ORIGINAL

12-011

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR PERMIT

RECEIVED

JAN 31 2012

HEALTH FACILITIES & SERVICES REVIEW BOARD

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	**Rush University Medical Center – CON III – Modernization of the Atrium and Kellogg Buildings**				
Street Address:	**1650 West Harrison and 1753 West Congress Parkway**				
City and Zip Code:	**Chicago, 60612**				
County:	**Cook**	Health Service Area:	**6**	Health Planning Area:	**A-02**

Applicant /Co-Applicant Identification

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

Exact Legal Name:	**Rush University Medical Center**
Address:	**1725 West Harrison Street Ste. # 364 Chicago, IL 60612**
Name of Registered Agent:	**Anne M. Murphy, Sr. V.P. of Legal Affairs and General Counsel**
Name of Chief Executive Officer:	**Larry J. Goodman, M.D.**
CEO Address:	**1725 West Harrison Street Ste. # 364 Chicago, IL 60612**
Telephone Number:	**312-942-7073**

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

Type of Ownership of Applicant/Co-Applicant

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

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

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

Primary Contact

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

Name:	**Mike LaMont**
Title:	**Associate Vice President, Capital Projects**
Company Name:	**Rush University Medical Center**
Address:	**1725 West Harrison Street Ste. # 364 Chicago, IL 60612**
Telephone Number:	**312-942-6195**
E-mail Address:	**Mike_Lamont@rush.edu**
Fax Number:	**312-942-6195**

Additional Contact

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

Name:	**Janet Scheuerman**
Title:	**Senior Consultant**
Company Name:	**PRISM Healthcare Consulting**
Address:	**1808 Woodmere Drive, Valparaiso, Indiana 46383**
Telephone Number:	**219-464-3969**
E-mail Address:	**prismjanet@aol.com**
Fax Number:	**219-464-0027**

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:	**Alicia M. Maitland**
Title:	**Director of Financial Planning**
Company Name:	**Rush University Medical Center**
Address:	**707 South Wood Street, Suite 301, Chicago, Illinois 60612**
Telephone Number:	**312-563-4419**
E-mail Address:	**Alicia_M_Maitland@rush.edu**
Fax Number:	**312-942-8372**

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	**Rush University Medical Center**
Address of Site Owner:	**1725 West Harrison, Ste. 364, Chicago, Illinois 60612**
Street Address or Legal Description of Site:	**Same**

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.

APPEND DOCUMENTATION AS ATTACHMENT-2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

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

Exact Legal Name:	**Rush University Medical Center**
Address:	**1725 West Harrison, Ste. 364, Chicago, Illinois 60612**

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

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

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

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT

1. Project Classification

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

Part 1110 Classification:	Part 1120 Applicability or Classification: [Check one only.]
☒ Substantive	☐ Part 1120 Not Applicable
☐ Non-substantive	☐ 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.

Rush University Medical Center's (Rush, Medical Center, RUMC) Master Design Permit #06-009 for the transformation of the Rush campus was approved by the Illinois Health Facilities Planning Board in June 2006. The first project to be constructed as part of the Master Design Permit was an ambulatory building with parking as well as a central energy plant and materials management services to serve the campus. The second, Project #07-125, was for the construction of a patient tower. The first project is complete and the new tower, formerly called the Atrium Addition, now called the East Tower, was partially occupied in January 2012.

At that time the East Tower opened, several functions located in existing campus buildings were relocated to the East Tower.

The purpose of this certificate of need application is to seek approval to move forward with the next redevelopment phase described in the master design project. More specifically, Rush is proposing to modernize 4 levels in the Atrium Building and one level in the Kellogg Building for clinical services and to upgrade the infrastructure of the Atrium Building. The modernized space will be used to house medical surgical, obstetrical and pediatric beds as well as surgery, endoscopy procedure rooms, PACUs and prep/recovery stations. The scope of the proposed project is as follows:

Atrium Building

Level 9	Modernize 64 medical surgical beds
Level 8	Relocate and modernize 34 rooming-in obstetrics beds, a 7-bassinet normal newborn nursery and antepartum testing
Level 7	Modernize 64 medical surgical beds
Level 6	There is no Level 6
Level 5	Modernize 8 operating rooms as well as relocate, expand and modernize 10 endoscopy rooms and modernize Stage I and Stage II recovery stations
Level 4	Will remain as is
Level 3	There is no Level 3
Level 2	Mechanical
Level 1	Will remain as is
Basement	Will remain as is

Kellogg Building

Level 6	Relocate and modernize 22 pediatric beds

This project is consistent with the Master Design Permit.

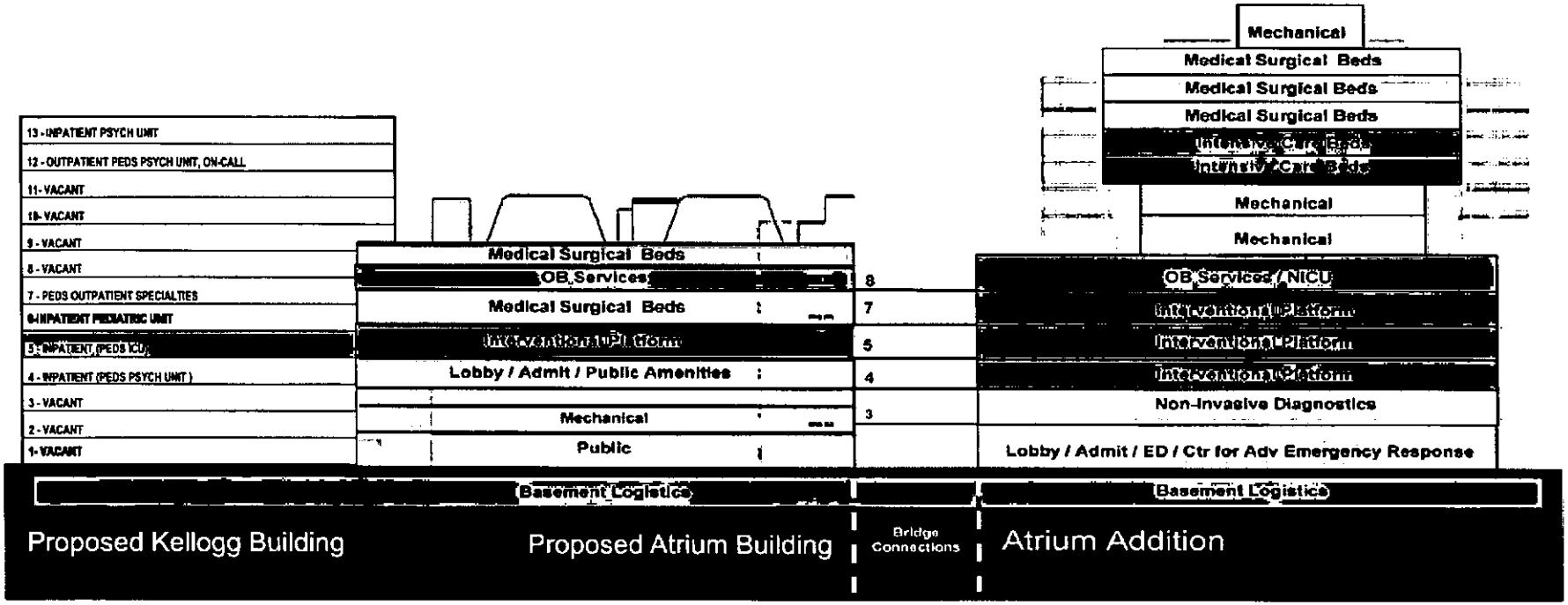
Narrative, Exhibit 1 is a stacking diagram that shows the level-by-level current and future use of each level of the Atrium Building and the relationship to the East Tower. The stacking diagram also shows the location of the pediatric beds in the Kellogg Building.

Letters of support for this project are included as Narrative, Exhibit 2.

The modernization of the Atrium and Kellogg buildings is expected to be complete by June 30, 2016. Total construction and contingency cost is expected to be $37,922,251 of the total, 45.7 percent will be clinical. Total project cost is expected to be $46,230,784.

The project will be funded with cash and securities.

The project is classified as substantive because the total project cost exceeds the Health Facilities and Services Review Board's review threshold.



Stacking Diagram **1/26/2012**

RUSH UNIVERSITY MEDICAL CENTER

PERKINS +WILL

Support Letters

Rush University Medical Center has received broad-based support for the proposed modernization project.

The preparation of this application was initiated in early 2010 and halted in Spring of 2011 because Rush determined that there would need to be substantial changes to the project. Support letters were solicited during this initial preparation phase; consequently, some of the appended letters were received in February and March of 2011 and may reflect a somewhat different project.

The attached letters are from:

- Public Officials
- Area Providers
- Members of the RUMC Board of Trustees
- Rush Physicians
- Members of the Rush Campus Transformation Team

GENERAL ASSEMBLY

STATE OF ILLINOIS

HOUSE OF REPRESENTATIVES

February 14, 2011

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

Dear Mr. Galassie:

I am writing to express my strong support for Rush University Medical Center's Atrium Modernization project. This is the third of a series of campus transformation projects and it will bring the patient care areas in the 30-year old Atrium Building into the 21st Century.

Rush University Medical Center provides a wide range of advanced patient care programs and services to the residents of the greater Chicago area and beyond. The currently planned project will update two levels of medical surgical beds, the obstetrics unit and the newborn nursery. Now the entire maternal and neonatal services will be on the same level connected by a bridge; this is certainly a wonderful accomplishment and will further advance the very fine work being done at Rush for high risk mothers and infants.

The continued implementation of the Medical Center's Campus Transformation initiative is critical in helping Rush keep pace with an every changing medical climate by providing state-of-the-art services to meet the needs of the Medical Center's patients.

I am in full support of your consideration and approval of the Medical Center's certificate of need application to modernize the Atrium Building.

Sincerely,

Arthur Turner
Illinois State Representative
9th Legislative District

Cook County Board of Commissioners
118 North Clark Street - Suite 567
Chicago, Illinois 60602
Phone: (312) 603-3019
Fax: (312) 603-4055
E-Mail: r.steele@robertsteele.org

District Office
3936 W. Roosevelt Rd.
1st Floor
Chicago, Illinois 60624
Phone: (773) 722-0140
Fax: (773) 722-0145

ROBERT STEELE
President Pro Tempore
COMMISSIONER
2nd District

February 17, 2011

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

Dear Mr. Galassie,

I am pleased to submit this letter of support for the modernization of Rush University Medical Center's Atrium Building. By investing in needed infrastructure enhancements and very modest upgrades to the patient care areas, this 30-year old building will be able to provide contemporary care at a very reasonable capital investment.

The redevelopment of the Rush campus obviously enhances the physical facilities for Rush patients and staff. The capital projects will also enhance the ability to attract new physicians to the area and retain current staff members. The new facilities will assure patient privacy and safety and enable the Medical Center to implement efficiencies that will control costs and provide more advanced care.

The redevelopment of Rush is also essential to the economic growth and development of the west side of Chicago. The presence of a state of the art hospital will encourage industrial, commercial, and professional business to locate to Chicago's west side.

I fully support the Board's approval of Rush University Medical Center's certificate of need application to modernize the Atrium Building.

Sincerely,

Robert Steele
President Pro Tempore
Commissioner, 2nd District
Cook County Board

Printed on Recycled Paper

JERRY BUTLER
COUNTY COMMISSIONER

OFFICE OF THE
BOARD OF COMMISSIONERS OF COOK COUNTY
118 NORTH CLARK STREET-ROOM 567
CHICAGO, ILLINOIS 60602
312 603-6391
312 603-5671 FAX

February 17, 2011

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

Dear Mr. Galassie:

I am pleased to submit this letter of support for the modernization of Rush University Medical Center's Atrium Building. By investing in needed infrastructure enhancements and very modest upgrades to the patient care areas, this 30-year old building will be able to provide contemporary care at a very reasonable capital investment.

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The redevelopment of Rush is also essential to the economic growth and development of the west side of Chicago. The presence of a state of the art hospital will encourage industrial, commercial, and professional business to locate to Chicago's west side.

I fully support the Board's approval of Rush University Medical Center's certificate of need application to modernize the Atrium Building.

Sincerely,

Jerry Butler

Printed on Recycled Paper

ROBERT W. FIORETTI
ALDERMAN – 2ND WARD

CITY HALL, ROOM 200 OFFICE 02
121 NORTH LASALLE STREET
CHICAGO, ILLINOIS 60602
TELEPHONE 312-744-6836

PUBLIC SERVICE OFFICE
429 SOUTH DEARBORN STREET
CHICAGO, ILLINOIS 60605
TELEPHONE 312-263-9273
FAX 312-786-1736

COMMITTEE MEMBERSHIPS

ENVIRONMENTAL PROTECTION & PUBLIC UTILITIES

HEALTH

LICENSE & CONSUMER PROTECTION

RULES & ETHICS

SPECIAL EVENTS

February 18, 2011

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

Dear Mr. Galassie:

As 2nd Ward Alderman, I am keenly aware of the importance of the services that are provided by Rush University Medical Center to the residents of Chicago. It is clear to me that Rush has been attentive to the changing and increasing health care needs of the area's residents. The decision of the Rush University Medical Center's Board of Trustees to move forward with the Campus Transformation project evidences appropriate planning and forward thinking.

The implementation of the Campus Transformation plan is apparent as I travel past the site and see the Orthopedic Ambulatory Building and the soon to be completed East Tower. As I understand it, these buildings will allow Rush to continue its mission of excellence in patient care.

I am pleased to extend my full support to Rush's Atrium Building modernization project. It will advance the redevelopment of critical patient care areas by providing additional surgery and endoscopy services, a modernized obstetrics and newborn nursery as well as additional beds to complete the proposed complement of 320 medical surgical beds. These are all services that will be in increasing demand as our national health reform initiative moves forward.

If you have questions about my support for this work, then please contact me directly through my chief of staff at (312) 263-9273.

Sincerely,

Robert W. Fioretti
Alderman, 2nd Ward

COOK COUNTY HEALTH & HOSPITALS SYSTEM

Toni Preckwinkle • President
Cook County Board of Commissioners

Warren L. Batts • Chairman
Cook County Health & Hospitals System

Jorge Ramirez • Vice-Chairman
Cook County Health & Hospitals System

William T. Foley • CEO
Cook County Health & Hospitals System

CCHHS

1900 West Polk Street, Suite 220
Chicago, Illinois 60612
Tel: (312) 864-6820
Fax: (312) 864-9994

Health & Hospitals System Board Members
Dr. David A. Ansell
Commissioner Jerry Butler
David N. Carvalho
Quin R. Golden
Benn Greenspan
Sr. Sheila Lyne
Dr. Luis R. Muñoz
Heather E. O'Donnell
Andrea L. Zopp

February 23, 2011

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

Dear Mr. Galassie,

I am writing in support of Rush University Medical Center's application for a certificate of need for its proposed modernization of the Atrium Building, which will house surgery and endoscopy services as well as obstetrics and medical surgical beds. I understand this project is a central component of the Medical Center's campus redevelopment plan.

Rush University Medical Center long has been a valued partner to the Cook County Health & Hospitals System, and a major asset to the West Side and wider metropolitan community.

Sincerely,

William T. Foley
Chief Executive Officer
Cook County Health & Hospitals System

SINAI

Sinai Health System California Avenue at 15th Street • Chicago, IL 60608 • (773) 542-2000 • TDD (773) 542-0040

Alan H. Channing
President and Chief Executive Officer
Office: 773-257-6434 • Fax: 773-257-6953
alan.channing@sinai.org

February 14, 2011

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

Dear Mr. Galassie,

I am writing in support of Rush University Medical Center's proposed modernization of the Atrium Building, which will house surgery and endoscopy services as well as obstetrics and medical surgical beds. This project is an essential component of the Medical Center's campus redevelopment and will bring the project one step closer to completion.

Rush University Medical Center is a valuable patient care, education, and research asset to north eastern Illinois—and especially the greater Chicago area. The Medical Center has strong private and community support for the project. In return Rush is an active and valued partner in the community. Rush enhances its community as an excellent health care provider and employer. The modernization of Rush campus is a benefit to healthcare in the greater Chicago area.

Thank you for your consideration and approval of the Medical Center's certificate of need application to modernize the Atrium Building.

Sincerely,

Alan H. Channing

LAWNDALE CHRISTIAN HEALTH CENTER
Loving God, Loving People

February 14, 2011

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

Dear Mr. Galassie,

I am writing in support of Rush University Medical Center's proposed modernization of the Atrium Building, which will house surgery and endoscopy services as well as obstetrics and medical surgical beds. This project is an essential component of the Medical Center's campus redevelopment and will bring the project one step closer to completion.

Rush University Medical Center is a valuable patient care, education, and research asset to north eastern Illinois—and especially the greater Chicago area. The Medical Center has strong private and community support for the project. In return Rush is an active and valued partner in the community. Rush enhances its community as an excellent health care provider, employer and community activist. Anything that enhances the Rush campus is a benefit to healthcare in the greater Chicago area.

Thank you for your consideration and approval of Rush University Medical Centers' certificate of need application to modernize the Atrium Building.

Please let me know if you have any questions are need additional information.

Sincerely,

Bruce E. Miller, CEO
Lawndale Christian Health Center

Triangle Office Building
1700 W. Van Buren St.
Suite 250
Chicago, IL 60612

Tel: 312.942.3203
www.rush.edu

RUSH

Office of the Trustees

March 24, 2011

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

Dear Mr. Galassie:

It is my pleasure to write this letter supporting Rush University Medical Center's request for a Certificate of Need from the Health Facilities and Services Review Board. As a businessman, Chairman of the Board of Trustees and the Trustee who is spearheading the fund raising campaign to support the campus transformation, I would like to share a few of my perspectives.

The planning for the transformation of the Rush campus that began more than a decade ago is now becoming reality. The Orthopedics Ambulatory Building is open and exceeding expectations. The East Tower, the centerpiece of the campus redevelopment project, is nearing completion. The next important project is the modernization of other patient care areas as well as the mechanical systems and infrastructure of the Atrium Building. The completion of the Atrium modernization project will allow for the relocation of patient care services that are in very old buildings. This will pave the way for their future demolition.

Health care is changing rapidly, but more significantly, patient expectations about health care are also changing. It is not enough for 21st century health care providers to be the best clinically; they must also meet and exceed patients' expectations. Facilities built in the 19th and 20th centuries simply cannot do this. First-rate patient care facilities, whether in new construction or modernized facilities, such as the Atrium Building, are key to providing patients with the most advanced medical care in contemporary, safe and efficient facilities. Our slogan, "It's How Medicine Should Be" captures the commitment to outstanding patient-focused care.

Twenty-first century patient care requires a host of new tools—information technology at the bedside, to document, track and coordinate multidisciplinary care; clinical services in close proximity to minimize the need for patients to traverse an entire campus for tests and treatments; diagnostic and treatment services in flexible space to accommodate continual medical advances; and a calming environment for patients and families for what may be the most stressful time of their lives. The modernized 30-year old Atrium Building will be able to accomplish all of these.

Rush is a not-for-profit health care, education and research enterprise comprising Rush University Medical Center, Rush University, Rush Oak Park Hospital and Rush Health.

As a Rush patient I have frequently navigated its block-long corridors and older buildings to receive my care. The care has always been exceptional. But Rush needs to finish the transformation project that has been started to truly transform the patient care experience for all patients.

Our community has also believed in Rush's vision of transformation and their gifts and pledges have been very generous. I hope that you, too, will help us achieve our vision by approving the Medical Center's request for a Certificate of Need to modernize the Atrium Building.

Sincerely,

Richard M. Jaffee
Chairman, Board of Trustees

cc: Ms. Courtney Avery
Administrator
Health Facilities and Services Review Board

Mr. Mike Constantino
Supervisor of Project Review
Health Facilities and Services Review Board

Larry J. Goodman, MD
Chief Executive Officer
Rush University Medical Center

Peter W. Butler
President and Chief Operating Officer
Rush University Medical Center

Triangle Office Building
1700 W. Van Buren St.
Suite 250
Chicago, IL 60612

Tel: 312.942.3203
www.rush.edu

RUSH

Office of the Trustees

March 23, 2011

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

Dear Mr. Galassie:

I am writing to support Rush University Medical Center's request for a Certificate of Need (CON) from the Health Facilities and Services Review Board for the modernization of the Atrium Building. As chairperson of Rush's Trustee Facilities Committee, I can attest to the thoroughness of the planning for each phase of the campus transformation endeavor, including this third major project that is directly related to the Master Design permit.

The modernization project will complete our proposed complement of 320 medical surgical beds. It will update our obstetrics beds and newborn nursery bassinets and relocate them so they will be linked via bridge to our other maternal and newborn services including the LDR (labor, delivery and recovery) rooms, the obstetrical surgical suite and the neonatal unit in the East Tower. Further, it will consolidate and expand the endoscopy area to 10 labs. These labs, in addition to 12 additional operating rooms to be used primarily for outpatient surgery, as well as needed PACUs and prep/recovery areas will also be linked via a bridge to a level of operating rooms in the new soon-to-be-open tower. In addition to these four levels of patient care areas, the mechanical systems and the infrastructure of this 30-year old building also will be upgraded to contemporary standards. At the completion of the project, Rush will have almost completed its transformation process and have a right-sized facility that will be safe for patients and efficient to operate.

Rush is a national leader in health care; the Medical Center draws patients from the neighborhood, the City of Chicago, and other Cook County communities as well as from the surrounding suburbs, other Illinois regions and from states beyond Illinois. Because of its advanced and often unique capabilities, more than 150 hospitals and their

Rush is a not-for-profit health care, education and research enterprise comprising Rush University Medical Center, Rush University, Rush Oak Park Hospital and Rush Health.

physicians refer patients to Rush. Patients from all of Illinois will benefit from the transformed Rush campus which is so urgently needed to support its continued leadership role. I ask you to approve Rush's Atrium Building CON request.

Sincerely,

Susan Crown
Chairman, Facilities Committee
Board of Trustees

cc: Ms. Courtney Avery
Administrator
Health Facilities and Services Review Board

Mr. Mike Constantino
Supervisor of Project Review
Health Facilities and Services Review Board

Larry J. Goodman, MD
Chief Executive Officer
Rush University Medical Center

Peter W. Butler
President and Chief Operating Officer
Rush University Medical Center

Stuart Levin, M.D.
The Ralph C. Brown, M.D. Professor
Chairman

Department of Internal Medicine
1653 West Congress Parkway
Chicago, Illinois 60612-3244

Tel: 312.942.6600
Fax: 312.942.5271
stuart_levin@rush.edu
www.rush.edu

RUSH UNIVERSITY
COLLEGE OF NURSING
RUSH MEDICAL COLLEGE
COLLEGE OF HEALTH SCIENCES
THE GRADUATE COLLEGE

RUSH UNIVERSITY MEDICAL CENTER

March 30, 2011

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

Dear Mr. Galassie:

The purpose of this letter is to express my strong support for the Atrium Building modernization project.

As Chairman of the Department of Medicine, I am in ongoing discussions with the physicians and nurses who take care of the medical patients at Rush University Medical Center. As the East Tower project nears completion, we have had a glimpse of the new medical surgical units; we are all delighted that the extensive planning that went into the development of these new units has resulted in patient care areas that will be safe and efficient to operate.

At the completion of the Atrium Building modernization project, all of the medical surgical beds at Rush will be in new or modernized space. Of the total 320 medical surgical beds, 128 will be in the Atrium Building in four 32-bed units on Levels 7 and 9. We are all pleased that the modernization plans for these units is following the same guidelines and principles that governed the development of the new East Tower. As part of the redesign of these units to be modernized in the Atrium Building, the number of beds on each unit is being reduced from 37 to 32. By reducing 5 beds on each unit, space was made available for adequate storage and support space, a serious limitation on the existing units in the Atrium Building; this is certainly a welcome improvement for our nurses. The current patient rooms will retain their size and configuration; however, they will all be private rooms, which will give our patients and their families the privacy that they so value during a hospitalization, which is a stressful time for all. And finally, the additional space will enhance our robust medical education program.

The cost of modernizing 128 beds in the Atrium Building is less than building all new medical surgical beds--which was an option we considered. This lower cost alternative is an important consideration in these times of limited capital.

Because this project provides us modernized facilities that will enhance patient care, help our nurses deliver that care, and enhance our medical education program, I hope that you will approve this much needed project.

Sincerely,

Stuart Levin, MD
Professor and Chairman
Department of Internal Medicine

copy: Ms. Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board

Mr. Michael Constantino, Supervisor of Project Review Section
Illinois Health Facilities and Services Review Board

Rush Children's Hospital
1653 West Congress Parkway
770 Jones
Chicago, IL 60612

Tel: 312.942.8928
Fax: 312.942.2243
Kenneth_M_Boyer@rush.edu

RUSH

Kenneth M. Boyer, MD
Rush University Medical Center
Women's Board Professor of Pediatrics
Chairman, Department of Pediatrics

January 4, 2012

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

Dear Mr. Galassie:

On behalf of the Department of Pediatrics and our patients and families, we are pleased to write this letter supporting Rush University Medical Center's renovation project for inpatient general pediatrics.

A key goal of the Rush campus transformation has been to move inpatient units out of the Pavilion building (built in 1908) and into modernized units. On January 8th, the adult Coronary Care Unit will move from Pavilion to the new Tower. The only remaining inpatient unit in the Pavilion building will be the 28-bed general pediatric unit on the 5th floor. As part of this project, the plan is to move the 5 Pavilion pediatric unit to a modernized 22-bed pediatric unit in the Kellogg building. The new unit will have single rooms with private bathrooms. This will greatly enhance privacy and infection control for our patients and their family members. It will bring our general pediatric inpatient unit to the building where our pediatric intensive care unit, child psychiatry unit, and heart station are currently located. This will also have the effect of physically consolidating the inpatient care of children in the Rush Children's Hospital.

We are proud to be a part of the planned modernization and improvement of the care we provide to our young patients and their families. We would be happy to answer any questions about this project and hope that you will support this Certificate of Need application.

Sincerely,

Kenneth M. Boyer, M.D.
Chairman, Department of Pediatrics
Rush University Medical Center

Diane Gallagher, RN, MSN
Director, Women's & Children's Nursing
Rush University Medical Center

Cc: Ms. Courtney Avery, Administrator
Mr. Mike Constantino, Supervisor of Project Review

Rush is a not-for-profit health care, education and research enterprise comprising Rush University Medical Center, Rush University, Rush Oak Park Hospital and Rush Health.

HOWARD T. STRASSNER, JR., MD
The John M. Simpson Professor and Chair
Director, Section of Maternal-Fetal Medicine
Co-Director, Rush Perinatal Center

Department of
Obstetrics and Gynecology
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RUSH UNIVERSITY
MEDICAL CENTER

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COLLEGE OF NURSING
RUSH MEDICAL COLLEGE
COLLEGE OF HEALTH SCIENCES
THE GRADUATE COLLEGE

March 24, 2011

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

Dear Mr. Galassie,

On behalf our perinatal patients and their families, my colleagues and I urge you to approve the Atrium Building Modernization Project.

Today, the antenatal and postpartum beds at Rush University Medical Center are located in the Jelke Building; this building was originally designed for laboratory and administrative functions and in the future will be used only for non patient care functions.

The proposed relocation and redevelopment of the obstetrics beds at the Medical Center is very exciting. The replacement unit will be located in modernized space on Level 8 in the Atrium Building. This is an excellent location since it is at the same level as the LDR, the surgical delivery suite, and the neonatal beds in the new East Tower. Our obstetrics beds will be connected to delivery functions and the neonatal beds with a bridge. Hence, in this new location and its adjacency to other related functions, continuum of care will be substantially enhanced.

Our patients will appreciate having rooms with updated finishes, enhanced lighting and new furnishings. In the modernized space, we will be able to provide our new mothers with a rooming-in option as well as normal nursery bassinets. If their infant is admitted to the neonatal unit, they will be able to be with them via a short commute across the bridge to the East Tower. Several of the rooms will provide an option for adjoining space that can be used for visitors and even as a sleeping area for a family member or significant other. This is especially important to our antepartum patients who may be hospitalized for many days or even weeks.

We are available to answer any questions you may have about our new unit and we sincerely hope that you will approve this certificate of need application.

Sincerely,

Howard T. Strassner
Chairman, Obstetrics and Gynecology
Rush University Medical Center

Anthony J. Perry, MD
Director

Johnston R. Bowman
Health Center
710 South Paulina Street
Chicago, Illinois 60612-3244

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MEDICAL CENTER

March 21, 2011

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

Dear Mr. Galassie,

I am writing this letter in support of the Rush University Medical Center CON submission. As you well know, Rush is in the midst of a significant campus renovation program. We are very excited about the delivery of our new hospital building which will happen in January of 2012. In particular, the quality and patient safety elements of the design create a great deal of excitement from our staff on behalf of the patients we serve.

It is for that same reason that we make this next phase submission to your review board for consideration. It is important to us that from the perspective of patient safety and quality we bring our current facilities to the same functional level as our new facilities. This means several things that range from updating the mechanical infrastructure of the building to rethinking the workflows on our clinical inpatient units.

Given my knowledge base, I will speak more to the inpatient units. Some of the principles that shaped our new hospital design include moving our staff closer to the patient room. This means many things, including distributing technology closer to the patients given our deep adoption of the electronic medical record in all of our work. This allows activities such as barcode confirmation at the point of medical administration, which we consider to be an important patient safety process. We also want to distribute staff work areas closer to the vicinity of the patient rooms. For example, we would like to take our 37 bed units in the Atrium hospital and change them to 32 bed units, allowing us to utilize space for more decentralized work stations, medication areas, and supply resources. This is an example where we are not increasing the number of beds in an area but rather trying to improve the work environment to improve patient centered care.

Distributing technology and staff closer to the point of care was one of the key elements in our campus transformation to date. It is our hope through this CON submission to continue that movement to help us get to error free and patient centered health services. I thank you for taking the time to read through this letter and hope that you favorably consider this request.

Sincerely,

Anthony J. Perry
Clinical Transformation Officer

Cc:
Ms. Courtney Avery
Mr. Mike Constantino

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1750 W. Harrison Street
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May 9, 2011

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

Dear Mr. Galassie,

I am writing this letter in support of the Rush University Medical Center CON submission. As you know, Rush is in the midst of a major campus transformation program. Over the past 5 years Rush has built a new parking structure, power plant, loading dock and an ambulatory care building. In addition, we are scheduled to open our new inpatient care facility in January, 2012. Combined, these projects have enhanced the efficiency of our campus as well as improved the quality of the patient, family and staff experience on campus.

Patient and staff safety, work flow efficiency, standardization and sustainability are foundational design elements that have been built into our new hospital. We strongly believe that incorporating these same elements into our existing Atrium building through renovation will substantially enhance the patient care environment in this building. Rush is committed to providing the same level of care and safety for patients, while creating the most efficient and safe work environment for our staff across campus.

Although we cannot completely replicate the design of the new hospital in our renovation project there are a number of design elements that we plan to incorporate which we believe will substantially improve the patient care environment. We plan to reconfigure the patient care units so that medication and clean supplies storage is decentralized allowing easier, more ready access for staff. In addition, we have decentralized work stations, added a documentation terminal in each patient room with the goal of keeping the staff in close proximity to the patients.

Upgrading the mechanical infrastructure is equally important to our renovation plans. Assuring that the Atrium building infrastructure is consistent with new building standards; appropriate air ventilation in the ORs and on the patient units, enhanced technology infrastructure to support current IT equipment and applications is essential to creating a modern, safe, comfortable patient care environment and work space. It is for these reasons I ask you to support the CON.

Sincerely,

Eileen M. Dwyer RN, MS
Director, Office of Transformation

Paula Dillon RN, MS, NEA-BC
Acting Vice President of Nursing & Chief Nursing OfficerCc:

Ms. Courtney Avery
Mr. Mike Constantino

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	$18,042	$1,958	$20,000
Site Survey and Soil Investigation	$0	$0	$0
Site Preparation	$0	$0	$0
Off Site Work	$0	$0	$0
New Construction Contracts	$0	$0	$0
Modernization Contracts	$15,080,354	$17,895,517	$32,975,870
Contingencies	$2,262,053	$2,684,327	$4,946,381
Architectural/Engineering Fees	$475,607	$564,393	$1,040,000
Consulting and Other Fees	$538,755	$639,328	$1,178,083
Movable or Other Equipment (not in construction contracts)	$2,609,187	$3,096,263	$5,705,450
Bond Issuance Expense (project Related)	$0	$0	$0
Net Interest Expense During Construction (project related)	$0	$0	$0
Fair Market Value of Leased Space or Equipment	$166,920	$198,080	$365,000
Other Costs to be Capitalized	$0	$0	$0
TOTAL USES OF FUNDS	$21,150,918	$25,079,866	$46,230,784
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$21,150,918	$25,079,866	$46,230,784
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$21,150,918	$25,079,866	$46,230,784

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

Itemization of each line item is included in Attachment 7

Related Project Costs

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

Land acquisition is related to project ☐ Yes ☒ No
Purchase Price: $_____
Fair Market Value: $_____

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

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

Estimated start-up costs and operating deficit cost is $ **Not Applicable; the project does not include the establishment of a new facility or a new category of service**.

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

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

Anticipated project completion date (refer to Part 1130.140): **June 30, 2016**
RUMC's fiscal year starts on July 1. June 30, 2106, is therefore in FY 2016 and the first full year of operation will be CY 2017

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

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

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

State Agency Submittals

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

Cost Space Requirements

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

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Total Clinical							
NON REVIEWABLE							
Total Non-clinical							
TOTAL							

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

Attachment 9 is on the following table.

Cost Space Requirements

Department/Area		Cost	Gross Square Feet		Amount of Proposed Total GSF That Is:			
			Existing	Proposed	New Const.	Remodeled	As Is	Vacated Space
Clinical								
1	Medical Surgical Beds	$ 6,360,996	194,822	199,842	-	69,792	130,050	-
2	Pediatric Beds	$ 2,226,169	11,160	11,520	-	11,520	-	-
3	Obstetrics Beds/ Rooming In	$ 619,634	13,525	19,131	-	19,131	-	-
4	Newborn Nursery	$ 520,088	1,152	1,174	-	1,174	-	-
5	Surgical Operating Rooms (Class C)	$ 1,110,452	83,885	80,437	-	6,061	74,376	-
6	Surgical Procedure Rooms (Class B) (Endoscopy Suite)	$ 2,042,773	7,879	9,109	-	9,109	-	-
7	Post Anesthesia Recovery Phase 1 (PACU)	$ 4,186,190	16,000	15,495	-	4,445	11,050	-
8	Post Anesthesia Recovery Phase II (Prep/Recovery)	$ 3,896,326	40,365	45,255	-	11,692	33,563	-
9	Antepartum testing (including procedure room)	$ 188,289	415	889	-	889	-	-
	Hybrid OR	$ -	1,312	1,312			1,312	
SUBTOTAL CLINICAL		$ 21,150,918	370,515	384,164	-	133,813	250,351	-
Non-Clinical								
12	Mechanical Infrastructure	$ 21,234,966	33,704	33,978	-	33,978	-	
10	Public/Family Spaces (including OB family rooms)	$ 1,535,231	2,683	10,116	-	10,116	-	-
11	General	$ 2,309,669	10,705	33,944		6,830	27,114	-
	Vacant	$ -	63,779	19,183				19,183
SUBTOTAL NON-CLINICAL		$ 25,079,866	110,871	97,221	-	50,924	27,114	19,183
TOTAL PROJECT		**$ 46,230,784**	**481,385**	**481,385**	**-**	**184,737**	**277,465**	**19,183**

Facility Bed Capacity and Utilization

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

FACILITY NAME: Rush University Medical Center		CITY: Chicago			
REPORTING PERIOD DATES:		From: 01/01/2010		to: 12/31/10	
Category of Service	Authorized Beds	Admissions	Patient Days [a]	Bed Changes [b]	Proposed Beds
Medical/Surgical	340	19,656	95,829	- 7	333
Obstetrics	38	2,617	9,064	- 4	34
Pediatrics	28	1,069	5,307	-6	22
Intensive Care	132	4,671	20,409	-	132
Comprehensive Physical Rehabilitation	59	1,099	13,486	-	59
Acute/Chronic Mental Illness	70	1,498	15,894	-	70
Neonatal Intensive Care	72	565	15,233	-	72
General Long Term Care	-	-	-	-	-
Specialized Long Term Care	-	-	-	-	-
Long Term Acute Care	-	-	-	-	-
Other (Dedicated Observation)	6	-	366	-	6
TOTALS:	739	30,140	175,588	-17	722

a) Includes inpatient days and observation days

b) At the conclusion of the project RUMC will have 320 medical surgical beds. Space for 13 hospice beds has been leased to Horizon Hospice and Palliative Care.

CERTIFICATION

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

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

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

SIGNATURE

Larry J. Goodman, MD
PRINTED NAME

Chief Executive Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 24th day of January

Signature of Notary

Seal

OFFICIAL SEAL
DENISE M GRITSCH
Notary Public - State of Illinois
My Commission Expires Oct 25, 2015

SIGNATURE

Peter W. Butler
PRINTED NAME

President and Chief Operating Officer
PRINTED TITLE

Notarization:
Subscribed and sworn to before me
this 24th day of January

Signature of Notary

Seal

OFFICIAL SEAL
DENISE M GRITSCH
Notary Public - State of Illinois
My Commission Expires Oct 25, 2015

*Insert EXACT legal name of the applicant

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

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

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

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

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

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

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

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

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative.**

2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following::

   a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies;

   b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that results in a size exceeding the standards of Appendix B;

   c. The project involves the conversion of existing space that results in excess square footage.

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

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

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

PROJECT SERVICES UTILIZATION:

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

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

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

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

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage of the proposed shell space;

2. The anticipated use of the shell space, specifying the proposed GSF tot be allocated to each department, area or function;

3. Evidence that the shell space is being constructed due to
   a. Requirements of governmental or certification agencies; or
   b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.

4. Provide:
   a. Historical utilization for the area for the latest five-year period for which data are available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

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

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.

2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and

3. The anticipated date when the shell space will be completed and placed into operation.

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

SECTION 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 - Not Applicable. This is not a Master Design project

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 - Not Applicable. This is not a Master Design project

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.

SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA

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

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

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

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

Category of Service	# Existing Beds	# Proposed Beds
☒ Medical/Surgical	340	333
☒ Obstetric	38	34
☒ Pediatric	28	22

Note: At the conclusion of the project, RUMC will have 320 medical surgical beds. Space for 13 hospice beds has been leased to Horizon Hospice & Palliative Care.

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

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

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

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

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	
☒ **Surgical Operating Suite (Class C)**	32	36	**Including 8 in the Atrium Building**
☒ **Surgical Procedure Suite (Endoscopy) (Class B)**	8	10	
☒ **Post Anesthesia Recovery (PACU) (Phase I)**	63	63	
☒ **Post Anesthesia Recovery Prep/Recovery (Phase II)**	100	118	
☒ **Antepartum Testing**	1	1	

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

:

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

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

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

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

VIII. - 1120.120 - Availability of Funds **Not Applicable – Rush University Medical Center has an A Bond rating.**

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:**

$46,230,784	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.
$46,230,784		**TOTAL FUNDS AVAILABLE**

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

Rush has been awarded Tax Incremental Financing (TIF) by the City of Chicago (the City) under the Tax Increment Allocation Redevelopment Act (the Act). Such monies can be utilized to pay for expenditures associated with renovation projects that qualify for reimbursement under the Act, provided that Rush has complied with all other terms of the Redevelopment Agreement (RDA) between Rush and the City. Rush believes that all or a portion of this project qualifies for TIF reimbursement, and that it will be in compliance with all other terms of the RDA. Rush must first expend the monies and then submit to an application process as prescribed by the RDA in order to receive the funds, which might not be received prior to the completion of this project. As such, funding for this project is accordingly reflected as Cash & Securities.

IX. 1120.130 - Financial Viability **Not Applicable – Rush University Medical Center has an A Bond rating and therefore meets the waiver requirements.**

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

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

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

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

2. Variance

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

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

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements **Not Applicable – Rush University Medical Center has an A Bond rating and therefore meets the waiver requirements.**

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

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

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

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

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

B. Conditions of Debt Financing **Not Applicable – Rush University Medical Center will not use debt to finance this project.**

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

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

XI. Safety Net Impact Statement

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

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

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

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

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

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

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

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

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

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

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

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

XII. Charity Care Information

Charity Care information MUST be furnished for ALL projects.

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

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

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

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

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

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

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

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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5	Flood Plain Requirements	57 – 59
6	Historic Preservation Act Requirements	60 – 61
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27	Non-Hospital Based Ambulatory Surgery	NA
28	General Long Term Care	NA
29	Specialized Long Term Care	NA
30	Selected Organ Transplantation	NA
31	Kidney Transplantation	NA
32	Subacute Care Hospital Model	NA
33	Post Surgical Recovery Care Center	NA
34	Children's Community-Based Health Care Center	NA
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ATTACHMENTS

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION
This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	**Rush University Medical Center – CON III – Modernization of the Atrium and Kellogg Buildings**				
Street Address:	**1650 West Harrison and 1753 West Congress Parkway**				
City and Zip Code:	**Chicago, 60612**				
County:	**Cook**	Health Service Area:	**6**	Health Planning Area:	**A-02**

Applicant /Co-Applicant Identification
[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name:	**Rush University Medical Center**
Address:	**1725 West Harrison Street Ste. # 364 Chicago, IL 60612**
Name of Registered Agent:	**Anne M. Murphy, Sr. V.P. of Legal Affairs and General Counsel**
Name of Chief Executive Officer:	**Larry J. Goodman, M.D.**
CEO Address:	**1725 West Harrison Street Ste. # 364 Chicago, IL 60612**
Telephone Number:	**312-942-7073**

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

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

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

A copy of the Certificate of Good Standing for Rush University Medical Center is included as Attachment 1, Exhibit 1.

File Number 0200-214-1

STATE OF ILLINOIS
OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

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

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 15TH *day of* DECEMBER *A.D.* 2011 .

Jesse White

SECRETARY OF STATE

Authentication #: 1134900456

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

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	**Rush University Medical Center**
Address of Site Owner:	**1725 West Harrison Street Ste. # 364 Chicago, IL 60612**
Street Address or Legal Description of Site:	**Same**

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.

Proof of ownership of the site, 1650 West Harrison and 1753 West Congress Parkway, Chicago, Illinois 60612 is included as Appendix A. This appendix contains 3 documents. The first is a quit claim deed from 1976. The second is a PIN map with the property outlined. Finally, the third document is the affidavit files with the Assessor's office indicating Rush's ownership of the listed PINs.

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Operating Identity/Licensee

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

Exact Legal Name:	**Rush University Medical Center**
Address:	**1725 West Harrison, Ste. 364, Chicago, IL 60623**

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

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

A copy of the State of Illinois Certificate of Good Standing for Rush University Medical Center is included as Attachment 3, Exhibit 1.

File Number 0200-214-1

To all to whom these Presents Shall Come, Greeting:

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

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

Authentication #: 1134900456

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

In Testimony Whereof, *I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this* 15TH *day of* DECEMBER *A.D.* 2011 .

Jesse White

SECRETARY OF STATE

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

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.

Attachment 4, Exhibits 1 and 2 describe Rush University Medical Center organizational relationships.

Rush University Medical Center's Organizational Relationships

Rush University Medical Center (RUMC) is the applicant on this project.
Rush University Medical Center and Rush Copley Medical Center are members of an obligated group. Members of the obligated group are jointly and severally liable on Master Trust Indenture Indebtedness. Rush Copley Medical Center is not a co-applicant on this CON application because this project will not be financed with debt.

Attachment 4, Exhibit 2 is a copy of the Rush System for Health organizational chart.

Rush System for Health is a not-for-profit Illinois corporation. Rush System for Health does not have any of the following rights or powers related to any of the organizations listed on the Organization Chart, Attachment 4, Exhibit 2.

Rush System for Health does not have the right or power to approve and remove a controlling portion of any of the organizations.

- Rush System for Health does not have the right or power to approve the use of funds or assets of any of the organizations.
- Rush System for Health does not have the right or power to approve, amend, or modify the by-laws or other rules of governance of any of the organizations.
- Rush System for Health will not be responsible for guaranteeing or making payments on any debt related to the project.
- Rush System for Health will not be involved in the operation or provision of care and control the use of equipment or other capital assets that are components of the project.

Rush Oak Park Hospital is operated by RUMC.

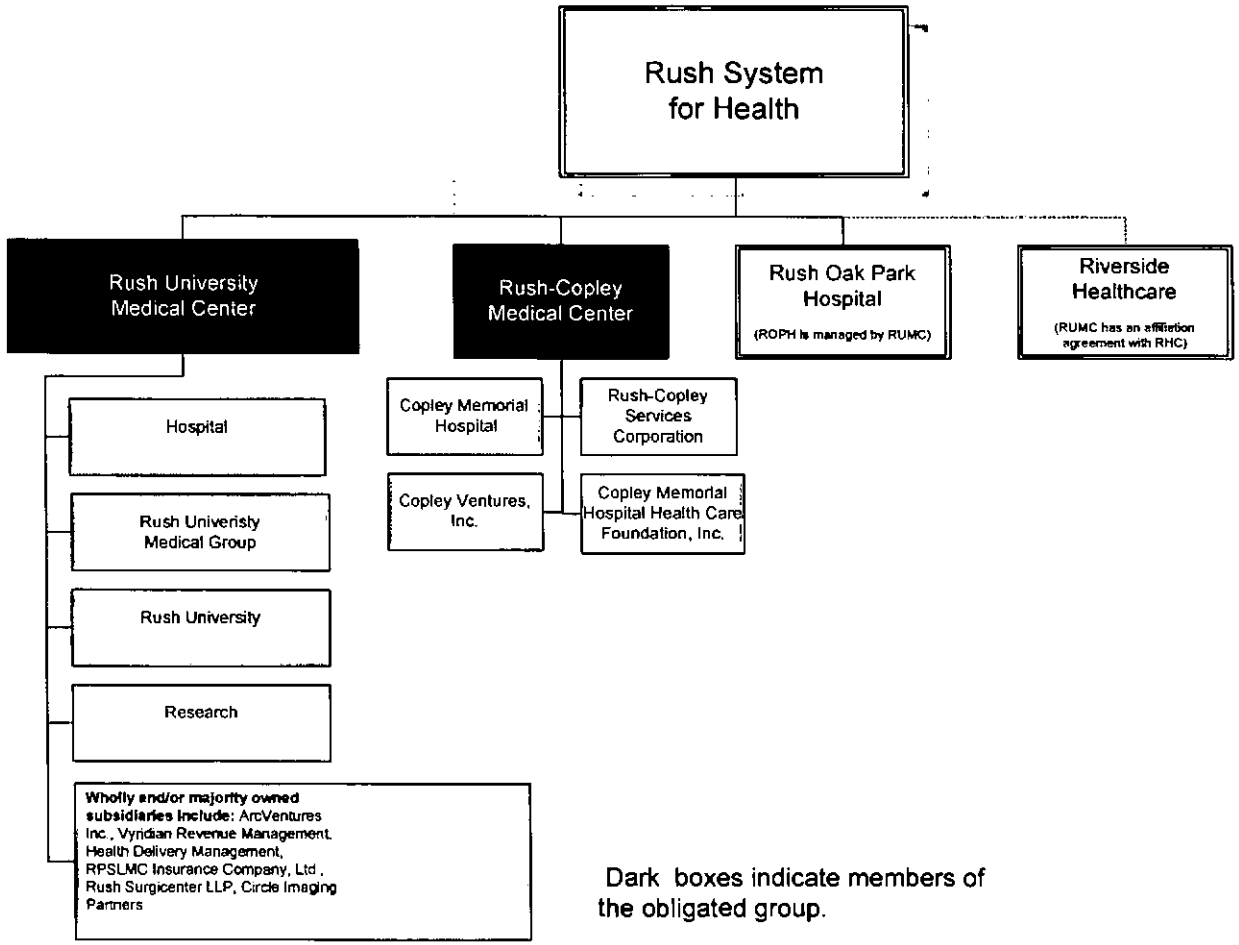
Riverside Healthcare has an affiliation with RUMC.

Neither Rush Oak Park Hospital nor Riverside Healthcare meet the above tests for co-applicancy.

RUMC has negotiated an agreement with Horizon Hospice & Palliative Care to lease space in which Horizon will operate 13 hospice beds. The need for these beds and the negotiations with Horizon began after the Master Design and Atrium Addition/East Tower applications were approved.

As a tenant in Rush's Johnson R. Bowman Building, Horizon does not meet the above tests for co-applicancy.

Rush System for Health Organizational Chart



SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects

Flood Plain Requirements

[Refer to application instructions.]

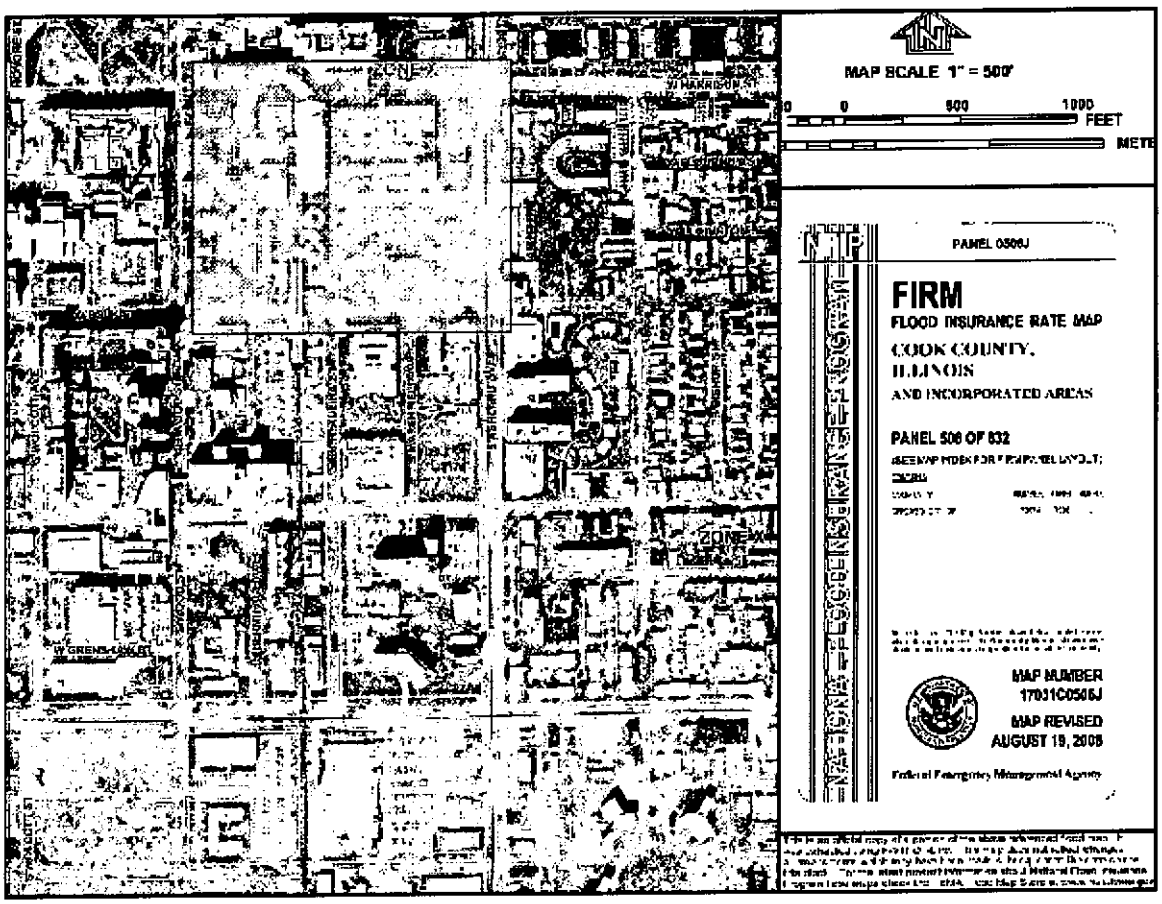
Provide documentation that the project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements please provide a map of the proposed project location showing any identified floodplain 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.

Rush University Medical Center attests that the project is not in a flood plain and that the location of the Atrium and Kellogg buildings modernization project complies with the Flood Plain Rule under Illinois Order #2005-5.

Attachment 5, Exhibit 1 is a Flood Insurance Rate Map of Panel 506, the location of the proposed construction of the Atrium and Kellogg buildings modernization. As shown on this map, the area is not located in a flood plain.

Attachment 5, Exhibit 2 is a letter from the Illinois Department of Natural Resources dated October 21, 2008 in which that Department determined that the site of the modernized Cancer Care Center "is not located within a designated 100-year floodplain." The Cancer Care Center is in the same Flood Insurance Rate Map –Panel 506 as the proposed Atrium and Kellogg buildings modernization project.


MAP SCALE 1" = 500'
0 0 500 1000
FEET
PANEL 0506J
FIRM
FLOOD INSURANCE RATE MAP
COOK COUNTY, ILLINOIS
AND INCORPORATED AREAS
PANEL 506 OF 832
MAP NUMBER
17031C0506J
MAP REVISED
AUGUST 19, 2008
Federal Emergency Management Agency

Illinois Department of
Natural Resources
One Natural Resources Way · Springfield, Illinois 62702-1271
http://dnr.state.il.us

Rod R. Blagojevich, Governor
Sam Flood, Acting Director

October 21, 2008

Ms. Janet Scheuerman
Prism Consulting Services Inc.
1808 Woodmere Drive
Valparaiso, Indiana 46383

RE: Rush University Medical Center, Coleman Cancer Care Center Relocation and Modernization.

Dear Ms. Scheuerman:

Thank you for requesting a floodplain determination for the proposed development at the Coleman Cancer Care Center at Rush University Medical Center in Chicago, Illinois to ensure compliance with Illinois Executive Order V (2006).

In brief, Executive Order V (2006) requires that state agencies ensure all projects meet the standards of the state floodplain regulations or the National Flood Insurance Program (NFIP), whichever is more stringent. These standards require that new or substantially improved buildings and other development activities be protected from damage by the 100-year flood. In addition, no construction activities in the floodplain may cause increases in flood heights or damages to other properties. Development activities which are determined to be "critical facilities" must be protected to the 500-year flood elevation.

Hospitals are specifically listed as critical facilities. After reviewing the information you have provided, **we have determined that this parcel is not located within a designated 100-year floodplain.** The Executive Order requires that all new critical facilities shall be located outside of the 100-year floodplain and built to the 500-year protection standards. Based on the site plans you have submitted, it appears that the new development does meet these requirements.

Should you have any questions or comments regarding this flood hazard determination feel free to contact me at (217) 782-0690.

Sincerely,

Annette Burris, CFM, CLA
Illinois Department of Natural Resources
State Flood Programs

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects

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.

Attachment 6, Exhibit 1 is documentation regarding compliance with the requirements of the Historic Resources Preservation Act. It is a letter from Anne E. Haaker, Deputy State Historic Preservation Officer dated December 19, 2011. The letter states that no historic, architectural, or archaeological sites exist within the project area.

Illinois Historic
Preservation Agency

FAX (217) 782-8161

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

Cook County
Chicago
CON - Demolition and New Construction, Rush University Medical Center Atrium Building - 1653 W. Congress - Modernization; Atrium Addition - 1653 W. Congress - New Construction; Ashland Ave. between Harrison St. and Flournoy St. - New Construction; SW Corner Flournoy St. and Ashland Ave. - New Construction; Kellogg Pavilion - 1717 W. Congress; Pavilion Building - 1733 W. Congress, Demolition; Senn Building - 1744 W. Harrison, Demolition; Rawson Building - 1758 W. Harrison, Demolition; Jones Building - 1753 W. Congress, Demolition; Jelke Building - 1742 W. Harrison, Demolition; West Side Plant - 517 S. Wood, Demolition; Murdock Building - 517 S. Wood, Demolition
IHPA Log #006121205

December 19, 2011

Janet Scheuerman
PRISM Healthcare Consulting
1808 Woodmere Drive
Valparaiso, IN 46383

Dear Ms. Scheuerman:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

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

Sincerely,

Anne E. Haaker

Anne E. Haaker
Deputy State Historic
Preservation Officer

A teletypewriter for the speech/hearing impaired is available at 217-524-7128. It is not a voice or fax line.

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects

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	$18,042	$1,958	$20,000
Site Survey and Soil Investigation	$0	$0	$0
Site Preparation	$0	$0	$0
Off Site Work	$0	$0	$0
New Construction Contracts	$0	$0	$0
Modernization Contracts	$15,080,354	$17,895,517	$32,975,870
Contingencies	$2,262,053	$2,684,327	$4,946,381
Architectural/Engineering Fees	$475,607	$564,393	$1,040,000
Consulting and Other Fees	$538,755	$639,328	$1,178,083
Movable or Other Equipment (not in construction contracts)	$2,609,187	$3,096,263	$5,705,450
Bond Issuance Expense (project Related)	$0	$0	$0
Net Interest Expense During Construction (project related)	$0	$0	$0
Fair Market Value of Leased Space or Equipment	$166,920	$198,080	$365,000
Other Costs to be Capitalized	$0	$0	$0
TOTAL USES OF FUNDS	$21,150,918	$25,079,866	$46,230,784
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$21,150,918	$25,079,866	$46,230,784
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$21,150,918	$25,079,866	$46,230,784

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

Description		Atrium Phase 1 – 4 and 6 Total	Kellogg Phase 5	Project Total
Preplanning		**$ -**	**$ 20,000**	**$ 20,000**
01100	Programming	$ -	$ 20,000	$ 20,000
Site Surveys & Soils Investigations		**$ -**	**$ -**	**$ -**
Site Preparation		**$ -**	**$ -**	**$ -**
Off-Site Work		**$ -**	**$ -**	**$ -**
New Construction Contracts		**$ -**	**$ -**	**$ -**
Modernization Contracts		**$ 31,175,056**	**$ 1,800,814**	**$ 32,975,870**
02150	Renovation	$ 31,175,056	$ 1,800,814	$ 32,975,870
Contingencies		**$ 4,676,258**	**$ 270,122**	**$ 4,946,381**
07000	Owner's Contingency	$ 4,676,258	$ 270,122	$ 4,946,381
Architecture & Engineering Fees		**$ 800,000**	**$ 240,000**	**$ 1,040,000**
Consulting & Other Fees		**$ 1,128,083**	**$ 50,000**	**$ 1,178,083**
04170	A/E Additional Services	$ 64,000	$ -	$ 64,000
04170-5	Leed	$ 42,000	$ -	$ 42,000
04170-7	Scope determination assistance	$ 20,000	$ -	$ 20,000
04800	Reimbursables	$ 2,000	$ -	$ 2,000
04400	Commissioning	$ 40,000	$ -	$ 40,000
04600	Certificate of Need Consultant	$ 85,120	$ -	$ 85,120
04800	Reimbursables	$ 8,210	$ -	$ 8,210
	MBE/WBE Consultant	$ 172,753	$ -	$ 172,753
	MBE/WBE Consultant for Atrium	$ 144,000	$ -	$ 144,000
04800	Reimbursables	$ 2,000	$ -	$ 2,000
	Permit Expeditor	$ 10,000	$ -	$ 10,000
04800	Reimbursables	$ 1,000	$ -	$ 1,000
04300	Project Management	$ 591,000	$ -	$ 591,000
04800	Reimbursable Expenses	$ 10,000	$ -	$ 10,000
Moveable & Other Equipment		**$ 5,355,450**	**$ 350,000**	**$ 5,705,450**
03110	Medical Equipment	$ 2,500,000	$ -	$ 2,500,000
03120	Data/Comm Equipment	$ 2,315,450	$ -	$ 2,315,450
03210	Furniture	$ 500,000	$ -	$ 500,000
	Signage	$ 40,000	$ -	$ 40,000
Bond Issuance Expense		**$ -**	**$ -**	**$ -**
Net Interest Expense During Construction		**$ -**	**$ -**	**$ -**
06200	Capital Interest During Construction	$ -	$ -	$ -
Other Costs to be Capitalized		**$ 365,000**	**$ -**	**$ 365,000**
05210	CON Application Fees	$ 100,000	$ -	$ 100,000
05220	Plan Review & Permitting	$ 10,000	$ -	$ 10,000
	Abatement	$ 225,000		$ 225,000
	Predesign T&B	$ 30,000	$ -	$ 30,000
Grand Total		**$ 43,499,847**	**$ 2,730,936**	**$ 46,230,784**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects

Project Status and Completion Schedules

Indicate the stage of the project's architectural drawings:

☐ None or not applicable ☐ Preliminary

☒ Schematics ☐ Final Working

Anticipated project completion date (refer to Part 1130.140): **June 30, 2016**

RUMC's fiscal year starts on July 1. June 30, 2016 is therefore in FY 2016 and the first full year of operation will be CY 2017.

