

ORIGINAL

12-002

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

APPLICATION FOR PERMIT- May 2010 Edition

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION JAN 17 2012

This Section must be completed for all projects.

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility/Project Identification

Facility Name:	Rehabilitation Institute of Chicago		
Street Address:	345 E. Superior Street		
City and Zip Code:	Chicago, IL 60611		
County:	Cook	Health Service Area	6 Health Planning Area: A-01

Applicant /Co-Applicant Identification

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

Exact Legal Name:	Rehabilitation Institute of Chicago		
Address:	345 E. Superior Street. Chicago, IL 60611		
Name of Registered Agent:			
Name of Chief Executive Officer:	Joanne C. Smith, MD		
CEO Address:	345 E. Superior Street. Chicago, IL 60611		
Telephone Number:	312-238-0815		

Type of Ownership of Applicant/Co-Applicant

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

- o Corporations and limited liability companies must provide an Illinois certificate of good standing.
- o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

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

Primary Contact

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

Name:	Nancy Paridy
Title:	Senior Vice President, General Counsel
Company Name:	Rehabilitation Institute of Chicago
Address:	345 E. Superior Street
Telephone Number:	312-238-6208
E-mail Address:	nparidy@ric.org
Fax Number:	312-238-2117

Additional Contact

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

Name:	Barry Fleischer
Title:	Planning Team, New Research Hospital
Company Name:	Rehabilitation Institute of Chicago
Address:	345 E. Superior Street
Telephone Number:	312-238-0816
E-mail Address:	bfleischer@ric.org
Fax Number:	312-238-2117

Additional Contacts

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

Name:	Honey Jacobs Skinner
Title:	Partner
Company Name:	Sidley Austin LLP
Address:	1 South Dearborn Street, Chicago, IL 60603
Telephone Number:	(312) 853-7577
E-mail address:	mskinner@sidley.com
Fax Number:	(312) 853-7036

Name:	Jack Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court, Suite 210, Palatine, IL 60067
Telephone Number:	(847) 776-7101
E-mail address:	jacobmaxel@msn.com
Fax Number:	(847) 776-7004

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:	Nancy Paridy
Title:	Senior Vice President, General Counsel
Company Name:	Rehabilitation Institute of Chicago
Address:	345 E. Superior St
Telephone Number:	312-238-6208
E-mail Address:	nparidy@ric.org
Fax Number:	312-238-2117

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Rehabilitation Institute Chicago
Address of Site Owner:	As above
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. See attached.	

Operating Identity/Licensee

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

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

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. See attached.
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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. Not applicable.

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. See attached letter.

DESCRIPTION OF PROJECT**1. Project Classification**

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

Part 1110 Classification:

- Substantive
 Non-substantive

Part 1120 Applicability or Classification:
[Check one only.]

- Part 1120 Not Applicable
 Category A Project
 Category B Project
 DHS or DVA Project

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.

See next page.

Narrative Description

The proposed Master Design project seeks approval for the Rehabilitation Institute of Chicago ("RIC") to expend funds in excess of the capital threshold for the purpose of planning a new research facility to be located at 630 N. McClurg Court in Chicago, two blocks south of the existing hospital. Throughout this application, RIC refers to its current hospital as the "RIC Flagship Hospital," which is located at 345 East Superior Street in Chicago. The new hospital is referred to as RIC's new "Research Hospital."

RIC has been engaged in a detailed planning process over the last several years to assess its facility needs and to identify the needs of patients as well as clinicians, and the future of physical rehabilitation medicine. Last summer, RIC retained external expertise for detailed planning and design. In this regard, RIC has been assisted by Rise Group for facility construction management, KSA for programming, HDR|Gensler collaboration for architectural design services, and Power Construction for budgeting and construction. See Attachment 12 for designations of these firms and their role in facility development. This application is being filed because we believe that the planning process will require us to spend in excess of the \$11,885,440 threshold and approximately \$7.5 million has been spent so far.

Throughout the planning process, RIC analyzed the growing market demand for its unique services and the increasing complexity of the patients who come to the hospital for care. This planning process concluded that RIC's existing hospital lacks sufficient beds and clinical space to accommodate patients' needs, and that it has been grossly undersized for many years. Continued renovation of the facility is not an option as the existing structure is not large enough to meet current needs, and the necessary expansions and updates are not possible giving the current infrastructure. A new facility is needed that will facilitate and enhance the close collaboration of researchers and clinicians in the care of existing patients and in the development of future innovations in the field of physical rehabilitation. This application will address the planning process, and will explain the rationale for the scope and size of the project. A separate Certificate of Need permit application for the establishment of a new hospital at the proposed site will be filed at the culmination of the planning process.

The Master Design project includes the following key components:

- The construction of 272-bed inpatient rehabilitation hospital with all single patient rooms. This includes an increase of 90 licensed beds based upon the demonstrated market need and capacity constraints of the RIC Flagship Hospital further identified in this application.
- Development of unique collaborative research and clinical spaces, known as Ability Labs[™], which are designed to seamlessly integrate the latest applied research to patient care in a way that results in advancing ability while inspiring hope.

- Development of clinical space in the building for outpatient rehabilitation and day rehabilitation services.
- Development of applied research space (e.g., dry-lab, computer and robotic equipment spaces) for projects that are not yet suitable for patient therapy
- Development of all related clinical support spaces, including ancillary diagnostic equipment as well as physician and staff offices as well as other necessary services. RIC may consider whether additional imaging capability, in particular MRI and CT, should be incorporated in the design plan.
- Assessment relating to whether additional parking and medical office capacity should be developed proximate to the new facility.
- A central power plant.

It is anticipated that construction will commence in early 2013 with a planned opening of the new Research Hospital in 2016. All architectural, construction management and related contracts will include a contingency with respect to Certificate of Need approval.

During the Master Certificate of Need, the following activities will occur:

- Grid Confirmation
- Structural Concept Design
- Alternate Structure Analysis
- Foundation and Structural Schematic Design
- MEP System Load Studies and Concept Design
- Preliminary Civil, Utility Design
- Preliminary Code and Zoning
- Completion of Design and Construction Documents

The Project appears to be non-substantive as defined by Section 1110.40(c).

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	\$122,772	\$71,228	\$194,000
Site Surveys and Soil Investigation	\$103,280	\$59,920	\$163,200
Site Preparation			\$0
Off Site Work			\$0
New Construction Contracts			\$0
Modernization Contracts			\$0
Contingencies	\$2,009,286	\$1,165,714	\$3,175,000
Architectural/Engineering Fees	\$9,543,682	\$5,536,890	\$15,080,572
Consulting and Other Fees	\$3,964,475	\$2,300,042	\$6,264,517
Movable or Other Equipment During Construction (project related)			\$0
Bond Issuance Expense			\$0
Net Interest Expense During Construction (project related)			\$0
Fair Market Value of Leased Space or Equipment			\$0
Other Costs to be Capitalized	\$903,441	\$524,143	\$1,427,584
Acquisition of Building or Other Property (excluding land)			\$0
TOTAL USES OF FUNDS	\$16,646,937	\$9,657,936	\$26,304,873
SOURCES OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$16,646,937	\$9,657,936	\$26,304,873
Pledges			\$0
Gifts and Bequests			\$0
Bond Issues (project related)			\$0
Mortgages			\$0
Leases (fair market value)			\$0
Government Appropriations			\$0
Grants			\$0
Other Funds and Sources			\$0
TOTAL SOURCES OF FUNDS	\$16,646,937	\$9,657,936	\$26,304,873

NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Not applicable.

We have completed the lines on the chart which are applicable to a Master Design Project. Also, of significance and as further elaborated upon in the narrative portions of the application, clinical and substantial research functions are uniquely integrated.

Related Project Costs

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

Land acquisition is related to project	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Purchase Price: \$	_____	
Fair Market Value: \$	_____	
The project involves the establishment of a new facility or a new category of service		
	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> 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

Indicate the stage of the project's architectural drawings:	
<input type="checkbox"/> None or not applicable	<input type="checkbox"/> Preliminary
<input checked="" type="checkbox"/> Schematics	<input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>March, 2016</u>	
Anticipated completion date of master planning process: <u>August, 2013</u>	
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):	
<input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.	
<input checked="" type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies	
<input type="checkbox"/> Project obligation will occur after permit issuance.	
APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	
<u>Not applicable.</u>	

State Agency Submittals

Are the following submittals up to date as applicable:	
<input type="checkbox"/> Cancer Registry	Not Applicable
<input type="checkbox"/> APORS	Not Applicable
<input checked="" type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted	
<input type="checkbox"/> All reports regarding outstanding permits	Not Applicable
Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.	

*This application is solely for planning purposes.

Cost Space Requirements

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

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

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

This application is solely for planning purposes. Also, the estimates are based upon preliminary discussions. Furthermore, as is set forth in the narratives of this applications, research and clinical care are uniquely interwoven.

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.

Rehabilitation Institute FACILITY NAME: of Chicago		CITY: Chicago			
REPORTING PERIOD DATES: From: January 1, 2010 to: December 31, 2010					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation	165 (11/2011) 182 (1/2012)	2,472	52,718	90	272
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:	165 (11/2011) 182 (1/2012)	2,472	52,718	90	272

*On May 5, 2011, RIC notified the State of Illinois that it was adding 17 additional licensed beds in January, 2012. As of January, 2012, RIC shall be licensed for 182 acute comprehensive rehabilitation beds.

CERTIFICATION

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

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

This Application for Permit is filed on the behalf of Rehabilitation Institute of Chicago 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.

Joanne C. Smith
 SIGNATURE
Joanne C. Smith, MD
 PRINTED NAME
President and CEO
 PRINTED TITLE

Nancy Paridy
 SIGNATURE
Nancy Paridy
 PRINTED NAME
Senior Vice President, General Counsel
 PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 12th day of January, 2012

Notarization:
Subscribed and sworn to before me
this 12th day of January, 2012

Jean M Holewa
 Signature of Notary
 Seal
OFFICIAL SEAL
JEAN M HOLEWA
 NOTARY PUBLIC - STATE OF ILLINOIS
 MY COMMISSION EXPIRES:01/14/16

Jean M Holewa
 Signature of Notary
 Seal
OFFICIAL SEAL
JEAN M HOLEWA
 NOTARY PUBLIC - STATE OF ILLINOIS
 MY COMMISSION EXPIRES:01/14/16

*Insert EXACT legal name of the applicant

SECTION II. DISCONTINUATION ----NOT APPLICABLE

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

Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

GENERAL INFORMATION REQUIREMENTS

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

REASONS FOR DISCONTINUATION

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

IMPACT ON ACCESS

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

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

Not applicable.

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. **Not Applicable**

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. See Attached.

PURPOSE OF PROJECT

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

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

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

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

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.

See Attached.

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. See attached.

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. See attached.

UNFINISHED OR SHELL SPACE: Not applicable.

Provide the following information:

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

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

ASSURANCES:

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 V. - MASTER DESIGN AND RELATED PROJECTS

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

Criterion 1110.235(a) - System Impact of Master Design

Read the criterion and provide documentation that addresses the following:

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

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

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

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

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

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

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

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

See attached.

B. Criterion 1110.630 - Comprehensive Physical Rehabilitation

- Applicants proposing to establish, expand and/or modernize Comprehensive Physical Rehabilitation category of service must submit the following information:
- Indicate bed capacity changes by Service: Indicate # of beds changed by action(s):

Category of Service	# Existing Beds	# Proposed Beds
<input checked="" type="checkbox"/> Comprehensive Physical Rehabilitation	165 (11/2011) 182 (1/2012)	272

- READ the applicable review criteria outlined below and submit the required documentation for the criteria:

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.630(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (formula calculation)	X		
1110.630(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.630(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.630(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.630(b)(5) - Planning Area Need - Service Accessibility	X		
1110.630(c)(1) - Unnecessary Duplication of Services	X		
1110.630(c)(2) - Maldistribution	X		
1110.630(c)(3) - Impact of Project on Other Area Providers	X		
1110.630(d)(1) - Deteriorated Facilities			X
1110.630(d)(2) - Documentation			X
1110.630(d)(3) - Documentation Related to Cited Problems			X
1110.630(d)(4) - Occupancy			X
1110.630(e)(1) and (2) - Staffing	X	X	
1110.630(e)(2) - Personnel Qualifications	X		
1110.630(f) - Performance Requirements	X	X	X
1110.630(g) - Assurances	X	X	X
APPEND DOCUMENTATION AS ATTACHMENT-21, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. See Attached.			

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

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

Service	# Existing Key Rooms	# Proposed Key Rooms
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		

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
<p>APPEND DOCUMENTATION AS ATTACHMENT-37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. See attached.</p>		

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

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

VIII. - 1120.120 - Availability of Funds

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

\$34,000,000	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.
\$34,000,000	TOTAL FUNDS AVAILABLE	

APPEND DOCUMENTATION AS ATTACHMENT-39, 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

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

2. Variance

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

APPEND DOCUMENTATION AS ATTACHMENT 41 IN NUMERIC 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 See attachment 42A.
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing Not applicable.

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

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

C. Reasonableness of Project and Related Costs The following are solely related to the cost for

Read the criterion and provide the following: the Master Design.

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

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs NOT Applicable

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

E. Total Effect of the Project on Capital Costs Not Applicable

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

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

XI. Safety Net Impact Statement Not applicable.

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

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

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

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

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

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

25

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

Not applicable.

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.

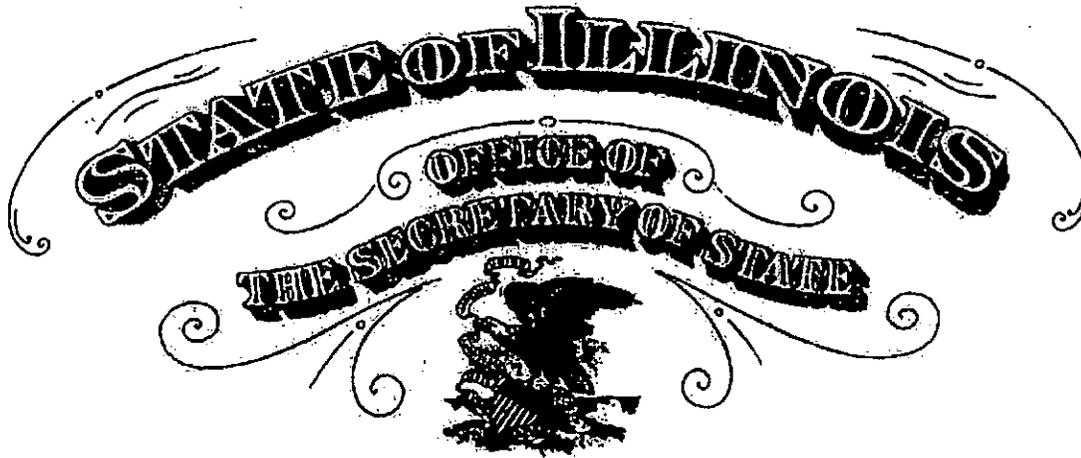
CHARITY CARE			
	Year-2009	Year-2010	Year-2011
Net Patient Revenue	141,360,000	144,475,000	155,378,000
Amount of Charity Care (charges)	1,165,324	1,387,937	2,513,983
Cost of Charity Care	523,395	568,031	1,041,161

APPEND DOCUMENTATION AS ATTACHMENT-44, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Notes:

- 1) As of FY 2011 RIC is reporting patient service revenue net of the provision for bad debts. In the prior years the provision for bad debt was reported in expenses. In the net patient revenue above for FY 2009 and FY 2010 the provision for bad debt has been netted from patient service revenue to be consistent with this new methodology.
- 2) The cost of charity was calculated for FY 2011 using the cost to charge ratio from FY 2010. Once the FY 2011 Medicaid cost report has been completed the cost of charity will be updated using the updated cost to charge ratio.

File Number 3272-594-5



To all to whom these Presents Shall Come, Greeting:

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

REHABILITATION INSTITUTE OF CHICAGO, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 05, 1951, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1130702358

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

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 3RD day of NOVEMBER A.D. 2011

Jesse White

SECRETARY OF STATE

ATTACHMENT 1

THIS DOCUMENT WAS)
PREPARED BY AND)
AFTER RECORDING)
RETURN TO:)



Doc#: 0884891082 Fee: \$44.00
Eugene "Gene" Moore F&HP Fee:\$10.00
Cook County Recorder of Deeds
Date: 12/16/2009 02:48 PM Pg: 1 of 6

DLA Piper LLP (US))
203 North LaSalle Street, Suite 1900)
Chicago, Illinois 60601)
Attn: David Glickstein, Esq.)

12/14 01190542 MAX



[This space reserved for recording data.]

SPECIAL WARRANTY DEED

THIS SPECIAL WARRANTY DEED (the "Deed") is made as of this 14th day of December, 2009, by GHB-630 LLC, a Delaware limited liability company (the "Grantor"), having an office at 625 N. Michigan Ave., Chicago, Illinois 60611, to REHABILITATION INSTITUTE OF CHICAGO, an Illinois not-for-profit corporation (the "Grantee"), having an office at 345 E. Superior St., Chicago, Illinois 60611.

WITNESSETH:

That the Grantor, for and in consideration of the sum of TEN AND 00/100THS DOLLARS (\$10.00) and other good and valuable consideration in hand paid by the Grantee, the receipt and sufficiency of which are hereby acknowledged, by these presents does GRANT, REMISE, RELEASE, ALIEN, SELL AND CONVEY unto the Grantee and its successors and assigns, FOREVER, all of the real estate situated in the County of Cook and State of Illinois described on Exhibit A attached hereto and made a part hereof (the "CBS Land"), together with all right title and interest of Grantor in and to (a) all strips and gores of land lying adjacent to the CBS Land, (b) all rights (including all air rights), easements and appurtenances belonging or pertaining to the CBS Land and (c) all roads, streets, alleys or public or private rights of way adjoining the CBS Land (collectively, the "Property"), subject only to those matters described on Exhibit B attached hereto and made a part hereof (the "Permitted Exceptions").

TO HAVE AND TO HOLD the Property, subject only to the Permitted Exceptions, unto the Grantee and its successors and assigns forever.

Grantor does covenant, promise and agree, to and with the Grantee and its successors and assigns, that it has not done, or suffered to be done, anything whereby the Property is, or may be, in any manner encumbered or charged, except as herein recited, and that it WILL WARRANT AND FOREVER DEFEND the Property against persons lawfully claiming, or to claim the same, by, through or under Grantor but not otherwise, except for claims arising under or by virtue of the Permitted Exceptions.

CENTRALJ1291146J

ATTACHMENT 2

IN WITNESS WHEREOF, the Grantor has caused its name to be signed to these presents on the day, month and year first set forth above.

GRANTOR:

GHB-630 LLC, a Delaware limited liability company

By:

Name:

Title:

Michael Y. [unclear]
Authorized Signatory

City of Chicago
- Dept. of Revenue
696774
12/15/2009 14:01
Batch 493,844

Real Estate
Transfer
Stamp
\$129,000.00

CENTRAL012911443

ATTACHMENT 2

STATE OF ILLINOIS)
)
COUNTY OF COOK) ss:

I, the undersigned, a Notary Public in and for said County and State aforesaid, DO HEREBY CERTIFY that Michael Newman, as General Manager of GHB-630 LLC, a Delaware limited liability company (the "Company"), personally known to me to be the same person whose name is subscribed to the foregoing instrument as such Michael Newman, appeared before me this day in person and acknowledged he/she signed and delivered said instrument as his/her free and voluntary act, and as the free and voluntary act of said Company, for the uses and purposes therein set forth.

GIVEN UNDER my hand and Notarial Seal this 10th day of DECEMBER, 2009.


Notary Public: ADAM LONG

07/10/2013
Commission Expiration:



Exhibit A to Special Warranty Deed

Legal Description

All of Lots 5 and 12 and that part of Lot 4 lying West of the West line of McClurg Court and that part of Lot 13 lying West of the West line of McClurg Court in Circuit Court Partition of Ogden Estate Subdivision of parts of Blocks 20, 31 and 32 in Kinzie's Addition to Chicago in Section 10, Township 39 North, Range 14, East of the Third Principal Meridian, in Cook County, Illinois.

TAX PIN 17-10-204-006

Exhibit B to Special Warranty Deed

Permitted Exceptions

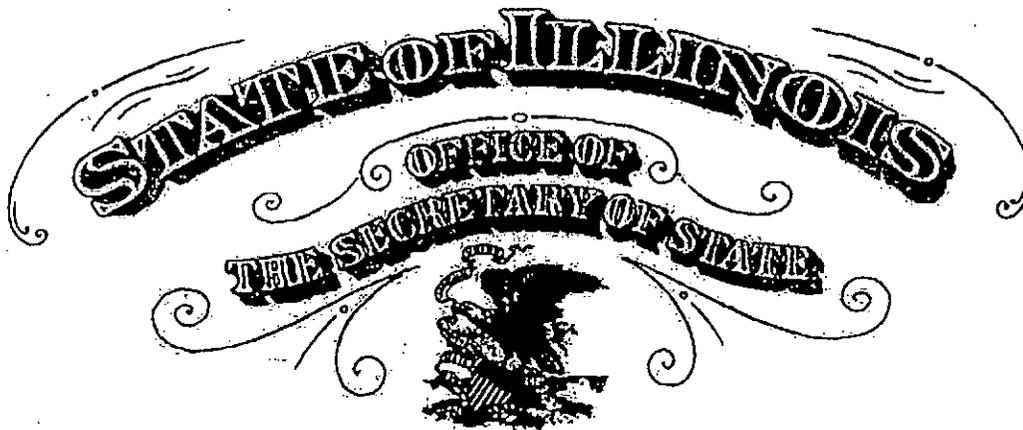
1. Real estate taxes for calendar year 2009, a lien not due and payable.
2. Matters arising due to acts done or suffered by or through Grantee.

CENTRAL31291148J

B-1

ATTACHMENT 2

File Number 3272-594-5



To all to whom these Presents Shall Come, Greeting:

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

REHABILITATION INSTITUTE OF CHICAGO, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON SEPTEMBER 05, 1951, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1130702358

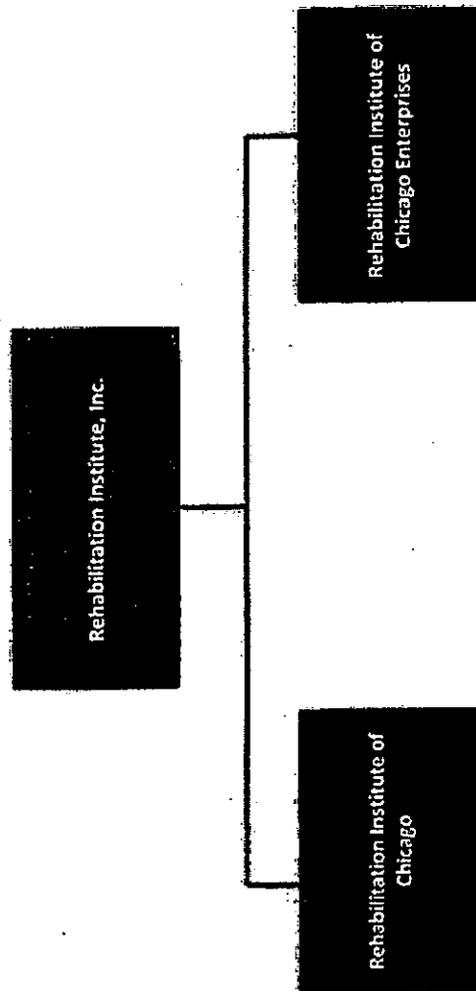
Authenticate at: <http://www.cyberdriveillinois.com>

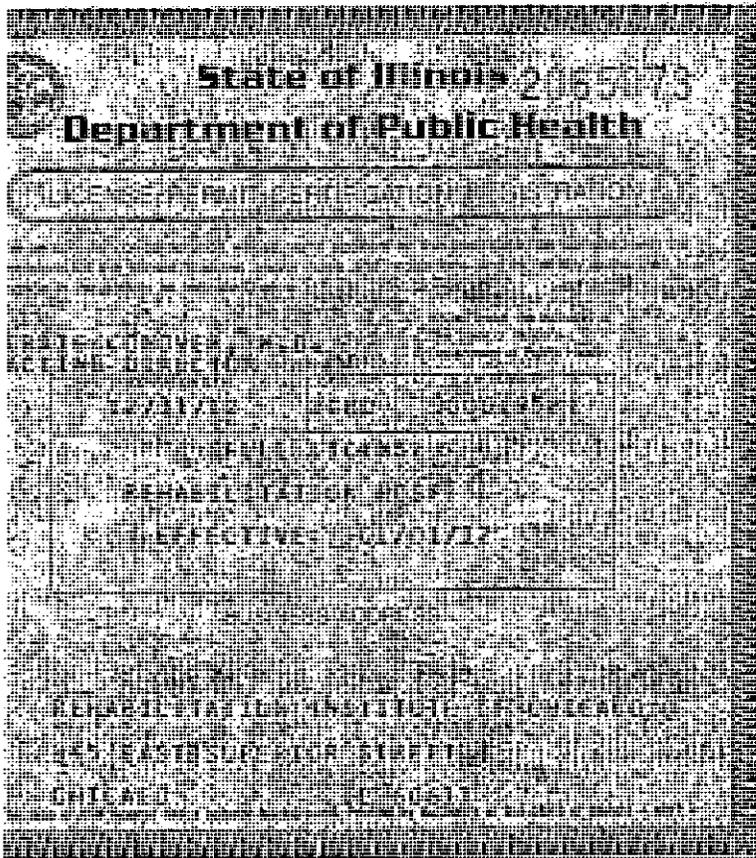
In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 3RD day of NOVEMBER A.D. 2011

Jesse White

SECRETARY OF STATE

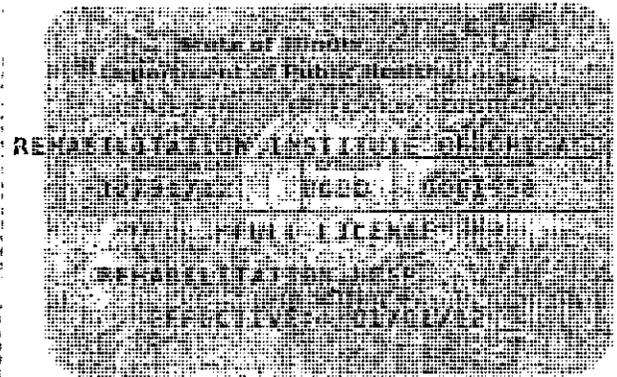
Rehabilitation Institute of Chicago Legal Structure





← DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION



11/08/11
REHABILITATION INSTITUTE OF CHICAGO
345 EAST SUPERIOR STREET
CHICAGO IL 60611

FEE RECEIPT NO.



October 21, 2011

Joanne C. Smith, MD, MBA
President and Chief Executive Officer
Rehabilitation Institute of Chicago
345 East Superior Street
Chicago, IL 60611

Joint Commission ID #: 7299
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of
Standards Compliance
Accreditation Activity Completed: 10/14/2011

Dear Dr. Smith:

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 July 30, 2011. 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,

Ann Scott Blouin RN, PhD

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

ATTACHMENT 4



Rehabilitation Institute *of* Chicago

Nancy E. Paridy, J.D., LL.M.
Senior Vice President, General Counsel
& Government Affairs / Corporate Secretary

345 East Superior Street
Chicago, Illinois 60611-2654
312-238-6208 telephone
312-238-7554 fax
nparidy@ric.org

December 21, 2011

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

RE: Illinois Historic Resources Preservation Act (IHRP)

Dear Ms. Avery:

This letter is submitted, following consultation with agency staff, to certify that this project, which seeks permission to expend dollars in excess of the capital threshold, will have no impact on historic resources since it is for planning purposes only. It will not involve (1) the demolition of any structure; (2) the construction of any new building; or (3) the modernization of existing buildings.

Very truly yours,

A handwritten signature in cursive script that reads "Nancy E. Paridy".

Nancy E. Paridy, J.D., LL.M.
Senior Vice President, General Counsel
& Government Affairs

NEP/jh

37

Attachment 6

Cost Space Requirements*

Dept. / Area	Cost	Departmental Gross Square Feet		Amount of Proposed Total Gross Square Feet that is:			
		Existing	Proposed	New Construction	Modernized	As Is	Vacated Space
REVIEWABLE							
Rehabilitation			383,283	383,283	0	0	
Research Clinical inc Rehabilitation Therapy			27,711	27,711	0	0	
Radiology			15,653	15,653	0	0	
Pharmacy			4,596	4,596	0	0	
Acute Dialysis			1,658	1,658	0	0	
Lab			3,751	3,751	0	0	
Total Clinical			436,651	436,651			
NON REVIEWABLE							
Administrative			138,468	138,468	0	0	
Retail			1,116	1,116	0	0	
Research Support			61,363	61,363	0	0	
Facilities			20,760	20,760	0	0	
Dietry			21,620	21,620	0	0	
Lobby			10,002	10,002	0	0	
Total Non-Clinical			253,329	253,329			
TOTAL			689,979	689,979			

*Estimates as of December 19, 2011

BACKGROUND OF APPLICANT

1. List of healthcare facilities owned or operated by the applicant, including licensing, and certification if applicable.

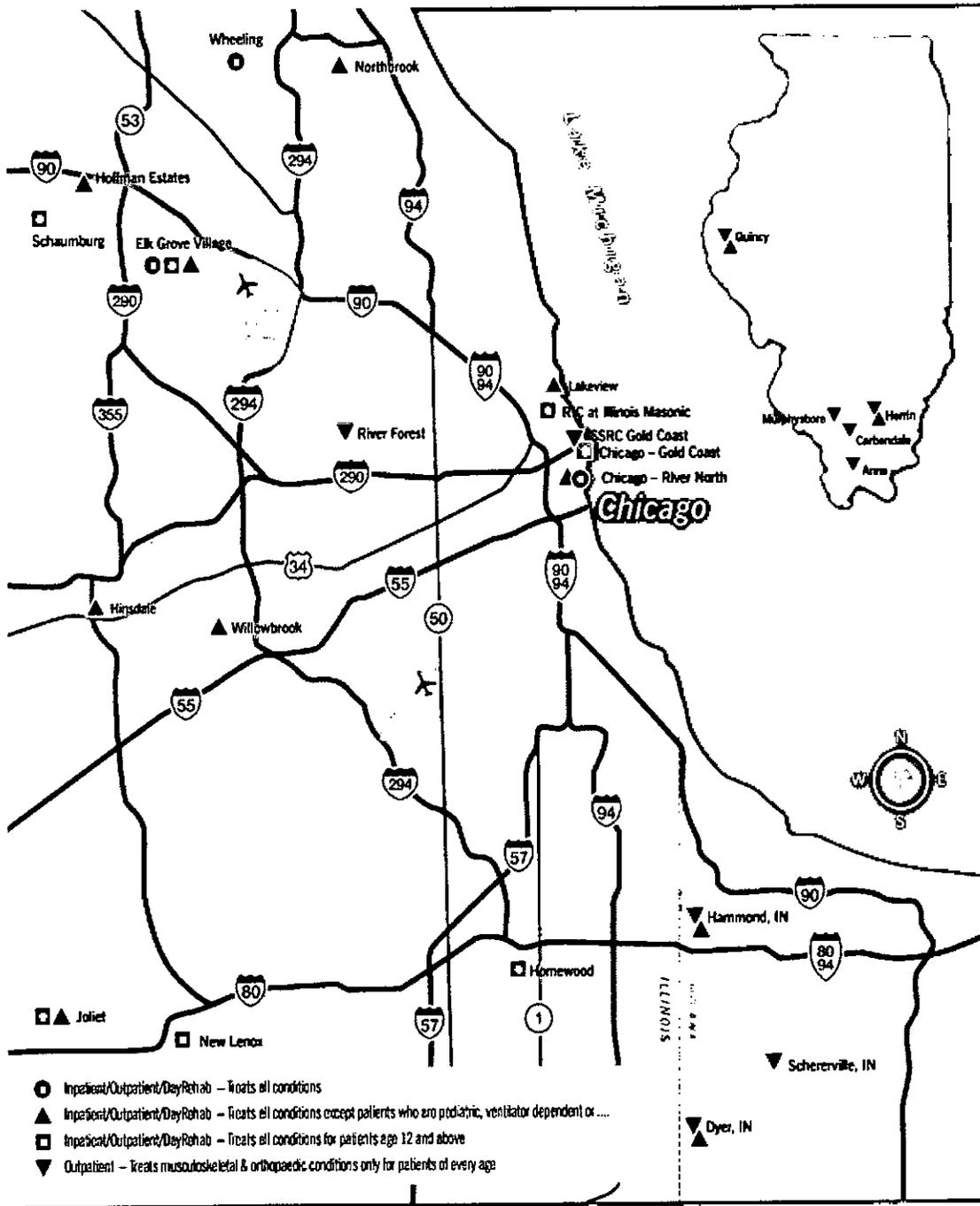
This healthcare facility owned and operated by applicant is RIC, located at 345 East Superior, Chicago, IL 60611. Attached hereto and made a part hereof is RIC's Hospital License and the Joint Commission Accreditation. See below a list of all other facilities owned and solely operated by RIC; these facilities are outpatient or day rehabilitation programs that do not require a specific licensure or accreditation.

- a. The primary location for the provision of services is RIC's existing flagship hospital located at 345 East Superior Street in Chicago. The project will replace the existing facility and create a new, expanded and modernized facility two blocks from the current location. Through the new facility, RIC will provide better access to patients and provide its unique healthcare services to a growing number of aging residents of Chicagoland, as well as a growing number of patients from across the country and the world. RIC will deliver care in a modern facility which will improve health outcomes as well as patient safety. RIC will be the scientific center for advancing human ability, leading a healthcare revolution. Effective January 2, 2012, the facility has 182 licensed comprehensive rehabilitation beds.
- b. Northbrook (755 Skokie Boulevard, Northbrook, IL 60062)
- c. Willowbrook (6705 Kingery Highway, Willowbrook, IL 60527)
- d. River Forest (420 Thatcher Avenue, River Forest, IL 60305)
- e. Spine and Sports Rehabilitation Center (1030 N. Clark Street, Chicago, IL 60610)
- f. Center for Pain Management (980 N. Michigan Avenue Suite 800, Chicago, IL 60611)
- g. River North (307 W. Grand Avenue, Chicago, IL 60610)
- h. Ravenswood (1945 W. Wilson Avenue Suite 100, Chicago, IL 60640)
- i. Wheeling (5150 Capitol Drive, Wheeling, IL 60090)
- j. Homewood (1055 W. 175th Street Suite 101, Homewood, IL 60430)
- k. Elk Grove Village (800 Biesterfield Road, Eberle Medical Office Building, Suite 635, Elk Grove Village, IL 60007)
- l. Southern Illinois (317 S. 14th Street Suite 3, Herrin, IL 62948)

m. Helen M. Galvin Health and Fitness Center (710 N. Lake Shore Drive, 3rd Floor,
Chicago, IL 60611)

2. The attached map identifies these locations.
3. There are no adverse action(s) taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application. See attached letter.
4. Authorization requirement : See letter attached from Nancy E. Paridy, Senior Vice President, General Counsel & Government Affairs.
5. Not applicable.

RIC Sites of Care





Rehabilitation Institute of Chicago

January 9, 2012

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

Nancy E. Paridy, J.D., LL.M.
Senior Vice President, General Counsel
& Government Affairs / Corporate Secretary

345 East Superior Street
Chicago, Illinois 60611-2654
312-238-6208 telephone
312-238-7554 fax
nparidy@ric.org

Dear Ms. Avery:

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

1. The Rehabilitation Institute of Chicago (RIC) does not have any adverse actions against any facility owned and operated by the applicant during the three (3) year period prior to the filing of this application, and
2. RIC authorizes the State Board and Agency access to information to verify documentation or information submitted in response to the requirements of Review Criterion 1110.230.b or to obtain any documentation or information which the State Board or Agency finds pertinent to this application.

If we can in any way provide assistance to your staff regarding these assurances or any other issue relative to this application, please do not hesitate to call me.

Very truly yours,

Nancy E. Paridy, J.D., LL.M.
Senior Vice President, General Counsel
& Government Affairs

State of Illinois)
) SS:
County of Cook)

On this, the 9th day of January, 2012, before me a notary public, the undersigned officer, personally appeared Nancy E. Paridy, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that she executed the same for the purposes therein contained.

In witness hereof, I hereunto set my hand and official seal.

