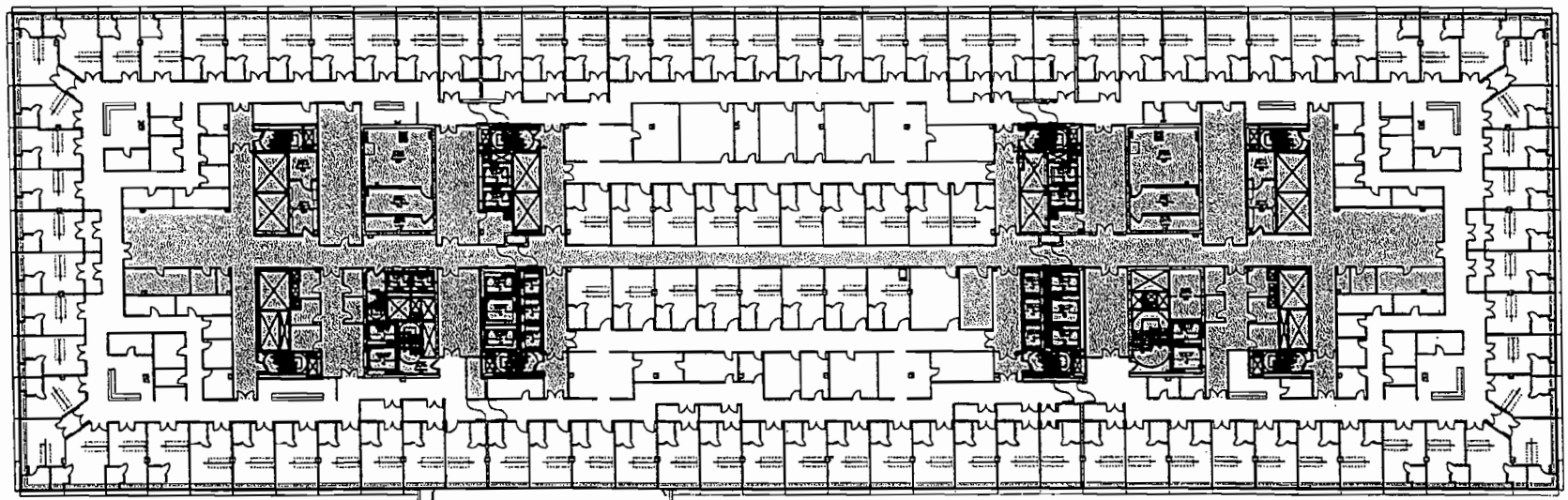
OFFICE OF SPACE PLANNING AND REAL ESTATE MANAGEMENT

DATE 03/17/2014

FLOOR 04

Attachment 14

ATTACHMENT 14



FOURTH FLOOR

NON CLINICAL SUPPORTS AREAS

Kahn

Albert Kahn Building
7430 Second Ave.
Detroit, Michigan 48202

0' 1' 2'
1" = 1'

UNIVERSITY OF CHICAGO BIOLOGY AND MEDICINE	A95: Center for Care and Discovery	
PLAN	NORTH ↑	
OFFICE OF SPACE PLANNING AND REAL ESTATE MANAGEMENT	DATE 03/17/2014	FLOOR 04

Attachment 14

Attachment 14

Section IV. Size of Project

University of Chicago Medical Center
Center for Care and Discovery Building
3rd and 4th Floor Build Out

Project Summary	Area		
Second Floor Area			
Mechanical Rooms Gross Square Feet	17,395		
Third Floor Area			
Net Square Feet	68,114		
Grossing factor	1.50		
Gross Square Feet	102,000		
Fourth Floor Area			
Net Square Feet	69,524		
Grossing factor	1.47		
Gross Square Feet	102,000		
Area By Department (bgsf)		**beds**	**bgsf/bed**
Med/Surg Patient Units	94,460	134	705
ICU Patient Units	20,964	32	655
Observation Patient Units	29,576	46	643
Total Clinical	145,000		
Non Clinical	76,395		
Grand Total	221,395		

Attachment 14

Section IV, Project Services Utilization

Attachment 15

UTILIZATION					
Year[1]	DEPT/ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS	PROJECTED UTILIZATION[2]	STATE STANDARD	MET STANDARD?
	Medical-Surgical			88%	
2010		74,254	68%		
2011		76,792	70%		
2012		79,179	72%		
2013		86,422	79%		
2014		94,869	87%		
2015		100,855	82%		
2016		97,566	79%		
2017		103,723	84%		
2018		110,268	89%	(88% 9/19/17)	Yes
	ICU			60%	
2010		26,887			
2011		25,842			
2012		26,558			
2013		26,343	63%		Yes
2014		28,433	68%		Yes
2015		28,833	63%		Yes
2016		29,239	64%		
2017		29,651	64%		
	Observation			NA	
2011		3,244			
2012		2,897			
2013		2,744			
2014		2,523			
2015		5,612			
2016		11,845			
2017		12,592			N/A
2018		13,387	80%	(80% 2/2/18)	

[1] Year ending 2/28
[2] Projected utilization does not include beds under construction.

1. **Medical-Surgical Beds**

We expect to begin construction in September 2014 and close the Project, after settling any issues and paying trailing invoices, by September 2017.

As can be seen in the chart above, we have experienced steady and significant growth in medical-surgical patient days since 2010, increasing from 74,254 for 2010 (year ending 2/28/10) to 94,869 for 2014 (year ending 2/28/14). This is an average annual rate of increase of 6.31 percent per year. We expect this trend to continue in the years ahead so that in 3 ½ years, we will have achieved the 88 percent occupancy standard for modernizing medical-surgical categories of 200 beds and greater. This is in advance of the expected opening of the new beds (9/30/17) and certainly earlier than two years after project completion (9/30/19).

The medical-surgical days' projection appears discontinuous from 2015 to 2016. This is because we expect CMS's "Two Midnight Rule" for defining inpatient versus observation stays will be in full effect for all payers during this time. As will be explained later in this section on Observation Days, this major change began on October 1, 2013. Formerly the general rule was that if a patient was in a bed at midnight, this was considered an inpatient stay, but, with the definition change, an inpatient stay now requires a two midnight stay. There are other requirements that must be met to qualify for an inpatient stay, but that is roughly the definition at present. As CMS' definition is adopted by other insurers as a cost saving measure (reimbursement for outpatients is generally less than for inpatients, for some patients much less), we expect a dramatic increase in observation days. Thus, beginning in FY15, we project a decline in medical-surgical days between 2014 to 2015 that reflects this change in patient type.

The historical growth of medical-surgical days is attributable to several factors. First, we have increased our clinical capacity with the CCD. In particular, we went from a mix of double occupancy rooms to all private rooms, which eliminates much bed blockage due to factors such as infection and gender mismatches. We have expanded some key drivers of bed utilization, such as expanding general operating rooms from 15 in 2007 to 24 presently, a 60 % expansion. GI procedures grew from 11 to 18 procedure rooms, which mostly creates a need for observation beds and some need for medical-surgical beds. Second, most beds are in the new facility which means rooms are unlikely to be closed for repairs or maintenance. Third, in the course of the last three years under new leadership, we have increased access to beds by eliminating bed designations by specialty service. By doing so we have been able to accept more transfers and to help the flow of patients from UCMC's Emergency Medicine Department, which has resulted in more efficient use of our beds. Finally, the Review Board granted UCMC approval in August 2013 for an additional 38 medical-surgical beds. We began to operate half of these beds in November 2013 and put the second half in service as of March 31, 2014.

Looking forward, we expect the increased utilization of the past four years to continue as we enjoy the benefits of the added beds. We have also been strengthening our clinical programs. For example, Orthopedics is undergoing a substantial revitalization. It is now established as a separate academic department and recruitment of a chairman and new surgeons has been aggressive and productive. Based on 8 months year-to-date data, we expect patient days for orthopedic patients alone to increase by 3,244 or 80% from the previous year. Orthopedics has hired 7 new surgeons in the last 18 months (Drs. Dirschl, Shi, Mok, Kang, Hudson, Adelani, and Lee). Other areas of Surgery have shown similar expansion, including Drs. Balky and Wigfield for Minimally Invasive and Robotic cardiac Surgery and Lung Transplantation, respectively; the chief of Colorectal Surgery being recruited presently; Dr. Gluth in Otolaryngology and Head and Neck Surgery; a surgeon under recruitment for Pediatric General Surgery; Dr. Chang for Plastic and Reconstructive Surgery; a surgeon in recruitment for Men's Health and General Urology; and a surgeon for Vascular Surgery. All of the aforementioned are additional surgeons, not replacements. Medicine is also active in expanding its clinical capacity. We are planning recruitment of a General cardiologist, a heart failure physician, and an electrophysiology physician. A search is also underway for physicians for Bone Marrow Transplant and Solid Tumor. In 2012 we hired Dr. Bishop to revitalize Bone Marrow Transplant and he brought in two researchers, one of whom spends time on clinical work. In Pulmonary Medicine we are adding physicians for Interventional Pulmonology and one to support Lung Transplant. These numerous additions to our clinical faculty will continue the growth in medical-surgical and ICU days.

2. <u>ICU Beds</u>

ICU bed utilization has also been steadily increasing at a 1.408% per year average increase since 2009 (year ending 2/28/09) through 2014 (year ending 2/28/14). We are requesting the addition of 12 ICU beds since our 84 adult ICU beds are often in very short supply. We surveyed the daily census of these beds for 2013 and found occupancy exceeded 80% at some time during the day for 89% of days. This causes frequent difficulties in having this critical type of bed available for patients coming from surgery, Emergency patients, and transfers of acutely ill patients from area hospitals. For the past two years combined, ICU occupancy, even assuming the addition of 12 beds, exceeded the State standard of 60%.

Historic growth of ICU beds was helped by the addition of 22 ICU beds in late February 2013, an increase of 35% adult ICU beds. These beds have quickly filled up, demonstrating substantial latent demand. There are 30 pediatric ICU beds, but they are located in Comer Children's Hospital.

Section IV, Project Services Utilization

Attachment 15

UTILIZATION					
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2014		94,869	87%		
2015		100,855	82%		
2016		97,566	79%		
2017		103,723	84%		
2018		110,268	89%	(88% 9/19/17)	Yes
	ICU			60%	
2010		26,887			
2011		25,842			
2012		26,558			
2013		26,343	63%		Yes
2014		28,433	68%		Yes
2015		28,833	63%		Yes
2016		29,239	64%		
2017		29,651	64%		
	Observation			NA	
2011		3,244			
2012		2,897			
2013		2,744			
2014		2,523			
2015		5,612			
2016		11,845			
2017		12,592			N/A
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[1] Year ending 2/28
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The medical-surgical days' projection appears discontinuous from 2015 to 2016. This is because we expect CMS's "Two Midnight Rule" for defining inpatient versus observation stays will be in full effect for all payers during this time. As will be explained later in this section on Observation Days, this major change began on October 1, 2013. Formerly the general rule was that if a patient was in a bed at midnight, this was considered an inpatient stay, but, with the definition change, an inpatient stay now requires a two midnight stay. There are other requirements that must be met to qualify for an inpatient stay, but that is roughly the definition at present. As CMS' definition is adopted by other insurers as a cost saving measure (reimbursement for outpatients is generally less than for inpatients, for some patients much less), we expect a dramatic increase in observation days. Thus, beginning in FY15, we project a decline in medical-surgical days between 2014 to 2015 that reflects this change in patient type.

The historical growth of medical-surgical days is attributable to several factors. First, we have increased our clinical capacity with the CCD. In particular, we went from a mix of double occupancy rooms to all private rooms, which eliminates much bed blockage due to factors such as infection and gender mismatches. We have expanded some key drivers of bed utilization, such as expanding general operating rooms from 15 in 2007 to 24 presently, a 60 % expansion. GI procedures grew from 11 to 18 procedure rooms, which mostly creates a need for observation beds and some need for medical-surgical beds. Second, most beds are in the new facility which means rooms are unlikely to be closed for repairs or maintenance. Third, in the course of the last three years under new leadership, we have increased access to beds by eliminating bed designations by specialty service. By doing so we have been able to accept more transfers and to help the flow of patients from UCMC's Emergency Medicine Department, which has resulted in more efficient use of our beds. Finally, the Review Board granted UCMC approval in August 2013 for an additional 38 medical-surgical beds. We began to operate half of these beds in November 2013 and put the second half in service as of March 31, 2014.

Looking forward, we expect the increased utilization of the past four years to continue as we enjoy the benefits of the added beds. We have also been strengthening our clinical programs. For example, Orthopedics is undergoing a substantial revitalization. It is now established as a separate academic department and recruitment of a chairman and new surgeons has been aggressive and productive. Based on 8 months year-to-date data, we expect patient days for orthopedic patients alone to increase by 3,244 or 80% from the previous year. Orthopedics has hired 7 new surgeons in the last 18 months (Drs. Dirschl, Shi, Mok, Kang, Hudson, Adelani, and Lee). Other areas of Surgery have shown similar expansion, including Drs. Balky and Wigfield for Minimally Invasive and Robotic cardiac Surgery and Lung Transplantation, respectively; the chief of Colorectal Surgery being recruited presently; Dr. Gluth in Otolaryngology and Head and Neck Surgery; a surgeon under recruitment for Pediatric General Surgery; Dr. Chang for Plastic and Reconstructive Surgery; a surgeon in recruitment for Men's Health and General Urology; and a surgeon for Vascular Surgery. All of the aforementioned are additional surgeons, not replacements. Medicine is also active in expanding its clinical capacity. We are planning recruitment of a General cardiologist, a heart failure physician, and an electrophysiology physician. A search is also underway for physicians for Bone Marrow Transplant and Solid Tumor. In 2012 we hired Dr. Bishop to revitalize Bone Marrow Transplant and he brought in two researchers, one of whom spends time on clinical work. In Pulmonary Medicine we are adding physicians for Interventional Pulmonology and one to support Lung Transplant. These numerous additions to our clinical faculty will continue the growth in medical-surgical and ICU days.

2. ICU Beds

ICU bed utilization has also been steadily increasing at a 1.408% per year average increase since 2009 (year ending 2/28/09) through 2014 (year ending 2/28/14). We are requesting the addition of 12 ICU beds since our 84 adult ICU beds are often in very short supply. We surveyed the daily census of these beds for 2013 and found occupancy exceeded 80% at some time during the day for 89% of days. This causes frequent difficulties in having this critical type of bed available for patients coming from surgery, Emergency patients, and transfers of acutely ill patients from area hospitals. For the past two years combined, ICU occupancy, even assuming the addition of 12 beds, exceeded the State standard of 60%.

Historic growth of ICU beds was helped by the addition of 22 ICU beds in late February 2013, an increase of 35% adult ICU beds. These beds have quickly filled up, demonstrating substantial latent demand. There are 30 pediatric ICU beds, but they are located in Comer Children's Hospital.

3. Observation Beds

ESTIMATION OF OBSERVATION BEDS NEEDED		
Jan-Sep, 2013 monthly	180	Avg. number of observation patients in adult ICU, medical-surgical
Oct-Dec, 2013 monthly avg.	354	CMS' Two Midnight Rule began
Increase over previous 9 months	174	
Medicare share of Jan-Sep	62	At 34.4%
Medicare Obs patients growth Oct-Jan	174	Increase attributable to Two Midnight Rule effective 10/1/13
Medicare monthly Obs patients	236	After Two Midnight Rule in effect
Other payors adopt Two Midnight Rule	685	Assume same increase in observation patients
Average hourly stay	31	
Monthly Observation hours	20,970	
Annual Observation hours	251,639	
Observation bed need incr. w/MS days	1.277	6.3% per year to five months after proj. completion 2/28/18
Observation Hours year ending 2/28/18	321,300	Five months after project completion
Observation beds needed at 100% occup.	37	
Observation Beds at 80% Occupancy	**46**	
Observation Beds Requested	**46**	

There are 46 observation beds proposed, an increase from the existing 15 observation beds we currently operate in a unit on the 3rd floor of Mitchell. The Mitchell observation unit would be discontinued and the vacated space would eventually be converted to non-clinical offices for faculty and staff. When relocated to the CCD there will be 5 observation beds along the exterior wall on each of the 3rd and 4th floors and 18 beds in along interior walls of these floors. These observation beds will not be located along external walls. Because these rooms will not have external windows, under the IDPH architectural standards they could not be converted into medical-surgical beds in the future.

The large increase in observation days reflects a major change in how observation days are defined by CMS which became effective October 1, 2013. While 33.4% of our inpatients are covered by Medicare, we expect that this cost saving mechanism will be adopted by other payers in an effort to reduce their payments for medical services. We have seen this dynamic occur for previous CMS rule changes.

The rule, popularly known as the "Two Midnight Rule", means that any stays in which the patient occupies a bed for fewer than two midnights are considered observation, and not inpatient stays. (This is a simplification, since patients must meet other clinical requirements to be considered inpatient even if they stay two or more midnights.) Prior to the rule change, from January through September 2013 we averaged 180 observation patients per month. After the new rule became affective in October 2013, between October and December the average number of patients increased to 340, nearly double, for Medicare Patients. During this period, the average stay for observation patients was 30.6 hours. In our utilization projection we assumed that initially the Two Midnight Rule would only be in effect for Medicare, however, by 2015, we expect other payers to adopt it as a cost saving measure. This accounts for the dramatic increase in forecast observation days between 2013 and 2015. We also assumed these days would increase apace the 6.31% historic growth rate for medical-surgical patients. The great majority of observation patients are medical-surgical in

PROBE REVIEWS OF INPATIENT HOSPITAL CLAIMS

Q1: Will CMS direct the Medicare review contractors to apply the 2-midnight presumption—that is, contractors should not select Medicare Part A inpatient claims for review if the inpatient stay spanned two midnights from the time of formal admission?

A1: Yes. The 2-midnight presumption directs medical reviewers to select Part A claims for review under a presumption that the occurrence of 2 midnights after formal inpatient hospital admission pursuant to a physician order indicates an appropriate inpatient status for a reasonable and necessary Part A claim. CMS will instruct the Medicare Administrative Contractors (MACs) and Recovery Auditors that, absent evidence of systematic gaming or abuse, they are not to review claims spanning 2 or more midnights after admission for a determination of whether the inpatient hospital admission and patient status was appropriate. In addition, for a period of 6 months, CMS will not permit Recovery Auditors to review inpatient admissions of 0 or 1 midnight that begin between October 1, 2013—March 31, 2014. CMS reminds providers that a claim subject to the 2 midnight presumption may still be reviewed for issues unrelated to appropriateness of inpatient admission in accord with the 2-midnight benchmark (i.e. patient status). CMS may review claims to ensure the services provided during the inpatient stay were reasonable and necessary in the treatment of the beneficiary, to ensure accurate coding and documentation, or other reviews as dictated by CMS and/or authoritative governmental agency.

Q2: Will Medicare contractors base their review of a physician's expectation of medically necessary care surpassing 2 midnights upon the information available to the admitting practitioner at the time of admission?

A2: Yes. CMS' longstanding guidance has been that Medicare review contractors should evaluate the physician's expectation based on the information available to the admitting practitioner at the time of the inpatient admission. This remains unchanged and CMS will provide clear guidance and training to our contractors on this medical review instruction.

Q3: What steps will CMS take to provide guidance and education about the inpatient rule, to ensure hospital understanding and compliance with the instructions?

A3: CMS will instruct the MACs to review a small sample of Medicare Part A inpatient hospital claims spanning 0 or 1 midnight after formal inpatient admission to determine the medical

ATTACHMENT 15

necessity of the inpatient status in accordance with the 2 midnight benchmark. CMS will establish a specific probe sample prepayment record limit of 10 to 25 claims per hospital.

MACs will conduct probe reviews on Medicare Part A inpatient hospital claims spanning less than two midnights after formal inpatient admission with dates of admission October 1, 2013 through March 31, 2013.

- This probe sample will determine each hospital's compliance with the new inpatient regulations (CMS-1599-F) and provide important feedback to CMS for purposes of jointly developing further education and guidance.
- Because the probe reviews will be conducted on a prepayment basis, hospitals can rebill for medically reasonable and necessary Part B inpatient services provided during denied Part A inpatient hospital stays provided the denial is on the basis that the inpatient admission was not reasonable and necessary. Hospitals may rebill for Part B inpatient services in accordance with Medicare Part B payment rules and regulations.
- A sample of 10 claims will be selected for prepayment review for most hospitals, while 25 claims will be selected for prepayment review for large hospitals.
- If a MAC identifies no issues during the probe review, the MAC will cease further such reviews for that hospital for dates of admission spanning October to March 2014, unless there are significant changes in billing patterns for admissions.
- Based on the results of these initial reviews, CMS will conduct educational outreach efforts during the following 3 months. Each non-compliant claim will be denied and the reasons for denial will be sent via letter. Individualized phone calls will be made by the MAC to those providers with either moderate to significant or major concerns. During such calls, the MAC will discuss the reasons for denial, provide pertinent education and reference materials, and answer questions.
- In addition to these educational outreach efforts, for those providers that are identified as having moderate to significant concerns or major concerns, the MACs will conduct additional probe reviews on claims with dates of admission between January and March 2014. The size of these additional probe reviews will be 10 (25 for large hospitals). For those providers identified as having continuing concerns after the 6 month period, samples of 100 claims (250 for large hospitals) will be selected.
- CMS will also monitor provider billing trends for variances indicative of abuse, gaming, or systematic delays in the submission of claims, for the purpose of avoiding the MAC prepayment probe audits during this initial probe and educate period.

- The MACs will submit periodic reports to CMS for purposes of tracking the frequency and types of errors seen during these probe reviews.

During the probe and educate period of October 1, 2013 until March 31, 2014, CMS will instruct the MACs and Recovery Auditors not to review Part A claims spanning 2 or more midnights after formal inpatient admission for appropriateness of inpatient admission. CMS reminds hospitals that while medical review will not be focused on Part A claims spanning 2 or more midnights after formal inpatient admission under the presumption the inpatient admission was reasonable and necessary, physicians should make inpatient admission decisions in accordance with the 2 midnight benchmark in the final rule. That is, physicians should generally admit as inpatients beneficiaries they expect will require 2 or more midnights of hospital services, and should treat most other beneficiaries on an outpatient basis. CMS believes that, with the exception of cases involving services on the inpatient-only list, only in rare and unusual circumstances would an inpatient admission be reasonable in the absence of a reasonable expectation of a medically necessary stay spanning at least two midnights. CMS will work with the hospital industry and with MACs to determine if there are any categories of patients that represent an appropriate inpatient admission, absent an expectation of a 2 midnight stay or unforeseen and interrupting circumstances such as unforeseen death, transfer to another hospital, departure against medical advice, or clinical improvement. Any evidence of systematic gaming, abuse or delays in the provision of care in an attempt to receive the 2-midnight presumption could warrant medical review. MACs and Recovery Auditors will not review any claims submitted by Critical Access Hospitals. In addition, during this period, CMS will not permit Recovery Auditors to review inpatient admissions of less than two midnights after formal inpatient admission that occur on or after October 1.

START TIME FOR CALCULATING THE 2 MIDNIGHT BENCHMARK

Q4: Can CMS clarify when the 2 midnight benchmark begins for a claim selected for medical review, and how it incorporates outpatient time prior to admission in determining the general appropriateness of the inpatient admission?

A4: For purposes of determining whether the 2-midnight benchmark was met and, therefore, whether inpatient admission was generally appropriate, the review contractor will consider time the beneficiary spent receiving outpatient services within the hospital. This will include services

such as observation services, treatments in the emergency department, and procedures provided in the operating room or other treatment area. From the medical review perspective, while the time the beneficiary spent as a hospital outpatient before the beneficiary was formally admitted as an inpatient pursuant to the physician order will not be considered inpatient time, it will be considered during the medical review process for purposes of determining whether the 2-midnight benchmark was met and, therefore, whether payment for the admission is generally appropriate under Medicare Part A. Whether the beneficiary receives services in the emergency department (ED) as an outpatient prior to inpatient admission (for example, receives observation services in the emergency room) or is formally admitted as an inpatient upon arrival at the hospital (for example, inpatient admission order written prior to an elective inpatient procedure or a beneficiary who was an inpatient at another hospital and is transferred), the starting point for the two midnight timeframe for medical review purposes will be when the beneficiary starts receiving services following arrival at the hospital. CMS notes that this instruction excludes wait times prior to the initiation of care, and therefore triaging activities (such as vital signs before the initiation of medically necessary services responsive to the beneficiary's clinical presentation) must be excluded. A beneficiary sitting in the ED waiting room at midnight while awaiting the start of treatment would not be considered to have passed the first midnight, but a beneficiary receiving services in the ED at midnight would meet the first midnight of the benchmark. The review contractor will count only medically necessary services responsive to the beneficiary's clinical presentation as performed by medical personnel.

DELAYS IN THE PROVISION OF CARE

Q5: If a Part A claim is selected for medical review and it is determined that the beneficiary remained in the hospital for 2 or more midnights but was expected to be discharged before 2 midnights absent a delay in the provision of care, such as when a certain test or procedure is not available on the weekend, will this claim be considered appropriate for payment under Medicare Part A as inpatient under the new 2 midnight benchmark?