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

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

☒ Project obligation will occur after permit issuance.

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

. Cost Space Requirements

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

		Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
Dept. / Area	**Cost**	**Existing**	**Proposed**	**New Const.**	**Modernized**	**As Is**	**Vacated Space**
REVIEWABLE							
Total Clinical							
NON REVIEWABLE							
Total Non-clinical							
TOTAL							

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

Attachment 9 is on the following page.

Cost Space Requirements

	Department/Area		Cost	Gross Square Feet		Amount of Proposed Total GSF That Is:			
				Existing	Proposed	New Const.	Remodeled	As Is	Vacated Space
Clinical									
1	Medical Surgical Beds	$	6,360,996	194,822	199,842	-	69,792	130,050	-
2	Pediatric Beds	$	2,226,169	11,160	11,520	-	11,520	-	-
3	Obstetrics Beds/ Rooming In	$	619,634	13,525	19,131	-	19,131	-	-
4	Newborn Nursery	$	520,088	1,152	1,174	-	1,174	-	-
5	Surgical Operating Rooms (Class C)	$	1,110,452	83,885	80,437	-	6,061	74,376	-
6	Surgical Procedure Rooms (Class B) (Endoscopy Suite)	$	2,042,773	7,879	9,109	-	9,109	-	-
7	Post Anesthesia Recovery Phase I (PACU)	$	4,186,190	16,000	15,495	-	4,445	11,050	-
8	Post Anesthesia Recovery Phase II (Prep/Recovery)	$	3,896,326	40,365	45,255	-	11,692	33,563	-
9	Antepartum testing (including procedure room)	$	188,289	415	889	-	889	-	-
	Hybrid OR	$	-	1,312	1,312			1,312	
SUBTOTAL CLINICAL		$	21,150,918	370,515	384,164	-	133,813	250,351	-
Non-Clinical									
12	Mechanical Infrastructure	$	21,234,966	33,704	33,978	-	33,978	-	
10	Public/Family Spaces (including OB family rooms)	$	1,535,231	2,683	10,116	-	10,116	-	-
11	General	$	2,309,669	10,705	33,944		6,830	27,114	-
	Vacant	$	-	63,779	19,183				19,183
SUBTOTAL NON-CLINICAL		$	25,079,866	110,871	97,221	-	50,924	27,114	19,183
TOTAL PROJECT		**$**	**46,230,784**	**481,385**	**481,385**	-	**184,737**	**277,465**	**19,183**

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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**

4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest the information has been previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

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

1. Health Care Facilities Owned and Operated by Rush University Medical Center

Rush University Medical Center (Rush, Medical Center, RUMC) owns and operates Rush University Medical Center in Chicago. Rush also operates Rush Oak Park Hospital in Oak Park.

The licensing, certification, and accreditation numbers for each of the organizations owned or operated by Rush, along with relevant identification numbers are listed below. See Attachment 11, Exhibit 1 for licenses and accreditation documents.

Name and Location of Facility	Identification Numbers
Rush University Medical Center Chicago, IL	2012 Chicago Hospital License ID # 11181 2012 Illinois Hospital License ID #2065072 JCAHO Hospital Accreditation JCAHO ID# 7297 – Stroke Accreditation JCAHO Behavioral Health
Rush Children's Services Chicago, Illinois	2012 Chicago Hospital License ID# 23452
Rush Oak Park Hospital Oak Park, IL	2012 Illinois Hospital License ID # 2305986 JCAHO ID # 7398 2012 Oak Park License # 3472

2. Certified Listing of Any Adverse Action Against Any Facility Owned and/or Operated by the Applicant

There have been no adverse actions taken against any facility owned and/or operated by Rush University Medical Center during the 3 years prior to filing the application. See Attachment-11, Exhibit 2 for certification of this statement.

3. Authorization Permitting HFPB and DPH to Access Necessary Documents

Attachment-11, Exhibit 2 includes authorization permitting HFPB and DPH to access any documents necessary to verify the information submitted in this application.

4. Exception for Filing Multiple Certificates of Need in One Year

Not applicable. The appended application is the first certificate of need filing for Rush in 2012.

Documentation of Licensure and Accreditation

CITY OF CHICAGO

LICENSE CERTIFICATE

NON-TRANSFERABLE

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

NAME: RUSH UNIVERSITY MEDICAL CENTER

DBA: RUSH UNIVERSITY MEDICAL CENTER
AT: 1653 W. CONGRESS PKWY., Floor POB III, Apt./Suite 364
CHICAGO, IL 60612

LICENSE NO.: 11181 CODE: 1375 FEE: $**2,200.00

LICENSE: Hospital

Beds Max.

PRINTED ON : 09/10/2010 $**2,200.00

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

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

EXPIRATION DATE: September 15, 2012

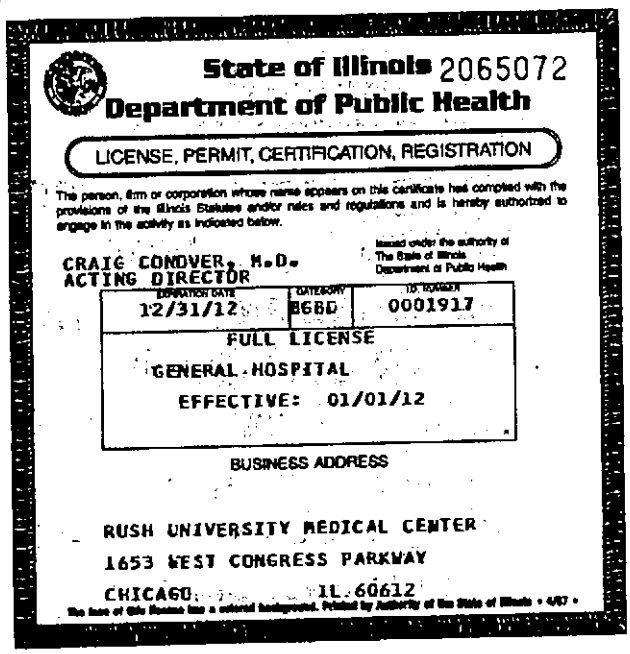
ATTEST:

Richard M Daley
MAYOR

Miguel del Valle
CITY CLERK

ACCOUNT NO. 62954 SITE: 2
TRANS NO.

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



State of Illinois 2065072
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

CRAIG CONOVER, M.D.
ACTING DIRECTOR

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

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/12	86BD	0001917

FULL LICENSE

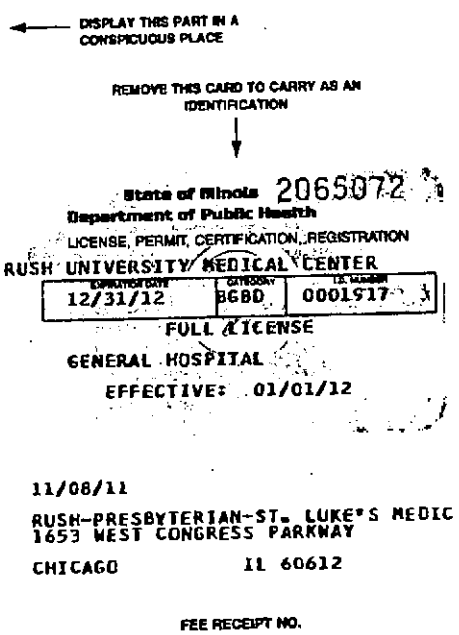
GENERAL HOSPITAL

EFFECTIVE: 01/01/12

BUSINESS ADDRESS

RUSH UNIVERSITY MEDICAL CENTER
1653 WEST CONGRESS PARKWAY
CHICAGO IL 60612

The face of this license has a colorful background. Printed by Authority of the State of Illinois • 4/87 •



DISPLAY THIS PART IN A CONSPICUOUS PLACE

REMOVE THIS CARD TO CARRY AS AN IDENTIFICATION

State of Illinois 2065072
Department of Public Health
LICENSE, PERMIT, CERTIFICATION, REGISTRATION

RUSH UNIVERSITY MEDICAL CENTER

EXPIRATION DATE	CATEGORY	ID NUMBER
12/31/12	86BD	0001917

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 01/01/12

11/08/11

RUSH-PRESBYTERIAN-ST. LUKE'S MEDIC
1653 WEST CONGRESS PARKWAY

CHICAGO IL 60612

FEE RECEIPT NO.

Rush University Medical Center

Chicago, IL

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

November 14, 2009

Accreditation is customarily valid for up to 39 months.

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

Organization ID #7297
Print/Reprint Date: 1/28/10

Mark Chassin, M.D.
President

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

The Joint Commission

November 18, 2010

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

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

Dear Dr. Goodman:

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

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

• Disease-Specific Care Certification Manual

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

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

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

Sincerely,

Ann Scott Blouin RN, PhD

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

www.jointcommission.org

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

LICENSE CERTIFICATE

NON-TRANSFERABLE

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

NAME: RUSH UNIVERSITY MEDICAL CENTER

DBA: RUSH CHILDREN'S SERVICES
AT: 1753 W. CONGRESS PKWY.
CHICAGO, IL 60612
1

LICENSE NO.: 23452 CODE: 1375 FEE: $**2,200.00

LICENSE: Hospital

Beds Max.

PRINTED ON : 09/10/2010 $**2,200.00

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

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

EXPIRATION DATE: September 15, 2012

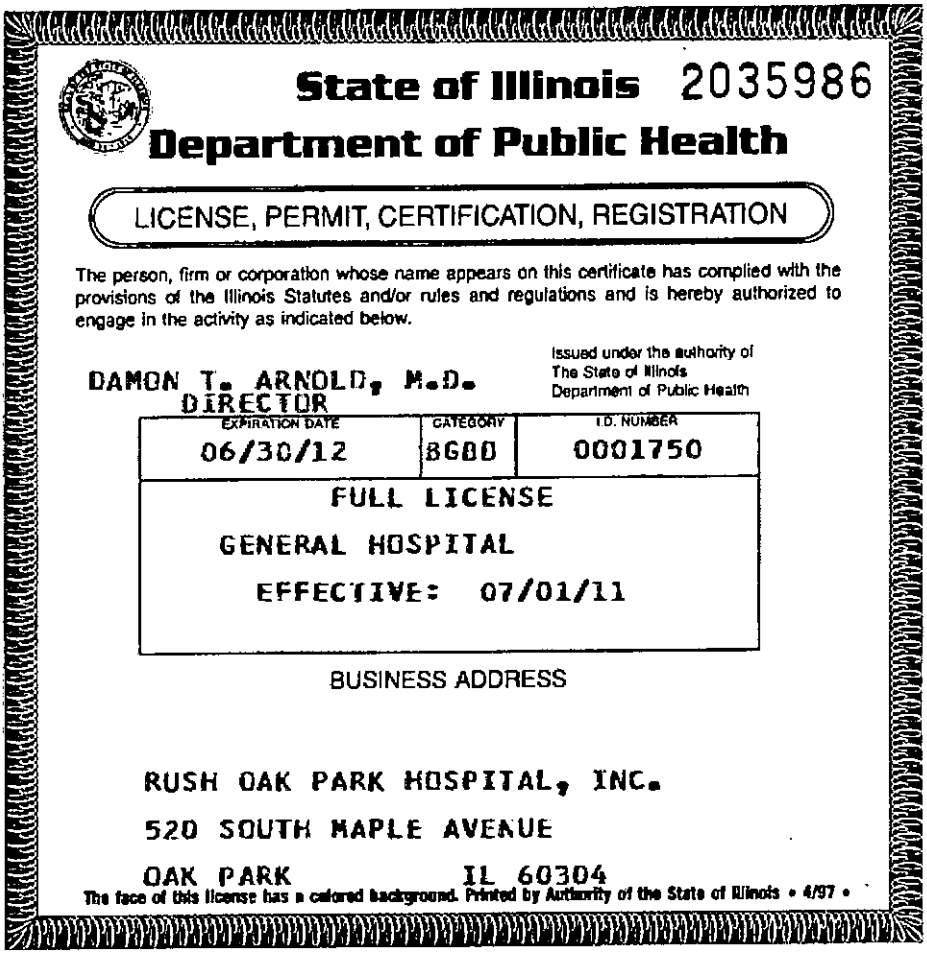
ATTEST:

Richard M Daley
MAYOR

Miguel del Valle
CITY CLERK

ACCOUNT NO. 62954 SITE: 5
TRANS NO.

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



State of Illinois 2035986

Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

DAMON T. ARNOLD, M.D.
DIRECTOR

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

EXPIRATION DATE	CATEGORY	I.D. NUMBER
06/30/12	8G00	0001750

FULL LICENSE

GENERAL HOSPITAL

EFFECTIVE: 07/01/11

BUSINESS ADDRESS

RUSH OAK PARK HOSPITAL, INC.
520 SOUTH MAPLE AVENUE
OAK PARK IL 60304

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

Rush Oak Park Hospital, Inc.

Oak Park, IL

has been Accredited by

The Joint Commission

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

Hospital Accreditation Program

This award excludes skilled nursing and nursing home services.

August 14, 2010

Accreditation is customarily valid for up to 39 months.

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

Organization ID #: 7398
Print/Reprint Date:

Mark Chassin, M.D.
President

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

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

Oak Park

License #
3472

Business License

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

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

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

October 12, 2011
Date Issued

December 31, 2012
Expiration Date

Village President

Teresa Powell
Village Clerk

NON-TRANSFERABLE MUST BE POSTED IN A VISABLE LOCATION

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

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

Tel: 312.942.8801
Fax: 312.942.2055
peter_butler@rush.edu

RUSH

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

January 5, 2012

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

Dear Mr. Galassie:

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

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

Sincerely,

Peter W. Butler

Peter W. Butler

cc: Mike Constantino, Supervisor of Project Review

Rush is a not-for-profit health care, education and research enterprise comprising Rush University Medical Center, Rush University, Rush Oak Park Hospital and Rush Health.

SECTION III. PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES - INFORMATION REQUIREMENTS

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.

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.*

Rush University Medical Center's (Rush, Medical Center, RUMC) Master Design permit describes Rush's plan to relocate patients from older buildings to the new East Tower when it is completed and to remodel space in the Atrium and Kellogg buildings vacated by the moves to the Tower.

As part of this application, Rush is proposing to modernize Levels 5, 7, 8 and 9 of Atrium and Level 6 of Kellogg. There will also be upgrades to the infrastructure in the Atrium Building. As a result of this facility investment, patients will benefit from:

- 128 modernized medical surgical beds on Levels 7 and 9 of the Atrium Building. At the completion of the modernization, the existing units will have fewer patient rooms; unassigned rooms will be used for needed storage and support and on the units.

- 34 modernized obstetrical beds on Level 8 of the Atrium Building. (Obstetrical beds are currently located in the Kellogg, Pavilion, and Jones buildings. The modernized unit will be used by both antepartum and postpartum patients; every room will have rooming in capability and 14 of the rooms will have a connecting family room that will support the family-centered care model at Rush. There will also be a normal newborn nursery and an antepartum testing area on the obstetrical unit. Level 8 of the Atrium Building will be connected to Level 8 of the East Tower that houses labor/delivery/recovery, delivery operating and recovery rooms, and the neonatal intensive care unit. Currently these important proximities do not exist.

  The vacated obstetrical space in Kellogg will be remodeled for pediatric. The vacated space in Pavilion and Jones will be used for needed administrative space..

- 8 operating rooms, 10 endoscopy rooms, 63 post surgery recovery rooms (PACUs) and 118 post surgery prep/recovery stations will be modernized on Level 5 of the Atrium Building. The operating rooms will be modernized in surgery space vacated when the new operating rooms are opened in the Tower; it will be used primarily for ambulatory and pediatric surgery. The endoscopy rooms will be moved from the Kellogg Building and Professional Office Building II to make the operation of the procedure area more efficient and to improve safety for the endoscopy patients. The PACUs and prep/recovery stations will support the operating and endoscopy rooms as well as the hybrid room (that will remain as is). The unused operating rooms will be decommissioned until needed. Other space vacated on Level 5 will also remain vacant.

- 22 general pediatric rooms will be relocated to and remodeled on Level 6 of the Kellogg Building. Pediatric beds are currently located in the Pavilion Building which was constructed in 1915. In addition to moving the pediatric rooms into a newer facility, the new location in the Kellogg Building will be in close proximity to the pediatric intensive care beds. The vacated pediatric space in Pavilion will be backfilled with administrative functions that are being vacated from Jones and Murdock buildings.

All of the remodeled spaces will be supported by enhanced infrastructure systems and will be fully code compliant.

2. Define the planning area

Rush's service area includes all of Cook County – city and suburbs, the other counties in the 8-County Chicago MSA, other Illinois and beyond.

Attachment 12, Table 1
RUMC's Medical Surgical, Pediatric and Obstetrics Service Areas, CY 2010

Area	Medical Surgical		Pediatric		Obstetrics	
	Admissions	Percent	Admissions	Percent	Admissions	Percent
Primary Service Area (Cook County)	6,771	34.5	488	45.7	1,413	54.0
Other Cook County	7,245	36.9	317	29.7	935	35.7
Total Cook County	14,016	71.3	805	75.3	2,348	89.7
Other Counties in 8-County Chicago MSA	3,454	17.6	185	17.3	228	8.7
Other Illinois	634	3.2	23	2.2	13	0.5
Total Illinois	18,104	92.1	1,013	94.8	2,589	98.9
Out of State and Other	1,547	7.9	56	5.2	30	1.1
Total	19,651	100.0	1,069	100.0	2,619	100.0

Source: RUMC records.

Complete patient origin detail is provided on Attachment 12, Exhibits 1, 2, and 3.

The three categories of service described in this application – medical surgical, pediatrics and obstetrics – have similar but somewhat different service areas.

Of the total obstetrical patients, almost 54 percent are from the primary service area and another 36 percent are from the rest of the rest of Cook County; overall, 90 percent of Rush's obstetrical patients are from Cook County. Of the remainder, 8.7 percent are from the 8-County Chicago MSA area and about 1.6 percent are from Other Illinois and Out of State and Other. This obstetrical patient distribution reflects the mix of both the normal and high risk obstetrical patients at Rush.

Of the total pediatric patients, 75 percent are from the primary service area and other Cook County, 46 and 30 percent respectively. Like medical surgical, about 17 percent of patients are from beyond Cook County but from within the 8-County Chicago MSA. The pediatric patient origin distribution demonstrates that Rush's pediatric service serves both the local community and an extended community for more complex pediatric services.

Of the three categories, medical surgical has the highest percentage, 7.9 percent from Out of State or Other. About 70 percent of medical surgical patients are from Cook County, but unlike pediatrics and obstetrics, about half are from the primary service area and the rest are from Other Cook County. The medical surgical patient distribution shows the strong referral reach of Rush's medical surgical programs from the 8-County Chicago MSA and beyond.

The population of Rush's service area for the years 2011 and 2016 by age cohort is provided on Attachment 12, Exhibit 4 and summarized in Table 2. These show overall growth in the 8-county area; however, the population of Cook County, or more than 5 million people and the major source of patients to the Medical Center overall, is expected to remain stable.

Attachment 12, Table 2
Population in Cook County, 2011 and 2016

Age Cohort	2011	2016	Percent Change
0-17	1,262,999	1,260,906	-0.17
18-44	2,036,452	1,935,220	-4.97
45-64	1,264,539	1,279,937	1.22
65+	629,827	690,541	9.64
Total	5,193,817	5,166,606	-0.52

Source: Claritas

The stable pediatric population will continue to need the pediatric services at Rush. The 18 to 44 age cohort, which includes women of childbearing age, is expected to decrease almost 5 percent. While this decrease portends a decline in births, Rush (as detailed in Attachment 20, Obstetrics Occupancy) has determined that the decline is primarily in the younger segments of the cohort and that the birth rates in the older segments of the cohort are increasing. Since a higher percentage of women in the older childbearing cohorts tend to be at high risk, high risk obstetrical and neonatal programs, such as the ones at Rush, are not expected to be affected by the modest overall decline in this age cohort. The two most senior cohorts, 45 to 64 and 65+, those cohorts with the greatest health care needs, are increasing and will benefit from the unique medical surgical services Rush is developing for them.

Rush has a more diverse patient population than all hospitals in Illinois; the racial mix and ethnicity in 2010 are provided below:

Attachment 12, Table 3
Patients by Race, 2010

Race	Percent	
	RUMC	Illinois
White	44.9	67.9
Black	36.5	21.8
American Indian	0.3	0.2
Asian	0.2	1.7
Hawaiian/Pacific	0.0	0.1
Unknown	18.1	8.3
Total	100.0	100.0

Source: RUMC records, 2010 Hospital Profiles

Attachment 12, Table 4
Patients by Ethnicity, 2010

Ethnicity	Percent	
	RUMC	Illinois
Hispanic or Latino	14.1	8.7
Not Hispanic or Latino	83.0	87.8
Unknown	2.9	3.7
Total	100.0	100.0

Source: RUMC records, 2010 Hospital Profiles

Rush has been nationally recognized for its service to this diverse community population. University HealthSystem Consortium (UHC) ranked Rush among the top performers in its annual Quality and Accountability study. Rush has consistently received a perfect score of 100 percent in the category of "equity of care." This ranking measures whether patients receive the same treatment and have the same outcomes regardless of their gender, race or socioeconomic status. Rush ranked better than any other hospital in the State of Illinois for equity of care.

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.]*

The proposed modernization of the Atrium and Kellogg buildings will substantially improve patient care. The problems and issues related to inadequate facilities include:

- Today, in addition to the units in the new East Tower, there are medical surgical units in the Atrium and Kellogg buildings. The Atrium and Kellogg buildings were built in 1982 and 1958; they are 30 and 54 years old, respectively. The infrastructure in the Atrium

Building needs to be upgraded and the patient care areas in both Rush and Kellogg need to have cosmetic upgrades.

- Rush's pediatric service is also located in the 1915 Pavilion Building and is of 1930's design. The pediatric unit has heating, air flow, and water flow issues in some of the rooms. The rooms are small and do not have bathrooms; there are no private rooms. General pediatrics is in a different building than the pediatric intensive care unit and remote from ancillary services needed by pediatric patients.
- The obstetrics unit at Rush is currently located in the Kellogg, Pavilion, and Jones buildings. In the current location, the obstetrical beds and newborn nursery are remote from the labor and delivery and neonatal services which now reside on Level 8 of the East Tower.
- Before the construction of the East Tower, the Atrium Building housed a 29-room operating suite. The operating rooms are small and can no longer accommodate the equipment and staff needed for the complex surgical cases being performed at Rush.
- Rush's endoscopy program is currently located in two sites. Four outpatient endoscopy rooms are located in Professional Office Building II; three additional endoscopy rooms are located on Level 1 of Kellogg and Pavilion buildings. These locations are remote from other procedural areas at Rush so they are inefficient to staff and operate. Since there are no other patient care functions on Level 1 of Kellogg, there is also concern for patient safety.
- The current number of PACU and prep/recovery stations is inadequate to satisfy the needs of the increasing volume of surgery and endoscopy patients.
- The infrastructure of the older buildings is inadequate to support the proposed functions.

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

In the preparation of this application Rush used many sources of information including:

- Rush University Medical Center patient origin, historical, as well as current and projected utilization, Community Benefits report, and financial information
- The Health Facilities and Services Review Board's rules (Ill. Adm. Code 77, Chapter II, Subchapter a.
- Illinois licensure code

- Technical assistance from HFSRB staff
- Perkins + Will and Proteus (project architects)
- Power-Jacobs Joint Venture (construction manager)
- Previous certificate of need submissions including Master Design Permit # 06-006; Orthopedics Ambulatory Building Permit # 06-073, Atrium Addition/East Tower Permit #07-125, and Brennan Entry Pavilion Permit # 10-041
- U.S Census and Claritas current and projected population
- Internet sites identified in the text
- State of Illinois, Office of the Secretary of State
- Illinois Department of Natural Resources
- Illinois Historic Preservation Society
- Patient Protection and Affordable Health Care Act, 2010

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

- A major portion of the proposed modernization project relates to enhancing the infrastructure of the Atrium Building. The emergency power systems, low voltage wiring, lighting and security systems will be improved. The emergency power system needs to be expanded to provide additional capacity in the event of a power loss and it needs to be connected to the new central energy plant for consistency and reliability of power. The low voltage wiring needs to be upgraded to contemporary wiring standards consistent with the East Tower and to have the ability to run the new nurse call system, physiological monitoring, and mobile clinical devices. These infrastructure improvements will enhance all of the modernized functions on Levels 5, 7, 8, and 9 of the Atrium Building.
- As part of the proposed modernization project, Levels 7 and 9 of the Atrium Building will be modernized to house 128 medical surgical beds. The Atrium Building is connected to the new East Tower. With the consolidation of the medical surgical beds and the bridge connection between the two buildings, all medical surgical inpatients will have immediate connection from the Emergency Department and to the ancillary services in the East Tower.

- The existing 37-bed units in the Atrium Building will be resized to have 32 beds; the unassigned rooms will be used for needed storage and support space. These modernized 32-bed units will have the same number of beds as the medical surgical units in the East Tower and will also be efficient to staff and operate. All rooms will be private with baths for improved patient safety including infection control as well as patient and family privacy. The current size and configuration of the rooms will remain the same but the rooms will receive cosmetic enhancements.

- The current pediatric unit at Rush is also located in the 1915 Pavilion Building. As part of this project, the general pediatrics unit will be reduced from 28 to 22 beds and it will be moved to the Level 6 of the Kellogg Building where it will be located in close proximity to the pediatric intensive care unit. It will also be closer to the remodeled surgery and recovery space in the Atrium Building. The renovated unit will have all private rooms and afford patients and their families' privacy and improved safety including infection control. As with the modernization of the medical surgical units, the room sizes and unit configuration will not change; however they will receive cosmetic upgrades.

- The current 38-bed obstetrical unit is located in the Kellogg, Pavilion, and Jones buildings. As part of this project, the obstetrical unit will be relocated to Level 8 of the Atrium Building and the number of the beds will be reduced to 34. In addition to antepartum and postpartum beds Level 8 will have a normal newborn nursery and an antepartum testing area. It will be connected to the labor and delivery and neonatal intensive care functions in the East Tower, thereby joining all of the obstetric-related functions for improved operations.

  Rush promotes family-centered obstetrical care. The room sizes and configuration of the rooms in Atrium will not be enlarged to accommodate this model of care. However, all of the rooms will be private and 14 of them will have an adjoining family room to allow for family to visit comfortably with the patient or to stay overnight. The private rooms will promote patient and family privacy and safety including infection control. The rooms will undergo cosmetic upgrades and reclining chairs will be added.

  The new LDR and neonatal unit in the East Tower will not be used until the obstetrical modernization in the Atrium Building is complete.

- Rush plans to reuse 18 of the vacated operating rooms in the Atrium Building now that the new operating rooms are open in the East Tower; the Atrium Building operating rooms will be used primarily for ambulatory and pediatric surgery (since it will be closer to the pediatric patients than the East Tower surgery suite and the room sizes are suitable for typically less complex ambulatory surgery). Levels 5 and 7 of the East Tower will be connected to the operating rooms in Level 5 of the Atrium Building with a bridge. This will enhance operations of the surgery function.

  Overall, the surgery suite in the Atrium Building is in good condition (other than the rooms being too small for complex surgery). Eight of the existing rooms will be reused for surgery and 10 of the rooms will be used to replace the endoscopy rooms that are currently located in Professional Office Building II, Kellogg, and Pavilion buildings. Endoscopy rooms will be consolidated to make the operation of the procedure area more operationally efficient and will improve safety for the endoscopy patients. These rooms will remain essentially "as is." The 11 unassigned surgery rooms will be decommissioned until some future time when they are needed.

- Level 5 of the Atrium Building also will be modernized to have 15 PACUs and 118 prep/recovery stations to support the operating rooms, the endoscopy rooms, (and a hybrid lab that will not be modernized as part of this project). These updated spaces are needed to recover patients immediately adjacent to the modernized operating and procedure rooms. Any space on Level 5 not assigned to operating rooms, procedure rooms or recovery stations or the hybrid lab will remain vacant at the completion of this project.

- Rush has several buildings on the campus that are very old, some more than 100 years old, that are scheduled for demolition. The redevelopment of the Atrium and Kellogg buildings allows for all clinical as well as some non clinical functions in the very oldest buildings to be relocated, thus paving the way for eventual demolition of these old buildings and the provision of open space on the campus.

6. *Provide goals and quantified measurable objectives, with specific time frames that relate to the achieving of the stated goals,* ***as appropriate.***

Rush University Medical Center's vision is to be the medical center of choice in Chicago and among the very best in the United States. Rush's mission is to provide the very best care to patients. The Atrium and Kellogg modernization project will advance the Medical Center's vision and mission with the following goals and objectives:

Goal: To modernize selected clinical areas and infrastructure in the Atrium and Kellogg buildings and ensure patient safety and privacy as well as to enhance the efficiency of operations.

Objective 1: To complete the Medical Center's target complement of 320 medical surgical beds and to lease 13 beds for hospice care, to provide 22 pediatric beds, and 34 obstetrical beds.

Objective 2: To complete the Medical Center's target complement of 36 operating rooms, 10 endoscopy rooms, and 63 PACUs and 118 prep/recovery stations.

Objective 3: To link the modernized categories of service and clinical service areas in the Atrium Building with like functions in the East Tower.

Objective 4: To upgrade certain infrastructure systems in the Atrium Building including emergency power, low voltage wiring, lighting and security systems.

Rush expects to achieve all objectives when the proposed modernization project is completed in June 2016.

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

The proposed project involves the modernization of the Atrium Building, which was constructed in 1982 as well as the Kellogg Building which was constructed in 1958.

Infrastructure improvements relate to the emergency power system which needs to be expanded to provide additional capacity in the event of a power loss and needs to be connected to the central energy plant for consistency and reliability of power. Other improvements relate to the low voltage wiring systems which need to be upgraded to the new wiring standards consistent with the East Tower and to have the ability to run the new nurse call system, physiological monitoring, and mobile clinical devices. See also Attachment 20.

Further the patient rooms require cosmetic improvements. As part of this project, multi-bed rooms will be converted to single rooms; some of the obstetric patient rooms will have an adjoining family room to enhance the family-centered model of care. Surgery and endoscopy will go through minimal changes initially and more extensive modernization in a later phase.

No clinical equipment is being replaced.

Medical Surgical Patient Origin, CY 2010

State	County with PSA Broken Out	Zip Code	Med/Surg Admits	Med/Surg Percent Admissions
IL	PSA	60607	270	1.4
		60608	633	3.2
		60609	314	1.6
		60612	589	3.0
		60616	208	1.1
		60617	330	1.7
		60619	292	1.5
		60620	292	1.5
		60622	165	0.8
		60623	449	2.3
		60624	524	2.7
		60628	319	1.6
		60629	298	1.5
		60632	228	1.2
		60636	205	1.0
		60638	259	1.3
		60639	234	1.2
		60644	384	2.0
		60647	182	0.9
		60651	434	2.2
		60804	162	0.8
	PSA Total (Cook County)		**6,771**	**34.5**
	Other Cook County		7,245	36.9
	Total Cook Cook		14,016	71.3
	DUPAGE, IL		1,107	5.6
	WILL, IL		834	4.2
	LAKE, IL		554	2.8
	KANE, IL		429	2.2
	MCHENRY, IL		310	1.6
	KANKAKEE, IL		129	0.7
	KENDALL, IL		91	0.5
	8-County Service Area Total		**17,470**	**88.9**
	All Other IL Total		634	3.2
IL Total			**18,104**	**92.1**
IN			856	4.4
MI			105	5.3
WI			73	0.4
All Other States			307	1.6
All Other (N/A)			206	1.0
Grand Total			**19,651**	**100.0**

Source: RUMC records

Pediatric Patient Origin

State	County with PSA Broken Out	Zip Code	Pediatric Admits	Pediatric Percent Admissions
ILLINOIS	PSA	60624	58	5.43
		60623	42	3.93
		60612	36	3.37
		60804	35	3.27
		60644	34	3.18
		60629	29	2.71
		60639	28	2.62
		60608	28	2.62
		60651	27	2.53
		60632	27	2.53
		60617	21	1.96
		60647	17	1.59
		60402	16	1.50
		60609	14	1.31
		60636	14	1.31
		60643	11	1.03
		60607	10	0.94
		60620	10	0.94
		60619	8	0.75
		60628	7	0.65
		60638	4	0.37
		60302	4	0.37
		60616	4	0.37
		60649	4	0.37
	PSA Total		488	45.65
	Other Cook County		317	29.65
	Total Cook County		805	75.30
	DUPAGE, IL		47	4.40
	WILL, IL		45	4.21
	LAKE, IL		40	3.74
	KANE, IL		36	3.37
	MCHENRY, IL		7	0.65
	KANKAKEE, IL		5	0.47
	KENDALL, IL		5	0.47
	8-County Service Area Total		990	92.61
	All Other IL Total		23	2.15
IL Total			1,013	94.76
IN			38	3.55
WI			4	0.37
MI			4	0.37
All Other States			6	0.56
All Other (N/A)			4	0.37
Grand Total			1,069	100.00

Obstetrics / Gynecology Patient Origin, CY 2010

State	County with PSA Broken Out	Zip Code	OB/GYN Admits	OB/GYN Percent Admissions
IL	PSA	60607	50	1.9
		60608	131	5.0
		60609	94	3.6
		60612	135	5.2
		60616	77	2.7
		60617	29	1.1
		60619	24	0.9
		60620	27	1.0
		60622	34	1.3
		60623	146	5.6
		60624	102	3.9
		60628	27	1.0
		60629	76	2.9
		60632	86	3.3
		60636	18	0.7
		60638	28	1.1
		60639	62	2.4
		60644	98	3.7
		60647	41	1.6
		60651	80	3.1
		60804	48	1.8
	PSA Total (Cook County)		**1,413**	**54.0**
	Other Cook County		935	35.7
	Total Cook County		2,348	89.7
	WILL, IL		133	5.1
	DUPAGE, IL		51	1.9
	KANE, IL		19	0.7
	LAKE, IL		13	0.5
	MCHENRY, IL		7	0.6
	KENDALL, IL		3	0.1
	KANKAKEE, IL		2	0.1
	8-County Service Area Total		**2,576**	**98.4**
	All Other IL Total		13	0.5
IL Total			2,589	98.9
IN			7	0.3
IA			3	0.1
WI			3	0.1
All Other States			5	0.2
All Other (N/A)			12	0.5
Grand Total			**2,619**	**100.0**

Souce: RUMC records

Population Changes in 8-County Area
City of Chicago and RUMC's Primary Service Area, 2011 - 2016

	Population			2011 Population by Age Group				2016 Population by Age Group				2011-2016 % Change by Age Group			
8-County Area	2011	2016	% Chg	<18	18-44	45-64	>65	<18	18-44	45-64	>65	<18	18-44	45-64	>65
COOK, IL	5,193,817	5,166,603	-0.52%	1,262,999	2,036,452	1,264,539	629,827	1,260,905	1,935,220	1,279,937	690,541	-0.17%	-4.97%	1.22%	9.64%
DUPAGE, IL	954,663	969,333	1.54%	237,207	333,870	270,651	112,935	231,238	325,713	278,013	134,369	-2.52%	-2.44%	2.72%	18.98%
KANE, IL	508,853	552,536	8.58%	151,025	182,733	127,915	47,180	162,495	186,889	142,393	60,759	7.59%	2.27%	11.32%	28.78%
KANKAKEE, IL	128,127	133,248	4.00%	32,220	45,136	33,159	17,612	32,978	46,322	33,739	20,209	2.35%	2.63%	1.75%	14.75%
KENDALL, IL	103,757	125,456	20.91%	31,322	40,572	23,230	8,633	37,566	45,407	30,386	12,097	19.93%	11.92%	30.80%	40.13%
LAKE, IL	738,243	765,876	3.74%	201,861	251,249	206,281	78,852	201,952	250,018	217,912	95,994	0.05%	-0.49%	5.64%	21.74%
MCHENRY, IL	347,672	375,529	8.01%	92,087	118,190	97,802	39,593	94,314	121,427	110,626	49,162	2.42%	2.74%	13.11%	24.17%
WILL, IL	707,190	784,287	10.90%	200,035	259,585	180,881	66,689	213,525	271,102	212,067	87,593	6.74%	4.44%	17.24%	31.35%
Grand Total	**8,682,322**	**8,872,868**	**2.19%**	**2,208,756**	**3,267,787**	**2,204,458**	**1,001,321**	**2,234,973**	**3,182,098**	**2,305,073**	**1,150,724**	**1.19%**	**-2.62%**	**4.56%**	**14.92%**

	Population			2011 Population by Age Group				2016 Population by Age Group				2011-2016 % Change by Age Group			
Area	2011	2016	% Chg	<18	18-44	45-64	>65	<18	18-44	45-64	>65	<18	18-44	45-64	>65
City of Chicago	2,806,084	2,788,956	-0.61%	690,964	1,183,358	631,264	300,498	688,176	1,114,895	656,039	329,846	-0.40%	-5.79%	3.92%	9.77%

	Population			2011 Population by Age Group				2016 Population by Age Group				2011-2016 % Change by Age Group			
Area	2011	2016	% Chg	<18	18-44	45-64	>65	<18	18-44	45-64	>65	<18	18-44	45-64	>65
PSA	1,622,057	1,600,012	-1.36%	459,635	661,411	341,092	159,919	452,593	628,394	346,720	172,305	-1.53%	-4.99%	1.65%	7.75%

Source: Claritas

SECTION III, - PROJECT PURPOSE, BACKGROUND AND ALTERNATIVES - INFORMATION REQUIREMENTS

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.

1. and 2. Documentation of Alternatives Considered

Introduction

In June 2006, Rush University Medical Center's (Rush, the Medical Center, RUMC) Master Design application for permit was approved by the Illinois Health Facilities Review Board (Permit #06-009). The Medical Center's application to construct a 15-level patient tower was approved approximately 18 months later in January 2008 (Permit # 07-125). These two applications established the future use of both the Atrium and Kellogg buildings and detailed alternatives related to joint venturing and using other health care resources. The rationales used in these previous applications are applicable to the present filing that includes the modernization of parts of these two buildings. Hence the range of alternatives to assess was limited when the time arrived to modernize parts of the Atrium and Kellogg buildings.

The vision for the future of Rush University Medical Center was first presented in the alternatives section in the Master Design application. In this application, a wide range of alternatives was presented. The first alternative included a "do nothing" alternative and the second described a project that would involve the modernization of all the buildings on the campus, including several that are more than 100 years old. The third alternative included a very limited scope project that involved modernizing only the Atrium and Kellogg buildings. These alternatives ranged in cost from $0 to $600 million and all represented smaller projects than Alternative 4, the alternative of choice.

The fifth alternative described in the Master Design permit described relocating Rush's patient care services to a new site leaving the Medical Center on two campuses. The sixth alternative envisioned replacing all of the Medical Center on a remote new site. The cost of these alternatives ranged from $950 million to $1.5 billion, respectively, and represented larger projects than the alternative of choice.

The fourth alternative, the alternative of choice, outlined a campus development plan that included construction of a new patient tower to house the highest acuity services and the modernization of the Atrium and Kellogg buildings for other inpatient, outpatient, and support services. Hence, as early as 2006, the future roles of the Atrium and Kellogg buildings were established. See Attachment 13, Exhibit 1 for a summary of the alternatives.

In the Master Plan State Agency Report regarding Rush's description of alternatives, Staff noted that "Materials provided by the applicants appear to indicate they carefully evaluated all of the needs of the current facility. An alternative has been selected and it appears to best meet the needs identified by the applicants as necessary to provide care to the planning area in the most cost effective manner. The State Agency is able to make a positive finding on these criteria."

This approval of the Master Design application initiated the actual transformation of the Rush campus in its current location on Chicago's West Side. The construction of a 15-level patient tower (the Atrium Addition, now referred to as the East Tower) needed to be completed before the modernization of the Atrium and Kellogg buildings could begin.

The rationale used in the East Tower application relative to pursuing underutilized space or using other health care facilities is equally relevant to the modernization of the Atrium and Kellogg buildings. The following is taken from the East Tower application beginning on page 214:

"Use of Underutilized Space

The proposed new Atrium Addition (East Tower) is being developed to support adult intensive care and neonatal intensive care, high acuity medical surgical care, very advanced diagnostic and therapeutic services, as well as the Center for Advanced Emergency Response and the Center for Bioterrorism Preparedness. These services are at the core of Rush's mission of patient care, education and research. It is not feasible to use other area facilities for these services; to relocate or disseminate these services to other facilities would compromise the continuity of care that is accomplished by the highly skilled multidisciplinary teams that treat Rush patients.

Although the IDPH Inventory may show an excess of beds in Planning Area A-02, these excess beds are either in facilities that do not offer the same clinical intensity of care Rush provides or are in other area academic centers that are also currently faced with substantial facility issues. To use other facilities would compromise Rush's graduate medical education, nursing and other professional education programs as well as the extensive translational research initiatives and the national security efforts of the Center for Advanced Bioterrorism.

Patients are routinely referred to Rush from other providers located in Chicago and beyond in order to access Rush's nationally recognized clinical programs. Rush seldom refers patients to other area providers for care. Rush's services are essential to the healthcare delivery system in Chicago and Cook County. Using other facilities is not a reasonable alternative.

Use of Underutilized Space at RUMC

The only underutilized bed space on the Rush campus is in buildings that are approximately 100 years old and are scheduled for demolition. Reusing this space would be very costly. Even with extensive investment to correct all code violations and partially improve operational, functional, and infrastructure deficiencies, these facilities would not meet contemporary patient care standards. Using underutilized space is not a reasonable alternative."

Pursuit of Joint Venture

Rather than pursue joint ventures for the services that are part of the campus transformation, Rush has elected to pursue collaborative arrangements with others in the area. This was described on page 8 of the Master Design State Agency Report:

> "The applicants are seeking a CON for the master design of a new construction and modernization project for RUMC. The applicants state that the proposed project will improve access to services by continuing to provide care to severely ill patients that have been referred by over 150 facilities from throughout the area. In addition, the project will allow the applicants to continue its collaboration with John H. Stroger Hospital of Cook County and the Chicago Department of Public Health. ...Therefore it appears the intended scope of the proposed project is reasonable. It also appears that the future construction project will have a positive impact in terms of access, availability of services, and long-term institutional viability."

The East Tower application also set important parameters for the modernization of the Atrium and Kellogg buildings. These included:

1. The total complement of medical surgical beds would be reduced to 320 and the number of beds on each of the four medical surgical units in the Atrium Building on Levels 7 and 9 would be reduced from 37 to 32 to be consistent with the size of the medical surgical units in the East Tower; the rooms no longer used for patient care would be reassigned as needed support and storage space on the units. This plan is being implemented as part of the Atrium modernization.
2. The number of obstetrics beds would be reduced and the obstetrics unit would be relocated to Level 8 of the Atrium Building so it could be on the same level as the LDRs, surgical obstetrics rooms and PACUs, as well as the neonatal unit in the East Tower. The total perinatal program – obstetrics and neonatology would be connected with a bridge. This plan is being implemented as part of the Atrium modernization.
3. Part of the surgical suite in the Atrium Building would be reused for additional surgical operating rooms, especially for pediatric and outpatient surgery as well as for surgical procedure rooms (endoscopy), and related recovery stations. Level 5 (surgery, procedure, and recovery space) in the Atrium Building would be connected to the East Tower surgical suite with a bridge. This plan is being implemented as part of the Atrium modernization.

4. The general pediatric bed complement would be reduced. This plan is being implemented as part of the proposed project. Pediatric beds are being reduced from the current authorized complement of 28 beds to 22 beds. The reduced unit will be relocated to Level 6 of the Kellogg Building in proximity to the pediatric intensive care unit on Level 5. The existing pediatric unit is located in the Pavilion Building that will no longer be used for patient care services.
5. The infrastructure of the Atrium Building would be upgraded. This plan is being implemented as part of the Atrium modernization.

2. Rationale for Alternatives of Choice

As the East Tower project neared completion, Rush began to address the modernization of the Atrium and Kellogg buildings. Since the future use of the buildings had already been approved for a defined group of services and number of beds as well as clinical service areas, only two major alternatives remained to be resolved. First, how extensive would the required modernization be and second, should the modernization be accomplished in a single or multiple phases?

Alternative 1 Extensive Modernization

The original modernization plan included more extensive infrastructure modernization in addition to more comprehensive modernization of procedural and recovery spaces as well as the bed areas. This alternative included rebuilding all the prep/recovery bays on Level 5 to match the standard set in the East Tower. In addition, all patient rooms received more extensive upgrades including new lighting and ceilings, new wardrobes, new television sets and new flooring.

The extensive modernization option was rejected because it was deemed not to be essential and added substantial capital cost to the project.

The modernization cost for the proposed extensive modernization project is $80 million.

Alternative 2 Limited Modernization

After further evaluation, Rush learned that components of the infrastructure and mechanical improvements could be deferred. The second alternative includes modest upgrades to the procedural and the bed areas, as well as less extensive infrastructure upgrades than envisioned in Alternative 1. Alternative 2 is an alternative of choice because it reduces the cost of the project while not compromising the operation of the facility.

The modernization cost for the proposed phased project is $26 Million.

Once Rush had determined that Alternative 2 would be pursued, the Medical Center addressed whether the limited modernization could be done in a single phase or whether multiple phases would be necessary.

Alternative 3 Modernize the Atrium and Kellogg Buildings in a Single Phase

Alternative 3 envisions vacating Levels 5, 7, 8, and 9 of the Atrium Building and Level 6 of the Kellogg Building and using only existing beds, using only the new operating rooms and recovery rooms in the East Tower, and existing endoscopy suites in the Kellogg and Pavilion buildings as well as in the Professional Office Building II. While this alternative was very attractive in that:

- Construction time would be reduced from 18 months to 13 months (compared to a multiple phase project)
- Patients would have access to the modernized areas in less time, and
- Patients would not be in the building during construction, thereby potentially minimizing patient safety and infection control issues.

However, this alternative was rejected because certain services in the Atrium Building could not be vacated. For example, medical surgical beds and a limited number of operating rooms and recovery spaces must stay in service during the modernization.

The modernization cost of a single phase modernization project would be $75 million.

Alternative 4 Modernize the Atrium and Kellogg Buildings in Multiple Phases

The fourth alternative envisions a project that embraces both limited modernization and multiple phases. The proposed phasing plan includes:

Phase 1	Infrastructure upgrades and interim modernization of Level 5 to accommodate the endoscopy rooms from Level 1 of the Kellogg Building and maintain operation of the hybrid room, 4 operating rooms, 15 PACUs and 28 prep/recovery rooms. Phase I will be completed in 2012.
Phase 2	Relocation and modernization of the obstetrical beds, newborn nursery, and antepartum testing to Level 8 of the Atrium building. Phase 2 will be completed in 2013.
Phase 3	Modernization of the medical surgical beds on Level 9 of the Atrium Building. Phase 3 will be completed in 2013.

Phase 4 Modernization of the medical surgical beds on Level 7 of the Atrium Building. Phase 4 will also be completed in 2013.

Phase 5 Relocation and modernization of the pediatric beds on Level 6 of the Kellogg Building. Phase 5 will be completed in 2014.

Phase 6 Extensive modernization of Level 5 of the Atrium Building including relocation of the endoscopy rooms from Professional Office Building II and reconfiguration of the space to accommodate the full complement of 8 operating rooms, 15 PACU stations and 46 prep/recovery stations. Phase 6 will be completed in 2016.

The multiple phasing option is the option of choice. Modernization in multiple phases is the only option feasible because services such as the hybrid lab, 4 operating rooms, the relocated Kellogg endoscopy rooms and required PACUs and prep/recovery stations as well as the medical surgical beds in the Atrium Building must remain operational. Patient safety and infection control will be maintained throughout the modernization project. The construction team is working very closely with the Department of Patient Safety and Clinical Effectiveness to ensure high standards of patient safety and infection control are maintained.

The modernization cost for the proposed phased project is $46,230,784.

The cost benefit analysis of these alternatives is located in Attachment 13, Exhibit 2.

3. Empirical Evidence That Verifies Improved Quality of Care

Rush University Medical Center (Rush, Medical Center, RUMC) is a nationally renowned academic medical center and ranked in various studies by several prominent publications as being among the very best in the county. For example, the 2011 *U.S. News & World Report "Best Hospitals"* issue ranked Rush nationally in orthopedics; neurology and neurosurgery; geriatrics; cardiology and heart surgery; gynecology; urology; cancer; pulmonary; ear, nose and throat; and, nephrology. Rush Children's Hospital was listed among the nation's top children's hospitals for the first time.

For the third time, Rush University Medical Center has received Magnet Status, the highest recognition given for nursing excellence. The designation recognizes Rush nursing staff for overall excellence and for providing the very best care to patients. The American Nurses Credentialing Center – an independently governed organization within the American Nurses Association – first awarded Rush the 4-year Magnet designation in 2002, and then again in 2006 and 2010. Rush was the first hospital in Illinois serving both adults and children to receive the designation for the third time.

Every 3 years, Rush is evaluated by the Joint Commission, the preeminent standards setting body in health care. Recognized as a national symbol of quality, accreditation by the Joint Commission reflects an organization's commitment to performance standards. Rush's high score demonstrates the Medical Center's ability to delivery quality patient care.

In 2011, Rush was named among only five hospitals in Illinois for safety, quality and resource use by the Leapfrog Group, a national organization that promotes health care safety and quality improvement. To earn this recognition Rush had to fulfill the following criteria:

- Fully meet Leapfrog standards for using physician order entry (has shown to reduce adverse drug events by 88 percent)
- Fully meet stringent standards for at least half of the complex, high risk procedures such as bypass surgery (research indicates that a patient's risk of death is reduced between two and four times, depending on the procedure when these standards are met)

- Meet standards for staffing the intensive care units with physicians and nurses specifically trained in critical care (has been shown to reduce mortality by 40 percent), and
- Achieve a score of at least 69 out of 100 for efficiency (the intersection of quality and cost).

All of Rush's clinical programs are included in the effort to reduce infections, prevent complications, and set new standards for quality. The patient care units, surgical operating and procedure rooms, the post anesthesia recovery and prep/recovery areas are all included in this focus on quality.

In 2007, Rush created the Department of Patient Safety and Clinical Effectiveness, the singular focus of which is making sure Rush provides the safest, most effective care available anywhere. The team of experts who staff this department analyze patient data to identify opportunities for quality improvement across clinical programs and then give patient safety officers, nursing leaders, and clinical pharmacists throughout Rush the training and resources they need to implement best practices.

Among the patient safety and quality improvement initiatives currently underway at Rush are:

- A new approach to reducing medical errors.
- A program that empowers nurses to play a new role at the patient bedside.
- Establishment of the Rush Stroke Center which was awarded the Silver Performance Achievement Award by the American Stroke Association and accredited by the Joint Commission.
- A multidisciplinary approach to redefine the cancer patient experience, The Coleman Foundation Comprehensive Cancer Clinics at Rush was designed to facilitate this multidisciplinary approach.
- An innovative artificial intelligence program designed to detect infectious agents and help caregivers protect the community.
- A team charged with designing a patient-centered hospital from the caregiver's perspective. This team, the Office of Transformation, is leading the modernization of the Atrium and Kellogg buildings as well as other elements of the Campus Transformation initiative.

- A high-tech, all-in-one cardiac catheterization lab designed for flexibility and collaboration in an emergency. This suite is located in the Atrium Building on Level 5 and will remain "as is".

  Built in 2008, Rush's state-of-the-art hybrid lab combines cardiac catheterization with advanced imaging to prepare physicians and surgeons to safely respond to unforeseeable complications.

  This unique suite is equipped with a bi-plane fluoroscopic x-ray and intravascular ultrasound. The technology increases the accuracy of diagnoses and the safety of nonsurgical treatments with continuous, real-time images of a patient's cardiovascular system from multiple angles, In this high tech suite, the physicians use a thin catheter to open narrowing vessels or to repair a hole in a beating heart without cutting into the patient's chest cavity. Patients recover faster, go home earlier, and experience fewer complications with this advanced technology.

These are a few highlights relating to Rush's commitment to improve quality of care and patient safety. This commitment is fully consistent with the Patient Protection and Affordable Care Act's priorities and goals to reduce the number of patients readmitted, improve management of chronic diseases, minimize potentially avoidable complications, establish linkages across the Rush organization and with other organizations, increase capacity for outpatient and emergency services, and improve access to preventative services.

Cost Benefit Analysis of Alternatives in the Atrium Addition (East Tower) Application

Alternative	Construction/Modernization Cost	Project Cost	Select Limitations/Benefits
Alternative 1 – Do Nothing	NA	NA	Bed capacity would be reduced and result in loss of clinical programs and staff. Fewer private rooms would be available to improve quality/infection control. Commitment to education and research would be curtailed. Access to services would be compromised for local and regional patients. Center for Advanced Emergency Response would not be built. Operating costs would increase. Maintenance costs would continue to be very high. RUMC would be converted from a respected academic medical center to a mid-sized community hospital. Unrealistic alternative.
Alternative 2 – Correct Code, Modify Infrastructure, Improve Inadequacies	$325 million	$460 million	Even with more than $325 million of improvements, the buildings would remain outdated, obsolete, inefficient and structurally challenged. Bed capacity would be reduced and result in loss of clinical programs and staff. Fewer private rooms would be available to improve quality/infection control. Access to services would be compromised for local and regional patients. Operating costs would remain unchanged. Center for Advanced Emergency Response would not be built. Maintenance costs would continue to be very high. RUMC would be converted from a respected academic medical center to a large community hospital with "patched together facilities." Unrealistic alternative.

Alternative	Construction/Modernization Cost	Project Cost	Select Limitations/Benefits
Alternative 3 – Modernize Only the Atrium and Kellogg Buildings for Patient Care	$400 million	$600 million	Bed capacity would be reduced and result in loss of clinical programs and staff. Fewer private rooms would be available to improve quality/infection control. Commitment to education and research would be curtailed. Access to services would be compromised for local and regional patients. Center for Advanced Emergency Response would not be built Space would need to be leased off site and services would need to be outsourced. Operating costs would increase. RUMC would be converted from a respected academic medical center to a mid-sized community hospital. Consistent with RUMC's financial resources.
Alternative 4 – New Construction and Modernization	$500 million	$760 million	RUMC would remain a strong academic medical center participating in Chicago's growing importance as a major teaching and research center. Bed complement would support programs and staff. Increased private rooms would improve quality/infection control. Commitment to education and research would continue. Excellent access would be maintained via public and private transportation. Operating costs would decrease. Consistent with RUMC's financial resources.
Alternative 5 – Replace Clinical Functions on a Brown Field Site	$600 million	$950 million	The current integration of patient care, education and research would be disrupted. Operating costs would increase. Not within the financial capability of RUMC. Unrealistic alternative.
Alternative 6 – Replace on a Remote New Site	> $1 billion	> $1.5 billion	The current patient care, education and research collaboration with John H. Stroger Jr. Hospital of Cook County would be compromised. Operating costs will decrease. Not within the financial capability of RUMC. Unrealistic alternative.

Cost Benefit Analysis of Scope and Phasing Alternatives for the Atrium and Kellogg Buildings Modernization Project

Alternative	Construction/ Modernization Cost	Project Cost	Select Limitations/Benefits
Alternative 1 Extensive Modernization	$ 60 Million	$80 Million	Highest cost alternative Can be postponed without compromising patient care Rejected
Alternative 2 Limited Modernization	$ 20 Million	$26 Million	Includes necessary upgrades to patient care as well as infrastructure but at a substantially lower cost than Alternative 1 This is the scope alternative of choice.
Alternative 3 Single Phase Modernization	$56 Million	$75 Million	Construction time would be less Patients could access the modernized space sooner Minimizes patient safety and infection control Rejected Unique services in the building could not be vacated.
Alternative 4 Multiple Phase Modernization	$37.9 Million	$46.2 Million	Although this alternative adds cost, it is the only feasible option because services such as the hybrid cath lab in the Atrium Building must remain in service. Patient safety and infection control will be assured. This is the phasing alternative of choice

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/GSF 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/GSF**	**STATE STANDARD**	**DIFFERENCE**	**MET STANDARD?**
See Attachment 14, Table 1				

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

1. Proposed Physical Space is Necessary

2. Describe the Discrepancies Between Proposed and State Agency Standards

Clinical

Rush University Medical Center's (Rush, Medical Center, RUMC) Atrium and Kellogg buildings modernization project includes three categories of service (medical surgical, pediatrics, and obstetrics beds) and five clinical service areas (Class C operating rooms, Class B procedure rooms, Phase I post anesthesia recovery [PACU], Phase II post anesthesia recovery [prep/recovery], and antepartum testing. The Atrium Addition/East Tower also includes medical/surgical beds, Class C operating rooms, Phase I and Phase II recovery stations.

As summarized below and detailed on Attachment 14, Exhibit 1, the GSF of all of the clinical areas in the proposed Atrium Building modernization project except post-anesthesia recovery (Phase 1) are below the State Standards.

Attachment 14, Table 1
Atrium and Kellogg Buildings GSF at Project Completion Compared to State Standard

Department/Service	GSF	Number of Key Rooms	GSF/Key Room	State Standard	Difference	Met Standard ?
Medical Surgical Beds	69,792	128	545	500-660 GSF/room	+ 45 to - 115	Yes
Pediatrics	11,520	22	524	500-660 GSF/room	+ 24 to - 136	Yes
Obstetrics Beds	19,131	34	563	500-660 GSF/room	+ 63 to - 97	Yes
Newborn Nursery Bassinets	1,174	34 OB rooming-in plus 7 in normal newborn nursery	NA	160 GSF/OB bed or 5,440 allowable	- 4,266	Yes
Surgical Operating Rooms Class C	18,362	8	2,320	2,750 GSF/room	- 430	Yes
Surgical Procedure Rooms Class B	9,109	10	911	1,100 GSF/room	- 189	Yes
Post Anesthesia Recovery (PACU) Phase I	4,445	15	296	180 GSF/station	+ 116	No
Post Anesthesia Recovery Stations (Prep/recovery) Phase II	11,692	46	254	440 GSF/station	- 186	Yes
Antepartum Testing	889	1	889	900 GSF/room	- 11	Yes

2. Only the Gross Square Footage of Post Anesthesia Recovery (Phase 1) exceeds the State Agency standards.

Attachment 14, Table 2
Total GSF Per PACU Station

Location	GSF / Station
Atrium Building	296
East Tower	231
Total	246
State Standard	180

The GSF of all the departments and services that are located in the Atrium, Kellogg, and East Tower are described below. In some instances there is only square footage located in the Atrium or Kellogg building (such as obstetrics, pediatrics, operating procedure rooms (endoscopy/bronchoscopy), and antepartum testing); others are located in both the Atrium Building and the East Tower (such as medical surgical, operating rooms, PACU and prep/recovery).

Medical Surgical Units

At the completion of the currently proposed modernization project, Rush will have 192 medical surgical beds in the East Tower and 128 in the Atrium Building for a total of 320 beds.

As shown on Attachment 14, Exhibit 1, the medical surgical square footage in the Atrium Building and total medical surgical square footage is below the State Agency standard.

Attachment 14, Table 3
GSF per Unit

	Atrium	East Tower	Total	State Agency Standard
Medical Surgical Beds	545	677	625	500 to 660

The square footage of the medical surgical beds in the East Tower was approved as part of Permit # 07-125. The square footage for the Atrium includes 2,679 GSF of satellite rehabilitation space and 342 GSF of radiology storage.

Pediatric Beds

As part of the proposed project, 22 pediatric beds will be redeveloped on Level 6 of Kellogg.

Attachment 14, Table 4
GSF per Unit

	Kellogg	Total	State Agency Standard
Pediatric Beds	524	524	500 to 660

As shown on Attachment 14, Exhibit 1, the GSF being modernized for pediatric beds in the Kellogg Building is below the State Agency standard.