Notary Public



NEP/jh

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ATTACHMENT 11

PURPOSE OF THE 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.**

Preeminence of RIC as a Leader in Physical Medicine and Rehabilitation Care, Research, and Education

RIC was founded in 1954 by Dr. Paul Magnuson, former Medical Director of the Veterans' Administration. Dr. Magnuson was passionate about proper treatment for people with disabilities as a result of his experience in World War II. He established RIC to bring forth post-acute, life-enabling care for military heroes and civilians alike. Since that time, RIC has been a pioneer in providing cutting edge rehabilitation care while maintaining a leadership position in rendering care for patients who have suffered catastrophic injuries such as stroke, brain injury, spinal cord injury or as well as patients struggling with orthopedic conditions, arthritis, chronic pain, Alzheimer's, Parkinson's, cancer and many other debilitating conditions.

Today, RIC is widely recognized as the premier rehabilitation provider in the country, and arguably in the world. RIC enjoys the unique position of being rated the #1 Physical Medicine and Rehabilitation Hospital in the nation by *US News and World Report* for 21 consecutive years. (See chart below.) In 2010, for the first time, RIC earned the highest percent favorable rating among all specialties, including cardiology, neurology, orthopedics, cancer and pediatrics. In addition, RIC has the largest margin between its top ranking and the hospital that was ranked second among all specialty hospitals.

**US News and World Report
Best Hospitals Ranking
(Select Provider Ranking by Percentage of Votes)**

Provider	City, State	2007	2008	2009	2010	2011
Rehabilitation Institute of Chicago	Chicago, IL	65%	68%	68%	65%	82%
Kessler Institute for Rehabilitation	West Orange, NJ	35%	36%	41%	40%	49%
University of Washington Medical Center	Seattle, WA	34%	37%	37%	34%	42%
Mayo Clinic	Rochester, MN	24%	24%	24%	23%	33%
TIRR Memorial Herman	Houston, TX	29%	31%	30%	24%	36%
Spaulding Rehabilitation Hospital	Boston, MA	11%	11%	19%	24%	37%
Craig Hospital	Englewood, CO	16%	17%	16%	17%	24%
Gap Between RIC and # 2 Facility		30%	32%	27%	25%	33%

Note: The percentage shown represents the percent of physicians who named a hospital as one of the top five providers in the publication's annual survey.

It is noteworthy to consider RIC's peer group of rehabilitation organizations shown above are not located in Illinois, but are regional and national leaders, including organizations that are part of

large, prestigious academic medical centers such as TIRR Memorial Herman (Memorial Herman Healthcare System) and Spaulding Rehabilitation Hospital (part of Harvard System). In many ways, even these regional and national leaders are not at RIC's level when measured by ranking of clinical care (as shown above) and rehabilitation research (as will be described below). RIC can be better compared to top national academic health centers such as Johns Hopkins in Baltimore, Maryland, which is the only other hospital of any kind to hold the #1 Best Hospitals ranking for as long as RIC.

In addition to world-class patient care, a significant driver of RIC's success is the strength of its research. With \$75 million in single and multi-year grants and an annual operating budget of over \$20 million, RIC is the largest rehabilitation research organization in the world. In fact, RIC has received substantially more funding from the National Institutes of Health than any other rehabilitation provider in the world. Over 200 researchers and 30 principal investigators conduct research at RIC, as well as through collaborations with local academic partners at Northwestern University, University of Chicago and University of Illinois Chicago, as well as international partners in Canada, Korea, China, Switzerland and other countries across the globe. Some of the world's most innovative and groundbreaking research has come from RIC's laboratories, including the world's first bionic arm, initially developed in 2002 and recently showcased on global forum TED GLOBAL¹ which hosted RIC's own Dr. Todd Kuiken, MD, PhD describing the latest advancement in prosthetics.

Most notably, RIC holds seven (7) federal research designations, more than any other specialty hospital in the nation. Federal research designations represent multi-year, multi-million dollar grants to serve as recognized centers in the following areas:

- Spinal Cord Injury Model System
- Brain Injury Model System
- Stroke Rehabilitation Research and Training Center¹
- Rehabilitation Outcomes and Research Training Center¹
- Rehabilitation Engineering Research Center
- Neurological Rehabilitation – Bionic Medicine
- Technologies for Children with Orthopedic Disabilities

¹ RIC is the only hospital in the country to hold this designation

By comparison to other top rehabilitation providers, RIC again far surpasses its peer group. The most designations any other rehabilitation hospital including those on the *US News and World Report's* Best Hospitals ranking holds is two (2) similar designations. This is another demonstration of RIC's unique expertise and strengths.

¹ TED GLOBAL is an international conference where innovative leaders from around the world share projects, designs and ideas as part of the well-known TED Series of conferences. TED began as a forum to share "ideas worth spreading" and has grown to be one of the most sought-after forums for innovators, thinkers and doers.

RIC's research is patient-centered, meaning that researchers work directly with patient subjects, applying engineering and technology solutions to real patient problems. RIC's research draws heavily on its own patient populations, especially those with neurologic disorders. Patient examples below demonstrate the real impact RIC's research has on patients.

One 8-year old child with advanced cerebral palsy was unable to walk more than a few steps, in spite of intensive standard physical therapy. She was given a trial of intensive training with a pediatric Lokomat®, a robotic gait trainer that drives the legs in a prescribed movement pattern as the patient is suspended above a treadmill. To enable continued training, her family moved from the west coast to Illinois, to allow more prolonged and effective therapy with the Lokomat®. She is now able to walk independently for long distances.

A 27-year-old U.S. Marine Sergeant was injured in a motorcycle accident, losing her left arm as a result. RIC and the surgical staff at Northwestern Memorial Hospital provided her with an innovative Targeted Muscle Reinnervation (TMR) procedure, which was pioneered by RIC under the leadership of Todd Kuiken, MD, PhD. The TMR procedure is a surgical technique involving the transfer of an amputee's residual arm nerves to *target* muscles in the chest. After transfer, the arm nerves grow into, or *reinnervate*, the target muscles, which then contract in response to nerve signals generated by attempted movement of missing limb. When muscle reinnervation was complete, recordings from these chest muscles provided clinicians with access to a full array of command signals to control an advanced arm prosthesis, in which many motors need to be controlled separately. Now, she can perform arm movements involving many joints simultaneously, providing smooth, precise and more intuitive and natural movements. She may soon be able to return to active service.

In addition to its highly rated clinical excellence and leading research, RIC also operates the largest medical education program in Physical Medicine and Rehabilitation in the country. RIC's medical education is provided in conjunction with the Department of Physical Medicine and Rehabilitation at Northwestern University's Feinberg School of Medicine. Education is comprised of RIC's prestigious residency program, medical student training, physician fellowships, internships for rehabilitation professionals (e.g., physical and occupational therapy, speech language pathology, nursing) as well as a wide-range of continuing education courses for rehabilitation professionals.

RIC's residency program is one of the most sought-after programs in the country, with 40 residents and accredited fellows each year. The program has trained leaders in rehabilitation medicine who have graduated to become medical directors and industry leaders across the country. RIC's medical student education provides training and elective rotations for Northwestern University's medical students including clerkships and summer externship programs. RIC's Fellowship program offers specialized training each year to a select number of fellows seeking to become expert and outstanding physicians in their subspecialty areas, teaching them the necessary tools to conduct research in the area and become leaders in the field of psychiatry. RIC is unsurpassed in the clinical services it offers, its research programs and as an educational institution.

At the same time that RIC is investing in the future of physical rehabilitation medicine, research and education, it is also fulfilling its broader commitment to our community. As RIC's 2010 Community Benefit Report details, hospital's contributions included \$600,000 in charity care; \$3.8 million in unreimbursed Medicaid and Medicare costs; \$5.8 million in unreimbursed costs attributable to medical education; \$4.6 million in research costs; and \$2.1 million in support for a wide range of programs that directly impact patients. These include Wirtz Sports Program, the Vocational Rehabilitation Program, and the Life Center. This later initiative provides education and a range of resources to patients and families after discharge, and its website is among the top sites selected globally by people seeking information on rehabilitation medicine.

RIC's Current Physical Plant

In 1974, twenty years after its founding, RIC built the world's first freestanding rehabilitation hospital. The hospital was the first of its kind in that it brought together the continuum of physical rehabilitation care under one roof, dedicated singularly to the treatment of disabled patients. That building continues today as RIC's Flagship Hospital, located at 345 East Superior Street in Chicago.

Many changes and enhancements over the past 37 years have helped maintain an adequate infrastructure for patient care and, to a lesser extent, research. However, the facility no longer meets RIC's needs for current patient care or research space and is significantly lacking in meeting RIC's future space needs. It is not designed to facilitate the integral interactions between clinicians and researchers which ultimately drive innovations and care processes. Further, there is little space for incorporating best practice clinical care standards such as private medication rooms and universal access in all bathrooms.

RIC is not able to satisfy the current demand for our services within the facility, much less any future demand for patients. As of January 1, 2012, RIC operated regularly at 90% occupancy, despite only having 45 private rooms. Moreover, in the last fiscal year 2011, RIC was operating at 90% occupancy or greater 3 out of every 4 days, and 95% or greater 1 out of every 5 days. This data is set forth in the chart that appears later in this attachment. Consistently operating at such high occupancy levels within the current bed configuration requires significant movement of patients which increases operating costs and decreases patient satisfaction.

Physical Constraints and Layout

- When the facility was constructed, the state-of-the-practice in rehabilitation was to create semi-private rooms to promote patient socialization and camaraderie. In fact, RIC had 3- and 4-bed "wards" in many rooms. As a result, RIC's current 182 beds are housed within 122 rooms, representing only 62 private rooms and 60 semi-private rooms. Today's clinical standards are significantly different – requiring much more sophistication in infection control monitoring and management of patient bed placement. Moreover, patients today expect to stay in private rooms where they can avoid unnecessary disruptions and where loved ones can stay with them overnight. Instead, RIC patients are

forced to manage relationships with “roommates” – many times more than one during the course of their 3 to 4 week recovery at RIC. RIC staff must address these challenges of coordinating room assignments based not just on infection control, but patient condition, gender and personality. The result is significant inefficiency in the movement of patients between rooms and the corresponding impact on patient satisfaction. Despite these significant space constraints, RIC has been operating at near capacity (90% or higher) for the last five years and the existing facility can no longer meet the demand for beds.

- Due to the need to add beds over the years, RIC has moved many functions out of the hospital building. Most notably, critical specialty outpatient services have been moved to other locations in Chicago. In addition, research and administrative office space has moved to rental space in the Streeterville area. Given the significant need for collaboration and proximity in medical research, particularly in RIC’s applied research paradigm, this separation of services has been detrimental to fostering sharing of ideas and has been disruptive to patients’ care continuum.
- The current facility has an 18,000 sq. ft. footprint, designed as a rectangle with narrow corridors and two center cores that comprise up to 30% of the footprint. This “racetrack” configuration, while reflecting best practices in hospital design in the 1970s, forces many functions to be squeezed into spaces that are not adequate for today’s demands. Specifically, basic storage space for equipment and minimal closet space for patient needs are lacking. While the use of advanced equipment and technology has become essential for therapy, it has increased the need for space within the facilities. Basic assistance devices, like wheelchairs, have further increased the need for space. In fact, in order to accommodate larger patients, wheelchairs and other assistive devices are now customized and take up even more room within the facility. The existing layout and design does not allow for alcoves and proper storage space for equipment and supplies.
- All of RIC’s inpatients arrive via medical ambulance after being transferred from an acute care hospital. The current drop-off area is at the lobby level and in direct public view/access. While every effort is made to take patients directly to the patient unit, this configuration is unacceptable for patient privacy and, at best, uncomfortable for public/visitor access to the building.
- The inpatient units in RIC’s existing facility lacks space for a myriad of functions that have become standard practice in newer facilities. The functions include patient/family support space, dedicated medication rooms, universally accessible bathrooms in every patient room, pressurized air in every patient room, and separate bathrooms for clinical staff. While none of these functions are required to provide outstanding clinical care, their absence represents a challenge to efficiently and effectively treating patients and caring for the well-being of families and staff. As an example, patients stay at RIC on average over 20 days, significantly longer than a typical acute care stay, requiring families and caregivers to disrupt their lives for an extended time. The lack of family

support space and few private rooms means that families spend significant time within the crowded and often stressful inpatient environment with few options for “getting away” or tending to personal or business needs. Family members must leave the floor to find free space, often in the cafeteria, which represents other privacy challenges. Similarly, the lack of dedicated medication room is a challenge for nursing staff to ensure proper and accurate medical administration. As a potential for medical errors, the absence of a medication room is a significant limitation of the existing building’s footprint.

- Other building limitations includes single pane windows and lack of insulation on the exterior walls which create very difficult heating/cooler issues to address during Chicago’s extreme seasons and increases operating costs. The building’s single elevator system is not adequate for separation of transporting trash from patients, and visitors.
- Finally, as the design team has confirmed, RIC’s existing room sizes are not designed to contemporary standards. Kurt Salmon Associates (KSA) is the national leader in hospital facility planning and has consulted with most hospitals across the country, including such local hospitals as Northwestern Memorial Hospital, University of Chicago, Rush University Medical Center and Lurie Children’s Hospital of Chicago. KSA performed due diligence on RIC’s space program and concluded that only one of RIC’s six inpatient floors even approached minimum standards. The standards are based on industry accepted practice for the minimum amount of space required on an inpatient unit to safely and comfortably provide patient care and all necessary support (nursing care, therapy, documentation, etc.). The table below shows RIC’s current inpatient floors against KSA’s minimum recommended standard.

**RIC Flagship Hospital
Departmental Gross Square Foot (DGSF) per Bed**

Inpatient Floor	Number of Beds	DGSF per Bed
10	20	750
9	24	625
8	27	556
7	28	536
6	28	536
5	23	652
4	33	455

KSA’s minimum recommended standard is 750 DGSF.

Infrastructure

- The existing hospital was designed during a period when patients did not require the high-intensity and complexity of services that are required today. Some of the infrastructure needs to accommodate upgrades have been cost prohibitive and therefore only selectively completed. The patient rooms do not all have oxygen, and few are designed for ventilator patients. The hospital's bed management staff needs to keep strict account of proper medical gas needs for every patient, and must engage in a daily room assignment process to make sure that a room is properly equipped for an individual patient.
- Ceiling heights in the facility are standard office building distances and these dimensions have constrained our clinicians. Harnesses and other bulky equipment are used in clinical therapies and they must "work around" the limitations of the hospital's design. Many research areas have "carve out" areas in ceilings as are necessary for proper function of equipment. However the lack of flexibility creates challenges for research and clinical collaboration.

Long-Term Ownership

- Another significant limitation of our current facility is that while RIC owns the hospital building, it does not own the land under the building. In order to build the Flagship Hospital, RIC entered into a 99 year lease with Northwestern University beginning on January 1, 1971 and ending December 31, 2069. Without ownership of the land, the existing facility will never be a sufficient long-term solution for RIC. In addition, Northwestern University has declared a need for the land under the hospital and would not only let the lease expire without renewal, it may want use of the site before the termination date.

In summary, the current facility does not allow for sufficient and necessary expansion, and will be prohibitively costly to renovate to future standards.

RIC's Role in the Future of Rehabilitation Medicine

Historically, rehabilitation care has been a collaborative process involving clinicians – including physician, nursing and allied health professionals – working together to help patients after they have been through a disabling accident or illness, or suffer from a congenital disability. The rehabilitation process is traditionally one of amelioration, compensation and adaptation. Professionals use increasingly sophisticated devices and therapeutic techniques to adapt individuals' physical activities, their environments and their expectations. As a result, rehabilitation has been focused on improving a patient's function in order to compensate for their lost ability.

While the rehabilitation process continues, new clinical opportunities are presenting exciting prospects for patients. The promises of cutting-edge medical science – and the growing expectations of patients – are driving scientists and collaborating clinicians to push the boundaries of what is possible. Medical advances are being discovered that could not even be imagined years ago. Advances in stem cell therapies, “smart” devices, nanotechnology, and pharmacology are leading to breakthroughs in medicine that will enable patients to restore lost ability, not just compensate for it.

In the past, patients, doctors and families credited miracles when patients of catastrophic injuries showed any improvement. Today, RIC has the tools, technology and talent to make those miracles occur every day, as a result of established clinical protocol. Impossible is no longer part of the medical lexicon used at RIC.

Rehabilitation at RIC is now about recovery, regeneration, and renewal of function. RIC is working -- not just to compensate for disabilities -- but to eliminate their effects. In the near future, rehabilitative clinicians will be able to speak, for the first time, of *cures*. The opportunity to harness tomorrow’s technological, scientific and medical advances with world-class rehabilitation medicine and research is significant for patients and for the medical community, but it is not futuristic. RIC has repeatedly created groundbreaking solutions, from the world’s first sip-and-puff control system for motorized wheelchairs in 1972 to world’s first bionic arm – developed at RIC and showcased in medical journals and global conferences. Attached are several articles from national and local sources that feature RIC’s leadership in innovative therapies, such as thought-controlled prosthetics for amputees. RIC’s future will be based on even further integration of research and clinical care to create new breakthroughs. For patients served by RIC, the cornerstone of the future in rehabilitation medicine is the new Research Hospital proposed in this application.

RIC’s New Care Paradigm

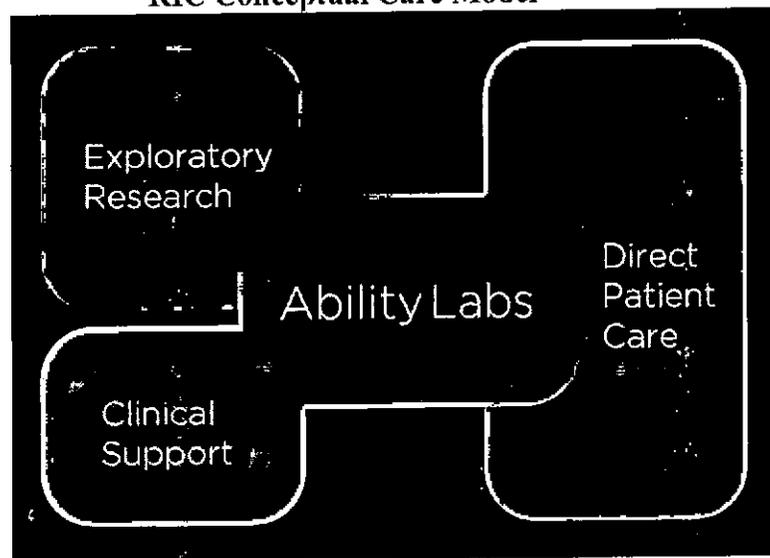
Today, RIC is already moving into the future where breakthroughs occur every day. RIC’s approach to care delivery has integrated innovative changes and is continually evolving. That approach fuses live medical research and clinical care, surrounding the patient within the hospital setting. RIC’s new Research Hospital will be an inspiring, state-of-the-art environment with the most advanced technology and tools where clinicians and researchers will collaborate live, assessing patient needs and developing solutions to solve patient problems better and faster. This radical new design of rehabilitation will enable RIC to create new possibilities for patient recovery. As RIC has been designing this new care model and physical environment, the planning team has included national leadership in facility design planning and construction. (See attached firm descriptions.)

The core design element of RIC’s new Research Hospital will be the physical integration of all of its human-subject and applied research activities surrounding each and every patient. RIC is currently testing new designs that enable the embedding of research and patient care activities, real time, 24/7/365. The result of current tests will be incorporated into the new Research Hospital.

Within the proposed new hospital, RIC's future Patient Recovery Units will be comprised of an active multi-disciplinary team of healthcare professionals. Physicians, therapists, nurses, researchers, engineers, and other specialists will be assigned to a patient upon admission and continuously work with those patients every day. In addition, family members are often part of the care process and frequently spend important daytime and overnight time with their family/loved ones. The activity in and around the Patient Recovery Unit will promote and inspire ability – from design elements like natural light and efficient floor plans to technological advancements with active and passive measurements to track patients' progress. Patients, researchers and clinicians will interact in ways never before conceived in a hospital setting.

A central element of the Patient Recovery Unit is the Ability Lab™ which represents the hub of patient activity on the Unit. The Ability Lab™ is where the majority of day-time activities take place, such as traditional patient therapies as well as applied research activities. It will be designed as an integrated space of therapy and research, where doctors, scientists, and therapists will work together to treat patients and conduct research. It will include a combination of equipment, smart devices and cutting-edge technology that will represent not only current best practice rehabilitation care but also new and innovative practices that hold promise for future methods of advancing patient ability. Clinical and research staff will move through this space together and through their activities create mutual motivation and learning. The Ability Lab™ will represent the bridge between research and direct patient care where solutions to real patient problems will be solved better and faster than anywhere else. The conceptual care model below visually displays the Ability Lab™ concept.

RIC Conceptual Care Model



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

Unlike most inpatient rehabilitation providers, RIC has a national and international market area, in addition to its local market. Most other rehabilitation providers capture patients from a local and multi-county area; patients typically travel no more than 30 miles. For RIC, patients travel across the country, and from countries around the world. In addition, RIC has significantly larger percentage of patients from out of state when compared to other top rehabilitation hospitals. The table below shows the percent of patients from out of state for RIC vs. the four other largest inpatient rehabilitation hospitals in Illinois. RIC's 10% out-of-state population is comparable to other specialty hospitals such as Mayo Clinic, Children's Hospital of Philadelphia, and MD Anderson.

Inpatient Rehabilitation
Percent of Patients Out of State
CY 2010

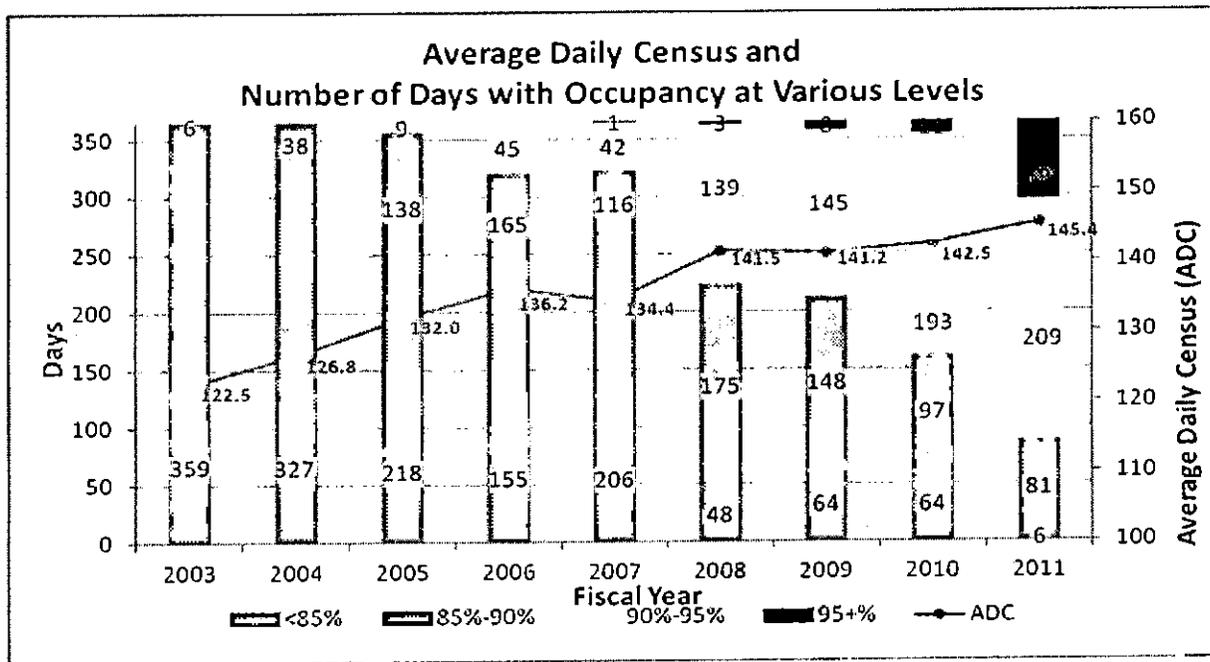
	% of patients Outside Illinois
RIC	10.1%
Rehabilitation Hospital 1	2.3%
Rehabilitation Hospital 2	2.0%
Rehabilitation Hospital 3	0.6%

Source: IHA CompData, CY2010

RIC's global reach and wide local service area make comparisons difficult. For this application however, RIC has calculated a Primary Service Area (PSA) and Secondary Service Area (SSA) for inpatient services using metrics comparable to other providers. Approximately 66% of RIC's inpatients come from Cook County, IL, and is therefore considered the PSA. Another 18% come from the SSA which includes the counties of DuPage, Will, Lake, Kankakee, McHenry, Kane and DeKalb. The remaining 15% of inpatients come from outside the PSA and SSA, which includes patients from 24 states and 18 countries. Of note, when including RIC's outpatient services, the hospital treated patients from 49 states and 43 countries during calendar year 2010.

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

RIC has been operating above optimal 85% occupancy in its existing facility since September, 2007 (which began RIC's 2008 fiscal year. RIC's fiscal year runs from September 1 through August 31). Prior to January 2, 2012, RIC operated 165 inpatient rehabilitation beds², although six (6) of those beds were part of triple-room configurations and were used only when absolutely necessary and for patients who could be safely cohorted such as very young pediatric patients. The majority of RIC's remaining 159 beds were in semi-private rooms, with only 45 rooms having private accommodations. Despite this limitation in capacity, RIC has maintained a census above 90% for the majority of days during the past two fiscal years (see Occupancy Table below).



As noted above, RIC serves patients from the Chicagoland area, which is defined by Cook County and the seven contiguous collar counties (DeKalb, DuPage, Kane, Kankakee, Lake, McHenry and Will). This represents the third largest metropolitan area in the country with over 8 million people. The population has been aging as reported by the US Census data, and is projected to continue to age for the foreseeable future. This dense, populous and aging metropolitan area has contributed to the need for the rehabilitation services that are the focus of RIC's clinical work. These issues are attributable to both accidents (e.g. Brain Injury, Spinal Cord Injury) as well as effects of aging (stroke, and orthopedic conditions such as arthritis).

² Effective, January 3, 2012, RIC increased its licensed bed capacity to 182. As a result, there are now 62 rooms having private accommodations.

The table below lists the top 8 patient conditions in addition to all pediatric patients that RIC treated on an inpatient setting in fiscal year 2011. This list represents 81% of the patient volume during the year.

Condition	Number of Patients – Fiscal Year 2011
Orthopedic (including fractures and replacement of joints)	429
Brain Injury (including Traumatic and Non-Traumatic)	331
Stroke	377
Spinal Cord Injury	322
Cancer	102
Neurological Conditions (including Parkinsons and Alzheimers)	169
Amputee	74
Transplant	47
Pediatrics (all conditions)	271
Total	2,122

For all of the conditions RIC treats, patients require extensive rehabilitation services to restore the loss of function suffered as a result of an accident/injury/event. As an example, stroke represents the leading cause of disability in the United States. It is estimated that 795,000 new strokes occur each year in the United States, with the majority occurring in people of older ages. The effects of stroke are numerous and depend on the extent of the damage as well as the specific parts of the brain that are impacted. Stroke patients may suffer from mobility issues due to full or partial paralysis, cognitive impairments which may impact judgment and memory, communication difficulty and a wide range of other issues that prevents a person from successfully navigating participating in their daily lives.

RIC's comprehensive services address all of patient issues for stroke as well as the other conditions noted above. For stroke patients, RIC's Stroke Neurorehabilitation and Recovery Program treats patients with a full team of rehabilitation experts whose goal is to help patients restore function and recover their abilities. As the only designated Stroke Rehabilitation Research and Training Center, RIC has the resources to provide patients with the best possible opportunity for recovery through the most advanced technologies, rehabilitation methods and clinical trials. The RIC team of clinicians is led by a physiatrist – a physician specializing in physical medicine and rehabilitation – and includes physical, occupational and speech therapists, as well as rehabilitation nurses, social workers, psychologists, dieticians, recreation therapists and others as needed. As RIC's care model evolves, researchers are becoming part of the care team as well, identifying research opportunities for the patient and keeping the clinical staff informed of the latest literature and techniques for treating complex conditions. The team creates a customized plan for each patient that includes comprehensive and rigorous therapy in

addition to assistive technology, custom-made braces and splints, seating and positioning-assistive devices, vocational rehabilitation and aquatic therapy.

In addition to RIC's Stroke Neurorehabilitation and Recovery Program, RIC has comprehensive clinical programs for all conditions that integrate research, clinical care, patient and family education, and additional (e.g., assistive technology, vocational rehabilitation) to treat patients and provide the best opportunity to advance each patient's ability. Other examples of RIC's more specialized programs are below:

Prime of Life Stroke

RIC has created a stroke recovery program specially designed for people whose multi-faceted and rigorous lives demand aggressive intervention. Often, those patients are younger and face greater demands, such as caring for a family, continuing a career or community involvement, engaging in an active social life and enjoying intimate relationships.

Like RIC's Stroke Neurorehabilitation and Recovery Program, the Prime of Life Program integrates the traditional therapies and specialized services noted above, with specific emphasis on tailoring activities to achieve patients life goals; vocational, family, recreational. RIC therapists utilize resources such as a kitchen, car, and bedroom that pose real-life challenges patients need to overcome. Experts in rehabilitation engineering and seating and positioning work with patients to make modification to equipment, wheelchairs and even home adaptations that patients will need to use to resume their daily activities and participate in their roles in life as parent, sibling, caregiver, and/or employee.

Important for patients in their prime of life, RIC also introduces all patients to the robust resources for patient and family education through the RIC Life Center (physical and virtual resource center for people with disabilities) and RIC's Galvin Health & Fitness Center for sports programs and exercise activities to maintain healthy lifestyle recovery from stroke.

RIC's stroke research is the largest in the country, and patients benefit from novel therapies not typically available elsewhere. These therapies may include Constraint-Induced Movement Therapy, Robot-Assisted Walking Therapy (Lokomat®), clinical drug therapy trials, and aphasia management. Stroke patients also benefit from the latest advancement in upper extremity/arm therapy through use of the Armeo®. The research behind this device was created by RIC clinicians, who saw a need for improved arm therapy. With the Armeo®, RIC patients conduct exercises using a virtual environment as built-in sensors and software record arm movements so that RIC clinicians can evaluate and track progress for patients.

Brain Injury

The brain contains approximately a hundred billion cells, with a hundred trillion connections among them. Injury and disease can damage the way brain cells function affecting memory, behavior, thinking, problem solving, physical abilities, judgment - even personality. Brain injury is a complex and challenging condition that impacts patients in unique ways. RIC's brain injury

rehabilitation and recovery program treats approximately 400 inpatients with traumatic and non-traumatic brain injuries each year. Also designated a Model System of Care by NIDRR, one of only 16 centers in the country, RIC's program leverages unique talents, resources and research available to RIC patients.

RIC clinicians utilize the brain's adaptive capacity -- known as neuroplasticity -- to reroute connections, relocate compromised areas of function and strengthen remaining connections to maximize ability and quality of life. Meanwhile, RIC researchers work on the newest developments, giving patients early access to cutting-edge treatments.

RIC's specialized team of brain injury experts -- with similar composition to other clinical program -- are seasoned staff who have seen many types of brain injury and therefore know that each is unique, with specific needs, capabilities and potential. Therefore, each patient's treatment is completely individualized and modified as recovery progresses. Together, the rehabilitation team, patient and family set appropriate goals and work together to achieve these goals. Similar to other specialized services noted above (Lokomat®, assistive technology, vocational rehabilitation). RIC's brain injury patients benefit from RIC's breadth and depth of services and capabilities.

Spinal Cord Injury

Spinal cord injury is a devastating event that affects over 10,000 new people each year in the United States. In a spinal cord injury, the pathway along which nerves transmit information between the brain and the rest of the body is severed or blocked. An injury to the spinal cord impairs movement and sensation, resulting in the inability for some people to walk or use their arms. Sometimes breathing, sexual function, and bowel and bladder control also may be affected. RIC's team of spinal cord injury experts treats over 300 inpatient spinal cord patients each year and has been designated a Model System of Care by the National Institute on Disability and Rehabilitation Research, one of only 14 centers in the nation with this distinction. As a result of the staff expertise and access to latest research, RIC has more experience treating patients and providing the best opportunities for recovery.

Similar to other RIC programs, the care team is led by a physiatrist and includes other specialists and researchers as needed to create a customized plan of care. RIC clinicians use state-of-the-art rehabilitation tools including body-weight supported treadmill training, robot-assisted walking therapy (Lokomat®) and aquatic therapy to treat patients. RIC researchers are working on new developments, giving patients early access to cutting-edge treatments.

Spinal cord injured patients also benefit from specialized services, which complement the core team in helping patients realize their full potential. These include diaphragmatic pacing, sexual dysfunction clinic, assistive technology center, therapeutic recreation, vocational rehabilitation, wheelchair and seating center and introduction and access to the Wirtz Sports Program where patients are able to participate in a wide variety of adaptive sports programs after discharge from RIC.

Since spinal cord injury affects the whole family, the RIC team provides support to everyone involved. Families are encouraged to participate in therapy and support groups. In addition, caregivers may participate in support groups, hands-on education for care at home and access to the LIFE Center, RIC's interactive library. RIC also helps connect patients and family members with resources in the local community for ongoing care, support and services.

In addition, RIC also offers its unique *Second Look Program* as a recheck for people who have sustained a spinal cord injury in the past. In this program, patients receive a comprehensive medical and rehabilitation review to ensure patients are receiving the latest and most advanced treatment and participating in appropriate research trials.

Pediatrics

RIC treats children of all ages, from birth through adolescence, and with any kind of disability. RIC treats over 200 pediatric inpatient rehabilitation patients each year, more than any other inpatient rehabilitation provider in Illinois.

The causes of pediatric disabilities vary and the best treatments are difficult to determine, requiring an experienced and highly-trained team of experts to care for the entire child. RIC's care team includes physicians, many of whom have dual specialties in both pediatrics and physical medicine and rehabilitation, as well as our physical therapists, occupational therapists, speech-language pathologists and nurses who work extensively with children and adolescents. Understanding the importance of social, emotional and developmental issues, the RIC team also includes a child psychologist, social worker and child life specialist.

During treatment, therapists use developmentally appropriate games, activities, sports and adaptive equipment to strengthen muscles, increase range of motion, and improve coordination, memory, attention span and daily living skills. RIC researchers are working on the newest developments in pediatric rehabilitation, giving patients early access to groundbreaking advances in treatment.

RIC's specialized programs are also geared toward children, including assistive technology, prosthetics and orthotics, and wheelchair seating and positioning. RIC is one of the few providers in country to offer robot-assisted walking therapy through the Pediatric Lokomat®.

Finally, family participation is essential to success, particularly for pediatric population. Family members provide vital insights to help develop an effective treatment plan and continue progress outside of the hospital. Parents and caregivers are involved in the decision-making and communications for each patient. In addition, family member education is designed to ensure patients are appropriately cared for after discharge from RIC.

Musculoskeletal Conditions

Tens of millions of people suffer from musculoskeletal conditions in the US. From low back pain, arthritis, sports and spine injuries, and chronic pain patients treated on an outpatient basis to

fractures and joint replacements treated on an inpatient basis, musculoskeletal conditions are among the fastest growing ailments. The aging population is contributing to the growth of conditions, while new technologies and pharmaceuticals are available to treat conditions safely and effectively.

RIC treats all patients with musculoskeletal conditions, the majority of which are treated on an outpatient-basis. However, RIC has a large population of inpatients, over 400 each year, which include multiple joint replacements, fractures and patients with severe arthritis and associated co-morbid conditions requiring an inpatient hospitalization.

RIC's multi-disciplinary team is again utilized to treat patients and assist them in managing the deteriorating effects of many chronic and arthritic conditions. Physiatrists work closely with rheumatologists, nurses and physical and occupational therapists who specialize in joint and muscle conditions. RIC's services are focused on returning patients to daily activities and take advantage of RIC's resources including aquatic therapy, prosthetics and orthotics, assistive technologies and various support groups. RIC research includes investigating the effects of pharmacologic agents and exercise protocols on patient recovery.

Cancer

RIC has treated cancer patients for over twenty years, but only in the past few years has the field of oncology realized the benefits of inpatient rehabilitation on patients' recovery and quality of life. As a result, while cancer has not traditionally been considered an inpatient rehabilitation condition, the number of cancer patients at RIC has been steadily increasing. Integrated with the Robert H. Lurie Comprehensive Cancer Center at Northwestern University, RIC's cancer program treats patients after treatment at the Lurie Cancer Center.

While medicine is making great strides in the fight against cancer, patients often experience debilitating fatigue, pain, joint stiffness, weakness, emotional strain and limited mobility. Other problems may include swallowing difficulty, poor nutrition, skin breakdown, bowel and bladder dysfunction, and lymphedema - a swelling condition.