A5: Section 1862(a)(1)(A) of the Social Security Act statutorily limits Medicare payment to the provision of services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body. As such, CMS' longstanding instruction has been and continues to be that hospital care that is custodial, rendered for social purposes or reasons of convenience, and is not required for the diagnosis or treatment of illness or injury, should be excluded from Part A payment. Accordingly, CMS expects review

contractors will exclude extensive delays in the provision of medically necessary services from the 2 midnight benchmark. Review contractors will only count the time in which the beneficiary received medically necessary hospital services.

DOCUMENTING THE DECISION TO ADMIT

Q6: What documentation will review contractors expect physicians to provide to support that an expectation of a hospital stay spanning 2 or more midnights was reasonable?

A6: Review contactors' expectations for sufficient documentation will be rooted in good medical practice. Expected length of stay and the determination of the underlying need for medical or surgical care at the hospital must be supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event, which review contractors will expect to be documented in the physician assessment and plan of care. CMS does not anticipate that physicians will include a separate attestation of the expected length of stay, but rather that this information may be inferred from the physician's standard medical documentation, such as his or her plan of care, treatment orders, and physician's notes.

Q7: What factors should the physician take into consideration when making the admission decision and document in the medical record?

A7: For purposes of meeting the 2-midnight benchmark, in deciding whether an inpatient admission is warranted, the physician must assess whether the beneficiary requires hospital services and whether it is expected that such services will be required for 2 or more midnights. The decision to admit the beneficiary as an inpatient is a complex medical decision made by the physician in consideration of various factors, including the beneficiary's age, disease processes, comorbidities, and the potential impact of sending the beneficiary home. It is up to the physician to make the complex medical determination of whether the beneficiary's risk of morbidity or mortality dictates the need to remain at the hospital because the risk of an adverse event would otherwise be unacceptable under reasonable standards of care, or whether the beneficiary may be discharged. If, based on the physician's evaluation of complex medical factors and applicable risk, the beneficiary may be safely and appropriately discharged, then the beneficiary should be discharged, and hospital payment is not appropriate on either an inpatient or outpatient basis. If the beneficiary is expected to require medically necessary hospital services for 2 or more

midnights, then the physician should order inpatient admission and Part A payment is generally appropriate per the 2-midnight benchmark. Except in cases involving services identified by CMS as inpatient-only, if the beneficiary is expected to require medically necessary hospital services for less than 2 midnights, then the beneficiary generally should remain an outpatient and Part A payment is generally inappropriate.

We note that in the FY 2014 IPPS final rule we stated the 2-midnight benchmark provides that hospital stays expected to last less than 2 midnights are generally inappropriate for hospital admission and Medicare Part A payment absent rare and unusual circumstances. In that rule, we stated that we would provide additional subregulatory guidance on those circumstances. We believe that we have already identified many of these rare and unusual exceptions in our Inpatient Only List. In that list, we identify those services that we have said are rarely provided to outpatients and which typically require, for reasons of quality and safety, a significantly protracted stay at the hospital. We believe that it would be rare and unusual for a stay of 0 or 1 midnights, for patients with known diagnoses entering a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for less than 2 midnights, to be appropriately classified as inpatient and paid under Medicare Part A. This is consistent with our historical guidance in which we defined certain minor therapeutic and diagnostic services as appropriately furnished outpatient on the basis of an expected short length of stay. We also do not believe that the use of telemetry, by itself, constitutes a rare and unusual circumstance that would justify an inpatient admission in the absence of a 2 midnight expectation. We note that telemetry is neither rare nor unusual, and that it is commonly used by hospitals on outpatients (ER and observation patients) and on patients fitting the historical definition of outpatient observation (that is, patients for whom a brief period of assessment or treatment may allow the patient to avoid an inpatient hospital stay). We also specified in the final rule that we do not believe that the use of an ICU, by itself, would be a rare and unusual circumstance that would justify an inpatient admission in the absence of a 2 midnight expectation. In some hospitals, placement in an ICU is neither rare nor unusual, because an ICU label is applied to a wide variety of facilities providing a wide variety of services. Due to the wide variety of services that can be provided in different areas of a hospital, we do not believe that a patient assignment to a specific hospital location, such as a certain unit or location, would justify an inpatient admission in the absence of a 2 midnight expectation.

We recognize that there could be rare and unusual circumstances that we have not identified that justify inpatient admission absent an expectation of care spanning at least 2 midnights. As we continue to work with facilities and physicians to identify such other situations, we reiterate that we expect these situations to be rare and unusual exceptions to the general rule. If any such

additional situations are identified, we will include them in subregulatory instruction, and we will expect that in these situations the physician at the time of admission must explicitly document the reason why the specific case requires inpatient care, as opposed to hospital services in an outpatient status. We do not believe that these rare and unusual circumstances can be imputed from the medical record.

Q8: Under the new 2 midnight benchmark, how should facilities treat, and bill Medicare for beneficiaries who require potentially short-term, medical treatment in an intensive care setting?

A8: Beneficiaries treated in an intensive care unit are not an exception to the general rule that only patients requiring two or more midnights of hospital care require inpatient admission, as our 2-midnight benchmark policy is not contingent on the location of the beneficiary within the hospital. While patients requiring aggressive, intensive treatment would generally be expected to stay in the hospital for longer than 2 midnights, those patients that require a shorter period of time in the hospital should generally be furnished services that are billed on an outpatient basis. Therefore, absent rare and unusual circumstances, physicians should admit those beneficiaries whom they expect to require medically necessary hospital treatment spanning 2 or more midnights, and should generally provide care as outpatient for those beneficiaries whom they expect to require medically necessary hospital care for less than 2 midnights. If a physician believes at the time of admission that the situation is one of the rare and unusual situations where inpatient care is required despite the fact that such care is not expected to span at least two midnights, then he or she must explicitly document the reason why the specific case requires inpatient care, as opposed to hospital services in an outpatient status, for CMS review. Upon review, CMS and its contractors would retain the discretion to conclude that the documentation is not sufficient to support the medical necessity of the inpatient admission.

Q9: Does the beneficiary's hospital stay need to meet inpatient level utilization review screening criteria to be considered reasonable and necessary for Part A payment?

A9: If the beneficiary requires medically necessary hospital care that is expected to span 2 or more midnights, then inpatient admission is generally appropriate. If the physician expects the beneficiary's medically necessary treatment to span less than 2 midnights, it is generally appropriate to treat the beneficiary in outpatient status. If the physician is unable to determine at the time the beneficiary presents whether the beneficiary will require 2 or more midnights of

hospital care, the physician may order observation services and reconsider providing an order for inpatient admission at a later point in time . While utilization review (UR) committees may continue to use commercial screening tools to help evaluate the inpatient admission decision, the tools are not binding on the hospital, CMS or its review contractors. In reviewing stays lasting less than 2 midnights after formal inpatient admission (i.e., those stays not receiving presumption of inpatient medical necessity), review contractors will assess the reasonableness of the physician's expectation of the need for and duration of care based on complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event, which must be clearly documented.

Q10: If a beneficiary is admitted for a minor surgical procedure, but then requires hospital care beyond the usual anticipated recovery time, when would it be appropriate for the physician to utilize outpatient observation and when would it would be appropriate to admit the beneficiary for inpatient hospital services?

A10: If the beneficiary requires additional medically necessary hospital care beyond the usual anticipated recovery time for a minor surgical procedure, the physician should reassess the expected length of stay. Generally, if the physician cannot determine whether the beneficiary prognosis and treatment plan will now require an expected length of stay spanning 2 or more midnights, the physician should continue to treat the beneficiary as an outpatient. If additional information gained during the outpatient stay subsequently suggests that the physician would expect the beneficiary to have a stay spanning 2 or more midnights including the time in which the beneficiary has already received hospital care, the physician may admit the beneficiary as an inpatient at that point.

Q11: Are there any circumstances outside of beneficiary transfer, death, departure against medical advice, or receipt of a Medicare Inpatient-Only procedure that permit a beneficiary to be appropriately admitted as an inpatient for a stay of less than 2 midnights in the hospital?

A11: Yes. The regulation specifies that the decision to admit should generally be based on the physician's reasonable expectation of a length of stay spanning 2 or more midnights, taking into account complex medical factors that must be documented in the medical record. Because this is based upon the physician's expectation, as opposed to a retroactive determination based on actual length of stay, unforeseen circumstances that result in a shorter stay than the physician's

reasonable expectation may still result in a hospitalization that is appropriately considered inpatient. As enumerated in the final rule, CMS anticipates that most of these situations will arise in the context of beneficiary death, transfer, or departure against medical advice. However, CMS does recognize that on occasion there may be situations in which the beneficiary improves much more rapidly than the physician's reasonable expectation. Such instances must be clearly documented and the initial expectation of a hospital stay spanning 2 or more midnights must have been reasonable in order for this circumstance to be an acceptable inpatient admission payable under Part A.

The more usual situation would be the one in which the physician's initial expectation of the beneficiary's length of stay is uncertain. If the physician is uncertain whether the beneficiary will be able to be discharged after 1 midnight in the hospital or whether the beneficiary will require a second midnight of care, the initial day should be spent in observation until it is clearly expected that a second midnight would be required, at which time the physician may order inpatient admission. If the physician believes that a rare and unusual circumstance exists in which an inpatient admission is warranted, but does not expect the beneficiary to require 2 or more midnights in the hospital, the physician may admit the beneficiary to inpatient status but should thoroughly document why inpatient admission and Medicare Part A payment is appropriate. CMS will work with the hospital industry and with MACs to determine if there are any categories of patients that should be added to this list of exceptions to the 2-midnight benchmark. Suggestions should be emailed to IPPSAdmissions@cms.hhs.gov with "Suggested Exceptions to the 2-Midnight Benchmark" in the subject line. During the initial probe review of inpatient admissions, the Medicare Administrative Contractor is being instructed to deny these claims and submit them to CMS' Central Office for further review. If CMS believes that such a stay warrants an inpatient admission, CMS will provide additional subregulatory instruction and the Part A inpatient denial will be reversed during the administrative appeals process.

Q12: If a physician writes an inpatient order based on the expectation that the beneficiary will require care spanning 2 or more midnights, but prior to the passage of 2 midnights the beneficiary refuses any additional medical treatment and is discharged, would this be considered an unforeseen circumstance?

A12: Under the 2 midnight benchmark, if a beneficiary refuses any additional care and is subsequently discharged, this will be considered similarly to departures against medical advice and could be considered an appropriate inpatient admission, so long as the expectation of the need for medically necessary hospital services spanning 2 or more midnights was reasonable at

the time the inpatient order was written, and the basis for that expectation as well as the refusal of additional treatment, are documented in the medical record.

Q13: Under the new guidance, will all inpatient stays of less than 2 midnights after formal inpatient admission be automatically denied?

A13: No. Under the new guidelines we expect that the majority of short (total of zero or one midnight) Medicare hospital stays will be provided as outpatient services. Because this is based upon the physician's expectation, as opposed to a retroactive determination based on actual length of stay, we expect to see services payable under Part A in a number of instances for inpatient stays less than 2 total midnights after formal inpatient admission. First, there will be cases where the physician had a reasonable expectation of a two midnight stay but there was an unforeseen circumstance that resulted in a shorter stay than the physician's reasonable expectation. As enumerated in the final rule, CMS anticipates that most of these situations will arise in the context of beneficiary death, transfer, or departure against medical advice. Second, if the beneficiary received a medically necessary service on the Inpatient-Only List and was able to be discharged before 2 midnights passed, those claims would be appropriately inpatient for Part A payment. Third, inpatient stays spanning less than 2 midnights will be evaluated in accordance with the 2 midnight benchmark during review, and payment will be appropriate if the total time receiving medically necessary hospital care (including pre-admission services) spanned at least two midnights. Inpatient claims for patients who unexpectedly improved and were discharged in less than two midnights would be payable as long as the medical record clearly demonstrated that the admitting physician had reasonable expectation of a two midnight stay and the improvement that allowed an earlier discharge was clearly unexpected. Lastly, there may be rare and unusual cases where the physician did not expect a stay lasting 2 or more midnights but nonetheless believes inpatient admission was appropriate and documents such circumstance. Although the Medicare Administrative Contractor is being instructed to deny these claims, these claims will be submitted to CMS' Central Office for further review. If CMS believes that such a stay warrants an inpatient admission, CMS will provide additional subregulatory instruction and the Part A inpatient denial will be reversed during the administrative appeals process. Hospitals should focus their attention on short (0-1 total days) stays (without death, transfer, discharge against advice, an inpatient-only service or a preceding outpatient stay over midnight) to ensure that the physician clearly expected a longer stay, the discharge was unexpected, or some other rare and unusual circumstance supports that the Part A claims represent appropriate, payable inpatient services.

SELECTION OF CLAIMS FOR REVIEW

Q14: How will review contractors identify facilities conducting systematic gaming, abuse or delays in the provision of care in an attempt to qualify for the 2-midnight presumption (that is, inpatient hospital admissions where medically necessary treatment was not provided on a continuous basis and the services could have been furnished in a shorter timeframe)?

A14: Review contractors will identify gaming by reviewing stays spanning 2 or more midnights after formal inpatient admission for the purpose of monitoring and responding to patterns of incorrect DRG assignments, inappropriate or systematic delays, and lack of medical necessity for services at the hospital, but not for the purpose of routinely denying Part A payment on the basis that the services should have been provided at the hospital on an outpatient basis. CMS will shift its attention to the smaller anticipated volume of 0 and 1 day short inpatient stays and then, to the extent that facilities correctly apply the 2 midnight benchmark, away from short stays to other areas with persistently high improper payment rates. CMS and its review contractors may identify such trends through data sources, such as that provided by the Comprehensive Error Rate Testing (CERT) contractor, First-look Analysis for Hospital Outlier Monitoring (FATHOM) and Program for Evaluating Payment Patterns Electronic Report (PEPPER).

Q15: Is there a way for providers to identify any time the beneficiary spent as an outpatient prior to admission on the inpatient claim so that review contractors can readily identify that the 2-midnight benchmark was met without conducting complex review of the claim?

A15: CMS recognizes that currently, inpatient Part A claims only report the time the beneficiary spent as an inpatient (i.e., after the beneficiary is formally admitted as an inpatient pursuant to a physician order) and not the outpatient time that may have been considered by the physician when determining whether 2 or midnights of hospital care are expected. CMS is exploring means by which any outpatient time may be recorded on the Part A inpatient claim to identify Part A claims that met the 2-midnight benchmark. Stakeholders have offered suggestions such as changes to the claim date instruction; the creation of new condition codes, remittance codes or occurrence span codes; and provider input in the remarks fields. CMS will evaluate potential changes in claim information and notify providers if changes in claim submission are required. CMS reminds providers that claims for stays of less than 2 midnights after formal inpatient admission may still be subject to complex medical record review, to which the 2-midnight

benchmark will be applied. Information in the medical record will support whether total outpatient and inpatient time met the 2-midnight benchmark.

Section VII, A, Deteriorated Facilities, Modernization and Performance Requirements

Attachment 20

A. Medical/Surgical Bed Modernization

We propose to modernize 134 Medical/Surgical beds with no change from our current total number of 338.

1. Applicable Review Criteria

a. 1110.530 (b)(2)(B) – Planning Area Need – Service to Planning Area Residents

The attached map shows our primary service area (PSA), which closely approximates Planning Area A-03, the Chicago South Planning Area. (Planning Area A-03 is roughly bounded by Roosevelt Road (12th Street) to the north, Cicero Avenue to the west, 127th Street to the south, and Lake Michigan/Indiana state line to the east.) Patients who occupied medical-surgical beds during calendar year 2013 and reside in our PSA represented 46.5% of total patients in this group. This is near the standard of 50%, though we believe the standard is more appropriate to community hospitals than major teaching hospitals that draw from a far wider area for their specialty services. By simply adding the community areas surrounding much of the periphery of our PSA and extending into the south suburbs, we reach 51.2% of total medical-surgical patients. We choose to define our PSA more tightly though to reflect the greatest concentration of our patients.

In the past two years, UCMC attracted patients not only from the Chicago metropolitan area, but also from every single state in the country. In the past five years we have served patients from 86 countries. If UCMC were to extend the self-defined boundaries of our PSA a few miles in each direction, we would meet the 50% standard. 92% of patients who occupied a medical-surgical bed in 2012 reside in the Chicago Metropolitan area and over half of those live in our PSA.

We are one of nine hospitals providing medical-surgical inpatient care in Planning Area A-03. We are licensed for 338 of these beds, which is 22% of Planning A-03's total, but provide 30% of the patient days of care in the planning area as reported to IDPH for 2012. While we provide services well beyond our immediate area, nearly half of our medical-surgical inpatients are from our community.

A listing of patients occupying medical-surgical beds during 2013 by PSA zip code is attached.

b. **1110.530 (d)(1) -- Category of Service Modernization**

With this Project, beds would be moved from 31 year-old Mitchell to the built out 3rd and 4th floors of the CCD, which opened in February 2013. Mitchell Hospital contains a combination of formerly double occupancy rooms that are now single occupancy, measuring 248 net square feet plus a 34 net square feet bathroom and single rooms that are 157 net square feet plus a 34.5 net square foot bathroom. A weighted average of these dimensions is 182 net square footage for the bedroom and 34 for the bathroom. The planned rooms in the larger CCD are 288 net square feet for the bedroom and 55 for the bathroom. The bathrooms in the CCD will be ADA compliant (wheelchair accessible), with showers, while the Mitchell bathrooms are 38% smaller. The big advantage is in the bed area, in which the CCD rooms will be on average 106 net square feet larger. This affords ample room for family space, away from the caregivers' zone. The CCD has couches that fold into beds for overnight stays by a family member, in addition to storage room, and a comfortable chair. These are modern standards and are now expected by patients and families. Patients have been very pleased with the rooms in the CCD after the first year of operation.

In addition to providing a more pleasing environment for patients and visitors, there are operational reasons to consolidate operations as much as possible into the CCD. With the 240 patient beds in Mitchell presently, which includes 46 Obstetrics beds, adult inpatient bed areas are in two separate locations. Attending physicians, residents, fellows, and nurse managers, not to mention physical therapists, pharmacists, respiratory therapists, patient transporters, meal deliverers, and other support staff must work in two locations and entails a 20 minute walk with several elevator rides. This results in inefficiencies with time spent traveling between the two locations. Physicians round twice a day, at a minimum, and respond to emergencies at any time, so the two locations can be a challenge. This separation hinders communication and team work.

Staffing efficiencies are realized when there is one location for the most acute patients, rather than several since clinical staff can aid their associates if an area gets unexpectedly busy. This flexibility is diminished with two locations. Similarly, supplying both locations is less efficient than having these resources consolidated.

Many of our nursing staff are specially trained and have key competencies for certain types of patients, but being able to make the fullest use of these skills is hindered with two physically separated inpatient areas.

There is also disruption for patients and their families when patients must be moved from the CCD to Mitchell, for example to make room for more acute

patients coming out of surgery. For the nursing staff, these patient transfers require much planning and often require a physician, nurse, respiratory therapist plus support equipment and the patient's belongings to make the trip. At the other end the nurse-to-nurse handoff must be managed, information, such as patient condition, special needs and medications being taken, must be exchanged, plus a physical handoff of dispensed medications. The receiving nurse performs a head-to-toe assessment of the patient which requires 5 to 10 minutes, logging into the electronic medical record to check for physician orders. It is desirable to minimize these situations and certainly the 20 minute length of the travel.

There are staffing inefficiencies in the smaller 19 bed units in Mitchell versus the 28 to 36 bed units in the CCD. Flexing up and down as patient census changes is easier in a larger unit. While there is not sufficient room in the CCD to completely move out of Mitchell, the medical-surgical beds that remain for less acute inpatients will number 28, or just 8% of the total, and there will be no ICU beds remaining in Mitchell. By building out the 221,000 square feet of shelled space in the CCD, we will be taking advantage of our large investment in this state-of-the-art building.

c. **1110.530 (d)(4) -- Occupancy**

UTILIZATION					
	DEPT./ SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS)**	**PROJECTED UTILIZATION[3]**	**STATE STANDARD**	**MET STANDARD?**
YEAR[4]					
	Medical-Surgical			88%	
2010		74,254	68%		
2011		76,792	70%		
2012		79,179	72%		
2013		86,422	79%		
2014		94,869	87%		
2015		100,855	82%		
2016		97,566	79%		
2017		103,723	84%		
2018		110,268	89%	(88% 9/19/17)	Yes

The chart above shows our projection of medical-surgical days. We experienced strong and steady growth between 2010 and 2014 (year ending 2/28), averaging 6.31% growth per year. We expect this to continue. We have accounted for

[3] Projected utilization does not include beds under construction.
[4] Year ending 2/28.

migration of patients from medical-surgical beds to observation beds as the changed definition of an observation versus inpatient stay spreads from Medicare to other payers. Continued growth of the remaining medical-surgical inpatients at the historic rate demonstrates that by September 2017, we will attain 88% utilization of our medical-surgical beds, which equals the State standard for modernization. A full explanation of the factors that underlie continued growth in patient demand is provided in Section IV, Project Scope, Utilization, and Unfinished/Shell Space (Attachment 15).

d. **1110.530 (f)(1) -- Performance Requirements**

The applicable minimum bed capacity for medical-surgical for UCMC is 100 beds. We exceed this minimum with our present licensed total of 338.

B. ICU Bed Expansion

We propose to expand the number of ICU beds by 12 from 114 to 126.

UTILIZATION					
	DEPT./ SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS)**	**PROJECTED UTILIZATION[5]**	**STATE STANDARD**	**MET STANDARD?**
YEAR[6]					
	ICU			60%	
2010		26,887			
2011		25,842			
2012		26,558			
2013		26,343	63%		Yes
2014		28,433	68%		Yes
2015		28,833	63%		Yes
2016		29,239	64%		
2017		29,651	64%		

[5] Projected utilization does not include beds under construction.
[6] Year ending 2/28.

1. **Applicable Review Criteria**

a. **1110.530 (b)(2) – Planning Area Need – Service to Planning Area Residents**

Our intention is to add ICU beds to serve patients in our area. In the past year we examined the origin of patients of our ICU beds. We found that 44% resided within our Primary Service Area (PSA), which resembles Planning Area A-03. While this is below the State's 50% standard, we believe that an academic research hospital with its many specialized services will draw from a wider area than a community hospital in an urban area. For 2013, patients from 589 different zip code areas were treated in our ICU. This indicates the geographical breadth that we serve. Expanding the boundaries to neighborhood areas surrounding our PSA and extending into the south suburbs, we reach 53% of ICU patients. A chart listing patient origin by zip code is attached.

b. **1110.530 (b)(4) – Service Demand – Expansion of Existing Category of Service**

(A) **Historical Service Demand**

For historical years 2013 and 2014 (year ending 2/28) the occupancy rate of our 114 ICU beds has ranged from 63 to 68%. The combined occupancy of the proposed additional 12 beds would be 60% (rounded up slightly). The occupancy rates shown above assume approval in 2015 (the 12 months ending 2/28/15) of the 12 additional beds requested and the occupancy rates for 2015, 2016, and 2017 are calculated for 126 beds. It should be noted that occupancy in 2013 was constrained in that the addition of 22 adult ICU beds approved by the Review Board in permit #07-153 only came into operation February 23, 2013 and thus were only available for the last 6 days of the 12 months ending 2/28/13. Previous to the addition of these beds, there were 64 adult ICU beds and they were occupied at a rate of 87% for 2013, which is extremely high for ICU beds.

(B) **Project Service Demand**

Planning Area A-03 presently has a shortage of 9 ICU beds, an indication of insufficient hospital capacity. There are 235 ICU beds in Planning Area A-03, nearly half of which are at UCMC. We have defined our Primary Service Area (PSA) by 16 zip codes in Planning Area A-03 which closely matches this planning area geographically. However, as discussed above, our hospital attracts 56% of our ICU patients from beyond our PSA. The many specialized services we offer draw patients from a broad area. As our patient origin data show, we attracted ICU patients from 589 different zip code areas in 2013. Thus, the patients we care for and the modest increases we forecast are not entirely based on the population of

the PSA, nor its projected growth.

We are forecasting, as we did for medical-surgical patient demand, that the growth in ICU patient days will occur at the same rate in the next several years as it has in an equal number of previous years. The historic increase averaged 1.4% per year for all ICU patients and 3.7% per year for adult ICU patients. The beds we are requesting to add will be dedicated to adult patients. The pediatric ICU beds are sufficient for that population and we do not place adult patients in the pediatric ICU beds, which are located in Comer Children's Hospital. The expected growth does come as much from an increase in the population of Planning Area A-03, which is expected to be modest, but from the population we serve as reflected by the 589 zip code areas located in 10 states. The growth is driven by many factors, changes in population size for one, but also by the excellent care and often the unique or highly specialized services we provide to the region. The need for ICU beds at UCMC is evidenced by the high historical utilization, which is above the State standard, and the steady growth over the past four years. We are requesting only the number of additional beds that will allow us to operate at the State standard of 60%.