Obstetrics Beds

The modernized obstetrics unit will have 563 GSF per bed; this square footage on Level 8 of the Atrium Building as shown on Attachment 14, Exhibit 1 is less than the State Agency standard.

Attachment 14, Table 5
GSF per Unit

	Atrium	Total	State Agency Standard
Obstetrics Beds	563	563	500 to 660

Newborn Nursery

The newborn nursery will also be located on Level 8 of the Atrium Building in close proximity to the obstetrics beds. The State Agency Standard for newborn nurseries is 160 GSF per bassinet. Rush's family-centered obstetrical program includes having a rooming in bassinet in each obstetrics room as well as a small nursery, as required by IDPH Code. Rush will have a total of 41 bassinets (34 rooming in and 7 in the nursery)

Attachment 14, Table 6
Newborn Nursery GSF for 34 Obstetrics Bed

	Atrium	Total	State Agency Standard
Newborn Bassinets	1,174	1,174	160 per OB Bed or 5,440

The State Agency standard for obstetrics and newborn nursery beds does not appear to take into account the rooming in model of obstetrical care. Another way to determine the square footage for a rooming in program would be to add the space allowed for maternal care and the space allowed for newborn baby care.

500 to 660 GSF for maternal care + 160 GSF for baby care =
660 to 820 GSF per obstetrics bed for total care

The Rush obstetrical program would have 19,131 GSF for maternal care and 1,174 GSF for baby care or a total of 20,305 total GSF. With 34 beds, the GSF per obstetrical beds would be 598 GSF or well within the combined standards for obstetrics and baby care. This is less than the State Agency guideline for obstetrical care.

20,305 GSF ÷ 34 obstetrical beds = 598 GSF for mother/baby care

Under either calculation, the Rush obstetrical and newborn nursery are under the State Agency standards.

Surgical Operating Rooms (Class C)

At the conclusion of the modernization of the Atrium Building, Rush will have 36 Class C operating rooms; of these, 28 will be in the East Tower and 8 will be in modernized space in the Atrium Building.

Attachment 14, Table 7
GSF per Unit

	Atrium	East Tower	Total	State Agency Standard
Surgical Operating Rooms (Class C)	2,320	2,210	2,234	2,750

The proposed square footage per room for the modernized operating rooms in the Atrium Building, the square footage for the new operating rooms in the East Tower, and the total square footage per room for both is below the State Agency standard.

Surgical Procedure Rooms (Class B)

The Class B operating rooms (the endoscopy/bronchoscopy rooms) will be consolidated on Level 5 of the Atrium Building; they will be relocated to vacated operating rooms.

Attachment 14, Table 8
GSF per Unit

	Atrium	Total	State Agency Standard
Surgical Operating Rooms (Class B)	911	911	1,100

The GSF of the Class B endoscopy/bronchoscopy procedure rooms are less than the State Agency standard.

Post Anesthesia Recovery (Phase I)

Since Rush is proposing to have post anesthesia recovery rooms (PACUs) in both the East Tower and the Atrium Building, the following table includes the square footage for both.

Attachment 14, Table 9
GSF per Unit

	Atrium	East Tower	Total	State Agency Standard
Post Anesthesia Recovery (Phase I)	296	230	246	180

The GSF for both the PACUs in the Atrium and the East Tower exceed the State Agency standard.

The GSF for the PACUs in the East Tower was approved in Permit #07-125. The factors used to justify the additional GSF in the East Tower included:

- Compliance with the intent of the code as well as allowance for a recovery bed rather than a stretcher, as well as consideration of patient privacy increased space planned for the East Tower PACUs.
- IDPH does not require isolation rooms within the PACU. Due to Rush's academic mission and its status as a Center for Advanced Emergency Response, Rush provided 1 isolation room including anterooms, the inclusion of isolation rooms required additional space.
- IDPH requirements for support space are minimal. To promote staff efficiency and maximize the amount of time the staff spends with the patient, Rush added additional support space.
- IDPH does not address the need for hand washing space. To promote patient safety and infection control standards, Rush provided decentralized hand washing sinks and work areas within the PACU area. The staff work zone also provides space for scanning medications and entering patient information.
- The PACU area in the East Tower has multi-disciplinary staff collaboration areas that encourage comprehensive patient care with enhanced opportunity for communication among physicians and allied health professionals; these staff collaboration areas also enhance Rush's teaching mission.

These same factors support the additional square footage in the Atrium Building.

In addition,

- The post anesthesia recovery stations will be located in existing space. This space has geometric limitations.
- In March 2011, the newly revised Hospital Licensure Code Part 250.1320 allows all patients to have visitors in the PACU; the previous code permitted only children to have visitors. Rush currently has the required policies to allow visitors in the PACUs. According to the code, PACUs must be sized to not only accommodate the patient, but also visitors, it must also be sized large enough to accommodate at least one additional staff person to oversee and

assist the visitors and to ensure patient privacy. Seating for visitors must also be provided. Further there will be a waiting area for visitors when they must leave the PACU.

- There will be stretcher – recliners with individual chargers that require additional space.
- The modernized PACUs will have a documentation computer at each bedside; these also require additional space.
- The physician dictation area will have PACUs display monitors that require additional space.
- Because the pediatric surgery will be performed in the Atrium operating rooms, crib storage for infants and small children must be provided.

Together, these factors justify the additional square footage in the Atrium Building PACUs.

Post Anesthesia Recovery
(Phase II)

Post anesthesia recovery (Phase II) or prep/recovery will be located in both the Atrium Building and in the East Tower.

Attachment 14, Table 10
GSF per Unit

	Atrium	East Tower	Total	State Agency Standard
Post Anesthesia Recovery (Phase II)	254	466	384	440

The prep/recovery area in the East Tower is somewhat larger than the State Agency standard; however, this square footage was approved by the Illinois Health Facilities Board in Permit #07-125. The square footage in the Atrium Building and the total square footage for all prep/recovery stations is less than the State Agency standard.

Antepartum Testing

The Antepartum Testing Area will be relocated to Level 8 of the Atrium Building to be part of the overall obstetrics service. This area includes one procedure room equipped with special ultrasound equipment. In a Technical Assistance call with State Staff, Rush was advised that the State Agency standard for ultrasound could be used for Antepartum Testing.

Attachment 14, Table 11
GSF per Unit

	Atrium	Total	State Agency Standard
Antepartum Testing	889	889	900

The proposed square footage for antepartum testing is less than the State Agency standard.

Non-Clinical

All non clinical spaces in the Atrium and Kellogg modernization have been categorized as general, public or mechanical/infrastructure.

General

There will be 50,924 GSF general non clinical space in the Atrium Building and 1,250 GSF in the Kellogg Building. General non clinical space includes administration, offices, conference rooms, transport, environmental services, storage, staff lounges, lockers and toilets. It also includes non departmental corridors as well as all stairs and elevators and vacated space.

Public

Of the total non-clinical square footage, 10,116 GSF will relate to public space. Functions located in public space include reception, waiting, consultation rooms, family lounges, vending and public toilets.

Mechanical/Infrastructure

Mechanical/Infrastructure accounts for 33,979 BGSF which includes 31,106 BGSF on Atrium Level 2; the remaining 2,876 BGSF will be IT closets in Levels 5,7, 8 and 9 in Atrium.

Drawings

Drawings for each of the levels to be modernized are included as Attachment 14, Exhibits 2, 3, 4, 5, and 6.

Impediments Letters

Attachments 7, 8, and 9 are letters from Perkins & Will (architect) and Power Jacobs (construction manager) describing the impediments encountered in the design and modernization of the Atrium and Kellogg buildings.

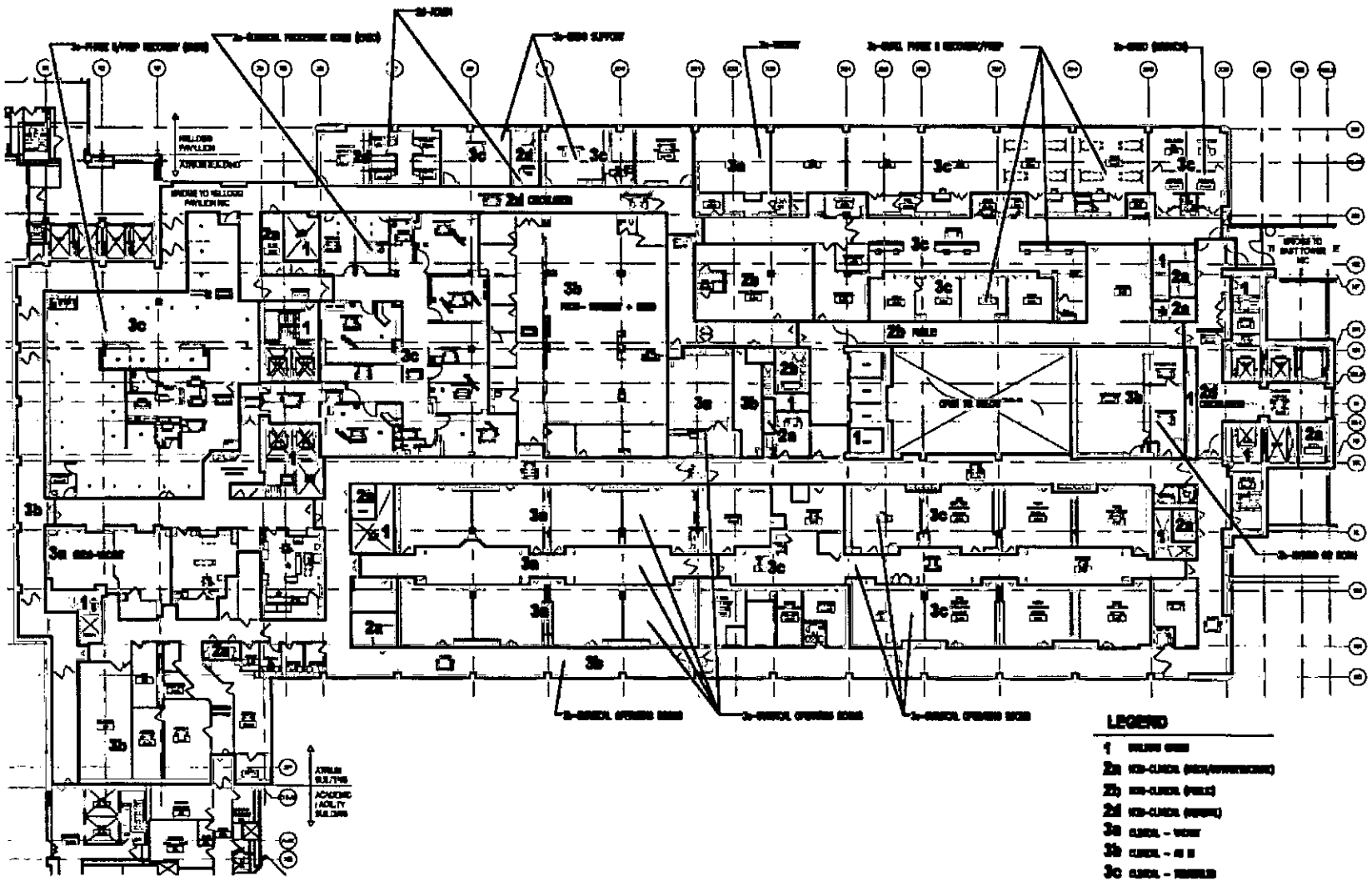
Departmental Gross Square Footage Per Clinical Department / Area

Clinical Department / Area	GSF				Units				GSF/Unit			
	Atrium	Kellogg	East Tower	Total	Atrium	Kellogg	East Tower	Total	Atrium	Kellogg	East Tower	Total
Medical / Surgical Beds	69,792		130,050	199,842	128		192	320	545		677	625
Pediatric Beds		11,520		11,520		22		22		524		524
Obstetrics Beds – Level 8	19,131			19,131	34			34	563			563
Newborn Nursery – Level 8	1,174			1,174	7			7	168			168
Surgical Operating Suite (Class C)	18,562		61,875	80,437	8		28	36	2,320		2,210	2,234
Surgical Operating Suite (Class B) (Endoscopy Suite)	9,109			9,109	10			10	911			911
Post Anesthesia Recovery Phase I	4,445		11,050	15,495	15		48	63	296		230	246
Post Anesthesia Recovery Phase II	11,692		33,563	45,255	46		72	118	254		466	384
Antepartum Testing	889			889	1			1	889			889

Comparison of Departmental Gross Square Footage to State Agency Standard

Clinical Department / Area	GSF / Key Room				State Agency Guidelines	Met Standard?			
	Atrium	Kellogg	East Tower	Total		Atrium	Kellogg	East Tower	Total
Medical / Surgical Beds	545		677	625	500 – 660 GSF/Unit	Y		N	Y
Pediatric Beds		524		524	500 – 660 GSF/Unit		Y		Y
Obstetrics Beds	563			563	500 – 660 GSF/Unit	Y			Y
Newborn Nursery	168			168	160 GSF / OB Bed	Y			Y
Surgical Operating Suite (Class C)	2,320		2,210	2,234	2,750 GSF/Unit	Y		Y	Y
Surgical Operating Suite (Class B) (Endoscopy Suite)	911			911	1,100 GSF/Unit	Y			Y
Post Anesthesia Recovery Phase I	296		230	246	180 GSF/Unit	N		N	N
Post Anesthesia Recovery Phase II	254		466	384	400 GSF/Unit	Y		N	Y
Antepartum Testing	889			889	900 GSF/Unit [√]	Y			Y

[√] See GSF need determination in text; State Agency Staff approved 900 GSF because this is a special ultrasound room

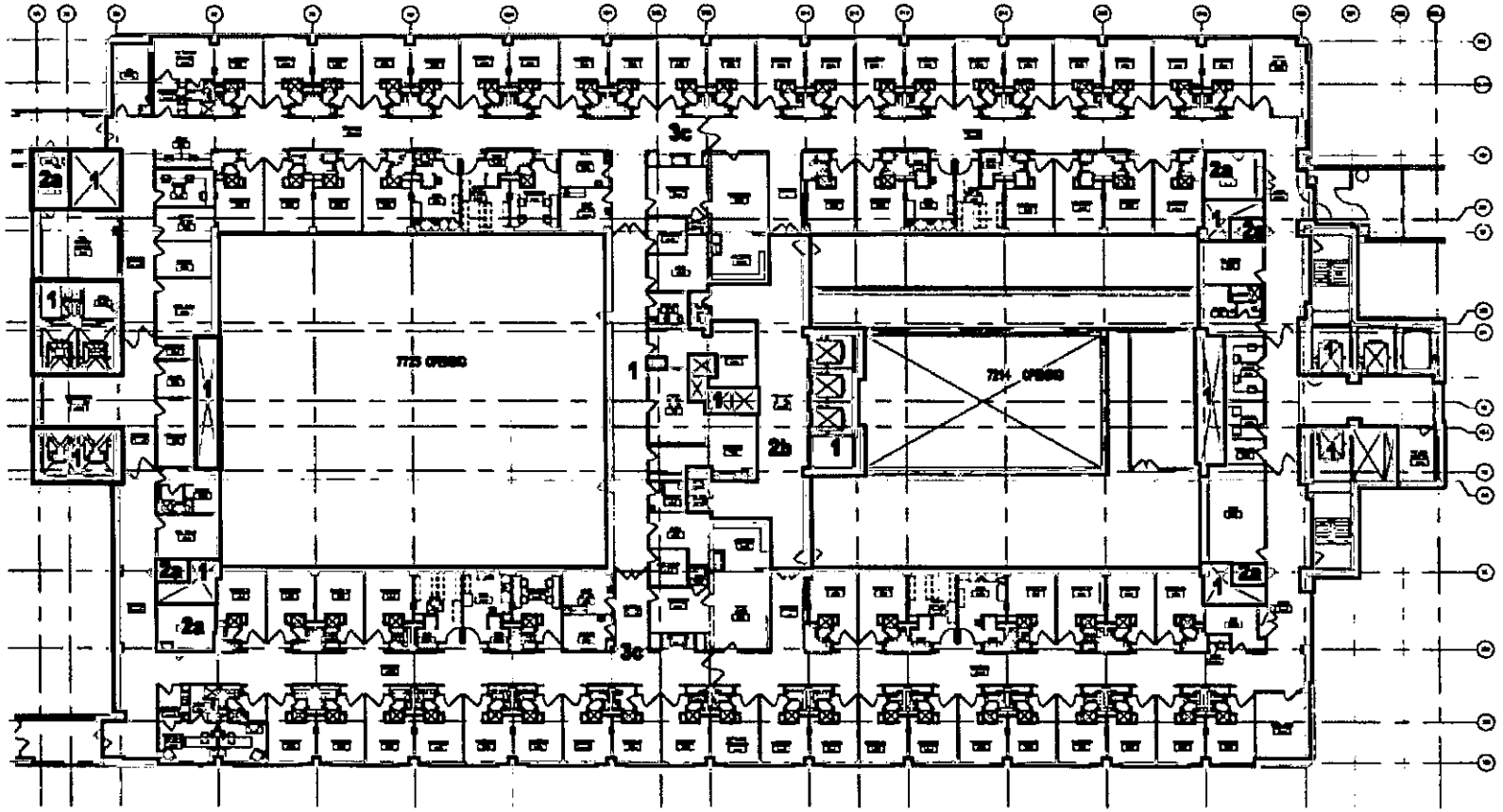


ATRIUM BUILDING – LEVEL 5

1/30/2012

RUSH UNIVERSITY MEDICAL CENTER
ATRIUM BUILDING

PERKINS + WILL

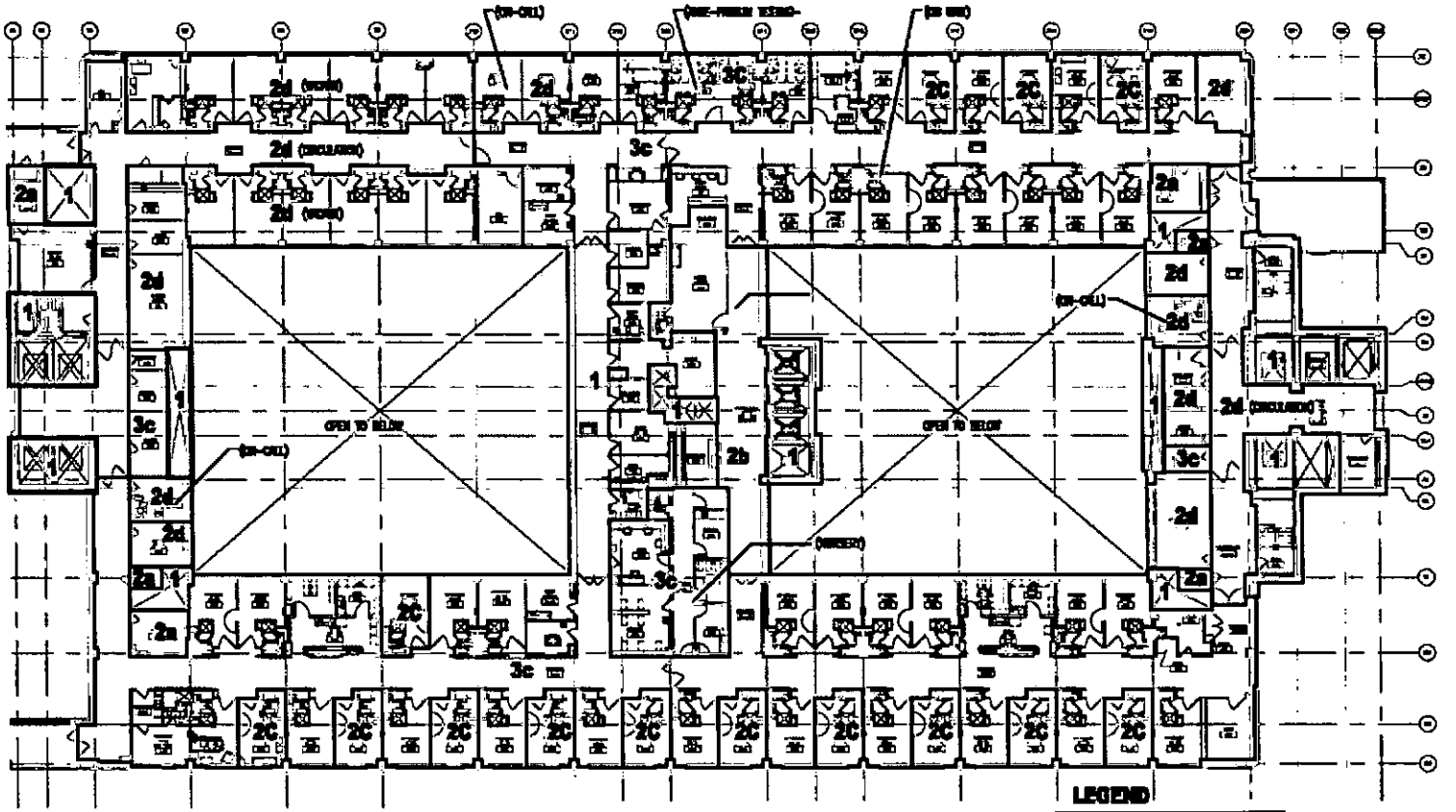


ATRIUM BUILDING - LEVEL 7

1/27/2012

RUSH UNIVERSITY MEDICAL CENTER
ATRIUM BUILDING

PERKINS + WILL

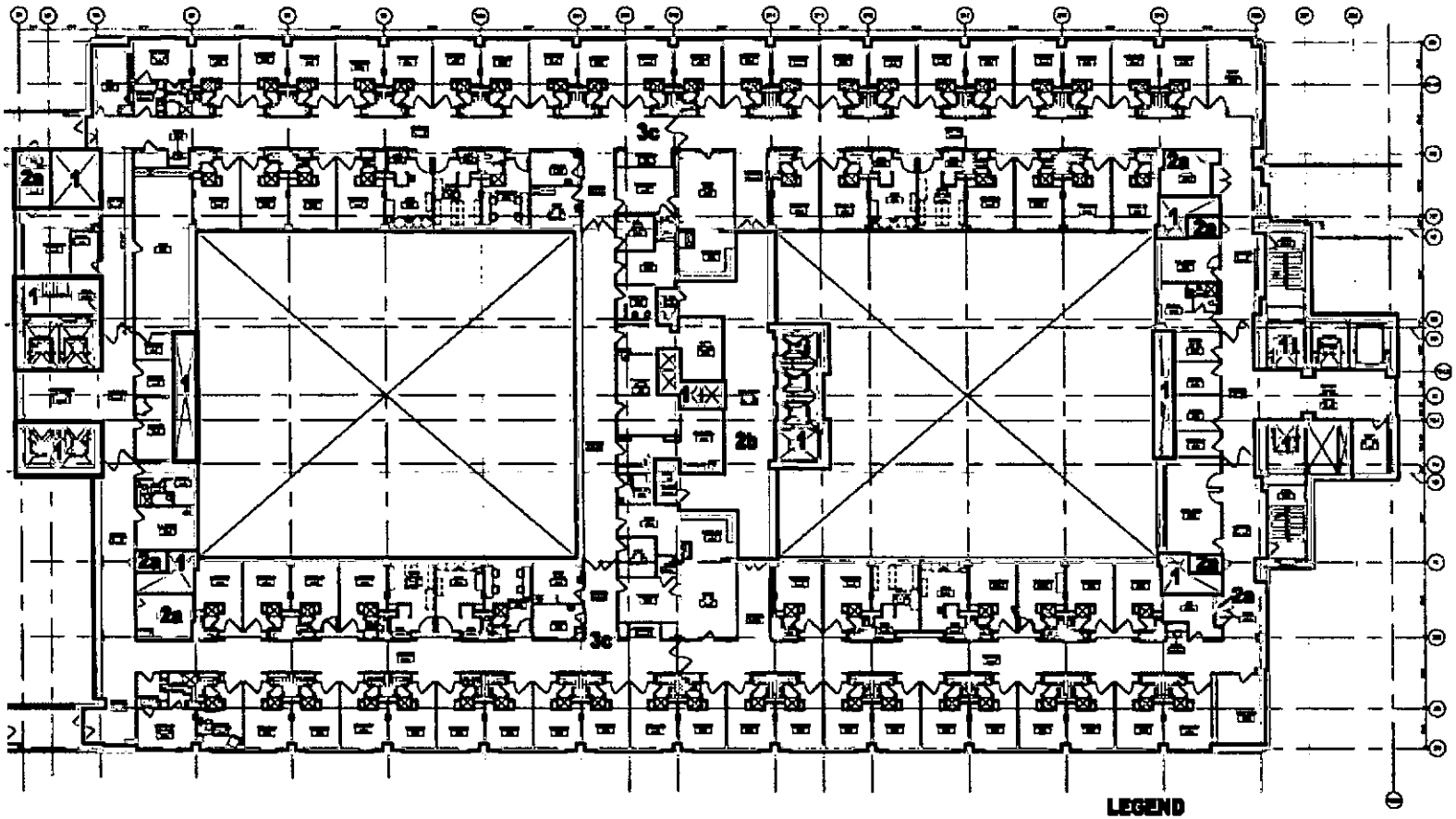


ATRIUM BUILDING – LEVEL 8

1/30/2012

RUSH UNIVERSITY MEDICAL CENTER
ATRIUM BUILDING

PERKINS + WILL

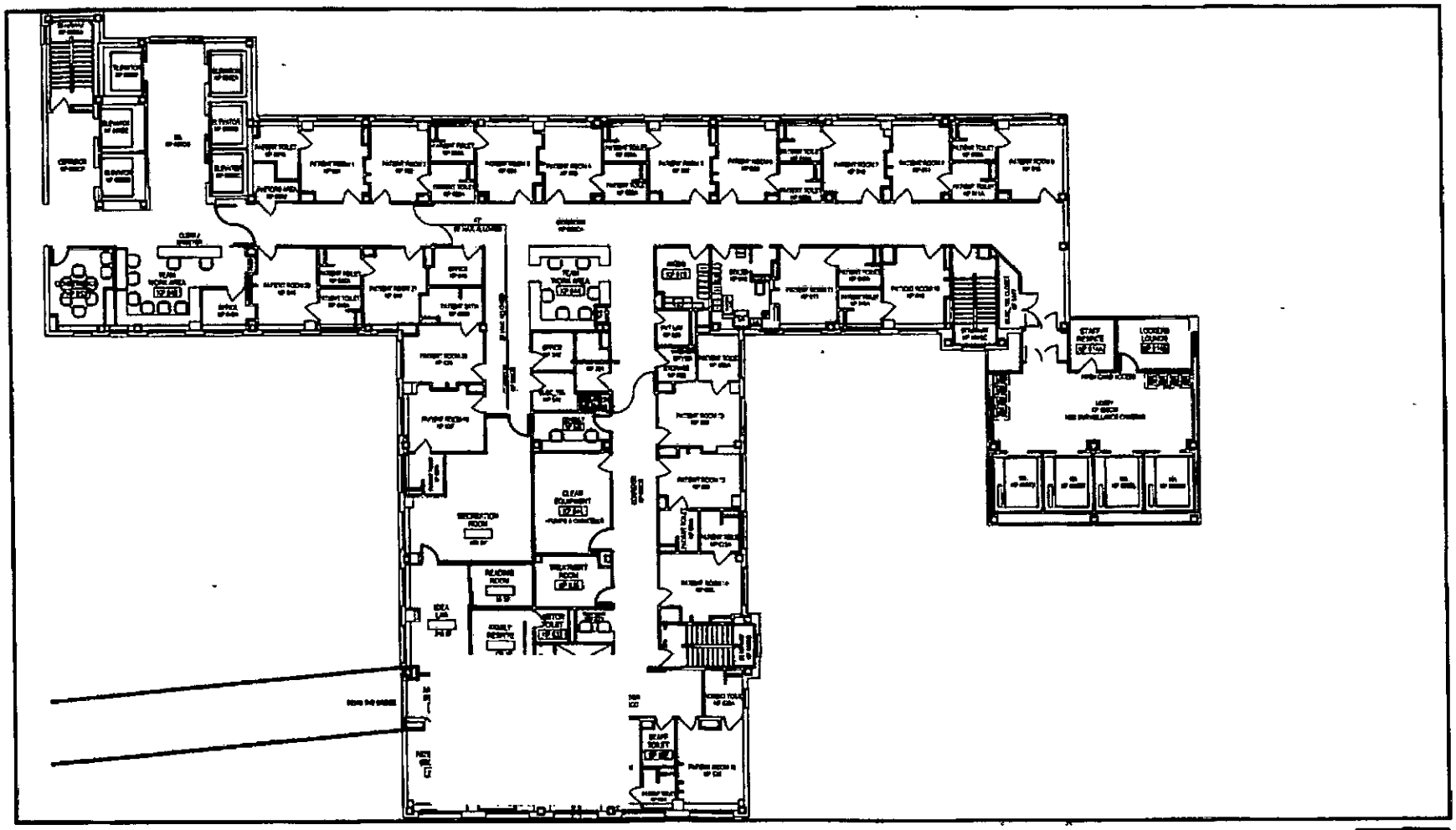


ATRIUM BUILDING – LEVEL 9

1/27/2012

RUSH UNIVERSITY MEDICAL CENTER
ATRIUM BUILDING

PERKINS + WILL



RUSH UNIVERSITY MEDICAL CENTER

6 KELLOGG OPTION C: 22 ROOMS

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PERKINS
+WILL

December 16, 2011

Office of Transformation
Rush University Medical Center
1650 West Harrison Street
Chicago, IL 60612

Re: Atrium Building Renovation (Phase III) Architectural Impediments

To Whom It May Concern:

Perkins+Will has been retained as the Architect of Record for the Atrium Building Renovation (Phase III) and has been working with RUMC over the past months to develop the design of this project. In the course of this process, there have been a number of architectural challenges that have significantly affected the project design. Following is an accounting of these impediments.

- The project is an interior renovation of an existing facility. As such, there are many physical constraints on the ability to lay out spaces and achieve desired adjacencies. These constraints include:
    - Immovable architectural elements such as the 2 atrium spaces imposed restrictions on both the architectural planning and design of the mechanical/electrical/plumbing systems.
    - Inability to alter the layout of the patient rooms. These rooms were designed prior to the implementation of the Americans With Disabilities Act (ADA) and, thus, are not compliant with current Barrier Free requirements. This condition limits the amount of permissible work in the patient room to finish upgrades. If more significant work, specifically layout revisions, were engaged, the rooms would have to be upgraded to compliance with ADA and would require wholesale demolition and rebuilding.
    - Infrastructure systems that must be maintained such as ductwork, telecommunications pathways and plumbing risers.
    - Existing functions in the Subbasement, Level 1 and Level 4 will remain intact and functioning throughout the course of this project. This condition required concessions in planning and will require careful coordination during construction.
    - Existing life safety and egress systems are not being substantially modified. Existing fire separations and egress paths that must be maintained drove many planning and layout decisions.
- The design must accommodate existing connections to adjacent buildings that will remain as well as new connections to the Atrium Addition project to the east. Maintenance of

these connections and the resulting flows of patients, staff and materials imposed restrictions on the planning.

We believe that the project has been designed to successfully accommodate these impediments and meet the current and future needs of Rush University Medical Center.

Sincerely,

Bridget Lesniak

Bridget Lesniak,AIA,NCARB
Principal
Perkins+Will

POWER JACOBS

A Project Specific Joint Venture
Rush University Transformation Program

January 19, 2011

Office of Transformation
Rush University Medical Center
1650 West Harrison Street
Chicago, IL 60612

Re: Atrium Building Renovation Phase III – Construction Impediments

To Whom It May Concern:

The renovations planned for the Atrium Building will require a well thought out execution plan to maintain the integrity of the systems and functions required to stay in service during the renovation project.

There are several departments, medical surgical patient floors, clinical service areas, administrative areas, food services, and mechanical/infrastructure areas remaining in service during the renovation project. These include the Subbasement, Level 1, Level 2, Level 4, Level 5, Level 7, and Level 9. Complete and functioning building systems will be required to be operational and in service during the entire duration of the renovation. These include HVAC, Mechanical, Electrical and Plumbing, Control Systems, Patient Monitoring, Life Safety systems, Elevators, and pathways between the East Tower, Atrium Building, and buildings adjoining the Atrium Building to the west and south which include the Kellogg Building, Pavilion Building, Jelke Building, Armour Academic Building, Professional Office Buildings I, II, and III; and the Johnston R. Bowman Health Center (JRB).

The following outlines the impediments to the construction in specific areas of the Atrium Building and adjoining spaces.

Subbasement:

There are Rush departments and services that must stay in full operation and service during the entire renovation project. The construction team must maintain uninterrupted service (HVAC, MEP, Life Safety, Lighting, and Controls) to all functions in the Subbasement, including the horizontal and vertical pathways between the Atrium Building, East Tower, Kellogg, Pavilion, and Jelke Buildings. The Rush hospital departments include Food & Nutrition Services; Materials Management, EVS, Clinical Engineering, and Medical Center Engineering. All deliveries to the hospital will travel from the loading dock in the Orthopedic Building through the tunnel connection in the Atrium subbasement, therefore the pathways and systems in this area must be maintained at all times.

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Level 1:

Level 1 is a direct link to Level 4 from which patients, visitors, and staff can access the waiting area and restaurant on Level 4 of the Atrium Building, the East Tower, the parking garage on the South side of Harrison Street, the Professional Office Buildings I, II, and III; the Armour Academic Center, and the Johnston R. Bowman Health Center (JRB); and the buildings to the west - Kellogg, Jelke, and Pavilion. The challenges for the construction team will include maintaining the following functions and systems for adjacent buildings and for Atrium Building Level 1:

- Coordination of construction deliveries, construction dumpsters, removal of construction debris, and access to Level 1 elevators by patients, visitors, and staff.
- Maintain uninterrupted ambulance service to the Emergency Department in the East Tower.
- Maintain uninterrupted access the Rush Woman's Board Center for Radiation Therapy at the West end of the Atrium Building. Access is from Harrison Street.
- Maintain access to the Edward A. Brennan Entry Pavilion and East Tower on the South side of each of these areas. Access if from Harrison Street.
- Maintain valet service on the exterior of the Atrium building – both on the North side and South side.
- Maintain elevator service between Atrium Level 1 and Level 4.
- Maintain the staff/service elevators on the East side of the Atrium building.
- HVAC, Life Safety, Egress, Power and Lighting systems.

Level 2:

This level is the mechanical floor for the Atrium. All major services for the Atrium Building are located on Level 2. There are several challenges for the construction team that will require close coordination and execution during construction on Level 2:

- Maintain a complete operational air supply and return system to the Subbasement, Level 1, Level 2, Level 4, Level 5, Level 7, Level 8, and Level 9.
- Maintain uninterrupted electrical service to normal, emergency, and critical power distribution to the Subbasement, Level 1, Level 2, Level 4, Level 5, Level 7, Level 8, and Level 9.
- Replace two emergency generators with one set of receiving gear, two 15Kva substations, replacement of the existing automatic transfer switches (ATS), and the installation of additional new ATS'.

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Level 4:

The Atrium Building Level 4 is the main above ground connection between the parking garage, East Tower, Kellogg and Jelke buildings, Armour Academic Center, and the Professional Office Buildings I, II, and III. Patient Registration is also located on Level 4, as is the Au Bon Pain food service operation. There is also a waiting area on Level 4 at the intersection of the Au Bon Pain restaurant, Harrison Street Bridge, and the East Tower. The construction team will have the following challenges on Level 4 during construction:

- Maintain HVAC, MEP, Life Safety, and elevator service to the food service operation and waiting area.
- Maintain all required HVAC, MEP, and IS services operational at all times for the Patient Registration area. We must also maintain access and egress at all times.
- Keep all food service delivery pathways open and accessible.
- Maintain open corridors for ambulatory patients, visitors, and staff.

Level 5:

Level 5 of the Atrium Building will be the main connection for patients and staff between the East Tower, Kellogg, Pavilion, and Jelke Buildings. The Hybrid Lab currently on Level 5 will stay in service and must be accessible to and from the East Tower. The construction team will have the following challenges while renovating Level 5:

- Maintain an existing corridor or rated construction barrier on Level 5 for patient transport and staff movement between the Atrium Addition and Kellogg Buildings.
- Maintain existing corridors or rated construction barriers on Level 5 for the clinical service areas staying on Level 5. These include the Hybrid Lab, Class B and C Operating Rooms, and PACU Phase I and II.
- Maintain normal, emergency, and critical electrical power distribution to the patient and staff corridors.
- Maintain normal, emergency, and critical electrical power to the Hybrid Lab, Class B and C Operating Rooms, and PACU Phase I and II.
- Maintain HVAC, MEP, Control Systems, and Med Gases to the Hybrid Lab.
- Maintain the Life Safety systems to the Hybrid Lab, Operating Rooms, and PACU's; in addition to all other area of Level 5.

Level 7:

Level 7 is currently a medical surgical patient floor. This floor will remain occupied during the upgrades to Level 7. The plan is to close off one-half of the floor for renovation and keep the remaining half as medical surgical patient care. Patients would be moved to the newly renovated

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half when construction is completed thereby vacating the remaining half for renovation. The construction team will have the following challenges while renovating Level 7:

- Construct and maintain rated construction barriers on either side of the construction area.
- Maintain normal, emergency, and critical electrical power to the floor.
- Maintain HVAC, MEP, Control Systems, and Med Gases to the floor.
- Maintain all Life Safety, Fire Alarm, and Fire Protection Systems on the floor.
- Maintain all Patient Monitoring Systems to the floor.

Level 8:

Level 8 will be fully vacated for the renovation of this floor. When completed, Level 8 will become an Obstetrics and Newborn Nursery floor. The construction team will have the following challenges while renovating Level 8:

- Construct and maintain rated construction barriers on either side of the construction area.
- Maintain the HVAC systems.
- Isolate MEP systems where required.
- Maintain all Life Safety, Fire Alarm, and Fire Protection Systems on the floor.

Level 9:

Level 9 is currently a medical surgical patient floor. This floor will remain occupied during the upgrades to Level 9. The plan is to close off one-half of the floor for the renovation and keep the remaining half as medical surgical patient care. Patients would be moved to the newly renovated half when construction is completed thereby vacating the remaining half for renovation. The construction team will have the following challenges while renovating Level 9:

- Construct and maintain rated construction barriers on either side of the construction area.
- Maintain normal, emergency, and critical electrical power to the floor.
- Maintain HVAC, MEP, Control Systems, and Med Gases to the floor.
- Maintain all Life Safety, Fire Alarm, and Fire Protection Systems on the floor.
- Maintain all Patient monitoring Systems to the floor.

Sincerely,

Patrick Mulroy
Sr. Project Manager

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POWER JACOBS

A Project Specific Joint Venture
Rush University Transformation Program

January 19, 2012

Office of Transformation
Rush University Medical Center
1650 West Harrison Street
Chicago, IL 60612

Re: Kellogg Building Renovation – Construction Impediments

To Whom It May Concern:

The renovation planned for the Kellogg Building will require an execution plan to maintain the integrity of the systems and functions required to keep the Kellogg Building in service during the renovation project.

The renovation of the Kellogg Building is a result of programs and services moving to the East Tower and the Atrium Building.

Level 6:

Level 6 is currently occupied by Labor & Delivery and the Postpartum unit. Level 6 will be fully vacated for the renovation. These units will move to Level 8 in the Atrium when the renovations are complete in Atrium. The plan for 6 Kellogg is a renovation for the floor to become a general pediatric unit. The construction team will have the following challenges while renovating Level 6:

- Construct and maintain rated construction barriers on either side of the construction area.
- Maintain the HVAC Systems.
- Maintain the MEP Systems where required.
- Maintain the Security Systems.
- Maintain all Medical Gas Systems for the floor.
- Maintain all Life Safety, Fire Alarm, and Fire Protection Systems on the floor.

Sincerely,

Patrick Mulroy
Sr. Project Manager

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

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

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.

As shown in Attachment 15, Exhibit 1, the projected services utilization for medical surgical beds, pediatric beds, obstetrical beds, surgical operating rooms, surgical procedure rooms, and antepartum testing meet or exceed the State Agency standard for utilization.

Projected Services Utilization In Second Full Year

Department/Service	Historical Utilization		Projected Utilization Second Full Year	State Standard	Number Requested Calculation of Allowable	Met Standard
	2009	2010				
Medical Surgical Beds	100,447 days	95,829 days	105,455 days	88% Occupancy	320 *105,455 ÷ 365= 288.9 ADC ÷ 88% = 329 beds*	Yes
Pediatric Beds	5,575 days	5,307 days	5,820 days	65% Occupancy	24 *5,820 ÷ 365 = 15.9ADC ÷ 65% = 25 beds*	Yes
Obstetrics Beds	9,126 days	9,064 days	9,418 days	78% Occupancy	34 *9,418 ÷ 365 = 25.8 ADC ÷ 78% = 34 beds*	Yes
Surgery (Class C)	59,761 hours	59,475 hours	62,932 hours	1,500 hours per room	36 *62,932 room hours ÷ 1,500 hours = 42 rooms*	Yes
Surgery (Class B) (Endoscopy)	9,343 hours	10,616 hours	16,856 hours	1,500 hours per room	10 *16,856 hours ÷ 1,500 hours = 12 rooms*	Yes
Antepartum Testing	1,789 visits	1,850 visits	1,850 visits	2,000 visits per room	1 *1,850 visits ÷ 2,000 visits = 1 room*	Yes

Note:

1. Does not include 13 medical surgical room leased for hospice care.

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

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

UNFINISHED OR SHELL SPACE:

Provide the following information:

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

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

1. and 2. Total Square Footage and Anticipated Use of the Proposed "Shell" Space

At the completion of the Atrium Building modernization project there will be no unfinished or shell space. However, there will be vacated space that will remain unused at the completion of the project. For the purposes of this application, Rush University Medical Center (Rush, Medical Center, RUMC) is addressing this section in order to describe what will be done with this vacated space. The vacated, unassigned space includes the following.

Kellogg Building – The Kellogg Building was constructed in 1958 and currently houses medical surgical beds on Level 9. At the completion of the Atrium Building these beds will be relocated to the Atrium Building. The future use of the vacated medical surgical bed space in the Kellogg Building has not been determined. Similarly, the reuse of the vacated space on Level 1 of the Kellogg Building has not yet been determined.

Pavilion Building – The Pavilion Building was constructed in 1913 and currently houses 26 medical surgical beds, 6 obstetrical beds, the newborn nursery and endoscopy that are going to be relocated to the Atrium Building. The Pavilion Building will be reused for administrative space.

POB II – POB II (Suite 339) current houses 4 outpatient endoscopy rooms and 9 prep/recovery stations in 5,165 GSF. At the completion of the Atrium Building modernization project, the endoscopy rooms and recovery space will be relocated to vacated operating rooms and other space on Level 5 of the Atrium Building. The vacated space in POB II will be converted to needed physician office space. A letter from Peter Butler, President and COO of RUMC, enclosed as Attachment 16, Exhibit 1, explains the future use of the vacated POB space

Attachment 16, Table 1
Summary of Reuse of Vacated Space

Clinical Area/Department	Current Location(s)	GSF Being Vacated	Proposed Location	Reuse of Vacated Space
Medical Surgical Beds	9 Kellogg	12,450	9 Atrium	Vacant
Pediatric Bed	5 Pavilion	11,160	6 Kellogg	Administration
Obstetrics Beds	6 Kellogg 6 Jones 6 Pavilion	12,355 708 600	8 Atrium	Pediatric Beds + Administration
Newborn Nursery	6 Pavilion	1,152	8 Atrium	Administration
Surgery	5 Atrium	5,448	5 Atrium	Endo
Endoscopy	1 Kellogg 1 Pavilion 339 POB2	3,541 1,677 2,921	5 Atrium	Vacant + Physician offices
Phase I Recovery (PACU)	1 Kellogg	505	5 Atrium	Vacant
Phase II Recovery	1 Kellogg 339 POB2	1,010 888	5 Atrium	Vacant Physician offices
Antepartum Testing	6 Kellogg	415	8 Atrium	Pediatric Beds

3. Reason the Shell Space Is Being Constructed

NA. There is no shell/unfinished space being constructed as part of the proposed modernization project. The vacated space described in 1) and 2) above is all existing space.

4. Historical and Projected Use of the Shell Space

Since the proposed vacated shell space will all be reassigned to non-clinical functions, there is no relevant historical projected data.

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

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peter_butler@rush.edu

RUSH

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

January 24, 2012

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

Dear Mr. Galassie:

Rush University Medical Center (Rush, RUMC) received Master Design Permit #06-009 in June 2006. The second project to be approved under the master design application was the Atrium Addition, now known as the East Tower (Permit #07-125). The East Tower was partially occupied in January 2012.

Rush's master plan includes relocating high acuity services from other buildings on campus into the East Tower. One of the services that will be relocated, in part, is surgery. At the completion of the East Tower project, 28 operating rooms will reside in the East Tower. Today, there are 29 small operating rooms in the Atrium Building, which will be the first building to be modernized as part of the master design application and the focus of the attached application. Of these, 8 will continue to be used for low risk, primarily outpatient surgery, 10 will be used for endoscopy. The remaining space will be modernized and reused as recovery stations or support areas.

Rush currently has 7 endoscopy rooms. Three of these rooms are located on the first floor of the Kellogg Building; these endoscopy rooms will be relocated to the Atrium Building and the vacated space will be reassigned to non clinical functions that are now located in very old buildings scheduled for demolition.

The remaining 4 endoscopy rooms are located in Suite 339 of the Professional Office Building II (POB II). This space is located across the street from other interventional services; having endoscopy rooms in multiple locations is very inefficient. These endoscopy rooms will also be relocated to the Atrium Building.

As soon as the 4 endoscopy rooms in POB II are relocated to the Atrium Building, that space will be leased to physicians who want offices on the RUMC campus near the hospital. At the present time, Rush does not have lease agreements for this space. However, several physicians have already indicated interest, but they are reluctant to commit to a lease until a time closer to when the space will become available. In addition, we continue to actively recruit physicians; these will be new physicians to our staff who will not join RUMC for at least 2 years, or about the time that the POB II space becomes available. It is important for us to have available lease space for these newly recruited physicians as well as for others who elect to move to our campus.

Rush is a not-for-profit health care, education and research enterprise comprising Rush University Medical Center, Rush University, Rush Oak Park Hospital and Rush Health.

We have no doubt that at least 80 percent of the available space will be leased as soon as it becomes available. Hence, at all times the space will be self -supporting and will not result in increased charges to patients.

Sincerely,

Peter W. Butler

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

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

ASSURANCES:
Submit the following:

1. Verification that the applicant will submit to HFPB 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.

1., 2., and 3 Verifications

At the completion of the Atrium Building modernization project, the Atrium, Kellogg, Jelke, Jones, Pavilion, and POB II buildings will have no shell space; they will, however, have vacated space. Attachment 16 was completed to provide the State Staff information about the space that was being vacated and its proposed use if currently determined.

Rush University Medical Center verifies that the Medical Center will submit a CON application to HFSRB to develop and utilize the vacated space regardless of the capital threshold in effect at the time or the reuse of the space.

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 -

Not applicable. This is not a master design project.

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

Not Applicable. This is not a master design project.

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.

1. Schematic Architectural Plans

   Not applicable – No architectural plans were approved in the master design permit.

2. Estimated Project Cost for the Proposed Projects and Total Construction/Modification Projects Approved in the Master Design Permit;

   The total construction/modernization cost and project cost for each of the projects approved under the Master Design Permit (#06-009) as well as this proposed project are as follows:

Project Title	Permit	Construction/ Modernization Cost	Contingency	Total Construction Cost	Project Cost
Master Design	#06-009	NA	NA	NA	$28,222,000
Orthopedics Ambulatory Building	#06-073	$101,353,343	$10,135,334	$111,488,677	$137,866,000
Atrium Addition	#07-125	$360,757,465	$31,245,911	$392,003,376	$617,273,380
Brennan Entry / East Tower Pavilion	#10-041	$12,954,000	$1,080,000	$14,O34,000	$16,300,000
Atrium Building Modernization (Current project)	#12-XXX	$32,975,870	$4,946,381	$37,922,251	$46,230,784

Source: CON applications and SARs

3. Comparison of the Construction Elements in the Proposed Project to the Approved Master Design Project

The Master Design application did not provide projections for beds or services. Rather, (page 7) "Among the key questions that need to be resolved in the proposed planning process are: How many beds by category of service will be needed to meet the current and future need of RUMC's patients? How many beds can be discontinued?"
In the Atrium Addition/East Tower permit the projection process is described (pages 8 and 9), "For services that will be in both the Atrium Addition and in existing Rush buildings, at the completion of Phase II (East Tower project) volumes have been projected for the final expected complement of rooms or units. Rush is committed to reducing its bed complement by 181 beds or from 901 to 720. At the completion of Phase II, Rush is proposing a net reduction of 76 beds which includes a decrease of 128 medical surgical beds and the addition of 32 intensive care beds and 15 neonatal intensive care beds. At the completion of Phase II, Rush proposed to 825 authorized beds. Rush will reduce an additional 105 beds which will include 20 medical surgical beds and an estimated 85 beds via an undetermined mix of pediatric, OB/GYN, acute mental illness, and rehabilitation beds. The remaining beds will be decreased in a future certificate of need filing."
The following bed reduction plan was presented in the East Tower application.

Rush's Bed Reduction Plan

Category of Service	Current Authorized Bed Complement	Proposed Bed Change CON II	Proposed Authorized Beds at the Completion of CON II	Proposed Future Bed Change	Authorized Beds at Completion of Campus Transformation
Intensive Care	95	+37	132		132
Medical Surgical	468	-128	340	-20	320
Neonatal	57	+15	72		72
Pediatric	70			-85	196
OB/GYN	44				
Acute Mental Illness	101				
Rehabilitation	66				
Total Bed Change	--	-76		-105	-181
Total Beds	901		825		720

Source: Permit #07-125

By the end of 2010, Rush's total bed complement had been reduced to 739 beds.

Rush prepared volume projections and key room needs for medical surgical beds and surgery operating rooms, Class C for both the East Tower and the Atrium Building as part of the East Tower application.

The departments/areas identified in the master design and East Tower applications are compared on the following table. Any discrepancies are explained.

Attachment 18, Table 1
Comparison of Key Rooms by Department/Area

Department/ Area	Key Rooms Projected in the East Tower Application	Key Rooms Proposed in the Atrium/Kellogg Addition Modernization	Discussion
Medical Surgical Beds	320	320 + 13 hospice beds	The number of medical surgical beds in the East Tower and the Atrium Building at the completion of the Atrium and Kellogg modernization project, or 320, is consistent with the Master Design and East Tower permits. Between the approval of the Master Design and East Tower permits, Rush determined the need for hospice beds and has finalized a lease agreement with Horizon Hospice & Palliative Care; Horizon will provide care in 13 vacated long-term care beds in the Johnson R. Bowman Health Center; these beds meet code for medical surgical beds. IDPH requires that hospice in leased space be in authorized medical surgical or long-term care beds. Rush currently has 340 authorized medical surgical beds; at the completion of the Atrium Building modernization, Rush will have 333 medical surgical beds; of these 13 will be hospice beds and 320 will be general medical surgical beds.
Pediatrics	No number of beds was specified; however, pediatrics was targeted as a category of service that would be reduced	22	At the time that the East Tower application was filed, Rush had 70 authorized pediatric beds. On April 22, 2009, the Planning Board reduced the number of general pediatric beds at Rush by 42 beds, leaving the Medical Center with 28 authorized beds. As part of this application the number of pediatric beds will be further reduced to 22 authorized beds. This is consistent with the intent of the Master Plan and the Atrium/East Tower applications.

Department/ Area	Key Rooms Projected in the East Tower Application	Key Rooms Proposed in the Atrium/Kellogg Addition Modernization	Discussion
Obstetrics Beds	No number of beds was specified; however, obstetrics was targeted as a category of service that would be reduced	34	Since the East Tower project did not contain obstetrics beds, the East Tower application did not include a projected number of obstetrics beds. The East Tower application, however, did indicate that Rush would decrease the number of obstetric beds. On April 22, 2009, the Planning Board reduced the number of obstetrics beds at Rush from 44 to 38 beds As part of this application the obstetrics bed complement is being further reduced to 34 beds. This is consistent with the intent of the Master Plan and the Atrium/East Tower Application.
Newborn Nursery Bassinets	NA	34 rooming-in plus 7 in a nursery	Since the East Tower project did not contain newborn nursery bassinets, the East Tower application did not include a projected number of newborn nursery bassinets. Each obstetric room will have a rooming-in bassinet and there will be 7 in a normal newborn nursery. At the completion of the Atrium modernization project, Rush will have from 41 bassinets, consistent with Illinois licensure code.
Surgical Operating Rooms, (Class C)	39 Class C operating rooms	36 Class C operating rooms	In the East Tower application, Rush anticipated the need for 28 Class C operating rooms in the East Tower and 11 additional Class C operating rooms in the Atrium Building. At the time the East Tower application was filed, Rush had 29 Class C operating rooms. In the completion of the Atrium Building modernization project, Rush will have 28 operating rooms in the East Tower and 8 Class C operating rooms in the Atrium Building. This is consistent with the East Tower application.

Department/ Area	Key Rooms Projected in the East Tower Application	Key Rooms Proposed in the Atrium/Kellogg Addition Modernization	Discussion
Surgical Procedure Rooms (Class B)	NA	10 Class B procedure rooms	The East Tower application mentioned that the endoscopy service would be consolidated in vacated rooms in the Atrium Building surgical suite; it did not project the number of future rooms. Rush currently has 7 endoscopy rooms At the completion of the Atrium Building modernization project, Rush will have 10 Class B operating rooms.
Post Anesthesia Recovery (PACU), Phase I	NA	15	The Master Design application did not address the total number of PACU spaces to be developed. However, the East Tower application included 54 PACUs in the East Tower; there was no projection of the number of PACUs in the Atrium Building. At the conclusion of the Atrium Building modernization, there will be a total of 63 PACUs; of these, 48 will be in the East Tower and 15 will be in the Atrium Building.
Post Anesthesia Recovery (Prep/Recovery) Phase II	NA	46	The Master Design application did not address the number of prep/recovery spaces to be developed. However, the East Tower application included 56 prep/recovery areas. At the conclusion of the Atrium Building modernization project, Rush will have 72 prep/recovery areas in the East Tower and 46 in the Atrium Building for a total of 118. The number of prep/recovery stations addresses the increase in the number of Class C and Class B operating rooms and the expected volume of outpatients and the need for a very timely turnover of the operating rooms to increase utilization and efficiency.
Antepartum Testing	NA	1	Neither the Master Design nor the Atrium/East Tower applications addressed Antepartum Testing.

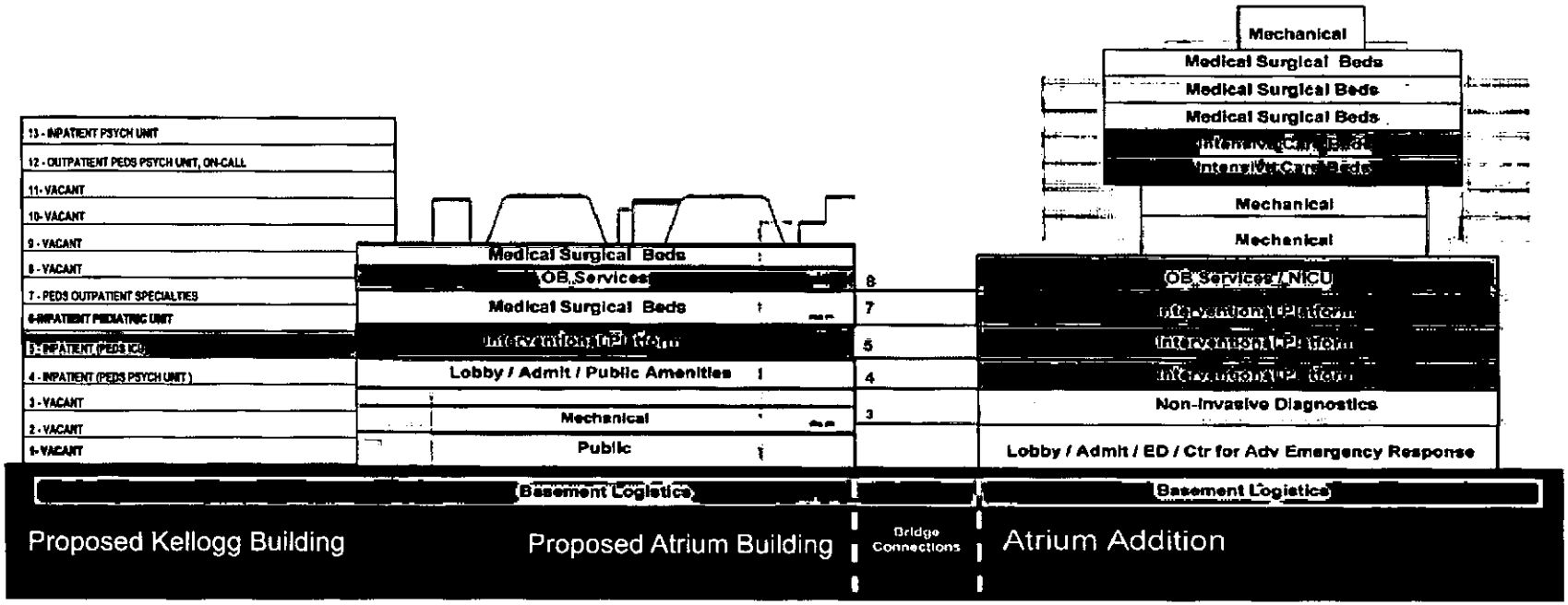
4. Comparison of Proposed Beds and Services to Those Approved under the Master Design Permit.

Not applicable.

In June 2006, the Illinois Health Facilities Planning Board awarded the Rush University Medical Center (Rush, Medical Center) Master Design Permit #06-009. The permit was for programming, site survey and soil investigation, architectural and engineering fees, consulting and other fees, and other costs to be capitalized. No construction or modification was approved as part of the project. No beds or services were approved as part of the project.

The first project approved under the master design permit was #06-009; this permit was for a medical office building known as the Orthopedics Ambulatory Building including a parking structure with a central energy plant and materials management. The Orthopedics Ambulatory Building is complete. The second project approved under the master design permit was a 15-level patient tower known as the Atrium Addition which has been renamed the East Tower; this is Permit #07-125 approved in January 2008. The East Tower is currently occupied except for Level 8 which houses obstetrics delivery functions and the neonatal intensive care unit. The original project connected the East Tower to the nearby Atrium Building with a series of bridges at the upper levels. (See the stacking diagram included as Attachment 18, Exhibit 1.) In the SAR for this project, Staff noted that the project was in conformance with the relationship to previously approved master design projects criteria.

In September 2010, the HFSRB approved Project #10-041; this project included the construction of a 3-story entry pavilion under the bridges. The SAR for the entry pavilion project, as well as for all of the other master design projects, noted that "the applicant has documented this project (submitted pursuant to an approved Master Design Project-Permit #06-009) is consistent with the approved design permit".



Stacking Diagram **1/26/2012**

RUSH UNIVERSITY MEDICAL CENTER

PERKINS +WILL

SECTION VII - SERVICE SPECIFIC REVIEW CRITERIA

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

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

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

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

Category of Service	# Existing Beds	# Proposed Beds
☒ **Medical/Surgical**	**340**	**333***
☒ **Pediatrics**	**28**	**22**
☒ **Obstetrics/Newborn Nursery**	**38**	**34**

*** Including 320 medical surgical beds and 13 hospice beds**

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

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

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

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

1110.530 d.1), d.2), and d.3)

1) *if the project involves modernization of a category of hospital bed service, the applicant shall document that the inpatient bed areas to be modernized are deteriorated or functionally obsolete and need to be replaced or modernized, due to such factors as, but no limited to:*
   A) *High cost of maintenance*
   B) *Non-compliance with licensing or life safety codes*
   C) *Changes in standards of care (e.g. private vs. multiple rooms); or*
   D) *Additional space for diagnostic or therapeutic services*
2) *Documentation shall include the most recent:*
   A) *IDPH Centers for Medicare and Medicaid Services (CMMS) inspection reports; and*
   B) *Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reports.*
3) *Other documentation shall include the following, as applicable to the factors cited in the application:*
   A) *Copies of maintenance reports*
   B) *Copies of citations for life safety code violations; and*
   C) *Other pertinent reports and data.*

Documentation of Need to Modernize Atrium 5, 7, 8, and 9 and Kellogg 6

Rush University Medical Center (Rush, Medical Center, RUMC) is an academic medical center and provides a wide range of tertiary and quaternary services. The Medical Center also provides other primary and secondary services. In January of 2008, the Medical Center received a permit to move forward with the construction of a 15-level patient tower to provide appropriate space for high acuity services; this East Tower is the centerpiece of the Medical Center's campus transformation. The new construction, now called the East Tower, includes intensive care beds, medical surgical beds, a 28-room surgery suite and attendant recovery space as well as high tech ancillaries including interventional radiology, cardiac catheterization and electrophysiology, and other advanced diagnostic imaging. The Tower also includes a replacement emergency department. In addition, the new building includes LDRs, surgical delivery and recovery room, and a replacement neonatal intensive care unit. These services resided in several existing buildings on the campus, some of which are more than 100 years old.