RIC's Cancer Rehabilitation Program meets the challenges facing modern cancer fighters and survivors by coordinating physical medicine and rehabilitation interventions with acute oncologic care. By working collaboratively with the Lurie Cancer Center (and other cancer centers, including MD Anderson), RIC's programs ensures the continuity of care for patients and support for families. This innovative approach delivers rehabilitation during and after cancer treatment on either an inpatient or outpatient basis, depending on the patients' needs. The program is one of only a few in the country to work with patients during cancer treatment, coordinating rehabilitation around chemotherapy cycles, radiation treatments and surgery. All of RIC's care is grounded in the most current scientific and clinical evidence. In addition, RIC continues to be engaged in clinical studies on cancer rehabilitation and provides access to the latest advances to restore patient ability.

A discussion of our specialized programs would be incomplete without reference to the patients who have used these therapies and whose lives have improved as a result. We have attached, at the end of this attachment, a few of those patients' stories. They include:

- Regena Guinhawa, who was unable to control her shaking and came to RIC after tremors effectively ruined her ability to enjoy life. Assisted by RIC's clinical team, Ms. Guinhawa's Parkinson's disease was aggressively treated and she was able to see progress immediately.
- Private First Class Thomas Young, who came to RIC after being hit by a bullet as part of a mission in Baghdad. After intensive physical, speech and occupational therapy, Young was able to return to his hometown to live.
- Senior Airman Justin Iverson received therapies when his parachute failed to open and he fell 60 to 100 feet to the ground. At RIC, he regained his memory and cognitive skills.
- Glen Lehman, retired U.S. Army sergeant, who lost his arm in Iraq, received RIC's Targeted Muscle Reinnervation procedure which allows amputees to control motorized prosthetic arms with their own neural impulses or thoughts.
- U.S. Army Sergeant Eric Edmonson, suffered a traumatic brain injury when his convoy was struck by a improvised explosive device. RIC fitted him with an electric Dynavox device, which allows him to communicate.
- Natalie Davis, 11, received muscle-lengthening surgery followed by extended rehabilitation at RIC to manage the effects of cerebral palsy.

RIC is committed to these individuals and the many others who are not identified here, as the hospital plans for the future and its role in therapy and care as its patients focus on their ability..

4. Cite the sources of the information provided as documentation.

RIC uses various data sources for planning purposes. Thompson Reuters aggregates data from the US Census through the Nielsen Company (Claritas) and provides population demographic data by city, state and zip code. The Illinois Hospital Association's CompData product aggregates patient-level data for all acute care hospitals in Illinois. The number of strokes in the United States was provided by the National Center for Health Statistics and National Heart, Lung, and Blood Institute.

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

As noted previously, RIC is known throughout the world as not only a provider of high quality care but a leader and innovator in research in the field of rehabilitation. RIC provides care for patients with various conditions, including stroke, brain injury, spinal cord injury, and multiple

orthopedic problems such as back pain and arthritis. RIC's model of care is designed to bring together the latest research and science to address a patient's problem, and to develop clinical protocols to meet each patient's needs. RIC's new Research Facility will enable the clinical and research team to integrate services around the patient in a way not found anywhere else in the market. Specifically, the improvements in physical layout, all private rooms, advanced technology and innovative therapy space with embedded research will allow the care team to provide a superior service and help patients achieve their maximum abilities.

The RIC care team members are at the core of RIC's services. The care team is led by a physiatrist, a physician specializing in physical medicine & rehabilitation. RIC physiatrists are recognized leaders in the field of rehabilitation. They provide expert care to manage each patient's condition, help avoid complications that could impede progress, map out strategies to maximize recovery and help avoid a recurrence of a disabling condition. (See attached articles.)

Joining the physiatrist is a team of research and clinical experts including physical and occupational therapists and speech language pathologists who work with patients individually and as a team to help address the unique effects of a disabling condition. Whether the goal is (1) to help build strength and balance for better mobility; (2) regain the skills of everyday activities, enhance memory, understanding and communication; or (3) recover the ability to speak and swallow, the team identifies the latest evidence-based practice to help patients regain their independence and return to their communities.

In RIC's model of care, the research team also plays a critical part in the patient recovery. By maintaining current knowledge on the latest diagnostic and therapeutic advances, the research team informs the clinical team regarding the most appropriate treatment for each patient's individual needs. In return, the research team learns first-hand the challenges and complexities of patients which helps drive the research agenda to create more practical patient solutions.

Other professionals on a team include rehabilitation nurses, who assist in medical management of patients, as well as specialists in assistive technology, prosthetics and orthotics, wheelchair positioning, spasticity, therapeutic recreation and vocational rehabilitation. These team members all provide services that address specific needs of each patient.

In addition to care providers, RIC utilizes the latest technology and research protocols to enhance clinical care. One of RIC's unique offerings is the Lokomat®, a robot-assisted walking therapy that helps patients regain their ability to walk after a stroke, brain injury or spinal cord injury. Commercialized and sold by Hocoma, a Swiss-based medical technology company, the Lokomat® is only found in select rehabilitation centers around the country. However, RIC is the only provider to have four Lokomats®, two used for research and two dedicated to clinical care. In addition, RIC was one of the first providers to acquire a pediatric adaptor for Lokomat® and as a result is now one of the few providers in the country to offer pediatric robot-assisted walking therapy for kids as young as four years old.

RIC has also developed technologies that are used for advanced clinical care. Created by RIC clinicians and tested at RIC, the Armeo® is an arm therapy device which uses gaming technology to improve arm movement and grip strength in patients with stroke and other

neurological conditions. Also manufactured by Hocoma, the Armeo® is now commercially available but only found in the Midwest at RIC.

RIC has a major role in the transformation of research related to bionic limbs. Numerous articles chronicle the amazing progress being made by RIC patients who use bionics to regain abilities. (See attached articles.) Although it has partnered with many, one of RIC's major funders related to this research is the Department of Defense. In fact, since 2006, RIC has received over \$18 Million in grants for this innovative research. Numerous articles chronicle the amazing progress being made toward patients having the ability through bionics to regain their ability. Certain articles are attached hereto and incorporated by reference related to the Bionic Program. (See attached articles.)

In addition to research and technological innovation supporting the military, RIC has also sought to embrace all aspects of care relating to soldiers who have been wounded. These patients and their families require specialized case management to support patients, families and their related parties including foreign governments, embassies, insurance carriers, case management companies, and military treatment facilities – both the U.S. Department of Defense and Veteran's Administration. RIC serves these patient populations throughout its System of Care (inpatient, outpatient and day rehabilitation), predominantly at the flagship hospital campus.

RIC's international patients also require care that takes into account the complexities of their personal and clinical condition. Global patients often require multiple services throughout the RIC care continuum, as they are typically very complex patients seeking the unique services that only RIC has to offer, such as bionic medicine or research-based protocols for ambulation following SCI, Stroke or for children with Cerebral Palsy. The RIC Center for Global Patient Services was established September, 2011 to support continued growth in these market segments as well as a growing national and international presence. Global Patient Services consist of dedicated specialized case managers, interpreters, referral liaisons, administrative staff, and leadership.

RIC's international reach positions it to provide assistance in times of crisis. For example, following the 2010 earthquake in Haiti, Suy Bazelais, who had spent twelve days on his back in a makeshift field clinic, came to RIC. Mr. Bazelais's spine had been crushed and he was paralyzed from the waist down. In July, after six months at RIC, he went home to Haiti and walked through the streets. While at RIC, he received specialized physical therapy and occupational therapy. RIC provided all care free of charge.

6. Provide goals with quantified and measurable objectives, with specific timeframes that are related to achieving the stated goals as appropriate.

RIC is leading the healthcare revolution in physical rehabilitation medicine. The time has come to build a new RIC to capitalize on these new treatments and scientific opportunities so that this new facility can radically transform the quality of life for patients today and for many generations to come. Rehabilitation patients do not want RIC to focus on what they can do. They want to focus on what they *cannot do*, and they want RIC to make those things possible.

Twenty-first century biomedical science has opened miraculous doors to knowledge and understanding that were unimagined just a few years ago. Extraordinary possibilities of more rapid scientific progress are waiting to be seized and realized. As bold and innovative as it was in its time, RIC's vision cannot be achieved in a building that was designed and constructed in the early seventies of the last century.

RIC envisions a new flagship facility in which research and patient care will not just coexist but in which these core activities will be fully integrated into the environment, surrounding every patient. In this facility like no other in the world, RIC will achieve scientific advancements and turn those advancements into new treatments for patients on a faster, more productive basis than ever.

The core of the RIC mission is patient care – and the primary goal of the new facility is to improve access to more patients in need of RIC services. As noted earlier, RIC is currently not able to provide services for all the patients seeking admission, due to RIC's capacity constraints. Specifically, RIC has been operating above 90% occupancy and yet continues to limit access to patients. The following table illustrates the number of patients who sought care at RIC but were not admitted due to limitation in capacity.

Limited Access due to RIC Capacity Constraints

	Calendar Year 2010	Calendar Year 2011 (Thru October)
Patients Lost	882	596
Patient Days ¹	16,949	12,582
Average Daily Census	46.4	41.3

¹Patient days for CY 2010 based on actual average length of stay of 19.2 days for types of patients lost. CY 2011 based on 21.1 average length of stay, which is RIC's overall average for all patients.

The new facility will provide additional beds and all private room configuration to enable greater capacity to serve more patients. The table below shows the projected patient admissions and average daily census goals for opening in 2016 and in 2018- two years after opening.

**RIC Patient Volume Goals
New Facility Opening and Operating Targets**

Patient Volume Goals	2016	2018
Inpatient Admissions	3,896	4,298
Number of Beds	272	272
Average Daily Census	215.9	236.8
% Occupancy	79%	87%

Brief Descriptions of Planning, Design and Construction Team Members

Architect Design Firms: HDR and Gensler

HDR has been ranked among the top 4 healthcare design firms in the national by *Modern Healthcare* magazine's annual Design and Construction Survey every year since the survey was established in 1978 and has been ranked the No. 1 firm for the last seven years in a row. Headquartered in Omaha, Nebraska, HDR is a full-service professional practice staffed with architects, engineers, planners, consultants, interior designers and medical equipment planners.

HDR's Chicago office was established in 1996 and continues to serve as a hub for healthcare clients across the country. With more than 7,800 professionals in over 185 offices, HDR is also ranked the world's No 1 healthcare design firm by the World Architecture 100 Survey.

Gensler was founded in 1965 as an architecture, design, planning and consulting firm. Gensler employs more than 2,500 architectural professionals in 35 locations across the world, including the Chicago office – located in the Chicago loop. Gensler is a multiple winner of the prestigious Business Week Design Award, which recognized innovative design solutions. The American Institute of Architects named Gensler Firm of the Year, its highest award to a collaborative practice. *Building Design + Construction* named Gensler No. 1 on the top 300 list of architecture giants and *Interior Design* magazine has named Gensler the largest interior architecture firm in the US for more than two consecutive decades.

Together, the HDR|Gensler team brings a diverse portfolio of work, with a combined emphasis on designing facilities in the healthcare, urban and community, science and technology, civic, mixed-use and commercial markets. The following list of clients is representative of the combined HDR|Gensler's experience with local and other leading institutions:

- Advocate Christ Medical Center (Chicago)
- Block 37 (Chicago)
- John H. Stroger Hospital (Chicago)
- Fourth Presbyterian Church (Chicago)
- Cleveland Clinic (UAE)
- Parkland Hospital (Texas)
- Shanghai Tower (China)
- MD Anderson Cancer Center (Texas)

HDR|Gensler has demonstrated the creativity, teamwork, and commitment to building an efficient and functional facility for RIC.

Owner's Representative: The Rise Group

The Rise Group is an international program management, technical services and strategy consulting company whose work with clients to deliver capital improvement projects and major infrastructure programs. Rise uses leadership, industry knowledge, process expertise and customized control systems to deliver solutions to tough challenges. As the clients' advocate and

Brief Descriptions of Planning, Design and Construction Team Members

representative, RISE delivers across a spectrum of projects and provides results that add value to projects and our clients' underlying business plans.

Headquartered in Chicago and Anchorage, Rise is leading programs across North America and internationally. Rise has been ranked one of the nation's Top 40 Program Managers by *Engineering News-Record* for six consecutive years.

Construction Manager: Power Construction

Founded in 1926 in Chicago, Power Construction is an 85-year old management-owned commercial construction company with a unique business model. Power has focused its geographic reach to just the greater Chicago area, which enables its senior leaders to provide hands-on leadership for each project day-to-day. With more than \$500 million in revenue each year, Power is the largest builder that works exclusively in this region.

Power has chosen to concentrate on serving just five client types that tend to have the more complex kinds of projects. These are healthcare, education, corporate, developer, mixed-use, and hospitality.

Power's list of local clients is impressive and represents a deep level knowledge of the local market to ensure cost-effective and creative solutions for clients. Select clients include:

- Children's Memorial Hospital
- Rush University Medical Center
- Northwestern Memorial Hospital
- Advocate Health and Hospitals Corp.
- NorthShore University HealthSystems
- Resurrection Healthcare Corp.
- Centegra Health System
- Ingalls Health System

Brief Descriptions of Planning, Design and Construction Team Members

Space Programming Consultant: Kurt Salmon Associates (KSA)

Kurt Salmon Associates (KSA) is a global management consultancy of more than 1,600 consultants in 15 countries across five continents. KSA's healthcare group is the most well-respected in the industry when it comes to developing cutting-edge, operationally efficient facilities.

KSA has worked with many of the largest and most successful hospitals in the country, including local providers Northwestern Memorial Hospital and Children's Memorial Hospital, Rush University Medical Center and University of Chicago.

Kurt Salmon's well-defined methodology involves clinical staff input coupled with their industry benchmark data. For RIC, KSA performed early operational modeling and space flow analysis, including analysis of benchmarks for patient room sizes.

Clinical Care Design Consultant: IDEO

IDEO is an award-winning global design firm that takes a human-centered, design-based approach to helping organizations in the public and private sectors innovate and grow. IDEO has become widely recognized as the leader in innovative design, including its perennial recognition on *Fast Company's* list of the Top 25 Most Innovative Companies. IDEO is credited as the designer of the first Apple mouse, and countless design innovations for famous brands worldwide.

IDEO professional staff identifies new ways to serve and support people by uncovering latent needs, behaviors, and desires. The process has helped numerous new and established companies build brands and design the products, services, spaces, and interactive experiences that bring ideas to life.

IDEO has received accolades from every sector, including being ranked as one of the most innovative companies in the world by Boston Consulting Group (*BusinessWeek*) and being awarded the Smithsonian Cooper-Hewitt National Design Museum's National Design Award for Product Design.

From science fiction to fact: Rehabilitation Institute's Todd Kuiken develops computerized limbs for amputees

By Howard Wolinsky

On television's "The Six Million Dollar Man," astronaut Steve Austin was rebuilt as a bionic man after losing his legs and right arm in a crash landing. Todd Kuiken, who was captivated by the program as a teenager in Idaho in the 1970s, is coming closer to constructing his own mechanically enhanced humans.

Dr. Kuiken, director of the Rehabilitation Institute of Chicago's Center for Bionic Medicine and Amputee Services, and his colleagues at Northwestern Memorial Hospital and elsewhere have equipped more than 50 people with computerized arms that are controlled by their nerve impulses. Now he's experimenting with brain-powered legs, under a project funded by the U.S. Army.

"We can do better with legs than arms because their job is simpler. Basically, you need something to stand on as you walk. Captain Hook was able to walk around on what essentially was a stick," Dr. Kuiken says. "We're going to make something much better than a stick."

His prosthetic arms aren't as lifelike or superhuman as the appendages in the TV series, but at about \$100,000 they cost a fraction as much. They also are much easier to operate than conventional strap-and-cable artificial arms, which have changed little from models used in the Civil War.

"Most above-elbow amputees don't wear a prosthesis at all because they're just not good enough," Dr. Kuiken says. "The

state of the art in upper-limb prosthetics was really pretty poor. I felt we could do better."

The breakthrough came after Dr. Kuiken, 51, ran across a scientific paper suggesting that nerves in amputees' stumps could be transferred to other muscles where impulses could be amplified enough to signal external semiconductors. That would allow patients with upper-arm amputations to control a computerized prosthesis, for basic movements such as bending at the elbow to fine-motor hand motions. He began experimenting on lab rats while pursuing dual doctoral degrees in medicine and biomedical engineering at Northwestern University in the late 1980s.

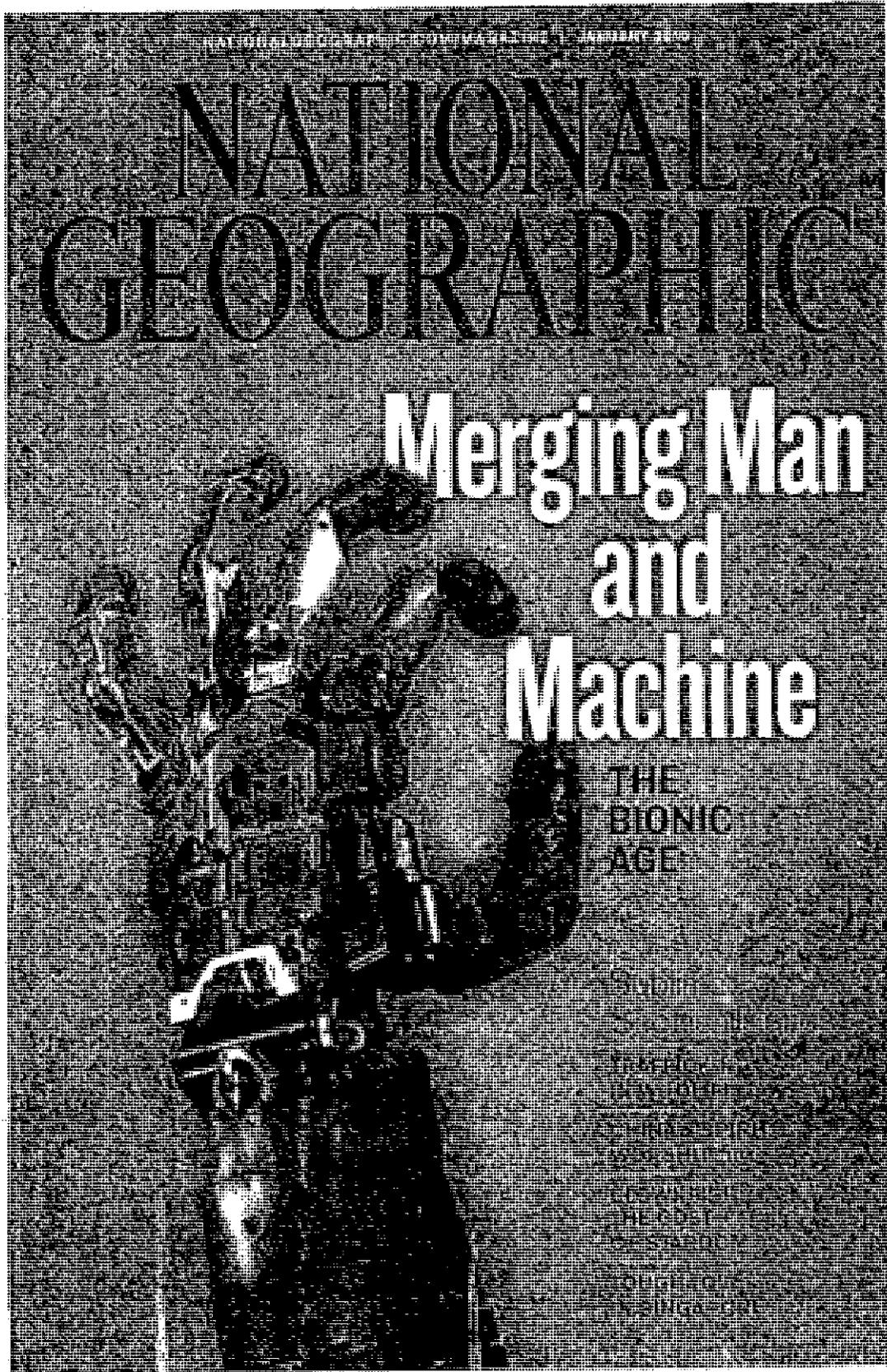
In 2002, he was ready to test the device on a person: Jesse Sullivan, a utility employee from Dayton, Tenn., who had lost both arms the year before after he accidentally touched a high-voltage power line. Dr. Kuiken's surgical colleague at Northwestern Memorial Hospital, Greg Dumanian, relocated four nerves from Mr. Sullivan's stump to his chest muscle, aiming to control his left arm. They then attached a custom-made bionic arm.

After six months of healing, Mr. Sullivan returned to the Rehab Institute for an exam. "We hooked him up and had the hand sitting on the table, and he thought, 'Close hand,' and the hand closed," Dr. Kuiken recalls.



Mr. Sullivan now can dress and feed himself, shave, do household chores and work in his garden. More surprising, in experiments using sensors in his prosthetic left hand, he can "feel" what he picks up as if he were using his own hand.

Col. Paul Pasquina, director of the Center for Rehabilitation Sciences Research at Uniformed Services University of the Health Sciences in Bethesda, Md., says Dr. Kuiken has changed the world for upper-arm amputees, many of them injured during military service. "His research in the area of improving human performance by developing novel interface strategies for individuals to better control a prosthesis are revolutionary," he says.



bi-on-ics

Etymology: from bi (as in “life”) + onics (as in “electronics”); the study of mechanical systems that function like living organisms or parts of living organisms

By Josh Fischman; Photography by Mark Thiessen

Amanda Kitts is mobbed by four- and five-year-olds as she enters the classroom at the Kiddie Kottage Learning Center near Knoxville, Tennessee. “Hey kids, how’re my babies today?” she says, patting shoulders and ruffling hair. Slender and energetic, she has operated this day-care center and two others for almost 20 years. She crouches down to talk to a small girl, putting her hands on her knees.

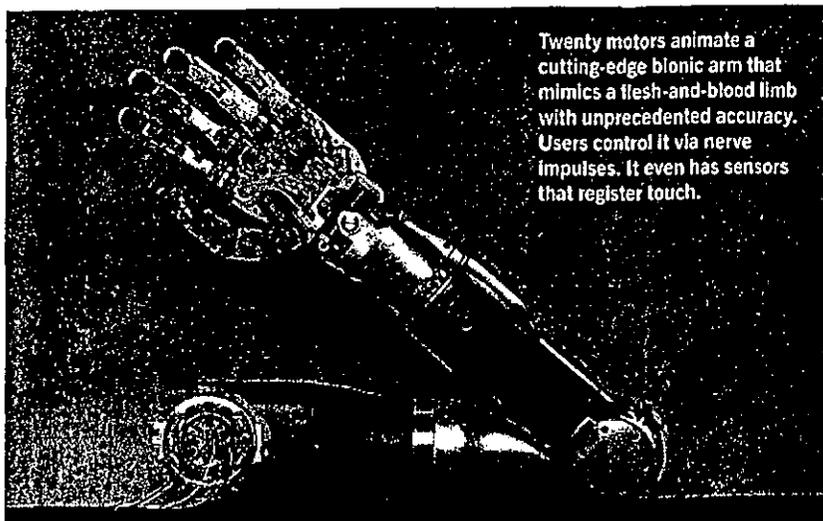
“The robot arm!” several kids cry.

“You remember this, huh?” says Kitts, holding out her left arm. She turns her hand palm up. There is a soft whirring sound. If you weren’t paying close attention, you’d miss it. She bends her elbow, accompanied by more whirring.

“Make it do something silly!” one girl says.

“Silly? Remember how I can shake your hand?” Kitts says, extending her arm and rotating her wrist. A boy reaches out, hesitantly, to touch her fingers. What he brushes against is flesh-colored plastic, fingers curved slightly inward. Underneath are three motors, a metal frame, and a network of sophisticated electronics. The assembly is topped by a white plastic cup midway up Kitts’s biceps, encircling a stump that is almost all that remains from the arm she lost in a car accident in 2006.

Almost all, but not quite. Within her brain, below the level of consciousness,



Twenty motors animate a cutting-edge bionic arm that mimics a flesh-and-blood limb with unprecedented accuracy. Users control it via nerve impulses. It even has sensors that register touch.

lives an intact image of that arm, a phantom. When Kitts thinks about flexing her elbow, the phantom moves. Impulses racing down from her brain are picked up by electrode sensors in the white cup and converted into signals that turn motors, and the artificial elbow bends.

“I don’t really think about it. I just move it,” says the 40-year-old, who uses both this standard model and a more experimental arm with even more control. “After my accident I felt lost, and I didn’t understand why God would do such a terrible thing to me. These days I’m just excited all the time, because they keep on improving the arm. One day I’ll be able to feel things with it and clap my hands

together in time to the songs my kids are singing.”

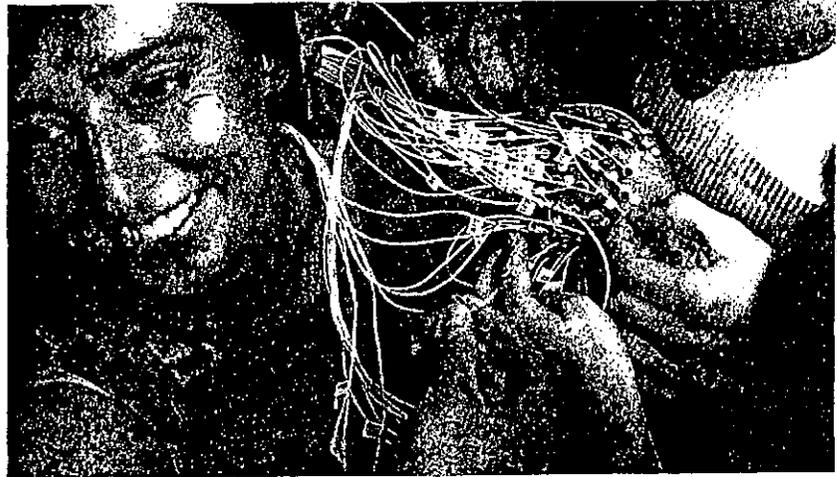
Kitts is living proof that, even though the flesh and bone may be damaged or gone, the nerves and parts of the brain that once controlled it live on. In many patients, they sit there waiting to communicate—dangling telephone wires, severed from a handset. With microscopic electrodes and surgical wizardry, doctors have begun to connect these parts in other patients to devices such as cameras and microphones and motors. As a result, the blind can see, the deaf can hear, and Amanda Kitts can fold her shirts.

Kitts is one of “tomorrow’s people,” a group whose missing or ruined body



parts are being replaced by devices embedded in their nervous systems that respond to commands from their brains. The machines they use are called neural prostheses or—as scientists have become more comfortable with a term made popular by science fiction writers—bionics. Eric Schremp, who has been a quadriplegic since he shattered his neck during a swimming pool dive in 1992, now has an electronic device under his skin that lets him move his fingers to grip a fork. Jo Ann Lewis, a blind woman, can see the shapes of trees with the help of a tiny camera that communicates with her optic nerve. And Tammy Kenny can speak to her 18-month-old son, Aiden, and he can reply, because the boy, born deaf, has 22 electrodes inside his ear that change sounds picked up by a microphone into signals his auditory nerve can understand.

The work is extremely delicate, a series of trials filled with many errors. As scientists have learned that it's possible to link machine and mind, they have also



Doctors and lab personnel attach sensors to tiny ink dots on Kitts's residual arm in order to measure how her muscles respond to her attempts to control them. Unlike the simpler task of fitting the prosthesis, which has only a handful of sensors, this setup can take hours.

learned how difficult it is to maintain that connection. If the cup atop Kitts's arm shifts just slightly, for instance, she might not be able to close her fingers. Still, bionics represents a big leap forward, enabling researchers to give people back much more of what they've lost than was ever possible before.

"That's really what this work is about: restoration," says Joseph Pancrazio, program director for neural engineering at the National Institute of Neurological Disorders and Stroke. "When a person with a spinal-cord injury can be in a restaurant, feeding himself, and no one else notices, that is my definition of success."

A history of body-restoration attempts, in the form of man-made hands and legs and feet, lines the shelves in Robert Lipschutz's office at the Rehabilitation Institute of Chicago (RIC). "The basic

technology of prosthetic arms hasn't changed much in the last hundred years," he says. "Materials are different, so we use plastic instead of leather, but the basic idea has been the same: hooks and hinges moved by cables or motors, controlled by levers. A lot of amputees coming back from Iraq get devices like these. Here, try this on." Lipschutz drags a plastic shell off one of his shelves.

It turns out to be a left shoulder and arm. The shoulder part is a kind of breastplate, secured across the chest by a harness. The arm, hinged at the shoulder and elbow, ends in a metal pincer. To extend the arm, you twist your head to the left and press a lever with your chin, and use a little body English to swing the limb out.

It is as awkward as it sounds. And heavy. After 20 minutes your neck hurts from the odd posture and the effort of pressing

NATIONAL GEOGRAPHIC

bi-on-ics (CONTINUED)

the levers. Many amputees end up putting such arms aside.

"It's hard for me to give people these devices sometimes," Lipschutz says, "because we just don't know if they will really help." What could help more, he and others at RIC think, is the kind of prosthesis Amanda Kitts has volunteered to test—one controlled by the brain, not by body parts that normally have nothing to do with moving the hand. A technique called targeted muscle reinnervation uses nerves remaining after an amputation to control an artificial limb. It was first tried in a patient in 2002. Four years later Tommy Kitts, Amanda's husband, read about it on the Internet as his wife lay in a hospital bed after her accident. The truck that had crushed her car had also crushed her arm, from just above the elbow down.

"I was angry, sad, depressed. I just couldn't accept it," she says. But what Tommy told her about the Chicago arm sounded hopeful. "It seemed like the best option out there, a lot better than motors and switches," Tommy says. "Amanda actually got excited about it." Soon they were on a plane to Illinois.

Todd Kuiken, a physician and biomedical engineer at RIC, was the person responsible for what the institute had begun calling the "bionic arm." He knew that nerves in an amputee's stump could still carry signals from the brain. And he knew that a computer in a prosthesis could direct electric motors to move the limb. The problem was making the connection. Nerves conduct electricity, but they can't be spliced together with



a computer cable. (Nerve fibers and metal wires don't get along well. And an open wound where a wire enters the body would be a dangerous avenue for infections.)

Kuiken needed an amplifier to boost the signals from the nerves, avoiding the need for a direct splice. He found one in muscles. When muscles contract, they give off an electrical burst strong enough to be detected by an electrode placed on the skin. He developed a technique to reroute severed nerves from their old, damaged spots to other muscles that could give their signals the proper boost.

In October 2006 Kuiken set about rewiring Amanda Kitts. The first step was to salvage major nerves that once went all the way down her arm. "These are the same nerves that work the arm and hand, but we had to create four different muscle areas to lead them to," Kuiken says. The nerves started in Kitts's brain, in the motor cortex, which holds a rough map of the body, but they stopped at the end of her stump—the disconnected telephone wires. In an intricate operation, a surgeon

Kitts imagines a hand movement, and muscle activity in her residual arm—decoded by a computer on her back—causes the actual motion. When she straps on the experimental Johns Hopkins-developed arm at the Rehabilitation Institute of Chicago, she says, "often it feels like I'm not missing anything."

rerouted those nerves to different regions of Kitts's upper-arm muscles. For months the nerves grew, millimeter by millimeter, moving deeper into their new homes.

"At three months I started feeling little tingles and twitches," says Kitts. "By four months I could actually feel different parts of my hand when I touched my upper arm. I could touch it in different places and feel different fingers." What she was feeling were parts of the phantom arm that were mapped into her brain, now reconnected to flesh. When Kitts thought about moving those phantom fingers, her real upper-arm muscles contracted.

A month later she was fitted with her first bionic arm, which had electrodes in the cup around the stump to pick up the signals from the muscles. Now the challenge was to convert those signals into commands to move the elbow and hand. A storm of electrical noise was coming from the small region on Kitts's arm. Somewhere in there was the signal that meant "straighten the elbow" or "turn the wrist." A microprocessor housed

in the prosthesis had to be programmed to fish out the right signal and send it to the right motor.

Finding these signals has been possible because of Kitts's phantom arm. In a lab at the RIC Blair Lock, a research engineer, fine-tunes the programming. He has Kitts slide off the artificial arm so that he can cover her stump with electrodes. She stands in front of a large flat-panel TV screen that displays a disembodied, flesh-colored arm floating in blue space—a visualization of her phantom. Lock's electrodes pick up commands from Kitts's brain radiating down to her stump, and the virtual arm moves.



The Proto 1 arm developed by the Johns Hopkins University Applied Physics Laboratory gives amputee Amanda Kitts enough fine motor control that she can pick up very small objects, like a key resting on the edge of a table.

In a hushed voice, so as not to break her concentration, Lock asks Kitts to turn her hand, palm in. On-screen, the hand turns, palm in. "Now extend your wrist, palm up," he says. The screen hand moves. "Is that better than last time?" she asks. "Oh yeah. Strong signals." Kitts laughs. Now Lock asks her to line up her thumb alongside her fingers. The screen hand obliges. Kitts opens her eyes wide. "Wow. I didn't even know I could do that!" Once the muscle signals associated with a particular movement are identified, the computer in the arm is programmed to look for them and respond by activating the correct motor.

Kitts practiced using her arm one floor below Kuiken's office in an apartment set up by occupational therapists with everything a newly equipped amputee might ordinarily use. It has a kitchen with a stove, silverware in a drawer, a bed, a closet with hangers, a bathroom,

stairs—things people use every day without a second thought but that pose huge obstacles to someone missing a limb. Watching Kitts make a peanut butter sandwich in the kitchen is a startling experience. With her sleeve rolled back to reveal the plastic cup, her motion is fluid. Her live arm holds a slice of bread, her artificial fingers close on a knife, the elbow flexes, and she swipes peanut butter back and forth.

"It wasn't easy at first," she says. "I would try to move it, and it wouldn't always go where I wanted." But she worked at it, and the more she used the arm, the more lifelike the motions felt. What Kitts would really like now is sensation. That would be a big help in many actions, including one of her favorites—gulping coffee.

"The problem with a paper coffee cup is that my hand will close until it gets a solid grip. But with a paper cup you never get

a solid grip," she says. "That happened at Starbucks once. It kept squeezing until the cup went 'pop.'"

There's a good chance she'll get that sensation, says Kuiken, again thanks to her phantom. In partnership with bioengineers at the Johns Hopkins University Applied Physics Laboratory, RIC has been developing a new prototype for Kitts and other patients that not only has more flexibility—more motors and joints—but also has pressure-sensing pads on the fingertips. The pads are connected to small, pistonlike rods that poke into Kitts's stump. The harder the pressure, the stronger the sensation in her phantom fingers.

"I can feel how hard I'm grabbing," she says. She can also tell the difference between rubbing something rough, like sandpaper, and smooth, like glass, by how fast the rods vibrate. "I go up to Chicago

NATIONAL GEOGRAPHIC

bi-on-ics [CONTINUED]

to experiment with it, and I love it," she says. "I want them to give it to me already so I can take it home. But it's a lot more complicated than my take-home arm, so they don't have it completely reliable yet."

Eric Schremp, unlike Kitts, doesn't need artificial hands. He just needs his natural ones to work. They haven't done that on their own since Schremp broke his neck in 1992, leaving him a quadriplegic. Now, however, the 40-year-old Ohio man can grip a knife or a fork.

He can do this because of an implanted device developed by Hunter Peckham, a biomedical engineer at Case Western Reserve University in Cleveland. "Our goal is to restore hand grasping," Peckham says. "Hand use is key to independence."

Schremp's finger muscles and the nerves that control them still exist, but the signals from his brain have been cut off at the neck. Peckham's team ran eight micro-thin electrodes from Schremp's chest under the skin of his right arm, ending at the finger muscles. When a muscle in his chest twitches, it triggers a signal that's sent via a radio transmitter to a small computer hanging from his wheelchair. The computer interprets the signal and radios it back to a receiver implanted in his chest, where the signal is sent by wires down Schremp's arm to his hand. There the signal tells his finger muscles to close in a grip—all within a microsecond.

"I can grab a fork and feed myself," Schremp says. "That means a lot."

About 250 people have been treated with this technique, which is still experimental. But another bionic device has shown that the marriage of mind and machine can be both powerful and enduring, having been implanted in nearly 200,000 people around the world during the past 30 years. That device is the cochlear implant, and Aiden Kenny is among the latest recipients. Tammy Kenny, his mother, remembers when, a year ago, she learned that her baby was beyond the help of hearing aids.

"I would just hold him in my arms and cry," she says, "knowing he couldn't hear me. How would he ever get to know me? One time, my husband banged pots together, hoping for a response." Aiden never heard the noise.