Although the calculated need for ICU beds lacking in the area is 9, we planned for 3 additional beds for two reasons. First, even with the additional beds, we still expect to exceed the State utilization standard in the future. Second, there is a facility concern as well. The design for the CCD's 3rd and 4th floors accommodates 8 bed ICU units in each corner of the rectangular shaped building. If we were to request only 9 additional ICU beds, one of these units would only have 5 beds, which is inefficient for staffing and does not make optimal use of this high value clinical space.

c. **1110.530 (e) -- Staffing Availability**

Our nurse recruiters indicate that the job market for new nursing graduates is soft. Such graduates spend 6 to 12 months finding their first position. We hire between 20 to 30 staff nurses per month. Our ability to staff a new patient unit was demonstrated several months ago when we were able to quickly hire 20.8 FTE's for a 19 bed unit. When new positions are posted on a Friday, we average 50 to 75 applications received over the weekend. We are confident we can staff the additional 12 ICU beds we propose.

d. **1110.530 (f)(13) -- Performance Requirements**

The applicable minimum bed capacity for ICU is 4 beds. We exceed this minimum with our present licensed total of 114.

ATTACHMENT 20

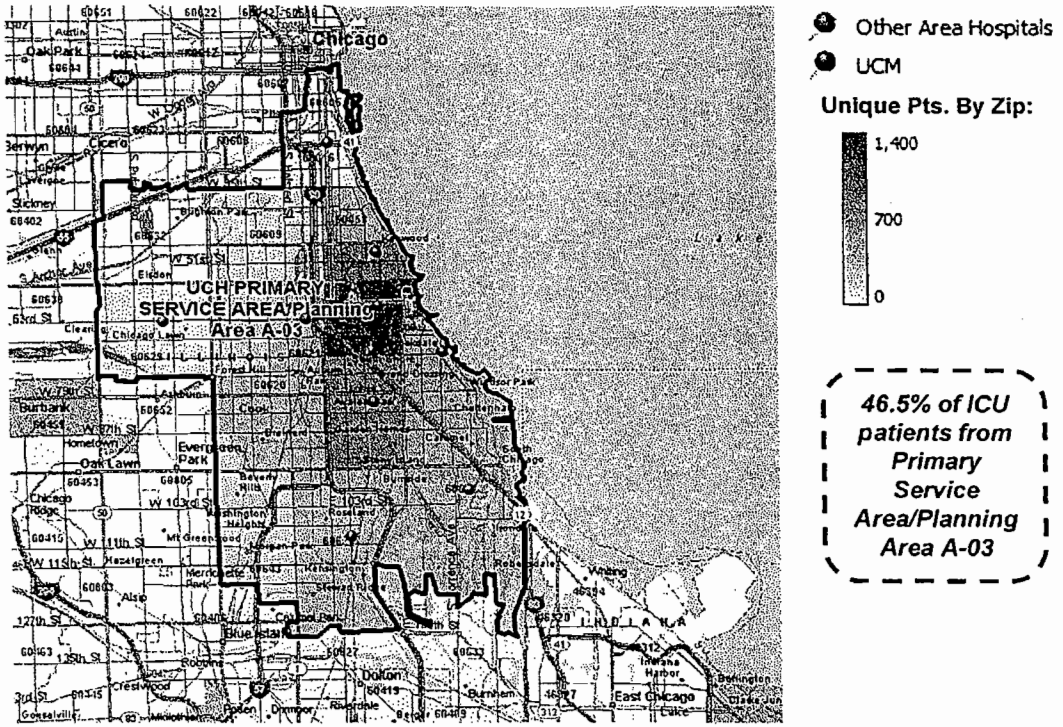
e. **1110.530 (g) – Assurances**

Project completion is September 30, 2017. We will meet the utilizations standard by the second year of operation after Project completion.

ATTACHMENT 20

The majority of med/surg patients come from the hospital zipcode, 60537

Medical/Surg Bed Unique Patient Heat Map by ZIP (CY 2013)



Note: Only zips with at least 10 patients were mapped; Source: TSI CY 2013

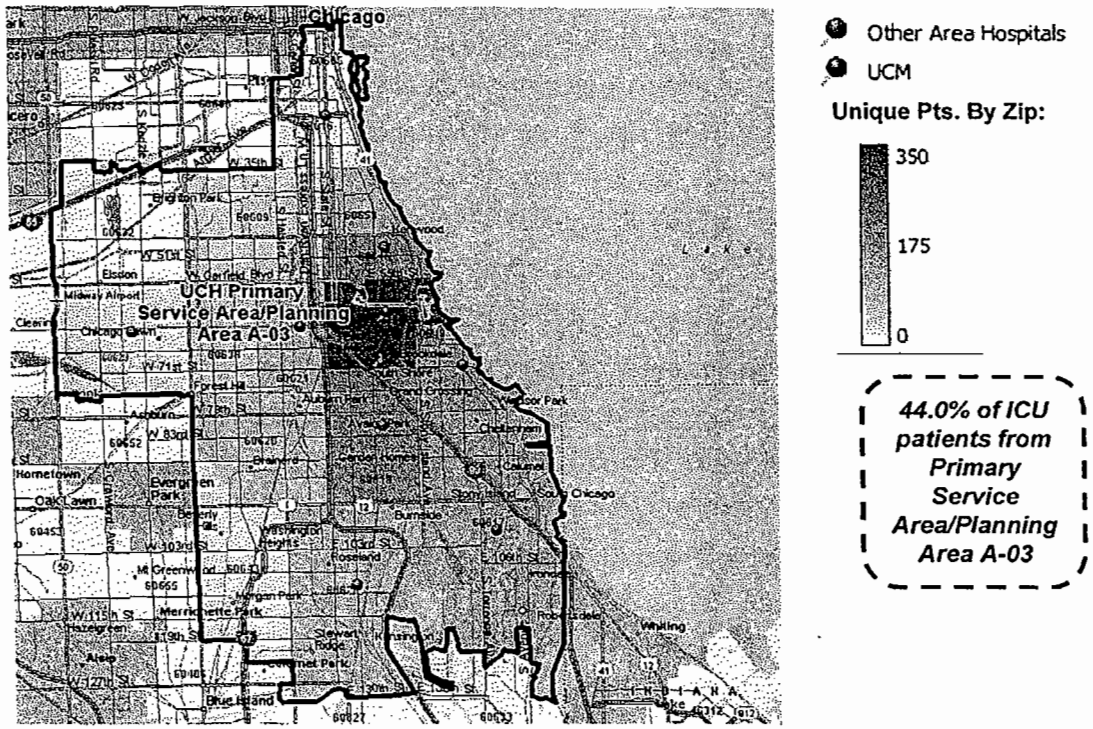
Section 1110.530(b)(2)

Primary Service Area Zip Code	Med/Surg
60637	1,322
60615	900
60619	857
60617	557
60649	624
60620	423
60653	452
60628	397
60621	384
60636	239
60643	217
60609	194
60629	153
60616	126
60605	45
60632	44
	6,934
Percent of total	46.5%
Areas surrounding PSA	
60633	46
60419	82
60409	116
60473	84
60476	5
60438	77
60426	70
60406	37
60469	7
60655	51
60642	16
60652	72
60608	45
	708
Outside PSA and Close	7,642
Percent PSA and Close	51.2%
Beyond PSA and Close	7,278
Total	14,920

ATTACHMENT 20

ICU patients also predominately come from the hospital zipcode, 60637

ICU Unique Patient Heat Map by ZIP (CY 2013)



Note: Only zips with at least 10 patients were mapped; Source: TSI CY 2013

Section 1110.530(b)(2)

Primary Service Area		
Zip Code	ICU Patients	
60637	345	
60615	217	
60619	202	
60649	167	
60617	142	
60653	123	
60628	104	
60621	102	
60620	88	
60636	58	
60609	55	
60629	41	
60643	38	
60616	34	
60605	14	
60632	13	
	1,743	44%

Close to PSA		
Zip Code	ICU Patients	
60409	37	
60411	29	
60426	25	
60466	24	
60438	21	
60827	20	
60473	18	
60462	18	
60633	17	
60419	16	
60652	15	
60452	14	
60430	13	
60422	13	
60406	12	
60655	12	
60477	12	
60608	10	
60429	6	
60469	4	
60642	4	
Close to PSA	340	9%
PSA+Close		53%

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Section 1110.530(b)(2)

ICU Patient Origin

Beyond Primary & Close

Zip Code	ICU Patients
46307	34
46342	27
46410	25
46360	22
46368	19
60901	19
46322	18
46385	18
46383	17
46323	16
46321	15
60440	15
60453	15
60618	15
60647	15
60914	15
46304	14
60443	14
60610	14
46312	13
46319	13
46375	13
60467	13
60451	12
60478	12
60543	12
60626	12
60640	12
46311	11
46324	11
46350	11
46404	11
46409	11
60401	11
60441	11
60623	11
60625	11
60638	11
46310	10
46408	10
60148	10
60423	10
60506	10
60564	10

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60586	10
60657	10
46394	9
46403	9
60035	9
60436	9
60445	9
60612	9
46356	8
46407	8
46514	8
60010	8
60016	8
60425	8
60446	8
60491	8
60504	8
60527	8
60540	8
60611	8
60622	8
60631	8
60645	8
46406	7
60056	7
60091	7
60123	7
60133	7
60188	7
60189	7
60201	7
60435	7
60487	7
60561	7
60714	7
60915	7
60950	7
46405	6
49120	6
60004	6
60014	6
60031	6
60067	6
60101	6
60103	6
60107	6
60120	6

60142	6
60181	6
60402	6
60403	6
60433	6
60448	6
60463	6
60471	6
60515	6
60538	6
60613	6
60639	6
60659	6
60954	6
46327	5
46391	5
60002	5
60015	5
60025	5
60076	5
60089	5
60090	5
60156	5
60172	5
60194	5
60404	5
60432	5
60447	5
60475	5
60505	5
60532	5
60624	5
60630	5
60644	5
60706	5
60804	5
46303	4
46341	4
46373	4
46545	4
49022	4
49038	4
49127	4
60005	4
60041	4
60046	4
60062	4

60073	4
60126	4
60137	4
60185	4
60192	4
60415	4
60417	4
60428	4
60439	4
60455	4
60472	4
60481	4
60482	4
60510	4
60521	4
60563	4
60585	4
60606	4
60614	4
60634	4
60641	4
60651	4
60707	4
60803	4
60805	4
61822	4
46320	3
46392	3
46534	3
46628	3
60007	3
60020	3
60030	3
60045	3
60047	3
60050	3
60060	3
60068	3
60077	3
60085	3
60087	3
60093	3
60099	3
60104	3
60110	3
60124	3
60130	3

60143	3
60154	3
60175	3
60191	3
60193	3
60202	3
60304	3
60431	3
60459	3
60465	3
60517	3
60559	3
60565	3
60602	3
60607	3
60646	3
60660	3
60964	3
61071	3
61101	3
61341	3
61350	3
61554	3
61604	3
61615	3
61761	3
46112	2
46347	2
46402	2
46530	2
46544	2
46563	2
46614	2
49085	2
49112	2
53022	2
60008	2
60018	2
60022	2
60044	2
60048	2
60064	2
60074	2
60081	2
60097	2
60098	2
60115	2

Section 1110.530(b)(2)

ICU Patient Origin

60118	2
60134	2
60139	2
60151	2
60153	2
60160	2
60169	2
60174	2
60176	2
60177	2
60178	2
60184	2
60302	2
60420	2
60421	2
60442	2
60450	2
60464	2
60490	2
60502	2
60513	2
60525	2
60541	2
60544	2
60546	2
60548	2
60550	2
60552	2
60555	2
60558	2
60560	2
60601	2
60654	2
60656	2
60712	2
60922	2
60941	2
60970	2
61032	2
61081	2
61109	2
61115	2
61265	2
61277	2
61364	2
61523	2
61561	2

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61571	2
61611	2
61701	2
61704	2
62526	2
97140	2
0	1
784	1
5404	1
7044	1
14057	1
20706	1
22182	1
25314	1
29073	1
29108	1
29605	1
30120	1
32501	1
32534	1
32701	1
33412	1
33434	1
34114	1
34145	1
34219	1
34491	1
34952	1
36303	1
36722	1
37128	1
37215	1
37388	1
38125	1
38804	1
40272	1
42029	1
42741	1
43612	1
45324	1
45331	1
45429	1
46037	1
46041	1
46065	1
46346	1
46355	1

Section 1110.530(b)(2)

ICU Patient Origin

46358	1
46366	1
46371	1
46382	1
46390	1
46517	1
46532	1
46536	1
46561	1
46574	1
46601	1
46613	1
46615	1
46619	1
46635	1
46637	1
46723	1
46761	1
46818	1
46825	1
46902	1
46923	1
46996	1
47150	1
47620	1
47918	1
47932	1
47933	1
47950	1
47975	1
47977	1
47978	1
48183	1
48187	1
48207	1
48642	1
48651	1
48912	1
49015	1
49043	1
49090	1
49099	1
49101	1
49102	1
49106	1
49117	1
49221	1

Section 1110.530(b)(2)

ICU Patient Origin

49302	1
49321	1
49505	1
49508	1
49706	1
49707	1
52245	1
52653	1
53024	1
53033	1
53045	1
53066	1
53072	1
53076	1
53115	1
53122	1
53129	1
53132	1
53140	1
53150	1
53193	1
53208	1
53405	1
53406	1
53511	1
53534	1
53565	1
54313	1
54642	1
54901	1
55117	1
55409	1
59102	1
59301	1
60026	1
60040	1
60043	1
60051	1
60069	1
60070	1
60075	1
60083	1
60084	1
60108	1
60112	1
60119	1
60140	1

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60150	1
60155	1
60163	1
60164	1
60187	1
60305	1
60408	1
60410	1
60416	1
60424	1
60434	1
60437	1
60461	1
60468	1
60484	1
60488	1
60503	1
60512	1
60514	1
60516	1
60526	1
60531	1
60537	1
60545	1
60554	1
60600	1
60603	1
60604	1
60661	1
60664	1
60918	1
60921	1
60927	1
60940	1
60949	1
60955	1
60957	1
60958	1
60966	1
61008	1
61021	1
61051	1
61054	1
61063	1
61064	1
61068	1
61072	1

61080	1
61105	1
61107	1
61111	1
61114	1
61201	1
61238	1
61250	1
61254	1
61270	1
61301	1
61310	1
61318	1
61329	1
61354	1
61356	1
61362	1
61401	1
61427	1
61473	1
61525	1
61605	1
61607	1
61610	1
61614	1
61726	1
61728	1
61741	1
61801	1
61818	1
61820	1
61821	1
61832	1
61842	1
61847	1
61853	1
61856	1
61862	1
61866	1
61877	1
62025	1
62040	1
62401	1
62521	1
62535	1
62549	1
62565	1

62626	1	
62656	1	
62681	1	
62711	1	
62832	1	
62896	1	
62901	1	
62959	1	
63104	1	
64112	1	
65020	1	
65281	1	
65706	1	
65807	1	
65809	1	
67218	1	
68117	1	
68154	1	
70122	1	
72758	1	
74114	1	
75287	1	
77471	1	
77505	1	
78727	1	
78873	1	
85338	1	
87132	1	
89014	1	
89130	1	
90020	1	
92117	1	
92345	1	
96815	1	
96817	1	
99523	1	
99999	1	
Beyond	1,878	47%
Grand Total	3,961	

ATTACHMENT 20

THE UNIVERSITY OF CHICAGO MEDICINE

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April 16, 2014

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: University of Chicago Medical Center Permit Application – Assurance of Occupancy

Dear Ms. Avery:

This letter attests to the fact that if this Project is approved by the Illinois Health Facilities and Services Review Board, University of Chicago Medical Center understands that it is expected to achieve and maintain the occupancy specified in §1110.234(e)(l) by the second year of operation after project completion. The University of Chicago Medical Center reasonably expects to meet this occupancy. Our ability to maintain this occupancy level could be affected by various factors, however, such as natural disasters, regulatory changes in healthcare, interruption of necessary utilities, physical plant problems, or other unexpected issues outside of our control which could have a direct or indirect effect upon our occupancy rate.

Sharon O'Keefe
President

Notarization:
Subscribed and sworn to before me
This 16th day of April, 2014

Signature of Notary Public

Seal

"OFFICIAL SEAL"
CASSANDRA COLE
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 8/3/2017

Attachment 20

Section VII, B, Clinical Service Areas Other Than Categories of Service

Attachment 37

A. **1110.3(c)(2) -- Service Modernization Necessary Expansion**

We propose to increase observation beds from 15 to 46. The 15 bed observation unit currently located in Mitchell would be relocated to the CCD and the vacated space in Mitchell converted to non-clinical, academic faculty and staff offices. Two observation units of 23 beds each would be constructed on the 3rd and 4th floors of the CCD to operate in conjunction with the medical-surgical and ICU units to be located on those floors. It is ideal to have these units proximal to take advantage of the skilled staffing that can support the observation patients if special expertise is called on and to handle the ebb and flow of the needs of observation patients.

Observation patients relating to medical-surgical and ICU services have ranged in number from 3,244 in 2009 to 2,513 for 2013. In earlier years there were enough open inpatient beds to place these patients in medical-surgical and ICU beds. However, since 2009 medical-surgical patients have increased steadily at an average rate of 6.3% a year which necessitated the creation of a 15 bed observation-only unit in Mitchell. This unit was vacated after our move to the CCD in early 2013.

Beginning on October 1, 2013, CMS instituted a new rule for Medicare patients, the "Two Midnight Rule," which defines an inpatient stay as requiring two midnights in a bed, versus observation which is only one midnight in a bed. Observation is considered outpatient and is subject to reimbursement as such. This change will have a substantial operational and financial impact on hospitals. For patients under the former rule, we were reimbursed more than four times as much for a stay defined as inpatient than we will be with the patient categorized as an outpatient, for similar services provided.

Operationally, this change in definition will also have a significant impact. Just as Medicare is trying to lower its costs, so are other payers and we expect this rule to be adopted widely. While this amounts to a re-categorization of patients, because the reimbursement will be less, we must be operate as efficiently as possible, while still providing high quality care. By establishing observation units where the acuity is uniformly lower, we can staff more precisely according to the needs of these patients. Further, by locating these units adjacent to the medical-surgical and ICU units proposed for the 3rd and 4th floors of the CCD, when help is needed for a short period the staff from these other units can assist.

Our experience with the first three months of the Two Midnight Rule serves as the basis for projecting a rapid increase in observation hours. This is discussed in detail in the following section, but briefly stated, the monthly average of observation patients in the first 9 months of 2013 was 180 and the average increased for the last 3 months after the rule change to 354. Considering that this surge is most likely due just to the Medicare rule change and thus Medicare patients, we estimate that this was an increase from 62

Medicare patients to 174, nearly threefold. As other payers adopt this cost saving rule, we expect similar increases for the rest of patients. As our medical-surgical patient days increase at historic rates, and assuming the current length of stay of 28 hours per observation stay, we forecast 323,670 hours, or 37 beds, at 100% occupancy by 2018. To accommodate daily peak loads, we consider a utilization rate of 80% to be prudent for these beds, which yields a need for 46 beds.

C. 1110.3(c)(3)(C) Service Modernization Utilization – No Standards Exist

ESTIMATION OF OBSERVATION BEDS NEEDED		
Jan-Sep, 2013 monthly	180	Avg. number of observation patients in adult ICU, medical-surgical
Oct-Dec, 2013 monthly avg.	354	CMS' Two Midnight Rule Began
Increase over previous 9 months	174	
Medicare share of Jan-Sep	62	At 34.4%
Medicare Obs patients growth Oct-Jan	174	Increase attributable to Two Midnight Rule effective 10/1/13
Medicare monthly Obs patients	236	After Two Midnight Rule in effect
Other payors adopt Two Midnight Rule	685	Assume same increase in Observation patients
Average hourly stay	31	
Monthly Observation hours	20,970	
Annual Observation hours	251,639	
Observation bed need incr. w/MS days	1.277	6.3% per year to five months after proj. completion 2/28/18
Observation Hours year ending 2/28/18	321,300	Five months after project completion
Observation beds needed at 100% occup.	37	
Observation Beds at 80% Occupancy	**46**	
Observation Beds Requested	**46**	

There are 46 observation beds proposed, an increase from the existing 15 observation beds we currently operate in a unit on the 3rd floor of Mitchell. The Mitchell observation unit would be discontinued and the vacated space would eventually be converted to non-clinical offices for faculty and staff. When relocated to the CCD there will be 5 observation beds along the exterior wall on each of the 3rd and 4th floors and 18 beds in along interior walls of these floors. These observation beds will not be located along external walls. Because these rooms will not have external windows, under the IDPH architectural standards they could not be converted into medical-surgical beds in the future.

The large increase in observation days reflects a major change in how observation days are defined by CMS which became effective October 1, 2013. While 33.4% of our inpatients are covered by Medicare, we expect that this cost saving mechanism will be adopted by other payers in an effort to reduce their payments for medical services. We have seen this dynamic occur for previous CMS rule changes.

The rule, popularly known as the "Two Midnight Rule", means that any stays in which the patient occupies a bed for fewer than two midnights are considered observation, and not inpatient stays. (This is a simplification, since patients must meet other clinical requirements to be considered inpatient even if they stay two or more midnights.) Prior to the rule change, from January through September 2013 we averaged 180 observation patients per month.

After the new rule became affective in October 2013, between October and December the average number of patients increased to 340, nearly double, for Medicare Patients. During this period, the average stay for observation patients was 30.6 hours. In our utilization projection we assumed that initially the Two Midnight Rule would only be in effect for Medicare, however, by 2015, we expect other payers to adopt it as a cost saving measure. This accounts for the dramatic increase in forecast observation days between 2013 and 2015. We also assumed these days would increase apace the 6.31% historic growth rate for medical-surgical patients. The great majority of observation patients are medical-surgical in terms of general service type.

As mentioned above in the medical-surgical Beds section above, the change in status brought about from this rule change is reflected in both the projection of observation days and also in the medical-surgical days projection. Thus, these patients are not double counted between these two categories in the table at the beginning of this Attachment 15.

The table above shows the calculation of observation patients and the hours they occupy a bed. Traditionally, we have been able to accommodate observation patients in medical-surgical beds, but as those beds have become very tight in recent years, we need dedicated observation units. By 2017, we expect 321,300 observation hours for medical-surgical and adult ICU patients, which we would fill at 100% for 37 beds. We believe an appropriate utilization rate would be 80%, in order to give us more flexibility to handle daily peak census. Average daily discharges for observation patients from October to December 2013 was 11.6, versus average observation patients at the daily peak census of 16.8. Thus, on a daily basis, the peak load is 45% greater than the average for the day, necessitating a lower occupancy target to accommodate the surges. By 2018, we expect the proposed 46 observation beds will be used at a rate of 80%. This is only 5 months after Project completion, well within the maximum 2 years.

UTILIZATION					
	DEPT/ SERVICE	**HISTORICAL UTILIZATION (PATIENT DAYS)**	**PROJECTED UTILIZATION[7]**	**STATE STANDARD**	**MET STANDARD?**
	Observation			N/A	
YEAR[8]					
2011		3,244			
2012		2,897			
2013		2,744			
2014		2,523			
2015		5,612			
2016		11,845			
2017		12,592			N/A
2018		13,387	80%	(80% 2/28/18)	

[7] Projected utilization not based on beds under construction.
[8] Year ending 2/28.

ATTACHMENT 37

Section IX, Financial Viability

Attachment 38

Evidence of UCMC's most recent bond ratings from Standard & Poor's (AA-) and Moody's (Aa3) is attached.

ATTACHMENT 38

STANDARD
&POOR'S
RATINGS SERVICES

RatingsDirect®

Illinois Finance Authority University of Chicago Medical Center; Hospital; Joint Criteria

Primary Credit Analyst:
Brian T Williamson, Chicago (1) 312-233-7009; brian.williamson@standardandpoors.com

Secondary Contact:
Suzie R Desai, Chicago (1) 312-233-7046; suzie.desai@standardandpoors.com

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Illinois Finance Authority
University of Chicago Medical Center; Hospital; Joint Criteria

Credit Profile		
Illinois Fin Auth, Illinois		
University of Chicago Med Ctr, Illinois		
Series 2003		
Unenhanced Rating	AA-(SPUR)/Stable	Affirmed
Series 2009D1-2		
Unenhanced Rating	AA-(SPUR)/Stable	Affirmed
Long Term Rating	AAA/A-1	Affirmed
Series 2009E-1 & E-2		
Unenhanced Rating	AA-(SPUR)/Stable	Affirmed
Long Term Rating	AAA/A-1	Affirmed
Series 2011C & 2012A		
Long Term Rating	AA-/Stable	Affirmed

Rationale

Standard & Poor's Ratings Services affirmed its 'AA-' long-term rating and underlying rating (SPUR) on the Illinois Finance Authority's (IFA) series 2003, 2009A, 2009B, 2009C, 2009D, 2009E, 2011C, and 2012A bonds issued on behalf of the University of Chicago Medical Center (UCMC). The outlook is stable.

In addition, Standard & Poor's affirmed its 'AAA/A-1' rating on IFA's series 2009E-1 and 2009E-2 variable-rate demand revenue refunding bonds also issued on behalf of UCMC. The rating on the series 2009E-1 and 2009E-2 is based on the joint support of irrevocable, direct-pay letters of credit (LOCs) provided by JPMorgan Chase Bank N.A. (A+/A-1) and the pledged support of UCMC.