Rush's plan included constructing the new East Tower to house the most high tech services and then modernize the two newest buildings on the campus (Atrium, 1982 and Kellogg, 1958) for less acute services. With the completion of the modernization, all clinical services could be relocated from the oldest buildings to Atrium and Kellogg buildings and older but serviceable buildings such as Jelke and, perhaps Pavilion could be used for non clinical services still in the oldest building so that they, in turn, could be demolished.

In January 2012, Rush moved into the East Tower, except for the level housing the LDRs, the delivery surgery and PACUs, and the neonatal intensive care unit. These services will not be operational until the obstetrics unit currently in the Kellogg, Pavilion, and Jones buildings can be relocated to modernized space in the Atrium Building on the same level as the other obstetric services in the East Tower. The total obstetrical service will be located in two buildings and connected with a bridge.

With the move into the East Tower almost complete, the next step in Rush's campus redevelopment plan is the modernization of the Atrium and Kellogg buildings.

These buildings are neither deteriorated nor functionally obsolete. Rather they are structurally sound and the modernization of these buildings for selected services is completely consistent with the Master Design application.

The major facility problem is with the infrastructure in the Atrium Building. Of the total modernization project cost, almost 50 percent relates to the infrastructure improvements. The goal is to upgrade emergency power systems, low voltage wiring, lighting and security systems. The emergency power system needs to be expanded to provide additional capacity in the event of a power loss and needs to be connected to the new central energy plant for consistency and reliability of power. The low voltage wiring needs to be upgraded to the contemporary wiring standards consistent with the Tower and to have the ability to run the new nurse call, physiological monitoring, and mobile clinical devises.

The patient care areas will retain their current configurations. As part of this project, it will be possible for Rush to provide all private patients rooms with baths. The patient rooms will also undergo modest cosmetic improvement so they will be refreshed.

At the completion of the modernization project, the Atrium and Kellogg buildings with these infrastructure upgrades and very modest cosmetic improvements will be fully code compliant and comfortable for patients, families, and staff.

Attachment 20, Exhibits 1 and 2 are Statements of Condition Reports related to the Atrium and Kellogg buildings.

1110.530 (d) 4) – Occupancy

Projects involving the replacement or modernization of a category of service or hospital shall meet or exceed the occupancy standards for the categories of service, as specified in 77 Ill. Adm. Code 1100.

Medical Surgical Beds

Rush University Medical Center (Rush, Medical Center, RUMC) offers a very comprehensive range of medical surgical services. Many of these services have received national rankings as reported in 2011 *U.S. News & World Report "Best Hospital"* issue. Among these nationally ranked programs are:

- Orthopedics – The Medical Center is home to the nationally respected orthopedic physicians at Rush who are known for their research and leading edge therapies. These physicians performed the world's first minimally invasive hip surgery and pioneered many advances in hip and knee implants, including minimally invasive techniques that enable patients to return home within a day. They were among the first to implant "growth prosthesis" for children with bone cancer, which can be lengthened as the child grows and lessens the need for repeated surgeries.

  Included in this section are:

  - Cartilage Restoration Center
  - Foot and Ankle Injury Treatment
  - Hand, Elbow and Shoulder Injury Treatment
  - Healthy Hip Program
  - Joint Replacement and Surgery
  - Limb Preservation and Treatment
  - Orthopedic Trauma Treatment
  - Pediatric Orthopedics Screening and Treatment
  - The Orthopedic Cancer and Transplant Program
  - Sports Medicine and Treatment
  - The Spine and Back Center at Rush, and
  - Women's Sports Medicine.
- Neurological Care

  Rush's neurology and neurosurgery teams are at the leading edge of advances in medicine, including neurological-related minimally invasive surgical procedures, diagnostic tests and drug treatments.

These experienced physicians at Rush and the neuroscientists explore and unravel mysteries of the brain and the body's intricate assembly of nerves and muscles, helping to improve care for patients at Rush and around the world.

Included in this section are

- Chicago Sports Concussion Clinic at Rush
- Endovascular Services
- The Epilepsy Center at Rush (for adults and children)
- Multiple Sclerosis Center (the largest in the Midwest)
- Neuromuscular Clinic
- Neurosurgery (Brain and spine)
- Parkinson Disease and Movement Disorders
- Rush Alzheimer's Disease Center
- Cerebrovascular Disease and Neurocritical Care, and
- The Spine and Back Center at Rush

- Cardiology and Heart Surgery

From prevention to diagnosis to treatment, heart and vascular experts at Rush provide comprehensive care for patients with heart disease and suspected heart disease. The team of physicians at Rush includes adult and pediatric cardiologists and cardiovascular and vascular surgeons.

In addition to heart disease prevention and general cardiac care, the Heart and Vascular Program at Rush offers the following special programs:

- Outpatient Chest Pain Center
- Rush Center for Congenital and Structural Heart Disease
- Electrophysiology, Arrhythmia and Pacemaker Program
- Heart Failure, Transplant and Mechanical Circulatory Support Program
- Interventional Cardiology Program (non surgical treatment of patients with narrowed blood vessels)
- Pulmonary Hypertension Clinic
- Rush Valve Disease Clinic
- Rush Vein Specialists, and
- Rush Heart Center for Women.

Other nationally recognized programs at Rush include geriatrics, gynecology, urology, cancer, pulmonary, nephrology, and ear, nose, and throat.

Changes in Medical Surgical Authorized Beds at Rush

As part of the East Tower project, Rush decreased its authorized bed complement from 468 to 340 medical surgical beds with an expectation to further reduce the bed complement to 320 beds when the Atrium Building modernization project was filed.

The following schedule summarizes increases and decreases in medical surgical bed numbers from the initiation of the Campus Transformation at Rush through the completion of the proposed Atrium / Kellogg modernization project:

Medical Surgical Authorized Beds in 2007	468
Less Medical Surgical Beds Scheduled for Demolition	144
These beds are located in the Jones and Pavilion Buildings	
Equals Remaining Medical Surgical Beds	324
Less Medical Surgical Beds to be Modernized Includes 94 beds in the Atrium Building and 102 beds in the Kellogg Building. 222 medical surgical beds in the Atrium Building will be replaced with 128 medical surgical beds and 34 obstetric beds. One level of the Kellogg Building will be modernized for the general pediatric unit; the remaining space will be backfilled with administrative departments.	196
Equals Remaining Medical Surgical Beds To Be Modernized in the Atrium Building	128
Plus Medical Surgical Beds Being Replaced in New Construction in the East Tower	192
Equals Proposed Medical Surgical Beds	320
Plus Lease for 13 Medical Surgical Beds in the Johnson R. Bowman Health Center	13
Total Medical Surgical Beds at Completion of Campus Transformation	333

In each of the last 3 years, the Medical Center's 340 medical surgical beds operated at from 72.6 to 77.5 percent occupancy. The recent decline in occupancy is consistent with other hospitals' experience and reflects the downturn in the economy.

Attachment 20, Table 1
Occupancy of Medical Surgical Beds without Observation Days, 2008 to 2010

	2008	2009	2010
Patient Days	93,026	96,133	90,034
Average Daily Census	254.9	263.4	246.7
Authorized Beds	340	340	340
Percent Occupancy	75.0	77.5	72.6

Source: RUMC records

During this period, medical observation patients also occupied medical surgical beds. This additional volume increased the occupancy of the medical surgical beds from 77.9 to 80.9 percent occupancy.

Attachment 20, Table 2
Occupancy of Medical Surgical Beds with Observation Days, 2008 to 2010

	2008	2009	2010
Patient Days	93,026	96,133	90,034
Observation Days	3,671	4,314	5,799
Total Days	96,697	100,447	95,829
Average Daily Census	264.9	275.2	262.5
Authorized Beds	340	340	340
Percent Occupancy	77.9	80.9	77.2

Source: RUMC records.

The current medical surgical bed complement includes two-bed rooms. Often only one bed in a two-bed room is occupied because the second bed is blocked (unused) to accommodate the special needs of the patient and family. In addition, at any time a number of beds are unavailable for patients because of maintenance, especially in the "mature" Atrium, Kellogg and Pavilion buildings that have historically housed all of the medical surgical beds. Finally, census varies so the average daily census is not a true indication of peak occupancy. For example, in 2010, Rush's medical surgical average daily census was 262.5 or 77.2 percent occupancy; however, on some days peak census was 306 or 90 percent occupancy.

The 2010 average occupancy for all Illinois hospitals, according to Hospital Profiles, was 58.5 percent. Rush is operating at a substantially higher occupancy than the average of all Illinois hospitals.

Medical Surgical Facility Development

The following is a brief explanation of the process used to develop 32-bed units with private rooms in both the East Tower and in the Atrium Building. First, Rush researched and debated the merits of single vs. multi-occupancy rooms and determined that all medical surgical rooms should be private. The benefits of private rooms include:

- Improved infection control
- Reduced medication errors
- Reduced number of patient falls
- Fewer sleep disturbances
- Improved patient confidentiality and privacy
- Reduced noise
- Reduced patient stress
- Improved social support
- Improved communication between patients and clinicians
- Fewer patient transfers, and
- Ability to operate at higher occupancies.

The footprint of the East Tower required that the optimal unit configuration would be 32-bed medical surgical units. This number is divisible by four, permitting efficient staffing and is large enough to justify an oversight structure.

Early on, it was determined that the modernization of the Atrium Building would be governed by as many of the same principles as those used in the East Tower; for example, the unit sizes will be the same and all rooms will be private. To that end, Atrium 7 and 9 will each house two 32-bed units for a total of 64 beds per floor or a total of 128 beds. In order to accomplish this, each existing unit was reduced from 37 to 32 beds, mirroring the bed size of the Atrium units. However, the patient rooms will retain their current size and configuration. While the patient rooms will not change, the reduction of patient rooms per unit will permit the rooms no longer assigned to patient care to be used for support and storage space, a serious limitation of the current units.

Projected Medical Surgical Utilization

Despite the strong utilization of the medical surgical beds, the current census does not meet the State Agency's target occupancy of 88 percent for modernization.

Before finalizing modernization plans, Rush prepared projections of future medical surgical bed need.

Between 2002 and 2009, Rush experienced 22.7 percent growth in medical surgical volume. In 2010, like other hospitals in Illinois, Rush's medical surgical volume decreased, reportedly due to unfavorable economic conditions. Consequently the growth rate between 2002 and 2010 was reduced from 22.9 percent to 17.2 percent.

Attachment 20, Table 3
Historical Medical Surgical Utilization 2002 - 2010

Year	2002	2009	Percent Change 2002 to 2009	2010	Percent Change 2009 to 2010	Percent Change 2002 to 2010
Patient Days including Observation Days	81,752	100,447	22.9	95,829	-4.6	17.2

Source: RUMC records

In order to project future utilization, Rush prepared a CAGR (compound average growth rate) trend line from 2002 to 2010 and extended the trend line to 2018. All details of the projected growth are presented on Attachment 20, Exhibits 3 and 4. Had the trend line been based on the stronger growth rate through 2009, the projected need would have been greater. However, by using the 2010 trend line, Rush is assuming a more conservative growth trend.

Rush anticipates that the modernized medical surgical beds will be available in 2013. Projections to 2018 are included to show volume at project completion as well as the expected continued increase in need for medical surgical beds.

The trend line shows the need for 329 medical surgical beds in 2015, the second full year of occupancy. The initial trend line for medical surgical patient days was adjusted to account for the relocation of pediatric epilepsy patients to the pediatric unit. In 2010, pediatric epilepsy patients were cared for in adult medical surgical beds. The physicians determined that these patients should be relocated to the pediatric unit. In 2010, the pediatric epilepsy patients accounted for 336 days of care. To adjust for this relocation of patients,

336 days of care were subtracted from the medical surgical days and the same number of days was added to the pediatric days. Since there is no projection of epilepsy days, Rush is conservatively holding the number of days constant.

The projected higher occupancy of 90.3 percent is a function of continued modest growth and a decrease in the number of authorized medical surgical beds.

Attachment 20, Table 4
Projected Medical Surgical Utilization, 2010 - 2016

Year	2010	2015 Second Full Year of Operation	Percent Change 2010 to 2016
Medical Surgical Patient Days Including Observation	95,829	105,791	12.6
Adjustment for Pediatric Epilepsy Patients	-336	-336	
Adjusted Medical Surgical Days	95,493	105,455	12.6
Average Daily Census	261.6	288.9	12.6
Bed Need at 88 Percent Occupancy	298	329	+ 37
Current/Proposed Number of Beds at Project Completion	340 Actual	320 Proposed (excluding 13 leased hospice beds)	-5.9
Current and Proposed Percent Occupancy	76.9	90.3	+15.2

Source: RUMC

Rush has reviewed and believes these projections are realistic based on the following factors:

- The population of the Medical Center's service area continues to age with the greatest increase in the 45-64 and 65+ age cohorts, those that require the most per capita inpatient care.

Attachment 20, Table 5
Change in Population, 2011 to 2016

Area	Percent Change in Age Cohorts				
	< 18	18-44	45-64	65+	Total
8-County Area	1.19	-2.62	4.56	14.92	2.19
City of Chicago	-0.4	-5.79	3.92	9.77	-0.61
RUMC Primary Service Area	-1.53	-4.99	1.65	7.75	-1.36

Source: Claritas

- Rush is continually adding new programs and services consistent with its role as a quaternary medical center engaged in research. These new programs and the physicians that are being recruited to staff them will bring new patients to Rush.
- Rush continues to expand its neurotelemedicine capabilities in partnership with other hospitals in the 8-county area, ensuring the best possible care to patients in the community and the appropriate transfer of only those patients needing the most advanced interventions that Rush can offer. The new McCormick Foundation Center for Advanced Emergency Response, which includes Rush's expanded emergency department, will allow easier access for ambulances and with expanded treatment areas, is expected to bring additional medical and surgical inpatient volume to Rush.
- Rush is developing collaborative arrangements that have the potential to bring new patients to Rush. An example is the affiliation with DuPage Medical Group to provide cancer services in the western suburbs.
- The economy can be expected to improve and current high unemployment expected to decline as the economy improves. Pent-up demand will be satisfied with lower unemployment (and more employed/insured population) and an improved economy.
- The Rush campus has been under construction for several years; this has resulted in congestion that has discouraged the use of the facilities. With the completion of the construction of the Midwest Orthopedics Building, the East Tower, and the modernization of Atrium and Kellogg buildings, and improved access to the buildings as well as enhanced signage and improved parking, the campus will be easier to navigate for patients and some many return to Rush.
- With the implementation of National Health Reform in 2014, primary service area residents who do not seek care because they lack health insurance may look to Rush for care; today 4.4 percent of the primary service area residents are uninsured.

Hospice

After conducting an assessment of the need for hospice services, Rush determined that an inpatient hospice program would meet a compelling community need. To meet this need, Rush will contract with Horizon Hospice & Palliative Care to lease space in which Horizon will operate 13 hospice beds. In order for Rush to lease these beds to Horizon, IDPH requires that the hospice beds be housed in either authorized medical surgical or long-term care beds. Since Rush discontinued its long-term care category of service and since there are still 340 authorized beds in the medical surgical bed

complement, the leased beds will be included in medical surgical bed count. The leased hospice unit will be located in space in the Johnson R. Bowman Heath Center. The space was formerly used for long-term care; however, it meets code for medical surgical occupancy. A copy of the lease is included as Appendix B. A copy of the cover sheet of the lease is included at Attachment 20, Exhibit 5.

Summary

As part of the proposed project, Rush will modernize Levels 7 and 9 of the Atrium Building; each level will have two-32 bed units for a total of 128 medical surgical beds. The beds will all be located in private rooms. Rush used a very conservative trend line projection to determine future medical surgical bed need. This conservative projection suggested that Rush would need as many as 329 medical surgical beds by 2015, the expected second full year of occupancy of these beds. To be conservative, Rush is requesting only 320 medical surgical beds at the completion of the project. This proposed bed complement is consistent with State Agency rules as well as the Master Design and East Tower CON permits. The proposed 320 medical surgical beds are projected to achieve 90.3 percent occupancy by 2015, the second full year of occupancy. This will exceed the State Agency's target of 88.0 percent occupancy of modernized or replaced medical surgical beds.

90.3 percent occupancy > 88 percent State target occupancy

Rush will lease space for 13 hospice beds in a building on the campus that is remote from the East Tower and the Atrium Building where the 320 medical surgical beds will be located. Rush did not anticipate the need for hospice beds at the time that the Master Design and East Tower permits were granted by the Illinois Health Facilities Planning Board. The hospice beds will bring the total number of medical surgical beds at the Medical Center to 333.

1110.530 (d) 4) – Occupancy

Projects involving the replacement or modernization of a category of service or hospital shall meet or exceed the occupancy standards for the categories of service, as specified in 77 Ill. Adm. Code 1100.

Pediatric Beds

Rush Children's Hospital, located on the Rush University Medical Center (Rush, Medical Center, RUMC) campus is a regional referral center for children and a leader in caring for children of all ages, from newborns to young adults.

Rush physicians from more than 30 specialties address the full range of pediatric diseases and congenital problems, from the common to the complex. With expertise that earned a state designation as an official children's hospital, Rush physicians, pediatric surgeons, nurses and other health professionals provide care that aims to fulfill community needs, empower parents, and advance medical science.

Each of the following programs at Rush Children's Hospital emphasizes comprehensive, multidisciplinary care for children.

- Congenital and Structural Heart Disease
- The Rush Cystic Fibrosis Center
- The Rush Eating Disorders Program
- Fetal and Neonatal Medicine Center (fetal anomalies and birth defects)
- Genetic Disorder Diagnosis and Care
- Pediatric Cancer and Blood Disorders (including hemophilia, thrombophilia, and hemostasis)
- Pediatric Cardiovascular Services
- Pediatric Endocrinology and Metabolism
- Pediatric Gastroenterology
- Pediatric Infectious Disease
- Pediatric Intensive and Critical Care Center
- Pediatric Nephrology
- Pediatric Neurology (muscular dystrophy, movement disorders, and epilepsy)
- Pediatric Psychology
- Pediatric Pulmonology
- Pediatric Surgery Procedures and Treatment, and
- Teen and Young Adult Family Center.

In addition Rush offers services to help patients and families cope with the challenges of illness. These include Child Life Services, which cater to the emotional and developmental well-being of hospitalized children and their families.

Pediatric Facility Development at Rush

The 28-bed general pediatric unit at Rush is currently located in the Pavilion Building which is no longer suitable to use for clinical services; it may be retained, however, for non clinical services at the completion of the Rush Campus Transformation.

As part of this project, Rush proposes to relocate pediatric general beds from the Pavilion Building to Level 6 of the Kellogg Building which currently is occupied by some of the obstetrical services. This location will be in close proximity to the pediatric intensive care beds which are on Level 5 of the Kellogg Building.

As with the medical surgical floors in the Atrium Building, the majority of the spaces on the pediatric floor in the Kellogg Building will remain unchanged. The modernized pediatric rooms will retain their current size and configuration, but will receive cosmetic improvements.

At the time that the East Tower application was filed, Rush had 70 pediatric beds. In April 22, 2009, the Planning Board reduced the number of general pediatric beds at Rush by 42 beds, leaving the Medical Center with 28 authorized pediatric beds.

Between 2008 and 2010, pediatric utilization at Rush compared very favorably to pediatric utilization at all hospitals in Illinois. While Rush' pediatric admissions decreased only 1.4 percent, pediatric admissions statewide decreased 10.5 percent. Similarly, Rush's pediatric patient days increased 2.3 percent while pediatric patient days statewide decreased 7.6 percent.

Attachment 20, Table 6
Comparison of RUMC and Illinois Pediatric Utilization

	2008	2009	2010	Percent Change 2008 - 2010
Illinois Hospitals				
Admissions	58,056	56,042	51,975	-10.5
Days	227,628	222,578	210,244	-7.6
Rush				
Admissions	1,084	1,171	1,069	-1.4
Days	5,190	5,575	5,307	+2.3

Source: Hospital Profiles 2008, 2009, and 2010; RUMC records

In part, this decline in pediatric utilization reflects the decline in births. Declining births have an immediate impact on pediatric utilization. According to experience at the Medical Center, approximately 46 percent of pediatric admissions are for children age 3 or under. See also Attachment 20, Obstetrics.

Projected Pediatric Utilization

Once the determination was made to relocate the general pediatric unit to the Kellogg Building, Rush prepared projections of future pediatric bed need. The projections are based on a CAGR (compound average growth rate) trend line from 2002 to 2010.

Rush's pediatric patient days decreased by 13.1 percent between 2002 and 2009, and decreased by 17.4 percent between 2002 and 2010. Consequently, the trend line shows a substantially larger decline using the 2010 data.

Attachment 20, Table 7
Historical and Projected Pediatric Volume Using a CAGR Trend Line Analysis

Year	2002	2009	Percent Change 2002 to 2009	2010	Percent Change 2009 to 2010	Percent Change 2002 to 2010
Patient Days including Observation Days	6,419	5,575	-13.1	5,307	-4.9	-17.4
Average Daily Census	17.6	15.3	-2.3	14.5	-0.8	-17.6
Authorized Beds	70	41*	-41.4	28	-31.7	-60.0
Percent Occupancy	20.3	37.3	17.0	51.8	14.5	31.5

Source: RUMC records.
Note: Pediatric patient days exclude neonatal and newborn days.
Note: Pediatric patient days for 2002 were revised from 4,236 to 6,419 as part of a Declaratory Ruling approved on June 12, 2007 by the Illinois Health Facilities Planning Board.
*Weighted average

Rush expects the relocated, remodeled pediatric beds to be open in 2014.

Using this steeper decline, albeit a more conservative projection, suggests that Rush would have 4,601 pediatric patient days in 2016, the second full year of utilization.

Attachment 20, Exhibit 6 shows the historical utilization of Rush's pediatric unit. Attachment 20, Exhibit 7 shows the projected utilization

Net Additions to the Pediatric Trend Line Projection

To further refine the pediatric utilization projections, Rush considered several factors that will influence future utilization of the pediatric beds. These include:

1. Relocation of Pediatric Epilepsy Patients

   At the present time, pediatric epilepsy patients are cared for in adult medical surgical beds. Rush physicians have determined that the care of these patients should be relocated to the general pediatric unit. Rush recorded 336 patient days for pediatric epilepsy patients in fiscal year 2010. Rush adjusted for this relocation of patients by adding 336 patient days to future pediatric utilization and subtracting 336 patient days from future adult medical surgical utilization.

2. Addition of Pediatric General Surgeons

   Rush recently added two pediatric general surgeons to the medical staff. They are replacing two pediatric general surgeons no longer on the staff. Since the physicians who left the staff were not full time, Rush assumed that the incremental difference between the new surgeons and those no longer on the staff is 0.2 FTE. In Rush's experience, a pediatric surgeon accounts for 300 patient days per year; two surgeons would account for 600 days per year. Based on the average, Rush has assumed that the new surgeons will report 120 incremental additional days by 2016, the second full year of utilization of the modernized unit, as the practices of the new physicians increase.

   600 days per year x 0.2 incremental new general surgeons = 120 days per year

3. Addition of Pediatric Cardiology/Transplant Physician

   In 2011, a pediatric cardiology/transplant physician joined the medical staff and began practicing at Rush in December 2011. Rush is conservatively projecting that this cardiology/transplant surgeon will report 28 admissions and 280 patient days by 2016, as his programs mature.

   28 admissions x 10 ALOS = 280 patient days

   Attachment 20, Exhibit 8 is a letter confirming that the general surgeons and the pediatric cardiology/transplant physicians are members of Rush's medical staff.

4. Implications of the Newly Opened, Expanded Emergency Department

The McCormick Foundation Center for Advanced Emergency Response, which includes Rush's expanded emergency department, opened in January 2012. The Emergency Department is part of the East Tower project. There is a separate waiting area for children and family members in the new Emergency Department.

Rush has assumed that pediatric admissions through the Emergency Department will increase. While some of this increase will include walk-in patients, the majority of the increase will include pediatric patients that arrive by ambulance. Today only 7 percent of Rush's Emergency Department visits arrive by ambulance. In contrast, according to the National Center for Health Statistics, nationally about 15 percent of emergency patients arrive by ambulance. Rush believes that this disparity exists because ambulance access to the old Emergency Department was very poor. There was only room for one ambulance and that ambulance had to back into the ambulance bay. The current Emergency Department has multiple bays in a large enclosed garage that allows up to five ambulances to drive in one side, park in an ambulance bay, move the patient into the facility, and depart from the other side of the garage.

In 2011, 491 pediatric patients were admitted through the Medical Center's Emergency Department. Rush has assumed that pediatric admissions through the Emergency Department will increase 5 percent in 2012 and 3 percent each year thereafter. The average length of stay of pediatric patients admitted through the Emergency Department patients is 3.4 days. Rush expects that pediatric volume through the Emergency Department will increase to 303 days by 2016, the expected second year of occupancy.

Attachment 20, Table 8
Summary of Pediatric Patient Days
Increase through the Emergency Department

	2011	2012	2013	2014	2015	2016	2017	2018
Pediatric Admissions from the Emergency Department	491	516	531	547	563	580	598	616
Incremental Admission from the Emergency Department		25	40	56	72	89	107	125
Incremental Days at 3.4 Average Length of Stay		85	136	190	246	303	364	425

Source: Rush Business Development

5. Improved Economy

As the economy improves, it is likely that birthrates will also improve. Based on improved birthrates and (as noted above), the relationship between birthrate and pediatric volume, Rush assumed that as the result of market recovery the pediatric department will experience 15 additional pediatric admissions at the current overall pediatric length of stay of 4.0 days, or 60 addition pediatric patient days by 2016.

15 additional pediatric admissions x 4.0 ALOS = 60 additional pediatric patient days in 2016

6. Health Reform Coverage Expansion

The pent-up demand of pediatric patients newly covered by Medicaid is expected to increase volume in the pediatric practices. Rush has assumed that expanded insurance coverage will result in 30 additional pediatric admissions at the current pediatric length of stay of 4.0 days or 120 additional pediatric patient days by 2016.

30 additional pediatric admissions x 4.0 ALOS = 120 additional pediatric patient days in 2016

The following table is a summary of total projected utilization of Rush's pediatric unit in 2016, the second full year of operation.

Attachment 20, Table 9
Summary of Projected and Net Additional Pediatric Patient Days, 2016

Justification of Pediatric Patient Days	2016 Patient Days
CAGR Projection	4,601
Relocation of Pediatric Epilepsy Patients	336
Recruitment of New General Surgeons	120
Recruitment of Pediatric, Cardiology/Transplant Surgeons	280
ED Visit and Ambulance Growth	303
Economy and Birth Rate Improvement	60
Health Reform Coverage Expansion	120
Total	5,820

Source: RUMC and Business Development

The proposed total 2016 projected pediatric patient days justifies the need for 25 pediatric beds.

5,820 patient days ÷ 365 days = 15.9 average daily census

15.9 average daily census ÷ 65 percent State Agency target occupancy = 25 justified beds

Because of space constraints in the Kellogg Building, only 22 pediatric beds will be modernized. Rush believes that these 22 beds will operate at 72.3 percent occupancy by 2016.

15.9 average daily census ÷ 22 beds = 72.3 percent occupancy

Summary

Rush Children's Hospital (Hospital) is a regional referral center for children and a leader in caring for children of all ages. Physicians from more than 30 specialties address a full range of pediatric diseases and congenital problems.

As part of this project, Rush proposes to move the general pediatric unit from the Pavilion Building to the Kellogg Building where it will be in close proximity to the pediatric intensive care unit. The new unit will have single rooms with bathrooms as well as greatly enhanced privacy and infection control for patients and families.

As part of this relocation, the bed complement will be reduced from 28 to 22 beds.

Rush is conservatively projecting that pediatric patient days will increase by 17.2 percent between 2010 and 2016, the second full year of operation.

5,820(2016 patient days) ÷ 4,966 (2010 patient days) = 1.172 = 17.2 percent.

At the conclusion of the project, Rush will have 22 general pediatric beds. These 22 beds are projected to operate at 72.5 percent occupancy in 2016 or to exceed the State Agency's target of 65 percent for modernized or replaced pediatric beds.

72.5 percent occupancy > State Agency target occupancy of 65 percent

1110.530 (d) 4) – Occupancy

Projects involving the replacement or modernization of a category of service or hospital shall meet or exceed the occupancy standards for the categories of service, as specified in 77 Ill. Adm. Code 1100.

Obstetrical Beds

The Department of Obstetrics and Gynecology at Rush University Medical Center (Rush, Medical Center, RUMC) is dedicated to delivering the highest quality medical care to women of all ages. An important service of the department relates to the care of normal and high risk mothers and their babies.

Rush offers a full range of services that help parents-to-be prepare for the birth of a new baby; these courses include childbirth education, CPR for infants and children, breastfeeding, cesarean birth, and multiple births.

At Rush, the obstetrical service is known as the New Life Family Center.

The physicians at Rush deliver approximately 2,250 babies each year in the New Life Family Center. Of these, more than 300 are high risk maternal transports from hospitals that are within the Rush Perinatal Network as well as from hospitals in the Northwestern Illinois Region and beyond. When these maternal transports as well as Rush physicians' high risk maternal patients arrive at Rush, they may go directly to an LDR or a delivery operating room. Or, they may be admitted to antepartum beds on the obstetrics unit where both mother and fetus are monitored until the time of birth – this may be several hours or even days from the day of admission. High risk infants are immediately admitted to the neonatal intensive care unit in the East Tower. Rush's neonatologists provide comprehensive care for critically ill newborn infants. Normal mothers and their infants are admitted to postpartum beds that are also part of the obstetrics unit after mothers have delivered. Both antepartum beds and postpartum beds are included in a single obstetrical unit and are flexed depending on the mix of high risk and normal patients.

The Rush team is committed to a family-centered birthing experience for each patient. At Rush, the caregivers believe that the first hours and days a mother spends with her baby allow bonding time and create memories. All obstetrics rooms will be equipped for rooming in – where the mother will have the baby with her throughout her stay, promoting bonding while she receives education and care by staff members specially trained in obstetrical care.

On April 22, 2009, the Planning Board reduced the number of obstetrical beds at Rush by 6 beds, leaving the Medical Center with 38 obstetrics beds. Between 2007 and 2009, the utilization of the 38-bed obstetrical unit overall increased modestly; however there was a slight dip in utilization between 2009 and 2010. This growth occurred at a time when births in Illinois declined 5.2 percent.

Attachment 20, Table 10

Births (All Ages) at RUMC an in Illinois, 2007 to 2010

	CY 2007	CY 2008	CY 2009	Percent Change 2007-2009	CY 2010
RUMC	2,306	2,061	2,340	+ 1.5	2,269
Illinois Hospitals	180,530	176,634	171,077	-5.2	NA

Sources: RUMC records and IDPH, Health Statistics

Rush's stronger utilization trend than that reported by all Illinois hospitals reflects the high proportion of older (and typically high risk mothers) that are cared for at Rush. According to national statistics published by the Advisory Board, the birth rate of younger women declined substantially while that of women in the older childbearing age groups was almost stable or increased.

Attachment 20, Table 11
Difference in Birth Rates, 2008-2009
(Birth Rates per 1,000 Women in Age Categories)

Age Group	Change in Birth Rate
15-19	-6%
20-24	-7%
25-29	-4%
30-34	-2%
35-39	-1%
40-44	+3%
All Ages	-3%

Source: The Advisory Board, 2011

The Advisory Board suggests that the younger women are postponing pregnancy because of the current economic situation. As the economy improves, the birth rate is likely to increase and, because of their postponing pregnancy, more of the mothers-to-be will be in the older, higher risk childbearing age groups that will need the advanced obstetrical services at Rush.

Obstetrical Facility Development at Rush

As part of the East Tower construction project, several key components of the Rush obstetric-related facilities were developed on Level 8 of the Tower; these include 10 new LDR (labor-delivery-recovery) rooms, 3 delivery surgical operating rooms, and 6 Phase I recovery stations. A new 72-bed neonatal unit was developed adjacent to the surgical delivery rooms and the LDRs. This adjacency of the neonatal unit to the labor and delivery functions is necessary to minimize the time needed to transfer a high risk infant from the delivery area to the neonatal unit. This grouping of functions is clinically appropriate and operationally efficient.

Today, Rush's obstetrics beds are located in the Kellogg, Pavilion and Jones buildings. As part of the Atrium modernization project, Rush is proposing to redevelop its obstetrics unit (antepartum and postpartum) on Level 8 of the Atrium Building. At the completion of the Atrium modernization project, the obstetrics unit for both normal and high risk mothers, the normal newborn nursery, and antepartum testing in the Atrium Building, as well as the LDRs, surgical delivery suite, and the neonatal unit in the East Tower will be on the same level and connected with a bridge.

As with the modernized medical surgical floors, the majority of the obstetrics floor will remain unchanged. The patient rooms (formerly medical surgical rooms) will retain their current size and configuration but will receive cosmetic improvements and reclining chairs.

In addition to these modest improvements, a communicating door will be added to the foot walls of 14 mirrored pairs of obstetrics rooms. This door will allow one room to be used by the patient while the other adjoining room is used as a "family room" or sleeping area for families.

The modernized unit will have 34 private patient rooms. Of these, 20 will be single rooms and 14 will have a family area.

Rush currently has 38 authorized obstetrics beds. In each of the last 3 years, the Medical Center's obstetric beds operated at from 53.4 to 65.3 percent occupancy or somewhat below the State Agency target of 78 percent for units with 26 or more beds.

Attachment 20, Table 12
Utilization of Obstetric Beds, 2008 to 2010

	2008	2009	2010
Patient Days	8,483	9,016	8,822
Observation Days	103	110	242
Total Days	8,586	9,126	9,064
Average Daily Census	23.5	25.0	24.8
Authorized Beds	44	40 [1]	38
Percent Occupancy	53.4	62.5	65.3

Source: RUMC records
1. Weighted average

Projected Obstetrical Utilization

Before finalizing modernization plans, Rush prepared projections of future obstetrics bed need. The projections are based on a CAGR (compound average growth rate) trend line from 2002 to 2010.

Attachment 20, Exhibit 9 shows the historical utilization of Rush's obstetrical unit. Attachment 20, Exhibit 10 shows the CAGR trend line to 2018.

Rush anticipates that the modernized obstetrical beds will be available in 2013. The trend line projection shows that by 2015, the second full year of operation of the Atrium Building, Rush could expect 9,418 obstetric patient days or enough to support 34 beds. Projections to 2018 are included to show volume at project completion and as the expected continued increase in the need for obstetrical beds.

2015

9,418 patient days ÷365 days per year = 25.8 average daily census

25.8 average daily census ÷ State Agency target occupancy of 76 percent = 34 beds

Based on the CAGR trend line, obstetrical volume and related occupancy are expected to increase through 2018. Other factors are that will increase volume include successful physician recruitment that is underway, a higher proportion of high risk patients, pent-up demand as the result of the economic downturn and an increasing birthrate.

Rush is conservatively requesting 34 obstetrics beds.

Rush did not make an adjustment for the decline population of women of childbearing age, Attachment 20, Exhibit 11. The decline in total childbearing population is expected to be offset by the increasing proportion of older, high risk mothers who require the advanced prenatal and neonatal services provided at Rush.

Summary

As part of the Atrium project, Rush will modernize Level 8 of the Atrium building for obstetrics beds – both antepartum and postpartum. The vacated medical surgical rooms on Level 8 will retain their current size and configuration but will receive cosmetic improvements and reclining chairs. At the conclusion of the project, Rush can justify 34 obstetrics beds by the second full year of utilization. Volume is expected to continue to increase in succeeding years.

The number of future obstetric beds was not defined in the East Tower and Master Design Certificates of Need. However, obstetrics was a service to be considered for a bed reduction.

1110.530, d.4)

Newborn Nursery Bassinets

Illinois Hospital licensure requirements state that there "must be a number of bassinets at least equal to the number of postpartum beds and that when a rooming-in program is used, the total number of bassinets provided in these units may be appropriately reduced, but the full-term nursery may not be omitted (Section 250.1850 c) 1)). Licensure also requires that "Bassinets equipped to provide for the medical examination of the newborn infant and for the storage of necessary supplies and equipment shall be provided in a number to exceed obstetric beds by at least 20 percent to accommodate multiple births, extended stay, and fluctuating patient loads (Section 250 250.1830 e) 1) B)).

To meet these licensure requirements, Rush will have 34 rooming in bassinets and a 7-bassinet full term nursery. This is a total of 41 bassinets and meets licensure's 20 percent requirement.

34 rooming in bassinets x 1.20 = 41 total required bassinets

34 rooming in bassinets + 7 normal nursery bassinets = 41 total required bassinets

The full-term nursery at Rush will be available for those times when a mother needs additional rest, for infant examinations by the pediatrician, as well as for minor procedures and treatments.

The number of future full-term nursery bassinets was not defined in either the Master Design or the East Tower CON applications.

Summary

As part of the Atrium Modernization project, Rush proposes to develop a 7-bassinet full-term nursery on Level 8 of the Atrium Building in close proximity to the obstetrical beds. These 7 bassinets will be in addition to the 34 rooming-in bassinets. At the conclusion of the project, Rush will have enough bassinets to meet licensure requirements, to support normal newborns, accommodate multiple births, respite times for new mothers, and infants that must stay longer than their mothers. The projected number of newborn nursery beds meets Illinois licensure requirements; there will be a full term (normal) nursery and the number of proposed bassinets is equal to 120 percent of the proposed obstetrics beds.

1110.530 f) Performance Requirements

Rush University Medical Center is located in a Metropolitan Statistical Area

1) Medical Surgical

The minimum bed capacity for a medical surgical category of service within a Metropolitan Statistical Area (MSA) is 100 beds.

Rush is proposing to have 333 medical surgical beds (320 medical surgical beds and 13 beds leased to Horizon Hospice & Palliative Care) at the completion of this project; 320 medical surgical beds exceeds the State Agency's minimum bed capacity for a medical surgical category of service.

320 proposed medical surgical beds > State Agency's minimum capacity of 100 beds

2) Obstetrics

A) The minimum unit size for a new obstetric unit within an MSA is 20 beds.

B) The minimum unit size for a new obstetric unit outside an MSA is 4 beds.

Rush is not proposing to establish an obstetric unit. The Medical Center currently provides obstetrical services. Even so, the proposed obstetric unit at Rush will exceed the minimum size guideline.

34 proposed obstetrical beds > State Agency's minimum capacity of 20 beds

3) Intensive Care

The minimum unit size for an intensive care unit is 4 beds.

Rush will not modernize any intensive care beds as part of this project.

4) Pediatrics

The minimum size for a pediatric unit within an MSA is 4 beds.

Rush is proposing to have 22 pediatric beds at the completion of this project and will exceed the State Agency's minimum bed capacity for pediatric beds.

22 proposed pediatric beds > State Agency's minimum capacity of 4 beds

1110.530 g) Assurances

The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the understanding that, by the second year of operation after project completion, the applicant shall achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the project.

The required assurance letter is included as Attachment 20, Exhibit 12.

Atrium Statement of Conditions (SOC) Deficiencies

Building	Floor	Room No.	Location	ID	Specific Description	Corrective Action	Funds Source	Projected Comp. Date
ATRIUM	0B	AB25-0056	STORAGE	541		PROVIDE DOOR WITH DOOR CLOSER	CAPITAL	6/30/2012
ATRIUM	0B	AB25-0000CG	CORRIDOR	543	SIDEWALL SPRINKLER OBSTRUCTED	RE-INSTALL AUTOMATIC SPRINKLER IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012
ATRIUM	0B	AB25-0060A	GIFT SHOP STOR	545		PROVIDE DOOR WITH DOOR CLOSER	CAPITAL	6/30/2012
ATRIUM	0B	AB25-0064A	FIRE PUMP RM	548		PROVIDE SPRINKLERS INSTALLED IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012
ATRIUM	0B	AB25-0064BA	VAULT	552	NO SPRINKLER PROTECTION	PROVIDE AUTOMATIC SPRINKLER(S) INSTALLED IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012
ATRIUM	0B	AB25-0064B	UTILITY/ MECH RM	553	INACTIVE LEAF	PROVIDE POSITIVE LATCHING HARDWARE FOR THE DOOR	CAPITAL	6/30/2012

Building	Floor	Room No.	Location	ID	Specific Description	Corrective Action	Funds Source	Projected Comp. Date
ATRIUM	0B	AB25-0000EP	ELEVATOR	555	(2) FLOOR ACCESS DOORS	REPLACE FLOOR ACCESS DOORS WITH 1.5-HOUR RATED FLOOR ACCESS DOORS AND RATED DOOR FRAME	CAPITAL	6/30/2012
ATRIUM	0B	AB25-0090	FOOD FC SVC	560	NO SMOKE DETECTORS ON EITHER SIDE TO RELEASE DOORS	PROVIDE SMOKE DETECTOR ON EACH SIDE OF DOORS TIED TO THE EXISTING MAGNETIC HOLD-OPEN DEVICES AND THE FIRE ALARM SYSTEM SO DOORS ARE AUTO-CLOSING	CAPITAL	6/30/2012
ATRIUM	0B	AB25-0082E	ELEC/ TEL CLOSET	567		PROVIDE DOOR WITH DOOR CLOSER	CAPITAL	6/30/2012
ATRIUM	0B	AB25-0091W	INCOMING WATER SUPPLY	569		PROVIDE DOOR WITH DOOR CLOSER	CAPITAL	6/30/2012
ATRIUM	GR	AB25-000SK	STAIRWAY	594	OPEN PIPE SHAFT	EXTEND PIPE CHASE SEPARATION WALL CONSTRUCTION TO THE FLOOR DECK	CAPITAL	6/30/2012
ATRIUM	2	AB25-202	ELEV. MACHINE RM	609	DUCT, NO DAMPER	PROVIDE 1.5-HOUR RATED FIRE DAMPER LOCATED IN THE PLANE OF THE RATED WALL	CAPITAL	6/30/2012

Building	Floor	Room No.	Location	ID	Specific Description	Corrective Action	Funds Source	Projected Comp. Date
ATRIUM	2	AB25-208	MECHANICAL AREA	611	NO SMOKE DETECTOR AT FIRE ALARM PANEL	PROVIDE SMOKE DETECTOR TIED TO THE FIRE ALARM SYSTEM	CAPITAL	6/30/2012
ATRIUM	2	----	SHAFT	615	(2) INSULATED PIPES	PROPERLY FIRESTOP WALL PENETRATIONS	CAPITAL	6/30/2012
ATRIUM	3	AB25-300SE	STAIR	619	4 HR WALL HAS A 1-1/2 HOUR ACCESS PANEL	PROVIDE NEW ACCESS PANEL WITH CORRECT RATING	CAPITAL	6/30/2012
ATRIUM	4	AB25-466J	CLOSET	622	NO SPRINKLER PROTECTION	PROVIDE AUTOMATIC SPRINKLER(S) INSTALLED IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012
ATRIUM	5	AB25-576S	OPERATING RM	655	NON-RATED DOORS	REPLACE DOORS WITH 1.5-HOUR RATED DOORS AND RATED DOOR FRAME	CAPITAL	6/30/2012
ATRIUM	5	AB25-562S	PVT CIRCULATION	657	NO DOORS	PROVIDE1.5-HOUR RATED DOORS AND RATED DOOR FRAME	CAPITAL	6/30/2012
ATRIUM	5	AB25-562S	PVT CIRCULATION	658	NO DOORS	PROVIDE DOORS WITH DOOR CLOSERS	CAPITAL	6/30/2012
ATRIUM	5	AB25-504ST	ELEC/ TEL CLOSET	687	NO SPRINKLER PROTECTION	PROVIDE AUTOMATIC SPRINKLER(S) INSTALLED IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012
ATRIUM	5	AB25-500CW	PVT CIRCULATION	688	NO LABELS ON PAIR OF DOORS	REPLACE (2) DOORS WITH 1.5-HOUR RATED DOORS	CAPITAL	6/30/2012
ATRIUM	7	AB25-700Z	SHAFT	700	HOLE	PROPERLY PATCH WALL PENETRATION	CAPITAL	6/30/2012

Building	Floor	Room No.	Location	ID	Specific Description	Corrective Action	Funds Source	Projected Comp. Date
ATRIUM	7	AB25-700CD	CORRIDOR	708	SPRINKLER 9` OFF WALL	RELOCATE EXISTING OR PROVIDE ADDITIONAL AUTOMATIC SPRINKLER(S) INSTALLED IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012
ATRIUM	7	AB25-705N	CONFERENCE RM	712	SMOKE DETECTOR 12` AWAY FROM DOOR	PROVIDE SMOKE DETECTOR, WITHIN 5 FEET OF DOOR, TIED TO THE EXISTING MAGNETIC HOLD-OPEN DEVICE AND THE FIRE ALARM SYSTEM SO DOOR IS AUTO-CLOSING	CAPITAL	6/30/2012
ATRIUM	7	AB25-700CF	CORRIDOR	713	SPRINKLER 9` OFF WALL	RELOCATE EXISTING OR PROVIDE ADDITIONAL AUTOMATIC SPRINKLER(S) INSTALLED IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012
ATRIUM	7	AB25-700CA	CORRIDOR	715	SPRINKLER 9` OFF WALL	RELOCATE EXISTING OR PROVIDE ADDITIONAL AUTOMATIC SPRINKLER(S) INSTALLED IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012
ATRIUM	7	----	SHAFT	716	DUCT, NO DAMPER	PROVIDE 1.5-HOUR RATED FIRE DAMPER LOCATED IN THE PLANE OF THE RATED WALL	CAPITAL	6/30/2012
ATRIUM	7	AB25-761SH	ELEC/ TEL CLOSET	717	NO SPRINKLER PROTECTION	PROVIDE AUTOMATIC SPRINKLER(S) INSTALLED IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012

Building	Floor	Room No.	Location	ID	Specific Description	Corrective Action	Funds Source	Projected Comp. Date
ATRIUM	7	AB25-762SH	ELEC/ TEL CLOSET	721	NO SPRINKLER PROTECTION	PROVIDE AUTOMATIC SPRINKLER(S) INSTALLED IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012
ATRIUM	7	AB25-761ST	ELEC/ TEL CLOSET	722	SPRINKLER 20` FROM DECK	RELOCATE EXISTING AUTOMATIC SPRINKLER(S) INSTALLED IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012
ATRIUM	7	AB25-700CD	CORRIDOR	723	SPRINKLER 9` OFF WALL	RELOCATE EXISTING OR PROVIDE ADDITIONAL AUTOMATIC SPRINKLER(S) INSTALLED IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012
ATRIUM	8	AB25-800CD	CORRIDOR	731	SPRINKLER 9` OFF WALL	RELOCATE EXISTING OR PROVIDE ADDITIONAL AUTOMATIC SPRINKLER(S) INSTALLED IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012
ATRIUM	8	AB25-800Z	SHAFT	743	DUCT, NO DAMPER	PROVIDE 1.5-HOUR RATED FIRE DAMPER LOCATED IN THE PLANE OF THE RATED WALL	CAPITAL	6/30/2012
ATRIUM	8	AB25-800CD	CORRIDOR	752	SPRINKLER 8`-5" OFF WALL	RELOCATE EXISTING OR PROVIDE ADDITIONAL AUTOMATIC SPRINKLER(S) INSTALLED IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012
ATRIUM	9	AB25-900SB	STAIRWAY	754	NO LABEL	REPLACE DOOR WITH 1.5-HOUR RATED DOOR	CAPITAL	6/30/2012

Building	Floor	Room No.	Location	ID	Specific Description	Corrective Action	Funds Source	Projected Comp. Date
ATRIUM	9	AB25-901N	WAITING	761		PROVIDE 1.5-HOUR RATED FIRE DAMPER LOCATED IN THE PLANE OF THE RATED WALL	CAPITAL	6/30/2012
ATRIUM	9	AB25-900CF	CORRIDOR	765	SPRINKLER 8' - 6" OFF WALL	RELOCATE EXISTING OR PROVIDE ADDITIONAL AUTOMATIC SPRINKLER(S) INSTALLED IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012
ATRIUM	9	AB25-961ST	ELEC/ TEL CLOSET	767	NO SPRINKLER PROTECTION	PROVIDE AUTOMATIC SPRINKLER(S) INSTALLED IN ACCORDANCE WITH NFPA 13	CAPITAL	6/30/2012
ATRIUM	5	514NA	ANTE ROOM	1129	PATIENT ROOM 514N ANTE-ROOM - CORRIDOR DOOR GAP > 1/8"	MODIFY OR REPLACE DOOR TO CORRECT DOOR GAP > 1/8"	CAPITAL	6/30/2012
ATRIUM	5	515NA	ANTE ROOM	1130	PATIENT ROOM 515N ANTE-ROOM - CORRIDOR DOOR GAP > 1/8"	MODIFY OR REPLACE DOOR TO CORRECT DOOR GAP > 1/8"	CAPITAL	6/30/2012
ATRIUM	8	AB-810S	CLEAN UTILITY	1134	CLEAN UTILITY 810S CORRIDOR DOOR UNDERCUT IS > 1"	MODIFY OR REPLACE DOOR TO CORRECT UNDERCUT	CAPITAL	6/30/2012
ATRIUM	5	548N	ON-CALL	1131	ON-CALL 548N - CLOSETS LACK SPRINKLER PROTECTION	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013

Building	Floor	Room No.	Location	ID	Specific Description	Corrective Action	Funds Source	Projected Comp. Date
ATRIUM	5	547N	ON-CALL	1132	ON-CALL 547N - CLOSETS LACK SPRINKLER PROTECTION	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	5	527S	STORAGE ROOM	1133	ORTHO STOREROOM CLOSET LACKS SPRINKLER PROTECTION	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	8	AB-811S	ON-CALL RM	1135	CLOSET IN ON-CALL 811S IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	9	AB-908S	CLEAN UTILITY	1204	CLEAN UTILITY 908S HAS DOOR UNDERCUT > 1 INCH	MODIFY OR REPLACE DOOR TO CORRECT UNDERCUT	CAPITAL	6/30/2013
ATRIUM	9	----	CORR.	1205	ALCOVE ACROSS FROM 948N IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	9	----	CORR.	1206	ALCOVE ADJACENT TO JANITORS CLOSET 961NJ IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	9	----	CORR.	1207	ALCOVE ADJACENT TO JANITORS CLOSET 961SJ IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013

Building	Floor	Room No.	Location	ID	Specific Description	Corrective Action	Funds Source	Projected Comp. Date
ATRIUM	9	AB-900CD	CORRIDOR	1208	ALCOVE ACROSS FROM 948S IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	8	---	CORR.	1209	ALCOVE ACROSS FROM 859S IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	8	---	CORR.	1210	ALCOVE ACROSS FROM 859N IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	8	AB-800CF	CORRIDOR	1211	ALCOVE ACROSS FROM 848N IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	8	AB-829S	ON-CALL RM	1212	ON-CALL ROOM 829S CLOSET IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	8	AB-800CD	CORRIDOR	1213	ALCOVE ACROSS FROM 848S IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	7	AB-729S	ON-CALL RM	1216	ON-CALL ROOM 729S DOOR UNDERCUT > 1 INCH	MODIFY OR REPLACE DOOR TO CORRECT UNDERCUT	CAPITAL	6/30/2013
ATRIUM	7	AB-708S	CLEAN UTILITY	1217	CLEAN UTILITY 708S DOOR UNDERCUT > 3/4 INCH	MODIFY OR REPLACE DOOR TO CORRECT UNDERCUT	CAPITAL	6/30/2013

Building	Floor	Room No.	Location	ID	Specific Description	Corrective Action	Funds Source	Projected Comp. Date
ATRIUM	7	----	CORR.	1219	STORAGE ALCOVE ACROSS FROM 759S IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	7	----	CORR.	1221	STORAGE ALCOVE ACROSS FROM 759N IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	7	AB-700CF	CORRIDOR	1222	STORAGE ALCOVE ACROSS FROM 748N IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	7	AB-729SA	STORAGE	1223	ON-CALL ROOM 729S CLOSET IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	7	AB-700CD	CORRIDOR	1225	STORAGE ALCOVE ACROSS FROM 748S IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013
ATRIUM	7	AB-760S	STORAGE	1226	DIALYSIS 760S DOOR UNDERCUT > 3/4 INCH	MODIFY OR REPLACE DOOR TO CORRECT UNDERCUT	CAPITAL	6/30/2013
ATRIUM	5	----	----	1229	PACU SUITE BOUNDARY DOORS ADJ TO 560SA HAVE GAP > 1/4 INCH	MODIFY OR REPLACE DOOR TO CORRECT UNDERCUT	CAPITAL	6/30/2013
ATRIUM	5	583T	TELE.	1232	COMM 583T IS NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013

Building	Floor	Room No.	Location	ID	Specific Description	Corrective Action	Funds Source	Projected Comp. Date
ATRIUM	5	500CB	PRIVATE CIRCULATION	1234	ALL 4 SICU SUITE BOUNDARY DOORS ARE MISSING A POSITIVE LATCH	INSTALL POSITIVE LATCHING HARDWARE ON DOORS	CAPITAL	6/30/2013
ATRIUM	5	507S	PRIVATE CIRCULATION	1235	STERILE CORE INNER DOORS HAVE CLOSERS BUT ROLLER LATCHES; NEED POS LATCH	INSTALL POSITIVE LATCHING HARDWARE ON DOORS	CAPITAL	6/30/2013
ATRIUM	4	AB-400CD	NA	1236	A 2-HOUR FIRE SEPARATION BETWEEN THE HOSPITAL AND THE PEDESTRIAN BRIDGE IS MISSING.	INSTALL 2 HOUR FIRE SEPARATION ON THE BRIDGE	CAPITAL	6/30/2013
ATRIUM	4	AB-400SE	STAIRWAY	1237	STAIR E HAS UNDERCUT > 3/4 INCH	MODIFY OR REPLACE DOOR TO CORRECT UNDERCUT	CAPITAL	6/30/2013
ATRIUM	GR	AB-020CC	CORRIDOR	1245	ACROSS FROM 020P AND 020Q, PATIENT HOLDING IS OPEN TO THE CORRIDOR	BUILD A ROOM SO THAT THE HOLDING AREA IS NOT EXPOSED TO THE CORRIDOR	CAPITAL	6/30/2013
ATRIUM	0B	AB-0090D	BAKERY	1246	OVENS IN KITCHEN ARE NOT SPRINKLERED	PROVIDE PROPER SPRINKLER COVERAGE	CAPITAL	6/30/2013

Building	Floor	Room No.	Location	ID	Specific Description	Corrective Action	Funds Source	Projected Comp. Date
ATRIUM	5	---	CORR.	1247	ALL 4 SICU SUITE BOUNDARY DOORS ARE MISSING A POSITIVE LATCH	INSTALL POSITIVE LATCHING HARDWARE ON DOORS	CAPITAL	6/30/2013
ATRIUM	0B	AB-0000SB	STAIRWAY	1297	STAIR B DOOR TO SUB-BASEMENT IS NOT LABELED; NEED 90 MINUTES	REPLACE THE DOOR SO THAT IT IS A 90 MINUTE DOOR	CAPITAL	6/30/2013
ATRIUM	0B	AB-0000SD	STAIRWAY	1298	STAIR D DOOR TO SUB-BASEMENT IS NOT LABELED; NEED 90 MINUTES	REPLACE THE DOOR SO THAT IT IS A 90 MINUTE DOOR	CAPITAL	6/30/2013
ATRIUM	0B	AB-000SE	STAIRWAY	1299	STAIR E DOOR TO SUB-BASEMENT IS NOT LABELED; NEED 90 MINUTES	REPLACE THE DOOR SO THAT IT IS A 90 MINUTE DOOR	CAPITAL	6/30/2013
ATRIUM	9	AB-900SB	STAIRWAY	1301	STAIR B DOOR LABEL IS ILLEGIBLE, NEED 90 MINUTES	REPLACE THE DOOR SO THAT IT IS A 90 MINUTE DOOR	CAPITAL	6/30/2013
ATRIUM	0B	AB-0028	PVT CIRCULATION	1317	MRI SUITE > 2,500 SQ. FT. WITH ONLY 1 EXIT.	INSTALL A SECOND EXIT	CAPITAL	6/30/2014
ATRIUM	0B	AB-0028	PVT CIRCULATION	1318	MRI SUITE HAS 2 INTERVENING ROOMS AND TRAV DIST TO EXIT ACC DOOR > 50 FT.	INSTALL A SECOND EXIT WITH IN 50 FEET OF THE TWO ROOMS.	CAPITAL	6/30/2014

Kellogg Statement of Conditions (SOC) Deficiencies

Building	Floor	Room No.	Location	ID	Specific Description	Corrective Action	Funds Source	Projected Comp. Date
KELLOGG	6	---	SHAFT	329	DUCT, NO DAMPER AND DUCT NOT SEALED (8' WIDE DUCT TO 6TH FLOOR SHAFT)	PROVIDE 1.5-HOUR RATED FIRE DAMPERS LOCATED IN THE PLANE OF THE RATED SHAFT WALL AND PROPERLY SEAL DUCT PENETRATION	CAPITAL	12/31/2011
KELLOGG	6	KP1-600CB	CORRIDOR	323	(2) DUCTS, NO DAMPERS	PROVIDE SMOKE DAMPERS LOCATED AT THE RATED WALL	CAPITAL	12/31/2011
KELLOGG	6	---	CORRIDOR	333	NO SMOKE DETECTOR TO RELEASE EXISTING HOLD-OPEN DEVICES	PROVIDE SMOKE DETECTOR TIED TO THE EXISTING MAGNETIC HOLD-OPEN DEVICES AND THE FIRE ALARM SYSTEM SO DOORS ARE AUTO-CLOSING	CAPITAL	12/31/2011

Historical Medical Surgical Volume and Bed Need, 2002 – 2010

Category of Service	2002A	2003A	2004A	2005A	2006A	2007A	2008A	2009A	2010A
Medical Surgical Days	81,752	80,317	92,375	88,493	87,637	87,679	93,026	96,133	90,030
Total Observation Days			3,029	2,991	4,675	3,453	3,671	4,314	5,799
Total Days with Observation Days	81,752	80,317	95,404	91,484	92,312	91,132	96,697	100,447	95,829
% Change 2002-2010									2.0

Source: RUMC records

Projected Medical Surgical Volume and Bed Need, 2011 – 2018

Category of Service	2011P	2012P	2013P	2014P	2015P	2016P	2017P	2018P
Medical Surgical Days								
Total Observation Days								
Total Days with Observation Days	97,743	99,696	101,688	103,719	105,791	107,904	110,060	112,258

Source: RUMC records and Business Development

Hospice Program Lease (First Page Only)
Entire Lease included as Appendix B

LEASE

HOSPICE PROGRAM

SUMMARY OF LEASE PROVISIONS

1.	Lessor and Address:	RUSH UNIVERSITY MEDICAL CENTER 1725 W. HARRISON STREET, SUITE 229 CHICAGO, ILLINOIS 60612
2.	Lessee and Address:	HORIZON HOSPICE & PALLIATIVE CARE, INC. 833 WEST CHICAGO AVENUE CHICAGO, ILLINOIS 60622
	Attorney and Address:	Patricia S. Ullman Schiff Hardin LLP 233 S. Wacker Drive, Suite 6600 Chicago, IL 60606
3.	Premises:	See **Exhibit A**
4.	Date of Lease:	July 1, 2011, 2011
5.	Term:	60 months
6.	Commencement Date:	July 1, 2011
7.	Expiration Date:	June 30, 2016
8.	Annual Base Rent:	[redacted]
9.	Monthly Base Rent:	[redacted]
10.	Rentable Area of Premises:	5,758 square feet
11.	Security Deposit:	Intentionally deleted

The terms used above shall have the meanings provided in the Lease.