He hears banging pots now. In February 2009 surgeons at Johns Hopkins Hospital snaked thin lines with 22 electrodes into each cochlea, the part of the inner ear that normally detects sound vibrations. In Aiden, a microphone picks up sounds and

sends signals to the electrodes, which pass them directly to the nerves.

"The day they turned on the implant, a month after surgery, we noticed he responded to sound," Tammy Kenny says. "He turned at the sound of my voice. That was amazing." Today, she says, with intensive therapy, he's picking up language, quickly catching up to his hearing peers.

Bionic eyes may soon follow bionic ears. Jo Ann Lewis lost her sight years ago to retinitis pigmentosa, a degenerative disease that destroys light-detecting cells in the eyes called rods and cones. Lately, however, she has partially regained her vision as a result of research by Mark Humayun, an ophthalmologist at the University of Southern California and a company called Second Sight.

As is common with this disease, part of an inner layer of her retina had survived. This layer, filled with bipolar and ganglion cells, normally gathers signals from outer rods

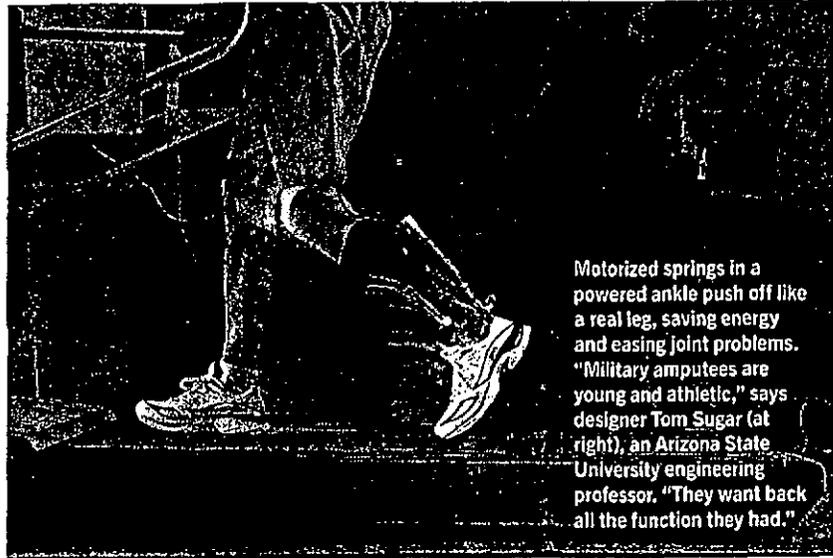


Aiden Kenny got two cochlear implants when he was ten months old. Bypassing parts of his ears that don't work, the implants—visible in an x-ray—carry electronic signals to his auditory nerves. Within months of the surgery, a child who'd grown increasingly quiet spoke the words his hearing parents longed for: Mama and Dada. "You're looking at a real bionic kid," says Johns Hopkins University surgeon John Niparko.

and cones and passes them to fibers that fuse into the optic nerve. No one knew what language the inner retina spoke or how to feed it images it could understand. But in 1992, Humayun began laying, for a short time, a tiny electrode array on the retinas of RP patients undergoing surgery for other reasons.

"We asked them to follow a dot, and they could," he says. "They could see rows, and they could see columns." After another decade of testing, Humayun and his colleagues developed a system they dubbed Argus. (Greek mythology. A giant. Hundreds of eyes.) Patients got a pair of dark glasses with a tiny video camera mounted on them, along with a radio transmitter. Video signals were beamed to a computer worn on a belt, translated to electrical impulse patterns understood by ganglion cells, and then beamed to a receiver resting behind the ear. From there a wire took them inside the eye, to a square array of 16 electrodes gently attached to the retinal surface. The impulses triggered the electrodes. The electrodes triggered the cells. Then the brain did the rest, enabling these first patients to see edges and some coarse shapes.

In the fall of 2006 Humayun, Second Sight, and an international team increased the electrodes in the array to 60. Like a camera with more pixels, the new array produced a sharper image. Lewis, from Rockwall, Texas, was among the first to get one. "Now I'm able to see silhouettes of trees again," she says. "That's one of the last things I remember seeing naturally. Today I can see limbs sticking out this way and that."



Motorized springs in a powered ankle push off like a real leg, saving energy and easing joint problems. "Military amputees are young and athletic," says designer Tom Sugar (at right), an Arizona State University engineering professor. "They want back all the function they had."

Pushing the neural prosthetic concept further, researchers are beginning to use it on the brain itself. Scientists behind a project called BrainGate are attempting to wire the motor cortex of completely immobilized patients directly into a computer so that patients can move remote objects with their minds. So far, test subjects have been able to move a cursor around a computer screen. Researchers are even planning to develop an artificial hippocampus, the part of the brain that stores memories, with the intent of implanting it in people with memory loss.

Not everything will work perfectly. One of the four initial BrainGate patients decided to have the plug removed because it interfered with other medical devices. And Jo Ann Lewis says her vision isn't good enough for her to safely cross a

street. Today, however, Kitts has a new, more elastic cup atop her arm that better aligns electrodes with nerves that control the arm.

"It means I can do a lot more with the arm," she says. "A new one up in Chicago lets me do lots of different hand grasps. I want that. I want to pick up pennies and hammers and toys with my kids." These are reasonable hopes for a replacement part, Kuiken says. "We are giving people tools. They are better than what previously existed. But they are still crude, like a hammer, compared with the complexity of the human body. They can't hold a candle to Mother Nature."

Still, at least the people using the tools can grab the candle. And some can even see it flicker in the dark.



An RIC Story of Ability — Regena Guinhawa

Moving Better, Thinking Clearer, Talking Louder

Regena Guinhawa was used to leading an active life. A native Californian, she loved the beach and headed for the mountains whenever she could. "I loved taking the kids up there, and later, my grandkids," she recalled. "She's always lived her life to the fullest," agreed her son, Russ Byrd.

Regena was 55 years old when she noticed her hands had begun to twitch. "I started shaking a lot, and that got me scared," she said. She was diagnosed with Parkinson's Disease and began taking medication. Initially it helped, but over time, the benefits wore off. "I was delivering Meals on Wheels and I had to stop. I couldn't drive anymore. It made me angry, like I was losing my life.

"After about four years, I was in bad condition. I was down to 100 pounds. My body would freeze. My tremors were getting worse. One time, I didn't stop shaking for six hours and I had to go the ER," she said. "I never went that long before. I was ready to try anything."

Her son brought her to his home in Chicago. "When she got off the plane, she was in a wheel chair. She couldn't walk at all. She was bent over at a 90-degree angle," he said. "She needed help going to the bathroom. We had to be physically in the shower with her. We needed help, so we made an appointment and brought her to RIC."



Rehabilitation
Institute of Chicago
Center for Parkinson's
Rehabilitation

Before coming to RIC, Regena Guinhawa experienced uncontrollable shaking and weakness which landed her in the ER.

Treatment Targeted Toward Parkinson's Disease

RIC's Center for Parkinson's Rehabilitation has the nation's largest team of clinicians who are specially trained in treating Parkinson's Disease.

Among them was occupational therapist Summer Shepstone. "For people with Parkinson's Disease, a lot of the problem is perception. They think they're moving normally, but they're much slower and stiffer—for instance, they think they're walking normally, but they're taking small, shuffling steps," she said. "To overcome the symptoms, they have to increase their efforts. We cue them to increase their awareness, we teach them to cue themselves."



Rehabilitation Institute of Chicago

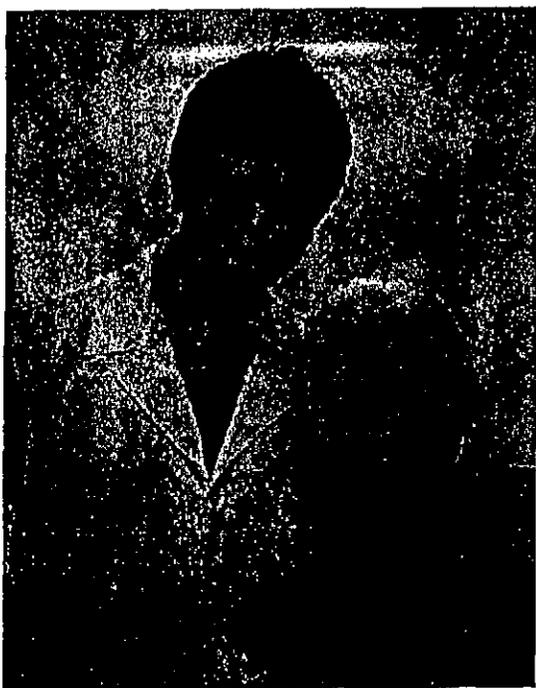
#1 Rehabilitation in America

A Story of Ability

Because fear, anxiety and pain play crippling roles for Parkinson's patients, RIC therapists also teach stretches, progressive relaxation and other techniques that help patients lead more productive lives.

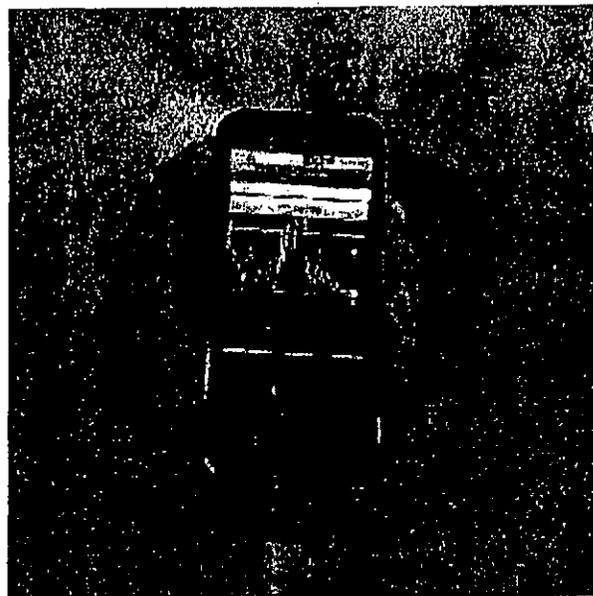
Shepstone was part of the team guided by Dr. Santiago Toledo, medical director of the Center for Parkinson's Rehabilitation. Under their care, Regena quickly improved. "The therapists got me to lay on my back straight out. It was the first time I'd done that in years," she said. "They taught me how to work through a lot of things."

Her son saw the progress immediately. "We were so excited. She came here and stopped shaking," her son said. "Within two weeks of inpatient treatment, she could put on her own shoes now, her own clothing. She was able to start putting makeup on again, and obviously that lifted her huge."



Making an Appointment
To schedule an appointment,
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Cutting-Edge Research Trials

Regena even took part in a cutting-edge research trial at RIC. Researchers are harnessing the sensor tracking technology in smart phones to help track movements of patients with Parkinson's Disease. Using mathematical algorithms, they can better assess how patients move as they go through their day-to-day lives outside a doctor's office, even tracking a patient's progress over time. "

These modern mobile phones have very good movement sensors built in," said Konrad Kording, PhD, director of RIC's Economics of Movement Lab. "This technology allows us to monitor how the patients' lives get more active after they've come to RIC."

Regena has begun to live her life pain-free and is making plans for the future. "I'm ready to go to the beach, to see Lake Michigan," she said. "And I'd like to travel to California and see my other grandchildren and my great-grandchildren."

Go to www.ric.org/parkinsons to see a short video on Regena's story.



RIC Military Recovery Programs – Stories of Advancing Ability



Iverson returned to his unit and awaits full active duty

TOMAS YOUNG

Coming Back From Spinal Cord Injury

Private First Class Thomas Young, 25, was riding in a truck, part of a mission in Baghdad, when it was hit by insurgent snipers from above. He was hit with a bullet that went through his collarbone and hit his spinal cord leaving him with a permanent spinal cord injury and paralyzed from the chest down. After he was stabilized at Walter Reed Army Medical Center and returned home, he was cleared to go to RIC. Young participated in physical therapy, speech therapy and occupational therapy 5 days a week regaining strength and the ability to be more independent in his self care.

Young has returned to his hometown and is busy traveling and spending time with his fiancée.



RIC is honored to deliver the nation's **most exceptional rehabilitation care** to our nation's most deserving citizens

JUSTIN IVERSON

Return to Active Duty

Senior Airman Justin Iverson spent his 21st birthday in Baghdad, assigned to a military team recruiting and training local police. After returning home from harm's way, he assumed MP duties in Georgia. But the war left him—like so many fellow returning military—a self-described "adrenaline junky," craving the challenge and excitement of scuba diving, white-water rafting and skydiving. In summer 2010, 22-year-old Iverson was in Florida making his fifth skydiving jump of the day—the 49th of his life—when his parachute canopy collapsed during a turn. He fell between 60 and 100 feet to the ground. The accident left Iverson with multiple traumas and a brain injury.

He was treated at St. Joseph's Hospital in Tampa and James A. Haley Veteran's Hospital. When Iverson's physicians decided he was ready for outpatient care, they agreed that RIC was "the best place he could be. He credits RIC for getting his memory and cognitive skills to "click back" and for strengthening his left-side weakness. (Justin is left handed.)

By March 2011, Iverson had returned to his base, his unit and currently awaits clearance to return to full active duty.



Rehabilitation Institute of Chicago

#1 Rehabilitation Hospital in America

Human Stories of Ability

GLEN LEHMAN

State-of-the-Art Bionic Arms

Glen Lehman, a retired U.S. Army sergeant who lost his arm in Iraq, is one of approximately a dozen service members who have lost limbs to receive RIC's state-of-the-art Targeted Muscle Reinnervation (TMR) procedure, which allows for amputees to control motorized prosthetic arms with their own neural impulses or thoughts.

"It feels great; it feels intuitive. It is a lot better than the other prosthetic I have now," said Lehman, whose forearm and elbow were blown off in a Baghdad grenade attack in 2008.

"The other one is still controlled by muscle impulse, you just flex muscle to make it move. It is not intuitive. This arm is more trained to me, whereas the other arm I had to train to it," he said.

With his Bionic Arm, Lehman can pinch his finger and thumb together, lift his forearm and bend his elbow, and turn his wrist just by thinking about those actions.

RIC continues to develop this technology and has been working to adapt these scientific findings to improve control over lower limb prostheses.



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for a RIC Military Liaison**



ERIC EDMUNDSON

Coming Back from Traumatic Brain Injury(TBI)

U.S. Army Sergeant Eric Edmundson was severely injured when an improvised explosive device (IED) struck his convoy, resulting in a traumatic brain injury (TBI). Doctors once thought he would remain in a vegetative state for life. However, after months of comprehensive therapy at RIC, Edmundson regained the ability to eat and even enjoyed a piece of cake at RIC on his 26th birthday. Through RIC's advanced technology center, he was fitted with an electric Dynavox device, which allows him to communicate. He even re-learned how to maneuver a fishing pole so he could go fishing again—his favorite pastime—while on a fishing trip with his therapists at Lake Michigan. On June 30, 2007, Edmundson actually walked out the front doors of RIC into the arms of his wife and daughter as he was discharged. His friends and family gathered to celebrate the accomplishments they thought he'd never achieve again.

Today Edmundson and his wife celebrate the birth of their second child. The family continues to enjoy life riding bikes, fishing and hunting and being together.

Standing Tall, Scoring Goals

Natalie Davis' Cerebral Palsy Patient Story

Natalie Davis, 11, is no stranger to therapy. She has had ongoing treatments, medication and medical techniques to manage the effects of cerebral palsy since she was a baby. Today, after a muscle-lengthening surgery in January and extended rehabilitation at the Rehabilitation Institute of Chicago — including cutting-edge robot-assisted walking therapy — she is ready to take on the world... or at least the competitors on the soccer field.

Cerebral palsy (CP) is a neurological condition sometimes resulting in orthopaedic consequences, affecting muscle tone, reflexes, coordination, balance and ability to walk. There are severe to mild cases. Natalie has a more mild form called spastic diplegia CP, characterized by difficulty moving and walking due to tight, stiff muscles (spasticity) in her arms and legs. She has worn leg braces since she was a toddler and uses a walker to help her walk short distances, relying on a wheelchair for longer distances. Her difficulties are purely physical; she communicates well, is a good student and has many friends at Emily G. Johns School in Plano, Ill.

Natalie began receiving physical and occupational therapy through a DeKalb County early intervention program when she was six months old. When she was five, she had a rhizotomy-surgery to reduce spasticity by cutting certain nerve roots as they enter the spinal cord. She also received multiple Botox treatments, a cutting edge treatment for loosening muscles and helping ease spasticity.

Like many adolescents with CP, Natalie began to grow, and when her muscles couldn't keep up with the growth of her bones, she stopped seeing improvements in her mobility. This is common for children with CP during the pre-adolescent growth spurt, because as their bones grow, spastic muscles become tighter and tighter. In Natalie's case, tight hamstrings and a rolled-in ankle caused her to walk with a crouch, risking permanent damage to adjacent joints. "Natalie had started using her wheelchair more and more, which can be hard to deal with for a child that age," says France Malate, her physical therapist at RIC.

As Natalie's ability to walk worsened, her parents consulted with local experts Deborah Gaebler-Spira, M.D., director of the Cerebral Palsy Program at RIC



and a specialist in pediatric physical medicine and rehabilitation, and Luciano Dias, M.D., a pediatric orthopaedic surgeon on the attending staff at both Children's Memorial Hospital and RIC. In January, she underwent a five-hour surgery at Children's Memorial to lengthen her hamstrings and loosen the tension and spasticity in her leg muscles in hopes of increasing her ability to walk.

Innovative Technology

As soon as her casts were removed, Natalie was admitted to RIC's pediatric unit for intensive rehabilitation with the goal of getting her back on her feet and walking. The pediatric floor is specially designed for children with a variety of neurological and orthopaedic conditions, to receive intensive rehabilitation in a friendly environment. The floor includes multiple tricycles and bikes for kids to ride as part of therapy, a classroom so kids can continue their studies while they recover, and multiple games including Nintendo Wii and a basketball hoop that help make therapy fun. The pediatric rehabilitation team focuses on making life in the hospital as normal as possible, and the presence of other children in similar situations provides companionship, support, encouragement and inspiration.

During her month-long stay on the unit, Natalie's therapists worked with her as she healed. She had to relearn things such as transferring from her bed to her chair because at first, she relied mainly on her

wheelchair. As she began to regain strength in the muscles that were weakened as a result of having been surgically lengthened, she began to stand and take small, slow steps.

She also received care from specialized rehabilitation nurses each day. "Natalie is a very sweet, determined little girl," said Caryn Summerville, one of Natalie's nurses on the inpatient pediatric rehabilitation unit. "It's amazing to see the progress that patients make and the confidence gained throughout their stay at RIC."

Therapy goals also included regaining endurance, increasing mobility and range of motion, improving coordination and balance, and regulating her gait pattern, or the way her feet move to take steps. Malate reports that she was a model patient, willing to do anything to help achieve her goals and driven by the hope that one day soon she could play soccer, her favorite sport.

"When we asked her what her ultimate goal would be, she told us she wanted to play soccer, so that helped us design therapies that would get her to where she wanted to be," he said.

The Pediatric Lokomat® Advantage

In her quest to walk more easily and play soccer, Natalie was fortunate to have access to robot-assisted walking therapy on the Lokomat, a high-tech treadmill with an robotic frame attached by straps to the outside of the legs. It is designed to improve gait, or one's walking pattern, speed and endurance. The Lokomat controls the movement of the patient's hip and knee. The computer-controlled format provides users with real-time visual feedback on their progress through a virtual-reality gaming interface that motivates the children and provides instruction through cartoon characters and games. The computer controls the pace and measures the body's response to the movement. Natalie, for instance, could see immediately if she was putting too much weight on one leg by watching a ninja or a cowboy walk across a computer screen.

When her steps began to falter or become weak, the robot sensed it and the virtual reality character would start to head for a tree. When she engaged more and improved her gait, the robot sensed it and headed for a gold coin — worth extra points. "It's quite the



contraption," says her mother, Christine Davis. "Natalie really did enjoy using it, and we did see improved strength and endurance in her walking."

Without this state-of-the-art device, walking therapy requires two physical therapists to manually move the patient's legs while another therapist supports the patient's body. This type of manual therapy is very tiring for both the therapists and the patient and can only be sustained for about 10 minutes at a time. With the machine supporting the patient's weight and controlling the legs, therapy can be much more sustained, consistent — and effective.

RIC was the first hospital in the U.S. to obtain a Lokomat for adult patients when the federal Food and Drug Administration approved it in 2002; the pediatric version became available in early 2009, just in time for Natalie to reap its benefits. RIC researchers are now examining and tracking the effects of this therapy for both adults and children, and continue to participate in new research and clinical trials that provide more data on its effectiveness.

"RIC is committed to discovering new treatments that maximize the abilities of children with cerebral palsy," says Dr. Gaebler-Spira. "There is an immense need for research in this area, and RIC is dedicated to examining

the vast opportunities and discovering new treatments that advance ability for those living with CP?"

Before starting Lokomat therapy, Natalie was able to walk about 200 feet at a slow to moderate pace, taking a few breaks to rest. By the time her inpatient stay was over, she was able to walk up to 30 minutes on the Lokomat at a fairly quick pace of more than a mile an hour, reports Malate. "Our goal in Natalie's rehabilitation was to maintain the positive effects of her surgery for as long as possible," he says. "With the Lokomat, we found the perfect tool to help in that mission."

When asked what she would tell other kids who might be thinking about Lokomat therapy, Natalie said, "It's awesome! Its fun and it really will help."

In addition to Lokomat therapy three times a week, Natalie also participated in occupational therapy to work on fine motor skills and activities of daily living such as bathing and dressing, pool therapy and art therapy (her favorites, her mother reports); and group activities like cooking with other children on the unit. To keep up

with school, she worked with a certified teacher each day through a special tutoring program between RJC and Chicago Public Schools.

"She is so much stronger," her mother reports. "Without even thinking about it, she will pick up her walker, hold it in the air and move it to where she wants it. Natalie's posture also has improved dramatically. "She is about two inches taller than she was before her surgery and therapy," says her mom. "She stands nice and tall."

And, for the first time in her life, she can kick a soccer ball. "We're really proud of her and the work she has put in to get where she is today," said her mother.

Natalie is now back at home in Plano with her parents, older sister and younger brother, where she is walking with much more strength and endurance. Today, Natalie is enjoying her summer including swimming, bicycling and playing with her family and friends. And there is a soccer program in nearby Oswego that Natalie's family is looking into so Natalie can achieve her goal of playing soccer.



Rehabilitation Institute of Chicago

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ATTACHMENT 12

2011 Rehabilitation Institute Zip Code Draw Area

(September 1, 2010 - August 31, 2011)

Zip	County	Discharges	% of Total Volume	Cumulative Volume
60611	Cook IL	111	4.3%	4.3%
60610	Cook IL	98	3.8%	8.0%
60615	Cook IL	65	2.5%	10.5%
60637	Cook IL	48	1.8%	12.3%
60619	Cook IL	48	1.8%	14.2%
60657	Cook IL	44	1.7%	15.9%
60617	Cook IL	42	1.6%	17.5%
60620	Cook IL	38	1.5%	18.9%
60628	Cook IL	36	1.4%	20.3%
60614	Cook IL	36	1.4%	21.7%
60616	Cook IL	33	1.3%	22.9%
60618	Cook IL	30	1.1%	24.1%
60653	Cook IL	29	1.1%	25.2%
60613	Cook IL	27	1.0%	26.2%
60625	Cook IL	26	1.0%	27.2%
60640	Cook IL	25	1.0%	28.2%
60605	Cook IL	25	1.0%	29.1%
60639	Cook IL	25	1.0%	30.1%
60649	Cook IL	23	0.9%	31.0%
60608	Cook IL	23	0.9%	31.9%
60621	Cook IL	22	0.8%	32.7%
60062	Cook IL	22	0.8%	33.6%
60601	Cook IL	22	0.8%	34.4%
60626	Cook IL	20	0.8%	35.2%
60609	Cook IL	19	0.7%	35.9%
60645	Cook IL	18	0.7%	36.6%
60612	Cook IL	17	0.7%	37.2%
60643	Cook IL	17	0.7%	37.9%
60647	Cook IL	17	0.7%	38.5%
60629	Cook IL	17	0.7%	39.2%
60085	Lake IL	17	0.7%	39.8%
60660	Cook IL	16	0.6%	40.4%
60402	Cook IL	16	0.6%	41.1%
60045	Lake IL	16	0.6%	41.7%
60641	Cook IL	16	0.6%	42.3%
60201	Cook IL	16	0.6%	42.9%
60638	Cook IL	16	0.6%	43.5%
60623	Cook IL	15	0.6%	44.1%
60712	Cook IL	15	0.6%	44.7%
60411	Cook IL	15	0.6%	45.2%
60630	Cook IL	14	0.5%	45.8%
60477	Cook IL	14	0.5%	46.3%
60632	Cook IL	13	0.5%	46.8%
60659	Cook IL	13	0.5%	47.3%
60646	Cook IL	13	0.5%	47.8%
60624	Cook IL	12	0.5%	48.3%
60462	Cook IL	12	0.5%	48.7%
60651	Cook IL	12	0.5%	49.2%
60521	DuPage IL	12	0.5%	49.6%
60655	Cook IL	12	0.5%	50.1%
60804	Cook IL	11	0.4%	50.5%

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2011 Rehabilitation Institute Zip Code Draw Area

(September 1, 2010 - August 31, 2011)

Zip	County	Discharges	% of Total Volume	Cumulative Volume
60707	Cook IL	11	0.4%	50.9%
60453	Cook IL	11	0.4%	51.4%
60443	Cook IL	11	0.4%	51.8%
46307	Lake IN	11	0.4%	52.2%
60409	Cook IL	11	0.4%	52.6%
60634	Cook IL	11	0.4%	53.0%
60035	Lake IL	11	0.4%	53.5%
60030	Lake IL	10	0.4%	53.8%
46385	Porter IN	10	0.4%	54.2%
60010	Lake IL	10	0.4%	54.6%
60410	Will IL	9	0.3%	55.0%
60527	DuPage IL	9	0.3%	55.3%
60478	Cook IL	9	0.3%	55.6%
60622	Cook IL	9	0.3%	56.0%
60654	Cook IL	9	0.3%	56.3%
60432	Will IL	9	0.3%	56.7%
60142	McHenry IL	9	0.3%	57.0%
60123	Kane IL	9	0.3%	57.4%
60108	DuPage IL	9	0.3%	57.7%
60098	McHenry IL	9	0.3%	58.1%
60661	Cook IL	8	0.3%	58.4%
60636	Cook IL	8	0.3%	58.7%
60435	Will IL	8	0.3%	59.0%
60425	Cook IL	8	0.3%	59.3%
60422	Cook IL	8	0.3%	59.6%
60656	Cook IL	8	0.3%	59.9%
60803	Cook IL	8	0.3%	60.2%
60014	McHenry IL	8	0.3%	60.5%
60172	DuPage IL	8	0.3%	60.8%
60107	Cook IL	8	0.3%	61.1%
60073	Lake IL	8	0.3%	61.4%
60068	Cook IL	8	0.3%	61.7%
60067	Cook IL	8	0.3%	62.0%
60061	Lake IL	8	0.3%	62.4%
60015	Lake IL	8	0.3%	62.7%
60076	Cook IL	8	0.3%	63.0%
60202	Cook IL	8	0.3%	63.3%
60302	Cook IL	8	0.3%	63.6%
46324	Lake IN	8	0.3%	63.9%
46342	Lake IN	8	0.3%	64.2%
46360	La Porte IN	8	0.3%	64.5%
60467	Cook IL	7	0.3%	64.8%
60126	DuPage IL	7	0.3%	65.0%
60631	Cook IL	7	0.3%	65.3%
46383	Porter IN	7	0.3%	65.6%
60607	Cook IL	7	0.3%	65.8%
60464	Cook IL	7	0.3%	66.1%
60004	Cook IL	7	0.3%	66.4%
60438	Cook IL	7	0.3%	66.6%
60077	Cook IL	7	0.3%	66.9%
60644	Cook IL	7	0.3%	67.2%

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2011 Rehabilitation Institute Zip Code Draw Area

(September 1, 2010 - August 31, 2011)

Zip	County	Discharges	% of Total Volume	Cumulative Volume
60093	Cook IL	7	0.3%	67.4%
60106	DuPage IL	7	0.3%	67.7%
60525	Cook IL	7	0.3%	68.0%
46311	Lake IN	7	0.3%	68.2%
60565	DuPage IL	7	0.3%	68.5%
60305	Cook IL	7	0.3%	68.8%
60417	Will IL	7	0.3%	69.1%
60449	Will IL	7	0.3%	69.3%
60440	Will IL	7	0.3%	69.6%
60827	Cook IL	7	0.3%	69.9%
60430	Cook IL	6	0.2%	70.1%
60022	Cook IL	6	0.2%	70.3%
60446	Will IL	6	0.2%	70.5%
60016	Cook IL	6	0.2%	70.8%
60439	Cook IL	6	0.2%	71.0%
60901	Kankakee IL	6	0.2%	71.2%
60046	Lake IL	6	0.2%	71.5%
61021	Lee IL	6	0.2%	71.7%
60652	Cook IL	6	0.2%	71.9%
60805	Cook IL	6	0.2%	72.2%
60304	Cook IL	6	0.2%	72.4%
60465	Cook IL	6	0.2%	72.6%
60005	Cook IL	5	0.2%	72.8%
60031	Lake IL	5	0.2%	73.0%
60087	Lake IL	5	0.2%	73.2%
60558	Cook IL	5	0.2%	73.4%
46322	Lake IN	5	0.2%	73.6%
60490	Will IL	5	0.2%	73.8%
60441	Will IL	5	0.2%	74.0%
60545	Kendall IL	5	0.2%	74.1%
60013	McHenry IL	5	0.2%	74.3%
60426	Cook IL	5	0.2%	74.5%
49330	Kent MI	5	0.2%	74.7%
46405	Lake IN	5	0.2%	74.9%
46394	Lake IN	5	0.2%	75.1%
60156	McHenry IL	5	0.2%	75.3%
60428	Cook IL	5	0.2%	75.5%
60423	Will IL	5	0.2%	75.7%
60455	Cook IL	5	0.2%	75.9%
60048	Lake IL	5	0.2%	76.1%
60089	Lake IL	5	0.2%	76.3%
60642	Cook IL	5	0.2%	76.4%
60178	DeKalb IL	5	0.2%	76.6%
60450	Grundy IL	5	0.2%	76.8%
60064	Lake IL	5	0.2%	77.0%
60152	McHenry IL	5	0.2%	77.2%
60706	Cook IL	5	0.2%	77.4%
61350	La Salle IL	5	0.2%	77.6%
60516	DuPage IL	4	0.2%	77.7%
60148	DuPage IL	4	0.2%	77.9%
60504	DuPage IL	4	0.2%	78.1%

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(September 1, 2010 - August 31, 2011)

Zip	County	Discharges	% of Total Volume	Cumulative Volume
46375	Lake IN	4	0.2%	78.2%
60101	DuPage IL	4	0.2%	78.4%
60119	Kane IL	4	0.2%	78.5%
60110	Kane IL	4	0.2%	78.7%
60175	Kane IL	4	0.2%	78.8%
60534	Cook IL	4	0.2%	79.0%
60102	McHenry IL	4	0.2%	79.1%
60429	Cook IL	4	0.2%	79.3%
60491	Will IL	4	0.2%	79.4%
60451	Will IL	4	0.2%	79.6%
60053	Cook IL	4	0.2%	79.7%
60056	Cook IL	4	0.2%	79.9%
60060	Lake IL	4	0.2%	80.0%
60026	Cook IL	4	0.2%	80.2%
60193	Cook IL	4	0.2%	80.4%
60099	Lake IL	4	0.2%	80.5%
60069	Lake IL	4	0.2%	80.7%
46368	Porter IN	4	0.2%	80.8%
60452	Cook IL	4	0.2%	81.0%
60404	Will IL	4	0.2%	81.1%
46410	Lake IN	4	0.2%	81.3%
60090	Cook IL	4	0.2%	81.4%
60091	Cook IL	4	0.2%	81.6%
60047	Lake IL	4	0.2%	81.7%
60018	Cook IL	4	0.2%	81.9%
61701	McLean IL	4	0.2%	82.0%
61342	La Salle IL	4	0.2%	82.2%
61615	Peoria IL	4	0.2%	82.3%
61010	Ogle IL	4	0.2%	82.5%
60546	Cook IL	4	0.2%	82.7%
61102	Winnebago IL	4	0.2%	82.8%
60914	Kankakee IL	3	0.1%	82.9%
60714	Cook IL	3	0.1%	83.0%
60461	Cook IL	3	0.1%	83.1%
62711	Sangamon IL	3	0.1%	83.3%
62526	Macon IL	3	0.1%	83.4%
61571	Tazewell IL	3	0.1%	83.5%
60442	Will IL	3	0.1%	83.6%
60115	DeKalb IL	3	0.1%	83.7%
60964	Kankakee IL	3	0.1%	83.8%
60436	Will IL	3	0.1%	84.0%
61764	Livingston IL	3	0.1%	84.1%
61028	Jo Daviess IL	3	0.1%	84.2%
61832	Vermilion IL	3	0.1%	84.3%
61364	La Salle IL	3	0.1%	84.4%
60154	Cook IL	3	0.1%	84.5%
61053	Carroll IL	3	0.1%	84.6%
60419	Cook IL	3	0.1%	84.8%
60160	Cook IL	3	0.1%	84.9%
60169	Cook IL	3	0.1%	85.0%
60181	DuPage IL	3	0.1%	85.1%

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 (September 1, 2010 - August 31, 2011)

Zip	County	Discharges	% of Total Volume	Cumulative Volume
60406	Cook IL	3	0.1%	85.2%
61081	Whiteside IL	3	0.1%	85.3%
60188	DuPage IL	3	0.1%	85.4%
61114	Winnebago IL	3	0.1%	85.6%
60194	Cook IL	3	0.1%	85.7%
61008	Boone IL	3	0.1%	85.8%
60505	Kane IL	3	0.1%	85.9%
42301	Ohio KY	3	0.1%	86.0%
60532	DuPage IL	3	0.1%	86.1%
46350	La Porte IN	3	0.1%	86.3%
60561	DuPage IL	3	0.1%	86.4%
60515	DuPage IL	3	0.1%	86.5%
60510	Kane IL	3	0.1%	86.6%
60506	Kane IL	3	0.1%	86.7%
60563	DuPage IL	3	0.1%	86.8%
48867	Shiawassee MI	3	0.1%	86.9%
52641	Kankakee IL	3	0.1%	87.1%
60586	Will IL	3	0.1%	87.2%
65109	Kankakee IL	3	0.1%	87.3%
60471	Cook IL	3	0.1%	87.4%
61252	Whiteside IL	2	0.1%	87.5%
60151	Kane IL	2	0.1%	87.6%
61354	La Salle IL	2	0.1%	87.6%
60044	Lake IL	2	0.1%	87.7%
60008	Cook IL	2	0.1%	87.8%
60155	Cook IL	2	0.1%	87.9%
46637	St Joseph IN	2	0.1%	87.9%
46404	Lake IN	2	0.1%	88.0%
68135	Kankakee IL	2	0.1%	88.1%
61443	Henry IL	2	0.1%	88.2%
60173	Cook IL	2	0.1%	88.2%
61401	Knox IL	2	0.1%	88.3%
60025	Cook IL	2	0.1%	88.4%
46323	Lake IN	2	0.1%	88.5%
62704	Sangamon IL	2	0.1%	88.5%
46321	Lake IN	2	0.1%	88.6%
60192	Cook IL	2	0.1%	88.7%
46310	Jasper IN	2	0.1%	88.8%
46304	Porter IN	2	0.1%	88.9%
60195	Cook IL	2	0.1%	88.9%
85650	Kankakee IL	2	0.1%	89.0%
60050	McHenry IL	2	0.1%	89.1%
61109	Winnebago IL	2	0.1%	89.2%
60081	McHenry IL	2	0.1%	89.2%
53142	Kenosha WI	2	0.1%	89.3%
52807	Scott IA	2	0.1%	89.4%
61925	Moultrie IL	2	0.1%	89.5%
60097	McHenry IL	2	0.1%	89.5%
49116	Berrien MI	2	0.1%	89.6%
61606	Peoria IL	2	0.1%	89.7%
47711	Vanderburgh IN	2	0.1%	89.8%

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(September 1, 2010 - August 31, 2011)