The ratings reflect our view of UCMC's solid enterprise profile, as evident in admissions growth of more than 10% during the past two years coupled with solid operations for unaudited fiscal 2013. The ratings also reflect our view of UCMC leadership's ability to complete the construction and opening of the Center for Care and Discovery on time and on budget. As the leadership has made the transition into the new hospital, UCMC operations have been on par with what the team shared with us for fiscal 2013. However, UCMC's budget calls for a softer fiscal 2014 after accounting for the expenses associated with operating the Center for Care and Discovery for a full fiscal year. If UCMC performs at the budgeted level for 2014, the outlook and/or rating could come under pressure.

The ratings further reflect our opinion of UCMC's:

MOODY'S
INVESTORS SERVICE

7 World Trade Center
250 Greenwich Street
New York, NY 10007
www.moodys.com

November 8, 2013

Mr. James Watson
Chief Financial Officer
The University of Chicago Medical Center
Room M-116, MC 1111
5841 S. Maryland
Chicago, IL 60637-0970

Dear Mr. Watson:

We wish to inform you that Moody's Investors Service has affirmed The University of Chicago Medical Center's **A3** rating on bonds issued through the Illinois Finance Authority and Illinois Health Facilities Authority. The outlook is revised to negative.

Moody's will monitor this rating and reserves the right, at its sole discretion, to revise or withdraw this rating at any time.

The rating as well as any other revisions or withdrawals thereof will be publicly disseminated by Moody's through the normal print and electronic media and in response to verbal requests to Moody's rating desk.

In order for us to maintain the currency of our rating, we request that you provide ongoing disclosure, including annual and quarterly financial and statistical information.

Should you have any questions regarding the above, please do not hesitate to contact me.

Sincerely,

Mark Pascaris

Mark Pascaris
Vice President/Senior Analyst
Phone: 312-706-9963
Fax: 212-298-6377
Email: mark.pascaris@moodys.com

MP:rl

cc: Ms. Ann McColgan, Vice President & Chief Treasury Officer, The University of Chicago Medicine
Mr. Mark Melio, Melio & Company
Ms. Beth Chevalier, Melio & Company

Section X, Economic Feasibility

Attachment 39

A. **Reasonableness of Financing Arrangements.**

A letter attesting to the financial viability of the project is attached along with a list of the cost and gross square feet by department or service are attached.

B. **Conditions of Debt Financing.**

This is Project is being paid for through cash and securities and, therefore, this criterion is not applicable.

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department	A Cost/Sq. Foot	B	C Gross Sq. Ft.	D	E	F Gross Sq.	G Const. $	H Mod. $	Total Costs
	New	Mod.	New	Circ.	Mod	Circ.	(A x C)	(B x E)	(G + H)
Reviewable:									
M/S Patient Units	$416.24		94,460				$39,318,228		$39,318,228
ICU Patient Units	$460.17		20,964				9,647,060		9,647,060
Observation Patient	$438.21		29,576				12,960,421		12,960,421
Reviewable Total	$427.07		145,000	35%			61,925,709		61,925,709
Non-reviewable:									
Non-Clinical	346.10		76,395				26,440,661		26,440,661
Non-reviewable Total	$346.10		76,395	13%			26,440,661		26,440,661
Contingency	$27.94						6,186,000		6,186,000
TOTALS	$427.08		221,395	28%			$94,552,370		$94,552,370

State $/SF Standard – State Staff Computation 4/14/14:	
State $/sf 1/1/14	$410
Zip code adjustment – 60637	1.0300
Inflation to 6/15/15 midpoint	1.0453
Diagnostic Intensity – Medium	1.1100
Adjusted $/sf standard	$490
Project $/sf Total	$427
Project Clinical + Conting. only	$470

D. **Project Operating Costs**.

	Medical-Surgical	ICU	Observation
Compensation	22,823,112	9,981,776	4,875,646
Supplies	2,047,494	1,672,540	56,778
Services	328,893	1153,976	39,914
Other	7,128	2,076	4,747
Total Operating Costs	25,206,628	11,810,368	4,977,085
Beds Relocated	134	32	46
Annual Operating Cost Per Bed	$188,109	$3,074	$108,198

2014 Dollars

E. **Total Effect of Project on Capital Costs**.

	Year 2018
Annual Depreciation	$7,521,277
Equivalent Patient Days	541,077
Capital Cost Per Equivalent Day	$13.90

ATTACHMENT 39

THE UNIVERSITY OF CHICAGO MEDICINE

James M. Watson
Chief Financial Officer

April 15, 2014

Ms. Courtney R. Avery
Administrator
ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: University of Chicago Medical Center Permit Application

Dear Ms. Avery:

The total estimated project costs and related costs will be funded in total with cash and equivalents.

Sincerely,

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

James Watson
Chief Financial Officer

Notarization:
Subscribed and sworn to before me
This 10th day of April, 2014

Signature of Notary Public

Seal

"OFFICIAL SEAL"
CASSANDRA COLE
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 8/3/2017

Attachment - 39

5841 South Maryland Avenue · MC 1000 · Chicago, Illinois 60637
Telephone: 773-834-7243 · Fax: 773-702-9005 · E-mail: James.Watson@uchospitals.edu

THE UNIVERSITY OF CHICAGO MEDICINE

James M. Watson
Chief Financial Officer

April 15, 2014

Ms. Courtney R. Avery
Administrator
ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: University of Chicago Medical Center Permit Application

Dear Ms. Avery:

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Sincerely,

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

James Watson
Chief Financial Officer

Notarization:
Subscribed and sworn to before me
This 10th day of April, 2014

Signature of Notary Public

Seal

"OFFICIAL SEAL"
CASSANDRA COLE
NOTARY PUBLIC, STATE OF ILLINOIS
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Attachment - 39

5841 South Maryland Avenue MC 1000 · Chicago, Illinois 60637
Telephone: 773-834-7243 · Fax: 773-702-9005 · E-mail: James.Watson@uchospitals.edu

The University of Chicago Medical Center

Financial Statements
June 30, 2013 and 2012

Attachment - 39

The University of Chicago
Medical Center
Index
June 30, 2013 and 2012

Attachment - 39

pwc

Independent Auditor's Report

To the Board of Trustees of
The University of Chicago Medical Center:

We have audited the accompanying financial statements of The University of Chicago Medical Center, which comprise the balance sheets as of June 30, 2013 and 2012, and the related statements of operations, of changes in net assets, and of cash flows for the years then ended.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Company's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of The University of Chicago Medical Center at June 30, 2013 and 2012, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

PricewaterhouseCoopers LLP

October 10, 2013

PricewaterhouseCoopers LLP, One North Wacker, Chicago, IL 60606
T: (312) 298 2000, F: (312) 298 2001, www.pwc.com/us

Attachment - 39

The University of Chicago Medical Center
Balance Sheets
June 30, 2013 and 2012
(In thousands of dollars)

	2013	2012
Assets		
Current assets		
Cash and cash equivalents	$ 164,504	$ 74,348
Patient accounts receivable, less allowance for doubtful accounts for 2013 - $29,612 and 2012 - $30,796	204,279	209,006
Current portion of investments limited to use	11	27,033
Current portion of malpractice self-insurance receivable	22,502	17,629
Current portion of pledges receivable	2,243	4,799
Other current assets	35,176	23,627
Total current assets	428,715	356,442
Investments limited to use, less current portion	797,305	897,405
Property, plant and equipment, net	1,189,623	1,066,494
Pledges receivable, less current portion	2,465	5,634
Malpractice self-insurance receivable, less current portion	98,821	100,524
Other assets, net	15,722	27,349
Total assets	$ 2,532,651	$ 2,453,848
Liabilities and Net Assets		
Current liabilities		
Accounts payable and accrued expenses	$ 131,206	$ 117,678
Current portion of long-term debt	10,385	11,290
Current portion of other long-term liabilities	2,033	688
Current portion of estimated third-party payor settlements	51,836	27,379
Current portion of malpractice self-insurance liability	22,502	17,629
Due to University of Chicago	14,799	15,593
Total current liabilities	232,761	190,257
Other liabilities		
Worker's compensation self-insurance liabilities, less current portion	9,528	8,216
Malpractice self-insurance liability, less current portion	98,821	100,524
Long-term debt, less current portion	820,341	833,255
Interest rate swap liability	88,769	135,872
Other long-term liabilities, less current portion	44,741	56,370
Total liabilities	1,294,961	1,324,494
Net assets		
Unrestricted	1,149,627	1,027,917
Temporarily restricted	81,971	95,345
Permanently restricted	6,092	6,092
Total net assets	1,237,690	1,129,354
Total liabilities and net assets	$ 2,532,651	$ 2,453,848

The accompanying notes are an integral part of these financial statements.

Attachment - 39

The University of Chicago Medical Center
Statements of Operations
Years Ended June 30, 2013 and 2012
(in thousands of dollars)

	2013	2012
Operating revenues		
Net patient service revenue	$ 1,303,787	$ 1,267,104
Provision for doubtful accounts	47,812	45,133
Net patient service revenue after provision for doubtful accounts	1,255,975	1,221,971
Other operating revenues and net assets released from restrictions	81,184	67,914
Total operating revenues	1,337,159	1,289,885
Operating expenses		
Salaries, wages and benefits	595,968	532,949
Supplies and other	335,358	324,844
Physician services from the University of Chicago	191,862	185,026
Insurance	18,382	20,902
Interest	19,883	12,789
Medicaid provider tax	26,691	26,691
Depreciation and amortization	70,466	67,522
Total operating expenses	1,258,610	1,170,723
Total operating income	78,549	119,162
Nonoperating gains		
Investment income and unrestricted gifts, net	59,788	24,857
Derivative ineffectiveness gain (loss)	2,993	(3,679)
Excess of revenues over expenses	141,330	140,340
Other changes in net assets		
Transfers to University of Chicago, net	(74,544)	(90,396)
Net assets released for capital purchases	14,277	225
Liability for pension benefits	3,878	(2,659)
Changes in valuation of derivatives	36,713	(85,079)
Other, net	56	562
Increase (decrease) in unrestricted net assets	$ 121,710	$ (37,007)

The accompanying notes are an integral part of these financial statements.

The University of Chicago Medical Center
Statements of Changes in Net Assets
Years Ended June 30, 2013 and 2012
(In thousands of dollars)

	2013	2012
Unrestricted net assets		
Excess of revenues over expenses	$ 141,330	$ 140,340
Transfers to University of Chicago	(74,544)	(90,396)
Net assets released for capital purchases	14,277	225
Liability for pension benefits	3,878	(2,659)
Changes in valuation of derivatives	36,713	(85,079)
Other, net	56	562
Increase (decrease) in unrestricted net assets	121,710	(37,007)
Temporarily restricted net assets		
Contributions	3,137	3,345
Net assets released from restrictions used for operating purposes	(4,621)	(4,539)
Investment income	4,604	2,825
Net assets released for capital purchases	(14,277)	(225)
Other	(2,217)	-
Increase (decrease) in temporarily restricted net assets	(13,374)	1,406
Permanently restricted net assets		
Contributions and other	-	(20)
Increase (decrease) in net assets	108,336	(35,621)
Net assets at beginning of year	1,129,354	1,164,975
Net assets at end of year	$ 1,237,690	$ 1,129,354

The accompanying notes are an integral part of these financial statements.

Attachment - 39

The University of Chicago Medical Center
Statements of Cash Flows
Years Ended June 30, 2013 and 2012
(in thousands of dollars)

	2013	2012
Cash flows from operating activities		
Increase (decrease) in net assets	$ 108,336	$ (35,621)
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Net change in unrealized gains on investments	(1,108)	13,425
Transfers to University of Chicago	74,544	90,396
Restricted contributions and other changes	(921)	(3,344)
Realized gains on investments	(63,284)	(41,941)
Net change in valuation of derivatives	(47,103)	77,808
Pension and other changes in unrestricted net assets	(3,934)	2,566
Loss on disposal of assets	935	388
Loss on extinguishment of debt	-	2,891
Depreciation and amortization	70,329	67,522
Increase (decrease) in cash resulting from a change in		
Patient accounts receivable, net	4,727	(69,641)
Other assets	26,429	(7,369)
Accounts payable and accrued expenses	11,545	12,072
Due to the University of Chicago	(794)	2,658
Estimated settlements with third-party payors	24,504	(8,622)
Self-insurance liabilities	1,312	20
Other liabilities	11,061	(6,758)
Net cash provided from operating activities	216,578	96,450
Cash flows from investing activities		
Purchases of property, plant and equipment	(209,359)	(240,737)
Decrease in construction/capitalized interest funds	14,730	125,620
Acquisition of business purchased	-	(2,607)
Purchases of investments	(221,928)	(146,314)
Sales of investments	371,690	186,875
Net cash used in investing activities	(44,867)	(77,163)
Cash flows from financing activities		
Proceeds from issuance of long-term debt	686	80,945
Payments on long-term obligations	(14,343)	(90,631)
Transfers paid to the University of Chicago, net	(74,544)	(90,396)
Restricted contributions	6,646	6,936
Net cash used in financing activities	(81,555)	(93,146)
Net increase (decrease) in cash and cash equivalents	90,156	(73,859)
Cash and cash equivalents		
Beginning of year	74,348	148,207
End of year	$ 164,504	$ 74,348

The accompanying notes are an integral part of these financial statements.

Attachment - 39

1. Organization and Basis of Presentation

The University of Chicago Medical Center ("UCMC" or the "Medical Center") is an Illinois not-for-profit corporation. UCMC operates the Center for Care and Discovery, the Bernard Mitchell Hospital, the Chicago Lying-In Hospital, the University of Chicago Comer Children's Hospital, the Duchossois Center for Advanced Medicine, and various other outpatient clinics and treatment areas.

The University of Chicago (the "University"), as the sole corporate member of UCMC, elects UCMC's Board of Trustees and approves its By-Laws. The UCMC President reports to the University's Executive Vice President for Medical Affairs. The relationship between UCMC and the University is defined in the Medical Center By-Laws, an Affiliation Agreement, an Operating Agreement, and several Leases. See Note 3 for agreements and transactions with the University.

UCMC is a tax-exempt organization under Section 501(c)3 of the Internal Revenue Code. Accordingly, no provision for income taxes related to these entities has been made.

2. Summary of Significant Accounting Policies

New Accounting Pronouncements
During 2012, the Medical Center adopted the provisions of Accounting Standards Update 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision of Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities* ("ASU 2011-07"). ASU 2011-07 requires health care entities to change the presentation of the statements of operations by reclassifying the provision for doubtful accounts from an operating expense to a deduction from patient service revenues.

During 2013, the Medical Center adopted the provisions of Accounting Standards Update 2011-04, Amendments to Achieve Common Fair Value Measurement and Disclosure Requirements in U.S. GAAP and IFRS ("ASU 2011-04"), ASU 2011-04 requires entities to provide additional disclosures related to fair value measurements of assets and liabilities classified as level 3 within the fair value hierarchy. See Note 5 for related fair value disclosures.

Use of Estimates
The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. The most significant estimates are made in the areas of patient accounts receivable, accruals for settlements with third-party payors, malpractice liability, fair value of investments, goodwill, intangibles, and accrued compensation and benefits.

Community Benefits
UCMC's policy is to treat patients in immediate need of medical services without regard to their ability to pay for such services, including patients transferred from other hospitals under the provisions of the Emergency Medical Treatment and Active Labor Act (EMTALA). UCMC also accepts patients through the Perinatal and Pediatric Trauma Networks without regard to their ability to pay for services.

UCMC developed a Financial Assistance Policy (the "Policy") under which patients are offered discounts of up to 100% of charges on a sliding scale. The policy is based both on income as a percentage of the Federal Poverty Level guidelines and the charges for services rendered. The policy also contains provisions that are responsive to those patients subject to catastrophic healthcare expenses. Since UCMC does not pursue collection of these amounts, they are not reported as net patient service revenue. The cost of providing care under this policy, along with the unreimbursed cost of government sponsored indigent healthcare programs, unreimbursed cost to support education, clinical research and other community programs for the years ended June 30, 2013 and 2012, are reported in Note 4.

Fair Value of Financial Instruments
Fair value is defined as the price that the Medical Center would receive upon selling an asset or pay to settle a liability in an orderly transaction between market participants.

The Medical Center uses a framework for measuring fair value that includes a hierarchy that categorizes and prioritizes the sources used to measure and disclose fair value. This hierarchy is broken down into three levels based on inputs that market participants would use in valuing the financial instruments based on market data obtained from sources independent of the Medical Center. Inputs refer broadly to the assumptions that market participants would use in pricing the asset, including assumptions about risk. Inputs may be observable or unobservable. Observable inputs are inputs that reflect the assumptions market participants would use in pricing the asset developed based on market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own assumptions about the assumptions market participants would use in pricing the asset developed based on the best information available. The three tier hierarchy of inputs is summarized in the three broad levels as follows:

Level 1 – quoted market prices in active markets for identical investments.

Level 2 – inputs other than quoted prices for similar investments in active markets, quoted prices for identical or similar investments in markets that are not active, or inputs other than quoted prices that are observable including model-based valuation techniques.

Level 3 – valuation techniques that use significant inputs that are unobservable because they trade infrequently or not at all.

Cash and Cash Equivalents
Cash equivalents include U.S. Treasury notes, commercial paper, and corporate notes with original maturities of three months or less, except that such instruments purchased with endowment assets or funds on deposit with bond trustees are classified as investments. Cash equivalents are considered Level 1 in the fair value hierarchy.

Inventory
UCMC values inventories at the lower of cost or market, using the first-in first-out method.

Investments
Investments are recorded in the consolidated financial statements at estimated fair value. If an investment is held directly by the Medical Center and an active market with quoted prices exists, the market price of an identical security is used as reported fair value. Reported fair values for shares in mutual funds are based on share prices reported by the funds as of the last business day

of the fiscal year. The Medical Center's interests in alternative investment funds such as private debt, private equity, real estate, natural resources, and absolute return are generally reported at the net asset value (NAV) reported by the fund managers, which is used as a practical expedient to estimate the fair value, unless it is probable that all or a portion of the investment will be sold for an amount different from NAV. As of June 30, 2013 and 2012, the Medical Center had no plans to sell investments at amounts different from NAV.

A summary of the inputs used in valuing the Medical Center's investments as of June 30, 2013 and 2012 is included in Note 5.

A significant portion of UCMC's investments are part of the University's Total Return Investment Pool (TRIP). UCMC accounts for its investments in TRIP based on its share of the underlying securities and records the investment activity as if UCMC owned the investments directly. The University does not engage directly in unhedged speculative investments; however, the Board of the University of Chicago has authorized the use of derivative investments to adjust market exposure within asset class ranges.

A summary of the inputs used in valuing the Medical Center's investments as of June 30, 2013 and 2012 is included in Note 5.

Endowment Funds with Deficits
From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the value of the initial and subsequent donor gift amounts (deficit). When donor endowment deficits exist, they are classified as a reduction of unrestricted net assets. As of June 30, 2013 and 2012, there were no endowments in a deficit position.

Investments Limited as to Use
Investments limited as to use primarily include assets held by trustees under debt and other agreements and designated assets set aside by the Board of Trustees for future capital improvements and other specific purposes, over which the Board retains control and may at their discretion subsequently use for other purposes.

Derivative Instruments
In August 2006, UCMC entered into a forward starting swap transaction against contemplated variable rate borrowing for the Center for Care and Discovery. This is a cash flow hedge against interest on the variable rate debt. The fair value of these swap agreements is the estimated amount that the Medical Center would have to pay or receive to terminate the agreements as of the consolidated balance sheet date, taking into account current interest rates and the current creditworthiness of the swap counterparty. The swap values are based on the London Interbank Rate ("LIBOR"). The inputs to the fair value estimate are considered Level 2 in the fair value hierarchy. The effective date of the swap was August 2011. In July 2011, UCMC novated the original swap agreement to divide the original notional amount in two equal parts between financial institutions. The fair value of the terminated portion of the hedge on the date of the novation was recorded in net assets in the amount of $35,123 and will be amortized into interest expense over the life of the related debt, commencing on the date the Center for Care and Discovery was placed into service. The new agreement is being accounted for as a hedge. The combined notional amount of the swap is $325,000 and the effective start date was August 2011. Management determined that the interest rate swaps are effective, and have qualified for hedge accounting.

Management has recognized a net recovery (loss) of ineffectiveness of approximately $3,000 and $(3,700) in 2013 and 2012. This movement reflects the spread between tax exempt interest rates and LIBOR during the period. The effective portion of these swaps are included in other changes in unrestricted net assets. The interest rate swaps terminate on February 1, 2044. Cash settlement payments related to the swaps for 2013 and 2012 were $7,900 and $10,900, respectively. These payments were accumulated in net assets while the Center for Care and Discovery was under construction, and will be amortized into depreciation expense over the life of the building, commencing on the date the Center for Care and Discovery was placed into service.

UCMC is required to provide collateral on one of the interest rate swap agreements when the liability of that swap exceeds $50,000. At June 30, 2013 and 2012 approximately $0 and $26,400, respectively, was held as collateral and classified as current portion of investments limited to use.

Property, Plant and Equipment
Property, plant and equipment are reported on the basis of cost less accumulated depreciation and amortization. Donated items are recorded at fair market value at the date of contribution. The carrying value of property, plant and equipment is reviewed if the facts and circumstances suggest that it may be impaired. Depreciation of property, plant and equipment is calculated by use of the straight-line method at rates intended to depreciate the cost of assets over their estimated useful lives, which generally range from three to eighty years. Interest costs incurred on borrowed funds during the period of construction of capital assets, net of any interest earned, are capitalized as a component of the cost of acquiring those assets. During 2013, UCMC evaluated the remaining useful lives of the buildings based on their condition by performing detailed assessments of the facilities and modifying estimated useful lives where appropriate to properly reflect the remaining useful life of the facility. Based on these changes, depreciation expense recorded was approximately $5,800 less in 2013 than if the estimated useful lives were not modified.

Asset Retirement Obligation
UCMC recognizes a liability for the fair value of a legal obligation to perform asset retirement activities that are conditional on a future event if the amount can be reasonably estimated. Upon recognition of a liability, the asset retirement cost is recorded as an increase in the carrying value of the related long-lived asset and then depreciated over the life of the asset. The UCMC asset retirement obligations arise primarily from regulations that specify how to dispose of asbestos if facilities are demolished or undergo major renovations or repairs. UCMC's obligation to remove asbestos was estimated using site-specific surveys where available and a per square foot estimate where surveys were unavailable. These inputs to the fair value estimate are considered Level 3 in the fair value hierarchy.

Pledges Receivable
Unconditional promises to give are recognized initially at fair value as private gift revenue in the period the promise is made by a donor. Fair value of the pledge is estimated based on anticipated future cash receipts (net of an allowance for uncollectible amounts), discounted using a risk-adjusted rate commensurate with the duration of the payment plan. These inputs to the fair value estimate are considered Level 3 in the fair value hierarchy. In subsequent periods, the discount rate is unchanged and the allowance for uncollectible amounts is reassessed and adjusted if necessary.

Other Assets and Liabilities
Other assets and liabilities, including deferred financing costs, which are amortized over the term of the related obligations, do not differ materially from their estimated fair value and are considered Level 1 in the fair value hierarchy

Net Assets
Permanently restricted net assets include the historical dollar amounts of gifts that are required by donors to be permanently retained. Temporarily restricted net assets include gifts, which can be expended but for which restrictions have not yet been met. Such restrictions include purpose restrictions where donors have specified the purpose for which the net assets are to be spent, or time restrictions imposed by donors or implied by the nature of the gift (such as pledges to be paid in the future) or by interpretations of law. Unrestricted net assets include all the remaining net assets of UCMC. See Note 15 for further information on the composition of restricted net assets.

Realized gains and losses are classified as changes in unrestricted net assets unless they are restricted by the donor or law.

Gifts and Grants
Unconditional promises to give assets other than cash to UCMC are reported at fair value at the date the promise is received. Conditional promises to give are recognized when the conditions are substantially met. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. Donor-restricted contributions whose restrictions are met within the same year received are reported as unrestricted gifts in the accompanying financial statements.

Gifts of cash or other assets that must be used to acquire long-lived assets are reported as additions to temporarily restricted net assets until the assets are placed into service.

Statement of Operations
All activities of UCMC deemed by management to be ongoing, major and central to the provision of healthcare services are reported as operating revenues and expenses. Activities deemed to be nonoperating include certain investment income (including realized gains and losses).

UCMC recognizes changes in accounting estimates related to third-party payor settlements as more experience is acquired. Adjustments to prior year estimates for these items resulted in an increase in net patient service revenues of $3,700 in 2013 and $6,000 in 2012.

In 2013, UCMC recognized a gain of $2,400 related to the unwinding of the Weiss Liquidation Trust and received $16,000 in cash from the liquidation. In 2012, UCMC recognized a gain of $5,500 as a result of a favorable settlement with Medicare relating to the rural floor budget neutrality adjustment for fiscal years 1999 through 2011. UCMC recognized a gain of $21,000 in 2012 relating to the flow through of the 1996 IME and GME FTE caps for years 2006 through 2011.

The statement of operations includes excess (deficit) of revenues over expenses. Changes in unrestricted net assets that are excluded from excess (deficit) of revenues over expenses include transfers to the University, contributions of long-lived assets released from restrictions (including assets acquired using contributions which by donor restriction were to be used for acquisition of UCMC assets), the effective portion of changes in the valuation of the interest rate swap, and pension benefit liabilities.