Historical Utilization of Pediatric Beds, 2002 – 2010

Category of Service	2002A	2003A	2004A	2005A	2006A	2007A	2008A	2009A	2010A
Pediatric Inpatient Days	6,419	6,237	6,641	5,026	4,692	4,882	4,830	5,216	4,966
Total Observation Days			228	272	473	280	360	359	341
Total Days with Observation Days	6,419	6,237	6,869	5,298	5,165	5,162	5,190	5,575	5,307
% Change 2002-2010									-2.3

Source: RUMC records

Projected Pediatric Volume and Bed Need, 2011 – 2018

	2011P	2012P	2013P	2014P	2015P	2016P	2017P	2018P
Base Projections Using 2002 to 2010 CAGR	5,182	5,061	4,942	4,825	4,712	4,601	4,493	4,388
Net Adds								
Relocation of Epilepsy Patients	336	336	336	336	336	336	336	336
Pediatric General Surgeons	0	28	56	78	100	120	120	120
Pediatric Cardiology/Transplant	0	70	140	210	280	280	280	280
ED Visits & Ambulance Growth	0	85	136	190	246	303	364	425
Economy/Birth Rates Improve	0	0	40	40	60	60	60	60
Health Reform Coverage Expansion	0	0	0	80	100	120	140	160
Total Projected Days	5,518	5,580	5,650	5,759	5,834	5,820	5793	5769
ADC	15.1	15.3	15.5	15.8	16.0	15.9	15.9	15.8
Beds at 65% Occupancy	24	24	24	25	25	25	25	25

Source: RUMC records and Business Development

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RUSH

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

January 17, 2012

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

Dear Ms. Avery,

The purpose of this letter is to confirm that the following physicians are members of the Rush University Medical Center Medical Staff.

Srikumar Pillai, MD	Pediatric General Surgeon
Thomas Weber, MD	Pediatric General Surgeon
Damien Kenny, MD	Pediatric Cardiology/Transplant

These physicians joined the Medical Staff in 2011 and will have admissions beginning in 2012.

Sincerely,

Peter W Butler

Peter W. Butler

Rush is a not-for-profit health care, education and research enterprise comprising Rush University Medical Center, Rush University, Rush Oak Park Hospital and Rush Health.

Historical Utilization of Obstetric Beds, 2002 – 2010

Category of Service	2002A	2003A	2004A	2005A	2006A	2007A	2008A	2009A	2010A
Obstetrics Inpatient Days	8,505	8,711	10,047	10,027	10,009	9,307	8,483	9,016	8,822
Observation Days			75	55	52	71	103	110	242
Total Obstetrics Days + Observation Days	8,505	8,711	10,122	10,082	10,061	9,378	8,586	9,126	9,064
% Change 2002-2010									0.8%

Source: RUMC records

Projected Utilization of Obstetric Beds and Bed Need, 2011 – 2018

Category of Service	2011P	2012P	2013P	2014P	2015P	2016P	2017P	2018P	2002-2010 CAGR
Obstetrics Inpatient Days									
Observation Days									
Total Obstetrics Days + Observation Days	9,134	9,204	9,275	9,346	9,418	9,491	9,564	9,637	0.8%
Change based on days and observations (none reported in 2002 or 2003)	70	70	71	71	72	72	73	73	
% Change	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	
ADC (Days/365)	25.0	25.2	25.4	25.6	25.8	26.0	26.2	26.4	
Beds at 78%	32.08	32.33	32.58	32.83	33.08	33.34	33.59	33.85	

Source: RUMC records and Business Development

Population Changes in 8-County Area
City of Chicago and RUMC's Primary Service Area, 2011 - 2016

	Population			2011 Population by Age Group				2016 Population by Age Group				2011-2016 % Change by Age Group			
8-County Area	2011	2016	% Chg	<18	18-44	45-64	>65	<18	18-44	45-64	>65	<18	18-44	45-64	>65
COOK, IL	5,193,817	5,166,603	-0.52%	1,262,999	2,036,452	1,264,539	629,827	1,260,905	1,935,220	1,279,937	690,541	-0.17%	-4.97%	1.22%	9.64%
DUPAGE, IL	954,663	969,333	1.54%	237,207	333,870	270,651	112,935	231,238	325,713	278,013	134,369	-2.52%	-2.44%	2.72%	18.98%
KANE, IL	508,853	552,536	8.58%	151,025	182,733	127,915	47,180	162,495	186,889	142,393	60,759	7.59%	2.27%	11.32%	28.78%
KANKAKEE, IL	128,127	133,248	4.00%	32,220	45,136	33,159	17,612	32,978	46,322	33,739	20,209	2.35%	2.63%	1.75%	14.75%
KENDALL, IL	103,757	125,456	20.91%	31,322	40,572	23,230	8,633	37,566	45,407	30,386	12,097	19.93%	11.92%	30.80%	40.13%
LAKE, IL	738,243	765,876	3.74%	201,861	251,249	206,281	78,852	201,952	250,018	217,912	95,994	0.05%	-0.49%	5.64%	21.74%
MCHENRY, IL	347,672	375,529	8.01%	92,087	118,190	97,802	39,593	94,314	121,427	110,626	49,162	2.42%	2.74%	13.11%	24.17%
WILL, IL	707,190	784,287	10.90%	200,035	259,585	180,881	66,689	213,525	271,102	212,067	87,593	6.74%	4.44%	17.24%	31.35%
Grand Total	**8,682,322**	**8,872,868**	**2.19%**	**2,208,756**	**3,267,787**	**2,204,458**	**1,001,321**	**2,234,973**	**3,182,098**	**2,305,073**	**1,150,724**	**1.19%**	**-2.62%**	**4.56%**	**14.92%**

	Population			2011 Population by Age Group				2016 Population by Age Group				2011-2016 % Change by Age Group			
Area	2011	2016	% Chg	<18	18-44	45-64	>65	<18	18-44	45-64	>65	<18	18-44	45-64	>65
City of Chicago	2,806,084	2,788,956	-0.61%	690,964	1,183,358	631,264	300,498	688,176	1,114,895	656,039	329,846	-0.40%	-5.79%	3.92%	9.77%

	Population			2011 Population by Age Group				2016 Population by Age Group				2011-2016 % Change by Age Group			
Area	2011	2016	% Chg	<18	18-44	45-64	>65	<18	18-44	45-64	>65	<18	18-44	45-64	>65
PSA	1,622,057	1,600,012	-1.36%	459,635	661,411	341,092	159,919	452,593	628,394	346,720	172,305	-1.53%	-4.99%	1.65%	7.75%

Source: Claritas

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RUSH

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

January 17, 2012

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

Re: Rush University Medical Center – Modernization of Categories of Service
Criterion 1110.530 (g) Assurances

Dear Mr. Galassie,

This letter provides the Statement of Assurance required with our application to modernize medical surgical, obstetrics, and pediatric beds in the Atrium Building at Rush University Medical Center.

We hereby state that it is our understanding, based upon information available to us at this time, that by the second year of operation after project completion, Rush University Medical Center reasonably expects to operate its improved complement of medical surgical, obstetric, and pediatric beds at the State Agency's target occupancies, which are the occupancies specified in 77 Ill. Adm. Code 1100.520 c) and 1100.530 c).

Sincerely,

Peter W. Butler

Peter W. Butler

Rush is a not-for-profit health care, education and research enterprise comprising Rush University Medical Center, Rush University, Rush Oak Park Hospital and Rush Health.

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
☒ Surgical Operating Rooms (Class C)	32	36
☒ Surgical Procedure Rooms (Class B)	8	10
☒ Post Anesthesia Recovery (PACU) Phase I	63	63
☒ Post Anesthesia Recovery (Prep/Recovery) Phase II	100	118
☒ Antepartum Testing	1	1

(See Narrative description below)

Rush University Medical Center (Rush, Medical Center, RUMC) has five clinical service areas that are part of this project; they are Surgical Operating Rooms (Class C), Surgical Procedure Rooms (Class B), Post Anesthesia Recovery (PACU) Phase I, Post Anesthesia Recovery (Prep/Recovery) Phase II, and Antepartum Testing. Each of these areas is described below.

1. Surgical Operating Rooms (Class C)

   As of early January 2012, the 28 new operating room in the East Tower and 4 of the operating rooms in the Atrium Building are in use. As noted in Attachment 14, Alternatives, the last phase in the modernization project includes a major reconfiguration and modernization of Level 5 of the Atrium Building including 8 of the existing 29 operating rooms for surgery. At the conclusion of the proposed modernization project, Rush will have 36 operating rooms including the 28 in the East Tower and 8 in the Atrium Building. Permit #07-125 (the East Tower) estimated that as many as 11 of the Atrium operating rooms would be reused; this application is requesting fewer than 11, or only 8.

2. Surgical Procedure Rooms (Class B)

   As part of Phase I of the Atrium/Kellogg modernization project, the 3 therapeutic endoscopy rooms and 1 bronchoscopy room on Level 1 of Kellogg will be relocated to vacated Atrium operating rooms. As part of Phase 6, Level 5 of the Atrium Building will undergo an overall reconfiguration and extensive remodeling. At that time, the additional endoscopy rooms in Professional Office Building II will also be relocated to Level 5 of Atrium. At the completion of the project, there will be 10 endoscopy rooms (including 2 bronchoscopy rooms) on Level 5 of the Atrium Building.

The vacated endoscopy space in Professional Office Building II will be used as physician office space; future use of the vacated space on Level 1 of the Kellogg Building has not been determined.

3. Post Anesthesia Recovery (PACU) Phase I

   and

4. Post Anesthesia Recovery (Prep/Recovery) Phase II

   The continuing utilization of 4 of the existing operating rooms for surgery and 4 endoscopy (including bronchoscopy) during the proposed modernization project requires that both PACU and prep/recovery stations also be available. In the interim between the opening of the East Tower and Phase 6 of the proposed project, 15 PACUs and 28 prep/recovery stations on Level 5 of the Atrium Building will remain in operation with only minimal investment. At the conclusion of the project, and after the extensive reconfiguration and modernization of Level 5, the following complements of PACUs and prep/recovery areas will be in the East Tower and in Atrium.

   At the completion of the modernization project, Rush will have the following complements of PACUs and recovery stations in the East Tower and the Atrium Building. Rush proposes to modernize 15 PACUs. At the completion of the Atrium modernization, Rush will continue to have a total of 63 PACUs; 48 in the East Tower and 15 in the Atrium Building.:

Location	Number of PACUs
East Tower	
Level 3 (Non Invasive Diagnostics)	4
Level 4 (IR, Cath, EP)	8
Level 5 (Surgery)	18
Level 7 (Surgery)	18
	48
Atrium Building	
Level 5 (Surgery, Therapeutic Endoscopy Recovery, Hybrid Lab)	15
Total	63

Rush has 72 Phase II prep/recovery stations in the East Tower and proposes to increase from 28 to 46 prep/recovery stations in the Atrium Building, to a total of 118 prep/recovery stations. They will be located on the following levels:

Location	Number of Prep/Recovery Stations
East Tower	
Level 3 (Non Invasive Diagnostics)	4
Level 4 (IR, Cath, EP)	24
Level 5 (Surgery)	23
Level 7 (Surgery)	21
	72
Atrium Building	
Level 5 (Surgery, Endoscopy, Hybrid Lab)	46
Total	118

At the completion of the Atrium Building modernization project, Rush will have a total of 181 PACU and prep/recovery stations. Planning for the total number and mix of PACU and prep/recovery stations was done in tandem and is described in this section.

5. Antepartum Testing

Rush's Antepartum Testing area will be relocated to the Atrium Building along with the obstetrical beds and the normal newborn nursery. The area will have one procedure room for ultrasound guided antepartum tests.

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 **Not applicable. There are neither new services, nor facility, nor equipment as part of this project.**
Service Modernization	(c)(1) –	Deteriorated Facilities
		and/or
	(c)(2) –	Necessary Expansion
		PLUS
	(c)(3)(A) –	Utilization – Major Medical Equipment
		Or
	(c)(3)(B) –	Utilization – Service or Facility

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

Introduction

CON III, Modernization of the Atrium Building includes five clinical service areas. Justification of these clinical service areas is appended in the following sections:

Attachment 37	A) Surgical Operating Rooms (Class C)
Attachment 37	B) Surgical Procedure Rooms (Class B)
Attachment 37	C) Ambulatory Care Services – Post Anesthesia Recovery (PACU) (Phase I) and D) Ambulatory Care Services – Post Anesthesia Recovery (Pre/Post) (Stage II)
Attachment 37	E) Antepartum Testing

A) Surgical Operating Rooms (Class C)

Surgical Operating Rooms

Surgical services provide the physical facilities as well as nursing and anesthesia to support surgeons performing surgical procedures. Class C operating rooms are defined by the American College of Surgeons as a setting designed for major surgical procedures that require general or regional block anesthesia and support of vital bodily functions.

Surgery can be performed on either an inpatient or an outpatient basis. In Illinois today, approximately 70 percent of the surgeries performed in hospitals are done as outpatient, 30 percent as inpatient. At tertiary/quaternary medical centers such as Rush, the ratio is reversed and 70 percent of the surgeries are inpatient and 30 percent is outpatient. Over time, however, even the tertiary/quaternary centers must be prepared to care for a greater proportion of outpatient surgery cases. Recent increases in outpatient surgery relate to the ability to perform increasingly complex surgery in the outpatient setting due to improved technology, procedures, and anesthesia. Patients often prefer an outpatient option because they can return to their homes after their surgery and be at less risk of being exposed to hospital-acquired infections and the cost is less.

c) Service Modernization

The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment or Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure of fire code deficiency citations involving the proposed project.

The justification for the modernization of the operating rooms in the Atrium Building is not based on deteriorated facilities. As the final phase of the project, Level 5 of the Atrium Building will be reconfigured and extensively remodeled to complete the final complement of operating rooms, the endoscopy rooms(including bronchoscopy), and the PACU and prep/recovery stations in a functionally efficient configuration. As part of Phase 1, modernization of the operating rooms will only include replacing lights in the hallways and minor cosmetic improvements to 4 rooms being used between 2012 and 2016.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

In the East Tower, Rush is operating two surgical areas that are connected to the Atrium Building by bridges on Levels 5 and 7. There are 28 operating rooms in the East Tower; these rooms are being used primarily for complex inpatient surgery. There will be 8 operating rooms in the Atrium Building on Level 5. These rooms will be used primarily for outpatient adult surgery and, due to the proximity of the pediatric inpatient units, for pediatric surgery.

Surgical utilization in the general operating rooms at Rush stabilized because the 29 rooms in the Atrium Building were being utilized at levels substantially above the State Agency target utilization. This capacity issue was addressed in the application for Permit #07-125 and is updated below:

Attachment 37, Table 1

Hours of Surgery at Rush

	2006	2008	2009	2010
Inpatient Hours	40,289	40,349	41,314	39,226
Outpatient Hours	19,487	17,019	18,447	20,249
Total Hours	59,776	57,398	59,761	59,475
Percent Outpatient Hours	32.6	29.7	30.9	34.0
Number of Rooms	28	29	29	29
Hours Per Room	2,135	1,979	2,061	2,051
Percent Over State Agency Guideline of 1,500 hours per room	42.3	31.9	37.4	36.7

Source: RUMC records

Table 1 above demonstrates two important findings. First, despite the addition of an operating room in 2007 that increased the number of general operating rooms from 28 to 29, the operating rooms at Rush continue to operate at approximately 37.0 percent over the State Agency target. This very high occupancy limits inpatient and outpatient access to the surgical suite.

Table 2 is a comparison of the percentage of outpatient surgery at Rush and at all hospitals in Illinois. Rush's percentage of outpatient surgery is below the State average, but increasing. Because the volume of complex, high acuity cases at the Medical Center takes precedence over lower acuity cases, historically Rush surgeons have had limited ability for the Medical Center to schedule lower acuity outpatient surgery cases.

Attachment 37, Table 2

Comparison of the Percentage of Outpatient Surgery at Rush and at All Illinois Hospitals

	2006	2008	2009	2010
Rush University Medical Center				
Inpatient Hours	40,289	40,349	41,314	39,226
Outpatient Hours	19,487	17,019	18,447	20,249
Total Hours	59,776	57,398	59,761	59,475
Percent Outpatient Hours	32.6	29.7	30.9	34.0
All Hospitals in Illinois				
Inpatient Hours	952,277	951,910	966,337	951,910
Outpatient Hours	836,189	847,344	854,169	847,344
Total Hours	1,790,856	1,814,692	1,820,514	1,814,692
Percent Outpatient Hours	46.6	46.7	53.1	46.7

Source: RUMC records and Hospital Profiles.

In the East Tower CON application, Rush considered several alternative ways of developing additional surgical capacity. For example, Rush considered building all of the needed operating rooms in new construction in the East Tower. This option was rejected in favor of building 28 new operating rooms sized for complex inpatient surgery in the East Tower and reusing a portion of the smaller existing operating rooms in the Atrium Building as part of the total surgical complement. The number of rooms to be modernized at that time was projected to be 11 operating rooms. This option results in a substantial reduction in capital investment because the rooms in the Atrium Building, though small, can be used with only

modest modernization for the short term. The remainder of the operating rooms will be reused for endoscopy (and bronchoscopy) or decommissioned until such time in the future that surgical volume increases and these rooms will then be reactivated with the approval of the HFSRB.

The reuse and modernization of the surgical area in the Atrium Building is consistent with the State Agency rules as well as the Master Design and East Tower permits.

At the completion of the Atrium Modernization Project, Rush will have 36 operating rooms.

28 operating rooms in the East Tower + 8 operating rooms in the Atrium Building = 36 total operating rooms

3) Utilization

A. Major Medical Equipment

Not applicable. There is no major medical equipment in the current project.

B. Service or Facility

Projects involving the modernization of a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number of justified by historical utilization rates for the latest two years, unless additional key rooms can be justified per subsection (c) (Necessary Expansion).

Utilization of Rush's operating rooms for the past 3 years is shown below along with the number of rooms that could be justified based upon the State Agency Standard of 1,500 hours per room.

Attachment 37, Table 3

Operating Rooms Justified by Utilization, 2008 through 2010

	2008	2009	2010
Total Hours of Surgery	57,398	59,761	59,475
State Agency Target Occupancy	1,500 Hours per Room	1,500 Hours per Room	1,500 Hours per room
Allowable Operating Rooms	39	40	40

Source: RUMC records and State Agency guidelines.

Based on the most current 2 years of data Rush can justify 40 operating rooms. Rush is proposing to have 36 operating rooms.

The Medical Center also projected future need for operating rooms. Attachment 37, Exhibit 1 is a CAGR (compound annual growth rate) trend line projection. This trend line shows that b y 2018, the second full year of operation of the fully remodeled operating rooms, Rush could justify 43 operating rooms. By developing only the 36 proposed rooms, the expected occupancy in 2018 would be 64,133 or 1,782 hours per room. This would be 18.9 percent higher than the State Agency standard.

64,133 hours ÷ 36 operating rooms = 1,782 hours per room

1,782 hours per room ÷ 1,500 hours per room =
1.188 or 18.8 percent over the State Agency standard

The modernization of vacated operating rooms in the Atrium Building to accommodate a consolidated surgery service (in two buildings but linked by bridges) is consistent with the State Agency rules as well as the Master Design and East Tower permits.

A) *If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.*

Surgical Operating Rooms (Class C) have a State Agency utilization standard of 1,500 hour per room per space. The proposed number of surgical operation rooms will operate at Rush at more hours per room than the State Agency standard.

1,782 projected hours per operating room at Rush > 1,500 hours per State Agency standard

B) Surgical Procedure Rooms (Class B)

Endoscopy Rooms

Using an instrument called an endoscope that has a tiny camera attached to a long thin tube, a physician moves the camera through a body passage to see inside the body. There are many types of endoscopy; at Rush, gastroenterology (GI) procedures (of the esophagus, stomach, and large intestine) are performed in the endoscopy rooms and bronchoscopy procedures (of the throat, larynx, trachea and lungs) are performed in a bronchoscopy room. Sometimes endoscopes are used for surgery, such as removing polyps from the colon.

Rush currently provides endoscopy services for adults and children in 7 rooms and bronchoscopy services in 1 room. Of the endoscopy rooms, 4 are outpatient rooms located in Suite 339 of Professional Office Building II; this office building is located across Harrison Street from the East Tower and the Atrium Building and is therefore removed from the other interventional services on the campus. Rush also has 3 other endoscopy rooms located on the first floor of the Kellogg Building. These 3 rooms are used for inpatient and outpatient endoscopy procedures that require fluoroscopy. The bronchoscopy room is co-located with the Kellogg endoscopy (GI) room. Approximately 50 percent of the endoscopy (GI and bronchoscopy) procedures at Rush are inpatient; the remainder are outpatient. Having endoscopy rooms in two locations is inefficient.

Rush proposes to relocate the existing endoscopy rooms and bronchoscopy room in Kellogg Level 1 to the space vacated as part of Phase I of the modernization project; the rest will be relocated as part of the final phase which includes a major modernization of the interventional and recovery services.

c) Service Modernization

The applicant shall document that the proposed project meets one of the following.

1) Deteriorated Equipment or Facilities

The proposed project will result in the replacement of equipment or facilities that have been deteriorated and need replacement. Documentation shall consist of, but not limited to, historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

The current equipment is not deteriorated and existing endoscopy suites have no licensure or fire code deficiencies. The existing endoscopy rooms, however, are isolated from other patient care functions and are in constrained spaces that cannot be expanded to meet the rapidly increasing demand for endoscopy services. The ultimate relocation of the entire endoscopy service to the vacated surgery area in the Atrium Building will consolidate inpatient and outpatient endoscopy facilities and the area will be conveniently located near the Phase I PACU and Phase II prep and recovery stations as well as anesthesia. Further, the space in Professional Office Building II is needed for physician offices; the space in Kellogg is more suitable for non clinical functions. The future use of Level 1 in Kellogg has not been determined.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic, treatment, ancillary training, or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

As part of the modernization project, Rush is proposing to consolidate pediatric and adult endoscopy and bronchoscopy services on Level 5 of the Atrium Building and increase the number of rooms from 8 (7 endoscopy rooms and 1 bronchoscopy room) to 10 (8 endoscopy and 2 bronchoscopy rooms).

Of the 10 rooms being proposed, for planning purposes 6 have been designated for outpatient procedures and 4 have been designated for inpatient (therapeutic procedures). However, depending on case mix, these rooms have some flexibility.

Diagnostic Endoscopic Procedures include:

- Colonoscopy
- Upper gastrointestinal endoscopy – EGD's
- Flexible sigmoidoscopy
- Proctosigmoidoscopy
- Capsule endoscopies (swallowed for observation of small bowel abnormality),
- Enteroscopy – ENTR and esophagoscopy – ESO
- Feeding tube placement
- Illeoscopy
- Liver biopsy, and
- Bronchoscopy

Therapeutic Procedures include:

- Endoscopic retrograde cholangiopancreatography – ERCP's
- LEUS – lower gastric examination and UEUS – upper gastric examination

Patients who undergo therapeutic procedures require deep sedation or general anesthesia and are recovered in the PACU. Those who undergo diagnostic procedures require only moderate sedation and typically recover in prep/recovery stations.

There have been important changes in industry standards. The Advisory Board, a health care research company, projects strong growth in endoscopy procedures based on emerging endoscopic diagnostic technologies capable of identifying gastric diseases at earlier stages, new minimally invasive techniques to replace older more invasive options, as well as new applications for established procedures.

The EndoNurse website (www.endonurse.com/blogs/2010/11/stats-on-the-gi-endoscopy-market.aspx 12/30/2010) similarly describes advances in gastroenterology techniques such as esophagus ablation with an expected CAGR growth of nearly 18 percent from 2009 to 2014 and small-bowel capsule endoscopies with an expected CAGR of more than 16 percent during the same period.

Millennium Research Group (MRG), a global medical technology market research association (as well as many other sources) report that the Patient Protection and Affordable Care Act of 2010 will make colorectal cancer screening a possibility for many more Americans than before. This improved reimbursement required by the Act will lead to a growing number of colorectal cancer screening/diagnostic procedures. Under the Health Care Act, all new health insurance policies must cover preventable exams, including colonoscopies (which account for more than 50 percent of all gastroenterology procedures at Rush) without charging out-of-pocket fees such as copayments or deductibles. Many new patients have access to colorectal screening colonoscopies beginning in January 1, 2011. This improved coverage increases access for endoscopy procedures which is especially important for historically underserved populations to reduce the higher incidence of colorectal cancer observed in these groups. (http://www.endonurse.com/news/2010/08/new-screening-coverage-will-boost-gi-endoscopy 12/30/10)

This new rule's insurance impact will grow over time as health plans lose exemptions from the health care law.

3) Utilization

A. Major Medical Equipment

Not applicable. There is no major medical equipment in the current project.

B. Service or Facility

Projects involving the modernization of a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for the latest two years, unless additional key rooms can be justified per subsection (c) (Necessary Expansion).

The endoscopy service at Rush has experienced very strong growth over the last 5 years. This historical growth reflects the growth and aging of the population, increasing awareness of the value of screening colonoscopies for the early diagnosis of colon cancer, and new technologies related to colon cancer.

Volume during the latest 2 years does not fully justify the 10 rooms that Rush is requesting.

Attachment 37, Table 4

Procedure Rooms Justified by Utilization, 2008 through 2010

	2008	2009	2010
Total Hours of Endoscopy	9,040	9,343	10,616
Allowable Endoscopy Rooms	6.1	6.2	7.1

Source: RUMC records

Rush has chosen to base future need on 5 years of historical data (2006 through 2010) because of the high confidence in this data. Between 2006 and 2010, endoscopy hours increased 29.8 percent with a CAGR (compound average growth rate) of 6.7 percent (See Attachment 37, Exhibit 3).

As noted above in (c) 2) Necessary Expansion, there are significant changes in industry standards that justify additional rooms. The first relates to improved technology and the second to expanded insurance coverage for colorectal cancer screening procedures. This improved coverage will increase access for this diagnostic procedure; this access is especially important for historically underserved populations to reduce higher incidence of colorectal cancer observed in these groups.

The Advisory Board projected the impact of technological advances and vastly improved reimbursement policies to be a 2.8 percent increase annually in Rush's service area over and above the historical growth trend based on population growth and aging.

The Medical Center expects the endoscopy relocation and expansion to be complete in 2016.

The Medical Center's projection for endoscopy hours has two components. The first is a CAGR trend line projection. This trend line shows that by 2018, the second full year of operation, Rush could expect 17,876 endoscopy hours. This projected endoscopy volume would justify 12 rooms in 2018.

When the initial trend line is coupled with the Advisory Board's expected additional growth of 2.8 percent per year, Rush's projected volume would justify 15 rooms in 2018.

Because Rush used only 5 years of historical data, the Medical Center can only claim 5 years of projections or from 2011 to 2015.

In 2015, Rush could justify 10 endoscopy rooms using the CAGR trend line

14,703 hours ÷ 1,500 hours per room = 10 rooms

In 2015, Rush could justify 12 endoscopy rooms using the CAGR trend line with the Advisory Board adjustment.

16,856 hours ÷ 1,500 hours per room = 12 rooms

Although Rush justified the need for as many as 12 rooms, the Medical Center is conservatively requesting only 10 rooms; of these 8 will be endoscopy rooms and 2 will be negative pressure bronchoscopy rooms.

See Attachment 37, Exhibits 3 and 4 for the historic and projected volumes and the trend lines of the CAGR projection and of the combined CAGR and Advisory Board projections.

B) If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.

Surgical Procedure Rooms (Class B) have a State Agency utilization standard of 1,500 hours per room. The proposed number of surgical procedure rooms at Rush will exceed this standard in 2015.

Unadjusted CAGR

2015

14,703 hours ÷ 10 rooms = 1,470 hours per room

Adjusted CAGR with Advisory Board Adjustment

2015

16,856 hours ÷ 10 rooms =1,686 hours per room

1,686 hours per endoscopy room at Rush > 1,500 hours per room State Agency standard

C) Post-Anesthesia Recovery (PACU) (Phase I)

And

D) Post-Anesthesia Recovery (Prep/Recovery) Phase II

c) Service Modernization

1. Deteriorated Equipment or Facilities

The proposed project will result in the replacement of equipment or facilities that have been deteriorated and need replacement. Documentation shall consist of, but not limited to, historical utilization data, downtime or time spent out of service due to operational failures, upkeep and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

At the completion of the proposed modernization project, 15 PACU recovery stations will be redeveloped in the space on Level 5 of the Atrium Building. In addition to the PACU stations, the project also includes developing 46 prep/recovery stations at the same level. This will result in a total of 63 PACUs and 118 prep/recovery stations on Level 5 of the Atrium Building and the East Tower.

Modernization is being proposed to right-size the complements of PACU and prep/recovery stations; there are no licensure or code deficiencies.

2. Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic treatment, ancillary training or other support services to meet the requirements of patient service demand. Documentation shall consist of, but is not limited to: historical utilization data, evidence of changes in industry standards, changes in scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

The need for recovery space, both Phase I and Phase II, is dependent on the number of patients using the surgical and procedure rooms as well as the hybrid lab. As part of the East Tower construction and the Atrium Building modernization, Rush is proposing to expand the number of surgical suites and endoscopy suites. The need also reflects the longer recovery times and short case times for outpatients. The majority of the cases using the Atrium Building operating rooms and endoscopy rooms will be outpatient.

3. Utilization

A. Major Medical Equipment

Not applicable. There is no major medical equipment in the current project.

B. Service or Facility

Projects involving the modernization of a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the number justified by historical utilization rates for the latest two years, unless additional key rooms can be justified per subsection (c) (Necessary Expansion).

According to the definitions in Section 1100.220 of the Rules, Post Anesthesia Recovery (PACU) Phase I refers to the phase of surgical recovery that focuses on providing transition from a totally anesthetized state to one requiring less acute intervention. This phase of recovery occurs in the PACU. The purpose of this phase is for patients to regain physiological homeostasis and receive appropriate nursing intervention as needed. The same source describes Post Anesthesia Recovery (Prep/recovery) Phase II as the phase in surgical recovery that focuses on preparing the patient for self care, care by family members, or care in an external care environment. The patient is discharged to Phase II recovery when intensive nursing care is no longer needed. In the Phase II area, the patient becomes more alert and functional.

At the end of the East Tower and Atrium Building projects, Rush will have the following configuration of operating rooms, procedure rooms, and other functions that may require either Phase I recovery, Phase II recovery, or both.

Attachment 37, Table 5

Proposed Locations of Operating Rooms/Procedure Rooms and
Related PACU and Prep/Recovery Stations at Modernization Project Completion

Location	Key Room	Number of Key Rooms	Phase I PACU Stations	Phase II Prep/Recovery Stations	Total Recovery Stations
East Tower Level 5	Operating Rooms	14	18	23	41
East Tower Level 7	Operating Rooms	14	18	21	39
Atrium Building Level 5	Operating Rooms (8) Endoscopy Rooms (10) Hybrid Lab (1)	19	15	46	61
Subtotal Rooms		47	51	90	141
East Tower Level 3	Cardiac Diagnostics	1	4	4	8
East Tower Level 4	MRI, Cath, EP, Interventional Radiology	18	8	24	32
Total		66	63	118	181

Planning for the PACUs and the prep/recovery areas in both the East Tower and the Atrium Building considered the needs of both inpatients and outpatients. In some instances, the same patient may require time in both PACU and prep/recovery. Inpatient surgical and procedural patients spend less time in recovery than outpatients as they can be transferred back to an inpatient room once they have completed and are discharged from Phase I recovery. Outpatients typically spend more time in the recovery area as they may need to complete both Phase I and Phase II recovery. Outpatient procedures tend to be of shorter duration than the more complex inpatient procedures. Therefore, more PACU/prep/recovery stations are required to allow for the rapid turn over of these procedures and the longer recovery.

Code Required Ratios for PACUs and Prep/Recovery Stations

lllinois Licensure Code requires 1 PACU for each inpatient key room and 3 additional recovery stations for each outpatient key room.

The high ratio of prep/recovery rooms supports the efficient operation and utilization of the procedure rooms and the associated equipment and personnel. The specific breakdown of inpatient vs. outpatient operating rooms and required recovery spaces to accommodate each of these populations is as follows:

PACU (Phase I)

- In the East Tower there are a total of 47 key rooms as well as cardiac diagnostics, MRI, cardiac catheterization, electrophysiology, interventional radiation rooms, and 48 PACU stations. Thus the number of PACU stations available exceeds the required number by 1 on each of the two levels.

  48 PACU stations > 47 key rooms requiring PACU = a ratio of 1:1 in the East Tower

- In the Atrium Building there will be 19 key rooms; however, it is estimated that 15 of the rooms will account for the inpatient procedures (8 operating rooms, 1 hybrid room, 4 therapeutic endoscopy and 2 bronchoscopy rooms) that require PACU recovery space. Therefore the 15 PACU stations will meet the needs of these patients.

  15 PACU stations = 15 key rooms requiring PACU support =
  a ratio of 1:1 in the Atrium Building

Prep/Recovery (Phase II)

- In the East Tower there will be 6 outpatient operating rooms and a total of 19 cardiac diagnostics, MRI, cardiac catheterization rooms, and interventional radiology rooms, for a total of 25 rooms that will be used primary by outpatients and require prep/recovery stations.
- In the East Tower there will be 72 prep/recovery stations.

  72 prep/recovery stations ÷ 25 key rooms = a ratio of 3:1 in the East Tower

- In the Atrium Building there will be 16 key rooms that require prep/recovery rooms (6 operating rooms and 10 endoscopy/bronchoscopy rooms).
- In the Atrium Building there will be 46 prep/recovery stations.

  46 prep/recovery stations ÷ 16 key rooms = a ratio of 3:1 in the Atrium Building

C) *If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions, or population use rates.*

The State Agency has no utilization standards for Phase I and Phase II recovery areas. Justification for 181 Phase I and Phase II recovery stations is detailed in B) above.

E) Antepartum Testing

c) Service Modernization
The applicant shall document that the proposed project meets one of the following:

1) Deteriorated Equipment or Facilities

The proposed project will result in the replacement of equipment or facilities that have deteriorated and need replacement. Documentation shall consist of, but is not limited to: historical utilization data, downtime or time spent out of service due to operational failures and annual maintenance costs, and licensure or fire code deficiency citations involving the proposed project.

Antepartum testing is currently located on 6 Kellogg. It is remote from other obstetrical functions; further, Rush is proposing to modernize Level 6 of Kellogg for general pediatric beds.

2) Necessary Expansion

The proposed project is necessary to provide expansion for diagnostic requirements of patient service demand. Documentation shall consist of, but not limited to: historical utilization data, evidence of changes in industry standards, changes in the scope of services offered, and licensure or fire code deficiency citations involving the proposed project.

Rush University Medical Center is a Level III Perinatal Center and reports approximately 2,250 births each year. An important diagnostic service related to the Medical Center's perinatal program is antepartum testing.

Antepartum testing can begin as early as 23 weeks, but usually begins after 32 weeks of pregnancy. High risk mothers may be admitted to antepartum beds before their delivery and undergo antepartum testing. Low risk mothers may also be referred to antepartum testing. Antepartum testing may be provided to either inpatients or outpatients.

These tests can help identify any problems or changes that may require additional testing or interventions. The testing results reflect how well the placenta is

functioning in its ability to adequately supply blood and oxygen to the fetus. Various reasons for administering antepartum tests include:

- Any chronic illness in the mother, such as high blood pressure or diabetes
- Problems with previous pregnancies
- Fetal complications such as intrauterine growth retardation
- Problems in the current pregnancy such as preeclampsia, gestational diabetes, premature rupture of the membranes, excessive amniotic fluid, or placenta previa
- Evaluation of decreased fetal activity
- Twins or other multiple fetuses; and
- Post term pregnancy (past 41 weeks)

Most antepartum testing involves ultrasound, amniocentesis, and vaginal exams. Among the most common antepartum tests performed at Rush are:

- Non Stress Test (NST) The NST involves the use of a fetal monitor to record the fetal heart rate and uterine contractions. The fetal heart rate is observed for increases that occur when the baby moves.
- Amniotic Fluid Index (AFI) The AFI involves the use of a special ultrasound unit to scan the fetus and measure the amount of amniotic fluid around the baby. The depth of the amniotic pockets is measured externally with sound waves. These measurements indicate whether there is adequate fluid surrounding the baby.
- Biophysical Profile (BPP). The BPP consists of observations made during antepartum ultrasound and fetal monitoring. This test is usually performed only when additional information is needed. After performing the NST and AFI, the physician observes various fetal movements with ultrasound.

The ultrasound units in Antepartum Testing are only available for obstetrical exams. They are specifically programmed for obstetrical applications; this programming is a very complicated process. The ultrasound tests are performed and read by Maternal and Fetal Medicine specialists, not by radiologists. The Maternal and Fetal Medicine specialists are assisted by specially trained sonographers who are certified by the American Registry of Diagnostic Medical Sonographers.

Utilization of Antepartum Testing
Attachment 37, Table 6

Year	2008	2009	2010
Number of Tests	1,959	1,789	1,850
Number of Rooms Justified at 2,000 Tests/Room	1	1	1

Source: RUMC records.

The Antepartum Testing service has recorded a stable utilization between 2008 and 2010. This reflects the high number of high risk mothers and infants referred to the Medical Center and the ability of the Maternal and Fetal Medicine physicians to diagnose in utero conditions early in the pregnancy and treat them aggressively for improved outcomes. An important member of the Antepartum Testing staff is the diabetic educator who helps diabetic mothers control their disease. This role in prevention of serious diabetic complications prevents unnecessary admissions.

Antepartum Testing at Rush enhances prenatal care, reduces premature births, and low birth weight babies.

3) Utilization

A) Major Medical Equipment

Proposed projects for the acquisition of major medical equipment shall document that the equipment will achieve or exceed any applicable target utilization levels specified in Appendix B within 12 months after acquisition.

NA. There is no antepartum diagnostic equipment in this project that meets or exceeds the major medical equipment threshold.

B) Service or Facility

Projects involving the modernization or a service or facility shall meet or exceed the utilization standards for the service, as specified in Appendix B. The number of key rooms being modernized shall not exceed the /number justified by historical utilization rates for each of the latest two years, unless additional rooms can be justified per subsection c) 2) Necessary Expansion.

A description of recent utilization of Antepartum Testing at Rush is described in Section c) 2).

Antepartum Testing is a Clinical Service Area; the State Standard for Clinical Service Areas is 2,000 visits per room.

The following calculations were used to quantify the number of rooms justified for Antepartum Testing.

Current need for antepartum testing is 1 procedure room.

1,850 antepartum tests ÷ 2,000 visits per room = 1 room

Rush anticipates that the Antepartum Testing area will open in 2013. Rush assumed that future antepartum testing utilization would be similar to the growth in obstetrical volume, or a 3.8 percent increase between 2010 and 2015, the second full year of utilization.

2015

1,850 antepartum tests x 3.8 percent increase = 1,921 antepartum tests

Based on these modest growth projections, Rush is requesting to maintain 1 antepartum testing room.

RUMC has Justified the Need for 1 Antepartum Testing Room

The Medical Center is requesting 1 antepartum ultrasound room. There will also be 5 monitoring/observation stations for antepartum test patients.

Rush is expecting to record 1,921 tests in 2015.

1,921 antepartum tests/visits = the State Standard of 2,000 visits per room

C) *If no utilization standards exist, the applicant shall document in detail its anticipated utilization in terms of incidence of disease or conditions or population use rates.*

Not applicable. The State Agency Standard is 2,000 visits per room for Clinical Service Areas.

Historic Utilization of Surgery Hours, 2002 - 2010

Category of Service	2002A	2003A	2004A	2005A	2006A	2007A	2008A	2009A	2010A	2002-2010 CAGR
Main OR Surgery Hours										
Inpatient Surgery Hours	36,798	33,539	39,564	40,071	40,289	41,449	40,379	41,314	39,226	0.8%
Outpatient Surgery Hours	18,373	13,959	17,137	18,829	19,487	17,959	17,019	18,447	20,249	1.2%
Total Surgery Hours	55,171	47,498	56,701	58,900	59,776	59,408	57,398	59,761	59,475	0.9%
Change		(7,673)	9,203	2,199	876	(368)	(2,010)	2,363	(286)	
% Change									-0.5%	
Rooms at 1,500 cases/room	36.8	31.7	37.8	39.3	39.9	39.6	38.3	39.8	39.7	
Source: AHQ										
Average IP Hours Per Case	3.9	3.4	3.7	3.8	3.8	3.6	3.5	3.5	3.5	
Average OP Hours Per Case	2.3	1.8	2.1	2.3	2.3	2.1	2.0	2.0	2.1	

Source: RUMC records

Projected Utilization of Surgery Hours 2011 - 2018

Category of Service	2011P	2012P	2013P	2014P	2015P	2016P	2017P	2018P	2002-2010 CAGR
Main OR Surgery Hours									
Inpatient Surgery Hours	39,541	39,858	40,177	40,499	40,824	41,152	41,482	41,814	0.8%
Outpatient Surgery Hours	20,497	20,747	21,001	21,258	21,518	21,781	22,047	22,317	1.2%
Total Surgery Hours	60,037	60,605	61,178	61,757	62,342	62,932	63,529	64,131	0.9%
Change	562	568	573	579	585	590	596	602	
% Change	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	
Rooms at 1,500 cases/room	40.0	40.4	40.8	41.2	41.6	42.0	42.4	42.8	
Source: AHQ									
Average IP Hours Per Case	3.4	3.4	3.3	3.3	3.3	3.2	3.2	3.1	
Average OP Hours Per Case	2.1	2.1	2.1	2.1	2.0	2.0	2.0	2.0	

Source: RUMC records and Business Development

Historic Utilization of Endoscopy Hours, 2006 – 2010

Category of Service	2006A	2007A	2008A	2009A	2010A
Actual CY 06-10 GI lab hours	8,181	9,375	9,040	9,343	10,616
Projected GI Hours at 6.7% internal CAGR					10,616
Projected GI Hours at 6.7% internal CAGR and 2.8% projected market/technology growth					

Source: RUMC records

Projected Utilization of Endoscopy Hours, 2011 – 2018

	CY 2011 Projected	CY 2012 Projected	CY 2013 Projected	CY 2014 Projected	CY 2015 Projected	CY 2016 Projected	CY 2017 Projected	CY 2018 Projected
Actual CY 06-10 GI lab hours								
Projected GI Hours at 6.7% internal CAGR	11,331	12,093	12,907	13,776	14,703	15,693	16,749	17,876
Projected GI Hours at 6.7% internal CAGR and 2.8% projected market/technology growth	11,644	12,773	14,010	15,367	16,856	18,489	20,280	22,244

Source: RUMC records and Business Development

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)**

See the following page.

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:**

Not Applicable. Rush University Medical Center (RUMC) qualifies for a waiver of this section because RUMC has an A bond rating. At Staff's request, however, RUMC is including Attachment 39, Exhibits 4 and 5 which include a brief overview of the funding for the Atrium Building Modernization Project and a copy of the most recent audited financial statement.

$46,230,784	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.
$46,230,784		**TOTAL FUNDS AVAILABLE**

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

There are five exhibits with Attachment 39.

Exhibit 1	Fitch Ratings (7/11/11) assigns RUMC an A- bond rating
Exhibit 2	Standard and Poors Research on 12/17/11 assigns RUMC an A- bond rating
Exhibit 3	Moody's Investor Services on 11/8/10 assigns RUMC an A^2 bond rating
Exhibit 4	Availability of funds schedule. Although this is not required, it has been requested by State staff
Exhibit 5	The cover sheet from RUMC's most current audited financial statement. The full financial statement is in Appendix C. This financial report shows that RUMC has adequate cash and securities to fund the modernization of the Atrium Building

Rush has been awarded Tax Incremental Financing (TIF) by the City of Chicago (the City) under the Tax Increment Allocation Redevelopment Act (the Act). Such monies can be utilized to pay for expenditures associated with renovation projects that qualify for reimbursement under the Act, provided that Rush has complied with all other terms of the Redevelopment Agreement (RDA) between Rush and the City. Rush believes that all or a portion of this project qualifies for TIF reimbursement, and that it will be in compliance with all other terms of the RDA. Rush must first expend the monies and then submit to an application process as prescribed by the RDA in order to receive the funds, which might not be received prior to the completion of this project. As such, funding for this project is accordingly reflected as Cash & Securities.

FitchRatings

FITCH AFFIRMS RUSH UNIVERSITY MEDICAL CENTER OBLIGATED GROUP (IL) REVS AT 'A-'; OUTLOOK TO POSITIVE

Fitch Ratings-Chicago-11 July 2011: As part of its ongoing surveillance efforts, Fitch Ratings has affirmed the 'A-' rating on the following approximately $618.9 million of debt issued by the Illinois Finance Authority or the Illinois Health Facilities Authority on behalf of Rush University Medical Center Obligated Group (Rush):

--Series 2009D revenue bonds;
--Series 2009C revenue bonds;
--Series 2009B revenue bonds;
--Series 2009A revenue bonds;
--Series 2008A variable rate demand revenue bonds;
--Series 2006B revenue bonds;
--Series 1998A revenue bonds.

The Rating Outlook is revised to Positive from Stable.

RATING RATIONALE:
--The Outlook revision to Positive reflects Rush's continued strong operating performance in a competitive market and near completion of its new hospital, which is on time and within budget.
--Rush's operating and operating EBITDA margins have exceeded Fitch's 'A' category medians in each of the last four fiscal years.
--Rush's leverage position is moderate with a conservative debt portfolio (92% fixed rate).
--Rush has strong physician alignment across an integrated platform.
--Credit concerns include execution risk associated with the opening of the new facility located on Rush's Chicago campus, an expected decline in liquidity metrics as capital spending remains high through fiscal 2012 to finish the campus transformation project and a competitive service area.

WHAT COULD TRIGGER AN UPGRADE:
--Successful completion and transition to the new facility with minimal operational impact.
--Maintenance of strong operating cash flow to offset the expected decline in liquidity.

SECURITY:
Debt payments are secured by a pledge of the gross revenues of the obligated group and a mortgage on certain property of the obligated group.

CREDIT SUMMARY:
The rating affirmation at 'A-' is based upon Rush's consistently strong operating performance since fiscal 2007, moderate leverage and strong alignment with physicians across an integrated platform.

Rush's operating and operating EBITDA margins have averaged 5.3% and 11.6%, respectively, between fiscal 2007 and fiscal 2010, exceeding Fitch's 2010 'A' category medians of 3% and 10%. Rush's strong operating performance continued through the nine-month interim period ending March 31, 2011 (the interim period) with operating and operating EBITDA margins of 5.7% and 12.4%, respectively. Management's 2012 budget includes operating and operating EBITDA margins of 3.4% and 11.3%. Rush receives approximately $50 million of supplemental funds per year including disproportionate share payments and Medicaid provider tax funds.

Rush's moderate leverage metrics are enhanced by a conservative debt portfolio, with 92% fixed rate debt. Debt to capitalization increased from 35% in fiscal 2008 to 52% in fiscal 2010 but moderated to 45.1% as of March 31, 2011 relative to Fitch's 'A' category median of 42.1%. Strong cash flow generation further mitigates the moderate leverage levels with debt to EBTIDA of 2.4

times (x) as of March 31, 2011 which compares favorably to Fitch's 'A' category median of 3.8x. Coverage of maximum annual debt service (MADS) by EBITDA was a solid 4.3x in fiscal 2010 and 4.6x in the interim period.

Credit concerns include execution risk associated with the opening of the new facility located on Rush's Chicago campus, an expected decline in liquidity metrics and a competitive service area. At March 31, 2011 Rush's unrestricted cash and investments totaled $642.1 million reflecting a sharp improvement from $514.4 million as of fiscal year-end 2009. Liquidity metrics have improved. However days cash on hand (158.8), cushion ratio (11.7x) and cash to long term debt (104.3%) are light relative to the respective 'A' category medians of 183.8, 14.4x and 105.5%. Moreover, Rush projects that days cash will decrease to 124 days in fiscal 2012 due to the completion of the new facility.

The new facility is set to open in January 2012 and is on time and on budget. The combination of the strength of Rush's clinical programs with the new facility should provide a boost to operations in the competitive Chicago-area marketplace.

Rush spent over $729 million between fiscal 2008 and March 31, 2011 on the estimated $1 billion Campus Transformation Plan. Capital expenditures are forecasted to equal $285 million in fiscal 2011, $215 million in fiscal 2012 (of which $53 million is carryover from fiscal 2011) and subsequently decrease to $105 million per year thereafter. Liquidity is expected to rebound after fiscal 2012 due to strong operating performance.

The Positive Outlook reflects Fitch's expectation of upward rating movement if Rush maintains its strong operating performance while successfully transitioning operations to the new facility.

Rush consists of three acute care hospitals including Rush University Medical Center, located in Chicago, IL; Rush Oak Park Hospital, located in Oak Park, Illinois; and Rush-Copley Medical Center, located in Aurora, Illinois. The three hospitals operate 985 staffed beds. Rush also operates a medical university, research facilities, a physician group practice with over 400 employed physicians, and a rehabilitation/skilled nursing facility. In fiscal 2010, the Obligated Group reported total revenues of $1.69 billion. Rush's disclosure practices are among the best in Fitch's health care portfolio with quarterly and annual disclosure consisting of balance sheet, income statements and cash flow statements, utilization statistics and a management discussion and analysis.

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Additional information is available at 'www.fitchratings.com'.

Applicable Criteria and Related Research:
--'Revenue-Supported Rating Criteria', dated Oct. 8, 2010;
--'Nonprofit Hospitals and Health Systems Rating Criteria', dated Dec. 29, 2009.

Applicable Criteria and Related Research:
Revenue-Supported Rating Criteria
http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=637130
Nonprofit Hospitals and Health Systems Rating Criteria
http://www.fitchratings.com/creditdesk/reports/report_frame.cfm?rpt_id=493186

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STANDARD &POOR'S

Standard & Poor's Research

October 17, 2011

Illinois Finance Authority Rush University Medical Center Obligated Group; Joint Criteria; System

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Illinois Finance Authority
Rush University Medical Center Obligated Group; Joint Criteria; System

Credit Profile

Illinois Fin Auth, Illinois		
Rush Univ Med Ctr Obligated Grp, Illinois		
Illinois Finance Authority (Rush University Medical Center Obligated Group)		
Long Term Rating	A-/Positive	Outlook Revised
Illinois Finance Authority (Rush University Medical Center Obligated Group) (MBIA) (National)		
Unenhanced Rating	A-(SPUR)/Positive	Outlook Revised
Illinois Fin Auth (Rush University Medical Center Obligated Group) hosp VRDO ser 2008		
Long Term Rating	AAA/A-1+	Affirmed
Unenhanced Rating	A-(SPUR)/Positive	Outlook Revised

Many issues are enhanced by bond insurance.

Rationale

Standard & Poor's Ratings Services revised its outlook to positive and affirmed the 'A-' long term rating on Illinois Finance Authority's $411.6 million series 2009A through 2009D fixed-rate hospital revenue bonds. S tandard & Poor's also revised it outlook to positive and affirmed the 'A-' underlying rating (SPUR) on the authority's $50 million series 2008A and $96.75 million series 2006B revenue bonds, all issued for the Rush University Medical Center Obligated Group (Rush). At the same time, Standard & Poor's affirmed its 'AAA/A-1+' dual rating on the authority's series 2008A variable-rate demand bonds (VRDBs), also issued for Rush.

The 'AAA/A-1+' dual rating on the series 2008A VRDBs is based on our joint criteria, with the long-term component of the rating based jointly on the Northern Trust Bank (AA) and Rush long-term ratings. The 'A-1+' short-term component of the rating is based on the Northern Trust short-term rating. The letter of credit expires December 2013.

The positive outlook reflects near completion of Rush University Medical Center's (RUMC) new patient tower (to open early in calendar 2012) and Rush's robust operating performance, which has helped to maintain a fairly stable balance sheet despite RUMC's recent period of major construction.

The 'A-' rating reflects the strength of RUMC, the obligated group's flagship hospital, as an academic medical center with well-defined market recognition despite concerns about competition. The rating also reflects RUMC's large net patient revenue base and robust operating income during the past five years. While capital spending will remain steady during the next few years, the opening of the new patient tower, Rush's largest project, is expected to open in early calendar 2012 and eliminates a major risk that has been part of Rush's profile for the past several years.

The 'A-' and positive outlook also reflect Rush's:

- Continued strong market recognition as an academic medical center with broad clinical services, extensive

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education and research capabilities, and a solid market position in several key service lines in the competitive Chicago-area market;
- Track record of solid financial operations and cash flow, with unaudited fiscal 2011 results showing a strong operating margin of 5.6%, a solid EBIDA margin of 13.6%, and very good maximum annual debt service coverage of 4.2x; and
- Large net patient revenue base of $1.5 billion from serving two distinct market areas with modest inpatient growth offset by steady outpatient growth in recent years.

Credit risks, in our view, include Rush's:

- Final cash outlay for RUMC's new patient tower project in 2012 and ability to absorb the higher expense base at the same time that inpatient volume growth has slowed and the state Medicaid program is experiencing some pressure;
- Adequate, 137 days' cash on hand as of June 30, 2011 (with a minimum threshold of 115 during the next few years); and
- Location in the highly competitive Chicago service area, with RUMC in close proximity to three other hospitals in its immediate service area and with several other area academic medical centers and hospitals or health systems providing strong competition for key services.

The bonds secured under the master trust indenture are secured by Rush's gross revenues and mortgages on the main hospital facilities' property, plant, and equipment. Rush's total long-term debt, including capital leases, other financing arrangements, and guarantees, is $658 million, with most of this debt to be secured under the master trust indenture.

Rush's largest single project during the past few years has been the construction of a new patient tower at RUMC ($637 million). The new patient tower, which has been funded through bond proceeds, capital campaign contributions, governmental funding, and operating cash flow, is scheduled to open in mid-fiscal 2012. While Rush's capital expenditures will remain high at $238 million in 2012, capital spending should decrease thereafter but still remain steady at around $100 million annually as RUMC completes remaining renovations at its existing facilities through 2016. Moreover, the completion of and successful move into the new patient tower will eliminate a significant risk that has been part of Rush's profile for the past few years. In addition, some flexibility in the future capital spending plans should allow Rush to strengthen its currently light balance sheet profile should operations come under any unforeseen pressure away from currently strong levels. In recent years, RUMC and the smaller Rush-Copley Medical Center have generated strong operations, supported partially by the Illinois Provider Tax (IPT), but also through a very strong focus on strengthening key service lines as well as on operations and expense controls.

John Mordach is the new full-time Chief Financial Officer (CFO) at Rush and filled that position, which has been open since last summer, in early calendar 2011. He's held several senior finance positions including CFO at several hospitals and was most recently the CFO at Loyola University Health System in Maywood, Ill., (a neighboring suburb of Chicago).

Rush is party to two interest-rate swaps with a total notional amount of $96.75 million. Standard & Poor's has assigned Rush a Debt Derivative Profile (DDP) overall score of '1.5' on a four-point scale, with '1' representing minimal risk. The overall score of '1.5' reflects our view that Rush's swap portfolio poses a very low risk.

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Outlook

The positive outlook reflects Rush's near completion of its major capital project at the same time that operations have remained strong and Rush has maintained its solid market position. If Rush is able to grow its balance sheet after final payments have been made for the new patient tower and absorb the higher expense base while continuing to make operating improvements as planned, Standard & Poor's could raise the ratings in the next year or two. Standard & Poor's could revise the outlook back to stable if the balance sheet shows limited growth with liquidity remaining at or near current levels. However, if operations experience sustained declines after the opening of the patient tower and margins remain below median levels, or operational liquidity levels decline and remain below Rush's floor of 115 days, the rating could be revised downward. Rush does not expect to issue any new-money debt during the next two years.

Operational Profile

The Rush health system consists of two medical centers in distinct service areas in the Chicago area:

- RUMC: A 664-staffed bed facility just west of downtown Chicago that also operates the 128-staffed-bed Rush Oak Park Hospital (ROPH) in the neighboring suburb of Oak Park; and
- Rush-Copley Medical Center (RCMC): Located in Aurora, Ill., a far-southwest suburb of Chicago, it serves as the parent holding company for Copley Memorial Hospital Inc. (a 210-staffed bed facility), Copley Ventures Inc., Rush-Copley Foundation, and Rush-Copley Medical Group NFP, all of which are Rush members.

Rush's operations include employed physicians as well as significant research and educational components such as Rush University, a health sciences university that includes Rush Medical College, College of Nursing, College of Health Sciences, and the Graduate College. Rush was created to diversify the revenue base that supports debt service, maximize debt capacity for the system, and generally strengthen overall creditworthiness. Although Rush is involved in some joint activities, the entities operate independently in terms of day-to-day activities and service delivery. However, management is focusing on how to strengthen collaboration clinically across its organizations and affiliates. RUMC's board exerts certain governance controls on the other entities' boards, which hold certain reserve powers through majority board representation. In 2011, Rush's admissions were down 2.5% relative to the prior year to 43,885; however, year-over-year outpatient volumes increased slightly by 0.5% to 442,088 and outpatient surgeries increased 2.6% to 29,664.

While RCMC generates positive operating income, RUMC -- Rush's largest component -- has helped Rush generate its strong financial performance in recent years. RUMC, which accounted for 88% of Rush's total assets, 83% of total revenues, and 85% of operating income as of fiscal year-end June 30, 2011, is in the Illinois Medical District with three other hospitals. It competes with four Chicago-area academic medical centers: Northwestern Memorial Hospital (AA+); University of Chicago Hospitals and Health System (AA-); Loyola University Health System; and University of Illinois Medical Center (A), as well as other suburban hospitals and systems. RUMC has well-known programs in orthopedics, neurology, neurosurgery, geriatrics, and kidney disease; and has generally maintained its 2.7% market share. The immediate service area and larger Chicago area remain competitive.

Admissions have flattened, similar to other markets and hospitals, although RUMC has continued to experience good outpatient growth through focus on certain key service lines and physician recruitment. Fiscal 2011 inpatient

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acute care admissions were down 1.4% from the prior year to 27,568. However, in fiscal 2011 adjusted admissions at RUMC rose 1.6% to 49,143 with total surgeries stable at 26,329. RUMC has made slight gains more than the past few years in its market share to 2.7% in a very fragmented market. ROPH, which operates in a service area near RUMC, has become more closely integrated with RUMC's strategy and Rush has focused on strengthening certain key service lines across RUMC and ROPH. After a strong uptick in 2010, admissions at ROPH decreased slightly by 1% to 3,740 in 2011 but are still higher than 2009 levels.

RCMC is in a far-southwest Chicago suburb that has experienced favorable population growth, although recent economic challenges have negatively affected volumes in that market in addition to slowing growth. RCMC admissions were down 5.2% from the prior year to 12,577 in 2011. RCMC, however, maintains the leading market share, which has been growing, but decreased slightly in 2011 and is at 38.8%. Total adjusted discharges are up 3%, and surgeries increased about 1%, in fiscal 2011.

Finances: Positive Operating Income Trends In Recent Years

During the past five years, Rush has generated solid operating performance, with operating margins averaging 5.0% and operating cash flow margins averaging a healthy 11.9%. More specifically, unaudited fiscal 2011 generated $98.1 million (5.6% margin) of operating income, as compared with $89.4 million (5.3% margin) in fiscal 2010 (included in fiscals 2010-2011 operating income is the $23.0 million annual net payment from the IPT program that is approved through June 30, 2014). In addition to the solid outpatient volumes and the net payment from the IPT, management has made a concerted effort to manage its expenses and will continue efforts to do so during the next several years. Unaudited excess income of $114.4 million (6.5% margin) in fiscal 2011 was on par with the audited $101.6 million (6.0% margin) generated in fiscal 2010 due to the improvements from the investment markets. (We note that excess income excludes any gains or realized losses on discontinued operations, unrealized gains and losses on investments, changes in the fair value of interest-rate swaps as well as any gains/losses on sales, and losses on the extinguishment of debt.) Rush generated healthy 4.2x and 3.9x MADS coverage in fiscals 2011 and 2010, respectively.