Zip	County	Discharges	% of Total Volume	Cumulative Volume
49022	Kankakee IL	2	0.1%	89.9%
60130	Cook IL	2	0.1%	89.9%
60118	Kane IL	2	0.1%	90.0%
60120	Kane IL	2	0.1%	90.1%
60007	Cook IL	2	0.1%	90.2%
62930	Saline IL	2	0.1%	90.2%
62522	Macon IL	2	0.1%	90.3%
61802	Champaign IL	2	0.1%	90.4%
62525	Macon IL	2	0.1%	90.5%
60124	Kane IL	2	0.1%	90.5%
48304	Oakland MI	2	0.1%	90.6%
49103	Berrien MI	2	0.1%	90.7%
60487	Cook IL	2	0.1%	90.8%
61068	Ogle IL	2	0.1%	90.8%
60466	Cook IL	2	0.1%	90.9%
60473	Cook IL	2	0.1%	91.0%
60958	Kankakee IL	2	0.1%	91.1%
60415	Cook IL	2	0.1%	91.2%
60475	Will IL	2	0.1%	91.2%
60526	Cook IL	2	0.1%	91.3%
60544	Will IL	2	0.1%	91.4%
60459	Cook IL	2	0.1%	91.5%
60523	DuPage IL	2	0.1%	91.5%
60910	Kankakee IL	2	0.1%	91.6%
60564	Will IL	2	0.1%	91.7%
60540	DuPage IL	2	0.1%	91.8%
60433	Will IL	2	0.1%	91.8%
61062	Stephenson IL	2	0.1%	91.9%
60204	Cook IL	2	0.1%	92.0%
61821	Champaign IL	2	0.1%	92.1%
60517	DuPage IL	2	0.1%	92.1%
61071	Whiteside IL	2	0.1%	92.2%
60403	Will IL	2	0.1%	92.3%
60560	Kendall IL	2	0.1%	92.4%
60457	Cook IL	2	0.1%	92.5%
60481	Will IL	2	0.1%	92.5%
60447	Grundy IL	2	0.1%	92.6%
47112	Harrison IN	1	0.0%	92.6%
47524	Knox IN	1	0.0%	92.7%
60514	DuPage IL	1	0.0%	92.7%
47906	Tippecanoe IN	1	0.0%	92.8%
47401	Monroe IN	1	0.0%	92.8%
66209	Kankakee IL	1	0.0%	92.8%
46514	Elkhart IN	1	0.0%	92.9%
47203	Bartholomew IN	1	0.0%	92.9%
46845	Allen IN	1	0.0%	93.0%
46804	Allen IN	1	0.0%	93.0%
46540	Elkhart IN	1	0.0%	93.0%
46601	St Joseph IN	1	0.0%	93.1%
46613	St Joseph IN	1	0.0%	93.1%
46614	Kankakee IL	1	0.0%	93.1%

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(September 1, 2010 - August 31, 2011)

Zip	County	Discharges	% of Total Volume	Cumulative Volume
46619	St Joseph IN	1	0.0%	93.2%
46530	St Joseph IN	1	0.0%	93.2%
49814	Marquette MI	1	0.0%	93.3%
53144	Kenosha WI	1	0.0%	93.3%
53128	Walworth WI	1	0.0%	93.3%
60482	Cook IL	1	0.0%	93.4%
52750	Clinton IA	1	0.0%	93.4%
52747	Kankakee IL	1	0.0%	93.5%
60484	Cook IL	1	0.0%	93.5%
52347	Iowa IA	1	0.0%	93.5%
52208	Kankakee IL	1	0.0%	93.6%
52003	Dubuque IA	1	0.0%	93.6%
49085	Berrien MI	1	0.0%	93.6%
50219	Marion IA	1	0.0%	93.7%
60513	Cook IL	1	0.0%	93.7%
49525	Kent MI	1	0.0%	93.8%
65713	Kankakee IL	1	0.0%	93.8%
49301	Kent MI	1	0.0%	93.8%
49128	Berrien MI	1	0.0%	93.9%
49117	Berrien MI	1	0.0%	93.9%
60585	Will IL	1	0.0%	93.9%
49101	Berrien MI	1	0.0%	94.0%
49022	Berrien MI	1	0.0%	94.0%
60501	Cook IL	1	0.0%	94.1%
48622	Clare MI	1	0.0%	94.1%
50548	Humboldt IA	1	0.0%	94.1%
34996	Martin FL	1	0.0%	94.2%
66442	Kankakee IL	1	0.0%	94.2%
45214	Hamilton OH	1	0.0%	94.3%
45056	Butler OH	1	0.0%	94.3%
44333	Summit OH	1	0.0%	94.3%
44141	Cuyahoga OH	1	0.0%	94.4%
44120	Cuyahoga OH	1	0.0%	94.4%
44119	Cuyahoga OH	1	0.0%	94.4%
44089	Erie OH	1	0.0%	94.5%
43110	Franklin OH	1	0.0%	94.5%
42076	Calloway KY	1	0.0%	94.6%
46012	Madison IN	1	0.0%	94.6%
37931	Knox TN	1	0.0%	94.6%
46204	Marion IN	1	0.0%	94.7%
34110	Collier FL	1	0.0%	94.7%
33957	Lee FL	1	0.0%	94.8%
33707	Pinellas FL	1	0.0%	94.8%
33707	Kankakee IL	1	0.0%	94.8%
33486	Palm Beach FL	1	0.0%	94.9%
33437	Palm Beach FL	1	0.0%	94.9%
33156	Miami-Dade FL	1	0.0%	94.9%
33036	Monroe FL	1	0.0%	95.0%
30066	Kankakee IL	1	0.0%	95.0%
29201	Richland SC	1	0.0%	95.1%
28562	Craven NC	1	0.0%	95.1%

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(September 1, 2010 - August 31, 2011)

Zip	County	Discharges	% of Total Volume	Cumulative Volume
41139	Greenup KY	1	0.0%	95.1%
92660	Kankakee IL	1	0.0%	95.2%
46408	Lake IN	1	0.0%	95.2%
66216	Kankakee IL	1	0.0%	95.3%
53168	Kenosha WI	1	0.0%	95.3%
72131	Kankakee IL	1	0.0%	95.3%
55391	Hennepin MN	1	0.0%	95.4%
77479	Kankakee IL	1	0.0%	95.4%
46373	Lake IN	1	0.0%	95.4%
80303	Kankakee IL	1	0.0%	95.5%
60555	DuPage IL	1	0.0%	95.5%
46356	Lake IN	1	0.0%	95.6%
45342	Montgomery OH	1	0.0%	95.6%
46349	Newton IN	1	0.0%	95.6%
46409	Lake IN	1	0.0%	95.7%
94027	Kankakee IL	1	0.0%	95.7%
60554	Kane IL	1	0.0%	95.7%
94577	Kankakee IL	1	0.0%	95.8%
60551	La Salle IL	1	0.0%	95.8%
46321	Kankakee IL	1	0.0%	95.9%
Unknown	Fairfield CT	1	0.0%	95.9%
60538	Kendall IL	1	0.0%	95.9%
Unknown	Kankakee IL	1	0.0%	96.0%
46304	Kankakee IL	1	0.0%	96.0%
46303	Lake IN	1	0.0%	96.1%
46301	Porter IN	1	0.0%	96.1%
46356	Cook IN	1	0.0%	96.1%
61531	Fulton IL	1	0.0%	96.2%
54449	Wood WI	1	0.0%	96.2%
60427	Cook IL	1	0.0%	96.2%
60140	Kane IL	1	0.0%	96.3%
60139	DuPage IL	1	0.0%	96.3%
60133	Cook IL	1	0.0%	96.4%
61032	Stephenson IL	1	0.0%	96.4%
20008	District of Columbia	1	0.0%	96.4%
Unknown	Noble Nova Scotia	1	0.0%	96.5%
61483	Stark IL	1	0.0%	96.5%
60954	Kankakee IL	1	0.0%	96.6%
60146	DeKalb IL	1	0.0%	96.6%
61525	Peoria IL	1	0.0%	96.6%
61359	Bureau IL	1	0.0%	96.7%
61548	Woodford IL	1	0.0%	96.7%
61561	Woodford IL	1	0.0%	96.7%
60104	Cook IL	1	0.0%	96.8%
60103	DuPage IL	1	0.0%	96.8%
60948	Iroquois IL	1	0.0%	96.9%
61603	Peoria IL	1	0.0%	96.9%
60941	Kankakee IL	1	0.0%	96.9%
60448	Will IL	1	0.0%	97.0%
60096	Lake IL	1	0.0%	97.0%
60938	Iroquois IL	1	0.0%	97.1%

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2011 Rehabilitation Institute Zip Code Draw Area

(September 1, 2010 - August 31, 2011)

Zip	County	Discharges	% of Total Volume	Cumulative Volume
60950	Kankakee IL	1	0.0%	97.1%
61073	Winnebago IL	1	0.0%	97.1%
61111	Winnebago IL	1	0.0%	97.2%
61107	Winnebago IL	1	0.0%	97.2%
61104	Winnebago IL	1	0.0%	97.2%
60341	La Salle IL	1	0.0%	97.3%
61087	Jo Daviess IL	1	0.0%	97.3%
60191	DuPage IL	1	0.0%	97.4%
60190	DuPage IL	1	0.0%	97.4%
60187	DuPage IL	1	0.0%	97.4%
60407	Grundy IL	1	0.0%	97.5%
61201	Rock Island IL	1	0.0%	97.5%
60145	DeKalb IL	1	0.0%	97.5%
60176	Cook IL	1	0.0%	97.6%
60924	Iroquois IL	1	0.0%	97.6%
60174	Kane IL	1	0.0%	97.7%
61270	Whiteside IL	1	0.0%	97.7%
60164	Cook IL	1	0.0%	97.7%
60163	Cook IL	1	0.0%	97.8%
60162	Cook IL	1	0.0%	97.8%
61065	Boone IL	1	0.0%	97.9%
60424	Grundy IL	1	0.0%	97.9%
60153	Cook IL	1	0.0%	97.9%
61046	Carroll IL	1	0.0%	98.0%
61036	Jo Daviess IL	1	0.0%	98.0%
60177	Kane IL	1	0.0%	98.0%
60602	Cook IL	1	0.0%	98.1%
62544	Macon IL	1	0.0%	98.1%
62567	Christian IL	1	0.0%	98.2%
62618	Cass IL	1	0.0%	98.2%
62656	Logan IL	1	0.0%	98.2%
60021	McHenry IL	1	0.0%	98.3%
62702	Sangamon IL	1	0.0%	98.3%
60603	Cook IL	1	0.0%	98.4%
60468	Will IL	1	0.0%	98.4%
62712	Sangamon IL	1	0.0%	98.4%
60469	Cook IL	1	0.0%	98.5%
61745	McLean IL	1	0.0%	98.5%
64105	Kankakee IL	1	0.0%	98.5%
60041	Lake IL	1	0.0%	98.6%
60002	Lake IL	1	0.0%	98.6%
58554	Morton ND	1	0.0%	98.7%
56601	Beltrami MN	1	0.0%	98.7%
55418	Hennepin MN	1	0.0%	98.7%
55358	Wright MN	1	0.0%	98.8%
54401	Marathon WI	1	0.0%	98.8%
53717	Kankakee IL	1	0.0%	98.9%
53704	Dane WI	1	0.0%	98.9%
53226	Milwaukee WI	1	0.0%	98.9%
53189	Waukesha WI	1	0.0%	99.0%
63034	Kankakee IL	1	0.0%	99.0%

ATTACHMENT 12

2011 Rehabilitation Institute Zip Code Draw Area
 (September 1, 2010 - August 31, 2011)

Zip	County	Discharges	% of Total Volume	Cumulative Volume
60458	Cook IL	1	0.0%	99.0%
53181	Kenosha WI	1	0.0%	99.1%
61772	McLean IL	1	0.0%	99.1%
61801	Champaign IL	1	0.0%	99.2%
60083	Lake IL	1	0.0%	99.2%
60915	Kankakee IL	1	0.0%	99.2%
60431	Will IL	1	0.0%	99.3%
60074	Cook IL	1	0.0%	99.3%
60071	McHenry IL	1	0.0%	99.3%
60070	Cook IL	1	0.0%	99.4%
61856	Platt IL	1	0.0%	99.4%
60034	McHenry IL	1	0.0%	99.5%
61910	Douglas IL	1	0.0%	99.5%
60604	Cook IL	1	0.0%	99.5%
61938	Coles IL	1	0.0%	99.6%
61956	Douglas IL	1	0.0%	99.6%
62220	St. Clair IL	1	0.0%	99.7%
62305	Adams IL	1	0.0%	99.7%
62448	Jasper IL	1	0.0%	99.7%
62514	Macon IL	1	0.0%	99.8%
62521	Macon IL	1	0.0%	99.8%
60633	Cook IL	1	0.0%	99.8%
60463	Cook IL	1	0.0%	99.9%
60606	Cook IL	1	0.0%	99.9%
61761	McLean IL	1	0.0%	100.0%
61858	Vermilion IL	1	0.0%	100.0%
Grand Total		2,611	100.0%	

Source: Rehabilitation Institute of Chicago, Internal 2011 Data

ALTERNATIVES

Through the course of planning over the past five years, RIC has critically evaluated several options to ameliorate the capacity constraints and provide secure, long-term capacity to serve RIC's growing local, regional, national and international patient demand.

One of the differentiating elements to RIC's new care model and design is the creation of an Ability Lab™ that will be on each patient recovery unit. It is within the RIC Ability Lab™ that clinical care and research come together, around the patient, to create more effective solutions to patient's issues, faster and more efficiently than anywhere else in the world. As described in previous attachments to this application, the Ability Lab will include a combination of equipment, smart devices and cutting-edge technology that will represent not only current best practice rehabilitation care but also new and innovative practices that hold promise for future methods of advancing patient ability. Through RIC's planning, it has become very clear that there are no alternatives to RIC's Ability Lab™, and any alternative solutions must incorporate the same capability within an RIC facility.

1. Alternatives

Option 1: Attempt to renovate the current structure and simultaneously construct a new bed tower separate from existing facility.

In 2005, RIC, in partnership with Northwestern Memorial Hospital (NMH), acquired the land owned by the Jessie Brown Veterans Affairs Medical Center at the Lakeside Campus. At that time, RIC began planning for a new bed tower to occupy 30% of the eastern portion of that land, which would be RIC's share of the parcel. During planning, RIC learned the maximum it could build on that land would not exceed 415,000 square feet in the approximately 40,000sf footprint, due to existing FAR constraints and requirements to jointly plan any construction with NMH. The 40,000 square foot did not allow for an efficient floor ratio to maximize the Ability Lab™ concept and create an efficient nursing care delivery model.

In order to create space for the full integration of RIC programming and eliminate space presently housed in downtown office buildings, it quickly became clear that RIC would need to maintain its current facility across the street at 345 E. Superior and operate both facilities simultaneously.

Introducing a second facility virtually eliminated the efficiencies RIC sought in putting research and clinical care together in one facility. As described, the fundamental driver of RIC's differentiation is the integration of research with clinical care and without a large enough foot print and space, this would not be possible. RIC today operates some clinical services and much of the administrative space outside of the Flagship Hospital on Superior Street. While sufficient for clinical operations, this is not optimal for coordinating among staff, and in particular between clinicians and researchers.

The primary concern with this alternative is it does not position RIC for long-term stability. Northwestern University (NU) is the land owner of the existing hospital and provides the use of the space to RIC under a land lease. Any capital changes made to the existing facility must be approved by NU, with potential restrictions on what could be done. Due to their need, NU has expressed interest in assuming control of the facility before the end of the lease. Making substantial capital improvements to the facility does not provide any future use beyond the term of the existing lease. RIC would not control its own future ability to provide services in the existing building and as a result, would not be in the long-term interests of RIC nor the patients.

Another major downside to this option is the lack of parking. Today, RIC provides limited parking onsite, with the majority of parking provided in third party garages located several blocks away. RIC's patient base has special needs related to parking and access. Today, RIC provides valet service, but that service is inconvenient and costly. In addition there are limits regarding the number of valet parking spaces available. The VA site is zoned to not include parking, so the option will not provide the critical parking required to support RIC's unique patient needs.

The costs to renovate the existing facility and construct the new facility would be significant, and in fact not meaningfully less than RIC's preferred option. Renovation of the existing facility alone is estimated to cost over \$100 million in hard costs*. While this cost would provide for additional capability, due to the small footprint (18,500 square feet) the space would be very inefficient, increasing operating costs. Building a second facility would cost an additional \$200 million in hard costs*. At the time of RIC's initial analysis, Jones Lang LaSalle, a large construction management and real estate consulting firm was engaged to verify these conclusions. More recently, Power Construction validated and updated the costs for this option.

In addition to the actual costs of renovation and construction, operating two facilities would be significantly inefficient. RIC would need to maintain multiple duplicative services, including heating and air conditioning plants, facilities and engineering staff and resources, mechanical and engineering maintenance, elevator maintenance, security, food service, environmental services, and energy consumption. Finally, while a new facility would have advantages of the latest efficiency technologies, the existing facility would not operate as efficiently as a new facility due to the outdated infrastructure, skin, etc.

Estimated total cost of this option: in excess of \$305 Million in hard costs*

*Hard cost estimates do not include cost of architecture, engineering, technology, furniture, fixtures and equipment, and other professional services. These costs are estimated to be 40% of the hard cost.

Option 2: Construct a new facility remote from Northwestern Memorial Hospital and the Medical Campus.

RIC considered building a facility outside of the medical campus, conceptually considering a suburban Chicagoland location. The most significant concern of this alternative is the potential loss of patients from Northwestern Memorial Hospital (NMH). NMH does not operate rehabilitation services, and therefore refers virtually all appropriate patients to RIC. RIC concluded that the close proximity to NMH is necessary in order to continue providing access to care for the hospital's common patients. With approximately 50% of RIC's inpatients coming from NMH, physical proximity is critical to RIC's work.

In addition, proximity to NMH is critical for patient care. NMH and RIC have developed processes and technology infrastructure to coordinate care between the organizations to provide safe and seamless cost efficient care across providers. As an example, medical information of patients being discharged from NMH to RIC can be viewed on-line by RIC physicians in advance of patient transfer. This capability allows RIC to ensure proper precautions, equipment and accommodations are in place to ensure patient safety and comfort. No other rehabilitation provider in Chicago has coordinated systems with NMH and as a result referrals to any other providers would be less efficient and risk interruptions and patient safety in transferring patients.

From a cost perspective, while a suburban facility would be less expensive to construct, it would require more costly operating expenses such as emergency services and operating rooms, and likely higher labor costs as RIC has historically had more difficulty hiring staff for suburban locations. Today, RIC does not operate an emergency department or operating room facilities, and does not plan to have these services in the new facility. Instead, RIC relies on NMH for such services. If RIC were to create a free-standing suburban hospital, it would lose immediate access to NMH services and therefore would need to duplicate these essential services. This duplication would be prohibitively costly to build, operate and maintain.

Finally, the contiguous location of RIC, NMH and NU facilitates research and training. RIC's relationship and collaboration with Northwestern University (NU) for research and training is critical to the future of RIC as it pursues advances in science to integrate with clinical care. NU researchers use RIC facilities for applied research, and RIC's researchers participate in animal lab research in NU facilities. Moreover, RIC is the clinical training site for 40 residents each year from the McGraw Medical Center; specifically, RIC is the residency training program for NU students. As before, a distant location would most likely require duplicating services for both organizations and be difficult for the NU residents. There are three components of this training program: RIC is the primary training site for the largest Physical Medicine and Rehabilitation training program in the country; RIC is the rehabilitation rotation for residents who are in other McGraw programs; and 170 Northwestern medical students are at RIC throughout the school year, with 30 students in one-month electives and an additional ten students who spend the summer at the hospital.

If RIC were to leave the McGraw Medical Center campus, it is unclear how NMH would respond, including potentially build rehabilitation beds to have closer services for its patients. This would result in unnecessary additional capital costs to the local healthcare system.

Estimated total cost of this options: \$270 million in hard costs* (see note above regarding hard costs). This cost does not include the cost of land. While difficult to estimate land costs, the eventual solution would require RIC to acquire land, assuming an attractive location would be possible to find.

Option 3: Make improvements to the facility's infrastructure and utilize other healthcare resources that are available to serve all or a portion of the population proposed to be served by the project.

RIC considered whether it would be possible to make improvements to the existing hospital and seek to meet the demand for increased services by utilizing other existing healthcare resources particularly those within RIC's alliance hospitals. This option was rejected for several reasons. Most notably, as described earlier in the application, RIC's programs are truly unique – as demonstrated by large and growing number of patients from outside Chicago and across the world. With the largest rehabilitation research enterprise in the country, the largest physical medicine and rehabilitation residency program in Illinois, one of the largest in the country, the largest number of complex rehabilitation patients, the most advanced technology and equipment, RIC has no peer hospital in Illinois. As additional evidence of RIC's recognized expertise, RIC receives referrals from most other hospitals in Illinois, including those with inpatient rehabilitation facilities (IRF).

***Hospitals Sending Patients to RIC
Fiscal Year 2011***

	Number of Hospitals with Inpatient Rehabilitation Facility/Unit (IRF)	Number of Hospitals with IRF that sent patients to RIC	% of Hospitals with IRF that sent patients to RIC
Chicagoland	31	21	67%
Illinois	46	28	61%

As this application details, RIC has developed twelve outpatient sites remote from the Flagship Hospital to bring needed access to physical rehabilitation services to patients needing care. While these sites are essential to patient therapies, they do not provide inpatient rehabilitation services.

Among the other rehabilitation providers in Illinois, RIC has nine existing strategic alliances with acute care providers serving patients across the state. These hospitals are:

- Advocate Illinois Masonic Medical Center (Chicago)
- Alexian Brothers Hospital Network (Elk Grove Village)

- Blessing Hospital (Quincy)
- RML Specialty Hospital (Hinsdale)
- Silver Cross Hospital (Joliet)
- Southern Illinois Healthcare (Herrin)
- Saint Margaret Mercy Healthcare Centers (Northwest Indiana)
- Saint Anthony Health – Crown Point (Northwest Indiana)
- Saint Anthony Health – Michigan City (Northwest Indiana)

Through these alliances, RIC operates the inpatient rehabilitation services and offers improved access to care remote from its main campus in Streeterville. For a portion of patients, these strategic alliances offer appropriate staff and resources to provide excellent care. In fact, RIC currently refers patients to an alliance location if the Flagship Hospital is full and if the patient can be appropriately cared for in the alliance. This is a common practice, particularly as the Flagship Hospital has been operating at such high occupancy rates. Patients benefit from RIC protocols and expertise in their local markets. However, for other, more complex patients – including all pediatric patients – RIC will refer patients to its Flagship Hospital because of the staff expertise and resources only available there. This referral pattern is a testament to the truly unique expertise that exists at the RIC's Flagship Hospital.

RIC's alliance hospitals do not currently have an Ability Lab™ as part of the space or care paradigm. This concept is being pioneered at the Flagship Hospital and as the concept is proven and improved, RIC may seek to distribute relevant elements to alliances. However, none of the alliance facilities have available space, technologies or research to appropriately incorporate the concept of the Ability Lab™ into the care model. Significant work and training would be required if RIC's alliances were to be able to care for patients in the same way as they are treated in the downtown facility.

RIC estimated the cost for this alternative, using a combination of renovations to the existing structure and enhancements to the alliance locations. As noted above, renovation costs for the existing Flagship Hospital are significant in a facility for which RIC does not own the land. In addition, since there would be no other facility downtown, RIC's patients would need to be diverted to other locations before the renovations were complete. Shutting down inpatient care units during renovation is costly from an operating income perspective, which is not calculated in the estimate provided. A phase premium has been estimated into the cost due to the time delays that would be required to accommodate ongoing operations.

After renovations would be completed, RIC's existing Flagship Hospital would continue to be inadequate and inefficient space for carrying out RIC's care model. A renovated facility still would not have sufficient space for incorporating Ability Labs™ and enough private rooms to meet the demand for patients.

Estimated total cost of this option: \$290 million in hard costs* (see note above regarding hard cost).

Option 4: Construct a new hospital with adequate space and appropriate design that can meet the needs of patients and which is located proximate to the McGaw Medical Campus.

Option 4 was selected for several strategic, operating and financial reasons, including:

- Based upon the data presented, RIC is at capacity. In order to support current needs and documented growth, RIC must build a new facility.
- Renovation of the existing facility would be cost prohibitive.
- A new facility design is necessary to facilitate clinical excellence. The future of medicine is the integration of scientists and physicians working together in the same space, solving patient problems fast, improving recovery, discovering cures. In order for this to occur, the hospital's space must accommodate and support this innovation.
- The new hospital must be located proximate to the McGaw campus, insuring the continuity of RIC's relationships with other medical partners. Strategically, RIC's proximity and link with campus partners Northwestern Memorial Hospital, Northwestern University and the future site of the Ann and Robert H. Lurie Children's Hospital of Chicago is critical to RIC's ability to support its patients, advance research, attract clinicians, and improve rehabilitation medicine. Moreover, NMH and Lurie Children's are two of RIC's most critical and largest referral sources, and these institutions rely on RIC to provide expert rehabilitation services that is easily accessible to their patients.
- The new RIC facility located on the McGaw Medical Center campus will provide all the campus partners with the highest level of patient safety. Seamless transfer of patients within the campus into an integrated facility will maximize patient oversight and treatment, thereby improving quality.
- RIC's continued presence within the Northwestern medical campus will insure patients' access to specialty and ancillary services.
- Locating the new facility proximate to the McGaw campus will help attract world-class clinicians to the medical center, and facilitate educational and training opportunities for clinicians, including medical residents and students.

- RIC's continued presence on the Northwestern campus promotes the overall medical center by leveraging RIC's national and international stature.
- RIC's facility in Streeterville insures that the Northwestern medical campus will continue to provide a broad continuum of medical services and will better position the Northwestern healthcare providers as they separately and collectively seek better outcomes and efficiencies in implementing the comprehensive changes confronting healthcare providers.
- Operating one facility, rather than two adjoining facilities, will result in significant cost and treatment efficiencies. A single facility will avoid unnecessary duplication of services and will facilitate the coordination of care by clinicians and researchers within RIC.
- The establishment of the hospital at the new site will secure RIC's long term future because ownership of the property is held by RIC.
- RIC's new Research Hospital will benefit from a more efficient physical plant, incorporating advances in resource-saving technologies while serving more patients. RIC can avoid creating duplicative services and focus its financial resources on the unique services it provides.
- The proposed site and the ability to integrate parking supports RIC's desire to respond to the unique patient care requirement of our patients.

Estimated total cost of this option: \$330 million in hard costs* (See note above regarding hard cost.)

2. The four options detailed above include a comparison of the project (Option 4) with the alternative options. The comparison includes total costs, patient access, quality and financial benefits in both the short term and long term.

3. The new facility will improve patient outcomes and quality of care.

The Center for Health Design's definition of evidence-based design in "the process of basing decisions about the built environment on credible research to achieve the best possible outcomes." Evidence is now abundant, with over 1,000 studies citing proven benefit to design decisions. RIC is currently in the process of design decisions, working in partnership with HDR|Gensler architecture team. While decisions have not yet been made, the following design elements are being considered for RIC's new Research Hospital.

Design Element	Benefits to RIC
Build single patient rooms	Reduced infections, increased privacy, increased functional capacity, increased patient satisfaction, reduced patient room transfers and related costs
Adequate space for families for overnight stay	Increased patient, family, staff satisfaction; better integration of family into education and preparation for discharge
Larger patient bathrooms with double door	Decrease in falls, staff back injuries; accommodate larger equipment (e.g., bathchairs)
Ceiling mounted lifts	Decreased patient falls, staff injuries; encourage patients with functional deficits to navigate their environment safely
Meet established noise-level standards	Decreased stress, sleep deprivation; increased patient satisfaction
Access to natural light	Decrease patient anxiety and depression, LOS; increased staff satisfaction
Decentralized caregiver workstations	Increased staff time on direct patient care
Effective wayfinding systems	Decreased staff time spent giving directions; Decreased patient and family stress

SIZE OF PROJECT

The proposed project is a master facility design and planning process that will culminate in a plan for the development of a replacement rehabilitation research hospital. Because that planning process has yet to be completed, the proposed square footage allocations have not been finalized, and will not be finalized until the planning process has been completed. RIC's new Research Hospital will, based on planning to date, include, only two functional areas for which the Illinois Health Facilities and Services Review Board (IHFSRB) maintains standards. Those two areas, consistent with IHFSRB reporting requirements, are identified in the table below.

DEPARTMENT/SERVICE	PROPOSED DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
Comp. Rehabilitation (272)	230,982	179,520	0.70/bed	no
Radiology*	15,653	16,200	(547)	yes

*assumes 9 general radiology, 1 ultrasound, 1 CT and 1 MRI

The proposed square footages identified above, because the planning process has yet to be completed, should be viewed as preliminary.

The space to be allocated to the comprehensive physical rehabilitation patient units will exceed the IHFSRB's standard, as a result of the scope of services provided as well as a variety of factors discussed in detail in ATTACHMENT 12. The patient units are not intended to mirror other rehabilitation units. Rather, they will incorporate concepts not seen at other Illinois hospitals, such as an Ability Lab, in which both therapies are provided and research is conducted by clinical and research staff. Among other factors contributing to the size of the units are RIC's commitment to physician and allied health professional educational and training programs; innovative treatment programs, some of which are provided only at RIC, and others of which are provided at only a handful of hospitals, nationwide; clinical, including patient-centered research programs; RIC's commitment to locate all patients in private rooms; the extraordinary need for equipment storage on the patient units; and the need to provide family support space.

PROJECT SERVICES UTILIZATION

It is anticipated that RIC's new Research hospital will include one "category of service" and four other clinical areas for which the Illinois Health Facilities and Services Review Board (IHFSRB) maintains utilization target levels or standards.

The hospital's only "category of service" will be comprehensive physical rehabilitation, and it is projected that the 85% target utilization rate will be reached during the first calendar year following the project's completion, and surpassed the following year.

Utilization projections are based on a number of factors to be discussed in detail in the Certificate of Need Application to replace the hospital. Those factors include: the hospital's historical high occupancy levels, the hospital's need to "turn" away 882 patients in 2010 due to a lack of beds, the impact of an aging service area population on demand, and new programs.

The remaining clinical areas to be provided and having IHFSRB-identified standards are all imaging modalities. Two of those imaging modalities that will be provided in the new Research Hospital---CT and MRI---are services that are not currently provided at RIC. Ultrasound (which is currently provided), CT and MRI are each modalities that are viewed by the applicant as being appropriate in the diagnosis and treatment of RIC's patient population. The IHFSRB standards for these three services are identified in the table below as being not applicable, because only one unit is being provided, and it is not anticipated that utilization will be sufficient to support a second unit in any of these methodologies. Some limited ultrasound and radiology services are currently provided to RIC patients at the Flagship Hospital. Additional radiology services as well as all MRI, CT and other specialty imaging services are provided at Northwestern Memorial Hospital. Planning is currently in process to identify the extent, if any, to which non hospital-based equipment will continue to be used, particularly for procedures that the IHFSRB classifies as "general" (i.e. procedures performed using a C-arm). As a result, the volume of general radiology procedures cannot be reasonably estimated at this point in the planning process.

The table on the following page provides both historical and projected utilization information, consistent with IHFSRB reporting requirements.

Dept./ Service	Historical ¹ Utilization (Patient Days) (TREATMENTS) ETC.	PROJECTED UTILIZATION		STATE STANDARD	MET STANDARD?
		YEAR 1 ²	YEAR 2		
Comp. Rehab.	53,221	84,388	86,432	84,388	yes
Gen'l. Radiology	8,392	--- ⁴	--- ⁴	64,001	--
Ultrasound	490	777	796	n/a ³	n/a
CT	0			n/a ³	n/a
MRI	0			n/a ³	n/a

¹calendar 2010
²calendar 2015
³one unit
⁴see discussion
above

Section V: Master Design and Related Projects

1110.235(a): System Impact

1. **The availability of alternative healthcare facilities within the planning area and the impact that the proposed project and subsequent related projects will have on the utilization of such facilities.**

No healthcare facilities within Planning Area 6, or in all of the State of Illinois, provide the comprehensive physical rehabilitation services that are available at RIC. RIC's clinical breadth, its scope of research and innovation, and its medical team distinguish it from all other providers of these services. Hospitals that are located in Planning Area 6, in the contiguous planning areas, throughout the State of Illinois, as well as around the country refer to RIC to access its unique specialty care. RIC is unlike any other provider of rehabilitation services in the country.

The map at the end of this section illustrates the Illinois counties from where RIC received at least one patient in the past fiscal year. The RIC map is contrasted with similar maps from the next five largest inpatient rehabilitation providers in the state. As clearly demonstrated, RIC's service area and patient flow exist far beyond those of Planning Area 6 and significantly more broad than the next largest state providers. (See map at the end of this attachment.)

One additional map illustrates RIC's reach relative to the State's Health Service Areas. This map shows that RIC has received patients from every one of the state's 11 Health Service Areas for rehabilitation. No other rehabilitation provider in the State has admitted patients from all Health Service Planning Areas.

Based on the State's inventory, there appears to be availability of beds in the service area for comprehensive physical rehabilitation. This is based on the state's planning assumptions, which RIC believes understates the demand for rehabilitation as we explain in Attachment 21 of this application. Moreover, none of the providers of comprehensive physical rehabilitation in Planning Area 6 provide the scope of services that RIC provides with regard to research and clinical care for the large number and complexity of patients that RIC treats daily.

RIC offers a very unique, tertiary level of rehabilitation care as evidenced by the fact RIC currently accepts patients from most every hospital in the market, particularly for catastrophic injuries and complex medical conditions, in addition to less-complex cases, as illustrated in the table below.

**Hospitals Sending Patients to RIC
Fiscal Year 2011**

	Number of Hospitals with Inpatient Rehabilitation Facility/Unit (IRF)	Number of Hospitals with IRF that sent patients to RIC	% of Hospitals with IRF that sent patients to RIC
Chicagoland	31	21	67%
Illinois	46	28	61%

***Inpatient Rehabilitation Facilities or Unit**

This existing referral pattern is due to the fact that most clinicians at acute care hospitals (physicians, case managers and social workers) recognize the need for appropriate specialty services and equipment in order to provide safe and quality care for patients. Since most inpatient rehabilitation facilities do not offer types of services that RIC provides, it is reasonable to expect that such referral patterns will continue in the future, with little impact on other provider facilities.

In addition to the current utilization for services in the market, the projections for future volume – as detailed in Attachment 21 – is based on acute care discharge growth, in general and also specifically from Northwestern Memorial Hospital, as well as population growth and aging. RIC expects utilization growth of rehabilitation services based on aging to drive a significant increase in the number of beds required. The table below illustrates the increase in utilization of inpatient rehabilitation by patients under and over age 65. There is clearly a significant difference in utilization and as the Chicagoland and Illinois population continues to age, there will be greater demand of inpatient rehabilitation services.

Inpatient Rehabilitation Utilization

	Under Age 65	Age 65+	Difference
Inpatient Rehabilitation Utilization per 10,000 people	10.3	116.1	11+ times greater (1,122%)

Source: IHA CompData, CY 2010

Finally, the increase in demand for RIC services can be expected to have similar, although less impact on other rehabilitation providers, since the overall utilization of services will increase, generating demand for all providers of rehabilitation services.

RIC's larger impact is due to the larger geographic reach, including patients from outside Illinois and around the world.

2. How the services proposed in future projects will improve access to planning area residents.

RIC currently is unable to accept all patients who need access to RIC's unique level of care at its flagship facility due to capacity constraints. The chart below shows the number of patients who were unable to access RIC in fiscal year 2011 due to either a lack of bed availability and/or other structural inadequacies, e.g., lack of private rooms.

**RIC Flagship Admissions and Additional Potential Admissions:
FY2010 and 2011**

	Fiscal Years	
	2010	2011
Admissions Lost	823	736

RIC's new facility would improve access to care by providing all private patient rooms and a modern facility with better access to ancillary clinical services and other amenities (e.g. patient lifts, enhanced technology) that would improve patient care and safety. Moreover, the unique collaboration of clinical care and research will result from the inspiration that happens when patients, clinicians and researchers are intimately knit together with one purpose—to minimize and eliminate the pain and effects of disease, injury, and disabling health conditions. No other rehabilitation provider has made the commitment to bring leading edge, life altering research to the patient unit like RIC intends to do.

The new facility would enable RIC to improve access to all patients, regardless of income or ability to pay. As noted earlier, RIC maintains a significant percentage of patients who rely on government payors such as Medicare and Illinois public aid. As RIC's occupancy expands, RIC expects to maintain the commitment to all patients and therefore would serve a growing number of Medicare and Illinois Public Aid patients.