Net Patient Service Revenue, Accounts Receivable and Allowance for Doubtful Accounts
UCMC maintains agreements with the Social Security Administration under the Medicare Program, Blue Cross and Blue Shield of Illinois, Inc. (Blue Cross), and the State of Illinois under the Medicaid Program and various managed care payors that govern payment to UCMC for services rendered to patients covered by these agreements. The agreements generally provide for per case or per diem rates or payments based on allowable costs, subject to certain limitations, for inpatient care and discounted charges or fee schedules for outpatient care.

Net patient service revenue is reported at estimated net realizable amounts from patients, third-party payors, and others for services rendered and include estimated retroactive revenue adjustments due to future audits, reviews, and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and UCMC estimates are adjusted in future periods as adjustments become known or as years are no longer subject to UCMC audits, reviews and investigations. Contracts, laws and regulations governing Medicare, Medicaid, and Blue Cross are 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. A portion of the accrual for settlements with third-party payors has been classified as long-term because UCMC estimates they will not be paid within one year.

The process for estimating the ultimate collectability of receivables involves significant assumptions and judgment. UCMC has implemented a standardized approach to this estimation based on the payor classification and age of outstanding receivables. Account balances are written off against the allowance when management feels it is probable the receivable will not be recovered. The use of historical collection experience is an integral part of the estimation of the reserve for doubtful accounts. Revisions in the reserve for doubtful accounts are recorded as adjustments to the provision for doubtful accounts.

Hospital Assessment Program/Medicaid Provider Tax
In December 2008, the State of Illinois, after receiving approval by the federal government, implemented a hospital assessment program. The program assessed hospitals a provider tax based on occupied bed days and provided increases in hospitals' Medicaid payments. The program results in a net increase of $28,300 in income from operations, which represents $55,000 in additional Medicaid payments offset by $26,700 in Medicaid provider tax for 2013. For 2012, the assessment program resulted in a net increase of $30,300 in operating income, which represents $57,000 in additional Medicaid payments offset by $26,700 in Medicaid provider tax.

Subsequent Events
UCMC has performed an evaluation of subsequent events through October 10, 2013, which is that date the financial statements were issued.

3. Agreements and Transactions with the University

The Affiliation Agreement with the University provides, among other things, that all members of the medical staff will have academic appointments in the University. The Affiliation Agreement has an initial term of 40 years ending October 1, 2026 unless sooner terminated by mutual consent or as a result of a continuing breach of a material obligation therein or in the Operating Agreement. The Affiliation Agreement automatically renews for additional successive 10-year terms following expiration of the initial term, unless either party provides the other with at least two years' prior written notice of its election not to renew.

(In thousands of dollars)

The Operating Agreement, as amended, provides, among other things, that the University gives UCMC the right to use and operate certain facilities. The Operating Agreement is coterminous with the Affiliation Agreement.

The Lease Agreements provide, among other things, that UCMC will lease from the University certain of the health care facilities and land that UCMC operates and occupies. The Lease Agreements are coterminous with the Affiliation Agreement.

UCMC purchases various services from the University, including certain employee benefits, utilities, security, telecommunications and insurance. In addition, certain UCMC accounting records are maintained by the University. During the years ended June 30, 2013 and 2012, the University charged UCMC approximately $25,200 and $22,500, respectively, for utilities, security, telecommunications, insurance and overhead.

The University's Division of Biological Sciences ("BSD") provides physician services to UCMC. In 2013 and 2012, UCMC recorded approximately $192,000 and $185,000, respectively, in expense related to these services.

UCMC's Board of Trustees adopted a plan of support under which it would provide annual net asset transfers to the University for support of academic programs in biology and medicine. All commitments under this plan are subject to the approval of UCMC's Board of Trustees and do not represent legally binding commitments until that approval. Unpaid portions of commitments approved by the UCMC Board of Trustees are reflected as current liabilities. UCMC recorded net asset transfers of $71,750 in 2013 and $63,000 in 2012 for this support.

4. Community Benefits

The unreimbursed cost of providing care under the Financial Assistance Policy, along with the unreimbursed cost of government sponsored indigent healthcare programs, unreimbursed cost to support education, clinical research and other community programs for the years ended June 30, 2013 and 2012, are as follows:

	Years Ended June 30, 2013	2012
Uncompensated care:		
Medicaid sponsored indigent healthcare	$ 49,623	$ 40,223
Medicare sponsored indigent healthcare - Cost Report	45,685	38,520
Medicare sponsored indigent healthcare - Physician Services	16,580	11,431
Total uncompensated care	111,888	90,174
Provision for doubtful accounts	12,270	11,995
Charity care	25,676	20,310
	149,834	122,479
Unreimbursed education and research:		
Education	86,157	81,735
Research	48,000	48,000
Total unreimbursed education and research	134,157	129,735
Total community benefits	$ 283,991	$ 252,214

Attachment - 39

(In thousands of dollars)

The Medical Center determines the costs associated with providing charity care by aggregating the applicable direct and indirect costs, including salaries, wages, and benefits, supplies, and other operating expenses, based on data from its costing system to determine a cost-to-charge ratio. The cost to charge ratio is applied to the charity care charge to calculate the charity care amount reported above.

5. Investments Limited as to Use

The composition of investments limited as to use is as follows at June 30:

	2013				
	Endowments				
	Separately Invested	TRIP	Other	Total	2012
Investments carried at fair value:					
Cash Equivalents	$ 19,024	$ 13,250	$ 505	$ 32,779	$ 15,423
Global Public Equities	79,915	95,132	-	175,047	235,444
Private Debt	-	21,328	-	21,328	22,848
Private Equity					
U.S. Venture Capital	4,187	28,667	-	32,854	33,918
U.S. Corporate Finance	-	32,022	-	32,022	33,196
International	353	37,767	-	38,120	40,233
Real Assets					
Real Estate	-	56,978	-	56,978	57,296
Natural Resources	-	58,786	-	58,786	59,953
Absolute Return					
Equity Oriented	-	36,155	-	36,155	28,983
Global Macro/Relative Value	-	35,143	-	35,143	40,235
Multi-Strategy	-	50,457	-	50,457	50,350
Credit-Oriented	-	16,376	-	16,376	11,214
Volatility-Oriented	-	11,227	-	11,227	9,975
Fixed Income					
U.S. Treasuries, including TIPS	66,151	38,718	-	104,869	149,665
Other Fixed Income	4,162	76,209	-	80,371	61,482
Funds in Trust	-	-	14,804	14,804	54,223
Total Investments	$ 173,792	$ 608,215	$ 15,309	$ 797,316	$ 924,438

Investments classified as other consist of construction and debt proceeds to pay interest, donor restricted, worker's compensation, self-insurance, and trustee-held funds. Investments are presented in the financial statements as follows:

	2013	2012
Current portion of investments limited to use	$ 11	$ 27,033
Investments limited to use, less current portion	797,305	897,405
Total investments limited to use	$ 797,316	$ 924,438

(In thousands of dollars)

The composition of net investment income is as follows for the years ended June 30:

	2013	2012
Interest and dividend income, net	$ 13,311	$ 14,831
Realized gains on sales of securities	45,738	23,970
Unrealized gains (losses) on securities	739	(13,944)
	$ 59,788	$ 24,857

Outside of TRIP, UCMC also invests in private equity limited partnerships. As of June 30, 2013, UCMC has commitments of $1,711 remaining to fund private equity limited partnerships.

Fair Value of Financial Instruments

The overall investment objective of the Medical Center is to invest its assets in a prudent manner that will achieve a long-term rate of return sufficient to fund a portion of its annual operating activities and increase investment value after inflation. The Medical Center diversifies its investments among various asset classes incorporating multiple strategies and external investment managers, including the University of Chicago Investment Office. Major investment decisions for investments held in TRIP and managed by the University are authorized by the University Board of Trustee's Investment Committee, which oversees the University's investment program in accordance with established guidelines.

Cash equivalent investments include cash equivalents and fixed-income investments, with maturities of less than one year, which are valued based on quoted market prices in active markets. The majority of these investments are held in U.S. money market accounts. Global public equity investments consist of separate accounts, commingled funds with liquidity ranging from daily to monthly, and limited partnerships. Securities held in separate accounts and daily-traded commingled funds are generally valued based on quoted market prices in active markets. Commingled funds with monthly liquidity are valued based on independently determined NAV. Limited partnership interests in equity-oriented funds are valued based upon NAV provided by external fund managers.

Investments in private debt, private equity, real estate, and natural resources are in the form of limited partnership interests, which typically invest in private securities for which there is no readily determinable market value. In these cases, market value is determined by external managers based on a combination of discounted cash flow analysis, industry comparables, and outside appraisals. Where private equity, real estate, and natural resources managers hold publicly traded securities, these securities are generally valued based on market prices. The value of the limited partnership interests are held at the manager's reported NAV, unless information becomes available indicating the reported NAV may require adjustment. The methods used by managers to assess the NAV of these external investments vary by asset class. The University's Investment Office on behalf of the Medical Center monitors the valuation methodologies and practices of managers.

The absolute return portfolio is comprised of investments of limited partnership interests in hedge funds and drawdown private equity style partnerships whose managers have the authority to invest in various asset classes at their discretion, including the ability to invest long and short. The majority of the underlying holdings are marketable securities. The remainder of the underlying

holdings is held in marketable securities that trade infrequently or in private investments, which are valued by the manager on the basis of an appraised value, discounted cash flow, industry comparables, or some other method. Most hedge funds that hold illiquid investments designate them in special side pockets, which are subject to special restrictions on redemption.

Fixed-income investments consist of directly held actively traded treasuries, separately managed accounts, commingled funds, and bond mutual funds that hold securities, the majority of which have maturities greater than one year. These are valued based on quoted market prices in active markets.

Funds in trust investments consist primarily of project construction funds, worker's compensation trust funds, and externally managed endowments.

The Medical Center believes that the reported amount of its investments is a reasonable estimate of fair value as of June 30, 2013 and 2012. Because of the inherent uncertainties of valuation, these estimated fair values may differ significantly from values that would have been used had a ready market existed.

(in thousands of dollars)

	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	2013 Total Fair Value
Assets				
Investments:				
Cash Equivalents	$ 32,779	$ -	$ -	$ 32,779
Global Public Equities	95,960	50,134	28,953	175,047
Private Debt	-	-	21,328	21,328
Private Equity				
U.S. Venture Capital	-	-	32,854	32,854
U.S. Corporate Finance	-	-	32,022	32,022
International	-	-	38,120	38,120
Real Assets				
Real Estate	-	-	56,978	56,978
Natural Resources	-	-	58,786	58,786
Absolute Return				
Equity Oriented	6,369	6,169	23,617	36,155
Global Macro/Relative Value	6,125	5,740	23,278	35,143
Multi-Strategy	-	2,666	47,791	50,457
Credit-Oriented	-	-	16,376	16,376
Volatility-Oriented	-	11,227	-	11,227
Fixed Income				
U.S. Treasuries, including TIPS	58,129	46,740	-	104,869
Other Fixed Income	9,892	70,479	-	80,371
Funds in Trust	14,804	-	-	14,804
Total investments	224,058	193,155	380,103	797,316
Other assets	3,045	-	-	3,045
Total assets at fair value	$ 227,103	$ 193,155	$ 380,103	$ 800,361
Liabilities				
Interest rate swap payable	$ -	$ 88,769	$ -	88,769
Total liabilities at fair value	$ -	$ 88,769	$ -	$ 88,769

(in thousands of dollars)

	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	2012 Total Fair Value
Assets				
Investments:				
Cash Equivalents	$ 15,422	$ -	$ -	$ 15,422
Global Public Equities	125,953	72,801	36,691	235,445
Private Debt	-	-	22,848	22,848
Private Equity				
U.S. Venture Capital	-	-	33,918	33,918
U.S. Corporate Finance	-	-	33,196	33,196
International	-	-	40,232	40,232
Real Assets				
Real Estate	-	-	57,296	57,296
Natural Resources	-	-	59,953	59,953
Absolute Return				
Equity Oriented	5,728	5,448	17,808	28,984
Global Macro/Relative Value	5,764	5,538	28,933	40,235
Multi-Strategy	-	-	50,350	50,350
Credit-Oriented	-	-	11,214	11,214
Volatility-Oriented	-	9,975	-	9,975
Fixed Income				
U.S. Treasuries, including TIPS	74,878	74,787	-	149,665
Other Fixed Income	81,482	-	-	81,482
Funds in Trust	54,223	-	-	54,223
Total investments	363,450	168,549	392,439	924,438
Other assets	41,580	-	-	41,580
Total assets at fair value	$ 405,030	$ 168,549	$ 392,439	$ 966,018
Liabilities				
Interest rate swap payable	$ -	$ 135,872	$ -	135,872
Total liabilities at fair value	$ -	$ 135,872	$ -	$ 135,872

During 2013 there were no transfers between investment Levels 1 and 2. During fiscal year 2013 and 2012, transfers occurred between investment levels 2 and 3 as a result of changes in observable market data. Changes to the reported amounts of investments measured at fair value using unobservable inputs (Level 3) as of June 30, 2013 and 2012 are as follows:

(In thousands of dollars)

	Separately Invested	Invested In TRIP	2013 Total
Fair value, July 1, 2012	$ 6,233	$ 386,206	$ 392,439
Realized gains	-	33,429	33,429
Unrealized gains (losses)	166	(23,415)	(23,249)
Purchases	-	29,498	29,498
Sales	(1,859)	(50,278)	(52,137)
Transfers	-	123	123
Fair value, June 30, 2013	$ 4,540	$ 375,563	$ 380,103

	Separately Invested	Invested In TRIP	2012 Total
Fair value, July 1, 2011	$ 7,510	$ 366,077	$ 373,587
Realized gains	18	23,569	23,587
Unrealized gains (losses)	297	(3,815)	(3,518)
Purchases	80	48,080	48,160
Sales	(1,672)	(50,008)	(51,680)
Transfers	-	2,303	2,303
Fair value, June 30, 2012	$ 6,233	$ 386,206	$ 392,439

The interest rate swap arrangement has inputs which can generally be corroborated by market data and is therefore classified within level 2.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while UCMC believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value at the reporting date.

The significant unobservable inputs used in the fair value measurement of UCMC's long-lived partnership investments include a combination of cost, discounted cash flow analysis, industry comparables and outside appraisals. Significant increases (decreases) in any inputs used by investment managers in determining net asset values in isolation would result in a significantly lower (higher) fair value measurement.

(In thousands of dollars)

UCMC has made investments in various long-lived partnerships and, in other cases, has entered into contractual agreements that may limit its ability to initiate redemptions due to notice periods, lockups and gates. Details on typical redemption terms by asset class and type of investment are provided below:

	Remaining Life	Redemption Terms	Redemption Restrictions and terms	Redemption Restrictions in Place at June 30, 2013
Cash	N/A	Daily	None	None
Global Public Equity:				
Separate accounts	N/A	Daily	None	None
Commingled funds	N/A	Daily to monthly with notice periods of 1 to 14 days	None	None
Partnerships	N/A	Quarterly to annually with notice periods of 30 to 180 days	Lock-up provisions ranging from 0 to 5 years, some investments have a portion of capital in side pockets with no redemptions permitted	None
Private debt	1 to 10 years	Redemptions not permitted	N/A	N/A
Private equity	1 to 19 years	Redemptions not permitted	N/A	N/A
Real assets	1 to 18 years	Redemptions not permitted	N/A	N/A
Absolute return:				
Partnerships	N/A	Monthly to annually with varying notice periods	Lock-up provisions ranging from 0 to 5 investments have a portion of capital in side pockets with no redemptions permitted	Approximately $46.5 million of investments are in gated or liquidating funds
Drawdown partnerships	1 to 4 years	Redemptions not permitted	N/A	N/A
Fixed income:				
Separate accounts	N/A	Daily	None	None
Commingled funds	N/A	Daily	None	None
Partnerships	N/A	Quarterly with notice periods of 90 days	Only one-third capital available in any 12-month period	None
Funds held in trust	N/A	Daily	None	None

6. Endowments

UCMC's endowment consists of individual donor restricted endowment funds and board-designated endowment funds for a variety of purposes plus the following where the assets have been designated for endowment: pledges receivable, split interest agreements, and other net assets. The endowment includes both donor-restricted endowment funds and funds designated by the Board of Trustees to function as endowments. The net assets associated with endowment funds including funds designated by the Board of Trustees to function as endowments, are classified and reported based on the existence or absence of donor imposed restrictions.

Illinois is governed by the "Uniform Prudent Management of Institutional Funds Act" (UPMIFA). The Board of Trustees of UCMC has interpreted UPMIFA as sustaining the preservation of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, UCMC classifies as permanently restricted net assets, (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by UCMC in a manner consistent with the standard of prudence prescribed by UPMIFA.

UCMC has the following donor-restricted endowment activities during the years ended June 30, 2013 and 2012 delineated by net asset class:

(In thousands of dollars)

	Unrestricted Funds Functioning	Temporarily Restricted	Permanently Restricted	2013 Total
Endowment net assets, beginning of year	$ 796,105	$ 67,279	$ 6,072	$ 869,456
Investment return:				
Investment income	38,437	3,518	-	41,955
Net appreciation (realized and unrealized)	21,351	1,086	-	22,437
Total investment return	59,788	4,604	-	64,392
Gifts and other additions	25,000	-	10	25,010
Appropriation of endowment assets for expenditure	(37,037)	(3,610)	-	(40,647)
Appropriation of endowment assets for capital	(134,707)			(134,707)
Other	(1,859)	361	-	(1,498)
Endowment net assets, end of year	$ 707,290	$ 68,634	$ 6,082	$ 782,006

	Unrestricted Funds Functioning	Temporarily Restricted	Permanently Restricted	2012 Total
Endowment net assets, beginning of year	$ 810,184	$ 67,857	$ 6,072	$ 884,113
Investment return:				
Investment income	36,192	3,140	-	39,332
Net appreciation (realized and unrealized)	(11,335)	(305)	-	(11,640)
Total investment return	24,857	2,835	-	27,692
Appropriation of endowment assets for expenditure	(37,343)	(3,792)	-	(41,135)
Other	(1,593)	379	-	(1,214)
Endowment net assets, end of year	$ 796,105	$ 67,279	$ 6,072	$ 869,456

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(in thousands of dollars)

Description of amounts classified as permanently restricted net assets and temporarily restricted net assets (Endowments only) as of June 30, 2013 and 2012:

	Perpetual	Time-Restricted by Donor	Time-Restricted by Law	2013 Total
Restricted for pediatric health care	$ 1,855	$ -	$ 15,580	$ 17,435
Restricted for adult health care	1,925	-	50,715	52,640
Restricted for educational and scientific programs	2,312	-	2,339	4,651
	$ 6,092	$ -	$ 68,634	$ 74,726

	Perpetual	Time-Restricted by Donor	Time-Restricted by Law	2012 Total
Restricted for pediatric health care	$ 1,835	$ -	$ 15,273	$ 17,108
Restricted for adult health care	1,925	-	49,751	51,676
Restricted for educational and scientific programs	2,312	-	2,255	4,567
	$ 6,072	$ -	$ 67,279	$ 73,351

Investment and Spending Policies

UCMC has adopted endowment investment and spending policies that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of endowment assets. UCMC expects its endowment funds over time, to provide an average rate of return of approximately 6% annually. To achieve its long-term rate of return objectives, UCMC relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized gains) and current yield (interest and dividends). Actual returns in any given year may vary from this amount.

For endowments invested in TRIP, the Board of Trustees of UCMC has adopted the University's method to be used to appropriate endowment funds for expenditure, including following the University's payout formula. The University utilizes the total return concept in allocating endowment income. In accordance with the University's total return objective, between 4.5% and 5.5% of a 12-quarter moving average of the fair value of endowment investments, lagged by one year, is available each year for expenditure in the form of endowment payout. The exact payout percentage, which is set each year by the Board of Trustees with the objective of a 5% average payout over time, was 5% for the fiscal years ended June 30, 2013 and 2012. If endowment income received is not sufficient to support the total return objective, the balance is provided from capital gains. If income received is in excess of the objective, the balance is reinvested in the endowment.

For endowments invested apart from TRIP, UCMC calculates a payout of 4% annually on a rolling 24-month average market value. In establishing this policy, the Board considered the expected long term rate of return on its endowment.

(In thousands of dollars)

7. Property, Plant and Equipment

The components of property, plant and equipment as of June 30 are as follows:

	2013	2012
Land and land rights	$ 36,008	$ 36,008
Buildings and improvements	1,255,542	649,565
Equipment	576,374	479,832
Construction in progress	74,688	610,211
	1,942,612	1,775,616
Less accumulated depreciation	(752,989)	(709,122)
Total property, plant and equipment, net	$ 1,189,623	$ 1,066,494

UCMC's net property, plant and equipment cost includes $10,600 representing assets under capital leases with the University, which are stated at the UCMC's historical cost. The cost of buildings that are jointly used by the University and UCMC is allocated based on the lease provisions. In addition, land and land rights includes $19,200, which represents the unamortized portion of initial lease payments made to the University. UCMC entered into a services agreement in 2013 for the exclusive right to operate certain food service operations at the Medical Center, which includes a capital commitment in the amount of $11,800 for equipment and renovations provided by the contractor. The amount outstanding as of June 30, 2013 was $11,300.

The Center for Care and Discovery was placed into service in 2013; approximately $134,800 was spent in 2013 related to the building. In 2013 and 2012, approximately $0 and $16,800 were capitalized related to software implementation of an electronic medical records system.

Capitalized interest costs in 2013 and 2012 were $14,600 and $10,000, respectively.

(in thousands of dollars)

8. Long-Term Debt

Long-term debt as of June 30 consists of the following:

	Final fiscal year maturity	Interest rate	2013	2012
Fixed rate:				
Illinois Health Facilities Authority:				
Series 2003	2015	5.0	$ 14,530	$ 21,235
Illinois Finance Authority:				
Series 2009A and B	2027	4.9	150,840	152,350
Series 2009C	2037	5.4	85,000	85,000
Series 2009D-1 and 2 (synthetically fixed rate)	2044	3.9	70,000	70,000
Series 2009E-1 and 2 (synthetically fixed rate)	2044	3.9	70,000	70,000
Series 2010 A and B (synthetically fixed rate)	2045	3.9	92,500	92,500
Series 2011 A and B (synthetically fixed rate)	2045	3.9	92,500	92,500
Series 2011C	2042	5.5	90,000	90,000
Series 2012A	2037	4.5	72,080	75,155
Unamortized premium			11,163	12,528
Total fixed rate			748,613	761,268
Variable rate:				
Series 2013A	2020	1.0	688	-
Illinois Educational Facilities Authority (IEFA)	2038	0.2	81,427	83,277
Total variable rate			82,113	83,277
Total notes and bonds payable			830,726	844,545
Less current portion of long-term debt			(10,385)	(11,290)
Long-term portion of debt			$ 820,341	$ 833,255

The fair value of long-term debt is based on the pricing of fixed-rate bonds of market participants, including assumptions about the present value of current market interest rates, and loans of comparable quality and maturity. The fair value of long-term debt would be a Level 2 hierarchy. The carrying value of long-term debt is below the estimated fair value of the debt by $10,729 and $34,439 as of June 30, 2013 and June 30, 2012, respectively, based on the quoted market prices for the same or similar issues.

Scheduled annual repayments for the next five years are as follows at June 30:

Year	Amount
2014	$ 10,385
2015	10,050
2016	12,778
2017	13,255
2018	13,868

Under its various indebtedness agreements, the Medical Center is subject to certain financial covenants, including maintaining a minimum debt service coverage ratio, maintaining minimum levels of days cash on hand, maintaining debt to capitalization at certain levels; limitations on selling, leasing, or otherwise disposing of Medical Center property; and certain other nonfinancial covenants. Each of the bond series is collateralized by unrestricted receivables under a Master Trust Indenture and subject to certain restrictions. The Medical Center was in compliance with its debt covenants as of June 30, 2013 and 2012.

Recent Financing Activity

In January 2013, the Medical Center entered into an issuance of a tax-exempt direct purchase loan with a financial institution, issued as $75,000 of Series 2013A bonds, allocated to the Medical Center for the purpose of constructing a new parking garage. This bond functions similar to a construction loan with principal being drawn down as construction proceeds. Interest at LIBOR plus 60 basis points is payable each month based on the outstanding principal balance. A mandatory purchase date of repayment is established for January 24, 2020.

Letters of Credit

Payment on each of the variable rate demand revenue bonds is also collateralized by a letter of credit. The letters of credit that support the Series 2009D and the Series 2009E bonds were due to expire in August 2012. The Medical Center replaced the letter of credit that supports the Series 2009D bonds with a new letter of credit in June 2012, which expires in June 2017. The letter of credit that supports the 2009E bonds was extended subsequent to June 30, 2012 and now expires in December 2014. The letters of credit that support the Series 2010A and Series 2010B bonds expire in November 2015 and the letters of credit that support the Series 2011A and Series 2011B bonds expire in May 2016. The letters of credit are subject to certain restrictions, which include financial ratio requirements and consent to future indebtedness. The most restrictive financial ratio is to maintain a debt service coverage ratio of 1.25:1. UCMC was in compliance with all applicable debt covenants at June 30, 2013.