According to its most recent plan from 2010, future operating and excess income margins should remain close to 2% and more than 5%, respectively, with EBIDA at 10%-12% to fund capital plans and begin to re-strengthen the balance sheet. Although management has operated within these targets for the past few years, the larger expense base, the general softness of the overall economy, and potentially lighter investment income required Rush to focus on core operations and key service-line enhancements. Management is updating its long-range financing plan to identify additional opportunities to strengthen its finances beyond current forecasts. Management is targeting an operating income of about $61.6 million in fiscal 2012, down from fiscal 2011 as the new patient tower is scheduled to open in mid-fiscal 2012.

Rush's balance sheet has remained relatively stable during the past year, despite increased spending for capital projects out of cash flow. However, balance sheet metrics could ease during the next year as management relies entirely on its own operating cash flow to complete and open its patient tower in 2012. Additionally, the state is experiencing some pressure and may delay payments to Rush as the year continues; Rush has a total of $150 million in two lines of credits as a back up to help manage any excess pressure related to receivables. As mentioned above, the largest-single project in Rush's capital plans is the new patient tower, which totals $637 million; to date, Rush has spent about $437 million on that project. There are other smaller projects scheduled to be completed during the

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Rating Update: MOODY'S UPGRADES RUSH UNIVERSITY MEDICAL CENTER OBLIGATED GROUP'S (IL) LONG-TERM AND UNDERLYING BOND RATINGS TO A2 FROM A3; OUTLOOK STABLE AT THE HIGHER RATING LEVEL

Global Credit Research - 08 Nov 2010

AFFECTS APPROXIMATELY $619 MILLION OF RATED DEBT

Illinois Finance Authority
Health Care-Hospital
IL

Opinion

NEW YORK, Nov 8, 2010 -- Moody's Investors Service has upgraded Rush University Medical Center Obligated Group's (RUMC Obligated Group) long-term and underlying bond ratings to A2 from A3 on bonds issued through the Illinois Finance Authority. The outlook is revised to stable from positive at the higher rating level. The upgrade reflects RUMC Obligated Group's improved operating performance in recent years, with particularly good results in audited fiscal year (FY) 2010 (adjusted 10.4% operating cash flow margin), despite facing a challenging economic environment and managing a major new hospital tower construction project on the main campus. This rating action affects approximately $619 million of rated bonds outstanding (see Rated Debt section at the end of this report).

RATINGS RATIONALE

LEGAL SECURITY: The bonds are secured by a gross revenue pledge and a mortgage pledge of the RUMC Obligated Group including Rush University Medical Center (RUMC) and Rush-Copley Medical Center (Copley). Rush North Shore Medical Center (North Shore) withdrew from the Obligated Group on December 31, 2008. Violating rate covenant of 1.1 times requires hiring of consultant. Additional debt test: (1) debt-to-Capitalization of 69% in FY 2009 (decreasing by 1% each year until 65% in FY 2012); or (2) Historical Pro-forma Debt Service Coverage greater than 1.25 times; or (3) Historical Debt Service Coverage greater than 1.1 times and Projected Debt Service Coverage greater than 1.1 times.

INTEREST RATE DERIVATIVES: The RUMC Obligated Group entered into fixed payor swaps with Morgan Stanley Capital Services, Inc. and Citibank, N.A. with a combined notional amount of $96.8 million that expire in November 2035. Under the agreements, the RUMC Obligated Group pays a fixed interest rate of 3.945% and receives 68% of LIBOR. $50 million of the interest rate swaps hedge the interest rate on the Series 2008AVRDB revenue bonds issued in December 2008. As a result of prior variable rate debt restructurings, the remaining $46.8 million notional amount is not hedging a particular variable rate bond series (the Obligated Group is considering terminating this portion of the interest rate swap depending on market conditions). The total net termination value of the swaps at audited fiscal year end (FYE) June 30, 2010 was a negative $18.9 million to RUMC Obligated Group. According to management, the net termination value of the swaps as of November 4, 2010 was a negative $20.7 million to RUMC. Management notes that the system has been required to post collateral.

STRENGTHS

*Sizeable academic medical center (AMC) with broad array of tertiary and quaternary services (the RUMC flagship had a Medicare case mix index of 2.01 in FY 2010)

*Track record of profitability since FY 2005 (10.4% adjusted operating cash flow margin in FY 2010)

*Improved liquidity with 143 days cash on hand at audited FYE 2010, up from 128 days at FYE 2009

*Significant restricted investments bolster liquidity; at FYE 2010, the system had $436 million of restricted investments (which excludes $61 of construction funds, $51 million of debt service reserve funds, and $145 million of self insurance funds)

CHALLENGES

*Very competitive AMC market in the Chicagoland as RUMC is one of five AMCs in the market

*Material capital projects continue, highlighted by construction of a new hospital tower on the RUMC flagship campus

*Somewhat modest 88% cash-to-debt compared to Moody's A2 medians (132% cash-to-debt)

*Underfunded defined benefit pension plan (72% pension funded ratio compared to a projected benefit obligation of $799 million at FYE 2010); management notes that the projected benefit obligation increased significantly from $614 million at FYE 2009 to $799 million at FYE 2010 due in part because of a significant decrease in the discount rate (from 6.85% to 5.45%)

*In August 2010 RUMC's CFO/Senior Vice President of Strategic Planning left for a position out of state and in September 2010 the Copley CFO retired. A process to replace the RUMC CFO, including a national search, currently is underway. Management notes that in the interim period RUMC's Vice President of Finance (who has over 25 years of experience in healthcare finance) is serving as the acting CFO. Copley recently promoted its Vice President of Finance (who has over 23 years of experience in healthcare finance) to CFO.

*The RUMC Obligated Group has been subject to various regulatory and similar reviews. Since June 2007, RUMC has been under review by the Office of Inspector General (OIG) with respect to anti-kickback and Stark laws regarding the lease of certain capital equipment and space to private physicians. According to management, in March 2010, RUMC entered into a $1.6 million settlement with federal government and State of Illinois. Also according to management, the remaining claims, in which the federal government and State of Illinois are not participating, were dismissed in US District Court in early November 2010.

RECENT DEVELOPMENTS/RESULTS

RUMC is the System's flagship hospital and is one of five AMCs in the Chicagoland market. Other academic medical centers in the market include: 20,500 admission University of Illinois Health Services; 47,700 admission Northwestern Memorial Hospital (rated Aa2); 32,400 admission Loyola University Health System (rated Baa3); and 22,700 admission The University of Chicago Medical Center (rated Aa3). In addition to the competing academic medical centers, RUMC faces competition from a number of sizeable acute care systems in the market, notably market share leader Aa2 rated Advocate Health Care Network and Baa1 rated Resurrection Health Care. Northwestern Memorial is the largest single hospital in the Chicagoland. RUMC shares a state-designated medical district campus with the University of Illinois Health Services, the John H. Stroger Jr. Hospital of Cook County, and the Jesse Brown VA Medical Center.

In addition to the RUMC flagship hospital, the RUMC Obligated Group includes 13,600 admission Copley in Aurora, IL. Effective December 31, 2008, Rush North Shore withdrew from the Obligated Group and joined Aa2 rated NorthShore University Health System. RUMC, through a joint venture with a third-party, operates and manages 4,500 admission Rush Oak Park Hospital (ROPH) in Oak Park, IL. Other non-obligated system affiliates include A2 rated Riverside Health System in Kankakee, IL.

The RUMC Obligated Group's operating performance generally has improved in recent years, which we view as a key credit positive. In audited FY 2010 (June 30 year end), the RUMC Obligated Group recorded adjusted operating income of $45.0 million (2.7% operating margin) and adjusted operating cash flow of $174.6 million (10.4% operating cash flow margin). In audited FY 2009, the RUMC Obligated Group recorded adjusted operating income of $59.5 million (3.7% margin) and operating cash flow of $168.8 million (10.5% margin) (Rush North Shore is not including in results beginning audited FY 2009). The FY 2009 and FY 2010 audited results are adjusted to reclassify the portion of investment included in operating revenue to non-operating ($9.2 million in FY 2009, $6.3 million in FY 2010) and to include capitalized interest in interest expense ($8.2 million in FY 2009, $18.1 million in FY 2010). FY 2010 is adjusted further to add $18.0 million to operating expense to account for a favorable one-time IRS settlement related to FICA tax on medical residents. Since FY 2005, RUMC Obligated Group has maintained profitable operating results. Looking forward, management is targeting an operating cash flow margin of between 10%-12% through FY 20016. To maintain these margins despite Medicare rate pressures management has identified significant expense savings and revenue growth initiatives over three years.

Factors contributing to continued good operating results for the RUMC Obligated Group in FY 2010 include: (a) while system inpatient admissions essentially were flat in FY 2010 observation stays increased 19.6% over FY 2009, resulting in a 3.2% increase in total combined admissions (management notes that admissions in the market are down, and as a result the system's market share has increased); (b) total surgery volumes increased 2.5% in FY 2010; (c) increased acuity, as, according to management, the Medicare case mix index (CMI) at the RUMC flagship increased from 1.83 in FY 2008 to a very high 2.01 in FY 2010 while the estimated system Medicare CMI increased from 1.74 to 1.89 over the period (the all ratings median Medicare CMI is 1.57); and expense savings efforts (the system's unadjusted total operating expenses increased a modest 3.8% in FY 2010).

The RUMC Obligated Group's Moody's adjusted debt ratios are somewhat modest, although adequate at the A2 rating level. Based on FY 2010 results, adjusted maximum annual debt service (MADS) coverage measures 4.0 times (A2 median is 5.0 times), adjusted debt-to-cash flow measures 3.9 times (A2 median is 3.2 times), and debt-to-total operating revenues measures 41% (A2 median is 34%).

The RUMC Obligated Group's unrestricted liquidity position improved in FY 2010. Absolute unrestricted cash and investments increased to $605 million at audited FYE 2010 (June 30 year end) from $514 million at audited FYE 2009. As a result, Moody's adjusted cash on hand improved to 143 days at FYE 2010 from 128 days at FYE 2009 (A2 median is 169 days). Due to the issuance of $200 million of Series 2009C&D fixed rate bonds shortly after FYE 2009, cash-to-debt decreased to a modest 88% at FYE 2010 from 101% at FYE 2009 (A2 median is 132%). According to management, at FYE 2010 RUMC Obligated Group's unrestricted cash and investments were allocated among approximately 90.7% cash and fixed income securities, 9.0% equities, and approximately 0.2% to other investments, and 100% of unrestricted cash and investments could be liquidated within one month. Due to expected cash and cash flow contributions to the system's material capital spending plans, absolute cash growth may be limited in the next year or two. Accordingly, management projects cash on hand to drop to approximately 120 days at FYE 2011 and FYE 2012 before rebuilding thereafter.

The RUMC Obligated Group is in the middle of a significant capital spending phase. The highlighted project is construction of the new RUMC hospital tower, which started in the last quarter of 2008 and is expected to open in early calendar year 2012. Management notes that the hospital tower is on schedule. Other key initiatives currently being developed include construction of an outpatient cancer center (which is expected to open in early calendar year 2011) and continued rollout of an electronic medical record system. Management does expect to issue additional new money debt in the coming years.

Outlook

The stable outlook at the higher rating level reflects our belief that the RUMC Obligated Group will continue to generate good operating results and that the system's liquidity ratios will improve after cash and cash flow contributions are made in FY 2011 and FY 2012 to support the capital projects.

What could change the rating – UP

Sustained cash flow growth and significantly improved debt ratios after completion of the new RUMC hospital tower project; material increase in liquidity ratios

What could change the rating – DOWN

Sustained weakening of operating results leading to thinner debt coverage and liquidity ratios; material market share loss; significant operating disruptions due to construction projects; material cost overrun of construction projects; unexpected increase in debt without commensurate increase in cash flow generation

KEY INDICATORS

Assumptions & Adjustments:

-Based on Rush University Medical Center Obligated Group consolidated financial statements

-First number reflects audited FY 2009 for the year ended June 30, 2009

-Second number reflects audited FY 2010 for the year ended June 30, 2010

-Interest expense adjusted to include capitalized interest

-FY 2010 adjusted to add $18.0 million to operating expense to account for a favorable one-time IRS settlement related to FICA tax on medical residents

-Investment returns reclassified as non-operating revenue and smoothed at 6%

*Inpatient admissions: 48,701; 48,683

*Total operating revenues: $1.61 billion; $1.68 billion

*Moody's-adjusted net revenues available for debt service: $212.2 million; $221.5 million

*Total debt outstanding: $511 million; $687 million

*Maximum annual debt service (MADS): $42.0 million; $55.1 million

*MADS Coverage with reported investment income: 4.18 times; 3.91 times

*Moody's-adjusted MADS Coverage with normalized investment income: 5.06 times; 4.02 times

*Debt-to-cash flow: 2.73 times; 3.88 times

*Days cash on hand: 128 days; 143 days

*Cash-to-debt: 100.6%; 88.0%

*Operating margin: 3.7%; 2.7%

*Operating cash flow margin: 10.5%; 10.4%

RATED DEBT

Issued through Illinois Finance Authority (debt outstanding as of June 30, 2010):

-Series 2009C&D Fixed Rate Hospital Revenue Bonds ($200.0 million outstanding), rated A2

-Series 2009A&B Fixed Rate Hospital Revenue Bonds ($211.6 million outstanding), rated A2

-Series 2008A VRDB Hospital Revenue Bonds ($50.0 million outstanding), supported by irrevocable direct-pay letter of credit (LOC) from The Northern Trust Company and rated Aa1/VMIG1 (reflecting Moody's approach to rating jointly supported transactions) (the LOC expires in December 2012), A2 underlying rating

-Series 2006B Fixed Rate Hospital Revenue Bonds ($86.8 million outstanding), insured by MBIA, rated A2

-Series 1998A Fixed Rate Hospital Revenue Bonds ($80.6 million outstanding), insured by MBIA, rated A2

CONTACTS

Obligor: Tony Davis, Vice President of Finance and Acting CFO, (312) 942-6158; Patricia O'Neil, Associate Vice President and Chief Investment Officer, (312) 942-5647

Financial Advisor: Errol Brick, Kilkarney Group, (212) 949-6858

Underwriter: Bruce Gurley, Morgan Stanley, (312) 706-4267

The last rating action with respect to RUMC Obligated Group was on July 1, 2009, when a municipal finance scale rating of A3 was assigned and affirmed and the outlook remained positive. That rating was subsequently recalibrated to A3 on May 7, 2010.

The principal methodology used in this rating was Not-for-Profit Hospitals and Health Systems published in January 2008.

REGULATORY DISCLOSURES

Information sources used to prepare the credit rating are the following: parties involved in the ratings, parties not involved in the ratings, public information, confidential and proprietary Moody's Investors Service information.

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$46,230,784	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;
$46,230,784	g)	All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
	TOTAL FUNDS AVAILABLE	

Rush has been awarded Tax Incremental Financing (TIF) by the City of Chicago (the City) under the Tax Increment Allocation Redevelopment Act (the Act). Such monies can be utilized to pay for expenditures associated with renovation projects that qualify for reimbursement under the Act, provided that Rush has complied with all other terms of the Redevelopment Agreement (RDA) between Rush and the City. Rush believes that all or a portion of this project qualifies for TIF reimbursement, and that it will be in compliance with all other terms of the RDA. Rush must first expend the monies and then submit to an application process as prescribed by the RDA in order to received the funds, which might not be received prior to the completion of this project. As such, funding for this project is accordingly reflected as Cash & Securities.

Rush University Medical Center and Subsidiaries

Consolidated Financial Statements as of and for the Years Ended
June 30, 2011 and 2010, and Independent Auditors' Report

RUSH

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

Not Applicable

Rush University Medical Center has an A- Bond Rating from Fitch Ratings and Standard and Poor's Research as well as an A^2 rating from Moody's Investor Service. The project will be funded through internal sources.

IX. 1120.130 - Financial Viability **Not Applicable – Rush University Medical Center has an A- Bond rating and therefore meets the waiver requirements.**

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.

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 NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements - The modernization of the Atrium Building will be financed with cash and securities. See Attachment 42, Exhibit 1.

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

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

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

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

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

B. Conditions of Debt Financing Not Applicable. No debt financing will be used to finance the project

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

1) That the selected form of debt financing for the project will be at the lowest net cost available;

2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;

3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

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

* Include the percentage (%) of space for circulation

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

E. Total Effect of the Project on Capital Costs

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

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

D. Criterion 1120.310.d, Projected Operating Costs

Completion of the project detailed in this application is anticipated to be **[June 2016]**. The first full fiscal year of operation after project completion will be **2017**.

It is estimated that direct operating costs in **FY2017** will be **$1,416.7**million or **$3,850.39** per equivalent patient day.

	FY2017
Salaries & Wages	$ 723,491
Benefits	194,744
Supplies	498,509
Estimated Direct Operating Costs (000's)	$ 1,416,744
Projected Total Patient Revenues (000's)	$ 4,204,799
Projected Inpatient Revenues (000's)	$ 2,132,543
% Total Revenues/Inpatient Revenues	197.2%
Projected Patient Days	186,612
Projected Equivalent Patient Days	367,948
Estimated Direct Operating Costs per Equivalent Patient Day	$ 3,850.39

E. Criterion 1120.310.e, Total Effect of the Project on Capital Costs

Completion of the project detailed in this application is planned for **[June 2016]**. Accordingly, the first full fiscal year of operation of the new facility proposed by this project is **2017**.

The estimated total project cost is $**[46.2]** million. It is estimated that the cost for this project will result in increased annual capital costs to Rush University Medical Center of approximately $**[0.9]** million or $**[2.51]** per equivalent patient day.

	FY2017
Total Project Cost (000's)	$ 46,231
Useful Life (in years)	50
Project Capital Costs (000's)	$ 925
Projected Total Patient Revenues (000's)	$ 4,204,799
Projected Inpatient Revenues (000's)	$ 2,132,543
% Total Revenues/Inpatient Revenues	197.2%
Projected Patient Days	186,612
Projected Equivalent Patient Days	367,948
Project Capital Costs per Equivalent Patient Days	$ 2.51

Departmental Gross Square Footage Per Clinical Department / Area									
	A	B	C	D	E	F	G	H	
	Cost/SF		Area (SF)		Gross Sq. Ft.		Const.$	Mod. $	Total Cost
Clinical Department / Area	New	Mod.	New	Circ.*	Mod.	Circ.	(A x C)	(B x E)	(G + H)
CLINICAL									
Medical / Surgical Beds		65.04			69,792			4,539,187	4,539,187
Pediatric Beds		136.78			11,520			1,575,712	1,575,712
Obstetric Beds		23.11			19,131			442,169	442,169
Newborn Nursery		316.13			1,174			371,133	371,133
Surgical Operating Suite (Class C)		130.74			6,061			792,415	792,415
Post Anesthesia Recovery Phase I		327.95			4,445			1,457,716	1,457,716
Surgical Operating Suite (Class B) (Endoscopy Suite)		327.95			9,109			2,987,252	2,987,252
Post Anesthesia Recovery Phase II		237.80			11,692			2,780,406	2,780,406
Antepartum Testing		151.14			889			134,362	134,362
									0
TOTAL CLINICAL		112.70			133,813			15,080,354	15,080,354
NON-CLINICAL									
Mechanical / Infrastructure		445.97			33,978			15,153,205	15,153,205
Public / Family Spaces		108.30			10,116			1,095,536	1,095,536
General		241.11			6,830			1,646,775	1,646,775
TOTAL NON-CLINICAL		351.42			50,924			17,895,517	17,895,517
TOTAL CONSTRUCTION								32,975,870	32,975,870
TOTAL CONTINGENCY								4,946,381	4,946,381
Grand Total								37,922,251	37,922,251

XI. Safety Net Impact Statement

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

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

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

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

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

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

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

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

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

Safety Net Information per PA 96-0031

CHARITY CARE

	2011 (in thousands)	2010 (in thousands)	2009 (in thousands)
Charity, (# of Patients)			
Inpatient	2,384	2,305	1,788
Outpatient	16,652	15,061	10,785
Total	19,036	17,366	12,573
Charity, (cost in dollars)			
Inpatient	$ 8,257	$ 7,966	$ 8,311
Outpatient	$ 9,950	$ 9,507	$ 7,903
Total	$ 18,207	$ 17,473	$ 16,214
MEDICAID			
Medicaid, (# of Patients)			
Inpatient	7,065	6,880	6,763
Outpatient	88,748	84,231	73,584
Total	95,813	91,111	80,347
Medicaid, (revenue)			
Inpatient	$ 402,933	$ 408,929	$ 379,908
Outpatient	$ 254,846	$ 228,672	$ 191,891
Total	$ 657,779	$ 637,601	$ 571,799

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

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.*

RUMC's Investments in the Community, 2007 through 2011

Rush University Medical Center's (Rush, Medical Center, RUMC) has an established history of providing safety net services to its community. Rush's investments in the community for each of the last 5 years are described in detail in Attachment 43, Exhibit 1. As presented in this exhibit, total community benefits provided by the Medical Center and Rush Oak Park Hospital (ROPH) between 2007 and 2011 increased by 64.1 percent, or from $134,570,000 to $220,778,000.

The Medical Center's consolidated 2011 Annual Non Profit Hospital Community Benefits Plan Report is included as Attachment 43, Exhibit 2. The Medical Center's Mission Statement and the complete FY 2011 Community Benefits Report are provided in Appendix D.

Rush funds a variety of vital programs that help meet specific health needs of the Medical Center's broad community. These include numerous health outreach projects in which Rush partners with neighborhood clinics, churches, schools and other centers to provide health screenings and vital health information for underserved children, youth and adults of all ages.

The modernization of the Atrium Building will have the following material impact(s) on the Medical Center's ability to provide safety net services in the community. According to Medicaid Cost Reporting Hospital Ranking of Medical Assistance Admissions and Covered Days for the year ending June 10, 2010, Rush University Medical Center ranked fifth in total Medicaid days and eighth in Medicaid admissions to Illinois and other hospitals reported.

The following hospitals ranked among the top 10 for Medicaid admissions and Medicaid patient days.

Top Ten Ranked Hospitals for Medicaid Patient Days and Admissions
Attachment 43, Table___

Hospital Name	Patient Days Rank	Admissions Rank
Saints Mary and Elizabeth Medical Center	1	1
Advocate Christ Medical Center	2	3
Kindred Hospital – Chicago Northlake	3	79
University of Illinois Medical Center @ Chicago	4	7
Rush University Medical Center	5	8
Mount Sinai Hospital Medical Center	6	2
University of Chicago Medical Center	7	13
Northwestern Memorial Hospital	8	5
OSF Saint Francis Medical Center	9	6
John H. Stroger Hospital of Cook County	10	10

Source: Illinois Medicaid Cost Reporting

Rush is clearly a major provider of Medicaid services (both inpatient and outpatient) and as such is an important safety net resource for the Medicaid population. The modernized medical surgical, pediatric, and obstetrical services will ensure code compliant, comfortable inpatient, surgery, endoscopy and recovery facilities for these patients.

Rush's new Emergency Department in the East Tower opened in January 2012. It is larger and far more accessible than the department that was replaced. This expanded state-of-the-art Emergency Department will be able to provide emergency safety net services to the West Side community. Approximately 22 percent of these visits will become admissions and will also need the inpatient and interventional services that are being modernized as part of the proposed project.

Further, the new Emergency Department has adequate ambulance capacity to expedite the transfer of high risk mothers and neonates as well as other adult and pediatric patients who need the advanced services offered by Rush. In this way, Rush serves as a safety net to not only the local community but also to Rush's broader regional service area.

Any weakening of the Medical Center with its emergency, inpatient, and outpatient services would diminish the availability of safety net services for the residents of Cook County and beyond.

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

Rush's proposed modernization of the Atrium and Kellogg buildings should not impact the ability of other providers or health care systems to cross-subsidize safety net services. The project does not include any increases in market share or market reach; the patients that will use the services in the modernized space have historically been served by the Medical Center.

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

Not applicable. There are no facilities or services being discontinued by the Medical Center as part of this project.

Safety Net Impact Statements shall also provide 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 Benefit 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.*

   Rush University Medical Center certifies that the following charity care information is complete and accurate and in accordance with the Illinois Community Benefits Act, and certifies the amount of care provided to Medicaid patients is consistent with the information published in the Annual Hospital Profiles.

The following table is in the required format.

Safety Net Information per PA 96-0031

CHARITY CARE

	2011 (in thousands)	2010 (in thousands)	2009 (in thousands)
Charity, (# of Patients)			
Inpatient	2,384	2,305	1,788
Outpatient	16,652	15,061	10,785
Total	19,036	17,366	12,573
Charity, (cost in dollars)			
Inpatient	$ 8,257	$ 7,966	$ 8,311
Outpatient	$ 9,950	$ 9,507	$ 7,903
Total	$ 18,207	$ 17,473	$ 16,214
MEDICAID			
Medicaid, (# of Patients)			
Inpatient	7,065	6,880	6,763
Outpatient	88,748	84,231	73,584
Total	95,813	91,111	80,347
Medicaid, (revenue)			
Inpatient	$ 402,933	$ 408,929	$ 379,908
Outpatient	$ 254,846	$ 228,672	$ 191,891
Total	$ 657,779	$ 637,601	$ 571,799

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

Rush University Medical Center performs many community benefits activities in neighborhoods within and surrounding the Illinois Medical District and throughout Chicago. Rush defines its immediate community using the recognized Chicago Community Areas of:

- 24-West Town
- 27-East Garfield Park, and
- 28-Near West Side.

Despite these boundaries, Rush does not plan to discontinue those activities currently undertaken outside the aforementioned community areas. For example, the Science and Math Excellence Network supports educational efforts in Chicago Public Schools across the city in more than 40 schools. In addition, Rush's financial assistance policies apply to all Rush patients in the State of Illinois.

RUMC provides a wide range of community benefits activities that fall into each of the four components of Rush's mission statement.

Rush's Mission and Related Community Benefits Activities

The Mission of Rush University Medical Center is "to provide the very best care for our patients. Our education and research endeavors, community service programs and relationships with other hospitals are dedicated to enhancing excellence in patient care for the diverse communities of the Chicago area, now and in the future."

1) To provide the very best patient care for the diverse communities of the Chicago area now and into the future

   Rush is a leading provider of patient care in the Chicago area and beyond. The Medical Center has received national recognition from *U.S. News & World Report* and the University HealthSystem Consortium (UHC). UHC ranked Rush among the top performers in the University Health Consortium's annual Quality and Accountability study. Rush has consistently received a perfect score of 100 percent in the category of "equity of care." This ranking measures whether patients receive the same quality treatment and have the same outcomes regardless of their gender, race, or socioeconomic status. Rush ranked better than any other hospital in the State of Illinois for equity of care.

   During FY 2011, Rush and Rush Oak Park Hospital provided $143.4 million in unreimbursed care to its patients. Unreimbursed care consists of charity care provided to patients who lack the means to pay for services (at cost), bad debt (at expected payment, not charges), and unreimbursed costs for Medicare and Medicaid services. Rush recognizes the need to expand assistance to the growing population of uninsured and underinsured patients. Rush's generous Financial Aid Policy is included in Attachment 44.

The Medical Center provides a full range of medical services to the community including an emergency department that is never closed and is open to everyone regardless of their ability to pay as well as numerous services that operate at a loss. Rush also provides primary and preventive care through its physician clinics as well as the community service projects operated by patient care staff. In this way, Rush hopes to have an impact on the health of patients before they get to the point of visiting the emergency department. During FY 2011, Rush subsidized $6.1 million in losses at physician clinics incurred from treating uninsured patients and those covered by Medicare and Medicaid.

As described in greater detail in the Community Benefits Plan Report, Rush has incurred $1.1 million in costs maintaining a staff of Spanish language interpreters and to supply other-language and sign language interpreter services.

These financial commitments are critical to providing safety net services the best patient care to the diverse communities of the Chicago area.

2) To provide education endeavors to enhance excellence in patient care for the diverse community of the Chicago area now and into the future

Rush is committed to providing programs to educate and train the health care workforce of the future. It is widely recognized that workforce demands in health care will rapidly escalate as the U.S. population ages. To help meet this need, Rush trains future physicians, nurses, and allied health professionals. During FY 2011, Rush provided $42.9 million in unreimbursed costs to maintain these education programs.

Rush is a recognized leader in health sciences education and is nationally ranked as a provider of top graduate programs. Each of the four colleges – Rush Medical College, the College of Nursing, the College of Health Sciences, and the Graduate College – supports the research and patient care endeavors of the Medical Center.

Recent records indicate that approximately 35 percent of Rush Medical College graduates secured their residency programs in the Chicago metropolitan area. Additionally 56 percent of the Rush College of Nursing entry-level nurse graduates and 50 percent of the advanced practice nurse graduates assume careers in the Chicago area. These statistics reflect the importance of Rush in the training of physicians and nurses to provide safety net services in the community.

Rush is the primary academic affiliate of the John H. Stroger Jr. Hospital of Cook County. Stroger Hospital is one of the busiest and most venerable public hospitals in the nation. The patient population at Stroger Hospital benefits from access to Rush specialists and the medical students experience first hand the essential need for safety net services. Each year, more than 400 Rush students and postgraduate residents receive training at Stroger Hospital.

The Rush College of Nursing was established in 1972 and more than 6,000 baccalaureate, master and doctoral students have graduated since then. Rush College of Nursing consistently ranks among the top 5 percent of nursing schools nationwide.

3) To provide research endeavors to enhance excellence in patient care for the diverse communities of the Chicago area now and into the future

Rush is committed to advancing medical care through translational research that aims to bring advances and improvements gained in research as rapidly as possible to the patient's bedside. Investigators at Rush are involved in numerous clinical studies to test the effectiveness and safety of new therapies and medical devices as well as many basic research studies designed to expand scientific and medical knowledge. The following are examples of current research activities and illustrate the wide range of community-based and clinical research taking place at Rush:

- Alzheimer's Disease Community-Based Epidemiologic Studies
- Chicago Parenting Program
- The Fatherhood Program and,
- Behavioral Intervention and Cardiovascular Disease

These and other research initiatives support Rush's commitment to safety net services.

4) To provide community service programs and build relationships with other hospitals to enhance excellence in patient care for the diverse communities of the Chicago are now and into the future

In addition to dedicating resources to patient care, education, and research activities, Rush has historically and continues to place emphasis on community service activities and relationships with other health care providers. During FY 2011, Rush provided over $5.7 million in other community benefits programs and over $2.7 million in volunteer time for various community outreach activities. Additionally, Rush made $358,000 in direct donations to various community groups and medical organizations throughout the Chicago area.

Rush's educational mission is the driving force behind the Medical Center's goal to provide students with unique exposure to the numerous public health disparities in Chicago while also offering distinctive opportunities for hands-on learning experience. The following are a number of programs that demonstrate Rush's commitment to improving the health of the Chicago community.

- Rush Community Service Initiative Programs
    - Clinic at Franciscan House of Mary & Joseph (Major source of medical care for 235 men and 35 women at the Franciscan House of Mary & Joseph shelter.)
    - Community Health Clinic (Provides free preventive and primary care services to members of the community who cannot afford or are ineligible for medical insurance; the Clinic hosts patient education classes and over 20 different specialty clinics; Rush volunteers cared for 700 patients in FY 2011.)
    - Chicago City Church (Free clinic at a church on Chicago's Southside that serves local residents and homeless persons.)
    - Freedom Center (Formerly the Pilsen Homeless Health Services.)
    - 20/20 (Free vision services to underserved populations.)

- Haymarket Center (A 400-bed medical detox facility serving 18,000 primarily homeless and indigent residents of Illinois. Rush provided 90 volunteers in 2011.)
- RU Caring Interdisciplinary Student Program (RU Caring significantly impacts the community through diverse initiatives such as comprehensive health fairs, health benefits enrollment, and referrals for follow-up care. RU Caring works to help others achieve wellness in several aspects of their lives.)

- Rush Community Service Initiative Non–Clinical Programs
  - BUDDIES Program (In cooperation with the Rush Departments of Pediatrics and Family Medicine, the BUDDIES program matches Rush medical student volunteers with chronically ill children and acts as a special "buddy" by visiting the child at the Medical Center.)
  - Healthifying the Refugee Transition (This program provides health- and medical-based workshops that educate refugee children in transitioning to life in America.)
  - Heart to Soles (Rush medical students in partnership with Midwest Orthopaedics at Rush examine the ankles and feet of residents of Franciscan House of Mary & Joseph.)
  - Keep It Fit Chicago (Partnership between Rush and the Salvation Army. Purpose is to work with families to help them achieve a better understanding of the roles nutrition and physical activity play in creating a healthier lifestyle.)
  - Marah's Place Health Education Program (Rush students prepare and present health education seminars to women who use the shelter's services.)

- Maternal Advocate's Program (Rush students partner with the Simpson Academy to provide health education, guidance, and resources to teenage mothers in advance of, during, and following childbirth.)
- Other programs include MLK Day of Service, Multicultural Summer Enrichment, Original Change Project, Red Ribbon Friends, Rush REMEDY, and Sankofa Initiatives.

- Science and Math Excellence Network (This is a large scale community service enterprise operated through the Department of Community Affairs at Rush to improve science, math, and reading test scores in Chicago schools on the West and Southwest sides of the City.)
  - Specific programs include the College Internship Program, College Preparatory Enrichment Program, Educator Program (formerly Preschool Teachers' Program), Lending Program (formerly the Scholars Program), High School Internship Program, Preschool Program, Network Preschool Science Awards Banquet, Rev. Dr. Martin Luther King, Jr. Memorial Service, and Coalition of HOPE (formerly the Senior Coalition.)

- Pediatric/Adolescent Community Health Programs
  - Specific outreach programs include: Kids-Shelter Health Improvement Project, Rush University Medical Center Adolescent Family Center, Rush Stroger Affiliation Agreement-Pediatrics, Pediatric Infectious Disease Faculty Outreach, Reach Out and Read, Rush University and the Medical Center Adolescent Clinic.

- Other Community Service Programs and Collaboration
  - Cook County Health and Hospitals System
  - Faculty Practice and Outreach
    - School-Based Health Centers

- Wellness Program with the Chicago Department of Family and Support Services
- Anne Byron Waud Patient and Family Resource Center for Health and Aging of Rush Generations
- Rush Mothers' Milk Club
- Rush Preemie Picnic
- Principal–For-A-Day Program
- You Care, the Rush Employee Community Grant Program
- Blood Drives and Donate Life Events
- Emergency Preparedness
- Partnership with Chicago Bulls' Read to Achieve Program
- Partnership with Malcom X College
- Community Workforce Hiring
- Alzheimer Disease Multicultural Outreach

- Department of Preventive Medicine
    - The Mexican-American Trial of Community Health Workers
    - Block-by-Block: The Greater Humboldt Park Community Campaign against Diabetes
    - HART Trial
- Building a Healthier Chicago Health Surveillance Pilot Program
- Community Benefits Plan & Health Assessment

- Integration with Chicago Department of Public Health's Strategic Plan

  Chicago surveys the health services it provides its citizens. The Chicago Department of Public Health initiated a strategic planning process aimed to focus the energies of the department, set organizational priorities, and guide the allocation of public health resources.

  Many of the community benefits/safety net activities implemented by RUMC address the Chicago Department of Public Health's strategic priorities. Rush's Community Benefits Plan focuses on applying the institutional strengths and available resources to programs that improve the physical, educational, and economic health of its communities. To further the effort, Rush continues to participate in the Metropolitan Chicago Healthcare Council's Community Needs Assessment Program and remains committed to collaborations that help identify and address those needs in the communities served by Rush. More information about these programs is in the RUMC Community Benefits Report which is provided in full in Appendix D.

Rush's Investment in the Community

	FY 2011 (in thousands)	FY 2010 (in thousands)	FY 2009 (in thousands)	FY 2008 (in thousands)	FY 2007 (in thousands)
Charity care and financial assistance	$18,207	$17,473	$ 16,214	$ 8,916	$ 5,179
This is the cost to provide services to patients who lack the means to pay and who were qualified for charity care or financial assistance under one of Rush's policies. Rush provides free care to patients with income levels under 250 percent of the federal poverty guideline who provide information that allows Rush to properly identify them. These are the only patients that are included in the accumulation of this amount. Care is provided at cost to patients who make up to four times the federal poverty level, and interest free payment plans are also available. Rush also provides a 50 percent discount for all patients without insurance, regardless of whether a request is made for financial assistance. These additional amounts foregone in terms of financial assistance are not included in the charity care amount.					
Expected payments not paid	38,768	34,059	40,523	35,927	33,719
These are expected payments that were not paid for health services that Rush provided. Expected payments are those due to Rush after consideration of discounts to insurers, government payers and patients who are responsible for their own bills. Payments that cannot be collected from patients who fail to provide required information to identify them for financial assistance must be categorized in this amount categorized as bad debt.					
Cost not covered by reimbursements from Medicare and Medicaid	86,436	84,372	69,304	68,306	40,299
These are costs in excess of reimbursements for government-Sponsored health care (Medicare and Medicaid).					
Total unreimbursed care	143,411	135,904	126,041	113,149	79,197

Rush's Investment in the Community

	FY 2011 (in thousands)	FY 2010 (in thousands)	FY 2009 (in thousands)	FY 2008 (in thousands)	FY 2007 (in thousands)
Support for educational programs	42,933	40,366	39,705	36,030	33,351
Support for research programs	18,343	13,808	11,487	10,114	10,565
Subsidized health services	6,068	4,827	8,402	7,987	6,627
Rush provides services in response to community needs that, because they operate at a financial loss, must be subsidized from other revenue sources. These services include pediatrics, primary care clinics, palliative care, to name a few.					
Language - assistance services	1,079	833	819	438	370
Donations	358	169	383	402	420
Included in this figure are donations of goods and services, such as meeting space and equipment to assist other community heath efforts.	2,798	2,897			
Volunteer services	5,788	1,894	2,447	2,202	1,927
Other community benefits			2,129	1,912	2,122
Total community benefits and services	**$ 220,778**	**$ 200,698**	**$ 191,413**	**$ 172,234**	**$ 134,579**

Source: Community Benefits Report

Form AG-CBP-I
2/05

LISA MADIGAN
ATTORNEY GENERAL

Annual Non Profit Hospital Community Benefits Plan Report

Hospital or Hospital System: _Rush University Medical Center_____

Mailing Address: ___1653 W. Congress Parkway_____Chicago, IL 60612_____
(Street Address/P.O. Box) (City, State, Zip)

Physical Address (if different than mailing address):

_____
(Street Address/P.O. Box) (City, State, Zip)

Reporting Period: _7__/_1_/_10__ through _6__/__30___/_11___ Taxpayer Number: ___36-2174823_____
Month Day Year Month Day Year

If filing a consolidated financial report for a health system, list below the Illinois hospitals included in the consolidated report.

Hospital Name	Address	EIN #
_Rush Oak Park Hospital_____	__520 S. Maple Avenue_____	_36-2183812_____
_____	__Oak Park, IL 60304_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. **ATTACH Mission Statement:**
The reporting entity must provide an organizational mission statement that identifies the hospital's commitment to serving the health care needs of the community and the date it was adopted.

2. **ATTACH Community Benefits Plan:**
The reporting entity must provide it's most recent Community Benefits Plan and specify the date it was adopted. The plan should be an operational plan for serving health care needs of the community. The plan must:
   1. Set out goals and objectives for providing community benefits including charity care and government-sponsored indigent health care.
   2. Identify the populations and communities served by the hospital.
   3. Disclose health care needs that were considered in developing the plan.

3. **REPORT Charity Care:**
Charity care is care for which the provider does not expect to receive payment from the patient or a third-party payer. Charity care does not include bad debt. In reporting charity care, the reporting entity must report the actual cost of services provided, based on the total cost to charge ratio derived from the hospital's Medicare cost report (CMS 2552-96 Worksheet C, Part 1, PPS Inpatient Ratios), not the charges for the services.

Charity Care..... $_18,207,186_

ATTACH Charity Care Policy:
Reporting entity must attach a copy of its current charity care policy and specify the date it was adopted.

4. **REPORT Community Benefits** actually provided other than charity care:
See instructions for completing Section 4 of the Annual Non Profit Hospital Community Benefits Plan Report.

Community Benefit Type

Language Assistant Services	$ 1,078,333
Government Sponsored Indigent Health Care	$ 86,436,308
Donations	$ 358,008
Volunteer Services	
a) Employee Volunteer Services	$
b) Non-Employee Volunteer Services	$
c) Total (add lines a and b)	$ 2,797,919
Education	$ 42,932,847
Government-sponsored program services	$ 0
Research	$ 18,343,000
Subsidized health services	$ 6,068,126
Bad debts	$ 38,768,171
Other Community Benefits	$ 5,788,074

Attach a schedule for any additional community benefits not detailed above.

5. **ATTACH Audited Financial Statements for the reporting period.**

Under penalty of perjury, I the undersigned declare and certify that I have examined this Annual Non Profit Hospital Community Benefits Plan Report and the documents attached thereto. I further declare and certify that the Plan and the Annual Non Profit Hospital Community Benefits Plan Report and the documents attached thereto are true and complete.

Larry J. Goodman, M.D., CEO
Name / Title (Please Print)

312-942-7073
Phone: Area Code / Telephone No.

Signature

12/15/11
Date

Gena Faas
Name of Person Completing Form

312-942-6559
Phone: Area Code / Telephone No.

Gena_Faas@rush.edu
Electronic / Internet Mail Address

312-942-6561
FAX: Area Code / FAX No.

XII. Charity Care Information

Charity Care Information MUST be furnished for ALL projects.

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

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

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

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

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

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

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

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 to net patient revenue.*

Rush University Medical Center's Philosophy of Charity Care

From physicians to students to nurses, support staff and administrators, everyone at Rush University Medical Center (Rush, the Medical Center) has one common purpose: to provide the very best care to patients. Guided by shared vision, values, and mission, Rush is dedicated to enhancing patient care. Through its educational and research endeavors, community service programs, and relationships with other hospitals, Rush expresses its dedication to enhancing patient care. For more than 170 years, Rush has been dedicated to serving the diverse communities in the local West Side neighborhood, in Chicago, in Cook County, and beyond.

The key component of Rush's "patients first" mission is meeting the health care needs of all patients, regardless of their ability to pay. All of Rush's staff and employees treat every patient as they would members of their own family – with compassion, understanding, and respect for their unique needs.

The University HealthSystem Consortium (UHC) has awarded Rush a perfect score 5 years in a row for "equity of care" during its annual quality and safety benchmark studies that it conducts with member institutions. This ranking measures whether patients receive the same quality of treatment and have the same outcomes regardless of their gender, race, or socioeconomic status. This is just one of the reasons UHC has named Rush one of the nation's "top-performing hospitals" for the last 2 years. Year after year, Rush is consistently ranked by *U.S. News & World Report* as one of the top medical centers in the country; many Rush physicians are routinely listed among Chicago magazine's "Top Doctors."

As further evidence of Rush's dedication to the community, the Medical Center and Rush Oak Park Hospital provided more than $220 million in community benefits in FY 2011 – more than 18 percent of net patient revenue – to the West Side, to the people of Chicago and Cook County, across the State of Illinois. Part of this total was $126 million in unreimbursed, but much needed, care that Rush provided to its patients.

Charity Care Assistance

Rush University Medical Center's Charity Care Policies and a complete description of all financial assistance programs are available for viewing at their website which is located at http://www.rush.edu/patients/general/financial_assistance.html (See Attachment 44, Exhibits 2 and 3.)

The amount of charity for the latest three audited fiscal years, the cost of charity care and the ratio of that charity care to net patient revenue for Rush University Medical Center is provided on Attachment 44, Exhibit 1.

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 facility under review.*

   Rush University Medical Center operates Rush Oak Park Hospital. The amount of charity care for the latest three audited fiscal years, the cost of charity care and the ratio of that charity care to net patient revenue for Rush Oak Park Hospital and consolidated for Rush University Medical Center and Rush Oak Park Hospital are also provided on Attachment 44, Exhibit 1.

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

   Not applicable. Rush University Medical Center is an existing facility.

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 payor. (20 ILCS 3960/3 Charity Care must be provided at cost.

Rush University Medical Center

RUMC CHARITY CARE			
	FY 2011 (in thousands)	FY 2010 (in thousands)	FY 2009 (in thousands)
Net Patient Revenue	1,118,958	1,079,553	1,038,134
Amount of Charity Care (charges)	65,788	59,180	53,737
Cost of Charity Care	18,124	16,756	15,339
Ratio of Charity Care to Net Patient Revenue	1.67%	1.67%	1.5%

Source: RUMC Records

Rush Oak Park Hospital

ROPH CHARITY CARE			
	FY 2011 (in thousands)	FY 2010 (in thousands)	FY 2009 (in thousands)
Net Patient Revenue	102,497	103,911	98,827
Amount of Charity Care (charges)	3,684	3,264	3,393
Cost of Charity Care	1,000	889	705
Ratio of Charity Care to Net Patient Revenue	1.0%	0.97%	0.77%

Source: RUMC Records

Consolidated

CONSOLIDATED CHARITY CARE			
	FY 2011 (in thousands)	FY 2010 (in thousands)	FY 2009 (in thousands)
CONSOLIDATED			
Amount of Charity Care Charges	69,472	62,444	57,130
Cost of Charity Care	19,124	17,645	16,044
Net Patient Revenue	1,221,455	1,183,464	1,136,961
Ratio	1.6%	1.5%	1.4%

Source: RUMC Audited Financial Statements

PATIENT & visitor svcs.

Financial Assistance

In keeping with Rush University Medical Center's mission to provide comprehensive, coordinated health care services to our patients, Rush offers several financial assistance programs to help patients with their hospital bills.

To help patients decide which is the right program for them, Rush offers the services of financial counselors and billing customer service representatives. These individuals will assist patients in completing financial application forms, obtaining an estimated cost of anticipated hospital services, and providing an explanation and copy of their hospital bill.

- *Financial Assistance (Charity Care)/Full Write-Off*
  After the financial counselor or customer service representative performs a financial assessment, the hospital bill can be discounted up to 100 percent if the patient's income is 300 percent of the Federal Poverty Guidelines (family size adjusted) or less.
- *Limited Income Program*
  After a financial assessment of the patient's income has been completed, the hospital will provide services at cost if the patient's income level meets the appropriate criteria. The Limited Income Discount criteria for family income is 400 percent of the Federal Poverty Guidelines. The Limited Income Discount is 70 percent.
- *Self-Pay Discount*
  For Illinois residents, a 65 percent discount will automatically be given to all self-pay patients unless a Global Case Rate is applicable. Out-of-state residents automatically receive a 50 percent discount, which is equivalent to Rush's average managed care discount.
- *Payment Plan*
  Patient can arrange for time payments with a financial counselor or customer service representative. After a financial assessment, the appropriate monthly payment will be assigned within a prescribed time frame.

To be evaluated for financial assistance programs, download and complete the Request for Determination of Eligibility for Financial Assistance (Charity Care). After filling out the form, please mail it to Customer Service at 1700 W. Van Buren St., Suite 161, Chicago, IL 60612.

Current Federal Poverty Guidelines

Federal Register Documentation on Charity Care

If you have any questions regarding a discount or payment plan, please call a financial counselor at (312) 942-5967. If you have already received services at Rush University Medical Center, please call a customer service representative at (312) 942-5693 or toll-free at (866) 761-7812.

the conversation continues...
rushstories.org

TOPIC INDEX

- Patient & Visitor Services
- Important Phone Numbers
- Information Resources
- Financial Assistance
- Hospital Bill FAQs
- **Financial Assistance**

RELATED TOPICS

- Chicago-Area Hotels
- Guia Para El Paciente (PDF)
- Patient Guide (PDF)
- Pay Your Hospital Bill Online
- Rush Map (PDF)

RUSH UNIVERSITY
MEDICAL CENTER

CURRENT FEDERAL POVERTY GUIDELINES

The January 20, 2011 Federal Register **(Vol. 76 No. 13 FR 3637 to 3638)** includes a notice from the U.S. Department of Health and Human Services of the annual updated federal poverty guidelines, which are used to establish eligibility for various federal assistance programs. These guidelines are effective 60 days from the date of publication for facilities obligated under the Hill-Burton Uncompensated Services Program, which requires certain hospitals and other healthcare facilities to provide free or reduced fee services to persons unable to pay for such care.
The 2011 guidelines for Illinois are:

Family Size	Poverty Guidelines
1	$10,890.00
2	$14,710.00
3	$18,530.00
4	$22,350.00
5	$26,170.00
6	$29,990.00
7	$33,810.00
8	$37,630.00

For family units of more than eight persons, add $3,820 for each additional person.

The Federal Poverty Guidelines can be for at http://aspe.hhs.gov/poverty/11poverty.shtml

Appendix A

Proof of Ownership

23 527 085

QUIT CLAIM DEED

THIS INDENTURE WITNESSETH, that the MEDICAL CENTER COMMISSION, a body politic and corporate, duly organized and existing under and by virtue of the laws of the State of Illinois (the "Grantor"), for and in consideration of the sum of SEVENTY SEVEN THOUSAND FIVE HUNDRED THIRTY-SIX DOLLARS ($77,536) paid to it by the Grantee named herein, pursuant to authority vested in the Grantor by law and the written approval of the execution of this conveyance by the Governor of the State of Illinois prior to the execution hereof, as required by statute, CONVEYS AND QUIT CLAIMS unto RUSH-PRESBYTERIAN - ST. LUKE'S MEDICAL CENTER, a corporation of the State of Illinois (the "Center"), the following described real estate, to-wit:

Block Thirteen (13) and vacated alleys therein in Ashland Addition to Chicago, in the North East Quarter (N.E. 1/4) of Section Eighteen (18), Township Thirty-nine (39) North, Range Fourteen (14) East of the Third Principal Meridian in Chicago, Cook County, Illinois,

23 527 085

TOGETHER WITH all and singular the hereditaments and appurtenances thereunto belonging or in any wise appertaining,

EXCLUDING, HOWEVER, any buildings or improvements located thereon and reversions, remainder and remainders, issues and profits pertaining to such building or improvements, and

SUBJECT TO the leasehold estate created by that certain Indenture of Lease dated December 31, 1963, between GLADYS R. TARTIERE, ET AL., as Lessors, and ALDENS, INC., an Illinois corporation, as Lessee, the Lessors' interest in the said Lease having been acquired by the Grantor, and the terms of the Lease having been modified, under a Judgment Order entered on

June 25, 1974, pursuant to certain condemnation proceedings, in case No. 74 L 8661 (Condemnation) in the Circuit Court of Cook County, Illinois, County Department, Law Division; and

SUBJECT TO possession of the property and all benefits and burdens thereof remaining in the Grantor, including all rentals and other payments under the aforesaid Lease, and all of Lessors' obligations thereunder, until such time as said Lease shall expire or be terminated and the buildings now located upon the aforesaid real estate shall have been demolished by the Grantor pursuant to that certain Purchase and Sale Agreement dated June 18, 1976, between Grantor and Grantee, pursuant to which this Deed is being delivered and there shall have been put of record, pursuant to the terms of said Purchase and Sale Agreement an instrument evidencing the date of the delivery of possession by the Grantor to the Grantee.

The foregoing conveyance is made upon the express condition that in the event that following the delivery of possession as aforesaid there shall be a non-use of said premises for the purposes described in "An Act in relation to establishment of a medical center district in the City of Chicago and for the control and management thereof", approved June 4, 1941, as amended to date, or of disuse of said premises for a period of one year following the date of delivery of possesion as aforesaid, title to said premises shall revert to the Grantor named herein, its successors or assigns, as provided in said Act, as amended to date.

IN WITNESS WHEREOF, said Grantor has caused these presents

23 527 085

to be signed by its President and has caused its corporate seal to be hereunto affixed and attested by its Secretary, this 18th day of June, 1976.

MEDICAL CENTER COMMISSION

By _____
Its President

ATTEST

_____
Its Secretary

23 527 085

APPROVED prior to execution, as required by statute, this 8th day of June, 1976:

_____
GOVERNOR
STATE OF ILLINOIS

STATE OF ILLINOIS)
) SS.:
COUNTY OF C O O K)

I, RAYMOND J. BAYSTER, a notary public in and for said County, in the State aforesaid, do hereby certify that PARK LIVINGSTON, President of the Medical Center Commission, a body politic and corporate of the State of Illinois, and KENNETH D. SCHMIDT, Secretary of said body politic and corporate, personally known to me to be the same persons whose names are subscribed to the foregoing instrument as such President and Secretary, respectively, appeared before me this day in person and acknowledged that they signed and delivered the said instrument as their own free and voluntary act and as the free and voluntary act of said body politic and corporate, for the uses and purposes therein set forth; and the said Secretary then and there acknowledged that he, as custodian of the corporate seal of said body politic and corporate, did affix the seal of the said body politic and corporate to said instrument as their own free and voluntary act and as the free and voluntary act of said body politic and corporate, for the uses and purposes therein set forth.

23 527 085

GIVEN under my hand and notarial seal this 18th day of June, 1976.

RAYMOND J. BAYSTER NOTARY PUBLIC COOK COUNTY, ILL.

Notary Public

My Commission Expires 3-5-77

-4-

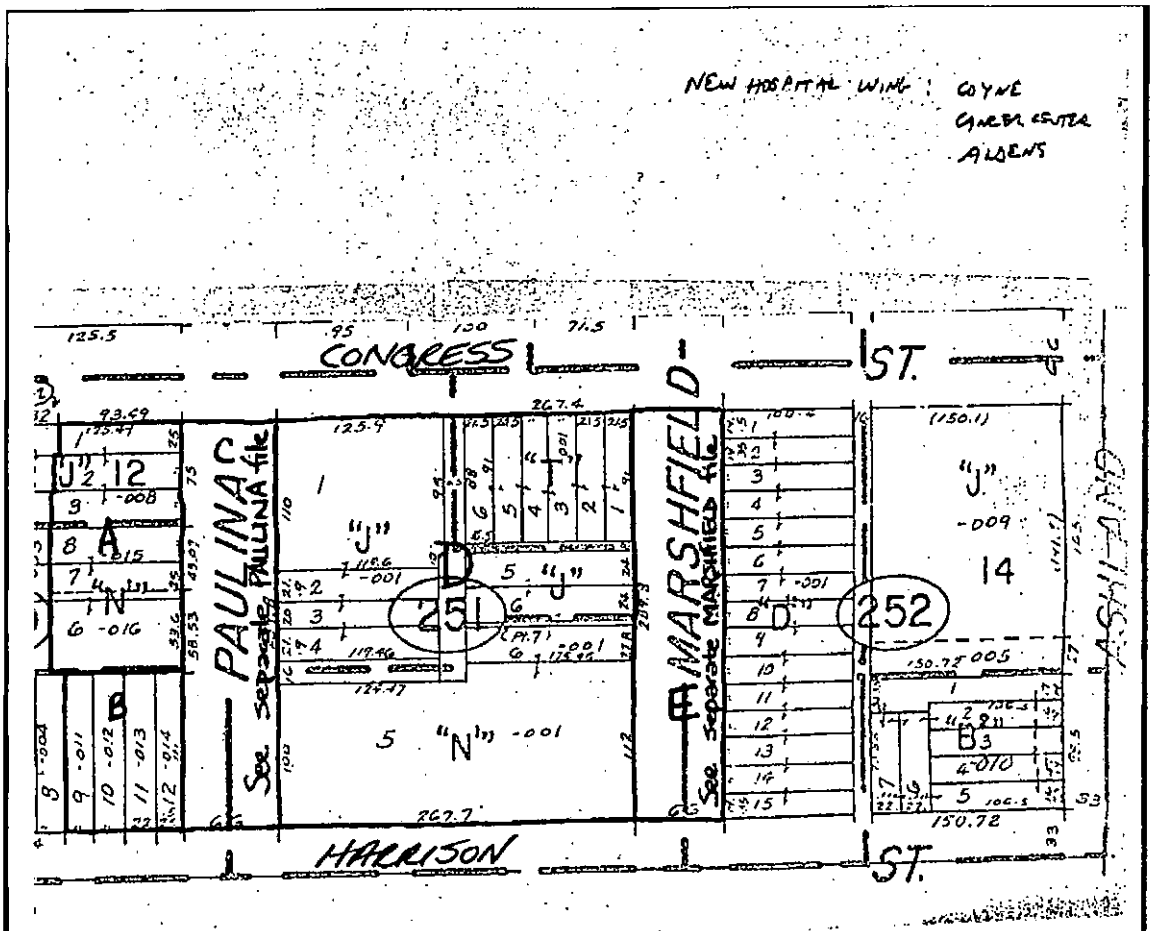
RECORDER OF DEEDS COOK COUNTY ILL.

1976 JUN 21 AM 10 18

JUN-21-76 10 8761 23527085 A — Rec 12.15

12 60 MAIL

23527085



PARCEL	DATE OF ACQUISITION	GRANTOR	INSTR.	DATE OF RECORDATION	RECORDATION NO.
A	12/20/57	COYNE ELEC. SCHOOL	SPEC. W.D.	1/22/58	1778504 T
B	6/10/52	MCC	QC	11/17/52	15486698
C	11/14/78 ORD.	CITY CHGO 7666 C.P.	VAC.		24748459
D	6/18/76	MCC	Q.C.	6/21/76	23527085
E	6/7/78 ORD	CITY CHGO 7804 CP	VAC.		

(F) 27.2-3(a)

24 329 229

INSTRUMENT REGARDING POSSESSION

THIS INSTRUMENT, dated as of February 6th, 1978, by and between MEDICAL CENTER COMMISSION, a body politic and corporate duly organized and existing under and by virtue of the laws of the State of Illinois (the "Commission"), and RUSH-PRESBYTERIAN-ST. LUKE'S MEDICAL CENTER, an Illinois not-for-profit corporation ("RPSL").

W I T N E S S E T H:

WHEREAS, the Commission has heretofore conveyed to RPSL, pursuant to a certain Quit Claim Deed, dated June 18, 1976 from Medical Center Commission, as grantor, to RPSL, as grantee, duly recorded in the office of the Recorder of Deeds for Cook County, Illinois, on June 21, 1976 as Document No. 23527085, certain real property, located in the City of Chicago, County of Cook, State of Illinois, commonly known as 511 South Paulina Street, and more particularly described as follows:

Block Thirteen (13) and Vacated Alley therein in Ashland Addition to Chicago, in the North East Quarter (N.E. 1/4) of Section Eighteen (18) Township Thirty-Nine (39) North, Range Fourteen (14) East of the Third Principal Meridian in Chicago, Cook County, Illinois,

11 00

said property being herein referred to as the "Premises"; and

WHEREAS, pursuant to the said Quit Claim Deed, the Commission retained possession of the Premises, and all benefits and burdens thereof, including all rentals and other payments under a certain Indenture of Lease described in the said Quit Claim Deed, until such time as the said Lease shall have expired or terminated, and the buildings located on the Premises shall have been demolished; and

WHEREAS, the said Lease has been terminated, and the tenant thereunder has quit and surrendered possession thereunder; and

WHEREAS, in accordance with the terms of a certain Agreement between the Commission and RPSL, dated January 3, 1978, RPSL has released the Commission of its obligation to demolish the said buildings, and, among other things, the Commission has agreed to execute and deliver this instrument;

NOW, THEREFORE, the Commission does hereby surrender to RPSL, and its successors and assigns, full and exclusive possession of the Premises, and all buildings and other improvements now or at any time hereafter located thereon, and all reversions, remainder and remainders, issues and profits pertaining to such buildings or improvements, effective from and after the date hereof, and consents to the demolition of all buildings and improvements now or at any time hereafter located on the Premises.

24 329 229

LATER DATE

The Commission further acknowledges that, as of the date hereof, the aforesaid Lease has been terminated, and all rights of any parties heretofore in possession of the Premises, or any part or parts thereof or any buildings or improvements located thereon, have either expired or been terminated, and the said Premises, and all buildings and improvements now located thereon, are free and clear of any rights of any parties at any time heretofore in possession thereof.

RPSL does hereby accept possession of the Premises, and all buildings and improvements located thereon, from and after the date hereof.

IN WITNESS WHEREOF, the parties hereto have caused this instrument to be duly executed on their behalf, and their respective seals to be hereunto affixed and attested, as of the day and year first above written.