3. What the potential impact upon planning area residents would be if the proposed services were not replaced or developed

A material and deleterious impact would result from the failure to permit RIC to establish a facility that is adequate to meet its patients' needs. As noted, access to care would continue to be limited to residents if the new facility was not developed since the existing facility is not equipped, in size or design, to provide necessary specialty care for patients. RIC's current capacity limits access, as noted in the table above. Patients from NMH and

all other Chicagoland hospitals would be impacted by limited access to RIC's market-leading services. RIC would be unable to develop the integrated care model due to space and configurations limitations. RIC's current bed configuration only provides 45 private rooms, at a time when private rooms have become an accepted standard of care at leading healthcare institutions and an expectation of RIC's patient population. RIC is at capacity, patients are currently being turned away, and no other provider in the region is able to provide them the high quality care and innovative research that is necessary and appropriate for their medical condition.

RIC not only treats patients, but helps them return to their prior employment and remain productive. Beginning a career, returning to school or reentering the working world is important to a patient's financial security and emotional wellbeing. Rehabilitation can facilitate the return to a productive, independent and fulfilling life. To that end, RIC provides comprehensive vocational rehabilitation services that are tailored to meet the needs of each patient. These services include an initial assessment, diagnostic evaluation, work trial assessments, job analysis, return-to-work evaluation, job placement, resume writing and interviewing workshops, an Internet Job Skills course, and internship coordination. Patients can receive vocational services at eight RIC facilities to ensure that employment assistance is closely tied to community reintegration. During the past six years, this program has served an average of 500 patients annually. For clients who enter into Job Placement Services, an average of 92% are successful at obtaining and maintaining employment.

The Vocational Rehabilitation Program maintains connection to the business community through the RIC Business TEAM, which is comprised of more than 100 recruiters and managers who help RIC promote employment for people with disabilities. RIC hosts several luncheons each year for Business TEAM members to receive information on topics such as litigation, reasonable accommodations, advantages to hiring people with disabilities, and sharing of successful employment outcomes based on partnership between businesses and the Vocational Rehabilitation Program. For 33 years, the program has sponsored an annual corporate awards luncheon to recognize exemplary employers and corporate leaders who support employment of people with disabilities. Additionally, Business TEAM members participate in an annual Career Day hosted by the Vocational Rehabilitation Program to introduce clients to prospective employers. The Vocational Rehabilitation Program distributes educational literature addressing a range of vocational issues, and invites all of its "graduates" to attend a monthly job maintenance group for ongoing peer support. The program also provides graduate students with internship opportunities and provides outreach services and presentations locally and nationally to the rehabilitation community.

RIC is also committed to insuring that pediatric patients do not experience an interruption of their education and also seeks to integrate their therapy into their educational programs. For inpatients of school age, RIC initiates specific educational activity with the child's school district and integrates educational activity and school work into therapy. The finalization of the educational plan then occurs in RIC's Day Rehabilitation program. RIC has two Chicago Board of Education (CBOE) teachers assigned to work

with patients between ages of 3 and 21. By law, hospitalized children who are unable to attend school are entitled to educational instruction in their hospital. RIC's CBOE teachers will instruct all eligible Chicago children, and will also instruct all eligible children from other school districts if appropriate and approved by the other school district. RIC maintains communication with the school throughout the patient's stay. When appropriate, a member of the team attends the Domain/IEP meeting at the school. Recommendations for modifications in the classroom are generated by the treating team and shared with the school and teachers.

Upon discharge to day rehabilitation, an RIC pediatric care coordinator works with patients' school to initiate home bound tutoring. At times, some of RIC's patients are not registered for school. In these cases, the pediatric care coordinator works with the family to get them registered.

Our links to students and educational institutions reach far beyond pediatric patients. As noted, every Northwestern Medical student is required to rotate through RIC for two weeks. Approximately 30 students do one-month electives, and 10 students spend the summer at RIC. RIC also has 193 student affiliation agreements, 122 of which are for nursing, occupational therapy (OT), physical therapy (PT) and speech language pathology (SLP) disciplines. (See attached list of student affiliations as of December 5, 2011.)

4. The anticipated role of the facility in the delivery system including anticipated patterns of patient referral, and contractual or referral agreements between the applicant and other providers that will result in the transfer of patients to the applicant's facility.

As noted above, RIC receives referrals from most other Chicagoland hospitals, including those with inpatient rehabilitation units. These strong referral relationships are expected to continue as RIC recruits national experts in rehabilitation medicine, as it extends its research programs, and as it works to integrate clinical innovations in all of its therapies. The only limitations on these referrals is the inadequate space and design of the current hospital.

RIC is a committed partner in providing the very best in rehabilitative care to the many Service Members who have returned from Iraq, Afghanistan and other combat zones with catastrophic injury and compromised physical ability. Traumatic brain injury (TBI) is the signature debilitating injury of the operations in Iraq and Afghanistan. In addition to TBI, service personnel have suffered traumatic amputation, spinal cord injury and numerous other major surface and internal injuries.

In 2007, RIC assisted Senator Richard J. Durbin with the development of federal legislation that will strengthen the rights of Service Members and Veterans who have experienced injuries. A key component of the bill allows the Department of Defense to

enter into partnerships with public and private entities “to prevent, diagnose, mitigate, treat and rehabilitation” Service Members. RIC has and continues to be a destination for certain catastrophic cases, receiving injured Service Members directly from military treatment facilities and returning patients home, fully coordinating and handing off Service Members’ care to lifetime medical support by the Veteran’s Administration. The application materials include articles relating to the clinical care of soldiers, and a discussion of how RIC interfaces with the Department of Defense and the Veterans’ Administration in treatment of wounded military personnel. (See Attachment 12.)

RIC’s new facility would enable the hospital to advance the treatment of Service Members, as well as non-military personnel, with state-of-the-art equipment and modern facilities that would improve patient care. RIC will strengthen referral relations to ensure acute care physicians are knowledgeable of RIC’s services.

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

- 1. The anticipated completion date: 2016**
- 2. Evidence that the proposed number of beds and services is consistent with the need assessment provisions of Part 1100; or documentation that the need for the proposed number of beds and services is justified due to such factors, but not limited to:**
 - a. Limitation on government funded patients that are expected to continue;**
 - b. Restrictive admission policies of existing planning area healthcare facilities**
 - c. Planning area population is projected to exhibit indicators of medical care problems such as average family income below poverty levels or projected high infant mortality.**

At the time of filing this application, RIC has 182 rehabilitation beds. At this juncture in its planning, RIC proposes that its new facility will open with 272 inpatient beds, representing a 90 bed increase in the hospital’s bed capacity. The increase in beds is necessary to provide sufficient access to inpatient care within a facility design that allows state of the art rehabilitation care to thrive. The outmoded facility design and limited space/beds leaves RIC unable to treat the patients that need its care, and forces it to turn away patients who cannot access appropriate services elsewhere. As noted above, RIC has not been able to admit over 1,500 patients over the past two fiscal years. In addition to providing access to current patient referrals, RIC projects robust need for rehabilitation services in the future. RIC’s methodology for future needs for its inpatient physical rehabilitation services is described in detail in Attachment 21.

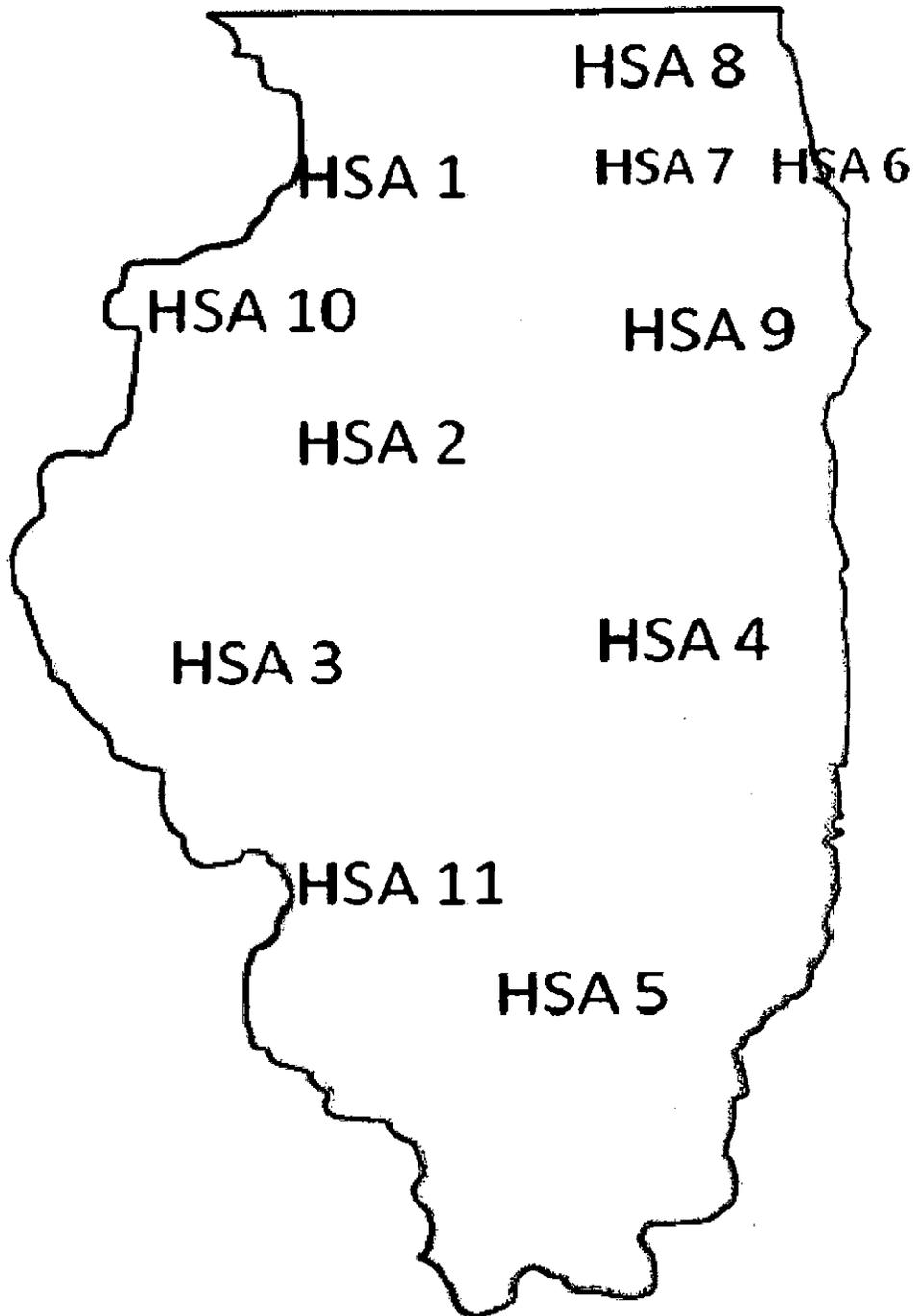
Moreover, RIC cares for patients around the globe. Specifically, in the last two years alone, patients have come from the following countries:

Australia	Bangladesh	Brazil	Canada	Chile
China	Denmark	England	Finland	Germany
Greece	Guatemala	India	Iran	Iraq
Israel	Italy	Japan	Korea	Kuwait
Lebanon	Mexico	Netherlands	Norway	Pakistan
Panama	Philippines	Qatar	Romania	Russia
Saudi Arabia	Switzerland	Turkey	UAE	Venezuela

No other hospital in the State of Illinois draws patient from as large a geographic market. RIC's global reach is testament to the uniqueness of its service and the quality outcomes that the hospital has been able to achieve.

RIC Patient Origin

In calendar year 2010, RIC admitted patients from every Illinois Health Service Area. No other rehabilitation provider has admitted patients from all Health Service Areas in the State.



Source: IHA CompData

Comprehensive Physical Rehabilitation

This attachment, in combination with Attachment 12 and 18, responds to those sections of Criteria 1110.630 that apply for the establishment of Comprehensive Physical Rehabilitation.

Bed Need Methodology

Background

Given the unique role that RIC plays in the world, a traditional analysis of bed need within the hospital's proximate geographic market materially underestimates the need for the care RIC provides. RIC's patients come from an expanded geographic market when compared to other Illinois hospitals, therefore, a broader approach to bed need planning is required. Moreover, RIC's own experience has shown that traditional acute care planning models are neither appropriate nor accurate for RIC's post-acute care planning purposes. Over a decade ago, RIC's strategic planning began to incorporate a more specific methodology to evaluate post-acute care services and has been evolving this methodology ever since.

Unlike traditional acute care methodologies, RIC's methodology projects patient volume for a specific post-acute provider. RIC does not use a generic market based method, but instead uses a market analysis based on rehabilitation-specific patients at acute care hospitals. RIC believes this method is unique in the industry, no other provider or consultancy has been found to have as accurate a method as RIC uses for forecasting post-acute patient volume.

RIC has been using and evolving the methodology over the past ten years as it conducted analyses to establish strategic alliances with acute care providers in the region. As a part of discussions with these hospitals, RIC completes an evaluation of the market opportunity so as to project the inpatient rehabilitation bed need at these remote locations. Since each RIC alliance is unique, each analysis is specific to the alliance hospital situation. The assessment examines different market areas, different competitive dynamics, and different acute care strengths. RIC's breadth of experience in creating and operating alliances has added a deeper level of understanding of how to apply this planning model.

The alliance agreements have confirmed RIC's confidence in its methodology. For each alliance RIC has established, the planning projections developed from the model have been accurate within 10% of the actual bed need just a few years after RIC's involvement.

Methodology Overview

For planning the new Research Hospital, RIC conducted a multi-year planning process to forecast patient volume for inpatient rehabilitation services. The basis for this planning tool was the proven methodology used in the alliance experience.¹ However, given the magnitude of the project and long-term time horizon associated with the projections, RIC retained an experienced, external consultancy to validate and augment the methodology. HealthCare Futures is a healthcare strategic consulting firm that has worked with leading hospitals and health systems across the country, including Northwestern University, University of Chicago and other nationally acclaimed academic medical centers. HealthCare Futures conducted a detailed market analysis approach while also incorporating RIC's methodology to create a new, more rigorous tool, uniquely for RIC. This tool incorporates acute care and rehabilitation market data into a more specific and detailed modeling tool that could be used to project further into the future (i.e., 10 years vs. a short-term focused). This planning methodology has continued to be updated and refined each year as RIC continues to monitor trends in utilization and patient demand for services. RIC has determined that its conclusions accurately forecast RIC's experience

The model has been most recently corroborated by HDR Architects, the #1 rated healthcare architecture design team in the country. HDR has validated the level of detail specific to rehabilitation that is built into the model and confirmed it is unique to the industry.

The market analysis and resulting methodology for projecting demand is based on key drivers of inpatient rehabilitation:

1. Population demographics, including population size and age
2. Acute care hospital discharges, including specifics for Northwestern Memorial Hospital, our primary referral source.
3. Assessment of technology advances for acute care and rehabilitation
4. RIC differentiated service offerings; including continuing attraction of local Chicagoland as well as out-of-state and international patients for Spinal Cord Injury, Brain Injury, Pediatrics, and other programs as described in Attachment 12 of this application.

Details within each of these drivers are analyzed as well as several other factors are used in the planning tool, such as length of stay and occupancy. In contrast to traditional acute care planning tools, the RIC model does not rely on service-line market share estimates to project growth. Instead, the number of patients by conditions (e.g. stroke, spinal cord injury, brain

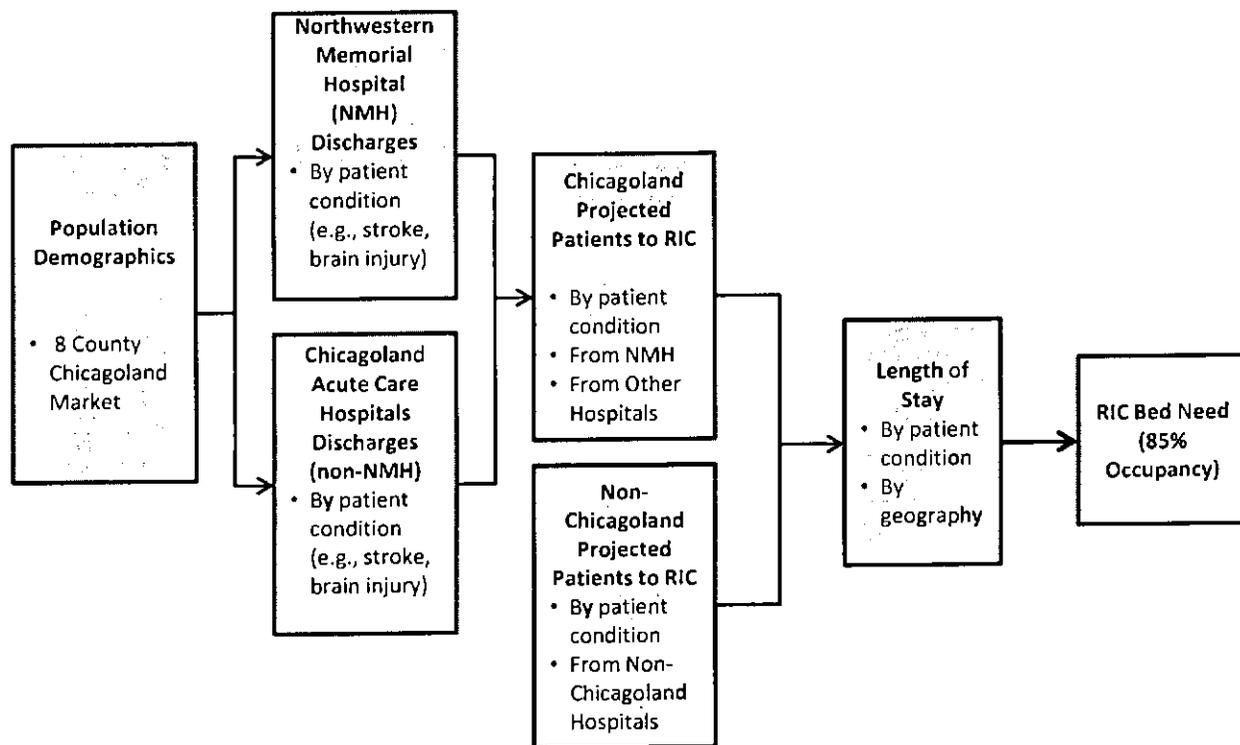
¹ As noted in Attachment 13, RIC has alliance agreements with: Advocate Illinois Masonic Medical Center (Chicago); Alexian Brothers Hospital Network (Elk Grove Village); Blessing Hospital (Quincy); RML Specialty Hospital (Hinsdale); Silver Cross Hospital (Joliet); Southern Illinois Healthcare (Herrin); Saint Margaret Mercy Centers (Northwest Indiana); Saint Anthony Health- Crown Point and Michigan City.

injury) are projected to be admitted to RIC. As a result, this model is more accurate in determining bed need for post-acute care.

Using market data and RIC expert opinion on the drivers of each factor, the model calculates multiple bed scenarios, based on sensitivities for each factor, to determine a bed range for future demand. The analytical results are then vetted by RIC experts for reasonability and risk assessment. Due to the changing complexity of acute rehabilitation services and the growing focus on brain related injuries and conditions, RIC sought the input and reaction from the country's leading neuroscience's medical expert who also has a focus in stem cell therapy from Northwestern University on RIC's bed projection. As a result of the detailed quantitative analysis and qualitative rehabilitation-specific assessment, RIC is confident that its bed projections are accurate.

The illustration below represents a simplified visual of the Market Analysis for RIC's bed need.

*RIC Bed Need Methodology
Adult Patients¹*



¹ Adult patients are calculated separate from Pediatrics. The pediatrics methodology is the same as adult, except it does not use Northwestern Memorial Hospital.

Detailed Methodology: Population Demographics

The Chicagoland population is one of the largest in the country, with approximately 8.5 million people. Growth rates are projected to range from -2% in Cook county to +18% in Will County – one of the fastest growing counties in the country. Based on US Census projections, the overall population is expected to grow 2% over five years. More significantly, the Chicagoland population is aging. There are approximately 1 million people over the age of 65 (11% of the population) and by 2025, this oldest cohort will reach 16% of the population. The trend in population aging is widely known and occurring across the country as baby boomers have now begun to reach age 65; it is estimated that 10,000 people will reach 65, every day for the next 19 years.

Healthcare demand substantially increases with the aging of the population. The population use rate of inpatient rehabilitation services for people over age-65 is eleven times (11x) the rate of people under age-65. This is due to the higher need for rehabilitation services for patient conditions that effect older Americans such as stroke, neurological condition, cancer and orthopedic conditions. The implications are significant: even with modest growth rates, the aging of the population will drive an ever greater need for rehabilitation services.

Inpatient Rehabilitation Utilization

	Under Age 65	Age 65+	Difference
Inpatient Rehabilitation Utilization per 10,000 people	10.3	116.1	11+ times greater (1,122%)

Source: IHA CompData, CY 2010

Detailed Methodology: NMH and Chicagoland Acute Care Discharges

As a post-acute provider, RIC treats patients who are transferred from an acute care hospital. RIC does not provide “life saving” stabilizing services such as an Emergency Department or operating rooms. Instead, RIC admits patients for inpatient services who have been evaluated and determined to be medically stable and able to participate in rehabilitation therapy, yet require 24-hour nursing services and daily physician oversight. Therefore, RIC is able to project patient demand using acute care hospital discharges as a significant driver.

The table below lists the number of patients discharged from acute care hospitals in the Chicagoland area with primary diagnosis shown by category. These patient categories are all appropriate for inpatient rehabilitation, the actual number being admitted to RIC or other providers depends on a number of factors described below.

*Chicagoland Patients by Condition
Fiscal Year 2010*

<i>Patient Condition</i>	<i>2010 Chicagoland Acute Care Discharges</i>
Orthopedic Conditions (including fractures and joint replacements)	40,702
Cancer	28,596
Neurological Conditions (including Parkinsons and Alzheimers)	25,179
Stroke	13,994
Brain Injury	12,966
Amputee	3,535
Spinal Cord Injury	2,332
Other Conditions (including cardiac, pulmonary, gastrointestinal, etc.)	192,499
Total	316,269

For each patient condition noted above, a patient may be transferred to inpatient rehabilitation based on the complexity of the condition and functional limitations that occurred as a result of the illness or injury. Therefore, the RIC model projects the acute care discharges for all Chicagoland hospitals, and identifies NMH separately (for reasons described below). The projections are done by age cohort for under age-65 and over age-65. The Chicagoland acute care market for these conditions over the past five years has grown approximately 2% on average per year; based on population growth and aging and technological changes (described in the following section), RIC expects continued growth in acute care services.

The attached exhibit shows the results of the market analysis RIC completed for the Chicagoland acute care historical discharges and projected need for the diagnostic groups that RIC treats. The data is grouped into categories similar to the above table. (See attachment.)

In addition to the general acute care market, RIC works closely with NMH to project the RIC bed need attributable to NMH's growth. As part of our strategy to deliver cost effective services, RIC believes that it is imperative to provide sufficient and appropriate rehabilitation capacity to meet the growing demands of NMH patients. NMH uses RIC as its primary rehabilitation provider. As a campus partner, RIC believes strongly in the obligation to support the patient population and advance the reputation status of the Northwestern Medicine medical center, while partnering in the delivery of cost effective services.

As RIC's largest referral source, NMH provides approximately 50% of the hospital's patient volume. NMH has had demonstrated success growing patient volume by providing high quality acute care services. Over the past five years, NMH has grown on average 3% in total admissions

per year. Looking forward, NMH projects admission growth projects to be 2.1% per year. This continued growth will generate need for rehabilitative services, the vast majority of which will be provided by RIC.

Similarly, Children's Memorial Hospital is RIC's primary referral source for pediatric patients. The pediatric methodology is similar to the adult methodology, with a focus on Children's Memorial Hospital as the primary referral source. Children's has been growing modestly under capacity constraints and projects future growth to be approximately 3% per year in the future. Importantly, with the opening of the new Lurie Children's Hospital of Chicago, RIC will be prepared to accommodate new growth of patients, including a growing number of patients that we have seen due to children being even more complex conditions and needing rehabilitation.

Technology Changes

The effects of technology and regulatory/legislative issues on healthcare remain unclear, and are even more uncertain for post acute providers. Since forecasting these issues is difficult, RIC has conducted research with internal and external experts to gauge the effects on the post-acute market. In short, there is little consensus – with opinion and historical facts leading to both increases and decreases in expected utilization of rehabilitation services.

Notwithstanding, RIC will continue to be a leader in the use of innovative and proven methods of treatment. RIC is the #1 rehabilitation hospital receiving NIH research support; leading the nation in the development and implementation of new treatments, while continuing to provide the highest level of care as measured by case mix index. As a result of such aggressive positioning, RIC believes certain patients and referrers will be more willing to seek care at RIC than other rehabilitation providers.

RIC has projected a range of results that will impact prospective need for post-acute services.

- Stem cell research offers important opportunities for persons with spinal cord injuries, potentially providing these patients with the opportunity to walk again.
- Advances in life-saving technology in acute care are enabling patient to survive previously fatal accidents. Patients now surviving traumatic events such as car accidents or cardiovascular and stroke events may be more likely to need inpatient rehabilitation services due to more significant injury or physical damage.
- Bionic Medicine, which is central to RIC's most innovative clinical work, is already transforming the lives of people with amputations.
- Other technological advances, such as minimally invasive surgeries, will actually decrease the need for post acute care services, enabling patients to return home after the acute care stay.

- New pharmacological treatments for cancer as well as neurological diseases (e.g. Parkinsons) will add a level of complexity to the functional impairments patients suffer. While pharmacologic agents may help patients slow or reverse the course of the disease, the impairments will remain and therefore must be treated more aggressively and coordinated with the acute care treatment.

Despite exciting new advances in technology and treatment, the specific impact of those innovations cannot be forecast precisely, and therefore we have put less emphasis on these changes to the overall bed need.

Projected Patients to RIC: Differentiated Service Offerings

The success of RIC's differentiated programs in attracting patients from the local, national and international market is a strong driver of growth for new beds at RIC's new Research Hospital. RIC has established disciplined processes, communications and marketing efforts to educate both referrers and patients on the benefits of RIC's integrated research and clinical care. These efforts have led to increases in patients being transferred to RIC, particularly for conditions that are more complex such as neurological conditions of stroke, brain injury, and spinal cord injury. As described earlier, RIC's programs for these conditions are examples of the differentiation that RIC has created. As the care model continues to evolve and more research is integrated with patient care, RIC believes the differentiated offerings will be even more compelling and will continue to attract patients from the local and distant markets.

As noted previously, RIC admits patients who have been transferred from an acute care hospital, the volume of which is projected as described above. Estimates are then made of the percent of patients from acute care hospitals that would transfer to RIC, based on geographic distance and patient type.

For example, according to modeling using Illinois Hospital Association's CompData, between 8% and 15% of patients with a brain injury in an acute care hospital will be discharged to an inpatient rehabilitation provider. RIC projects that between 5% and 40% of those patients will be transferred to RIC, depending on the age of the patient and distance from RIC. The large variation is due primarily to the difference in age groups: a traumatic brain injured patient under the age of 65 is 41%, while an over age-65 traumatic brain injury patient is 5%.

This same analysis is conducted for each patient condition. For example, RIC currently captures a high percentage of spinal cord injury patients in the Chicagoland market given the expertise and reputation of RIC's services and few competitors who can treat such patients. By contrast, patients with orthopedic conditions have many more options for care – RIC projects to capture fewer patients over time in this category.

Further detailed analysis is conducted for patients coming from NMH. As might be expected, given the close proximity to and relationship with NMH and the clinical staff, a higher percentage of patients currently transfer from NMH to RIC. In RIC's experience, between 60% and 80% of the spinal cord injury patients from NMH are transferred to RIC for post-acute care. Again, the range is based on patient age and complexity. Spinal cord patients have the highest percentage of admissions, given the clear clinical need, the lack of providers who can provide a comparable service, the integration with the spinal cord unit at Northwestern. (By way of example, the medical director of the NMH Spinal Cord Program is the medical director of RIC's Spinal Cord Program.) The transition of patients is well integrated which results in efficient communications and better overall care, and less overall cost to the healthcare system.

Importantly, RIC's experience working with acute care providers has led to a decrease in the amount of time that patients spend in the more expensive acute care setting. When RIC physicians provide consultation for patients in an acute care hospital such as NMH, the hospital has found that having a rehabilitation bed available will decrease the length of the acute care stay and reduce "avoidable days" for the acute care hospital. This is a direct cost savings to the acute care hospital and healthcare system overall. By contrast, when RIC is "full," referring hospitals will keep the most complex patients an extra day or longer until a bed becomes available as there are no other adequate providers who can treat the patient.

An additional component of this driver is the inclusion of out-of-market patients. Currently, approximately 10% of RIC inpatients come from outside Illinois, including international patients, representing over 200 patients. While it is not feasible to reasonably estimate market data for an international market, it is expected that the demand for out-of-market patients will continue to grow. This projection is based on RIC's historical growth of 2% per year over the past five years, and continued success in differentiated programs.

Other Operating Factors and Regulatory Environment

The final factors that are included in the modeling are operational measures. As an example, RIC estimates the length of stay (LOS) by condition to calculate total patient days. As part of this process, RIC internal physician experts inform the planning by estimating the expected changes in medical complexity and potential technology that may influence LOS in the future. For patients with more complex conditions, there are scenarios where LOS is maintained due to the increased need for medical attention. However, the vast majority of clinical situations expect a slight decrease over time in LOS.

Another factor that may have an impact is the regulatory environment. There are potentially significant changes possible as a result of government regulations. RIC has resources committed to maintaining current knowledge at the state and federal levels with regard to potential changes in regulations. Through its internal planning process, RIC has envisioned scenarios that could be

very favorable for RIC and other strong rehabilitation providers, and other situations that could be significantly deleterious to the hospital. At this time, without better knowledge to forecast such extreme cases, RIC has not factored in any regulatory scenarios into the bed need.

The table below is a summary of the resulting bed need for opening and five years following opening.

RIC new Research Hospital Projected Admissions

	2016	2017	2018	2019	2020
Admissions	3,896	4,094	4,298	4,506	4,720
Patient Days	78,819	82,569	86,444	90,448	94,582
ADC	215.9	226.2	236.8	247.8	259.1
Total Beds	272	272	272	272	272
% Occupancy	79%	83%	87%	91%	95%

Part 1100 calls for 85% utilization after 2 years of operation

Exhibit for Bed Need: RIC Market Analysis

Data Shown:

- Population Size and Growth by age cohort
- Acute Care Market for select categories. Some conditions have been combined; for example, amputee is part of orthopedic conditions.
- RIC projected patient admissions. RIC categories shown are based on grouping of patients based on underlying condition. For example, Stroke and Brain Injury are grouped into the "Brain" category. The underlying conditions are aggregated into these categories and become the basis for facility decisions during programming.

RIC Market Analysis: Acute Care Discharges; RIC Patient Projections by Condition Category; Data by Fiscal Year ending August 31

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Population														
Under age 65	7,691,007	7,731,661	7,704,818	7,746,111	7,765,341	7,784,571	7,803,802	7,823,032	7,842,262	7,886,377	7,930,492	7,974,607	8,018,722	8,062,837
Over age 65	944,744	950,330	965,738	970,914	998,904	1,026,895	1,054,886	1,082,876	1,110,867	1,156,387	1,201,907	1,247,427	1,292,947	1,338,467
Acute Care Discharges														
Stroke	14,181	14,123	13,919	13,994	14,245	14,494	14,740	14,984	15,226	15,639	16,049	16,455	16,856	17,254
Brain Injury	12,669	12,898	12,897	12,966	13,156	13,347	13,541	13,736	13,932	14,249	14,569	14,892	15,218	15,547
Spinal Cord Injury	2,293	2,307	2,320	2,332	2,368	2,383	2,409	2,434	2,459	2,503	2,547	2,591	2,635	2,679
Neurological Conditions	20,752	24,040	25,045	25,179	25,847	26,523	27,207	27,898	28,597	29,631	30,678	31,738	32,812	33,899
Orthopedic Conditions	39,860	40,588	40,485	40,702	41,448	42,193	42,939	43,685	44,430	45,670	46,910	48,149	49,389	50,629
Cancer	28,943	29,348	28,444	28,596	29,044	29,491	29,938	30,385	30,832	31,583	32,334	33,085	33,836	34,587
All Other General Conditions	194,832	197,558	191,473	192,499	195,509	198,519	201,529	204,539	207,549	212,604	217,659	222,714	227,768	232,823
Total	313,530	320,862	314,583	316,269	321,607	326,951	332,302	337,651	343,026	361,880	360,745	369,624	378,515	387,418

RIC Projections (RIC Patient Groupings)

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Brain	1,211	1,226	1,381	1,442	1,542	1,533	1,623	1,753	1,830	2,368	2,540	2,735	2,928	3,128
Spinal Cord	304	385	397	309	331	347	344	365	374	497	517	537	558	579
Neuromusculoskeletal	689	652	659	486	504	547	542	551	535	647	640	631	621	608
Pods	168	199	183	231	234	273	278	289	290	384	389	394	399	404
Total	2,372	2,462	2,620	2,468	2,611	2,684	2,787	2,958	3,029	3,896	4,094	4,298	4,506	4,720

CLINICAL SERVICE AREAS OTHER THAN CATEGORIES OF SERVICE

The proposed project, as identified in the table below, includes four clinical areas for which the Illinois Health Facilities and Services Review Board (IHFSRB) does not maintain utilization of space standards.

In the most general of terms, RIC's physical plant, which was built in 1974, has become obsolete when compared to the cutting edge treatment and research programs provided and envisioned, limits programmatic development, does not provide appropriately-sized patient rooms, requires most patients to be in multi-bed rooms, stifles the desired interaction between clinical and research staffs, and has required certain functions to move off-site. In addition, and of paramount importance, the existing hospital does not provide a sufficient number of beds to meet the hospital's demand for services.

RIC's new Research Hospital will be licensed by the Illinois Department of Public Health, and consistent with licensure requirements, both a pharmacy and a clinical laboratory must be provided.

As discussed in depth in Attachment 12, RIC is one of the leading physical medicine research institutions in the world, and as a result, the provision of clinical research space is absolutely consistent with its mission and purpose.

The remaining area in the table below is a small acute dialysis area, which will not be used as an End Stage Renal Disease (ESRD) provider, but rather, as a site for acute dialysis, consistent with the needs of a limited number of rehabilitation patients.

Service	# Existing Key Rooms	# Proposed Key Rooms
Clinical Research	N/A	N/A
Pharmacy	N/A	N/A
Acute Dialysis	N/A	N/A
Clinical Laboratory	N/A	N/A

Rehabilitation Institute, Inc. and Affiliates

Consolidated Financial Statements as of and
for the Years Ended August 31, 2011 and 2010,
and Independent Auditors' Report



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INDEPENDENT AUDITORS' REPORT

To the Finance and Audit Committee of
Rehabilitation Institute, Inc.
Chicago, Illinois

We have audited the accompanying consolidated balance sheets of Rehabilitation Institute, Inc. and Affiliates (the "Company") as of August 31, 2011 and 2010, and the related consolidated statements of operations and changes in net assets, and of cash flows for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Rehabilitation Institute, Inc. and Affiliates as of August 31, 2011 and 2010, and the results of their operations and their cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 5 to the consolidated financial statements, the consolidated financial statements include investments valued at \$142,212,000 (31.0% of total assets) and \$119,091,000 (29.1% of total assets) as of August 31, 2011 and 2010, respectively, whose fair values have been estimated by management in the absence of readily determinable fair values. In addition, the defined benefit pension plan assets disclosed in Note 12 to the consolidated financial statements includes investments of \$28,197,000,000 and \$21,833,000 as of August 31, 2011 and 2010, respectively, whose fair values have been estimated by management in the absence of readily determinable fair values. Management's estimates are based on information provided by the fund managers or the general partners.

As discussed in Note 2 to the consolidated financial statements, the Company adopted the presentation and disclosure provisions of Financial Accounting Standards Board (FASB) Accounting Standards Update (ASU) 2011-07, *Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debt and Allowance for Doubtful Accounts for Certain Health Care Entities*.