Payment on each of the IEFA bonds is collateralized by a letter of credit maturing November 2014. The letter of credit is subject to certain restrictions, which include financial ratio requirements. The most restrictive financial ratio is to maintain a debt service coverage ratio of 1.75:1. UCMC was in compliance with all applicable debt covenants at June 30, 2013.

Included in UCMC's debt is $81,427 of commercial paper revenue notes and $325,000 of variable rate demand bonds. In the event that UCMC's remarketing agents are unable to remarket the bonds, the trustee of the bonds will tender them under the letters of credit. Scheduled repayments under the letters of credit are between 1 and 3 years, beginning after a grace period of at least one year, and bear interest rates different from those associated with the original bond issue. Any bonds tendered are still eligible to be remarketed. Bonds subsequently remarketed would be subject to the original bond repayment schedules.

UCMC paid interest, net of capitalized interest, of approximately $18,300 and $13,000 in 2013 and 2012, respectively.

UCMC has a $15,000 line of credit from a commercial bank. As of June 30, 2013 and 2012, no amount was outstanding under this line.

(in thousands of dollars)

9. Commitments

Leases

UCMC has capital and noncancelable operating leases for certain buildings and equipment. Future minimum payments required under noncancelable operating and capital leases as of June 30 are as follows:

	Operating	Capital
2014	$ 2,232	$ 303
2015	2,074	172
2016	2,102	-
2017	548	-
2018 and thereafter	6,808	-
Total minimum lease payments	$ 13,764	475
Less - Amount representing interest		11
Present value of net minimum capital lease payments		$ 464

The amount of total assets capitalized under these leases at June 30, 2013 and 2012, is $3,000 and $3,200 with related accumulated depreciation of $2,400 and $2,100, respectively. Rental expense was approximately $5,500 and $4,700 for the years ended June 30, 2013 and 2012, respectively, including a $500 annual rental of a parking garage from the University.

10. Insurance

UCMC is included under certain of the University's insurance programs. Since 1977, UCMC, in conjunction with the University, has maintained a self-insurance program for its medical malpractice liability. This program is supplemented with commercial excess insurance above the University's self-insurance retention, which for the years ended June 30, 2013 and 2012 was $7,500 per claim and unlimited in the aggregate. Claims in excess of $7,500 are subject to an additional self-insurance retention limited to $12,500 per claim and $12,500 in aggregate.

The estimated liability for medical malpractice self-insurance is actuarially determined based upon estimated claim reserves and various assumptions, and represents the estimated present value of self-insurance claims that will be settled in the future. It considers anticipated payout patterns as well as interest to be earned on available assets prior to payment. The discount rate used to value the self-insurance liability is a risk-adjusted rate commensurate with the duration of anticipated payments. These inputs to the fair value estimate of the liability are considered Level 2 in the fair value hierarchy.

A comparison of the estimated liability for incurred malpractice claims (filed and not filed) and net assets for the combined University and UCMC self-insurance program as of June 30, 2013 and 2012, is presented below:

	2013	2012
Actuarial present value of self-insurance liability for medical malpractice	$ 254,328	$ 246,700
Total assets available for claims	$ 352,414	$ 330,431

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(In thousands of dollars)

If the present-value method were not used, the ultimate liability for medical malpractice self-insurance claims would be approximately $47,200 higher at June 30, 2013. The interest rate assumed in determining the present value was 4.5% for 2013 and 3.75% for 2012. The Medical Center has recorded its pro-rata share of the malpractice self-insurance liability as required under ASU 2010-24 in the amount of $121,300 at June 30, 2013 and $118,153 at June 30, 2012 with an offsetting receivable from the malpractice trust to cover any related claims.

The malpractice self-insurance trust assets consist primarily of funds held in TRIP.

UCMC recognizes as malpractice expense its negotiated pro-rata share of the actuarially determined normal contribution, with gains and losses amortized over six years, with no retroactive adjustments, as provided in the operating agreement. For fiscal year 2014, the Medical Center expense will be $15,300 related to malpractice.

UCMC designated $14,800 and $12,400 as of June 30, 2013 and 2012, respectively, as a workers' compensation self-insurance reserve trust fund. The self-insurance program investments consist of 65% bonds and 35% marketable equities. The specifically identified claim requirements and actuarially determined reserve requirements for unreported workers' compensation claims were $9,500 and $8,200 as of June 30, 2013 and 2012, respectively. The University also charges UCMC for its portion of other commercial insurance and self-insurance costs.

11. Pension Plans

Active Plans
A majority of UCMC's personnel participate in the University's defined benefit and contribution pension plan. Under the defined benefit portion of this plan, benefits are based on years of service and the employee's compensation for the five highest paid consecutive years within the last ten years of employment. UCMC and the University make annual contributions to this portion of the plan at a rate necessary to maintain plan funding on an actuarially recommended basis. UCMC recognizes its share of net periodic pension cost as expense and any difference in the contribution amount as a transfer of unrestricted net assets. The reduction to net assets for 2013 was $2,800. Contributions of $32,500 and $52,700 were made in the fiscal years ended June 30, 2013 and 2012, respectively. UCMC expects to make contributions of $32,500 for the fiscal year ended June 30, 2014 that will be entirely expensed as net periodic pension costs.

Under the defined contribution portion of the plan, UCMC and plan participants make contributions that accrue to the benefit of the participants at retirement. UCMC's contributions, which are based on a percentage of each covered employee's salary, totaled approximately $6,400 and $6,100 for the years ended June 30, 2013 and 2012, respectively.

Plan Name	EIN	Contributions of UCMC	
		2013	2012
University of Chicago Retirement Income Plan for Employees	36-2177139-002	$ 6,711	$ 35,000
University of Chicago Pension Plan for Staff Employees	36-2177139-003	25,789	17,700
		$ 32,500	$ 52,700

The benefit obligation, fair value of plan assets and funded status for the University's defined benefit plan included in the University's financial statements as of June 30, are shown below:

(In thousands of dollars)

	2013	2012
Projected benefit obligation	$ 795,133	$ 780,797
Fair value of plan assets	557,966	496,657
Deficit of plan assets over benefit obligation	$ (237,167)	$ (284,140)

The weighted-average assumptions used in the accounting for the plan are shown below:

	2013	2012
Discount rate	4.9%	4.5%
Expected return on plan assets	7.0%	7.1%
Rate of compensation increase	3.5%	3.5%

The weighted average asset allocation for the plan is as follows:

	2013	2012
Domestic equities	29 %	27 %
International equity	15 %	16 %
Fixed income	56 %	57 %
	100 %	100 %

The pension and other postretirement benefit obligation considers anticipated payout patterns as well as investment returns on available assets prior to payment. The discount rate used to value the pension and other postretirement benefit obligation is a risk-adjusted rate commensurate with the duration of anticipated payments. These inputs to the fair value estimate are considered Level 2 in the fair value hierarchy.

Total benefits and plan expenses paid by the plan were $36,200 and $32,200 for the fiscal years ended June 30, 2013 and 2012, respectively.

Expected future benefit payments excluding plan expenses are as follows:

Fiscal Year	
2014	42,109
2015	37,761
2016	40,072
2017	42,672
2018	45,160
2019-2023	265,818

Certain UCMC personnel participate in a contributory pension plan. Under this plan, UCMC and plan participants make annual contributions to purchase annuities equivalent to retirement benefits earned. UCMC's pension expense for this plan was $4,900 and $5,000 for the years ended June 30, 2013 and 2012, respectively.

(In thousands of dollars)

Curtailed and Frozen Plan

In June 2002, UCMC assumed sponsorship of the Louis A. Weiss Memorial Hospital Pension Plan (Employer Identification Number 36-3488183, Plan Number 003), which covers employees of a former affiliate. Participation and benefit accruals are frozen. All benefit accruals are fully vested.

Components of net periodic pension cost and other amounts recognized in unrestricted net assets include the following:

	Years Ended June 30, 2013	2012
Net periodic pension cost		
Interest cost	$ 2,340	$ 2,719
Expected return on plan assets	(2,860)	(2,921)
Amortization of unrecognized net actuarial loss	817	684
Net periodic pension cost	297	482
Other changes in plan assets and benefit obligations recognized in unrestricted net assets		
Liability for pension benefits	3,878	(2,659)
Total recognized in net periodic pension cost and unrestricted net assets	$ (3,581)	$ 3,141

The following tables set forth additional required pension disclosure information for this plan:

	Years Ended June 30, 2013	2012
Change in projected benefit obligation		
Benefit obligation at beginning of year	$ 58,098	$ 55,219
Interest cost	2,340	2,719
Net actuarial loss (gain)	(3,029)	3,425
Benefits paid	(3,319)	(3,264)
	54,090	58,099
Change in plan assets		
Fair value of plan assets at beginning of year	47,696	41,717
Actual return on plan assets	2,892	3,003
Employer contribution	1,091	6,240
Benefits paid	(3,319)	(3,264)
	48,360	47,696
Funded status at end of year	$ (5,730)	$ (10,403)

Amounts recognized in the balance sheet are included in noncurrent liabilities.

Accumulated plan benefits equal projected plan benefits. Assumptions used in the accounting for the net periodic pension cost were as follows:

(In thousands of dollars)

	2013	2012
Discount rate	4.8 %	4.2 %
Expected return on plan assets	6.0 %	6.0 %
Rate of compensation increase	N/A	N/A

Weighted average asset allocations for plan assets are as follows:

	2013	2012
Cash	2 %	8 %
Fixed income	51	53
Domestic equities	34	28
International equities	13	11
	100 %	100 %

All plan assets are valued using level 1 inputs. The target asset allocation is 40% equities and 60% fixed income. The expected return on plan assets is based on historical investment returns for similar investment portfolios.

UCMC expects to make contributions of $1,500 to the plan in the fiscal year ending June 30, 2014. Expected future benefit payments are:

Fiscal Year	
2014	$ 3,565
2015	3,547
2016	3,535
2017	3,535
2018	3,559
2019-2023	18,206

12. Acquisitions

On September 30, 2011, the Medical Center entered into an Asset Purchase Agreement, whereby the Medical Center acquired the operations of Midwest Center for Hematology/Oncology, S.C. a professional service corporation that specializes in oncology. The purchase price was $2,607 and there are no earn-out provisions with the agreements. The acquisition is accounted for under the purchase method of accounting and, accordingly, the cost has been allocated on the basis of estimated fair value of assets acquired and liabilities assumed. This resulted in $746 of the purchase price being allocated to goodwill and $905 being allocated to non-compete agreements. The non-compete agreements are amortized over a 5 year period.

13. Concentration of Credit Risk

As a hospital, UCMC is potentially subject to concentration of credit risk from patient accounts receivable and certain investments. Investments, which include government and agency securities, stocks, corporate bonds, real assets, absolute return, and private equities, are not concentrated in any corporation or industry or with any single counter-party. UCMC receives a

(In thousands of dollars)

significant portion of its payments for services rendered from a limited number of government and commercial third-party payors, including Medicare, Medicaid, and Blue Cross. For 2013 and 2012, Medicaid approximated 15% and 17% of the Medical Center's net revenue for the year. Medicaid represented 16% and 30% of UCMC's net accounts receivable at June 30, 2013 and 2012, respectively. Management does not anticipate any collection risk related to the Medicaid accounts receivable at June 30, 2013. UCMC has not historically incurred any significant credit losses outside the normal course of business.

14. Pledges

Pledges receivable at June 30 are shown below:

	2013	2012
Unconditional promises expected to be collected in:		
Less than one year	$ 2,272	$ 4,959
One year to five years	2,634	6,001
More than five years	-	-
	4,906	10,960
Less unamortized discount (discount rate 5.5%)	(197)	(527)
Total	$ 4,709	$ 10,433

15. Restricted Net Assets

Temporarily restricted net assets are available for the following purposes as of June 30:

	2013	2012
Pediatric health care	$ 17,943	$ 17,751
Adult health care	51,756	50,743
Educational and scientific programs	4,691	4,187
Capital and other purposes	7,581	22,664
Total	$ 81,971	$ 95,345

Income from permanently restricted net assets is restricted for:

	2013	2012
Pediatric health care	$ 1,855	$ 1,845
Adult health care	1,925	1,935
Educational and scientific programs	2,312	2,312
Total	$ 6,092	$ 6,092

(In thousands of dollars)

16. Functional Expenses

Total operating expenses by function are as follows for the years ended June 30:

	2013	2012
Health care services	$ 1,177,672	$ 1,103,904
General and administrative	80,938	66,819
Total	$ 1,258,610	$ 1,170,723

17. Contingencies

UCMC is subject to complaints, claims and litigation which have risen in the normal course of business. In addition, UCMC is subject to reviews by various federal and state government agencies to assure compliance with applicable laws, some of which are subject to different interpretations. While the outcome of these suits cannot be determined at this time, management, based on advice from legal counsel, believes that any loss which may arise from these actions will not have a material adverse effect on the financial position or results of operations of UCMC.

Section IX, Safety Net Impact Statement

Attachment 43

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.**

   The University of Chicago Medical Center ("UCMC" or the "Medical Center") is an established provider of safety net services, and is, itself, an essential, safety-net resource for the communities that it serves. At a time when many other hospitals are contracting their own bed inventories, UCMC's intent to invest in its facilities and to create additional capacity is a demonstration of its enduring commitment to low-income and other vulnerable populations and to anchor the South Side communities in which they make their homes. UCMC recognizes that financial and other barriers to healthcare are endemic to its constituency and seeks to remove its own bed shortage as potential obstacle to their timely receipt of quality health care in the community.

   The proposed development of two (2) inpatient floors of shelled space in the CCD, which includes an expansion of the number of ICU beds and observation beds at the Medical Center, will increase capacity and make more accessible the services that UCMC has historically provided to the communities that comprise its primary service area. The UCMC service area consists of a large, medically underserved, primarily low income population on Chicago's South Side, an area that is among one of the most economically challenged areas in the State of Illinois and that has a critical need for quality healthcare. The population of the South Side is approximately 87 percent African American, 6 percent White and 4 percent Hispanic. The South Side is relatively poor compared to the City of Chicago as a whole with 29 percent of community residents reporting family incomes below the poverty level compared with 20 percent for the city as a whole. In addition, just under half of the South Side community lives below 200 percent of the poverty level. (Source: *Serving Chicago's Underserved: Regional Health System Profiles,* Chicago Department of Public Health, Chicago Health and Health Systems Project (Oct. 20, 2005).)

   The South Side community is one of the least healthy in Cook County, with high rates of diabetes, asthma, hypertension and other chronic conditions. In fact, the target communities in UCMC's service area have some of the highest chronic disease and mortality rates in Chicago. UCMC is one of the few hospitals—and the only academic medical center—located in the South Side of Chicago. At the same time, hospitalization rates in UCMC's service area are much higher than the metropolitan average. The South Side of Chicago has the highest incidence in Chicago of admissions through the emergency room; at UCMC, approximately 20% percent of the visits becoming inpatient admissions. These high rates of admission through emergency departments may be attributed to the high number of uninsured,

underinsured and low income residents in the community which leads to a lack of access for these residents to primary care services.

UCMC remains the largest provider of Medicaid services (by admissions and patient days) on the South Side of Chicago and one of the largest in the State of Illinois. Notably, patients Medicaid or who are uninsured comprise almost one-half of UCMC's emergency department population.

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.**

UCMC's proposed development of two (2) inpatient floors in its new hospital, which includes the relocation of existing medical-surgical beds, the expansion of the number of its ICU beds, and the addition of observation beds, should not impact the ability of other providers or health care systems to cross-subsidize safety net services. The Project does not include any increases in market share or market reach; rather the purpose of the beds is to attempt to keep pace with current, but yet unmet, demand from the community, either directly or via community hospitals. The patients that will use the additional beds either have been served by UCMC in the past or would have been served but for UCMC's capacity constraints (patients could not be admitted because of UCMC's high census).

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.**

Not applicable.

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

UCMC already provides a substantial amount of care for which it does not receive payment. For fiscal year, 2012, UCMC provided $20,179,000 in care for which it did not expect to receive compensation, incurred losses on government programs of $78,872,000 and losses on education of $86,263,000, provided research support of $48,000,000 and $1,179,000 for other programs, and incurred uncompensated charges—or bad debt—of $11,917,000.

However, the community benefit provided by UCMC goes well beyond the number of charity care and Medicaid patients treated at the University of Chicago Medical Center. For example, UCMC's mission is to provide superior health care in a compassionate manner, ever mindful of each patient's dignity and individuality. To accomplish its mission, the Medical Center calls upon the skills and expertise of all who work together to advance medical innovation (patient care), service the health needs of the community (community service) and to further the knowledge of those dedicated to caring (research and education).

ATTACHMENT 43

A. Patient Care and Research

The University of Chicago Medical Center ("UCMC") is a nationally recognized leader in patient care, research and medical education. Renowned for treating some of the most complex medical cases, UCMC brings the very latest medical treatments to patients in Chicago's South Side community, and throughout the world. In this way, UCMC furthers its commitment to patient care, clinical practice and community health. UCMC partners with the University of Chicago physicians and the Pritzker School of Medicine to educate the next generation of physicians and other health care professionals. The Medical Center is a leading provider of complex care and routinely ranks among the top providers of Medicaid services (based on admissions and inpatient days) in the state of Illinois.

1. The Center for Care & Discovery and Bernard A. Mitchell Hospital

Completed in 2013, the Center for Care & Discovery is UCMC's new hospital, a 10-story "hospital for the future" that provides a home for complex specialty care with a focus on cancer, gastrointestinal disease, neuroscience, advanced surgery and high-technology medical imaging. The new hospital also has space for 28 operating rooms with leading-edge technology; and an integrated diagnostic and interventional platform including cardiac, gastrointestinal, neurological and vascular services.

Built in 1983, Bernard A. Mitchell Hospital was UCMC's primary adult inpatient facility until the construction of the Center for Care and Discovery, and includes the Emergency Department and the Arthur Rubloff Intensive Care Tower. The tower houses the University of Chicago Medical Center Burn Unit and Electrical Trauma Unit and remains an integral hub for intensive care and medical/surgical patients.

UCMC houses one of only two burn units in Chicago, at which UCMC provides care to critically-injured adult and pediatric patients, many of whom spend months in this intensive care facility.

UCMC admitted more than 19,440 adult patients in fiscal year 2012 with more than 409,000 visits to the outpatient ambulatory care facility. In addition, UCMC's Mitchell Hospital contains state-of-the-art obstetrical and gynecological facilities and has a leading program in reproductive endocrinology and infertility. The facilities include eight labor rooms, three delivery rooms, and two birthing rooms, as well as a 17-bed gynecology unit and four obstetric operating rooms. Over 1,400 babies were delivered at UCMC during FY 2012, many to women with high-risk pregnancies.

The Medical Center offers world-class transplantation programs in several areas, including transplantation of the liver, kidney, pancreas, lung, heart, bone marrow and other tissues, multiple-organ transplantation, and research in transplant immunology. UCMC performed 106 organ transplants in FY 2012 and 148 bone marrow or stem cell transplant procedures for treatment of various cancers.

UCMC's Emergency Department is open 24 hours a day, 7 days a week and in FY 2012, UCMC provided almost 47,000 adult ED visits, making it the busiest emergency room on Chicago's South Side. In addition, UCMC serves as a Resource Hospital for one of the emergency medical system ("EMS") regions in Illinois. UCMC is one of three (3) Resource Hospitals in Chicago and represents Chicago South. As a Resource Hospital, UCMC has authority and responsibility over the entire EMS regional system, including the clinical aspects, operations and educational programs. UCMC provides the entire budget for its participation as a Resource Hospital and spends over $300,000 per year on this service. As a Resource Hospital, UCMC also is responsible for replacing medical supplies and providing for equipment exchange in participating EMS vehicles. UCMC spends approximately $30,000 per year on replacement and restocking.

2. CHICAGO COMER CHILDREN'S HOSPITAL

As a major tertiary referral center, the University of Chicago Comer Children's Hospital sees children with medical problems that range from some of the most common to some of the most complex in its 155 bed, seven-story facility, which opened in February 2005. Families of these pediatric patients can stay at the 30,000 square-foot Ronald McDonald House on campus, which UCMC built and opened in December 2007, nearly doubling the size of the prior Ronald McDonald House. More than 4,700 children were admitted as patients to Comer Children's Hospital in fiscal year 2012 from the Chicago area, the Midwest, and around the world. In FY 2012, UCMC's outpatient clinics accommodated more than 44,000 general pediatric and specialty visits in its ambulatory care facility and more than 29,500 visits were made to the Comer pediatric emergency room.

Comer Children's Hospital is staffed by more than 100 physicians from the Department of Pediatrics at the University, as well as specialty nurses and caring support staff. The teams of healthcare professionals—including medical students, residents and fellows—work together to provide general and specialty medical care for newborns to young adults. At Comer Children's Hospital and through its outpatient clinics, children and teens receive advanced therapies in virtually all clinical areas.

Comer Children's Hospital is a pediatric Level-I trauma center that treats children with severe injuries for emergency trauma care. UCMC also cares for

critically ill and injured children in its technologically advanced Pediatric Intensive Care Unit ("PICU"). The 30-bed PICU is fully equipped to treat children with multiple traumas, complex medical problems, and conditions requiring major surgery, including cardiac, transplant, and neurosurgery. In fiscal year 2012, over 1,000 children were cared for in the PICU.

In addition, 47 designated tertiary care (Level III) beds in the Neonatal Intensive Care Unit and 18 convalescent (Level II) beds in the Transitional Care Unit provide premature and critically ill infants with the most advanced medical care and life support systems.

At the Comer Children's Hospital, infants who spend time in the NICU receive specialized follow-up care after they are discharged at its Center for Healthy Families ("Center"). The Center uses a multidisciplinary care approach that includes general pediatricians, neonatologists, nurse educators, pediatric social workers, registered dietitians, occupational therapists, physical therapists, speech therapists and home health nurses. The Center also draws on the expertise of other pediatric specialists as needed. The team addresses a host of concerns, including medical and physical needs, development, motor skills, speech, growth, nutrition, and the home environment. Team members are available by pager 24 hours a day and also teach parents how to give medications, monitor symptoms, and take other steps to meet their child's special needs. Sometimes, team members even visit the child's home to help parents and caregivers adapt to the physical and emotional environment to support the child's needs.

Comer Children's Hospital serves as the Center of a Regional Perinatal Network that is responsible for the administration and implementation of the Illinois Department of Public Health's ("IDPH") regionalized perinatal health care program. In this role, UCMC provides nine area hospitals with consultation as well as transport services for approximately 16,000 babies born in network hospitals, more than one-third of them considered high-risk. The network is committed to reducing fetal and infant mortality throughout the surrounding urban, suburban, and rural communities. UCMC also provides leadership in the design and implementation of IDPH's Continuous Quality Improvement program and participates in continuing education for other health professionals.

More than 60% of all care provided at Comer Children's Hospital is provided to children covered by the Medicaid program. Comer Children's Hospital has a strong commitment to its community and sponsors a number of programs and services that extend beyond its walls. For example, Comer Children's Hospital takes primary care to children in its surrounding neighborhoods through the Pediatric Mobile Medical Unit (the "Mobile Unit"), which features two fully equipped exam rooms and a team comprised of a physician, a nurse practitioner and a community health advocate. The 40-foot-long

Mobile Unit provides a full array of pediatric primary care services to children ages 3 to 19 who may not receive healthcare on a regular basis and brings medical resources to the children's school so parents or guardians don't have to work through obstacles, such as transportation.

At schools throughout the community, the Mobile Unit provides such services as immunizations; physicals for school and sports; screenings for vision, hearing, lead poisoning, and anemia; urine tests; and blood draws. At high schools, the Mobile Unit offers health education and treatment for minor injuries. When appropriate, children are referred for follow up care and specialty services to manage conditions such as asthma, diabetes, or mental health problems.

B. Community Service

UCMC's South Side community lacks needed health care services. Chicago's South Side has lost seven hospitals since 1985 – including most recently, the closure of Michael Reese Hospital in 2009 – and more than 2,000 beds in the past decade alone. Most recently, Roseland Community Hospital has been identified as another South Side hospital in trouble. This has resulted in a "shortage" of critical medical services and an increased demand for preventative care. Rooted in the firm belief that all patients should have access to the health care services they need, UCMC has partnered with other healthcare providers that serve this community to coordinate resources.

UCMC is committed to building strong and meaningful relationships with the surrounding community and recognizes that these relationships will help improve health outcomes on the South Side of Chicago.

One of UCMC's innovative approaches to addressing the health care shortage in its community is a program called the Urban Health Initiative ("UHI"). Under the UHI, UCMC pursues meaningful partnerships with other providers in the community to improve the long-term health of patients and to conduct important community-based clinical research, including research on the diseases that have the greatest impact in the South Side community (*e.g.,* diabetes, renal failure, asthma, etc.).

Under the UHI, UCMC established, and continues to expand, a series of relationships with other health care providers throughout the South Side to help patients establish a permanent "medical home" and to ensure that more patients are guided to the most suitable providers for the care they need. Research has shown that when patients have a medical home in the community, they can manage their health issues on a more consistent basis and get more effective care for the prevention and treatment of non-urgent conditions, routine care and management of health issues, and referrals to specialists or hospitals for more complex care as needed.