MEDICAL CENTER COMMISSION

By _____
President

ATTEST:

_____
Secretary

RUSH-PRESBYTERIAN-ST. LUKE'S MEDICAL CENTER

By _____

ATTEST:

_____
Assistant Secretary

24 329 229

STATE OF ILLINOIS)
) SS:
COUNTY OF C O O K)

I, _____, a Notary Public in and for said County, in the State aforesaid, do hereby certify that PARK LIVINGSTON, President of the Medical Center Commission, a body politic and corporate of the State of Illinois, and KENNETH D. SCHMIDT, Secretary of said body politic and corporate, personally known to me to be the same persons whose names are subscribed to the foregoing instrument as such President and Secretary, respectively, appeared before

me this day in person and acknowledged that they signed and delivered the said instrument as their own free and voluntary act and as the free and voluntary act of said body politic and corporate, for the uses and purposes therein set forth; and the said Secretary then and there acknowledged that he, as custodian of the corporate seal of said body politic and corporate, did affix the seal of the said body politic and corporate to said instrument as his own free and voluntary act and as the free and voluntary act of said body politic and corporate, for the uses and purposes therein set forth.

GIVEN under my hand and notarial seal this day of January, 1978.

Notary Public

My commission expires:_____

STATE OF ILLINOIS)
) SS:
COUNTY OF C O O K)

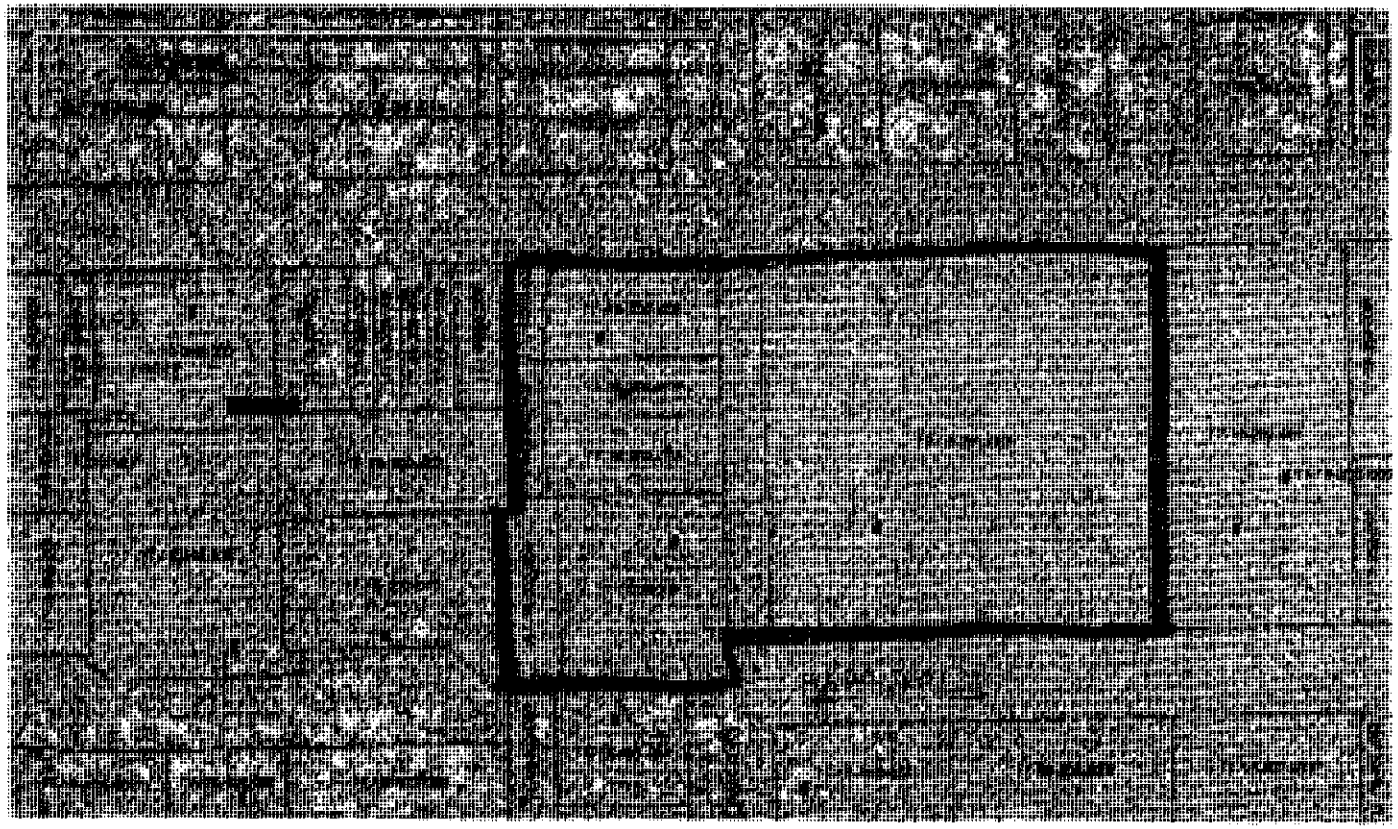
I, NANCY ROSE MARTINEZ, a Notary Public in and for said County, in the State aforesaid, do hereby certify that JAMES A. CAMPBELL, President of RUSH-PRESBYTERIAN-ST. LUKE'S MEDICAL CENTER, an Illinois corporation, and WILLIAM E. ROACH, JR., Assistant Secretary of said corporation, personally known to me to be the same persons whose names are subscribed to the foregoing instrument as such President and Assistant Secretary, respectively, appeared before me this day in person and acknowledged that they signed and delivered the said instrument as their own free and voluntary act and as the free and voluntary act of said corporation, for the uses and purposes therein set forth; and the said Assistant Secretary then and there acknowledged that he, as custodian of the corporate seal of said corporation, did affix the seal of said corporation to said instrument as his own free and voluntary act and as the free and voluntary act of said corporation, for the uses and purposes therein set forth.

Nancy Rose Martinez
Notary Public

My commission expires: 4/8/81

FEB 15 9 00 AM '78

24329223



The best source for your PIN is your deed or tax bill, or other documents from the purchase of your home. Matches from this site are not guaranteed.
Copyright 2010 Cook County

http://cookviewer.cookcountyil.gov/mapviewer/index.html

9/8/2011

Julie N. Lilie
Associate General Counsel

Office of Legal Affairs
1700 West Van Buren Street
Suite 301
Chicago, Illinois 60612-3244

Tel 312.942.6886
Fax 312.942.4233
Julie_Lilie@rush.edu
www.rush.edu

RUSH UNIVERSITY
COLLEGE OF NURSING
RUSH MEDICAL COLLEGE
COLLEGE OF HEALTH SCIENCES
THE GRADUATE COLLEGE

RUSH UNIVERSITY
MEDICAL CENTER

December 8, 2010

VIA FEDERAL EXPRESS

Mr. James M. Houlihan
Cook County Assessor
Exempt Department
Cook County Assessor's Office
118 N. Clark Street, 3rd Floor
Chicago, Illinois 60602

Re: **2011 Exempt Affidavit**

Dear Mr. Houlihan:

Enclosed please find the 2011 Exempt Property List for Rush University Medical Center. Please note that PIN 17-18-407-034 should be corrected to PIN 17-18-407-033.

If you have any questions, please contact me at your convenience.

Very truly yours,

Julie N. Lilie

Julie N. Lilie

JNL/sn
Enclosure

cc: Max D. Brown

K:\Public\WPDATA\Mamon\Correspondence\James Houlihan Ltr - 2011 Exempt Affidavit.doc

COOK COUNTY ASSESSOR'S OFFICE
JAMES M. HOULIHAN, ASSESSOR

2011 AFFIDAVIT

Agency Number: 5629 **Agency Name: RUSH UNIV.MEDICAL CNR**

1700 W VANBUREN RM 301, CHICAGO, IL 60612

Having been duly sworn, upon my oath, I Julie N. Lilie **, as authorized agent for the agency listed above, swear that I have reviewed the Property List on the Cook County Assessor's web site for the agency listed above and the following is true and correct:**

1. **The agency listed above is the owner of each of the properties on the Property List on the Cook County Assessor's web site, unless indicated as set forth below;**

2. **If any property has experienced a "change in ownership" (as defined under the Property Tax Code 35 ILCS 200/1-1 et seq.) since the Illinois Department of Revenue granted the exemption, I have checked the appropriate blank on the Property List on the Cook County Assessor's web site and completed an Exempt Property Information Sheet for each such property;**

3. **If any property has experienced a "change in use" (as defined under the Property Tax Code 35 ILCS 200/1-1 et seq.) since the Illinois Department of Revenue granted the exemption, I have checked the appropriate blank on the Property List on the Cook County Assessor's web site and completed an Exempt Property Information Sheet for each such property and returned the sheet to the Cook County Assessor's Office;**

4. **If any property has been leased, licensed or is otherwise used by others, I have checked the appropriate blank on the Property List on the Cook County Assessor's web site. If the property has been leased within the last year I have also checked the appropriate blank and completed an Exempt Property Information Sheet for each property and returned the sheet to the Cook County Assessor's Office;**

5. **This Affidavit is given to the Cook County Assessor's Office so that it may maintain the exemptions of the properties on the Property List on the Cook County Assessor's web site.**

Further affiant sayeth not.

Signature: Julie N. Lilie
Print Name: Julie N. Lilie
Title: Associate General Counsel
Phone: 312-942-6886

Subscribed and sworn to before me this 8th **day of** December **20** 10

Helen Casillas

NOTARY PUBLIC

"OFFICIAL SEAL"
HELEN CASILLAS
Notary Public, State of Illinois
My Commission Expires Sept. 27, 2013

118 NORTH CLARK STREET, CHICAGO, IL 60602
PHONE: 312 443 7550 WEBSITE: WWW.COOKCOUNTYASSESSOR.COM

COOK COUNTY ASSESSOR'S OFFICE
JAMES M. HOULIHAN, ASSESSOR

2011 Property List

Agency Number: 5629 Agency Name: RUSH UNIV.MEDICAL CNR

1700 W VANBUREN RM 301, CHICAGO, IL 606120000

All exempt properties owned by the above agency are listed below. If any of the columns apply to a particular property, please check the appropriate blank and attach a completed Exempt Property Information Sheet for each property (make copies as necessary).

Basis For Exemption

The property is exempt from property taxes because it is owned by a Charitable Hospital and used exclusively for charitable purposes. (35 ILCS 200 / 15-65)

PIN	Ownership Changed	Use Changed	Property Leased/ Used By Others (New Lease)	Owner Change Of Address
13-03-125-025-0000				
17-17-122-017-0000				
17-17-122-018-0000				
17-17-122-019-0000				
17-17-122-020-0000				
17-17-122-021-0000				
17-17-122-022-0000				
17-17-122-023-0000				
17-17-122-024-0000				
17-17-122-025-0000				
17-17-122-026-0000				
17-17-122-027-0000				
17-17-122-028-0000				
17-17-122-029-0000				
17-17-122-032-0000				
17-17-122-038-0000				
17-17-122-039-0000				
17-17-123-021-0000				
17-17-123-022-0000				
17-17-123-044-0000				

118 NORTH CLARK STREET, CHICAGO, IL 60602
PHONE: 312.443.7550 WEBSITE: WWW.COOKCOUNTYASSESSOR.COM

2011 Property List

PIN	Ownership Changed	Use Changed	Property Leased/ Used By Others (New Lease)	Owner Change Of Address
17-17-123-045-0000				
17-17-123-046-0000				
17-17-305-011-0000				
17-18-220-003-0000				
17-18-220-004-0000				
17-18-220-005-0000				
17-18-220-006-0000				
17-18-220-007-0000				
17-18-220-008-0000				
17-18-220-009-0000				
17-18-220-010-0000				
17-18-220-011-0000				
17-18-220-012-0000				
17-18-220-013-0000				
17-18-220-014-0000				
17-18-220-015-0000				
17-18-220-016-0000				
17-18-220-017-0000				
17-18-220-019-0000				
17-18-221-001-0000				
17-18-221-002-0000				
17-18-221-003-0000				
17-18-221-004-0000				
17-18-221-005-0000				
17-18-221-006-0000				
17-18-221-007-0000				
17-18-221-008-0000				
17-18-221-009-0000				
17-18-221-010-0000				

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PHONE: 312.443.7550 WEBSITE: WWW.COOKCOUNTYASSESSOR.COM

2011 Property List

PIN	Ownership Changed	Use Changed	Property Leased/ Used By Others (Now Lease)	Owner Change Of Address
17-18-221-011-0000				
17-18-221-013-0000				
17-18-221-014-0000				
17-18-221-015-0000				
17-18-221-016-0000				
17-18-221-017-0000				
17-18-221-018-0000				
17-18-221-019-0000				
17-18-222-006-0000				
17-18-222-007-0000				
17-18-222-008-0000				
17-18-222-009-0000				
17-18-222-010-0000				
17-18-222-011-0000				
17-18-222-012-0000				
17-18-222-013-0000				
17-18-222-014-0000				
17-18-222-015-0000				
17-18-228-001-0000				
17-18-230-001-0000				
17-18-230-002-0000				
17-18-230-003-0000				
17-18-230-004-0000				
17-18-230-005-0000				
17-18-230-006-0000				
17-18-230-010-0000				
17-18-230-011-0000				
17-18-230-012-0000				
17-18-230-013-0000				

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2011 Property List

PIN	Ownership Changed	Use Changed	Property Leased/ Used By Others (New Lease)	Owner Change Of Address
17-18-230-014-0000				
17-18-230-015-0000				
17-18-230-016-0000				
17-18-230-020-0000				
17-18-230-023-0000				
17-18-230-024-0000				
17-18-231-001-0000				
17-18-231-002-0000				
17-18-231-003-0000				
17-18-231-004-0000				
17-18-231-005-0000				
17-18-231-006-0000				
17-18-231-007-0000				
17-18-231-008-0000				
17-18-231-009-0000				
17-18-231-010-0000				
17-18-231-011-0000				
17-18-231-012-0000				
17-18-249-001-0000				
17-18-249-002-0000				
17-18-249-003-0000				
17-18-249-005-0000				
17-18-249-006-0000				
17-18-249-007-0000				
17-18-250-001-0000				
17-18-250-002-0000				
17-18-250-003-0000				
17-18-250-004-0000				
17-18-250-005-0000				

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2011 Property List

PIN	Ownership Changed	Use Changed	Property Leased/ Used By Others (New Lease)	Owner Change Of Address
17-18-250-006-0000				
17-18-250-007-0000				
17-18-250-008-0000				
17-18-250-010-0000				
17-18-250-015-0000				
17-18-250-016-0000				
17-18-250-017-0000				
17-18-251-003-0000				
17-18-252-001-0000				
17-18-252-005-0000				
17-18-252-009-0000				
17-18-252-010-0000				
17-18-404-001-0000				
17-18-404-002-0000				
17-18-404-003-0000				
17-18-404-008-0000				
17-18-404-009-0000				
17-18-404-010-0000				
17-18-404-011-0000				
17-18-404-012-0000				
17-18-404-013-0000				
17-18-404-014-0000				
17-18-404-015-0000				
17-18-404-018-0000				
17-18-405-016-0000				
17-18-405-022-0000				
17-18-405-023-0000				
17-18-405-024-0000				
17-18-405-025-0000				

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2011 Property List

PIN	Ownership Changed	Use Changed	Property Leased/ Used By Others (New Lease)	Owner Change Of Address
17-18-405-026-0000				
17-18-405-027-0000				
17-18-405-034-0000				
17-18-405-035-0000				
17-18-406-027-0000				
17-18-406-028-0000				
17-18-406-029-0000				
17-18-407-032-0000				
~~17-18-407-034-0000~~	should be 17-18-407-033-0000			
17-18-408-028-0000				
17-18-408-030-0000				
17-18-408-031-0000				
17-18-408-033-0000				
17-18-408-034-0000				
17-18-409-003-0000				
17-18-409-004-0000				
17-18-409-009-0000				
17-18-409-018-0000				
17-18-409-019-0000				
17-18-409-020-0000				
17-18-409-021-0000				
17-18-409-022-0000				
17-18-409-025-0000				
17-18-409-026-0000				
17-18-409-027-0000				
17-18-409-028-0000				
17-18-409-029-0000				
17-18-409-030-0000				
17-18-409-031-0000				

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PHONE: 312.443.7550 WEBSITE: WWW.COOKCOUNTYASSESSOR.COM

2011 Property List

PIN	Ownership Changed	Use Changed	Property Leased/ Used By Others (New Lease)	Owner Change Of Address
17-18-409-032-0000				
17-18-409-033-0000				
17-18-409-035-0000				
17-18-409-036-0000				
17-18-409-037-0000				
17-18-409-038-0000				
17-18-409-039-0000				
17-18-410-001-0000				
17-18-410-002-0000				
17-18-410-003-0000				
17-18-410-004-0000				
17-18-410-005-0000				
17-18-410-006-0000				
17-18-410-007-0000				
17-18-410-008-0000				
17-18-410-009-0000				
17-18-410-010-0000				
17-18-410-011-0000				
17-18-410-012-0000				
17-18-410-013-0000				
17-18-410-014-0000				
17-18-410-015-0000				
17-18-410-016-0000				
17-18-410-017-0000				
17-18-410-018-0000				
17-18-411-016-0000				
17-18-411-017-0000				
17-18-411-018-0000				
17-18-411-019-0000				

118 NORTH CLARK STREET, CHICAGO, IL 60602
PHONE: 312.443.7550 WEBSITE: WWW.COOKCOUNTYASSESSOR.COM

2011 Property List

PIN	Ownership Changed	Use Changed	Property Leased/ Used By Others (New Lease)	Owner Change Of Address
17-18-411-020-0000				
17-18-411-021-0000				
17-18-411-022-0000				
17-18-411-036-0000				
17-18-411-038-0000				
17-18-411-039-0000				
17-18-411-040-0000				
17-18-502-002-0000				
17-18-502-003-0000				
17-18-502-004-0000				
17-18-502-005-0000				
17-18-502-006-0000				
17-18-502-007-0000				
17-18-502-008-0000				

118 NORTH CLARK STREET, CHICAGO, IL 60602
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Appendix B

Rush University Medical Center, Lessor

Horizon Hospice & Palliative Care, Inc., Lessee

LEASE

HOSPICE PROGRAM

SUMMARY OF LEASE PROVISIONS

1.	Lessor and Address:	RUSH UNIVERSITY MEDICAL CENTER 1725 W. HARRISON STREET, SUITE 229 CHICAGO, ILLINOIS 60612
2.	Lessee and Address:	HORIZON HOSPICE & PALLIATIVE CARE, INC. 833 WEST CHICAGO AVENUE CHICAGO, ILLINOIS 60622
	Attorney and Address:	Patricia S. Ullman Schiff Hardin LLP 233 S. Wacker Drive, Suite 6600 Chicago, IL 60606
3.	Premises:	See **Exhibit A**
4.	Date of Lease:	July 1, 2011, 2011
5.	Term:	60 months
6.	Commencement Date:	July 1, 2011
7.	Expiration Date:	June 30, 2016
8.	Annual Base Rent:	[redacted]
9.	Monthly Base Rent:	[redacted]
10.	Rentable Area of Premises:	5,758 square feet
11.	Security Deposit:	Intentionally deleted

The terms used above shall have the meanings provided in the Lease.

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HOSPICE PROGRAM

This Lease Agreement (the **"Lease"**) is made as of July 1, 2011 by and between RUSH UNIVERSITY MEDICAL CENTER (**"Lessor"**) and HORIZON HOSPICE & PALLIATIVE CARE, INC. (**"Lessee"**);

WITNESSETH:

I. DEFINITIONS

a. **"Base Rent"**: The rent to be paid in monthly installments by Lessee to Lessor during the Term in the amount and in the manner provided in Section 4a below.

b. **"Building"**: Lessor's property commonly known as Johnston R. Bowman, also referred to as JRB, located at 710 S. Paulina, Chicago, Illinois 60612.

c. **"Commencement Date"**: JULY 1, 2011 MW MW

d. **"Common Areas"**: All areas and facilities outside the Premises and within the exterior boundary line of the Building that are provided and designated by the Lessor from time to time for the general non-exclusive use of Lessor, Lessee and of other lessees of the Building and their respective employees, suppliers, shippers, customers and invitees, including but not limited to common entrances, corridors, pedestrian walkways, elevators, elevator foyers, escalators, stairways and stairwells, public restrooms, mechanical rooms, janitor closets, vending areas, parking areas, loading and unloading areas, trash areas, roadways, sidewalks, walkways, parkways, ramps, driveways, landscaped areas, decorative walls, and other similar facilities for the use of all lessees in the Building.

e. **"Premises"**: The leased premises located in the Building known as Johnston R. Bowman, located on the 5th floor, consistent of 5,758 square feet of Rentable Area, as shown on **Exhibit A** attached hereto and made a part hereof. The sole purpose of the attached floor plan is to identify the general location of the Premises in the Building, and such floor plan is not a representation as to the actual size of the Premises. Notwithstanding any provision of this Lease to the contrary, Lessee shall have the right to have the Premises measured after completion of the work pursuant to **Exhibit C** hereof, and if Lessor and Lessee cannot agree on the actual size of the Premises then the parties shall appoint a qualified third party to measure the Premises and such third party's measurement shall be used to recalculate Rent pursuant to **Exhibit B** hereof.

f. **"Rent"**: Base Rent, and any other sums or charges due by Lessee under this Lease.

g. **"Use"**: Lessee shall use the Premises for only those purposes specified in paragraph 36 below.

2. **LEASE AND DEMISE.** Lessor hereby leases to Lessee and Lessee accepts and hereby leases from Lessor the Premises for the Term commencing on the Commencement Date and expiring on the Expiration Date, subject to the covenants, terms, provisions and conditions of this Lease.

3. **TERM.** The term of this Lease (the "Term") shall begin on July 1, 2011 (the "Commencement Date") and end on the last day of the sixtieth (60th) full calendar month after the Commencement Date, unless sooner terminated as provided herein. The Term shall be subject to automatic renewal for two (2) additional terms of five (5) years (each an "Extension Term"), provided that either party may terminate the Lease at the end of the Term or Extension Term, as applicable, by providing written notice of termination to the other party not less than eighteen (18) months prior to the end of such Term or Extension Term.

4. **RENT.** During the Term, the Lessee agrees to pay the following amounts to Lessor at Lessor's office in the Building or at such other place as Lessor may from time to time designate in writing, in legal tender at the time of payment without any notice or demand, and without abatement, set-off or reduction whatsoever. Notwithstanding any other provision of this Lease, (i) Lessee shall not be obligated to pay Base Rent until the date on which the Illinois Department of Public Health authorizes Lessee to accept patients at the Premises; (ii) Base Rent shall be abated by fifty percent (50%) for the first six (6) months for which Lessee is obligated to pay Base Rent; and (iii) the offset provided in Section 5.4 of the Work Letter attached as **Exhibit C** to this Lease shall be applied to any Rent owed by Lessee after accounting for the abatements provided in (i) and (ii) of this Section 4 until such offset amount is exhausted.

a. Lessee shall pay to Lessor as Base Rent for Lease Year 1 the amount of [redacted] per month, subject to rent abatement and offset for asbestos remediation as provided herein, on or before the first day of each month of the Term, and at the same per diem rate for fractions of a month if the Term shall begin on any date except the first day, or shall end on any day except the last day of a calendar month. Commencing on the first day of Lease Year 2 and on the first day of each successive Lease Year throughout the Term, Monthly Base Rent shall be equal to the sum of (a) the amount of Monthly Base Rent applicable during the immediately prior Lease Year, and (b) an amount equal to the product derived by multiplying (i) the amount of Monthly Base Rent applicable during the immediately prior Lease Year, times (ii) the annual percentage increase in the Consumer Price Index (as defined below) that occurred during the immediately preceding calendar year (which percentage increase shall be stated as a decimal percentage) times one hundred percent (100%). Notwithstanding the foregoing, in no event shall the change in Monthly Base Rent from one Lease Year to the next be less than zero percent (0.0%). For the purposes of this Lease, "**Consumer Price Index**" shall mean the Consumer Price Index for Midwest Urban Area, All Urban Consumers (1982-84=100) as published by the Bureau of Labor Statistics of the U.S. Department of Labor, or its

successor, last published within ten (10) days before the end of the prior Lease Year. If the Consumer Price Index as now constituted, compiled and published shall be revised or cease to be compiled and published during the Term, then Lessor and Lessee shall agree on some other index or comparable method by which to adjust the rental in the manner herein contemplated.

b. Landlord and Tenant may, by mutual agreement, change the Rentable Area. In the event the Rentable Area of the Premises changes in any calendar year during the term of the Lease, Lessor shall recompute such areas as of December 31 of such calendar year and the Rent shall be recalculated accordingly, with appropriate adjustments as of the date of such change in Rentable Area.

c. Any sum due from Lessee to Lessor which is not paid when due shall bear interest thirty (30) days from the date due until the date paid at the annual rate of three percent (3%) above the rate then most recently announced by *Wall Street Journal* as the Prime Rate, from time to time in effect, but in no event higher than the maximum amount permitted by law.

5. **SECURITY DEPOSIT**. Intentionally deleted.

6. **SERVICES.** Lessor will provide services in its discretion comparable to services generally furnished in similar buildings in Chicago as follows:

a. Maintenance services in and about the Premises during hours that licensed personnel are on the Premises and interior and exterior window washing at intervals to be determined by Lessor.

b. Subject to federal, state and local energy conservation regulations, heat whenever such heat shall be required, in the Lessor's reasonable judgment, for the comfortable occupancy and use of the Premises.

c. Air conditioning and heating (gas) when necessary in Lessor's reasonable judgment for normal comfort and humidity in occupation of the Premises, and subject to federal, state and local energy conservation regulations, from a system designed to function properly when the total heat load in any substantially enclosed space does not exceed one watt per square foot of electrical power (excluding the load of the permanent lighting fixtures provided by Lessor) plus one person per 100 square feet.

d. City water from the regular Building outlets for drinking, lavatory and toilet purposes.

e. Passenger elevator service at all times and freight elevator service Monday through Fridays from 8:00 a.m. to 5:00 p.m., subject to scheduling by Lessor.

f. Replacement and installation of fluorescent lamps for standard building lighting fixtures.

In addition, Lessor shall furnish telephone connection services and equipment as shown on approved plans, around-the-clock security services, patient transport services within the Rush University Medical Center facilities, and in-wall oxygen and suction.

Except with respect to the negligence or willful misconduct of Lessor Parties (as hereinafter defined), neither Lessor, nor any company, firm or individual operating, maintaining, managing or supervising the plant or facilities furnishing any of the above services, nor any of their respective agents or employees (collectively, "Lessor Parties") shall be liable to Lessee or any of Lessee's employees, agents, customers, or invitees or anyone claiming through or under Lessee for any damages, injuries, losses, expenses, claims or causes of action, because of any interruption or discontinuance at any time for any reason in the furnishing of any of the above services; nor shall any such interruption or discontinuance be deemed an eviction or disturbance of Lessee's use or possession of the Premises or any part thereof; nor shall any such interruption or discontinuance relieve Lessee from full performance of Lessee's obligations under this Lease.

Lessee agrees that Lessor shall not be liable for damages for failure of delay in furnishing any service stated above if such failure or delay is caused, in whole or in part, by any one or more of the events stated in Section 49 below, nor shall any such failure or delay be considered to be an eviction or disturbance of Lessee's use of the Premises, or relieve Lessee from its obligation to pay any Rent when due or from any other obligations of Lessee under this Lease, except as otherwise provided in this Section 6.

7. INTENTIONALLY OMITTED.

8. LESSEE'S PROPERTY. All property belonging to Lessee, and its employees, agents, and invitees, or any occupant of the Premises that is in the Building, or the Premises, shall be there at the risk of Lessee or other person only, and Lessor shall not be liable for damage thereto or theft or misappropriation thereof.

9. LESSOR'S TITLE. Lessor's title is and always shall be paramount to the title of Lessee and nothing herein contained shall empower Lessee to do any act which can, may, or shall cloud or encumber Lessor's title. Lessee's rights are and shall always be subordinate to the lien of any mortgage, deed of trust, or trust deed in the nature of a mortgage, trust indentures, or security agreements, or to any such underlying lease or leases as shall be requested by Lessor. Lessee hereby appoints the Lessor as attorney-in-fact for the Lessee with full power and authority to execute and deliver in the name of Lessee any such instrument or instruments.

10. DEFAULT AND REMEDIES

a. Default. The occurrence of any of the following shall constitute a default (a "default") by Lessee under this Lease:

(i) Lessee shall fail to pay any installment of Rent or other monies required to be paid by Lessee under this Lease when the same is due and payable, provided, however, that Lessee shall have two (2) five-day notice and cure periods in each calendar year before such failure to pay Rent or other monies becomes a default; or

(ii) Lessee shall fail to comply with any of the other terms, covenants, conditions or obligations of this Lease and such failure shall continue for a period of twenty (20) days after written notice from Lessor (or immediately if the failure involves a hazardous condition), or

(iii) Lessee makes any general assignment, or general arrangement, for the benefit of creditors, or Lessee files or there is filed against Lessee a petition to have Lessee adjudged a bankrupt or a petition for reorganization or arrangement or to declare Lessee insolvent or unable to pay Lessee's debts under any law relating to bankruptcy or insolvency (unless, in the case of a petition filed against Lessee, the same is dismissed within twenty (20) days or a trustee or receiver is appointed to take charge of Lessee's affairs or to take possession of any portion of property, tangible or intangible, at the Premises or Lessee's interest in this Lease, or any portion of Lessee's property, tangible or intangible, located at the Premises, is attached, executed or levied upon, or seized pursuant to judicial action where such attachment, execution, levy or seizure is not discharged within twenty (20) days; then, in any such event, Lessee shall be in default hereunder, or (iv) Lessee abandons or vacates the Premises.

b. Right of Re-Entry. Upon the occurrence of a default by Lessee, Lessor may elect to terminate this Lease or, without terminating this Lease, Lessee grants to Lessor the right to and Lessor may re-enter upon the Premises, with process of law, and expel Lessee and every other person occupying the same, repossess the Premises, and remove any and all property located therein, all without being liable for trespass, eviction, forcible entry or detainer, conversion or similar or dissimilar tortuous action and without relinquishing the right of Lessor to rent or any other rights given to Lessor under this Lease or by operation of law. Upon such termination, Lessee shall immediately surrender and vacate the Premises and deliver possession thereof to Lessor.

c. Termination of Lease. In the event that Lessor elects to re-enter and take possession of the Premises and to terminate this Lease, Lessee shall pay to Lessor the reasonable cost of recovering possession of the Premises, any past due Rent not paid, and the excess of the total Rent reserved for the remainder of the Term, or for the remainder of any extension term, over the fair rental value of the Premises for such remainder of the Term or extension term.

d. Reletting. In the event that Lessor elects to re-enter and take possession of the Premises but not to terminate this Lease, Lessor may, without terminating the lease, relet the Premises or any part thereof for the account of Lessee to any person, firm or corporation other than Lessee for such rent and for such period of time and upon such

other terms and conditions as Lessor, in its sole discretion, shall determine. Lessor shall not be required to accept any tenant offered by Lessee or observe any instructions given by Lessee concerning such reletting. In such case, Lessor may make repairs, alterations, and additions in or to the Premises, and redecorate the same to the extent deemed necessary or desirable by Lessor, and Lessee shall, upon demand, pay the reasonable costs thereof together with costs and expenses of Lessor with respect to such reletting. If the consideration collected by Lessor upon any such reletting is not sufficient to pay monthly the full amount of the Rent reserved under this Lease, together with the cost of repair, alterations, additions, redecorating and Lessor's other costs and expenses, Lessee shall pay to Lessor upon demand the amount of each monthly deficiency. Neither acts by Lessor to maintain and/or preserve the Premises nor efforts by Lessor to relet the Premises, nor a reletting of the Premises for the account of Lessee pursuant to the terms hereof, nor an appointment of a receiver upon the initiative of the Lessor to further protect Lessor's interest under this Lease shall constitute a termination of the Lease.

c. Other Remedies. Lessor may but shall not be obligated to perform any obligation of Lessor under this Lease; and, if Lessor so elects, all costs and expenses paid by Lessor in performing such obligation, together with interest at the default interest rate, shall be reimbursed by Lessee to Lessor on demand. All rights and remedies of Lessor under this Lease are cumulative and shall not exclude and shall be in addition to any other rights or remedies to which Lessor may be entitled at law or in equity. The exercise of any remedy by Lessor shall not be deemed an election of remedies or preclude Lessor from exercising any other remedies in the future.

11. **DAMAGE BY FIRE OR OTHER CASUALTY.** If the Premises or the Building are made substantially untenantable by fire or other casualty not due to negligence of the Lessee, Lessor may elect (a) to terminate this Lease as of the date of the fire or casualty by notice to the Lessee within thirty (30) days after that date, or (b) to repair, restore or rehabilitate the Building or the Premises at the Lessor's expense within one hundred and eighty (180) days, or within such longer time as may be necessary due to strikes, inability to obtain materials or equipment, or other cause beyond reasonable control of Lessor, after the Lessor is enable to take possession of the damaged Premises and undertake reconstruction or repairs, in which latter event this Lease shall not terminate but Rent shall be abated on a per diem basis while the Premises are untenantable; or, if due to act or neglect of the Lessee, Lessor shall have such rights at Lessee's cost and expense. If Lessor elects to repair, restore or rehabilitate the Building or the Premises and, in cases not due to act or neglect of the Lessee, does not substantially complete the work within the foregoing period, either party can terminate this Lease as of the date of such fire or casualty by notice to the other party not later than thirty (30) days after the expiration of such period. In the event of termination of the Lease pursuant to this Section 11, Rent shall be apportioned on a per diem basis and be paid to the date of the fire or casualty.

12. **INSURANCE; WAIVER OF SUBROGATION.** At all times during the Term and any extension thereof, Lessee shall, at its sole cost and expense, maintain in full force and effect, insurance protecting Lessee and Lessor and their respective agents and other parties designated by the Lessor from time to time as follows:

a. a policy of comprehensive general liability insurance with broad form general liability endorsement in an amount of not less than $1,000,000 combined single limit per occurrence of personal injury, bodily sickness, disease, or death and not less than $1,000,000 combined single limit per occurrence for damage or injury or destruction of property or in a greater amount as reasonably determined by Lessor. Compliance with the above requirement shall not, however, limit the liability of the Lessee hereunder.

b. a policy of replacement cost "all risk" fire and extended coverage insurance, with vandalism, malicious mischief, sprinkler leakage endorsements, in an amount sufficient to cover not less than 100% of the full replacement cost, as the same may exist from time to time, covering of all of Lessee's personal property, fixtures, equipment and tenant improvements on the Premises.

c. Workers' compensation and employer's liability insurance in the state in which the Premises are located, and in any other state in which the Lessee or its contractors or subcontractors may be subject to any statutory or other liability arising, in any manner whatsoever, out of the actual or alleged employment of others.

d. The form of all such policies shall be subject to Lessor's prior approval. The total amount of a deductible or otherwise self-insured retention under this Section shall not exceed $5,000.00 per occurrence. All such policies shall be issued by financially responsible insurers acceptable to Lessor and Lessor's lender, if any, and licensed to do business in the State of Illinois. The policies shall name Lessor and any other parties designated by Lessor as additional insureds, shall require at least thirty (30) days' prior written notice to Lessor of termination or modification and shall be primary and not contributory. Lessee shall, at least ten (10) days prior to the Commencement Date, and within ten (10) days prior to the expiration of any policy, deliver to Lessor certificates evidencing the foregoing insurance or renewal thereof, as the case may be. Such insurance required under this Section shall include "occurrence" rather than "claims made" policy forms and cover all liability assumed by Lessee under this Lease. The parties hereto agree to use good faith efforts to have any and all fire, extended coverage or any and all material damage insurance which may be carried, endorsed with the following subrogation clause: "This insurance shall not be invalidated should the insured waive in writing prior to a loss any or all right of recovery against any party for loss occurring to the property described herein," and each party hereto hereby waives all claims for recovery from the other party for any loss or damage to any of its property insured under valid and collectible insurance policies to the extent of any recovery collectible under such insurance, subject to the limitation that this waiver shall apply only when it is either permitted or by the use of such good faith efforts could have been so permitted by the applicable policy of insurance. Evidence of insurance coverage and limits as specified herein shall in no way limit Lessee's liabilities and responsibilities under this Lease. Any and all deductibles applicable to the required coverages shall be borne solely by Lessee.

13. **RESERVED RIGHTS.** Lessor shall have the following rights without notice or liability to Lessee (a) to change the name or street address of the Building; (b) to install and maintain a sign or signs on the exterior or in the interior of the Building; (c) to exhibit the Premises to prospective purchasers or lenders and, during the last one hundred and eighty (180) days of the Term, to prospective tenants; (d) to designate and control all types of window treatment; (e) to enter and decorate, remodel, repair, alter or otherwise prepare the Premises for re-occupancy during the last ninety (90) days of the Term or at any time after Lessee abandons the Premises; (f) to take any and all reasonable measures, including inspections, repairs, alterations, additions and improvements to the Premises or to the Building as may be necessary or desirable for the safety, protection or preservation of the Premises or the Building or Lessor's interests, or as may be necessary or desirable in the operation of the Building; (g) to designate, control or render any business and any service in or to the Building and its tenants; (h) to retain at all times, and to use in appropriate instances, keys to all doors and locked spaces within and into the Premises exclusive of Lessee's vaults and safes; and (i) to enter upon and inspect the Premises at reasonable times, and, if vacated or abandoned, prepare the Premises for re-occupancy.

Lessor may enter upon the Premises and may exercise any or all of the foregoing rights without being deemed guilty of an eviction or disturbance of Lessee's use or possession and without being liable in any manner to Lessee. Lessor agrees to provide sufficient notice to Lessee prior to such entry so that Lessee may provide licensed personnel to accompany Lessor while on the Premises, in accordance with applicable law, and Lessor shall use its best efforts to minimize interference with the conduct of Lessee's business at the Premises and disturbance of Lessee's patients.

14. **INTENTIONALLY OMITTED.**

15. **WAIVER OF CLAIMS.** To the extent permitted by law, Lessee releases Lessor and Lessor's agents and servants from, and waives all claims for damage to person or property sustained by Lessee resulting from the Building or Premises or any part of either or any equipment or appurtenance becoming out of repair, or resulting from any accident on or about the Building, or resulting directly or indirectly from any act or neglect of any tenant or occupant of the Building or of any other person, excluding Lessor, Lessor's agents and employees. This Section shall apply especially, but not exclusively, to the flooding of basements or other subsurface areas, and to damage caused by refrigerators, sprinkling devices, air-conditioning apparatus, water, snow, frost, steam, falling plaster, broken glass, sewage, gas, odors or noise, or the bursting or leaking of pipes or plumbing fixtures, and shall apply equally whether any such damage results from the act or neglect of Lessor or of other tenants, occupants, or servants in the Building or of any other person, and whether such damage is caused or results from anything or circumstances above-mentioned or referred to, or any other thing or circumstances whether of a like nature or of a wholly different nature. If any such damage, whether to the demised Premises or to the Building or any part thereof, or whether to Lessor or to other tenants in the Building, result from any act of neglect of Lessee, Lessor may, at Lessor's option, repair such damage and Lessee shall, upon demand by Lessor, reimburse Lessor forthwith for the reasonable cost of such repairs.

16. **RULES.** Lessee agrees to observe the reservations to Lessor in Section 13 hereof and to comply with the following rules and regulations and with such reasonable modifications thereof and additions thereto as Lessor may make for the Building, it being agreed Lessor shall not be responsible for any non-observance thereof by other tenants:

a. Any sign installed in Lessee's Premises shall be installed by Lessor at Lessee's cost and in such manner, character and style as Lessor may approve in writing.

b. Lessee shall not obstruct sidewalks, entrances, passages, courts, corridors, vestibules, halls, elevators, and stairways in and about the Building. Lessee shall not place objects against glass partitions or doors or windows which would be unsightly from the Building corridor.

c. Lessee shall not make noises, cause disturbances or vibrations or use or operate any electrical or electronic devices that emit sound or other waves or disturbances, or create odors that would be unduly offensive to other tenants and occupants of the Building or that would interfere with radio or television broadcasting or reception from or in the Building or elsewhere, and shall not place or install any antennae or aerials or similar devices outside of the Premises. Lessee shall not place any objects on the ledges or other parts of the Building exterior; and shall not permit objects, however small, to be thrown or dropped from Building windows.

d. Lessee shall not make any room-to-room canvas to solicit business from other tenants in the Buildings.

e. Lessee shall not waste electricity, water or air conditioning and agrees to cooperate fully with Lessor to assure the most effective operation of the Building's heating and air conditioning, and shall refrain from attempting to adjust any controls other than room thermostats installed for Lessee's use. Lessee shall keep corridor doors closed and shall not open any windows.

f. Door keys for doors in the Premises shall be furnished at the commencement of the Lease by Lessor. Lessee shall not affix additional locks on doors and shall purchase duplicate keys only from Lessor and will disclose to Lessor the combination of any safes, cabinets or vaults left in the Premises after Lessee vacates the Premises.

g. Lessee assumes full responsibility for protecting its space from theft, robbery and pilferage which includes keeping doors locked and windows and other means of entry to the Premises closed.

h. If Lessee requires telegraphic, telephonic, burglar alarm or similar services, it shall first obtain, and comply with, Lessor's instructions in their installation.

i. The Lessor may require that all persons who enter or leave the Building between 6:30 p.m. and 8:00 a.m. on business days, or at any time on Saturdays, Sundays or

holidays, must identify themselves to watchmen, by registration or otherwise, subject, however, to change in such hours by Lessor.

j. Peddlers, solicitors and beggars shall be reported to the office of the Building or as Lessor otherwise requests.

k. Lessee shall not overload floors and Lessor must give written approval as to size, maximum weight, routing and location of business machines, safes, and heavy objects. Lessee shall not install and operate machinery or any mechanical devices of a nature not directly related to Lessee's ordinary use of the Premises without the written permission of Lessor.

l. Furniture and other large articles may be brought into the Building only at times and in the manner designated by Lessor. Lessee shall furnish Lessor with a list of furniture, equipment and similar objects which are to be recovered from the Building. Movements of Lessee's property into or out of the Building and in the Building are entirely at the risk and responsibility of Lessee and Lessor may require permits before allowing anything to be moved in or out of the Building. Lessor will not move or transport any equipment or furnishings from Lessor's general receiving facilities to or from the Premises.

m. No person or contractor shall be employed to do window washing, decorating or repair in the Premises except by Lessor or with Lessor's advance written consent.

n. The electrical and mechanical closets, water and wash closets, drinking fountains and other plumbing, communications, electrical and mechanical fixtures shall not be used for any purposes other than those for which they were constructed, and no sweepings, rubbish, rags, coffee grounds, acids or other substances shall be deposited therein. Lessor shall have sole power to direct where and how telephone and other wires are to be introduced. No boring or cutting for wires is to be allowed without the consent of Lessor. The location of communication equipment affixed to the Premises shall be subject to the approval of Lessor. All damages resulting from any misuse of the fixtures shall be borne by the Lessee who, or whose employees, agents, assignees, sublessees, invitees or licensees, shall have caused the same.

o. In no event shall any person bring into the Building, inflammables such as gasoline, kerosene, naphtha and benzene, or explosives or any other articles of intrinsically dangerous nature, which are not in appropriate containers approved for such purpose by the Board of Underwriters and then only if the same will not increase the insurance risks of the Building.

p. Lessee shall comply with all applicable federal, state and municipal laws, ordinances and regulations and shall not directly or indirectly make any use of the Premises which may be prohibited by any thereof or which shall be dangerous to persons or property or shall increase the cost of insurance or require additional coverage.

q. Lessee agrees to store all trash and refuse (including, without limitation, biohazardous waste) in adequate containers within the Premises or such other places in the Building as Lessor may designate and to maintain such containers in a healthy, safe, neat and clean condition, and to attend to the daily disposal thereof in the manner specified by Lessor.

r. Lessee agrees that no weapons shall be used, allowed or kept on the Premises.

s. Lessee shall be responsible for the observance of all the foregoing rules by Lessee's employees, agents, clients, customers, invitees and guests.

t. **SMOKING IS PROHIBITED** everywhere within the Building, including each Lessee's private office suites, if any, or any common area (i.e. hallways, corridors, lobbies, restrooms, elevators, vestibules or stairwells), and, in addition, **SMOKING IS PROHIBITED** within 15 feet of any entrance or loading dock to the Building.

17. EMINENT DOMAIN

a. In the event that the whole or any substantial part of the Premises shall be lawfully condemned or taken in any manner for any public or quasi-public use, the Lease and the term hereby granted shall forthwith cease and terminate on the date of the taking of possession by the condemning authority and the Lessor shall be entitled to receive the entire award without any payment to Lessee, the Lessee hereby assigning to the Lessor the Lessee's interest in such awards, if any.

b. In the event that a part of the Building other than the Premises shall be so condemned or taken and if in the opinion of the Lessor, the Building should be restored in such a way as to alter the Premises materially, the Lessor may terminate this Lease without compensation to Lessee and the term and estate hereby granted by notifying the Lessee of such termination within sixty (60) days following the date of the taking of possession by the condemning authority, and this Lease and the term and estate hereby granted shall expire on the date specified in the notice of termination, not less than sixty (60) days after the giving of such notice, as for the expiration of the Term of this Lease, and the Rent hereunder shall be apportioned as of such date.

18. CONDITION OF PREMISES

Lessee's taking possession of the Premises shall be conclusive evidence as against the Lessee that the Premises were in good order and satisfactory condition when the Lessee took possession, except as to latent defects. No promise of the Lessor to alter, remodel, repair or improve the Premises or the Building and no representation respecting the condition of the Premises or the Building have been made by Lessor to Lessee, other than as may be in a separate Work Letter, attached hereto as **Exhibit C** and incorporated herein by reference. Lessee acknowledges that it has satisfied itself by its own independent investigation that the Premises are suitable for its intended use.

19. REPAIRS

a. Lessee shall, at its sole expense, keep the Premises in good repair and tenantable condition during the Term and Lessee shall promptly arrange with Lessor at Lessee's sole expense for the repair of all damages to the Premises (except for reasonable wear and tear and as otherwise provided in Section 18 of this Lease) and the replacement or repair of all damaged or broken glass (including signs thereon), fixtures and appurtenances (but excluding hardware and heating, cooling, ventilating, electrical, plumbing and other mechanical facilities in the Premises, for which Lessor shall be responsible at Lessor's sole cost and expense, except as provided in Section 20(b) of this Lease) within any reasonable period of time specified by Lessor. If Lessee does not promptly make arrangements for such repairs and replacements as Lessee is responsible, Lessor may, but need not make such repairs and replacements and the amount paid by Lessor for such repairs and replacements shall be deemed Additional Rent under this Lease and shall be due and payable with the payment of Base Rent immediately following such repairs by Lessor. Lessor may, but shall not be required so to do, enter the Premises, with permission from the Lessee in all but emergency situations, to make any repairs, alterations, improvements or additions, including, but not limited to, ducts and all other facilities for heating and air conditioning service as Lessor shall desire or deem necessary for the safety, preservation or improvement of the Building, or as Lessor may be required to do by the City of Chicago, or by the order or decree of any court or by any other proper authority.

b. In the event Lessor or its agents or contractors shall elect or be required by any governmental authority to make repairs, alterations, improvements or additions to the Premises or the Building, Lessor shall be allowed to take into and upon the Premises all material that may be required to make such repairs, alterations, improvements or additions and during the continuance of any of said work, to temporarily close doors, entryways, public space and corridors in the Building and to interrupt or temporarily suspend any services and facilities without being deemed or held guilty of an eviction of Lessee or for damages to Lessee's property, business or person, and the rent reserved herein shall in no way abate while said repairs, alterations, improvements or additions are being made so long as the Premises are readily accessible and so long as work shall be done in such manner as to minimize interference with Lessee's use of the Premises. Lessor may, at its option, make all such repairs, alterations, improvements or addition in and about the Building and the Premises during ordinary business hours, but if Lessee desires to have the same done at any other time, Lessee shall pay for all overtime and additional expenses resulting therefrom.

20. ALTERATIONS

a. Lessee shall not make alterations in or additions, improvements or installations to the Premises or puncture or otherwise make any openings in the walls or doors of the Premises without Lessor's prior written consent, and, if such consent be given, Lessee shall comply with all conditions contained in such consent. As a condition to granting its consent, Lessor may impose reasonable requirements in addition to any set forth in this

Lease, including without limitation, requirements as to the manner and term for the performance of any such work and the type and amount of insurance and bonds Lessee must acquire and maintain in connection with such alteration work. In addition, at Lessor's option, Lessor shall have the right: to approve or specify the contractors or mechanics performing the work; to approve all plans and specifications relating to the work; to review the work of Lessee's architects, engineers, contractors or mechanics and to control any construction or other activities being undertaken within the Building with Lessor to receive a supervisory fee of 1.5% of the cost of the work, as such fee may be modified from time to time, and with Lessor to be reimbursed for any costs incurred in connection with such review or control; and to require correction of the work in instances in which materials or workmanship is defective or not in accordance with plans or specifications previously approved by Lessor.

b. Except as set forth in any work letter attached hereto as **Exhibit C**, all work in connection with any alterations, improvements, changes, additions or repairs in the Premises or Building made by or for the benefit of Lessee shall be performed at Lessee's sole cost and expense in a good and workmanlike manner and in full compliance with all laws, ordinances, regulations, rules and requirements of all governmental entities having jurisdiction. Alterations and additions to the Premises so made on behalf of Lessee shall upon installation be and remain the property of Lessor without reimbursement of Lessee. At the expiration of the Term, Lessor may require Lessee to remove any or all of said alterations, additions, and improvements and to restore the Premises to their prior condition, all at Lessee's cost and expense, but only if Lessor has specified such removal at the time such alteration, addition or improvement was approved by Lessor. Notwithstanding any provision of this Lease to the contrary, Lessor shall be responsible for the repair and replacement of the heating, ventilating and air-conditioning system (the "HVAC") serving the Premises at Lessor's sole cost and expense, except that Lessee shall be responsible for the cost of any repairs or replacements caused by Lessee's neglect or failure to maintain the HVAC in accordance with the manufacturer's recommended service guidelines and for maintaining a contract to service the HVAC at least twice per year pursuant to a service contract approved by Lessor.

c. Upon completion of any alteration, Lessee shall promptly furnish Lessor with sworn owner's and contractor's statements and full and final waivers of lien covering all labor and materials included in such alteration.

21. **COVENANT AGAINST LIENS.** Lessee covenants and agrees not to suffer or permit any lien of mechanics or material to be placed against the Building or any part thereof and in case of any such lien attaching, to immediately pay off and remove the same. Lessee has no authority or power to cause or permit any lien or encumbrance of any kind whatsoever, whether created by act of Lessee, operation of law or otherwise, to attach to or be placed upon the Building or any part thereof. If any such lien is filed and not removed by Lessee within ten (10) business days, Lessor, without investigating the validity of such lien, may pay or discharge the same, and Lessee shall reimburse Lessor upon demand for the amount so paid by Lessor, including Lessor's expenses and attorneys' fees.

22. **STORAGE OF LESSEE'S PROPERTY.** If on termination of this Lease by expiration or otherwise, or on abandonment of the Premises, Lessee shall fail to remove any of Lessee's property from the Premises, Lessee hereby authorizes Lessor, at Lessor's option, to cause such property to be removed and placed in storage for the account of and at the expense of Lessee, or on such termination, to sell such property at public or private sale, following ten (10) days' notice, and to apply the proceeds thereof, after payment of all expenses of removal, storage and sale, to the indebtedness, if any, of the Lessee to Lessor, the surplus if any to be paid to Lessee upon demand.

23. **SUBLETTING OR ASSIGNMENT OR TRANSFER OF CONTROL.**

a. It is expressly understood and agreed that the Lessee shall not (a) allow or permit any transfer of this Lease or any interest under it, (b) assign or convey this Lease or any part thereof, (c) sublease all or any part of the Premises, or (d) permit the use or occupancy of the Premises or any part thereof by anyone other than Lessee (agents and servants of the Lessee excepted) without prior written consent of the Lessor. Lessee shall give Lessor at least thirty (30) days prior written notice of its desire to sublet which shall include a copy of the sublease and reliable information indicating that the proposed sublessee is reputable, financially responsible and is engaged in a medical or medical-related business. Lessor's decision to grant or deny any approval shall, in its sole discretion, be absolutely binding and Lessor shall not be held to any standard of reasonableness or other such standard in making such decision. If Lessee is a corporation, LLC or partnership and if, during the term of this Lease, the ownership of the shares of stock or other interest, as the case may be, which constitutes control of Lessee changes by reason of sale, gift, death or other transfer, Lessor may at any time thereafter terminate this Lease by giving Lessee written notice of such termination stated in the notice. The receipt of rent after such change of control shall not affect Lessor's rights under the preceding sentence.

b. In connection with any transfer, assignment or sublease to which Lessor may consent, Lessee agrees to furnish Lessor with copies of all documents, and subsequent amendments thereto, executed in connection with such transfer. Any consent of Lessor to a subletting, assignment or transfer of control shall be deemed to be a consent to the initial subletting, assignment or transfer of control only and shall not be deemed to be a consent to any further subletting, assignment or transfer of control. Further, notwithstanding any permitted subletting or assignment, the Lessee named hereunder shall at all times remain fully responsible and liable for the payment of the Rent and for compliance with all of Lessee's obligations under the terms, provisions and covenants of this Lease.

24. **SURRENDER OF PREMISES**

Upon any termination of this Lease, by expiration or otherwise:

a. Lessee shall immediately vacate the Premises and surrender possession thereof, including all keys as herein required, to Lessor;

b. Lessee shall surrender the Premises in as good a condition as when Lessee took possession, except for reasonable wear and tear and damage by any casualty not caused by Lessee; and

c. Lessee grants to Lessor full authority and license to enter the Premises and take possession in the event of any such termination.

d. All fixtures, installations, and personal property belonging to Lessee not removed from the Premises upon expiration or termination of this Lease and not required by Lessor to have been removed as provided herein shall be conclusively presumed to have been abandoned by Lessee and title thereto shall pass to Lessor under this Lease as by a bill of sale. This Subsection 24(d) shall survive the expiration or sooner termination of the Term.

25. HOLDING OVER

If Lessee retains possession of the Premises or any part thereof after the termination of the Lease Term by lapse of time or otherwise, Lessee may be required to pay Lessor rent at double the rate of Rent in effect immediately preceding such holding over computed on a monthly basis, for each month and prorated for each partial month that Lessee remains in possession, and in addition thereto, may be required to pay Lessor all direct damages sustained by reason of Lessee's retention of possession. If Lessee remains in possession of the Premises or any part thereof after termination of the Term by lapse of time or otherwise, such holding over shall, at the election of Lessor, expressed in a written notice to Lessee within thirty (30) days after termination of the Term, constitute a renewal of this Lease for one year at the fair market rental value of the Premises as reasonably determined by Lessor but in no event less than the Rent payable immediately prior to such holding over. Lessor's acceptance of any Rent after holding over does not renew this Lease except at the election of Lessor as specified in this Section 25and does not constitute a waiver of Lessor's right to re-entry.

26. TAX ON RENTALS; PERSONAL PROPERTY

a. In the event that any federal, state, local or other governmental authority shall impose or assess any tax, levy or other charges on or against all or any part of the Rent paid or to be paid by Lessee under the terms of this Lease, and Lessor is thereby required to collect from Lessee and/or pay such tax, levy or charge to such authority, Lessee covenants and agrees, within ten (10) days following written demand therefore, to pay to or reimburse Lessor (as the case may be) all such charges as may be imposed or assessed, which, for the purposes of this Lease, shall be deemed to be due from Lessee as Additional Rent.

b. Lessee shall pay prior to delinquency, all taxes assessed against and levied upon trade fixtures, furnishings, equipment and all other property Lessee contained in the Premises or elsewhere.

27. **ATTORNMENT.** Lessee agrees to attorn to any person or persons or other entity purchasing or otherwise acquiring the Premises or any right therein or thereto at any sale, sales, or other proceedings under any mortgage, deed of trust, or liens or security interest affecting the Premises in the same manner and with like effect as if such person or persons had been named as Lessor herein, and the event of transfer this Lease shall continue in full force and effect as aforesaid, Lessor shall, from and after the date of such transfer, be free of all liabilities and obligations not then incurred, provided that the transferee assumes all obligations of Landlord under the Lease, and Lessee hereby agrees to execute any and all documents evidencing such attornment and release of Lessor then or thereafter requested of Lessee, provided that the transferee agrees in writing not to disturb Lessee's tenancy under the Lease.

28. **ESTOPPEL CERTIFICATE**

a. Lessee shall at any time and from time to time upon not less than ten (10) business days' prior written notice from Lessor execute, acknowledge and deliver to Lessor a statement in writing (i) certifying that this Lease is unmodified and in full force and effect (or, if modified, stating the nature of such modification and certifying that this Lease as so modified, is in full force and effect) and the dates to which the rental and other charges are paid in advance, if any, and (ii) acknowledging that there are not, to Lessee's knowledge, any incurred defaults on the part of Lessor hereunder, or specifying such defaults if any are claimed. Any such statement may be relied upon by any prospective purchaser or encumbrancer of all or any portion of the real property of which the Premises are a part.

b. Lessee's failure to deliver such statement within such time shall be conclusive upon Lessee (i) that this Lease is in full force and effect, without modification except as may be represented by Lessor, (ii) that there are no incurred defaults in Lessor's performance, and (iii) that not more than one month's rental has been paid in advance.

29. **COVENANT OF QUIET ENJOYMENT.** Lessor represents and warrants that it has authority to execute this Lease and create the leasehold estate in Lessee which this Lease purports to create. As long as no default under this Lease exists, Lessor further agrees that Lessee, upon paying the Rent and keeping the agreements of this Lease on its part to be kept and performed, shall have peaceful and quiet possession of the Premises during the Term hereof.

30. **PAYMENT OF FEES AND EXPENSES.** Each party hereto agrees to pay upon demand all costs, charges and expenses, including the reasonable fees of attorneys, agents and others retained by the prevailing party, incurred in enforcing any of the obligations hereunder or incurred by said prevailing party in any litigation, negotiation or transaction in which the parties hereto become involved or concerned in connection herewith.

31. **GOVERNMENTAL REGULATIONS.** This Lease is subject to and Lessee agrees to comply, at Lessee's sole cost and expense, with all statutes, ordinances and other governmental rules and regulations which: (i) relate in any manner to Lessee's occupancy in the Building and Premises, including but not limited to, "An Act in Relation to the Establishment of a Medical Center District in the City of Chicago"; and (ii) relate to the conduct of Lessee's business there.

32. **NOTICES.** All notices and demands upon Lessor or Lessee desired or required under this Lease shall be given in writing. Any notices or demands from Lessor to Lessee shall be deemed to have been given if a copy thereof has been personally delivered to the President of Lessee (including, without limitation delivery by messenger or courier, with evidence of receipt) or mailed by United States registered or certified mail, return receipt requested, addressed to Lessee at the Premises after Lessee's occupancy of the Premises. Lessor shall also deliver a copy of any notices or demand to Lessee's attorney at the address shown on the Summary of Lease Provisions. Any notices or demands from Lessee to Lessor shall be deemed to have been given if a copy thereof has been personally delivered (including without limitation delivery by messenger or courier, with evidence of receipt) or mailed by US registered or certified mail, return receipt requested, addressed to Lessor at the address shown on the Summary of Lease provisions, and to the Office of Legal Affairs, Rush University Medical Center, 1700 W. Van Buren, Chicago, IL 60612.

33. **INCREASED FIRE INSURANCE RATES.** If, because of any act or omission of the Lessee or because of anything done, caused, suffered or permitted by the Lessee, any insurance rate on the said Building in which said Premises are located, or upon any of the contents thereof, shall be raised, the increase in premium which the Lessor, shall thereby be obliged to pay for such insurance, shall be borne by the Lessee, and said Lessee hereby expressly agrees that the amount of such increase in said premium shall be added to the Rent and become part thereof, and be paid by the Lessee as a part of the Rent for the Premises, or, if the Lessor shall at any time so determine and elect, this Lease shall by such act terminate, and the Lessor shall be allowed to re-enter in accordanee with the provisions in such case herein provided.