Deloitte & Touche LLP

November 22, 2011

Member of
Deloitte Touche Tohmatsu Limited

ATTACHMENT 39

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REHABILITATION INSTITUTE, INC. AND AFFILIATES

CONSOLIDATED BALANCE SHEETS AS OF AUGUST 31, 2011 AND 2010 (Dollars in thousands)

	2011	2010
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	\$ 33,378	\$ 30,265
Patient accounts receivable — less allowance for doubtful accounts of \$8,510 and \$6,513 in 2011 and 2010, respectively	23,834	20,693
Inventories of supplies	1,033	1,112
Estimated third-party payor settlements	1,450	1,192
Prepaid expenses	3,806	4,677
Pledges receivable	9,648	6,691
Grants receivable	4,503	4,974
Other current assets	<u>2,787</u>	<u>2,646</u>
Total current assets	80,439	72,250
INVESTMENTS:		
Unrestricted	145,341	116,872
Donor and other restricted	<u>92,804</u>	<u>82,023</u>
Total investments	238,145	198,895
INVESTMENTS IN JOINT VENTURES	11,940	12,459
PLEDGES RECEIVABLE — Net of current portion	34,659	30,302
LAND, BUILDING, AND EQUIPMENT — Net	91,432	92,699
DEFERRED COSTS, INTANGIBLES, AND OTHER LONG-TERM ASSETS	<u>2,081</u>	<u>2,083</u>
TOTAL ASSETS	<u>\$ 458,696</u>	<u>\$ 408,688</u>
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES:		
Current portion of long-term debt	\$ 249	\$ 14,785
Accounts payable and accrued expenses	11,868	12,389
Accrued salaries and wages	13,167	11,760
Deferred revenue	3,796	5,162
Current portion of self-insurance reserve	<u>1,000</u>	<u>2,000</u>
Total current liabilities	30,080	46,096
SELF-INSURANCE RESERVES — Net of current portion	3,906	3,276
ACCRUED PENSION BENEFITS	40,352	48,179
OTHER NONCURRENT LIABILITIES	21,325	13,390
LONG-TERM DEBT — Net of current portion	<u>110,912</u>	<u>95,890</u>
Total liabilities	<u>206,575</u>	<u>206,831</u>
NET ASSETS:		
Unrestricted	118,010	85,841
Temporarily restricted	83,714	67,691
Permanently restricted	<u>50,397</u>	<u>48,325</u>
Total net assets	<u>252,121</u>	<u>201,857</u>
TOTAL	<u>\$ 458,696</u>	<u>\$ 408,688</u>

See notes to consolidated financial statements.

REHABILITATION INSTITUTE, INC. AND AFFILIATES

CONSOLIDATED STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS FOR THE YEAR ENDED AUGUST 31, 2011 (Dollars in thousands)

	Unrestricted Net Assets	Temporarily Restricted Net Assets	Permanently Restricted Not Assets	Total
NET PATIENT SERVICE REVENUE				
Patient service revenue (net of contractual allowances and discounts)	\$ 157,237			\$ 157,237
Provision for bad debts (Note 2)	(1,859)			(1,859)
Net patient service revenue less provision for bad debts	<u>155,378</u>	<u>\$ -</u>	<u>\$ -</u>	<u>155,378</u>
OTHER REVENUE AND SUPPORT:				
Grants	16,271			16,271
Affiliation and partnerships	9,908			9,908
Unrestricted contributions	4,453			4,453
Net assets released from restriction for operating purposes	5,570			5,570
Other revenue	7,415			7,415
Total other revenue and support	<u>43,617</u>	<u>-</u>	<u>-</u>	<u>43,617</u>
Total revenue and support	<u>198,995</u>	<u>-</u>	<u>-</u>	<u>198,995</u>
EXPENSES:				
Salaries, wages, and employee benefits	120,282			120,282
Supplies and other	41,350			41,350
Professional fees and purchased services	18,208			18,208
Depreciation and amortization	10,835			10,835
Interest	1,951			1,951
Total expenses	<u>192,626</u>	<u>-</u>	<u>-</u>	<u>192,626</u>
INCOME FROM OPERATIONS	<u>6,369</u>	<u>-</u>	<u>-</u>	<u>6,369</u>
NONOPERATING GAINS (LOSSES):				
Investment returns	16,097			16,097
Loss on interest rate swap	(1,116)			(1,116)
Other gains and losses	396			396
Total nonoperating gains	<u>15,377</u>	<u>-</u>	<u>-</u>	<u>15,377</u>
EXCESS OF REVENUE, SUPPORT AND GAINS OVER EXPENSES AND LOSSES	21,746	-	-	21,746
PENSION-RELATED CHANGES OTHER THAN NET PERIODIC PENSION COST	7,847			7,847
RESTRICTED CONTRIBUTIONS		15,507	2,072	17,579
INVESTMENT RETURN ON RESTRICTED INVESTMENTS		8,586	76	8,662
NET ASSETS RELEASED FROM RESTRICTIONS FOR CAPITAL PURPOSES	2,500	(2,500)		-
NET ASSETS RELEASED FROM RESTRICTIONS FOR OPERATING PURPOSES		(5,570)		(5,570)
TRANSFER FOR ENDOWMENT REPLENISHMENT	76		(76)	-
CHANGE IN NET ASSETS	32,169	16,023	2,072	50,264
NET ASSETS — Beginning of year	85,841	67,691	48,325	201,857
NET ASSETS — End of year	<u>\$ 118,010</u>	<u>\$ 83,714</u>	<u>\$ 50,397</u>	<u>\$ 252,121</u>

See notes to consolidated financial statements.

REHABILITATION INSTITUTE, INC. AND AFFILIATES

CONSOLIDATED STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS FOR THE YEAR ENDED AUGUST 31, 2010 (Dollars in thousands)

	Unrestricted Net Assets	Temporarily Restricted Net Assets	Permanently Restricted Net Assets	Total
NET PATIENT SERVICE REVENUE				
Patient service revenue (net of contractual allowances and discounts)	\$ 146,755			\$ 146,755
Provision for bad debts (Note 2)	(2,010)			(2,010)
Net patient service revenue less provision for bad debts	<u>144,745</u>	\$ -	\$ -	<u>144,745</u>
OTHER REVENUE AND SUPPORT:				
Grants	16,760			16,760
Affiliation and partnerships	8,199			8,199
Unrestricted contributions	4,387			4,387
Net assets released from restriction for operating purposes	5,810			5,810
Other revenue	<u>7,080</u>			<u>7,080</u>
Total other revenue and support	<u>42,236</u>	-	-	<u>42,236</u>
Total revenue and support	<u>186,981</u>	-	-	<u>186,981</u>
EXPENSES:				
Salaries, wages, and employee benefits	111,090			111,090
Supplies and other	39,821			39,821
Professional fees and purchased services	17,496			17,496
Depreciation and amortization	11,083			11,083
Interest	<u>2,264</u>			<u>2,264</u>
Total expenses	<u>181,754</u>	-	-	<u>181,754</u>
INCOME FROM OPERATIONS	<u>5,227</u>	-	-	<u>5,227</u>
NONOPERATING GAINS (LOSSES):				
Investment returns	9,369			9,369
Loss on interest rate swap	(7,233)			(7,233)
Other gains and losses	<u>8,555</u>			<u>8,555</u>
Total nonoperating gains	<u>10,691</u>	-	-	<u>10,691</u>
EXCESS OF REVENUE, SUPPORT AND GAINS OVER EXPENSES AND LOSSES	15,918	-	-	15,918
PENSION-RELATED CHANGES OTHER THAN NET PERIODIC PENSION COST	(21,489)			(21,489)
RESTRICTED CONTRIBUTIONS		39,657	4,509	44,166
INVESTMENT RETURN		5,063	249	5,312
NET ASSETS RELEASED FROM RESTRICTIONS FOR CAPITAL PURPOSES	1,254	(1,254)		-
NET ASSETS RELEASED FROM RESTRICTIONS FOR OPERATING PURPOSES		(5,810)		(5,810)
TRANSFER FOR ENDOWMENT REPLENISHMENT	<u>249</u>		<u>(249)</u>	<u>-</u>
CHANGE IN NET ASSETS	(4,068)	37,656	4,509	38,097
NET ASSETS — Beginning of year	<u>89,909</u>	<u>30,035</u>	<u>43,816</u>	<u>163,760</u>
NET ASSETS — End of year	<u>\$ 85,841</u>	<u>\$ 67,691</u>	<u>\$ 48,325</u>	<u>\$ 201,857</u>

See notes to consolidated financial statements.

REHABILITATION INSTITUTE, INC. AND AFFILIATES

CONSOLIDATED STATEMENTS OF CASH FLOWS FOR THE YEARS ENDED AUGUST 31, 2011 AND 2010 (Dollars in thousands)

	2011	2010
CASH FLOWS FROM OPERATING ACTIVITIES:	\$ 50,264	\$ 38,097
Change in net assets		
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Pension-related changes other than net periodic pension cost	(7,847)	21,489
Provision for retirement costs	7,527	3,465
Retirement plan contributions	(7,507)	(4,400)
Depreciation and amortization	10,835	11,083
Net unrealized (gains) losses on investments	(16,925)	(12,814)
Net realized (gains) losses on investments	(6,315)	(873)
Net unrealized (gain) loss on swap valuation	(592)	5,978
Restricted contributions for endowment	(2,072)	(4,509)
Restricted contributions for land, building, and equipment	(4,862)	(5,122)
Termination of real estate purchase option	519	431
Equity income in joint ventures — net of cash distributions received	2,120	2,260
Provision for uncollectible accounts		
Changes in:		
Patient accounts receivable	(5,001)	(3,739)
Inventories	79	(7)
Estimated third-party payor settlements	(258)	(90)
Pledges receivable	(7,314)	(32,126)
Other assets	1,094	(4,911)
Accounts payable and accrued expenses	(750)	3,196
Accrued salaries and wages	1,407	594
Other liabilities	(2,039)	4,559
Net cash provided by operating activities	<u>12,363</u>	<u>12,993</u>
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchases of land, buildings, and equipment (net of disposals)	(7,594)	(34,220)
Purchases of investments	(46,429)	(39,829)
Sales of investments	38,196	35,264
Termination of real estate purchase option	-	9,568
Escrowed cash	-	(2,000)
Net cash used in investing activities	<u>(15,827)</u>	<u>(31,217)</u>
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payment of debt principal	(204)	(61,743)
Issuance of long-term debt	-	90,675
Issuance costs of long-term debt	(153)	(1,103)
Restricted contributions for endowment	2,072	4,509
Restricted contributions for land, building, and equipment	4,862	5,122
Net cash provided by financing activities	<u>6,577</u>	<u>37,460</u>
NET CHANGE IN CASH AND CASH EQUIVALENTS	3,113	19,236
CASH AND CASH EQUIVALENTS — Beginning of year	<u>30,265</u>	<u>11,029</u>
CASH AND CASH EQUIVALENTS — End of year	<u>\$ 33,378</u>	<u>\$ 30,265</u>
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION — Total interest paid	<u>\$ 3,696</u>	<u>\$ 3,123</u>
SUPPLEMENTAL DISCLOSURE OF NONCASH INVESTING AND FINANCING ACTIVITY — Assets acquired under a capital lease	<u>\$ 691</u>	<u>\$ -</u>

See notes to consolidated financial statements.

REHABILITATION INSTITUTE, INC. AND AFFILIATES

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
AS OF AND FOR THE YEARS ENDED AUGUST 31, 2011 AND 2010
(Columnar dollar amounts in thousands)

1. REHABILITATION INSTITUTE, INC. AND AFFILIATES

Rehabilitation Institute, Inc. (RII) was incorporated to promote and encourage rehabilitation services in the communities it serves. RII serves as the sole corporate member of Rehabilitation Institute of Chicago ("Institute"), Rehabilitation Institute Research Corporation ("Research Corporation"), and Rehabilitation Institute of Chicago Enterprises, Ltd. (RICE). The accompanying consolidated financial statements include the accounts of RII and affiliates (collectively referred to as the "Corporations") for which it serves as the parent corporation through ownership, the authority to approve Board membership, or the holding of certain reserve powers. Certain members of RII's Board of Directors are board members of the subsidiary corporations.

The Institute is a not-for-profit rehabilitation hospital, that provides comprehensive rehabilitative inpatient and outpatient services and programs.

The Research Corporation engages in, sponsors, and promotes medical and scientific research relating to the prevention and treatment of physical disabilities. On November 18, 2010, RII's Board of Directors approved the consolidation of the Research Corporation into the Institute. Effective August 31, 2011, all the assets and liabilities of the Research Corporation were transferred to the Institute. Additionally, all contracts, receivables, payables and obligations of the Research Corporation were assigned to the Institute.

RICE is a for-profit corporation which is currently not engaged in any business activities.

All significant intercompany balances and transactions have been eliminated in consolidation. RII, the Institute and the Research Corporation are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (the "Code") and are exempt from federal income taxes on related income pursuant to Section 501(a) of the Code.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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 consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents consist of demand deposits with banks and money market accounts with a maturity of less than 90 days from the date of purchase and are stated at cost which approximates fair value. Cash and cash equivalents held in the investment portfolio are classified as unrestricted investments.

Patient Accounts Receivable

Patient accounts receivable are stated at net realizable value. Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Institute analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Institute analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary. For receivables associated with self-pay patients, the Institute records a provision for bad debts and charity care in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates, if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Institute's allowance for doubtful accounts increased from 21.5 percent of net patient accounts receivable at August 31, 2010, to 24.2 percent of net patient accounts receivable at August 31, 2011. In addition, the Institute's self-pay writeoffs increased \$976,000 from \$3,398,000 for fiscal 2010 to \$4,374,000 for fiscal 2011. Both increases were the result of negative trends experienced in the collection of amounts from self-pay patients in fiscal 2011. The Institute has not changed its charity care or uninsured discount policies during fiscal 2010 and 2011. The Institute does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant writeoffs from third-party payors.

Financial Instruments

The Corporations' financial instruments consist primarily of cash, accounts receivable, investments, accounts payable, long-term debt, and an interest rate swap agreement. The carrying amounts for cash, accounts receivable, investments, accounts payable, and long-term debt approximate their fair values. The fair value of the interest rate swap agreement is disclosed in Note 10.

Investments

Unrestricted investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated balance sheets. Fair value is determined primarily on the basis of quoted market prices. Investments are classified as either long-term or short-term based on management's intent with respect to the expected use and reinvestment of such investments.

Investments in alternative securities, which consist primarily of hedged equity, international hedged equity, private equity partnerships, real assets partnerships, and absolute return funds, are accounted for at net asset value (NAV) reported by the fund, which approximates fair value, under a method similar to the equity method.

Investment return (including realized and unrealized gains and losses on investments, interest, and dividends) is included in excess of revenues, support, and gains over expenses and losses unless the income or loss is restricted by donors, in which case the investment return is recorded directly to temporarily restricted net assets. In addition, the Corporations report as other revenue allocated earnings on an amount of investments equal to the average self-insurance reserve balance during the fiscal year.

Derivative Instruments

Derivative instruments, specifically interest rate swaps, are recorded on the consolidated balance sheets at their respective fair values. The change in the fair value of the derivative instrument is reflected in nonoperating gains (losses).

Inventories

Inventories, consisting primarily of pharmaceuticals and supplies, are stated at the lower of cost, on the first in, first out method, or market.

Deferred Costs and Intangibles

Goodwill, underwriter fees, and other bond issuance costs are included with deferred costs, intangibles, and long-term assets in the accompanying consolidated balance sheets. The Institute evaluates goodwill for impairment on an annual basis. Deferred bond issuance costs and underwriter fees related to the variable rate demand bonds and commercial paper revenue notes are being amortized on a straight-line basis (which approximates the effective interest method) over the period the debt instruments are expected to be outstanding.

Property and Equipment

Land, buildings, and equipment are stated at cost less accumulated depreciation. Depreciation is provided utilizing the straight-line method over the estimated useful lives of depreciable assets. Estimated useful lives are ten to forty years for building and components and four to ten years for furniture and equipment.

Asset Impairment

The Institute evaluates long-lived assets for impairment on an annual basis. Long-lived assets are considered to be impaired whenever events or changes in circumstances indicate the carrying amount of an asset may not be recoverable from future cash flows. Recoverability of long-lived assets to be held and used is measured by a comparison of the carrying amount of an asset to future cash flows expected to be generated by the asset. When such assets are considered to be impaired, the impairment loss recognized is measured by the amount by which the carrying value of the asset exceeds the fair value of the asset. No impairment losses have been recognized in fiscal 2011 or 2010.

Income Tax Provision

A provision for income taxes of \$278,000 and \$97,000 is reported for the years ended August 31, 2011 and 2010, respectively, for estimated unrelated business income. Additionally, the Corporations perform an annual review of all tax positions and measure the potential tax benefit on the financial statements in which there is uncertainty as to whether the tax position will ultimately be sustained as filed within a tax return. The potential impact of the uncertainty on the Corporations' consolidated financial statements is minimal.

Net Assets

Resources are classified for reporting purposes into three net asset categories as unrestricted, temporarily restricted, and permanently restricted, according to the absence or existence of donor-imposed restrictions.

Temporarily restricted net assets are those whose use by the Corporations has been limited by donors to a specific time period or purpose. Temporarily restricted net assets at August 31, 2011 and 2010, principally represent amounts restricted for specific program purposes and future capital projects. Permanently restricted net assets represent contributions to be held in perpetuity, the income from which is restricted to support specific programs and charity care.

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive settlements under third-party reimbursement agreements with third-party payors. Estimated settlements are accrued in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Contributions

Unconditional promises to give cash or other assets are reported at fair value at the date the promise is received. Unrestricted contributions are reported as other revenues and support. Contributions are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the assets donated. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the consolidated statements of operations and changes in net assets as net assets released from restriction. Net assets released from restriction for operating purposes are included within other revenues and support. Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service. Donor-restricted contributions whose restrictions are met in the same reporting period as received are reported as unrestricted contributions in the consolidated statements of operations and changes in net assets.

Grant Revenue

Grant funds for research activities received prior to the incurrence of program expenses are recorded as deferred revenues and are recognized as revenues during the period in which the program expenses are incurred.

Excess of Revenue, Support, and Gains over Expenses and Losses

The consolidated statements of operations and changes in net assets include revenues, support, and gains in excess of expenses and losses. Transactions deemed by management to be related to principal operations are reported as revenues, support, and expenses. Peripheral and incidental transactions are reported as nonoperating gains and losses. Changes in unrestricted net assets which are excluded from revenues, support, and gains in excess of expenses and losses include pension-related changes other than net periodic pension cost and contributions of long-lived assets including assets acquired using contributions that by donor restriction were to be used for the purpose of acquiring such assets.

New Accounting Pronouncements

In January 2010, the Financial Accounting Standards Board (FASB) issued accounting guidance that amends current disclosure requirements under existing fair value accounting standard. It requires entities to disclose separately the amounts of significant transfers into and out of Level 1 and Level 2 fair value measurements along with the reasons for those transfers. In addition, it also requires entities to present separately information about purchases, sales, issuances, and settlements on a gross basis rather than as one net number in the reconciliation for fair value measurements using significant unobservable inputs

(Level 3). This guidance is effective for the Corporations' consolidated financial statements for the year ended August 31, 2011, except for Level 3 fair value measurement disclosure that is effective for the year ending August 31, 2012. The Corporations prospectively adopted this guidance, which resulted in additional disclosure in the fair value measurements footnote; however, it had no material impact on the Corporations' consolidated financial statements.

In August 2010, the FASB issued accounting guidance that clarifies the methods to be used for measuring charity care for disclosure. It requires health care entities to use cost as the measurement basis for charity care disclosures and that cost be identified as the direct and indirect cost of providing the charity care. This also requires disclosure of the method used to identify or determine such costs. The Corporations elected to adopt the new guidance effective September 1, 2010, and applied retrospectively to all periods presented. Adoption of this guidance had no impact on the Corporations' consolidated financial statements but resulted in additional disclosures as presented in Note 16.

In August 2010, the FASB issued accounting guidance that amends current accounting for insurance claims and related insurance recoveries for health care entities. The amendment clarifies that health care entities should not net insurance recoveries against a related claim liability. Additionally, the amount of the claim liability should be determined without consideration of insurance recoveries. The adoption is not expected to materially impact the consolidated financial statements.

In July 2011, the FASB issued accounting guidance that amends the presentation and disclosure of patient service revenue, provision for bad debts, and the allowance for doubtful accounts for certain health care entities. The Corporations elected to adopt the new guidance effective September 1, 2010, and applied retrospectively to all periods presented. Such adoption did not have a material impact on the Corporations' consolidated financial statements but resulted in a change in the presentation of the provision for bad debts in the consolidated statement of operations and changes in net assets and additional disclosures as presented above and in Note 15.

3. CONCENTRATIONS OF CREDIT RISK

The Institute grants credit without collateral to its patients. The mix of net receivables from patients and third-party payors as of August 31, 2011 and 2010, is as follows:

	2011	2010
Medicare	20 %	18 %
Medicaid	12	10
Blue Cross	17	18
Commercial and other	<u>51</u>	<u>54</u>
	<u>100 %</u>	<u>100 %</u>

4. INVESTMENT INCOME

The composition of investment return on the Corporations' investment portfolio for the years ended August 31, 2011 and 2010, is as follows:

	2011	2010
Interest and dividend income — net of fees and expenses	\$ 1,679	\$ 1,154
Net realized gains on sale of investments	6,315	873
Net change in unrealized gains and losses	<u>16,925</u>	<u>12,814</u>
Investment gains	<u>\$24,919</u>	<u>\$ 14,841</u>

Changes in net unrealized gains and losses are included with nonoperating gains and losses in the accompanying consolidated statements of operations and changes in net assets. Investment returns are included in the accompanying consolidated statements of operations and changes in net assets for the years ended August 31, 2011 and 2010, and are as follows:

	2011	2010
Other revenue	\$ 160	\$ 160
Nonoperating gains — investment return	16,097	9,369
Investment return on restricted investments	<u>8,662</u>	<u>5,312</u>
Investment gains	<u>\$24,919</u>	<u>\$ 14,841</u>

5. FAIR VALUE MEASUREMENT

Accounting guidance establishes a framework for measuring fair value, establishes a fair value hierarchy, and expands disclosures about fair value measurements. Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value is a market-based measurement and should be determined based on the assumptions that market participants would use in pricing the asset or liability in a hypothetical transaction at the measurement date.

The fair value hierarchy requires the Corporations to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are described below:

Level 1 — Unadjusted quoted prices in active markets that are accessible at the measurement date for identical assets or liabilities.

Level 2 — Quoted prices in active markets for similar assets or liabilities, quoted prices for identical or similar assets and liabilities in non-active markets, and inputs other than quoted prices that are observable for the asset or liability, either directly or indirectly.

Level 3 — Unobservable inputs for which there is little or no market data available and are based on the reporting entity's own assumptions about the assumptions that market participants would use in pricing the asset or liability.

The Corporations report investments in equity securities with readily determinable fair values and all investments in debt securities at fair value. Fair value of equity securities is determined primarily on the basis of quoted market prices.

The Corporations' shares in mutual funds are stated at fair value based on quoted market prices, which represents the net asset value of shares held by the Corporations at year-end.

The fair value of governmental fixed income obligations is primarily determined using techniques consistent with the income approach. Significant observable inputs to the income approach include data points for benchmark constant maturity curves and spreads.

The fair value of investments in corporate and other bonds is primarily determined using techniques that are consistent with the market approach. Significant observable inputs include benchmark yields, reported trades, observable broker/dealer quotes, and issuer spreads.

Investments in alternative securities consist of large-cap equity, small-cap equity, international equity, hedge funds, including hedged equity, international hedged equity, and absolute return funds, private and equity partnerships, real asset partnerships and guaranteed investment contracts.

In the case of large-cap equity, small-cap equity, international equity, and hedge funds, the holdings are in offshore corporations that are valued monthly. The underlying fund holdings are primarily exchange traded, readily marketable securities — both equities and bonds. A small percentage of holdings are in private investments and derivatives. All hedged equity, international hedged equity and absolute return has pricing policies that depend on outside pricing services to validate their pricing.

In the case of real assets partnerships and private and equity partnerships, the holdings are valued quarterly. The holdings are primarily private and not exchange traded. The fair value of these partnership investments is estimated by management of the limited partnerships based on audited financial statements and other relevant factors. As many factors are considered in arriving at the estimated fair value, the Corporations routinely monitor and assess methodologies and assumptions used in valuing these partnership interests.

In the case of guaranteed investment contracts, the holdings are valued monthly. The fair values have been determined to approximate contract values as the terms of the contract prohibit transfer or assignment of rights under the contract and provide for all distributions at a contract value, frequent resetting of contractual interest rates based upon market conditions, no significant liquidity restrictions and no defined maturities. In addition, management has determined that no adjustment from contract values is required for credit quality considerations.

The fair value of the interest rate swap agreement was determined using an industry standard valuation model, which is based on a market approach.

The information about the financial assets and liabilities measured at fair value on a recurring basis as of August 31, 2011, is as follows:

	Level 1	Level 2	Level 3	Total Fair Value
Investments:				
Cash and equivalents	\$ 14,542	\$ -	\$ -	\$ 14,542
Mutual funds	6,917			6,917
Large-cap equity	25,480		22,569	48,049
Small-cap equity	4,791		1,226	6,017
Governmental fixed income		12,568		12,568
International equity	13,855	7,407	10,543	31,805
International hedged equity			10,013	10,013
Corporate and other bonds		10,373		10,373
Hedged equity			18,984	18,984
Private and equity partnerships			15,732	15,732
Real assets partnerships			22,750	22,750
Absolute return			39,019	39,019
Guaranteed investment contracts			1,376	1,376
Total investments at fair value	<u>\$ 65,585</u>	<u>\$ 30,348</u>	<u>\$ 142,212</u>	<u>\$ 238,145</u>
Liabilities — obligations under interest rate swap agreement	<u>\$ -</u>	<u>\$ 11,375</u>	<u>\$ -</u>	<u>\$ 11,375</u>

Changes related to the fair values based on Level 3 inputs in fiscal 2011, are summarized as follows:

	Large-Cap Equity	Small-Cap Equity	International Equity	International Hedged Equity	Hedged Equity	Private and Equity Partnerships	Real Assets Partnerships	Absolute Return	Guaranteed Investment Contracts	Totals
Beginning balance — September 1, 2010	\$ 12,570	\$ 5,288	\$ 11,801	\$ 5,294	\$ 20,602	\$ 11,491	\$ 19,072	\$ 32,973	\$ -	\$ 119,091
Reclassification of fund			\$ (4,455)	\$ 4,455						
Total gains — realized/unrealized	2,499	(486)	207	264	1,219	3,061	4,100	2,643	(29)	13,478
Purchases/receipts	7,500		3,000		3,000	1,951	404	4,283	1,725	21,863
Sales/disbursements		(3,576)	(10)		(5,837)	(771)	(826)	(880)	(320)	(12,220)
Ending balance — August 31, 2011	<u>\$ 22,569</u>	<u>\$ 1,226</u>	<u>\$ 10,543</u>	<u>\$ 10,013</u>	<u>\$ 18,984</u>	<u>\$ 15,732</u>	<u>\$ 22,750</u>	<u>\$ 39,019</u>	<u>\$ 1,376</u>	<u>\$ 142,212</u>

The information about the financial assets and liabilities measured at fair value on a recurring basis as of August 31, 2010, is as follows:

	Level 1	Level 2	Level 3	Total Fair Value
Investments:				
Cash and equivalents	\$ 10,224	\$ -	\$ -	\$ 10,224
Large-cap equity	14,611	11,936	12,570	39,117
Small-cap equity	3,806		5,288	9,094
Governmental fixed income		8,972		8,972
International equity	12,746	6,185	11,801	30,732
International hedged equity			5,294	5,294
Corporate and other bonds		11,324		11,324
Hedged equity			20,602	20,602
Private and equity partnerships			11,491	11,491
Real assets partnerships			19,072	19,072
Absolute return			32,973	32,973
Total investments at fair value	\$41,387	\$38,417	\$119,091	\$198,895
Liabilities — obligations under interest rate swap agreement	\$ -	\$11,967	\$ -	\$ 11,967

Government securities and corporate obligations are included in Level 2 because of the matrix pricing characteristics of these instruments.

Changes related to the fair values based on Level 3 inputs in fiscal 2010, are summarized as follows:

	Large-Cap Equity	Small-Cap Equity	International Equity	International Hedged Equity	Hedged Equity	Private and Equity Partnerships	Real Assets Partnerships	Absolute Return	Totals
Beginning balance — September 1, 2009	\$11,167	\$5,046	\$ 4,724	\$ 7,051	\$20,083	\$ 9,058	\$16,304	\$ 30,481	\$103,914
Total gains — realized/unrealized	1,403	242	1,077	1,138	567	908	2,164	2,191	9,690
Purchases/receipts			6,000			1,935	1,314	19,810	29,059
Sales/disbursements				(2,895)	(48)	(410)	(710)	(19,509)	(23,572)
Ending balance — August 31, 2010	<u>\$12,570</u>	<u>\$5,288</u>	<u>\$11,801</u>	<u>\$ 5,294</u>	<u>\$20,602</u>	<u>\$11,491</u>	<u>\$19,072</u>	<u>\$ 32,973</u>	<u>\$119,091</u>

All Level 3 investments are recorded at the net asset value (NAV) reported by the fund, which the Corporations conclude approximates fair value. The majority of Level 3 large-cap equity, small-cap equity, international hedged equity, hedged equity, real assets partnerships, and absolute return funds are redeemable at NAV under the original terms of the agreements. However, it is possible that these redemption rights may be restricted or eliminated by the funds in the future in accordance with the underlying fund agreements. Due to the nature of the investments held by the funds, changes in market conditions and the economic environment may significantly impact the NAV of the funds and, consequently, the fair value of the Corporations' interests in the funds. Although a secondary market exists for these investments, it is not active and individual transactions are typically not observable. When transactions do occur in this limited secondary market, they may occur at discounts to the reported

NAV. It is therefore reasonably possible that if the Corporations were to sell these investments in the secondary market, a buyer may require a discount to the reported NAV, and the discount could be significant.

The following table summarizes the fair value measurements in alternative investments calculated using a net asset value (or its equivalent) with redemption restrictions:

	Fair Value 2011	Fair Value 2010	Unfunded Commitments	Redemption Frequency	Redemption Notice Period
1 Absolute Return	\$39,019	\$32,973	None	Quarterly, Annually	45-120 days
2 Hedged equity	18,984	20,602	None	Quarterly, Annually	30-90 days
3 International equity	10,543	11,801	None	Monthly	5-30 days
4 International hedged equity	10,013	5,294	None	Annually	60-120 days
5 Private equity and partnerships	15,732	11,491	\$5,431	None	None
6 Real assets partnerships	22,750	19,072	\$1,800	Quarterly, None	60 days
7 Small-cap equity	1,226	5,288	None	Semi-Annually	30 days

1. This category includes investments in hedge funds that pursue multiple strategies to diversify risks and reduce volatility. It also includes investments in a limited partnership that engages in event-driven investment strategies including merger arbitrage, distressed and bankrupt corporate debt, convertible arbitrage, healthcare long and short positions, and event-driven equities. The fair values of the investments in this category have been estimated using the net asset value per share of the investments. Investments in this category typically include a one to three year restriction on redemption. Investments representing approximately 7 percent of the value of the investments in this category cannot be fully redeemed because the fund is still in the initial lock up period which expires September 30, 2012. Additionally, this same investment includes restrictions that limit redemptions to 25 percent of the investment quarterly.
2. This category includes investments in hedge funds that invest in both fundamental long and short positions primarily in U.S. common stocks. The fair values of the investments in this category have been estimated using the net asset value per share of the investments. Investments in this category typically include a one year restriction on redemption. Investments representing approximately 13 percent of the value of the investments in this category cannot be redeemed because the fund is still in the initial lock up period which expires April 30, 2012.
3. This category includes investments in commingled funds that invest primarily in emerging markets and Asian markets. The fair values of the investments in this category have been estimated using the net asset value per share of the investments.
4. This category includes an emerging markets hedge fund and a hedge fund of funds that invests both long and short primarily in emerging market equities. The fair value of the investment in this category has been estimated using the net asset value per share of the investment. Approximately 57 percent of the investments in this category are in a hedge fund that limits liquidity to once every three years. The next available liquidation date is September 30, 2013.
5. This category includes investments in partnership funds that specialize in large company buy-outs as well as distressed debt. The fair value of the investment in this category has been estimated using the net asset value per share of the investment. Investments in this category cannot be redeemed until after ten years from inception. Current lock up expirations range from 2015 to 2018.

6. This category includes a hedge fund that invests primarily in fixed income arbitrage and portable alpha investments and other funds that specialize in opportunistic real estate, private equity structure and private investments in commodity related companies. The fair value of the investments in this category have been estimated using the net asset value of the Corporations' ownership interest in partners' capital. Twenty-six percent of the investments in this category cannot be fully redeemed because the investments include restrictions that limit redemptions for eight to ten years from inception with remaining expirations ranging from 2013 to 2018. The remaining 74 percent is held in a fund with only a one year lock up which has expired. Redemptions on this fund are available quarterly with a maximum redemption of 1/3 of the investment annually after a 60 day notice.
7. This category includes an investment in a fund that specializes in micro-cap investments concentrated in energy, consumer, healthcare and technology. The fair value of the investment in this category has been estimated using the net asset value per share of the investment. The original lockup has expired on this fund, but the liquidity is limited to 50 percent twice per year.

At August 31, 2011 and 2010, commitments for additional funding for alternative investment totaled \$7,231,000 and \$10,029,000, respectively.

6. INVESTMENTS IN STRATEGIC ALLIANCES (JOINT VENTURES)

The Institute is a joint venture partner and provides direction for the following rehabilitation programs:

- *Southern Illinois Hospital Services* — The Institute holds a 12 percent ownership interest in the entity that operates the acute care rehabilitation unit and outpatient rehabilitation.
- *Advocate Illinois Masonic Medical Center* — The Institute holds a 50 percent ownership interest in the entity that operates for the purpose of developing, implementing, and operating a comprehensive continuum of high quality, cost competitive inpatient acute rehabilitation services.

Similarly, the Institute is a member of a two-member limited liability company for the following joint venture rehabilitation program:

- *Alexian Brothers Hospital Network* — The Institute holds a 49 percent ownership interest in the entity that provides the full continuum of rehabilitation services provided at various Alexian Brothers Hospital Network facilities.

Investments in joint ventures are accounted for using the equity method of accounting. Administrative fees earned by the Institute from joint ventures are recognized in the period to which they relate. Amounts recognized as joint venture income, including management services and affiliation fees earned from joint ventures, are reported as other revenue and support in the accompanying consolidated statements of operations and changes in net assets.

A summary of financial information for joint venture activities for the years ended August 31, 2011 and 2010, is shown below:

	2011	2010
Joint venture operations:		
Net patient service revenue	\$ 47,544	\$ 43,807
Expenses	<u>40,750</u>	<u>38,604</u>
Excess of revenue over expenses	<u>\$ 6,794</u>	<u>\$ 5,203</u>
Components of joint venture income:		
Institute share of joint venture revenues and expenses	\$ 2,970	\$ 2,251
Management services and affiliation fees — net	<u>670</u>	<u>617</u>
Joint venture income recognized by the Institute	<u>\$ 3,640</u>	<u>\$ 2,868</u>

Cash distributions received from joint ventures amounted to approximately \$3,491,000 and \$2,683,000 in 2011 and 2010, respectively.

The Institute also has five other agreements which require management of the various aspects of other alliance hospital rehabilitation programs. Included in other current assets at August 31, 2011 and 2010, is \$1,414,000 and \$1,268,000, respectively, representing amounts due from strategic alliance partners for fees and reimbursement of expenses incurred by the Institute on behalf of those partners.

7. LAND, BUILDINGS, AND EQUIPMENT

A summary of cost and accumulated depreciation as of August 31, 2011 and 2010, is as follows:

	2011	2010
Land	\$ 33,054	\$ 32,971
Building and fixtures	122,933	121,542
Furniture and equipment	<u>84,125</u>	<u>80,981</u>
Total land, buildings and equipment	240,112	235,494
Less accumulated depreciation	(155,281)	(144,733)
Construction in progress	<u>6,601</u>	<u>1,938</u>
Total net land, buildings, and equipment	<u>\$ 91,432</u>	<u>\$ 92,699</u>

Construction in progress primarily relates to costs incurred by the Institute related to facility renovation and replacement projects.

During fiscal 2010, the Corporations entered into an agreement that exchanged \$28,000,000 and an existing parcel of vacant land with a carrying value of \$2,700,000 for a parcel to be considered for future development. Also during fiscal 2010, the Corporations terminated its option to purchase a parcel of land in exchange for \$9,568,000 from Northwestern Memorial Hospital. The gain is included in nonoperating gains in the accompanying consolidated statement of operations and changes in net assets.