ATTACHMENT 43

One of the key components of the UHI is the South Side Healthcare Collaborative (SSHC). The SSHC was established in 2005, with assistance from a two-year Healthy Communities Access Program grant from the United States Department of Health and Human Services, to help emergency room patients who report not having a primary care physician find appropriate care at a medical home where the patient can establish an ongoing relationship with a community clinic or physician. After the government grant ended, UCMC undertook the continued funding of the SSHCC operations.

To help patients connect with community health resources, UCMC staffs its Emergency Department with patient advocates whose goal is to meet with patients who have come to the emergency department and do not otherwise have a primary care provider. In addition, the program provides comprehensive social service assessments and referrals through social workers in the Emergency Department. Since 2005, UCMC has given information to more than 27,000 patients about available SSHCC resources and more than 16,000 of those patients have been connected to community resources.

Under the UHI, UCMC recently developed an ER Community Portal, a web-based site that gives SSHC physicians the ability to access the medical records of patients referred from UCMC's pediatric and adult emergency rooms. The Portal is aimed at helping to lower medical costs by reducing the need to re-order redundant tests; reducing medical errors by giving community physicians a more comprehensive view of patients' medical histories; and improving outcomes by providing better continuity of care. The Portal is just one of the many steps geared towards creating a seamless network of interconnected health care and social service agencies on the South Side.

UCMC also provides community residents with sub-specialty care through a number of additional programs. For example, in an effort to expand the availability of high quality medical care in the community, under the UHI, UCMC has placed specialty care providers at a federally qualified health center ("FQHC") in the South Side. This clinic aims to increase specialty services available to patients living in the community, as the absence of specialty care can lead to greater morbidity and perhaps mortality among patients from their underlying medical conditions.

UCMC has partnered with the public health system on the IRIS for Kids program, which is designed to expand access to pediatric specialty care and diagnostic services. This automated, Internet-based scheduling system allows parents to book specialty care appointments for children at the public hospital. Often the wait for these appointments is lengthy on the South Side and this system provides much-needed additional capacity.

ATTACHMENT 43

UCMC provides grants to community health care providers under the UHI to help them expand their capabilities to serve more patients with more resources. UCMC develops partnerships with community hospitals to help make the best use of resources in underutilized hospitals. In addition, UCMC physicians often provide care at these community providers and hospitals.

As part of the UHI, UCMC has undertaken research initiatives that engage South Side residents in finding innovative, community-based solutions to ongoing health care needs. For example, UHI has launched a Center for Community Health and Vitality ("CCHV"), which provides a community base for UHI to offer University data and research resources to the community and to facilitate research and demonstrations done by University investigators in collaboration with South Side residents.

One of the major CCHV initiatives is the South Side Health and Vitality Studies (the "Studies"). The Studies are guided by the fundamental premise that scientific inquiry in service to community priorities and in collaboration with community partners is needed to eliminate the most impenetrable barriers to health and vitality. The South Side Health and Vitality Studies focus on social, environmental and technological determinants of health.

More specifically, the Studies aim to track several thousand South Side households over a generation to discover ways to ensure long-term health and wellness. These discoveries will inform effective health policy and action. The first of these studies is a Community Asset Mapping project that engages community members in keeping current information about the availability and distribution of commercial, healthcare, social and civic resources in all thirty-four (34) South Side communities. The goal of the Community Asset Mapping project is to give area residents reliable information to help them find quality services, to identify gaps in such services, and to inform new community investments. Residents may view and give feedback on the Community Asset Mapping project at SouthSideHealth.org. This interactive website also provides professionals with detailed information about available resources for health and human services in Chicago's South Side.

UCMC provides financial incentives to encourage alumni to practice in surrounding, underserved communities through UCMC's funding of a program called Repayment for Education to Alumni in Community Health, or REACH. REACH encourages up to five graduates a year from the Medical School to practice medicine at a federally qualified health clinic or community hospital on the South Side of Chicago, once they have completed a residency. In exchange, students receive financial help, which can be used for education loan repayment, of $40,000 a year.

ATTACHMENT 43

C. COMMUNITY OUTREACH AND EDUCATION

As a member of a diverse neighborhood, UCMC is involved in a variety of activities with community groups, faith-based organizations, community leaders and residents. To this end, UCMC has launched a series of initiatives to build partnerships with local communities and engage directly in providing information and solutions that enhance healthcare in the neighborhoods surrounding UCMC.

UCMC routinely holds community events on specific diseases and diagnoses and invites community residents to participate through outreach efforts via churches and other community-based organizations. At these community events, UCMC clinical and administrative personnel speak directly to members of the community about a variety of issues, including how to manage particular medical issues and the importance of having a medical home.

On a bi-annual basis, UCMC holds a UHI Summit, which brings together UCMC physicians, administrators and staff; public healthcare officials; representatives of various community organizations; and the media to discuss ways to advance health in the community.

In addition, UCMC and the University of Chicago's Comprehensive Cancer Center are focused on addressing the gap between advances in cancer care and patient accessibility. To achieve the desired cancer prevention and control outcomes, the Comprehensive Cancer Center's priority is to identify the parts of Chicago most affected by cancer and provide resources that maximize the impact of its services. This includes improving the quality of life for cancer patients and survivors, reducing risk factors, increasing access to care, reducing tobacco use and increasing participation in cancer research. To this end, UCMC and the University of Chicago initiated the Community Engagement Centering on Solutions ("CECOS") program, with a goal of enhancing public awareness of cancer prevention, early cancer detection and control, and the role of genetics in cancer. The program also strives to provide sustained engagement with the South Side community to increase local awareness of the latest advances in cancer research.

UCMC also provides Best of the Best Tours to children and teens in grades 6 through 12. The Best of the Best Tours provide a hands-on look at what goes on inside the Medical Center and a personal introduction to the many job opportunities available at UCMC, one of the South Side's largest employers. Students visit an array of critical areas where they look at human organs to learn about disease; they learn about the impact of exercise on the body; and they see how technology is used in all facets of medical care — both diagnostically and administratively. It's a day of fun and inspiration as students learn about careers as sterile technicians, pathologists, nurses, phlebotomists, information systems

analysts, human resources specialists and other job roles. Since 2003, the Medical Center has provided between three and ten Best of the Best tours per year.

D. Research and Education

UCMC dedicates resources to a variety of clinical, research and education initiatives that are designed to promote better health results for the communities it serves. UCMC works with the University to conduct a wide array of externally and internally funded biologic research with the aim of finding solutions to some of the country's most critical health problems. Hundreds of clinical research projects are being conducted at UCMC facilities at any one time and are available to nearly every type of patient UCMC treats. As a result, UCMC provides the only comprehensive set of clinical trials to patients in the South Side of Chicago.

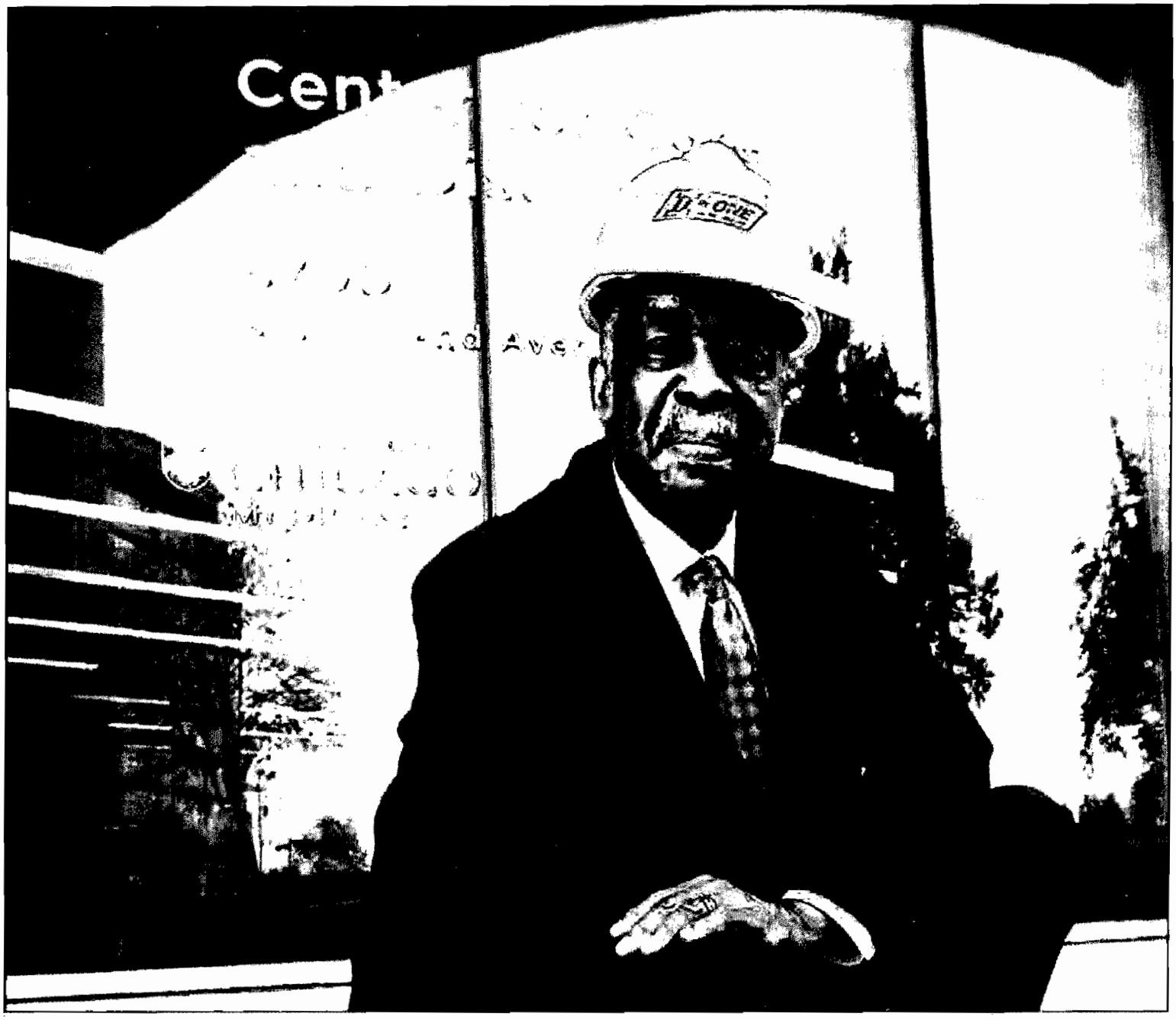
For example, the Center for Interdisciplinary Health Disparities Research focuses on achieving a trans-disciplinary approach to understanding population health and health disparities and the elimination of group differences in health. Currently the Center for Interdisciplinary Health Disparities Research is focused on understanding why African American women develop breast cancer at a younger age and have a higher incidence of mortality from breast cancer than do white women.

UCMC also invests in research conducted under a Clinical and Translational Science Award (CTSA) – funded by federal grants to the University with additional investment by UCMC – to provide more effective community health care by helping to translate basic science research into programs that benefit the community. The CTSA initiative is led by the National Center for Research Resources at the National Institutes of Health and is aimed at improving the way biomedical research is conducted across the country, reducing the time it takes for laboratory discoveries to become treatments for patients, engaging communities in clinical research efforts, and training the next generation of clinical and translational researchers. In an effort to marshal available intellectual resources, this research includes the involvement of University social scientists and social workers to help researchers and practitioners better understand how to overcome social and/or cultural hurdles and improve community health.

UCMC is deeply committed to providing health care solutions and services for patients, the community and the region. With a continued focus on its three critical missions – patient care, research and education – UCMC strives be a leader in complex care and to have a lasting impact on the health and vitality of Chicago's South Side.

The community benefit services are described in detail in the FY 2012 Community Benefit Report, included in Attachment 43.

ATTACHMENT 43

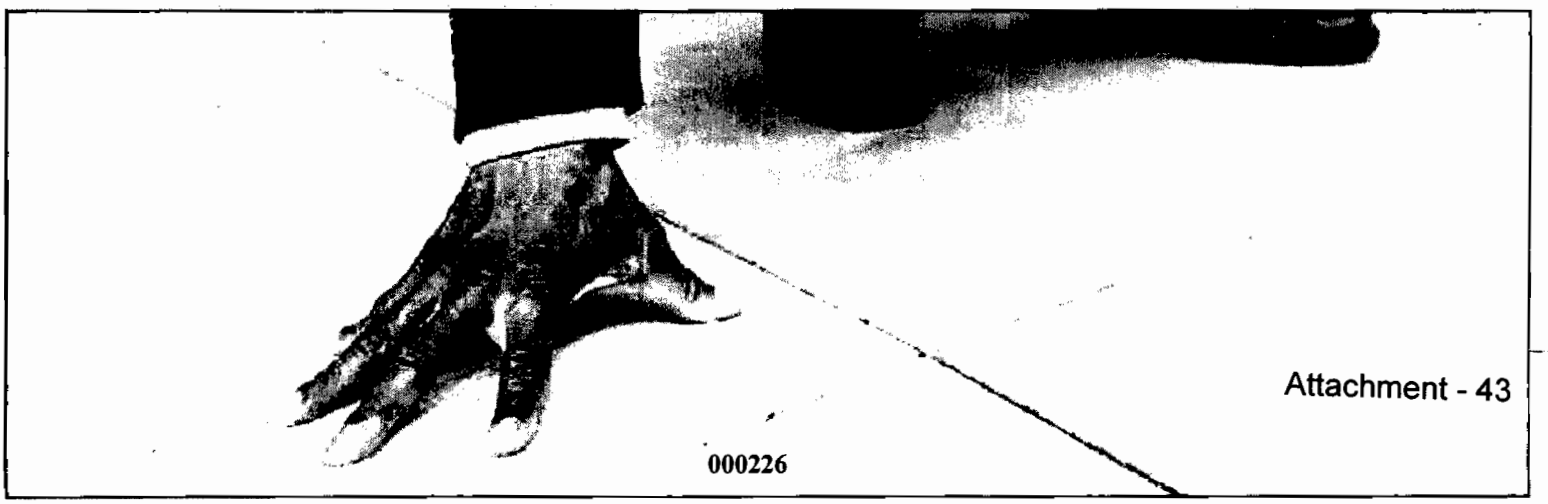


THE UNIVERSITY OF CHICAGO MEDICINE

AT THE FOREFRONT OF MEDICINE™

AT THE FOREFRONT OF OUR COMMUNITY

The University of Chicago Medicine's 2012 Report to the Community



Attachment - 43

Kicking Off a Big Year on the South Side

The past year has been an exciting one for the University of Chicago Medicine. As we moved ahead with monumental changes under health care reform, we also completed a new hospital that rivals any medical facility in the world.

About 200 guests were on hand for the dedication of the Center for Care and Discovery on Jan. 14, 2013. From left: the University of Chicago Medicine patient Tony Palumbo; Sharon O'Keefe, Medical Center president; Dr. Kenneth Polonsky, executive vice president for medical affairs; Illinois Gov. Pat Quinn; Robert Zimmer, president of the University of Chicago; Rep. Barbara Flynn Currie; Sen. Kwame Raoul; Ald. Leslie Hairston; Rep. Christian Mitchell; and Ndang Azang-Njaah, Pritzker School of Medicine student.

The Center for Care and Discovery represents our mission of delivering top-notch care in a collaborative setting where a critical mass of expertise and world-class research gives patients of today and tomorrow hope and a place to heal. The new hospital also exemplifies our contributions to the economic vitality of the region, bringing jobs to residents and pumping dollars into the local economy.

While we are proud of the new hospital, our commitment to the community goes beyond brick and mortar. It also involves supporting the next generation of physicians, charity care, losses tied to Medicaid, and donations to community groups. It extends even further to cover medical research, Medicare underpayments, unrecoverable patient debt, interpreters and volunteer work.

Altogether, the University of Chicago Medical Center and the Biological Sciences Division provided $254 million in benefits and services to the community in fiscal 2012.

This brochure highlights these community benefits and our plans to address health disparities. For details on how we work to improve the health of the South Side and beyond, visit us online at **uchospitals.edu/community** or call 773-702-0025 to get last year's Community Benefit Report.

Kenneth S. Polonsky, MD
Executive Vice President for Medical Affairs, University of Chicago
Dean, Biological Sciences Division and Pritzker School of Medicine

Sharon O'Keefe
President, University of Chicago Medical Center

ON THE COVER: *Robert McGee Jr., president of II in One Contractors Inc. in the Archer Heights neighborhood, and his workers laid the foundation for the Center for Care and Discovery. (See his story inside.)*

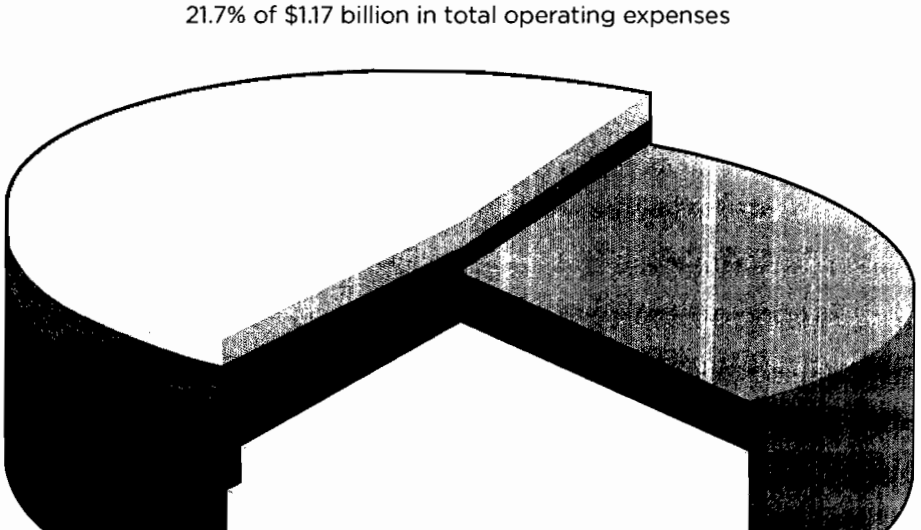
Photo by Bruce Powell

Providing Millions in Benefits and Services

$254.1 MILLION

Community Benefits, Services in Fiscal 2012

21.7% of $1.17 billion in total operating expenses



Total Uncompensated Care: $122.5 million

Medicare program losses: $50 million

Support to make up for Medicare and Medicaid reimbursement rates, which do not cover the cost of care. Medicare is a federal health insurance program for people 65 and older and those with certain disabilities. Medicaid is a federal-state program for those requiring financial assistance.

Medicaid program losses*: $40.2 million

Charity care*: $20.3 million

Cost of providing free or discounted services to qualified individuals

Unrecoverable patient debt: $12 million

Amount absorbed when a hospital cannot collect expected payment for services

Medical Education: $81.7 million

Cost to teach and train future health care professionals not covered by tuition, grants and scholarships

Medical Research: $48 million

Funding to investigate ways to better prevent, detect and treat disease and to advance patient care

Uncategorized Community Benefits: $1.2 million

Includes support for health improvement services, community activities, volunteers and language assistance

Cash and In-kind Contributions/Donations*: $676,285

Gifts to community groups for health-related activities

***An IRS-defined category of community benefit**

Components of community benefit for fiscal year 2012 (measured at cost). Data prepared based on the Illinois Attorney General's and IRS guidelines for fiscal year ended June 30, 2012.

Attachment - 43

Creating Opportunities for the South Side

In December 2012, well before sunrise, Angela McGowan arrived at Apostolic Church of God in the Woodlawn neighborhood to apply for one of the roughly 300 permanent positions created to staff the Center for Care and Discovery.

The South Side native had been trying for years to land a job on the University of Chicago campus. So when she saw a flyer for a job fair posted at a nearby Family Community Resource Center, she was thrilled at the opportunity to meet recruiters face-to-face.

By 10:30 a.m. the day of the fair, more than 1,000 people were waiting with resumes in hand for the opportunity to work at the University of Chicago Medicine's newest hospital.

"When I think about all the people who were there, I feel extremely fortunate," said McGowan, one of the approximately 300 permanent hires who now work in the Center for Care and Discovery. "This is my foot in the door. I want to do my best here, go back to college soon, then pursue other opportunities the Medical Center has to offer."

About a month later, Robert McGee Jr. was walking around the new hospital's Sky Lobby on the 7th floor with a sense of awe as he looked out over the surrounding Hyde Park community and downtown skyline.

His concrete and rebar firm, 11 in One Contractors Inc., was one of about 100 minority- and women-owned firms that helped build the

"This is my foot in the door. I want to do my best here, go back to college soon, then pursue other opportunities the Medical Center has to offer."

- **Angela McGowan,**
food service worker at the new Center for Care and Discovery

$700 million Center for Care and Discovery. He was there to represent them at the January 2013 dedication ceremony.

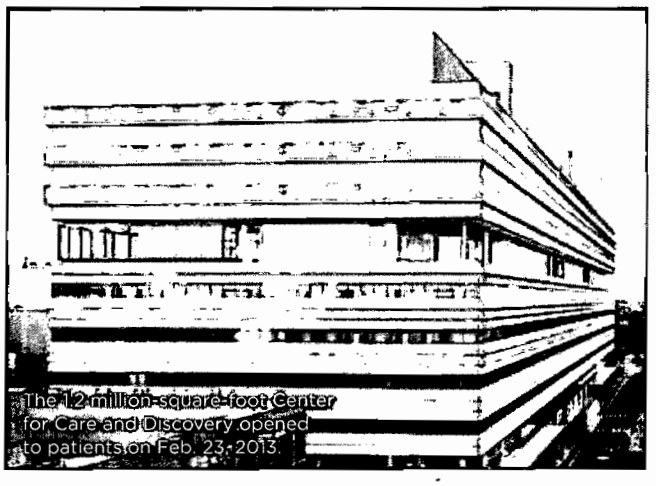
"I had a real sense of gratitude and thanksgiving that I was allowed to be a part of this project that is going to make such a profound difference in the lives of so many people," he said.

As South Side residents, both McGee and McGowan have common bonds to a community with a proud culture and rich heritage. Through the Center for Care and Discovery, they became part of a larger family sharing in the economic benefits and hope that the University of Chicago Medicine is bringing to its neighbors.

The ironworkers and laborers employed by McGee spent about 50,000 hours on the new hospital project, with more than two-thirds of the work going to minority and women workers. In fact, about 48 percent of the value of all construction contracts that were put out to bid for the 10-story facility went to certified women- and minority-owned businesses.

Construction of the 1.2 million-square-foot facility, which opened in February 2013, employed a total of 2,755 people over the four-year project. Roughly 42 percent were minority and women construction workers.

"In terms of dollars that trickled down to people in the community with the kind of participation in the workforce, it was huge," McGee said, adding he won other business from the contacts he made on the hospital job. "That's men and women feeding their families as a result of that project. It was not only good for my company; it was good for a lot of people in the African-American and other minority communities."



The 1.2 million-square-foot Center for Care and Discovery opened to patients on Feb. 23, 2013.

Center for Care and Discovery

Total Economic Impact of Hospital Project:

$571.5 million

$447.7 million
paid in contracts that were open for bid

Of that $447.7 million:

48%
went to **minority & women business enterprises** (MBE/WBE)

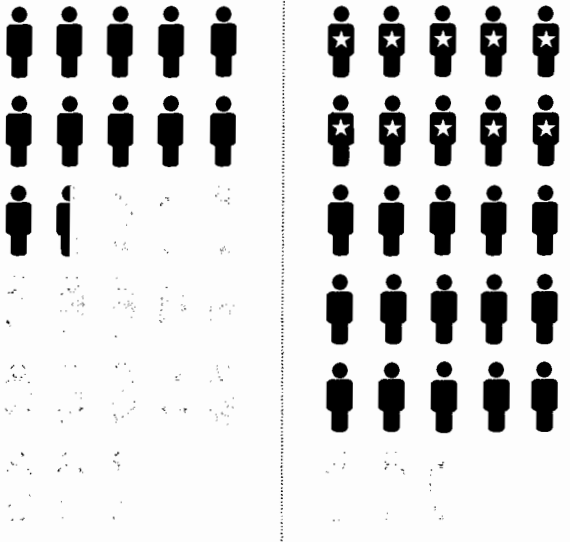
79%
went to **ILLINOIS** firms

43%
went to **MBE/WBE IN ILLINOIS**

$123.8 million
Economic value of total workforce of 2,755 (wages, benefits, other)

Of a total workforce of 2,755:

= 100



42% were minority and women construction workers

91% from Illinois

36% from Chicago

25% from the South Side

Attachment - 43

Fostering Health and Opportunity in the Community

The University of Chicago Medicine is committed to strengthening the South Side by supporting programs and initiatives that improve health and well-being among the community and help boost the local economy. That philosophy touches every facet of the medical campus, including what types of health programs are supported and how business partners are selected. In 2012 and 2013, the University of Chicago Medicine was recognized for its contributions to the community.

CommunityHealth's Visionary Award

April 20, 2013 — The University of Chicago Medicine was awarded CommunityHealth's 2013 Visionary Award for its "extraordinary contributions and its commitment to bringing high-quality, comprehensive health care to Chicago's more undeserved South Side communities." The University of Chicago Medicine has provided staffing and financial support for initiatives that have helped CommunityHealth expand its role as a medical home on the South Side.