8. PLEDGES RECEIVABLE

Pledges receivable at August 31, 2011 and 2010, is comprised of the following:

	2011	2010
Restricted for specific operating purposes or future capital acquisitions	\$ 43,307	\$ 35,485
Restricted for permanent endowment	<u>1,000</u>	<u>1,508</u>
	<u>\$ 44,307</u>	<u>\$ 36,993</u>

A schedule of the expected timing of pledge receipts at August 31, 2011 and 2010, is as follows:

	2011	2010
Pledges receivable — less than one year	\$ 9,648	\$ 6,691
Pledges receivable — one to five years	26,982	30,302
Pledges receivable more than five years	<u>7,677</u>	<u>-</u>
	<u>\$ 44,307</u>	<u>\$ 36,993</u>

The Institute and the Research Corporation have discounted pledges at the rate of 1% to 5%, respectively. Pledge receivable amounts are shown net of such present value discounts of \$2,555,000 and \$1,631,000 as of August 31, 2011 and 2010, respectively.

9. LONG-TERM DEBT

A summary of long-term debt at August 31, 2011 and 2010, is as follows:

	2011	2010
Illinois Finance Authority Variable rate demand revenue bonds, Series 2009A, interest payable monthly at the lesser of 10% or variable rate determined weekly (0.15% and 0.26% at August 31, 2011 and 2010, respectively), due April 1, 2039	\$ 22,630	\$ 22,765
Illinois Finance Authority Variable rate demand revenue bonds, Series 2009B, interest payable monthly at the lesser of 10% or variable rate determined weekly (0.15% and 0.26% at August 31, 2011 and 2010, respectively), due April 1, 2032	52,700	52,700
Illinois Finance Authority Variable rate demand revenue bonds, Series 2009C, interest payable monthly at the lesser of 10% or variable rate determined weekly (0.15% and 0.26% at August 31, 2011 and 2010, respectively), due April 1, 2039	15,210	15,210
Commercial paper revenue notes, effective November 2005, principal amount not to exceed \$20,000,000 under a Pooled Financing Program maturing November 1, 2015. The notes have maturities between 1 and 270 days and rollover continuously. The notes bear interest at current commercial paper rates (range of 0.14% to 0.32% and 0.28% to 0.32% at August 31, 2011 and 2010, respectively)	20,000	20,000
Capital lease	<u>621</u>	<u>-</u>
Total long-term debt	111,161	110,675
Less current installments of long-term debt	<u>(249)</u>	<u>(14,785)</u>
Long-term debt — net of current installments	<u>\$ 110,912</u>	<u>\$ 95,890</u>

On April 1, 1997, the Institute entered into a Master Trust Indenture (MTI) of which the Institute is currently the only member of the Obligated Group formed pursuant to the MTI. The purpose of the MTI is to provide a mechanism for the efficient and economical issuance of notes by individual members of the Obligated Group using the collective borrowing capacity and credit rating of the Obligated Group. The MTI requires members of the Obligated Group to make principal and interest payments on notes issued for their benefit, as well as other Obligated Group members if the other members are unable to make such payments. Obligations under the MTI are joint and several obligations of Obligated Group members. On April 1, 1997, the Illinois Finance Authority issued variable rate demand revenue bonds, Series 1997, in the aggregate principal amount of \$52,700,000 on behalf of the Institute. The Series 1997 bonds were issued pursuant to the MTI, and were fully redeemed on December 10, 2009.

On December 10, 2009, the Illinois Finance Authority issued variable rate demand revenue bonds, Series 2010A, Series 2010B, and Series 2010C (collectively "Series 2010 Bonds") in the aggregate principal amount of \$90,675,000 on behalf of the Institute. Each series of the Series 2009 Bonds was issued pursuant to the related bond indenture.

Interest payable on the Series 2009 Bonds may, at the option of the Institute and subject to the terms and conditions of the related bond indenture, be converted to alternative variable rate modes or into fixed rates. While the Series 2009 Bonds operate in certain variable rate modes, holders of such bonds have a tender option that allows them to tender Series 2009 Bonds prior to maturity. The Institute has an agreement with a financial institution to remarket any bonds tendered. In addition, each series of the Series 2009 Bonds is secured by an irrevocable letter of credit from one of two commercial banks that expires on December 10, 2012.

Under each letter of credit, the related commercial bank would make a liquidity advance in the amount necessary to purchase the related Series 2009 Bonds tendered in the event such Series 2009 Bonds are not remarketed. Assuming no existing events of default, the first installment of any liquidity advance principal repayment to the related commercial bank would not become due until twelve months following the related liquidity drawing. Some or all of the Series 2009 Bonds may be accelerated upon the occurrence of certain specified events.

The Institute is required to meet certain covenants including the delivery of audited financial statements, minimum debt service coverage, unrestricted cash and investments to funded indebtedness, and limitation on short-term indebtedness. As of August 31, 2011, the Institute was in compliance with these covenants.

On November 8, 2005, the Illinois Finance Authority approved a final resolution adopting the plan of financing for the Institute to issue Commercial Paper Revenue Notes in a principal amount not to exceed \$20,000,000 under its Pooled Financing Program. The Commercial Paper Revenue Notes are secured by a direct pay letter of credit from a financial institution that expires on November 30, 2014. Under this agreement, the financial institution would make liquidity advances to the Institute in the amount necessary to purchase the Commercial Paper Revenue Notes in the event the notes do not rollover. Principal repayments on any liquidity advance are due in semi-annual installments, commencing on the first anniversary of such principal drawing and ending on the third anniversary of such principal drawing. The Institute used such funds to purchase and implement clinical, financial, and administrative healthcare information systems.

On March 1, 2003, the Institute entered into a Project Loan Agreement, supplementing and amending the MTI dated as of April 1, 1997, providing for the issuance of a Direct Note Obligation in the amount of \$16,000,000. The purpose of the Agreement is to enable the Institute to finance, refinance, and/or be reimbursed for, all or a portion of the cost of acquiring, constructing, and/or installing capital projects. On March 5, 2003 and August 28, 2003, the Institute borrowed \$6,333,960 and \$7,715,213, respectively, through the Illinois Finance Authority pursuant to the Project Loan Agreement. Borrowings under the Project Loan Agreement are unsecured. This loan agreement was fully repaid on December 10, 2009.

Effective April 30, 2004, the Institute executed a \$7,000,000 Term Note with a commercial bank. The purpose of the Term Note was to provide initial capital funding to the Alexian Brothers Healthcare Network joint venture. Borrowings under the Term Note are unsecured. This Term Note was fully repaid on December 3, 2009.

The Institute had maintained a \$7,000,000 unsecured line of credit agreement with a commercial bank. Outstanding draws under the line of credit bear interest at London Interbank Offered Rate (LIBOR) plus 150 basis points. The line of credit expired on April 30, 2010.

On October 5, 2010, the Institute entered into a five year capital lease agreement with an office equipment leasing company for rental of office equipment. The capitalized cost of the lease obligation is \$691,000.

Scheduled annual principal repayments, assuming remarketing of the Series 2009 Bonds and the Commercial Paper Revenue Notes, on long-term debt and capital lease obligation for the ensuing five fiscal years and thereafter are as follows:

2012	\$ 273
2013	315
2014	313
2015	321
2016	20,157
Thereafter	<u>89,960</u>
	111,339
Less interest on capitalized lease	<u>(178)</u>
	<u>\$ 111,161</u>

10. INTEREST RATE SWAP AGREEMENT

In December 2007, Corporations entered into an interest rate swap agreement to offset future fluctuations in interest rates related to the Institute's variable rate debt. The swap agreement was a hedge for the Series 1997 variable rate bonds resulting in the swap of variable rate debt to a fixed rate. The Corporations have elected to not apply hedge accounting to this agreement. During fiscal 2010, the Series 1997 variable rate bonds were redeemed, and the Corporations chose not to link the swap to the Series 2009 variable rate debt.

The terms of the swap agreement is as follows:

Notional Amount	Effective Date	Maturity	Receive	Pay
\$52,700	December 18, 2007	April 1, 2032	67% of 1-month LIBOR	3.40 %

The fair value of the swap agreement at August 31, 2011 and 2010, within the consolidating balance sheets of \$11,375,000 and \$11,967,000, respectively, is recorded as a component of other noncurrent liabilities. The Institute recorded the net mark-to-market fair value adjustment on the swap as a gain of \$592,000 and a loss of \$5,978,000 for the years ended August 31, 2011 and 2010, respectively, within the excess of revenue and support over expenses and gains in the consolidated statements of operations and changes in net assets.

The net amounts paid under the interest rate swap agreement increased interest expense by \$441,000 for the year ended August 31, 2010. Beginning December 10, 2009, the net amounts paid under the interest rate swap agreement increased nonoperating losses by \$1,708,000 and \$1,255,000 for the years ended August 31, 2011 and 2010, respectively.

11. LEASE OBLIGATIONS

The Institute leases facilities for certain outpatient rehabilitation programs, as well as administrative office space under various noncancelable operating lease arrangements. Future minimum rental commitments under operating leases are as follows: fiscal years 2012 — \$2,873,000; 2013 — \$2,640,000; 2014 — \$2,360,000; 2015 — \$2,344,000; 2016 — \$1,946,000; and thereafter — \$5,376,000. Total rental expense for facilities, parking and equipment under operating leases for the years ended August 31, 2011 and 2010, was \$5,015,000 and \$4,936,000, respectively.

Under the terms of an agreement with Northwestern University, also a member of the McGaw Medical Center (see Note 18), the Institute leases the land at 345 East Superior, Chicago, Illinois, on which the Institute's inpatient facility is situated, for \$10 per year through December 31, 2069.

12. EMPLOYEES' RETIREMENT PLAN

The Corporations have a noncontributory defined benefit pension plan ("Plan") which provides retirement benefits to substantially all eligible employees. The normal retirement benefit of the Plan is a monthly retirement income, which is computed based on an average of the employee's monthly earnings and is payable upon the participant's retirement date and continues for the participant's lifetime. The Corporations make annual contributions to the Plan in accordance with the funding requirements of the Employee Retirement Income Security Act as calculated by an outside consulting actuary. The Corporations use a measurement date of August 31 for plan liabilities and assets. The assets of the Plan are held in trust by The Northern Trust Company and are comprised of U.S. Government obligations, common stock, mortgage-backed securities, The Northern Trust Company collective short-term investment funds, and alternative investments, which consist primarily of large-cap equity, hedged equity, and absolute return funds.

The Corporations recognize the cost related to employee service using the Unit Credit Cost method. Gains and losses, calculated as the difference between estimates and actual amounts of plan assets and the projected benefit obligation, are amortized over the expected future service period. Prior service cost is being amortized over 15 years.

The change in the projected benefit obligations and changes in plan assets for the defined benefit plan during fiscal 2011 and 2010 and the assumptions used in making these estimates:

	2011	2010
Change in benefit obligation:		
Projected benefit obligation — beginning of year	\$ 106,436	\$ 80,059
Service cost	4,023	2,872
Interest cost	5,214	4,889
Actuarial (gain) loss	(3,400)	20,822
Benefits paid	<u>(2,280)</u>	<u>(2,206)</u>
Benefit obligation — end of year	<u>\$ 109,993</u>	<u>\$ 106,436</u>
Change in plan assets:		
Fair value of plan assets — beginning of year	\$ 58,257	\$ 52,434
Actual return on plan assets	6,157	3,629
Employer contributions	7,507	4,400
Benefits paid	<u>(2,280)</u>	<u>(2,206)</u>
Fair value of plan assets — end of year	<u>\$ 69,641</u>	<u>\$ 58,257</u>
Unfunded status — included in accrued pension benefits	<u>\$ (40,352)</u>	<u>\$ (48,179)</u>

The components of net periodic pension cost for fiscal August 31, 2011 and 2010, are as follows:

	2011	2010
Components of net periodic pension cost:		
Service cost	\$ 4,023	\$ 2,872
Interest cost	5,214	4,889
Expected return on plan assets	(5,479)	(5,227)
Amortization of unrecognized net loss	3,756	918
Amortization of unrecognized prior service cost	<u>13</u>	<u>13</u>
Net periodic pension cost	<u>\$ 7,527</u>	<u>\$ 3,465</u>
Amounts recorded in unrestricted net assets, but not yet recognized as a component of periodic benefit cost for the plan as of August 31, 2011 and 2010:		
Prior service cost	\$ 40	\$ 53
Unrecognized actuarial loss	<u>40,503</u>	<u>48,337</u>
Total amounts recorded in unrestricted net assets	<u>\$ 40,543</u>	<u>\$ 48,390</u>
Pension-related changes other than net periodic pension cost recognized as changes in unrestricted net assets for the plan for fiscal 2011 and 2010:		
Unrecognized actuarial (gain) loss arising during the year	\$ (4,078)	\$ 22,420
Amortization of unrecognized actuarial loss	(3,756)	(918)
Prior service credit	<u>(13)</u>	<u>(13)</u>
Total recognized as changes in unrestricted net assets	<u>\$ (7,847)</u>	<u>\$ 21,489</u>
Accumulated benefit obligation	<u>\$ 100,478</u>	<u>\$ 97,014</u>

A summary of the expected amounts to be included in the net periodic pension cost in fiscal 2012 is as follows:

Prior service cost	\$ 13
Net actuarial loss	<u>3,213</u>
	<u>\$ 3,226</u>

	2011	2010
Weighted-average assumptions for balance sheet liability at end of year:		
Discount rate	5.35 %	5.00 %
Expected long-term rate of return	8.00	8.00
Rate of compensation increase	3.00	3.00
Weighted-average assumptions for benefit cost at beginning of year:		
Discount rate	5.00 %	6.20 %
Expected long-term rate of return	8.00	8.20
Rate of compensation increase	3.00	3.00
Estimated future benefit payments:		
Fiscal 2012	\$ 3,250	
Fiscal 2013	3,234	
Fiscal 2014	3,622	
Fiscal 2015	4,066	
Fiscal 2016	4,477	
Fiscal 2017–2021	30,583	
Expected fiscal 2012 contributions	\$ 13,564	

The Corporations' overall expected long-term rate of return on assets is 8.00%. The expected long-term rate of return is based on the portfolio as a whole and not on the sum of returns on individual asset categories. The return is based exclusively on historical returns, without adjustments.

The Corporations have developed a plan investment policy, which is reviewed and approved by the Investment Committee and the Board of Directors. The policy established goals and objectives of the fund, distinction of responsibilities, allocation, liquidity and diversification of assets, and performance evaluation for managers. The policy dictates a target asset allocation and an allowable range for such categories based on quarterly investment fluctuations. Investments are managed by independent advisors who are monitored by management and the Investment Committee.

The target allocation and acceptable ranges and actual asset allocation as of August 31, 2011, was as follows:

Asset Class	Target	Range	Actual
Large-cap equity	30 %	25%–35%	29.9 %
Small-cap equity	5	0–10	4.9
International equity	15	10–20	13.0
Fixed income	20	15–25	17.5
Absolute return	10	5–15	11.5
Hedged equity	10	5–15	9.6
International hedged equity	5	0–10	3.4
Real assets	5	0–10	4.2
Cash and cash equivalents			<u>6.0</u>
Total	<u>100 %</u>		<u>100.0 %</u>

The target allocation and acceptable ranges and actual asset allocation as of August 31, 2010, was as follows:

Asset Class	Target	Range	Actual
Large-cap equity	30 %	25%-35%	28.6 %
Small-cap equity	5	0-10	4.7
International equity	15	10-20	14.1
Fixed income	20	15-25	16.8
Absolute return	10	5-15	7.8
Hedged equity	10	5-15	10.8
International hedged equity	5	0-10	3.7
Real assets	5	0-10	4.2
Cash and cash equivalents			<u>9.3</u>
Total	<u>100 %</u>		<u>100.0 %</u>

The Corporations monitor the asset allocation and execute required rebalancing of the portfolio allocation on a regular basis in response to fluctuations in market conditions and the overall portfolio composition.

The information about the plan assets measured at fair value on a recurring basis as of August 31, 2011, is as follows:

	Level 1	Level 2	Level 3	Total Fair Value
Assets:				
Cash and equivalents	\$ 101	\$ 3,718	\$ -	\$ 3,819
Large-cap equity	13,927		6,997	20,924
Small-cap equity	1,991	1,469		3,460
Governmental fixed income		7,095		7,095
International equity	5,375	2,602	1,124	9,101
International hedged equity			2,369	2,369
Corporate and other bonds		5,166		5,166
Hedged equity			6,743	6,743
Real assets partnerships			2,913	2,913
Absolute return			<u>8,051</u>	<u>8,051</u>
Total assets at fair value	<u>\$21,394</u>	<u>\$20,050</u>	<u>\$28,197</u>	<u>\$69,641</u>

Changes related to the pension investments fair values based on Level 3 inputs in 2011, are summarized as follows:

	Large-Cap Equity	International Equity	International Hedged Equity	Hedged Equity	Real Assets Partnerships	Absolute Return	Totals
Beginning balance — September 1, 2010	\$ 5,319	\$ 1,097	\$ 2,143	\$ 6,298	\$ 2,430	\$ 4,546	\$ 21,833
Total gains — realized/unrealized	1,178	27	226	469	483	656	3,039
Purchases/receipts	500					3,000	3,500
Sales/disbursements				(24)		(151)	(175)
Ending balance — August 31, 2011	<u>\$ 6,997</u>	<u>\$ 1,124</u>	<u>\$ 2,369</u>	<u>\$ 6,743</u>	<u>\$ 2,913</u>	<u>\$ 8,051</u>	<u>\$ 28,197</u>

The information about the plan assets measured at fair value on a recurring basis as of August 31, 2010, is as follows:

	Level 1	Level 2	Level 3	Total Fair Value
Assets:				
Cash and equivalents	\$ 4,999	\$ -	\$ -	\$ 4,999
Large-cap equity	5,392	5,900	5,319	16,611
Small-cap equity	1,582	1,175		2,757
Governmental fixed income		4,001		4,001
International equity	4,945	2,168	1,097	8,210
International hedged equity			2,143	2,143
Corporate and other bonds		6,262		6,262
Hedged equity			6,298	6,298
Real assets partnerships			2,430	2,430
Absolute return			4,546	4,546
Total assets at fair value	<u>\$ 16,918</u>	<u>\$ 19,506</u>	<u>\$ 21,833</u>	<u>\$ 58,257</u>

Changes related to the pension investments fair values based on Level 3 inputs in 2010, are summarized as follows:

	Large-Cap Equity	International Equity	International Hedged Equity	Hedged Equity	Real Assets Partnerships	Absolute Return	Totals
Beginning balance — September 1, 2009	\$ 4,726	\$ 458	\$ -	\$ 4,768	\$ 2,041	\$ 5,737	\$ 17,730
Total gains — realized/ unrealized	593	139	143	39	389	545	1,848
Purchases/receipts		500	2,000	1,500		10	4,010
Sales/disbursements				(9)		(1,746)	(1,755)
Ending balance — August 31, 2010	<u>\$ 5,319</u>	<u>\$ 1,097</u>	<u>\$ 2,143</u>	<u>\$ 6,298</u>	<u>\$ 2,430</u>	<u>\$ 4,546</u>	<u>\$ 21,833</u>

In addition, the defined benefit pension plan assets disclosed above includes investments of \$28,197,000 and \$21,833,000 as of August 31, 2011 and 2010, respectively, whose fair values have been estimated by fund managers in the absence of readily determinable fair values.

The majority of Level 3 investments are recorded at the net asset value (NAV) reported by the fund, which the Corporations conclude approximates fair value. The majority of Level 3 large-cap equity, international equity, international hedged equity, hedged equity, real asset partnerships, and absolute return funds are redeemable at NAV under the original terms of the agreements. However, it is possible that these redemption rights may be restricted or eliminated by the funds in the future in accordance with the underlying fund agreements. Due to the nature of the investments held by the funds, changes in market conditions and the economic environment may significantly impact the NAV of the funds and, consequently, the fair value of the Corporations' interests in the funds. Although a secondary market exists for these investments, it is not active and individual transactions are typically not observable. When transactions do occur in this limited secondary market, they may occur at discounts to the reported NAV. It is therefore reasonably possible that if the Corporations were to sell these investments in the secondary market, a buyer may require a discount to the reported NAV, and the discount could be significant.

The following table summarizes the fair value measurements in alternative investments calculated using a net asset value (or its equivalent) with redemption restrictions:

	Fair Value 2011	Fair Value 2010	Unfunded Commitments	Redemption Frequency	Redemption Notice Period
1. Absolute return	\$ 8,051	\$ 4,546	None	Quarterly, Annually	45-65 days
2. Hedged equity	6,743	6,298	None	Quarterly, Annually	30-90 days
3. International equity	1,124	1,097	None	Monthly	30 days
4. International hedged equity	2,369	2,143	None	Annually	90 days
5. Real assets partnerships	2,913	2,430	None	Quarterly	60 days

1. This category includes investments in hedge funds that pursue multiple strategies to diversify risks and reduce volatility. It also includes investments in a limited partnership that engages in event-driven investment strategies including merger arbitrage, distressed and bankrupt corporate debt, convertible arbitrage, healthcare long and short positions, and event-driven equities. The fair values of the investments in this category have been estimated using the net asset value per share of the investments. Investments in this category typically include a one to three year restriction on redemption. Investments representing approximately 27 percent, as of August 31, 2011 and 2010, of the value of the investments in this category cannot be fully redeemed because the investment includes restrictions that limit aggregate redemptions to a third of the value of the investment per year.
2. This category includes investments in hedge funds that invest both long and short primarily in U.S. common stocks. The fair values of the investments in this category have been estimated using the net asset value per share of the investments. All investments in this category have past their initial lock up periods.
3. This category includes investments in a limited partnership that invests in Asian markets. The fair values of the investments in this category have been estimated using the net asset value per share of the investments.

4. This category includes an investment in a hedge fund of funds that invests both long and short primarily in emerging market equities. The fair value of the investment in this category has been estimated using the net asset value per share of the investments. All investments in this category have past their initial lock up periods.
5. This category includes a hedge fund that invests primarily in fixed income arbitrage and portable alpha investments. The fair value of the investments in this category have been estimated using the net asset value of the Plan's ownership interest in partners' capital. Redemptions on this fund are available quarterly with a maximum redemption of one third of the investment annually after a 60 day notice.

In fiscal 2011 the Corporations determined they had unintentionally failed to include several deferred compensation plans within their previous year financial statements. The error had no net effect on the Corporations' previously reported financial position, results of operations or cash flows. The assets and liabilities for these plans totaling \$8,216,000 each at August 31, 2011, are included in unrestricted investments and other noncurrent liabilities in the consolidated balance sheet. Equal and offsetting investment income and related compensation expense for the plans of \$663,000 for the year ended August 31, 2011, is recorded net within nonoperating gains (losses) in the consolidated statements of operations and changes in net asset. Prior year financial statements have not been restated as management concluded the error was not material.

13. SELF INSURANCE LIABILITY

The Institute maintains insurance programs for professional liability risks, workers' compensation, and employee health and dental, which have varying degrees of self-insured retention. Included in self-insurance reserves in the accompanying consolidated balance sheets is approximately \$3,935,000 and \$4,381,000 at August 31, 2011 and 2010, respectively, representing the Institute's estimate of the ultimate cost for the self-insured portion of known professional liability claims, as well as claims incurred but not reported as of the balance sheet date. Estimated self-insured professional liability claims have been discounted at a rate of 3%, representing a total discount of \$398,000 and \$421,000 at August 31, 2011 and 2010, respectively. Included in self-insurance reserves in the accompanying consolidated balance sheets is approximately \$971,000 and \$895,000 at August 31, 2011 and 2010, respectively, representing the Institute's estimate of the ultimate cost for the self-insured portion of known workers' compensation claims and employee health claims, as well as claims incurred but not reported as of the balance sheet date.

14. ENDOWMENT

The Corporations' endowment consists of approximately 70 individual funds established for a variety of purposes. Net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

Interpretation of Relevant Law — The Corporations have interpreted the Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring the preservation of the fair value 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, the Corporations classify 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, when applicable. 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 the organization in a manner consistent with the standard of prudence prescribed by UPMIFA. In accordance with UPMIFA, the organization considers the following factors in making a determination to appropriate or accumulate donor-restricted endowment funds:

- (1) The duration and preservation of the fund
- (2) The purposes of the organization and the donor-restricted endowment fund
- (3) General economic conditions
- (4) The possible effect of inflation and deflation
- (5) The expected total return from income and the appreciation of investments
- (6) Other resources of the organization
- (7) The investment policies of the organization

Endowment Investment and Spending Policies — The Corporations have adopted investment and spending policies for endowment assets that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of the endowment.

The endowment funds are pooled as part of the overall Corporations' portfolio and managed under the direction of the Investment Committee of the Board of Directors and their approved policy. Investment returns consist of realized and unrealized returns, net of investment manager fees. Returns are consistently allocated across all asset categories. The Investment Committee of the Board of Directors is responsible for defining and reviewing the investment policy to determine an appropriate long-term asset allocation policy. Investments in the portfolio are diversified by asset class and investment manager and style.

The objective of the investment policy is to generate an annual total rate of return for the fund sufficient to finance annual distributions; grow the value of the corpus of the funds annually by at least the annual rate of inflation; and cause the real value of the funds to increase. These results, if not attainable in any given year, should be achieved on average over long periods of time to the extent allowed by returns in the broad markets. The Corporations have established market-related benchmarks to evaluate the endowment funds' performance on an ongoing basis.

The Audit and Finance Committee of the Board approves the annual spending policy for program support. In establishing the annual spending policy, the Corporations' main objectives are to provide for intergenerational equity over the long-term, the concept that future beneficiaries will receive the same level of support as current beneficiaries on an inflation adjusted basis, and to maximize annual support to the programs supported by the endowment. The spending rate was 4.5% for the fiscal years ended August 31, 2011 and 2010, and income from the endowment fund provided \$2,899,000 and \$3,048,000 of support for the Corporations' programs during the fiscal years ended August 31, 2011 and 2010, respectively. The spending rate is applied to the average of ending market values for the trailing twelve calendar quarters ended June 30.

Changes in endowment net assets for the fiscal year ended August 31, 2011 consisted of the following:

	Board Designated	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets — beginning of year	<u>\$ 1,000</u>	<u>\$ 21,398</u>	<u>\$ 48,325</u>	<u>\$ 70,723</u>
Investment return:				
Investment income		567		567
Net appreciation (realized and unrealized)		<u>8,020</u>	<u>76</u>	<u>8,096</u>
Total investment return	<u>-</u>	<u>8,587</u>	<u>76</u>	<u>8,663</u>
Contributions			<u>2,072</u>	<u>2,072</u>
Appropriation of endowment assets for expenditure		<u>(2,899)</u>		<u>(2,899)</u>
Transfer to unrestricted			<u>(76)</u>	<u>(76)</u>
Endowment net assets — end of year	<u>\$ 1,000</u>	<u>\$ 27,086</u>	<u>\$ 50,397</u>	<u>\$ 78,483</u>

Changes in endowment net assets for fiscal year ended August 31, 2010 consisted of the following:

	Board Designated	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets — beginning of year	<u>\$ -</u>	<u>\$ 19,383</u>	<u>\$ 43,816</u>	<u>\$ 63,199</u>
Investment return:				
Investment income		431		431
Net appreciation (realized and unrealized)		<u>4,632</u>	<u>249</u>	<u>4,881</u>
Total investment return	<u>-</u>	<u>5,063</u>	<u>249</u>	<u>5,312</u>
Contributions	<u>1,000</u>		<u>4,509</u>	<u>5,509</u>
Appropriation of endowment assets for expenditure		<u>(3,048)</u>		<u>(3,048)</u>
Transfer to unrestricted			<u>(249)</u>	<u>(249)</u>
Endowment net assets — end of year	<u>\$ 1,000</u>	<u>\$ 21,398</u>	<u>\$ 48,325</u>	<u>\$ 70,723</u>

Funds With Deficiencies — From time to time, the fair value of assets associated with individual donor restricted endowment funds may fall below the level that the donor or UPMIFA requires the Corporations to retain as a fund of perpetual duration. Deficiencies of this nature that are reported in unrestricted net assets were \$76,000 as of August 31, 2010. These deficiencies resulted from unfavorable market fluctuations that occurred shortly after the investment of new permanently restricted contributions and continued appropriation for certain programs that was deemed prudent by the Board of Directors.

15. NET PATIENT SERVICE REVENUE

The Institute has agreements with third-party payors that provide for payments to the Institute at amounts different from its established rates. A summary of the payment arrangements with major third-party payors is as follows:

Medicare — The Institute participates as a provider of health care services under a Medicare provider agreement. The provisions of this agreement stipulate that services will be reimbursed under a prospective payment system. Prospective payment rates are determined based on clinical and diagnosis factors associated with services provided to Medicare beneficiaries. The Institute's Medicare cost reports have been audited by the Medicare fiscal intermediary through August 31, 2007.

Medicaid — The Institute is reimbursed by the Illinois Department of Public Aid at per diem formula rates for services rendered to Medicaid inpatients. The Institute also receives incremental Medicaid reimbursement for specific programs and services at the discretion of the State of Illinois Medicaid program. Total incremental reimbursement under these programs and services amounted to \$4,003,000 and \$1,985,000 in fiscal 2011 and 2010, respectively. Medicaid reimbursement may be subject to periodic adjustment, as well as to changes in existing payment methodologies and rates, based on the amount of funding available to the Medicaid program.

In November 2006, the Centers for Medicare and Medicaid Services approved the Illinois Hospital Assessment Program to improve Medicaid reimbursement for Illinois hospitals. The Illinois Hospital Assessment Program has subsequently been approved through June 30, 2013. Due to the tax assessment provisions contained in the legislation, implementation of the program impacted both operating revenues and expense in the consolidated statements of operations and changes in net assets. For each of the years ended August 31, 2011 and 2010, additional Medicaid payments of \$7,225,000 were included in net patient service revenue and the tax assessment of \$6,635,000 were included in supplies and other expense. Accordingly, during each of the years ended August 31, 2011 and 2010, the Corporations recorded a net benefit of \$590,000.

The Institute recognizes patient service revenue associated with the services provided to patients who have third-party payor coverage on the basis of contractual rates for the service rendered. For uninsured patients that do not qualify for charity care, the Institute recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a portion of the Institute's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Institute records a provision for bad debts related to uninsured patients in the period the services are provided.

The Institute recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Institute recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the Institute's uninsured patients will be unable

or unwilling to pay for the services provided. In addition, a portion of the Institute's insured patients will be unable or unwilling to pay the portion of their bill for which they are financially responsible. The Institute records a provision for bad debts related to uninsured patients and to insured patients for the portion of their bill for which they are financially responsible in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts and excluding the Illinois Hospital Assessment Program revenue), recognized in the period from these major payor sources, is as follows:

	2011	2010
Medicare	28 %	29 %
Medicaid	11	10
Blue Cross	26	25
Commercial and other	<u>35</u>	<u>36</u>
	<u>100 %</u>	<u>100 %</u>

Due to the nature of the Institute's patient base, the majority of uninsured patients qualify for Medicare or Medicaid programs, resulting in a very limited amount of self pay revenue.

16. COMMUNITY BENEFIT

It is an inherent part of the Institute's mission to provide necessary medical care free of charge, or at a discount, to individuals without insurance or other means of paying for such care. As the amounts determined to qualify for charity care are not pursued for collection, they are not reported as patient service revenue. Using the published Community Services Administration poverty guidelines, the Institute provides care to patients without charge at amounts less than its discounted rates. The Institute uses a sliding scale that provides charity care to individuals with incomes of up to 400% of these guidelines. The Institute provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its discounted rates. The Institute maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy, as well as equivalent service statistics.

In addition, the Institute maintains records that estimate the cost of unreimbursed services provided and supplies furnished under its charity care policy and the excess of cost over reimbursement for Medicaid patients. Actual cost for providing the care is estimated in the table below based the cost to charge ratios reported in the previous years cost reports. The Medicaid cost report is used for the portion related to the Medicaid population and the Medicare cost report is used for all other charity care.

The following information summarizes the level of charity care provided for the years ended August 31, 2011 and 2010, is as follows:

	2011	2010
Excess of allocated costs over reimbursement for services provided to Institute Medicaid patients	\$ 6,801	\$ 4,613
Benefit of State of Illinois Medicaid Add-on payments (Note 15)	(4,003)	(1,985)
Net benefit under the Medicaid Provider Assessment Program (Note 15)	<u>(590)</u>	<u>(590)</u>
Excess of allocated cost over reimbursement for services provided to Institute Medicaid patients	2,208	2,038
Estimated costs and expenses incurred to provide charity care in the Institute	<u>1,041</u>	<u>626</u>
Total cost of unreimbursed services provided	<u>\$ 3,249</u>	<u>\$ 2,664</u>

Many of the Institute's patients are reluctant and do not provide the information necessary to qualify for charity care. Therefore, management believes that a portion of the Institute's provision for bad debt represents patients that do not have the financial ability to pay.

17. FUNCTIONAL EXPENSES

The Corporations incur expenses for the provision of health care services, conduct of research and medical education programs, fundraising, and related general and administrative activities. For the years ended August 31, 2011 and 2010, expenses related to providing these services are as follows:

	2011	2010
Health care services	\$ 150,462	\$ 141,246
Research services	20,456	20,001
General and administrative	19,044	17,869
Fundraising	<u>2,664</u>	<u>2,638</u>
	<u>\$ 192,626</u>	<u>\$ 181,754</u>

18. RELATED PARTIES

The Corporations engage in transactions in the ordinary course of business with organizations with which members of the boards of directors are affiliated. Such transactions are conducted at arm's length and are fully disclosed to the boards of directors.

In addition, the Institute is a cooperative member of the McGaw Medical Center and has agreements for medical and support services with other cooperative member entities. Services provided to and by these member entities are charged at negotiated rates. Northwestern University and Northwestern Memorial Hospital are members of McGaw Medical Center. Payments to Northwestern University during fiscal 2011 and 2010 were approximately \$4,062,000 and \$3,153,000, respectively. Payments to Northwestern Memorial Hospital during fiscal 2011 and 2010 were approximately \$3,391,000 and \$2,514,000, respectively. Payments to McGaw Medical Center during fiscal 2011 and 2010 were \$2,611,000 and \$2,694,000, respectively.

19. NEW RESEARCH HOSPITAL PROJECT

The Corporation is in the design phase for the development and construction of a new research hospital to replace its existing flagship facility located in Chicago, Illinois. Current plans call for groundbreaking in 2013 and completion by early 2016. In connection therewith, the Corporation is in the early stages of a major capital campaign to fund the new research hospital.

As of August 31, 2011, the Corporation has received contributions, consisting of cash and unconditional promises to contribute, of approximately \$49,200,000 to be used for the design and construction of the new hospital (see Note 8). In addition, the Corporation has received conditional promises to contribute totaling approximately \$10,000,000 of which \$9,000,000 has not been recognized in the consolidated financial statements as of August 31, 2011. Conditions include matching gift requirements and other milestones associated with the construction of the new research hospital. The \$9,000,000 will be recognized as the related conditions are substantially met.

20. COMMITMENTS AND CONTINGENCIES

Litigation — The Corporations are involved in litigation arising in the normal course of business. In consultation with legal counsel, management believes that reserves are adequate and estimates that these matters will be resolved without material adverse effect on the Corporations' financial position or results of operations.

Regulatory Investigations — The U.S. Department of Justice and other federal agencies routinely conduct regulatory investigations and compliance audits of health care providers. The Corporations are subject to these regulatory efforts. Management is currently unaware of any regulatory matters which may have a material adverse effect on the Corporations' financial position or results of operations.

Insurance Coverage — The Institute is commercially insured for excess professional liability, general liability, and workers' compensation claims. There are no assurances that the Institute will be able to renew existing policies or procure coverage on similar terms in the future.

21. SUBSEQUENT EVENTS

The Corporation has evaluated subsequent events through November 22, 2011, the date the financial statements were issued.

* * * * *

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Rehabilitation Institute of Chicago

345 East Superior Street
Chicago, Illinois 60611-2654
312-238-1000 telephone
www.ric.org

January 12, 2012

Illinois Health Facilities
and Services Review Board
Springfield, IL

To Whom It May Concern:

Please be advised that the proposed master facilities design project will be funded entirely with cash and equivalents.

Very truly yours,

Edward B. Case
Executive Vice President
Chief Financial Officer

EBC/jh

State of Illinois)
) SS:
County of Cook)

On this, the 12th day of January, 2012, before me a notary public, the undersigned officer, personally appeared Ed Case, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he executed the same for the purposes therein contained.

In witness hereof, I hereunto set my hand and official seal.

Notary Public

EBC/jh

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ATTACHMENT 42A

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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