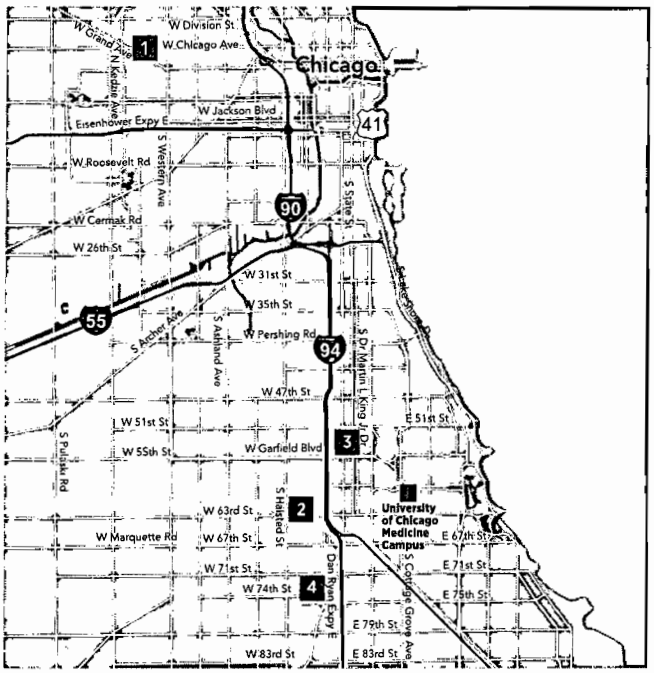
AAMC's Spencer Foreman Award

Nov. 3, 2012 — The University of Chicago Medicine was named a finalist for the Spencer Foreman Award for Outstanding Community Service from the Association of American Medical Colleges. The award honors medical schools and teaching hospitals with a longstanding commitment to communities that exceed the traditional role of academic medicine to address unmet health care needs. The University of Chicago Medicine's broad-based community collaborations, health education, patient care and prevention programs earned high marks among the 13 applicants for the award. The winner and other finalist were the University of California San Francisco School of Medicine and the University of Arizona College of Medicine, respectively.

UHC's Supplier Diversity Award

Sept. 14, 2012 — The University of Chicago Medicine was awarded the 2012 Supplier Diversity Leadership Award by UHC, an alliance of the nation's leading academic medical centers, for the development and implementation of an outstanding supplier diversity program. The award is based on several criteria, including the structure and strength of the organization's supplier diversity program, utilization of diversity contracts, senior leaders' involvement in supplier diversity, and community involvement and outreach to minority-, women- and veteran-owned businesses.

CommunityHealth's facilities are among the free clinics that the University of Chicago Medicine supports:



1. CommunityHealth West Town — Faculty and medical students support a weekly clinic at this facility.
2611 W. Chicago Ave. | 773-395-9900

2. CommunityHealth Englewood — Volunteer physicians, residents and medical students from the University of Chicago Medicine provide the bulk of services at this clinic.
641 W. 63rd St. | 773-994-1515

3. Washington Park Children's Free Clinic — From 5:30 to 7:30 p.m. each Tuesday, medical students provide acute medical care, social services and referrals for children.
5350 S. Prairie Ave. | 773-924-0220 ext. 110

4. Maria Shelter Clinic — Medical students and an attending physician provide care at this facility for homeless women and their children.
7320 S. Yale Ave. | 773-994-5350

Assessing Neighborhood Health Needs

In spring 2012, University of Chicago Medicine leaders set out to answer a question essential to the patient-focused mission of hospitals: How do we best leverage our knowledge and resources to make the greatest impact on health in the communities we serve?

Lolita Smith, a patient advocate at Comer Children's Hospital, offers assistance to a mother who is seeking a regular pediatrician for her young daughter.

While the health challenges facing many urban settings are known, developers of community initiatives on campus needed an evidence-based assessment of which issues South Side residents view as the most daunting and which untapped opportunities could drive significant improvements in those areas.

In pursuit of this data and as part of the requirements of the federal Affordable Care Act, the University of Chicago Medicine has conducted its most comprehensive assessment to date of health care concerns, behaviors and status across Chicago's South Side. An in-depth report called the Community Health Needs Assessment (CHNA), published in June in collaboration with the Metropolitan Chicago Healthcare Council, details the study's findings and provides a strategic compass for the health issues of the surrounding neighborhoods.

AREA OF STUDY

The analysis, conducted over an eight-month period, examined health status, barriers to care, demographics and socioeconomic factors that affect adults and children living in a dozen ZIP codes from 35th Street to 119th Street and east of Western Avenue. Insights gathered through numerous focus groups and phone interviews with residents, community leaders, public health experts and social service providers were weighted against metro Chicago health data from trusted sources including the U.S. Department of Health and Human Services' Healthy People 2020 initiative and the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System.

The CHNA uncovered three health care priorities for adults and three for children. For adults, they are access to health care, breast and colorectal cancer, and diabetes. For children, the critical areas are access to care, obesity and asthma. The report includes a plan to advance outreach, prevention and education initiatives in those areas.

In addition to identifying the issues of greatest concern in the community, the assessment provided another valuable insight: Confirmation that much of the work under way by the University of Chicago Medicine is on the right path.

"It was encouraging to find that many of our targeted interventions at the community level are on the mark," said Brenda Battle, RN, BSN, MBA, assistant dean for diversity and inclusion and vice president for care delivery innovation. "But the report also pointed to areas where there's still work to do. The primary benefit of this exercise is that we're able to better prioritize the numerous programs in progress, which promotes stronger collaboration and innovation toward improved outcomes."

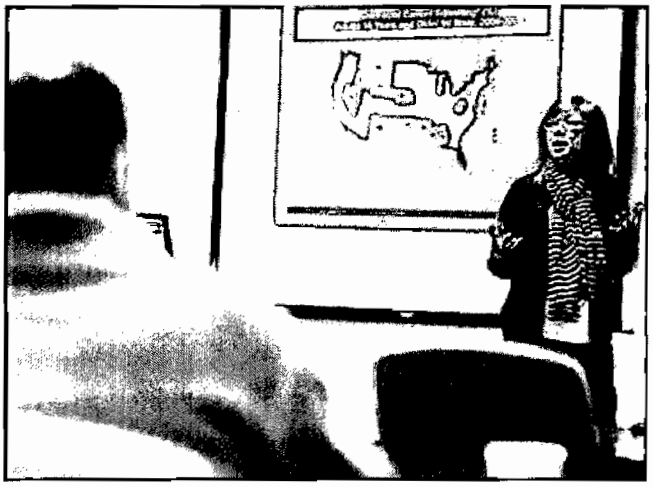
You will find a summary of the University of Chicago Medicine's plans to address these community health needs on the following pages.

For the complete Community Health Needs Assessment, please visit us online at uchospitals.edu/community-needs.

Assessing Community Health Needs: An Action Plan

Armed with new community insights and an arsenal of programs and research in development, the University of Chicago Medicine has crafted an aggressive plan to address the health needs identified in the Community Health Needs Assessment (CHNA). The priorities for adults and children and the plans to meet these needs are listed below and on the following page.

Adult-Focused Needs



Karen E. Kim, MD, professor of medicine, an expert on colon cancer prevention and screening methods, coordinates free colorectal cancer screenings, particularly for minority populations.

TARGET: Access to health care

Research increasingly points to a strong relationship with a primary care physician as the key to improved long-term health outcomes. The CHNA revealed that many South Side residents still lack an ongoing connection to frontline care and often seek treatment for chronic conditions in the emergency department (ED).

PLAN: Implement Medical Home Connection program

The University of Chicago Medicine is honing efforts to turn the tide on this longstanding concern through its Medical Home Connection program. First launched in 2005, the program has made significant strides toward reducing repeat visits to the ED for non-emergency health conditions and connecting patients with a regular doctor for preventive care, disease management, and referrals to specialists.

2,864
PEOPLE
CONNECTED
to a medical home or specialty care clinic through the Medical Home Connection since 2005
For fiscal year ended June 30, 2012

Patient advocates in the adult ED are central to this program. These specially trained staff members educate patients about the importance of having a regular doctor, and they schedule appointments with providers within the South Side Healthcare Collaborative, a network of 30 community health centers and two free clinics across Chicago's South Side. They also make reminder calls to help patients keep their appointments.

TARGET: Diabetes

Diabetes affects an estimated 23.6 million people in the United States and is the seventh-leading cause of death. Between 2007 and 2009, Cook County reported an annual average age-adjusted diabetes mortality rate of 22.7 deaths per 100,000 people. Of the adults in the CHNA survey area, 13.4 percent reported having been diagnosed with diabetes — compared to the Illinois average of 8.7 percent.

PLAN: Implement South Side Diabetes Project

The South Side Diabetes Project has set out to bring together local health systems with community organizations to improve the health and quality of life for people living with diabetes. The project works with six South Side clinics to train providers in culturally-relevant diabetes management, promote improvements to quality systems and connect patients to community resources, including exercise programs, local food pantries and educational grocery-store tours.

RECENT NEWS
The project has teamed up with a local farmer's market to offer vouchers for locally grown fruits and vegetables.

TARGET: Breast and colorectal cancer

Respondents to the CHNA survey say cancer remains among their top health concerns. According to the National Cancer Institute's Surveillance, Epidemiology and End Results (SEER), African-Americans and Hispanics carry the heaviest burden of cancer in the U.S., with a death rate for all cancers nearly 25 percent higher than that observed in other ethnic groups.

PLAN: Enhance and implement current programs

The University of Chicago Medicine is responding to these disparities with a multifaceted plan to bring cancer prevention, early detection and treatment information to populations most at risk. Coordinators plan to leverage community relationships, research and expertise to launch outreach initiatives to help educate the community.

One example of these initiatives is the Breast Cancer Survivorship Program. Outreach coordinator Zakiya Moton, MPH, says that in her six years spearheading grassroots programs across Chicago's underserved neighborhoods, demand for information about breast cancer risk factors and early detection has increased. "I've seen improvements in health literacy each year, and people are reaching out more than ever for resources and information to aid them in becoming self-empowered for better health," said Moton, who speaks at health fairs, workplace programs and faith-based events. "Because of our efforts, people are getting screened and diagnosed with cancer in the earliest stages."

Pediatric-Focused Needs

Nurse practitioner Pamela Beauduy checks the vital signs of a student during a visit to a high school. In the 2011–12 school year, the Comer Children's Hospital Pediatric Mobile Medical Unit visited 25 schools, the majority of them on the South Side.

TARGET: Access to health care

Access to comprehensive, quality health care services is vital to achieving health equity and improving the quality of life and life expectancy, particularly among children. Nearly 38 percent of parents in the CHNA survey area reported some type of challenge or delay in obtaining health care for a child in the past year. That is more than 7 percentage points higher than the national average.

MOBILE CLINIC IMPACT

111 SITE VISITS

954 MEDICAL ENCOUNTERS

196 MENTAL HEALTH ENCOUNTERS

PLAN: Enhance and implement current programs

The Medical Home Connection program is expanding its reach to in-patient floors at the University of Chicago Medicine Comer Children's Hospital to help ensure more young patients have the follow-up care needed to minimize the chance of a repeat hospital stay.

To reach more underinsured and uninsured children, coordinators plan to expand the offerings of the Comer Children's Hospital Pediatric Mobile Medical Unit, which has been visiting South Side schools for more than a decade. They plan on visiting more schools and moving the "clinic on wheels" beyond physicals, screenings, immunizations and mental health assessments to offer a broad range of health education services, acute care and chronic illness management.

For the complete Community Health Needs Assessment, please visit us online at uchospitals.edu/community-needs.

TARGET: Childhood obesity

Good nutrition and a healthy body weight are key to a child's development and to reducing the risk of developing many health conditions. About 40 percent of children in the CHNA survey area were found to be overweight or obese, nearly 9 percentage points higher than the national average.

PLAN: Enhance and implement current programs

To help address these startling statistics, the University of Chicago Medicine will tap its resources among community partners and researchers on the medical campus to develop programs focused on risk, prevention, weight management and culturally relevant nutrition education. It also will support Power-Up, an after-school program of activities for kindergarten through 6th grade at the Woodlawn Community School.

TARGET: Asthma

Asthma is the most common chronic illness affecting children in this country, and research confirms that children in underserved communities are more likely to experience asthma-related complications, ED visits and hospitalization. About 17 percent of children in the CHNA survey area have asthma, and almost 58 percent missed school because of asthma-related problems.

PLAN: Enhance and implement current programs

The University of Chicago Medicine's Asthma Care Coordination program is designed to reduce the occurrence of serious asthma episodes. The program, which involves patient and caregiver education along with specialized training for nurses, is aimed at increasing awareness of potential triggers and improving the ability to manage the condition at home. The initiative also connects frequent emergency department visitors with a medical home or regular primary care provider who will become familiar with the patient's needs. Community-based education and home assessments are on the horizon.

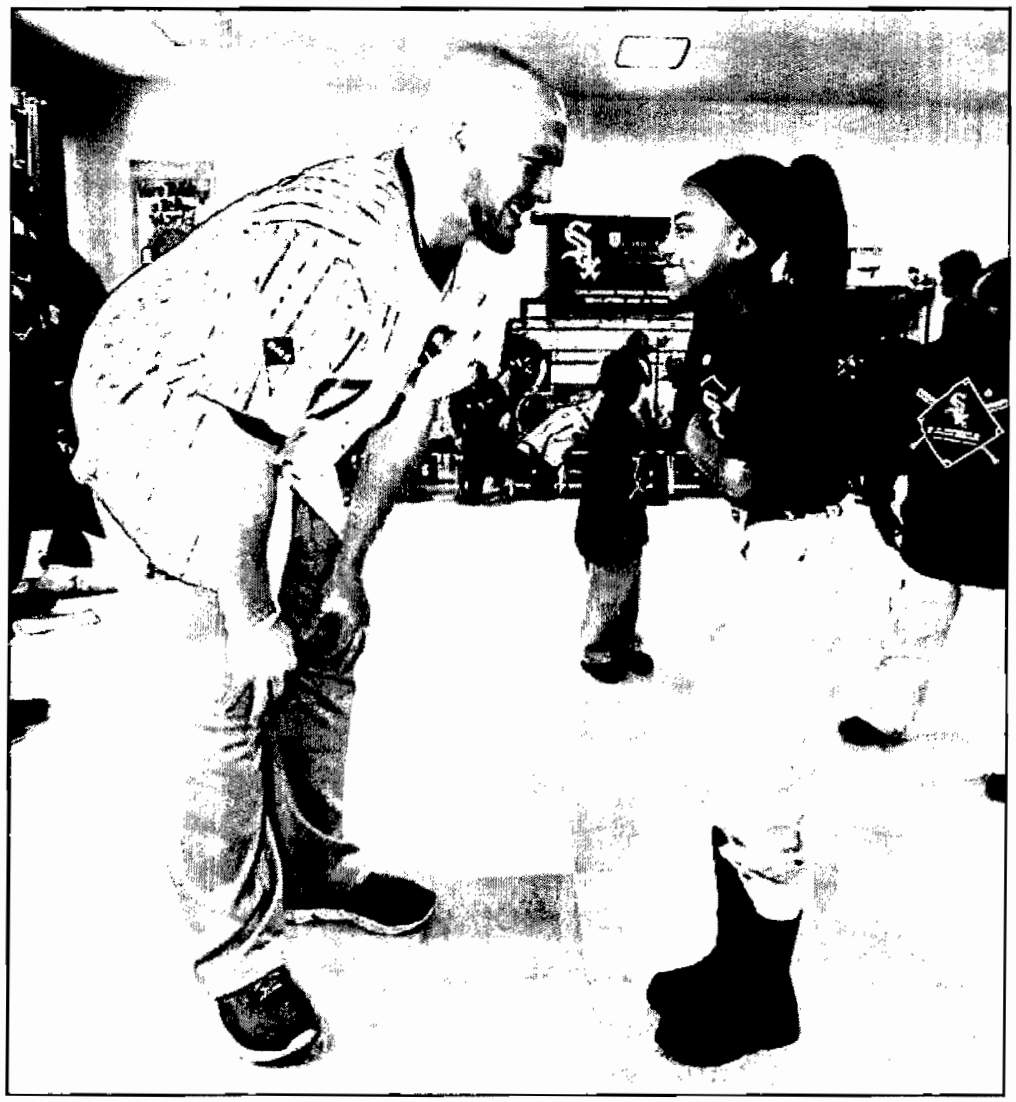
Making Headlines in Community-Related News

$12 million in federal grants to help improve health outcomes

July 10, 2012 The U.S. Department of Health and Human Services awarded $12 million to two University of Chicago Medicine-led programs: $5.9 million to create an automated system that will provide information about community-based services and resources and $6.1 million to test a comprehensive care physician model that seeks to improve health outcomes while also lowering costs.

The grants were part of the Centers for Medicare & Medicaid Services' Health Care Innovation Awards, a funding initiative under the Affordable Care Act that supports solutions to improve health outcomes and reduce medical costs. Of the nearly 3,000 applicants, the University of Chicago Medicine was one of 107 institutions, and the only academic medical center in Illinois, to get multiple grants in round one of the Innovation Awards.

The University of Chicago Medicine's South Side Health and Vitality Studies is leading the development of the CommunityRx system, a continuously updated database of health resources linked to the electronic health records of local safety net providers. In real time, the system processes data and prints out a "Health.eRx" for the patient, including referrals to community resources relevant to that person's condition and health status. The project is in partnership with the Chicago Health Information Technology Regional Extension Center and the Alliance of Chicago Community Health Services.



Comer Children's Hospital, White Sox team up to target childhood obesity
Jan. 25, 2013 Comer Children's Hospital and the White Sox have joined forces to combat childhood obesity. Through a sponsorship of the team's "Family Sundays" along with the White Sox Kids Club, Comer Children's Hospital will teach families how to make healthy lifestyle choices using its repertoire of research-based programs.

CommunityRx is expected to serve about 200,000 beneficiaries of the South Side, many of whom are covered by Medicare, Medicaid or the Illinois Comprehensive Health Insurance Plan.

"Our innovation helps people stay healthy and manage disease by connecting them to businesses and support organizations in their community," said Stacy Tessler Lindau, MD, associate professor of obstetrics and gynecology at the University of Chicago Medicine and lead researcher for this project. "The outcome will be better and more efficient health care delivery and stronger, more vital communities."

The other Innovation Award will fund the study of a model that improves continuity of care for frequently hospitalized patients by providing them with a physician who will care for them both in clinic and in the hospital. The goal is to address the issue of frequent hospitalizations by high-risk patients, who account for a disproportionate amount of health care spending in the United States. Under the model, a comprehensive care physician (CCP) will lead a team of nurse practitioners, social workers, care coordinators and other specialists to address the needs of frequently hospitalized patients. CCPs will carry a panel of approximately 200 patients at a time, serving as their primary care physician during clinic visits and supervising their care while hospitalized. "Our goal will be to really understand patients' needs so that we can give them the care that they need," said lead investigator David Meltzer, MD, PhD, associate professor and chief of the Section of Hospital Medicine at the University of Chicago Medicine. "That should be better for them, and should ultimately be less costly for the health care system and produce better outcomes."

Other Community-Related News in 2012 and 2013

Taxi drivers offered free flu shots at O'Hare, Midway
Sept. 21, 2012 As part of an initiative to vaccinate some of Chicago's most vulnerable populations, University of Chicago Medicine nurses administered free flu shots to licensed taxicab drivers at O'Hare International Airport and at Midway International Airport.

University of Chicago Medicine, CeaseFire partner to address violence
Feb. 7, 2012 In an effort to address urban violence on the South Side, the University of Chicago Medicine is partnering with CeaseFire Chicago to sponsor a "Violence Interrupter" who will focus on monitoring, mediating and defusing disputes in neighborhoods that the medical campus serves. In addition, it has co-hosted media screenings of "It Shoudda Been Me," a play about youth violence written by Doriane Miller, MD, director of the Center for Community Health and Vitality.

Annual Day of Service and Reflection marks 10 years of giving to community
May 11, 2012 Hundreds of University of Chicago Medicine staff, faculty members, students, their family and friends mobilized across Chicago's South Side to tackle a host of community projects as part of the 10th annual Day of Service and Reflection.

$23 million NIH grant to boost transformative medical research
July 23, 2012 A $23 million grant from the National Institutes of Health will energize the University of Chicago's efforts to harness innovative medical research for interventions that lead to better community health in Chicago and across the nation. The grant brings total NIH funding to the University's Institute for Translational Medicine (ITM) to more than $50 million. Among projects the ITM has supported: development of an automated 3D imaging tool for measuring upper airway inflammation in sinusitis cases, and a program called the Thirty Million Words Project, which helps parents improve their children's language environment.

Diabetes initiative taps power of Rx pad
Aug. 15, 2012 The University of Chicago Medicine and Walgreens teamed up to launch "Food Rx," an initiative that helps people with diabetes improve their eating habits by overcoming two major hurdles when shopping for food: access and affordability. As part of the Improving Diabetes Care and Outcomes on the South Side of Chicago, a project based at the University of Chicago Medicine, diabetes patients who visit one of six South Side clinics can receive a prescription-like checklist of their doctor's food recommendations and a coupon for $5 off $20 worth of healthy food at participating Walgreens locations. Patients also can get a $3 voucher for the weekly 61st Street Farmers Market in the Woodlawn neighborhood.

Annual event seeks to inspire diabetes patients, families
April 27, 2013 Sherri Shepherd, co-host of "The View," was the special guest speaker at the University of Chicago Medicine Kovler Diabetes Center's 7th annual Living Well with Diabetes event on April 27, 2013. Shepherd shared her personal struggle with weight loss and how she learned to enjoy life while managing her diabetes. Chef Jennifer Bucko Lamplough, star of Food Network's "Fat Chef" and author of blog FitFoodieChef, served up diabetes-friendly dishes and shared tips for healthful home-cooked meals. Living Well is a free annual event hosted by Kovler Diabetes Center to educate and inspire people living with diabetes.

Ci3's Game Changer Chicago earns MacArthur Foundation funding

April 10, 2013 Melissa Gilliam, MD, MPH, (above) heads the Center for Interdisciplinary Inquiry & Innovation in Sexual & Reproductive Health (Ci3), which received a $500,000 grant from the MacArthur Foundation. The grant will help support the creation of the Design Lab for Game Changer Chicago, an initiative to investigate how playing and designing games can promote the social and emotional well-being of youth and improve sexual and reproductive health outcomes.

To read more about these news items, go to www.uchospitals.edu/news.

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IN FY2012

9,700 Employees

INCLUDING

833 Attending Physicians

921 Residents and Fellows

1,654 Nurses

24,218 Admissions

76,461 ER Visits

320 Pediatric Trauma Admissions

283 Burn Admissions

128 Organ Transplants

22,844 Inpatient and Outpatient Surgeries

Medicaid Acute Care Days for Private Hospitals in Metro Chicago*

	Medicaid Days	Percent of Total Days
1. University of Chicago Medical Center	40,107	29%
2. Advocate Christ Medical Center	38,388	21
3. Northwestern Memorial Hospital	36,867	16
4. Rush University Medical Center	36,650	26
5. Lurie Children's Hospital	33,041	53
6. Mount Sinai Hospital	31,316	48
7. Loyola University Medical Center	30,241	27
8. Sts. Mary and Elizabeth Medical Center	26,314	33
9. Advocate Lutheran General Hospital	20,735	17
10. Mercy Hospital & Medical Center	18,638	32

*Acute care days provided to patients where Illinois Medicaid is the primary insurer; excluding normal nursery, psychiatry and rehabilitation days
Source: Illinois Department of Healthcare & Family Services, Medicaid cost reports filed for the state fiscal year ending June 30, 2011

Section XII, Charity Care Information

Attachment 44

	2011	2012	2013
Net Patient Revenue			
Amount of Charity Care (Charges)	**61,801,000**	**73,064,000**	**100,061,000**
Cost of Charity Care	**14,427,000**	**16,620,000**	**22,000,000**

ATTACHMENT 44

APPENDIX A-1

Support Letters
(Additional Letters to be Sent Directly)

Quad Communities Development Corporation

April 10, 2014

Ms. Courtney R. Avery
Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: University of Chicago Medical Center CON Application

Dear Ms. Avery:

As Executive Director for Quad Communities Development Corporation (QCDC), I am writing to express my support of the University of Chicago Medical Center's ("UCMC") Certificate of Need ("CON") application to develop two (2) floors of shelled space in its new hospital pavilion, the Center for Care & Discovery ("CCD"), to inpatient floors.

QCDC's mission is to improve the quality of life and economic strengths of its South Side communities by driving economic development, improving schools, and supporting organizations focused on workforce development, retail retention, and safety.

UCMC's project is consistent with QCDC's mission and its work on a wide range of community development projects. Simply put, the construction of modern medical facilities on the South Side of Chicago and access to medical care for its residents is important to QCDC.

Please feel free to contact me directly at if you need additional information. Thank you very much for your attention to this issue.

Sincerely,

Bernita Johnson-Gabriel
Executive Director

4659 South Cottage Grove Avenue, Suite 203, Chicago, Illinois 60653 (773) 268-7232