34. **BROKER.** Lessee represents and warrants to Lessor that Lessee has not dealt with any broker or finder in connection with the Lease, and agrees to indemnify and hold Lessor harmless from any damages, liability and expense (including reasonable attorneys' fees) arising from any claims and demands of any broker or finder for any commission alleged to be due such broker or finder in connection with this Lease.

35. **INTENTIONALLY OMITTED.**

36. **USE.** Lessee shall use the Premises as an inpatient hospice unit and for no other purpose. Lessee agrees not to engage in or conduct a commercial clinical laboratory or commercial radiological department in or from the Premises and Lessee agrees not to use or permit the use of pathology, X-ray or other equipment in such offices to provide services to

other doctors. Lessee further agrees not to operate an ambulatory surgical treatment center ("ASTC") as defined in the Ambulatory Surgical Treatment Center Act (210 ILCS 5/3(A)) or conduct procedures customarily performed at ASTC's, in the Premises. Lessee shall not use or occupy the Premises or permit the use or occupancy of the Premises by any of Lessee's employees, agents, invitees or contractors for any purpose or in any manner which is (i) unlawful or in violation of any applicable legal or governmental requirement, ordinance or rule; (ii) may be dangerous to persons or property; (iii) may invalidate or increase the amount of premiums for any policy of insurance affecting the Building or Premises; or (iv) may create a nuisance, unreasonably disturb any other tenant of the Building or injure the reputation of the Building.

37. **CONTROL OF PUBLIC AREAS; INSURANCE.**

a. All Common Areas shall at all times be subject to the exclusive control and management of Lessor and Lessor shall have the right from time to time to establish, modify and enforce reasonable rules and regulations with respect to all such facilities and areas.

b. All such areas and facilities not within the Premises which Lessee may be permitted to use and occupy, are to be used and occupied under a revocable license, and if the amount of such areas be diminished, Lessor shall not be subject to any liability nor shall Lessee be entitled to any compensation or diminution or abatement of rent except for an appropriate reduction in Additional Rental, nor shall such diminution of such areas be deemed constructive or actual eviction, provided, however, that no such diminution shall materially adversely affect Lessee's access to or use of the Premises.

c. Lessee shall not be responsible for maintaining public liability insurance with respect to any such areas and facilities, provided that Lessee, at Lessee's option, may elect to insure such areas and facilities and, to the extent of such insurance coverage, agrees to cause Lessor to be named as an additional insured.

38. **LESSOR'S DISCLAIMER OF OBLIGATION TO PROVIDE SECURITY IN PUBLIC SPACES.** Lessor shall not be responsible or obligated to provide security to Lessee or its invitees in the common areas. Lessee acknowledges that Lessee is not leasing the Premises in reliance upon the existing security force of Lessor or Building security guards to protect the Lessee or Lessee's invitees against criminal acts of third persons.

39. **ENTIRE AGREEMENT.** This Lease together with the Exhibits and Schedules attached hereto contains the entire agreement between the parties and shall not be modified in any manner except by an instrument in writing executed by the parties or their respective successors in interest.

40. **TERMS.** The words "Lessor" and "Lessee" as used herein shall include the plural as well as the singular. Words used in any gender include other genders. If there be more than one Lessee the obligations hereunder imposed upon Lessee shall be joint and

several. Introductory headings at the beginning of each numbered section of this Lease are solely for the convenience of the parties and should not be deemed to be a limitation upon or descriptive of the contents of any such paragraph.

41. **LIGHT AND AIR.** No rights to light and air over any property, whether belonging to Lessor or to any other person, are granted to Lessee by this Lease.

42. **TIME OF ESSENCE.** Time is of the essence of this Lease with the exception of Lessor's delivery of possession hereunder.

43. **EXAMINATION OF LEASE.** Submission of this instrument for examination does not constitute a reservation of or option for the Premises or in any manner bind the Lessor and no lease obligation on Lessor shall arise until execution by and delivery to both Lessor and Lessee.

44. **RECORDING.** Neither Lessor nor Lessee shall record this Lease or a short form memorandum hereof without the consent of the other.

45. **GOVERNING LAW.** This Lease shall be governed by and construed in accordance with the laws of the State of Illinois without regard to conflicts of law principles.

46. **SEVERABILITY.** If any provision of this Lease shall be determined to be illegal or non-enforceable, such provision shall be deemed severable from the balance of this Lease, and shall not impair or affect in any manner the validity or enforceability of the remainder of the Lease, which remains in full force and effect.

47. **MISCELLANEOUS**

a. No receipt of money by Lessor from Lessee after any default by Lessee or after the termination of this Lease or after the service of any notice or after the commencement of any suit, or after final judgment for possession of the Premises, shall waive such default or reinstate, continue or extend the term of this Lease or affect any such notice or suits, as the case may be.

b. No waiver of any default to Lessee hereunder shall be implied from omission by Lessor to take any action or account of such default, and no express waiver shall affect any default other than the default specified in the express waiver and that only for the time and to the extent therein stated.

c. Each provision of this Lease shall extend to and shall bind and inure to the benefit not only of Lessor and Lessee but also of their respective heirs, legal representatives, successors and assigns.

d. Lessee shall immediately notify Lessor in the event that Lessee becomes an excluded individual/entity from any applicable government program.

48. **SURVIVAL.** All obligations of Lessee under Sections 11, 15, 21, 22, 24, 25, and 30 shall survive the expiration or sooner termination of this Lease.

49. **FORCE MAJEURE.** Lessor shall not be in default under this Lease and Lessee shall not be excused from performing any of Lessee's obligations under this Lease if Lessor is prevented from performing any of Lessor's obligations due to any accident, strike, shortage of materials, acts of God or other causes beyond Lessor's reasonable control.

50. **NOTIFICATION.** Lessee shall immediately notify Lessor in the event that Lessee becomes an excluded entity/individual from any government program.

51. **LEASE OF MEDICAL/SURGICAL BEDS.** During the Term and any Extension Term, Lessee shall have the right to utilize up to a maximum of thirteen (13) of Lessor's allotment of medical/surgical beds pursuant to Lessor's license from the State of Illinois.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, Lessor and Lessee have caused this Lease to be executed as of the date first above written.

LESSEE:

HORIZON HOSPICE & PALLIATIVE CARE, INC.

By: Mary Runge
Name:
Its: President/CEO
Date: 9-23-11

LESSOR:

RUSH UNIVERSITY MEDICAL CENTER

By:
J. Robert Clapp, Jr.
Senior Vice President Hospital Affairs
Date: SEPT. 23, 2011

EXHIBIT A
Floor Plan

EXHIBIT B

Schedule of Rent

Year Beginning	Base Rent	Annual	Monthly
Year 1		[redacted]	[redacted]
Year 2		Increase by CPI	$
Year 3		Increase by CPI	$
Year 4		Increase by CPI	$
Year 5		Increase by CPI	$
Rentable Sq. Ft.	5,758		

EXHIBIT C

Work Letter

This Work Letter (the "Work Letter") is attached to and made a part of the Lease as Exhibit C, and sets forth the terms and conditions relating to the construction of improvements for the Premises (the "Improvements"). All references in this Work Letter to the "Lease" shall mean the relevant portions of the Lease to which this Work Letter is attached as Exhibit C. In the event of any conflict between the Lease and this Work Letter, the latter shall control.

SECTION 1.

THE WORK

1.1 The Work. Lessee shall, at its expense using Building standard materials, cause to be performed the work (the "Work") in the Premises provided for in the Construction Documents (as defined in Section 2 hereof) submitted to and approved by Lessor.

1.2 Costs Included in Work. The costs of the Work to be paid for by Lessee shall include, but not be limited to the following items:

1.2.1 Payment of the fees of the "Architect" as such term is defined in Section 2.1 of this Work Letter, and payment of the fees incurred by, and the cost (if any) of documents and materials supplied by, Lessor and Lessor's consultants in connection with the preparation and review of the Construction Documents, as that term is defined in Section 2.1 of this Work Letter;

1.2.2 The payment of permit and license fees relating to construction of the Improvements;

1.2.3 The cost of construction of the Improvements, including, without limitation, contractors' fees and general conditions, testing and inspection costs, costs of utilities, trash removal, parking and hoists, and the costs of after-hours freight elevator usage;

1.2.4 The cost of any changes to the Construction Documents or Improvements required by any applicable laws; and

1.2.5 All other costs to be expended by Lessee in connection with the construction of the Improvements.

1.3 General Terms. Lessee agrees to construct the Work in a good and workmanlike manner free from errors, omissions or defects, and substantially in accordance with the Construction Documents; in compliance with all applicable requirements of laws, ordinances, codes and regulations having jurisdiction over Lessor, the Premises or the Building; and without the use of asbestos, asbestos-containing materials, or other permanently installed hazardous materials as defined from time to time by applicable legal requirements.

1.4 Reimbursement by Lessor. Notwithstanding any provision of this Work Letter to the contrary, Lessor shall reimburse Lessee for Lessee's actual costs of such portions of the

Work as is listed on Schedule 1.4 attached hereto and made a part hereof, such costs not to exceed $243,931 in the aggregate.

SECTION 2.

CONSTRUCTION DOCUMENTS

2.1 Selection of Architect/Construction Drawings. Lessee will retain Proteus as its architect/space planner (the "Architect") for the design of the Improvements to be provided for in the Construction Documents (defined below). Lessee shall not change its Architect without the prior written consent of Lessor, which consent shall not be unreasonably withheld. The Architect has prepared space plans (the "Space Plans") that have been approved by Lessor as to scope and general layout, and will prepare working drawings (the "Final Working Drawings") consistent with the Space Plans no later than July 15, 2011, which will be labeled issued for permit and submitted to Lessor for its approval (the "Construction Documents"). Lessor's approval of the Construction Documents does not imply Lessor's review of the same, or obligate Lessor to review the same, for quality, design, compliance with applicable laws or other like matters. Accordingly, notwithstanding that the Construction Documents or any revisions thereto are reviewed by Lessor or its space planner, architect, engineers and consultants, and notwithstanding any advice or assistance which may be rendered to Lessee by Lessor or Lessor's space planner, architect, engineers, and consultants, Lessor shall have no liability whatsoever in connection therewith and shall not be responsible for any omissions or errors contained in the Construction Documents. The correction of any such omissions or errors shall be the responsibility of Lessee.

2.2 Construction Documents. Lessee will promptly take such steps as may be necessary to obtain approval of the Construction Documents by the applicable local governmental agency and to obtain all applicable building permits necessary to allow Contractor to commence and fully complete the construction of the Improvements (collectively, the "Permits"). Lessee shall be obligated to obtain all Permits and, if required by applicable law or ordinance, the certificate of occupancy for the Premises. Lessee shall provide copies of Permits and the certificate of occupancy to Lessor when delivered by the Contractor. Once approved by Lessor, no changes, modifications or alterations in the Construction Documents may be made without the prior written consent of Lessor, which consent shall not be unreasonably withheld provided that the change, modification, or alteration is required by applicable codes or ordinances, is consistent with the overall scope of the Work required to complete the Improvements, and does not adversely affect or compromise the structure or systems of the Building or demand more than the capacity of the Building allows.

2.3 Changes in the Work.

2.3.1 Minor Changes. Lessee may make minor changes in the Work arising during the construction process not inconsistent with the intent hereof.

2.3.2 Other Changes. Lessee, at its own expense, may make changes (other than minor changes), in the Work by submitting to Lessor the required revised Plans for approval

or disapproval, which approval shall not be unreasonably withheld or delayed. In the event that Lessee submits revised Plans which are approved by Lessor, Lessee shall also submit for approval by Lessor a timeline showing the delay in completion of the Work anticipated as a result of the proposed changes.

SECTION 3.

CONSTRUCTION OF THE IMPROVEMENTS

3.1 Contractor. Lessor shall approve the general contractor (the "Contractor") engaged by Lessee, and all subcontractors engaged by the Contractor for the Work to construct the Improvements, all of which shall be union labor. The Contractor and all subcontractors shall be chosen from a list pre-approved by Lessor.

3.2 Construction of Improvements by Contractor.

3.2.1 Lessor Requirements. After selection of the Contractor, Lessee shall enter into an agreement with the Contractor, subject to Lessor's approval, which contract shall, at a minimum, require delivery of partial and final lien waivers with every payment request and evidence of insurance coverage as required under Section 3.2.3 below. Lessee will cause Contractor to abide by the construction policies of Lessor, including but not limited to, safety programs.

3.2.2 Contractor's Warranties and Guaranties. Lessee hereby assigns to Lessor, to the extent assignable, all warranties and guaranties provided by Contractor and any equipment suppliers relating to the Improvements, which assignment shall be on a non-exclusive basis such that the warranties and guarantees may be enforced by Lessor and/or Lessee.

3.2.3 Lessee's Covenants. Lessee shall require Contractor and through Contractor, subcontractors, to maintain policies of insurance, including general liability, employer's liability including workers compensation and motor vehicle insurance in such amounts as Lessor may require, which policies shall be endorsed and include Lessor as an additional insured, and which shall provide thirty (30) days notice to Lessor of any termination or alteration in coverage. Lessee shall not permit its Contractor or subcontractors to commence any of the Work until all required insurance has been placed, and certificates evidencing coverages have been delivered to Lessor. Lessee shall require Contractor to maintain payment and performance bonds written by a company acceptable to Lessor until six months after completion of the Work. Lessee hereby indemnifies Lessor for any loss, claims, damages or delays arising from the actions of Lessee, Architect, Contractor or subcontractors on the Premises or in the Building in connection with the performance of the Work, to the extent that such claim, damage or delay is caused by the act or omission of Lessee, Architect, Contractor or any subcontractor or anyone directly or indirectly employed by any of them.

SECTION 4.

SUBSTANTIAL COMPLETION

4.1 Substantial Completion. For purposes of the Lease, including for purposes of determining the Completion Date, "Substantial Completion" of the Improvements shall occur upon the completion of construction of the Improvements in the Premises pursuant to the Construction Documents, with the exception of any punchlist items and any Lessee fixtures, work-stations, built-in furniture, or equipment to be installed by Lessee or under the supervision of Contractor, and the issuance by the Contractor, and delivery to Lessee, of a certificate of substantial completion in the form of AIA Document G704 (1992 Edition) or any successor or replacement certificate.

4.2 Completion Date/Final Completion. The "Completion Date" shall be the date on which Lessee has achieved Substantial Completion of the Improvements. The date of "Final Completion" shall be no later than 90 days after the date of Substantial Completion except for good cause approved in advance by Lessor. At Final Completion, Lessee shall submit to Lessor as-built drawings for Lessor's records.

SECTION 5.

MISCELLANEOUS

5.1 Lessee's Entry into the Premises during the Work. Subject to the terms hereof Lessee shall have access to the Premises for the purpose of overseeing the Work and to install standard equipment or fixtures (including Lessee's data and telephone equipment) in the Premises. In connection with any such entry, Lessee acknowledges and agrees that Lessee's employees, agents, contractors, consultants, workmen, mechanics, suppliers and invitees shall fully cooperate and work in harmony and not, in any material manner, interfere with Lessor, its agents, representatives, patients, residents or others, or with the general operation of the Building and/or the Work. If at any time any such person representing Lessee or the Contractor or any subcontractor shall not be cooperative or shall otherwise cause or threaten to cause any disharmony or interference, including, without limitation, labor disharmony or disharmony with any other occupant in the Building, and Lessee or Contractor, as the case may be, fails to immediately institute and maintain corrective actions (including as may be directed by Lessor), then Lessor may revoke Lessee's and Contractor's entry rights upon twenty-four (24) hours' prior written notice to Lessee. Lessee acknowledges and agrees that any such entry into and occupancy of the Premises or any portion thereof by Lessee or any person or entity working for or on behalf of Lessee shall be deemed to be subject to all of the terms, covenants, conditions and provisions of the Lease, excluding only the covenant to pay monthly Rent (until the occurrence of the commencement of the Term). Except with respect to the negligence or willful misconduct of Lessor, Lessor's employees, agents, contractors, consultants, workmen, mechanics, suppliers and invitees, Lessee agrees that Lessor shall not be liable for any injury, loss or damage which may occur to any of Lessee's Work made in or about the Premises in connection with such entry or to any property placed therein prior to the commencement of the Term, the same being at Lessee's sole risk and liability. Lessee shall be liable to Lessor for any damage to any portion of the Premises, including the Improvements, caused by Lessee or any of Lessee's employees, agents, contractors, consultants, workmen, mechanics, suppliers and invitees. In the event that the performance of Lessee's work or the Contractor's work, in connection with such entry, causes extra costs to be incurred by Lessor or requires the use of any Building services, Lessee shall promptly reimburse Lessor for such extra costs and/or shall pay Lessor for such Building services at Lessor's standard rates then in effect.

5.2 Time of Essence. Time is of the essence in this Work letter.

5.3 Lessee's Lease Default. Notwithstanding any provision to the contrary contained in the Lease, if an event of default by Lessee under the Lease or any default by Lessee under this Work Letter has occurred at any time on or before the Final Completion Date, then (i) in addition to all other rights and remedies granted to Lessor pursuant to the Lease, at law and/or in equity, Lessor shall have the right to cause Contractor to cease the construction of the Premises, and (ii) all other obligations of Lessor under the terms of this Work Letter shall be forgiven until such time as such default is cured pursuant to the terms of the Lease. In addition, if the Lease is terminated prior to the commencement of the Term, for any reason due to a default by Lessee under the Lease or under this Work Letter, in addition to any other remedies available to Lessor under the Lease, at law and/or in equity, Lessee shall pay to Lessor, as additional rent under the Lease, within five (5) days of receipt of a statement therefor, any and all costs incurred by Lessor and not reimbursed or otherwise paid by Lessee through the date of such termination in connection with the Improvements to the extent installed and/or constructed as of such date of termination, including, but not limited to, any costs related to the removal of all or any portion of the Improvements and restoration costs related thereto.

5.4 Remediation of Existing Asbestos. Lessor and Lessee acknowledge that the Premises as it exists at the time of Lease execution, is likely to contain asbestos. Lessee has obtained an estimate from Bulley & Andrews, LLC in the amount of [redacted] (the "Estimate") for asbestos remediation in the Premises. Lessee shall include such remediation in the Work. Lessor shall offset the Rent due up to the actual cost of the Remediation, not to exceed the Estimate. Any amount in excess of the Estimate shall be paid by Lessee directly to Bulley & Andrews, LLC upon receipt of the final invoice amount for the Remediation.

5.5 Capital Protection. Notwithstanding any provision to the contrary contained in the Lease, if Lessor terminates this Lease or fails to renew the Term such that the Term is less than fifteen (15) years, in either case for any reason other than Lessee's default, then Lessor shall pay to Lessee upon such termination, the unamortized amount of Lessee's initial capital investment in the Premises (the "Initial Investment"). The Initial Investment shall be the actual amount of capital funds expended by Lessee for the Work and other Improvements, plus the Architect and design fees, and furniture, fixtures and equipment costs for initial set up of the unit, the aggregate of which shall not exceed $1,500,000.00, which Initial Investment shall be amortized over fifteen (15) years on a straight-line basis. Lessor shall not be responsible for the unamortized amount of Lessee's initial capital investment in the event Lessee terminates the Lease at the end of the Term or Extension Term pursuant to Section 3 of the Lease.

Schedule 1.4

1. General conditions
2. HVAC
3. Medical gas outlet replacement
4. Insurance
5. Construction contingency
6. Contractor's overhead

CH2\9288017.9

ATTACHMENT A
ARRANGEMENTS/CONTRACT APPROVAL FORM

TO: Office of Legal Affairs

FROM: ___Anthony Perry_____

DATE: ___Aug 17, 2011_____

This form must be completed *prior to execution* of any Arrangement or Contract. This form must be submitted upon execution of an Unmodified Template; and upon issuance of a Template Purchase Order where the Template Purchase Order serves as the contract, and the purchase is for $20,000 or more.

☐ Please check this box and complete Sections 1-6 below if the attached contract is an Unmodified Template or Template Purchase Order where the Template Purchase Order serves as the contract, and the purchase is for $20,000 or more. If you check this box, you do not need to obtain approval signatures from the Office of Legal Affairs or Corporate Compliance.

1. Brief Description of the Arrangement/Contract:
_Lease agreement between RUMC and Horizon Hospice for the lease of the south half of the 5th floor in the Johnston R. Bowman Health Center at RUMC. ____

2. Parties to the Arrangement/Contract:
_RUMC (Lessor) and Horizon Hospice and Palliative Care (Lessee)_____

3. Proposed Date of Execution of Arrangement/Contract:
July 1, 2011 ___

4. Does the other Party to the Arrangement/Contract involve a physician or a physician's Immediate Family Member (this includes ownership by a physician or physician's Immediate Family Member)? If so, please explain:
___No_____

5. Lead Responsible Person: __Rush: Anthony Perry Horizon: Mary Runge_____

6. Individual(s) Expected to Sign the Arrangement/Contract on behalf of RUMC:
_____ Bob Clapp _____

7. Attach the final negotiated Arrangement/Contract (this includes all exhibits and attachments to the Arrangement/Contract)

Department	Signature	Title	Date
Office of Legal Affairs	Digitally signed by Chris E. Limperis Date: 2011.08.17 11:47:11 -05'00'	Associate General Counsel	

Appendix C

Rush University Medical Center

Most Recent Audited Financial Report

Rush University Medical Center and Subsidiaries

Consolidated Financial Statements as of and for the Years Ended June 30, 2011 and 2010, and Independent Auditors' Report

RUSH

RUSH UNIVERSITY MEDICAL CENTER AND SUBSIDIARIES

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Deloitte.

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INDEPENDENT AUDITORS' REPORT

To the Board of Trustees of
Rush University Medical Center:

We have audited the accompanying consolidated balance sheets of Rush University Medical Center and Subsidiaries (Rush) as of June 30, 2011 and 2010, and the related consolidated statements of operations and changes in net assets and cash flows for the years then ended. These consolidated financial statements are the responsibility of Rush's management. Our responsibility is to express an opinion on these consolidated 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 consolidated 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 Rush'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 consolidated financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall consolidated financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As described in Note 1, the financial position and results of operations of Rush-Copley Medical Center have been excluded from Rush's accompanying consolidated financial statements. Accounting principles generally accepted in the United States of America require consolidation of this entity.

In our opinion, except for the matter discussed in the preceding paragraph, such consolidated financial statements present fairly, in all material respects, the consolidated financial position of Rush University Medical Center and Subsidiaries as of June 30, 2011 and 2010, and the consolidated results of their operations and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Deloitte & Touche LLP

October 25, 2011

Member of
Deloitte Touche Tohmatsu Limited

RUSH UNIVERSITY MEDICAL CENTER AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(Dollars in thousands)

	As of June 30, 2011	As of June 30, 2010
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 127,797	$ 156,779
Short-term investments	115,613	115,459
Accounts receivable for patient services - net of allowance for doubtful accounts of $42,035 and $41,826 as of June 30, 2011 and 2010, respectively	136,511	127,145
Other accounts receivable - net of reserves of $930 and $705 as of June 30, 2011 and 2010, respectively	55,850	72,028
Self-insurance trust - current portion	24,467	27,953
Other current assets	27,035	31,930
Total current assets	487,273	531,294
ASSETS LIMITED AS TO USE AND INVESTMENTS:		
Investments - less current portion	263,659	244,312
Limited as to use by donor or time restriction	478,561	372,507
Collateral proceeds received under securities lending program	-	56,125
Investments on loan under securities lending program	-	54,348
Self insurance trust - less current portion	101,123	116,844
Project fund	-	60,811
Debt service reserve fund	40,119	41,169
Total assets limited as to use and investments	883,462	946,116
PROPERTY AND EQUIPMENT - net of accumulated depreciation of $789,273 and $727,204 as of June 30, 2011 and 2010, respectively	1,187,178	1,002,879
OTHER ASSETS	25,635	18,503
TOTAL ASSETS	$ 2,583,548	$ 2,498,792
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES:		
Accounts payable	$ 122,270	$ 123,464
Accrued expenses	121,448	122,685
Student loan funds	21,210	22,461
Estimated third-party settlements payable	106,076	121,799
Current portion of accrued liability under self-insurance program	29,773	33,599
Current portion of long-term debt	4,550	7,593
Total current liabilities	405,327	431,601
LONG-TERM LIABILITIES:		
Accrued liability under self-insurance program - less current portion	143,674	170,995
Postretirement and pension benefits	138,904	231,228
Long-term debt - less current portion, net	517,779	522,160
Obligation to return collateral under securities lending program	-	56,125
Obligations under capital lease and other financing arrangements	34,627	37,952
Other long-term liabilities	61,612	57,592
Total long-term liabilities	896,596	1,076,052
Total liabilities	1,301,923	1,507,653
NET ASSETS:		
Unrestricted	710,641	478,888
Temporarily restricted	343,248	297,969
Permanently restricted	227,736	214,282
Total net assets	1,281,625	991,139
TOTAL LIABILITIES AND NET ASSETS	$ 2,583,548	$ 2,498,792

See notes to consolidated financial statements.

RUSH UNIVERSITY MEDICAL CENTER AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
(Dollars in thousands)

	For the Year Ended June 30, 2011	2010
REVENUE:		
Net patient service revenue	$ 1,221,455	$ 1,183,464
University services:		
Tuition and educational grants	52,171	47,270
Research and other operations	106,754	105,440
Other revenue	60,841	59,042
Total revenue	1,441,221	1,395,216
EXPENSES:		
Salaries, wages, and employee benefits (Note 20)	747,988	692,586
Supplies, utilities, and other	413,128	414,094
Insurance	10,932	30,529
Purchased services	58,869	60,073
Depreciation and amortization	73,023	68,125
Provision for uncollectible accounts	38,768	34,059
Interest expense	15,015	17,298
Total expenses	1,357,723	1,316,764
OPERATING INCOME	83,498	78,452
NONOPERATING INCOME (EXPENSE):		
Investment income and other	18,999	26,809
Unrestricted contributions	7,093	8,124
Fundraising expenses	(6,395)	(5,811)
Change in fair value of interest rate swaps	1,442	(2,956)
Total nonoperating income	21,139	26,166
EXCESS OF REVENUE OVER EXPENSES	$ 104,637	$ 104,618

(Continued)

RUSH UNIVERSITY MEDICAL CENTER AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
(Dollars in thousands)

	For the Year Ended June 30, 2011	2010
UNRESTRICTED NET ASSETS		
Excess of revenue over expenses	$ 104,637	$ 104,618
Recovery of impaired endowment corpus	2,446	3,622
Net assets released from restrictions used for purchase of property and equipment and other	34,870	18,773
Postretirement-related changes other than net periodic postretirement cost	89,800	(103,106)
INCREASE IN UNRESTRICTED NET ASSETS	231,753	23,907
RESTRICTED NET ASSETS		
TEMPORARILY RESTRICTED NET ASSETS:		
Pledges, contributions, and grants	50,882	35,976
Net assets released from restrictions	(64,268)	(49,270)
Net realized and unrealized gains on investments	58,665	32,703
INCREASE IN TEMPORARILY RESTRICTED NET ASSETS	45,279	19,409
PERMANENTLY RESTRICTED NET ASSETS:		
Pledges and contributions	9,238	7,953
Change in unrealized gains impacting endowment corpus	2,446	3,622
Replenishment of impaired endowment corpus	(2,446)	(3,622)
Investment gains on trustee-held investments	4,216	1,245
INCREASE IN PERMANENTLY RESTRICTED NET ASSETS	13,454	9,198
INCREASE IN NET ASSETS	290,486	52,514
NET ASSETS — Beginning of year	991,139	938,625
NET ASSETS — End of year	$ 1,281,625	$ 991,139

See notes to consolidated financial statements. *(Concluded)*

RUSH UNIVERSITY MEDICAL CENTER AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(Dollars in thousands)

	For the Year Ended June 30, 2011	2010
OPERATING ACTIVITIES:		
Increase in net assets	$ 290,486	$ 52,514
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	73,192	68,290
Postretirement-related changes other than net periodic postretirement cost	(89,800)	103,106
Provision for uncollectible accounts	38,768	34,059
Change in fair value of interest rate swaps	(1,442)	2,956
Net unrealized and realized gains on investments	(70,031)	(53,684)
Restricted contributions and investment income received	(36,534)	(27,188)
Investment gains on trustee-held investments	(4,216)	(1,245)
Changes in operating assets and liabilities:		
Accounts receivable for patient services	(48,134)	(21,120)
Accounts payable and accrued expenses	(4,037)	(2,381)
Estimated third-party settlements payable	(15,723)	14,257
Postretirement and pension benefits	(2,601)	(10,976)
Accrued liability under self-insurance program	(31,147)	7,813
Other changes in operating assets and liabilities	10,446	(13,011)
Net cash provided by operating activities	109,227	153,390
INVESTING ACTIVITIES:		
Additions to property and equipment	(256,696)	(270,501)
Purchase of investments	(725,954)	(895,621)
Sale of investments	815,578	800,394
Proceeds from sale of building (Note 21)	-	26,079
Net cash used in investing activities	(167,072)	(339,649)
FINANCING ACTIVITIES:		
Proceeds from restricted contributions and investment income	39,613	23,540
Proceeds from issuance of long-term debt	-	171,668
Payment of bond issuance costs	-	(2,663)
Payment of long-term debt	(7,593)	(6,042)
Payment of obligations under capital lease and other financing arrangements	(3,157)	(3,014)
Net cash provided by financing activities	28,863	183,489
NET DECREASE IN CASH AND CASH EQUIVALENTS	(28,982)	(2,770)
CASH AND CASH EQUIVALENTS — Beginning of year	156,779	159,549
CASH AND CASH EQUIVALENTS — End of year	$ 127,797	$ 156,779
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:		
Cash paid for interest — including capitalized interest of $21,487 and $17,955 for the years ended June 30, 2011 and 2010, respectively	$ 36,489	$ 33,381
Noncash additions to property and equipment	$ 187	$ 9,138

See notes to consolidated financial statements.

1. ORGANIZATION AND BASIS OF CONSOLIDATION

The accompanying consolidated financial statements include the accounts of Rush University Medical Center and Subsidiaries (Rush). Rush owns and operates an academic medical center located in Chicago, Illinois. Rush is an Illinois not-for-profit corporation exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. Rush's operations consist of several diverse activities with a shared mission of patient care, education, research, and community service, and include the following:

Rush University Hospital (RUH) — Consists of an acute care hospital and the Johnson R. Bowman Health Center for the Elderly, a rehabilitation and psychiatric facility, licensed in total for 739 beds. RUH also includes a faculty practice plan, Rush University Medical Group (RUMG), which employed 399 physicians as of June 30, 2011.

Rush University — A health sciences university that educates students in health-related fields. This includes Rush Medical College, the College of Nursing, the College of Health Sciences, and the Graduate College. Rush University also includes a research operation with $137,974 and $126,415 in annual research expenditures during fiscal years 2011 and 2010, respectively.

Rush Oak Park Hospital (ROPH) — A 296-licensed bed acute care, rehabilitation, and skilled nursing hospital located in Oak Park, Illinois, eight miles west of RUH, which includes an employed medical group with 40 physicians as of June 30, 2011. Rush, through a joint venture arrangement with a third party, is responsible for the operations and management of ROPH. As a result, Rush controls and has an economic interest in ROPH. Substantially all assets, liabilities, and net assets, as well as all revenue and expenses, of ROPH are consolidated with the financial results of Rush. All significant intercompany transactions have been eliminated in consolidation.

RUH and ROPH together own 50% of Rush Health, a network of providers whose members include the hospitals and approximately 750 physicians and 50 allied health providers who are on the medical staff of the member hospitals, with the other 50% owned by the physicians. The financial results of Rush Health are not consolidated with the financial results of Rush and are accounted for using the equity method of accounting (see Note 18).

Rush has an affiliation with Rush-Copley Medical Center (RCMC), an acute care facility located in Aurora, Illinois, that covers governance and other organizational relationships. Pursuant to the Amended and Restated Master Trust Indenture dated August 1, 2006, Rush and RCMC established an Obligated Group of which both are members. Rush and RCMC are jointly and severally liable for certain debt issued through the Illinois Finance Authority (IFA) (see Note 9). Under accounting principles generally accepted in the United States of America (GAAP), as a result of these affiliations and financial interdependency, the financial accounts of RCMC should be consolidated with Rush, but have been excluded from the accompanying consolidated financial statements.

If the financial statements of RCMC had been consolidated with Rush, financial information as of and for the years ended June 30, 2011 and 2010, respectively, would have been as follows:

	2011	2010
Total assets	$ 2,943,532	$ 2,819,720
Total liabilities	1,486,456	1,680,758
Total net assets	$ 1,457,076	$ 1,138,962
Total revenue	$ 1,741,099	$ 1,685,185
Total expenses	1,643,016	1,595,791
Operating income	98,083	89,394
Nonoperating income	33,383	28,122
Excess of revenue over expenses	$ 131,466	$ 117,516
Increase in unrestricted net assets	$ 258,606	$ 36,908
Net cash provided by (used in):		
Operating activities	$ 151,290	$ 168,559
Investing activities	(193,569)	(364,975)
Financing activities	28,264	189,589
Net decrease in cash and cash equivalents	$ (14,015)	$ (6,827)

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

Except for the matter discussed in Note 1 related to the consolidation of RCMC, the accompanying consolidated financial statements have been presented in conformity with GAAP as recommended in the audit and accounting guide for health care organizations published by the American Institute of Certified Public Accountants.

Basis of Consolidation

Included in Rush's consolidated financial statements are all of its wholly owned or controlled subsidiaries. All significant intercompany transactions have been eliminated in consolidation.

Use of Estimates

The preparation of consolidated financial statements in conformity with generally accepted accounting principles 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 and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and investments having an original maturity of 90 days or less when purchased are considered to be cash and cash equivalents. These securities are so near maturity that they present insignificant risk of changes in value.

Net Patient Service Revenue, Patient Accounts Receivable and Allowance for Doubtful Accounts

Net patient service revenue is reported at the estimated net realizable amounts from third-party payors, patients, and others for services rendered. Rush has agreements with third-party payors that provide for payments at amounts different from established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, per diem payments, and discounted charges, including estimated retroactive settlements under payment agreements with third-party payors. Provisions for adjustments to net patient service revenue are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Patient accounts receivable are stated at net realizable value. Rush maintains an estimated allowance for uncollectible accounts based upon management's assessment of historical and expected net collections considering business and economic conditions, trends in healthcare coverage, and other collection indicators. Accounts receivable are charged to the provision for uncollectible accounts as they are deemed uncollectible.

Charity Care

It is an inherent part of Rush'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 net patient service revenue. Patients who would otherwise qualify for charity care but who do not provide adequate information would be characterized as bad debt and included in the provision for uncollectible accounts.

Inventory

Medical supplies, pharmaceuticals, and other inventories are stated at the lower of cost or market and are included in other current assets on the accompanying consolidated balance sheets.

Fair Value of Financial Instruments

Financial instruments consist of primarily cash and cash equivalents, investments, derivative instruments, accounts receivable, accounts payable, accrued expenses, estimated third-party settlements, and debt. The fair value of cash and cash equivalents, accounts receivable, accounts payable, accrued expenses, and estimated third-party settlements approximated their financial statement carrying amount as of June 30, 2011 and 2010, because of their short-term maturity. The fair value of the other instruments is discussed in Notes 6 and 9.

Assets Limited as to Use and Investments

Assets limited as to use consist primarily of investments limited as to use by donor or time restriction, including pledges, assets held by trustees under debt or other agreements and for self-insurance, and board designated assets set aside for a specified future use.

Investments in equity and debt securities with readily determinable fair values are designated as trading securities and measured at fair value using quoted market prices or model-driven valuations. Short-term investments having an original maturity greater than 90 days that are available for current operations are reported as current assets. Rush also holds an interest in a collective business trust that invests primarily in international equity and equity-related securities, which is also designated as a trading security. The trust is valued and priced daily, and liquidity is available on a daily basis.

Alternative investments, consisting of limited partnerships that invest in primarily marketable securities (hedge funds), real estate, and limited partnerships that invest in primarily nonmarketable securities (private equity), are designated as other-than-trading. Investments in hedge funds are measured at fair market value based on Rush's interest in the net asset value (NAV) of the respective fund. The estimated valuations of hedge fund investments are subject to uncertainty and could differ had a ready market existed for these investments. Such differences could be material. Investments in private equity funds are reported at cost, adjusted for impairment losses, based on information

provided by the respective partnership when Rush's ownership percentage is minor (less than 5%). Investments in private equity funds where Rush's ownership percentage is more than minor, but consolidation is not required (5% to 50%), are accounted for on the equity basis. These investments are periodically assessed for impairment. The financial statements of hedge funds and private equity funds are audited annually, generally on December 31. Investments in hedge funds and private equity funds are generally not marketable and may be divested only at specified times. Real estate investments are carried at amortized cost. Rush's risk in alternative investments is limited to its capital investment and any future capital commitments (see Note 5).

Investment income or loss (including interest, dividends, realized and unrealized gains and losses, and changes in cost based valuations) is reported within excess of revenue over expenses unless the income or loss is restricted by donor or interpretation of law. Investment gains and losses on Rush's endowment are recognized within temporarily restricted net assets until appropriated for use (see Note 7). Investment gains and losses on permanently restricted assets are allocated to purposes specified by the donor either as temporarily restricted or unrestricted, as applicable. Income earned on tax-exempt borrowings for specific construction projects is offset against interest expense capitalized for such projects.

Unconditional Promises to Give

Unconditional promises to give (pledges receivable) are recorded at the net present value of their estimated future cash flows. Estimated future cash flows due after one year are discounted using interest rates commensurate with the time value of money concept. Rush maintains an estimated allowance for uncollectible pledges based upon management's assessment of historical and expected net collections considering business and economic conditions and other collection indicators. Net unconditional promises to give are reported in assets limited by donor or time restriction on the accompanying consolidated balance sheets and amounted to $60,912 and $55,396 as of June 30, 2011 and 2010, respectively (see Note 16).

Derivative Instruments

Derivative instruments, specifically interest rate swaps, are recorded in the consolidated balance sheets as either assets or liabilities at their respective fair values. The change in the fair value of derivative instruments is reflected in nonoperating income (expense) in the accompanying consolidated statements of operations and changes in net assets. Net cash settlements and payments, representing the realized changes in the fair value of the interest rate swaps, are included in interest expense in the accompanying consolidated statements of operations and changes in net assets and as operating cash flows in the accompanying consolidated statements of cash flows (see Note 10).

Property and Equipment

Property and equipment are recorded at cost or, if donated, at fair market value at the date of receipt. Expenditures which substantially increase the useful life of existing property and equipment are capitalized. Routine maintenance and repairs are expensed as incurred. Depreciation expense, including amortization of capital leased assets, is recognized over the estimated useful lives of the assets using the straight-line method.

Costs of computer software developed or obtained for internal use, including external direct costs of materials and services, payroll, and payroll-related costs for employees directly associated with internal use software development projects, and interest costs incurred during the development period are expensed or capitalized depending on whether the costs are incurred in the preliminary project stage, development stage, or operational stage. Capitalized costs of internal use computer software are included in property and equipment in the accompanying consolidated balance sheets.

Capitalized Interest

Interest expense from bond proceeds, net of interest income, incurred during the construction of major projects is capitalized during the construction period. Such capitalized interest is amortized over the depreciable life of the related assets on a straight-line basis.

Asset Impairment

Rush continually evaluates the recoverability of the carrying value of long-lived asset by reviewing long-lived assets for impairment. When circumstances indicate the remaining estimated useful life of long-lived assets may not be recoverable, Rush adjusts the carrying value of a long-lived asset to fair value if an estimate of the undiscounted cash flows over the remaining life are less than the carrying value of the asset.

Asset Retirement Obligations

Rush recognizes the fair value of a liability for legal obligations associated with asset retirements in the period in which it is incurred, if a reasonable estimate of the fair value of the obligation can be made. When the liability is initially recorded, Rush capitalizes the cost of the asset retirement obligation by increasing the carrying amount of the related long-lived asset. The liability is accreted to its present value each period, and the capitalized cost associated with the retirement obligation is depreciated over the useful life of the related asset. Upon settlement of the obligation, any difference between the cost to settle an asset retirement obligation and the liability recorded is recognized as a gain or loss in the consolidated statements of operations and changes in net assets.

Ownership Interests in Other Health-Related Entities

An ownership interest in another health-related entity of more than 50% in which Rush has a controlling interest is consolidated. As of June 30, 2011 and 2010, non-controlling interests in consolidated subsidiaries amounted to $4,050 and $3,063, respectively. The amounts related to non-controlling interest are not material and accordingly, are not separately presented in the accompanying consolidated financial statements. An ownership interest in another health-related entity of at least 20% but not more than 50% in which Rush has the ability to exercise significant influence over the operating and financial decisions of the investee is accounted for on the equity basis (see Note 18), and the income (loss) is reflected in other revenue. An ownership interest in a health-related entity of less than 20%, in which Rush does not have the ability to exercise significant influence over the operating and financial decisions of the investee, is carried at cost or estimated net realizable value, which is not material to the consolidated financial statements.

Deferred Financing Costs

Debt issuance costs, net of amortization computed on the straight-line basis over the life of the related debt, are reported within other assets on the accompanying consolidated balance sheets. The straight-line basis approximates the effective interest method, which is required under GAAP. Unamortized debt issuance costs amounted to $9,179 and $9,593 as of June 30, 2011 and 2010, respectively.

Securities Lending

Rush records, as an asset, the fair value of its beneficial interest in cash collateral pools for securities loaned to third parties, as well as records a corresponding liability for the collateral received that will be paid back to the third party. Securities on loan are included within assets limited as to use and investments on the accompanying consolidated balance sheets as of June 30, 2010. During fiscal year 2011, Rush terminated all of its securities lending arrangements and no amounts were on loan as of June 30, 2011.

Other Long-term Liabilities

Other long-term liabilities include asset retirement obligations, employee benefit plan liabilities for certain defined contribution and supplemental retirement plans other than defined benefit pension plans (see Note 12), and other long-term obligations.

Net Assets

Resources of Rush are designated as permanent, temporary, or unrestricted. Permanently restricted net assets include the original value of contributions that are required by donors to be permanently retained, including any accumulations to the permanent endowment made in accordance with the direction of the applicable gift instrument. Temporarily restricted net assets include contributions and accumulated investment returns whose use is limited by donors for a specified purpose or time period or by interpretations of law. Unrestricted net assets include the remaining resources of Rush which are not restricted and arise from the general operations of the organization.

Contributions

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. Conditional gifts are reported at fair value when the conditions have been substantially met. Contributions are either reported as temporarily or permanently restricted if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the consolidated statements of operations as other revenue (if time restricted or restricted for operating purposes) or reported in the consolidated statements of changes in net assets as net assets released from restrictions used for purchase of property and equipment (if restricted for capital acquisitions). Donor restricted contributions for operating purposes whose restrictions are met within the same year as received are reported as other revenue in the accompanying consolidated statements of operations and changes in net assets.

Rush is the beneficiary of several split-interest agreements, primarily perpetual trusts held by others. Rush recognizes its interest in these trusts based on either Rush's percentage of the fair value of the trust assets or the present value of expected future cash flows to be received from the trusts, as appropriate, based on each trust arrangement.

Excess of Revenue over Expenses

The consolidated statements of operations and changes in net assets include excess of revenue over expenses as a performance indicator. Excess of revenue over expenses includes all changes in unrestricted net assets except for permanent transfers of assets to and from affiliates for other than goods and services, contributions of (and assets released from donor restrictions related to) long-lived assets, and other items that are required by generally accepted accounting principles to be reported separately (such as extraordinary items, the effect of discontinued operations, postretirement-related changes other than net periodic postretirement costs, and the cumulative effect of changes in accounting principle).

Nonoperating Income (Expense)

Nonoperating income (expense) includes items not directly associated with patient care or other activities not relating to the core operations of Rush. Nonoperating income (expense) consists primarily of unrestricted investment returns on the endowment investment pool when appropriated for use, the difference between total investment return and amount allocated to operations for investments designated for self-insurance programs, investment income or loss (including interest, dividends, and realized and unrealized gains and losses) on all other investments unless restricted by donor or interpretation of law, changes in the fair value of interest rate swaps, losses on extinguishment of debt, net gains (losses) on sales, unrestricted contributions, losses on impaired assets, and fundraising expenses.

New Accounting Pronouncements

In July 2011, the Financial Accounting Standards Board (FASB) issued new guidance related to the accounting by health care entities for all or a certain portion of the amount billed or billable to patients and amounts related to deductibles and copays for which payment is highly uncertain. Specifically, this guidance requires that health care entities present bad debt expense associated with net patient service revenue, as an offset to net patient service revenue within the statements of operations and changes in net assets. Additionally, the guidance requires enhanced disclosure of the policies for recognizing revenue and assessing bad debts, as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. This guidance is effective for Rush in fiscal year 2013 and is not expected to have a material impact to the consolidated financial statements.

In August 2010, the FASB issued new guidance to reduce the diversity in practice regarding the measurement basis used in the disclosure of charity care. Specifically, this guidance requires that cost be used as the measurement basis for charity care disclosure purposes and that cost be identified as the direct and indirect costs of providing the charity care. Furthermore, this amendment requires the disclosure of the method used to identify or determine the costs. This guidance is effective for Rush in fiscal year 2012 and is not expected to have a material impact to the consolidated financial statements.

Also in August 2010, the FASB issued new guidance related to the accounting by health care entities for medical malpractice claims and similar liabilities and their related anticipated insurance recoveries. Specifically, this amendment clarifies that a health care entity should not net insurance recoveries against a related claim liability. Additionally, the amount of the claim liability should be determined without consideration of insurance recoveries. This guidance is effective for Rush in fiscal year 2012 and is not expected to have a material impact on Rush's consolidated financial statements.

Consideration of Events Subsequent to the Consolidated Balance Sheet Date

Rush has evaluated events occurring subsequent to the consolidated balance sheet date through October 25, 2011, the date the consolidated financial statements were available to be issued.

3. NET PATIENT SERVICE REVENUE

The mix of net patient service revenue from patients and third-party payors for the years ended June 30, 2011 and 2010 was as follows:

	2011	2010
Medicare	27 %	26 %
Medicaid	11	11
Blue Cross	30	32
Managed care	24	24
Commercial and self-pay	8	7
Total	100 %	100 %

Changes in estimates relating to prior periods increased net patient service revenue by $13,000 and $1,311 in fiscal years 2011 and 2010, respectively. Laws and regulations governing government and other payment programs are complex and subject to interpretation. As a result, there is a reasonable possibility that recorded estimated third-party settlements could change by a material amount.

Rush has filed formal appeals relating to the settlement of certain prior-year Medicare cost reports. The outcome of such appeals cannot be determined at this time. Any resulting gains will be recognized in the consolidated statements of operations and changes in net assets when realized.

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to review and interpretation as well as regulatory actions unknown and unasserted at this time. Federal government activity continues with respect to investigations and allegations concerning possible violations of regulations by healthcare providers, which could result in the imposition of significant fines and penalties as well as significant repayment of previously billed and collected revenues from patient services. Management believes that Rush is in substantial compliance with current laws and regulations.

4. CHARITY CARE

Rush has an established charity care policy and maintains records to identify and monitor the level of charity care it provides. Rush provides free care to all patients whose family income is 300% of the federal poverty level or less and a 65% discount to all uninsured patients regardless of ability to pay and provides further discounts for patients with a family income up to 400% of the federal poverty level. These charity care records include the estimated cost of unreimbursed services provided and supplies furnished under its charity care policy and the excess of cost over reimbursement for Medicaid patients. Rush also monitors the unreimbursed cost of patient bad debts.

In December 2008, the Centers for Medicare and Medicaid Services approved the Illinois Hospital Assessment Program (the Program) to improve Medicaid reimbursement for Illinois hospitals. This Program increased net patient service revenue in the form of additional Medicaid payments and increased supplies, utilities, and other expense through a tax assessment from the state of Illinois. The net benefit to Rush from the Program was $16,565 during each of the years ended June 30, 2011 and 2010. For each of the years ended June 30, 2011 and 2010, the Medicaid payment of $42,871 was included in net patient service revenue, representing 4% of the net patient service revenue, and the tax assessment of $26,306 was included in supplies, utilities, and other expenses. The Program is approved through June 30, 2014; however, the future of the Program is uncertain.

The following table presents the level of charity care provided for the years ended June 30, 2011 and 2010:

	2011	2010
Excess of allocated cost over reimbursement for services provided to hospital Medicaid patients — net of net benefit under the Program	$ 50,497	$ 44,589
Estimated costs and expenses incurred to provide charity care in the hospitals	19,123	17,645
Total	$ 69,620	$ 62,234

The total number of patients that were either provided charity care directly by Rush or that were covered by the Program represented 22% of Rush's total patients in fiscal years 2011 and 2010.

Beyond the cost to provide charity care and unreimbursed services to hospital Medicaid patients, Rush also provides substantial additional benefits to the community, including educating future health care providers, supporting research into new treatments for disease, and providing subsidized medical services in response to community and health care needs as well as other volunteer services. These community services are provided free of charge or at a fee below the cost of providing them.

5. ASSETS LIMITED AS TO USE AND INVESTMENTS

Assets limited as to use and investments consist primarily of marketable equity and debt securities, which are held in investment pools to satisfy the investment objectives for which the assets are held or to satisfy donor restrictions. Rush also holds certain investments in alternative securities consisting of hedge funds, real estate investments, and private equity funds (see Note 2). Assets limited as to use by donor or time restriction also includes unconditional promises to give (see Note 16).

Following is a summary of the composition of assets limited as to use and investments as of June 30, 2011 and 2010.

	2011	2010
Marketable securities and short-term investment funds	$ 67,388	$ 209,336
Government securities	173,261	97,215
Corporate bonds	83,446	151,594
Fixed income mutual funds	79,630	74,350
Other fixed income, including asset backed securities	183,259	127,178
Equity securities and equity mutual funds	231,883	227,455
Equity commingled trust	13,820	10,578
World asset allocation mutual funds	42,902	-
Hedge fund of funds	26,329	24,433
Private equity	29,702	28,890
Real estate	3,474	3,658
	935,094	954,687
Beneficial interest in trusts	27,536	23,320
Interest in cash collateral pools	-	56,125
Total assets limited as to use and investments — excluding pledges receivable	962,630	1,034,132
Net pledges receivable	60,912	55,396
Total assets limited as to use and investments	1,023,542	1,089,528
Less amount reported as current assets	(140,080)	(143,412)
Assets limited as to use and investments — noncurrent	$ 883,462	$ 946,116

The table above comprises all of Rush's investments, including those measured at fair value as well as certain alternative investments in private equity partnerships or real estate measured under the cost or equity method of accounting. The fair value of private equity investments, as estimated by management of the limited partnerships based on audited financial statements and other relevant factors, was $34,932 and $29,447 as of June 30, 2011 and 2010, respectively. Rush's private equity investments have diverse strategies, consisting of the following as of June 30, 2011 and 2010:

Private Equity Fund Allocations	2011	2010
Buyout and growth capital	33%	41%
Distressed debt and special situations	35	26
Diversified private equity fund of funds	18	18
Venture capital	12	12
Direct equity	2	2
Co-investment private equity	-	1
	100%	100%

Investments in private equity funds recorded on the equity basis amounted to $803 and $692 as of June 30, 2011 and 2010, respectively. As many factors are considered in arriving at the estimated fair value, Rush routinely monitors and assesses methodologies and assumptions used in valuing these partnerships. As of June 30, 2011 and 2010, commitments for additional contributions to private equity partnerships totaled $16,167 and $20,319, respectively.

It is Rush's intent to maintain a long-term investment portfolio to support its self-insurance program. Accordingly, the total return on investments restricted for the self-insurance program is reported in the consolidated statements of operations and changes in net assets in two income statement line items. The investment return allocated to operations, reported in other revenue, is determined by a formula designed to provide a consistent stream of investment earnings to support the self-insurance provision reported in insurance expense in the accompanying consolidated statements of operations and changes in net assets. This allocated return, 5% for the years ended June 30, 2011 and 2010, approximates the real return that Rush expects to earn on its investments over the long-term and totaled $6,681 and $7,386 for the years ended June 30, 2011 and 2010, respectively. The difference between the total investment return and the amount allocated to operations is reported in nonoperating income (expense) and totaled $8,381 and $9,043 for the years ended June 30, 2011 and 2010, respectively. There is no guarantee that the investment return expected by management will be realized. For the years ended June 30, 2011 and 2010, the total annual investment return was approximately 11.8% and 11.6%, respectively.

Prior to February 1, 2011, Rush participated in a securities lending arrangement whereby Rush provided certain of its marketable securities to be loaned to independent third parties through a commercial bank. These loaned securities were collateralized against loss and/or default by a beneficial interest in various collateral pools maintained by the commercial bank. As of June 30, 2010, Rush loaned approximately $54,348 in securities and accepted cash collateral for these loans in the amount of $56,125, included in investments and long-term liabilities in the accompanying consolidated balance sheet. Of the $54,348 on loan as of June 30, 2010, $54,348 represented donor-restricted endowment funds. Cash collateral received under the program was invested in a commingled fund managed by the commercial bank. Eligible instruments for investment in the collateral pool included, but were not limited to, government securities, asset-backed and mortgage-backed securities, and corporate debt, all of which were subject to quality and liquidity guidelines established by the fund. Rush fully terminated the securities lending arrangement as of February 1, 2011, and no amounts were on loan as of June 30, 2011.

The composition and presentation of investment income and the realized and unrealized gains and losses on all investments for the years ended June 30, 2011 and 2010, are as follows:

	2011	2010
Interest and dividends	$ 18,075	$ 17,059
Net realized gains on sales of securities	24,913	6,740
Unrealized gains — unrestricted	7,579	20,406
Unrealized gains — restricted	41,659	28,112
	$ 92,226	$ 72,317
Reported as:		
Other operating revenue	$ 7,900	$ 7,938
Nonoperating income	18,999	26,809
Restricted net assets — net realized and unrealized gains on investments	65,327	37,570
	$ 92,226	$ 72,317

Rush reported gains and losses on its alternative investments (designated as other-than-trading) as of June 30, 2011 and 2010, as follows:

	2011	2010
Reported as:		
Nonoperating income	$ 83	$ 149
Restricted net assets — net realized and unrealized gains on investments	6,858	4,001
	$ 6,941	$ 4,150

6. FAIR VALUE MEASUREMENTS

As of June 30, 2011 and 2010, Rush held certain assets and liabilities that are required to be measured at fair value on a recurring basis, including marketable securities and short-term investments, certain restricted, trusteed and other investments, derivative instruments, interest in cash collateral pools and beneficial interests in trusts. Certain alternative investments measured using either the cost or equity method of accounting are excluded from the fair value disclosure provided herein.

Valuation Principles

Under FASB guidance on fair value measurements, fair value is defined as an exit price, representing 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. The valuation techniques used to measure fair value are based upon observable and unobservable inputs. Observable inputs generally reflect market data from independent sources and are supported by market activity, while unobservable inputs are generally unsupported by market activity. The three-level valuation hierarchy, which prioritizes the inputs used in measuring fair value of an asset or liability at the measurement date, includes:

Level 1 inputs — Quoted prices (unadjusted) for identical assets or liabilities in active markets. Securities typically priced using Level 1 inputs include listed equities and exchange traded mutual funds.

Level 2 inputs — Quoted prices for similar assets or liabilities in active markets, quoted prices for identical or similar assets and liabilities in non-active markets, and model-driven valuations whose inputs are observable for the asset or liability, either directly or indirectly. Securities typically priced using Level 2 inputs include government bonds (including U.S. treasuries and agencies), corporate and municipal bonds, collateralized obligations, interest rate swaps, commercial paper and currency options, and commingled funds where NAV is corroborated with observable data.

Level 3 inputs — Unobservable inputs for which there is little or no market data available and are based on the reporting entity's own judgment or estimation of the assumptions that market participants would use in pricing the asset or liability. The fair values for securities typically priced using Level 3 inputs are determined using model-driven techniques, which include option pricing models, discounted cash flow models, and similar methods. The Level 3 classification primarily includes Rush's interest in hedge funds and beneficial interests in trusts.

Fair Value Measurements at the Balance Sheet Date

The following tables present Rush's fair value hierarchy for its financial assets and liabilities measured at fair value on a recurring basis as of June 30, 2011 and 2010:

Fair Value Measurements as of June 30, 2011	Level 1	Level 2	Level 3	Total Fair Value
Assets:				
Marketable securities and short-term investments	$ 7,901	$ 59,487	$ -	$ 67,388
Fixed income securities:				
U.S. government securities	-	173,261	-	173,261
Corporate bonds	-	83,446	-	83,446
Fixed income mutual funds	1,023	73,664	-	74,687
Collateralized securities and other	106	180,145	-	180,251
U.S. equity securities	169,807	-	-	169,807
International equity securities	22,416	36,959	-	59,375
World asset allocation mutual funds	-	36,969	5,933	42,902
Moderate allocation mutual funds (a)	21,464	-	-	21,464
Alternative investments:				
Hedge fund of funds	-	-	26,329	26,329
Accrued interest and other	-	3,008	-	3,008
Beneficial interest in trusts	-	-	27,536	27,536
Total assets at fair value	$ 222,717	$ 646,939	$ 59,798	$ 929,454
Liabilities:				
Obligations under interest rate swap agreements	-	9,366	-	9,366
Total liabilities at fair value	$ -	$ 9,366	$ -	$ 9,366

(a) This class includes investments in mutual funds that allocate assets among equity and fixed income investments, and includes $4,943 (23%) in fixed income securities and $16,521 (77%) in equity securities as of June 30, 2011.

Fair Value Measurements as of June 30, 2010	Level 1	Level 2	Level 3	Total Fair Value
Assets:				
Marketable securities and short-term investment funds	$ 4,725	$ 204,611	$ -	$ 209,336
Fixed income securities:				
U.S. government securities	-	97,215	-	97,215
Corporate bonds	15,667	135,558	369	151,594
Fixed income mutual funds	1,054	68,717	-	69,771
Collateralized securities and other	108	124,027	462	124,597
U.S. equity securities	196,769	128	-	196,897
International equity securities	17,659	11,921	-	29,580
Moderate allocation mutual funds (a)	16,135	-	-	16,135
Alternative investments:				
Hedge fund of funds	-	-	24,433	24,433
Accrued interest and other	-	2,581	-	2,581
Beneficial interest in trusts	-	-	23,320	23,320
Interest in cash collateral pools	-	56,125	-	56,125
Total assets at fair value	$ 252,117	$ 700,883	$ 48,584	$1,001,584
Liabilities:				
Obligations under interest rate swap agreements	-	10,808	-	10,808
Obligation to return collateral under securities lending program	-	56,125	-	56,125
Total liabilities at fair value	$ -	$ 66,933	$ -	$ 66,933

(a) This class includes investments in mutual funds that allocate assets among equity and fixed income investments, and includes $4,579 (28%) in fixed income securities and $11,556 (72%) in equity securities as of June 30, 2010.

There were no significant transfers to or from Level 1 and Level 2 during the periods presented.

Valuation Techniques and Inputs for Level 2 and Level 3 Instruments

The Level 2 and Level 3 instruments listed in the preceding fair value tables use the following valuation techniques and inputs as of the valuation date:

Marketable Securities and Short-term Investments – Marketable securities classified as Level 2 are invested in a short-term collective fund that serves as an investment vehicle for cash reserves. Fair value was determined using the calculated NAV as of the valuation date based on a constant price. These funds are invested in high-grade and short-term money market instruments with daily liquidity.

U.S. Government Securities – The fair value of investments in U.S. government and agency securities classified as Level 2 was primarily determined using techniques consistent with the market approach, including matrix pricing. Significant observable inputs to the market approach include institutional bids, trade data, broker and dealer quotes, discount rates, issuer spreads, and benchmark yield curves.

Corporate Bonds and Fixed Income Mutual Funds – The fair value of investments in corporate bonds of U.S. and international issuers, including mutual and commingled funds that invest primarily in such bonds, classified as Level 2 was primarily determined using techniques that are consistent with the market approach. Significant observable inputs include benchmark yield curves, reported trades, observable broker or dealer quotes, issuer spreads and security specific characteristics. Significant unobservable inputs may be used, including bid or ask/offer quotes that are uncorroborated, which results in a Level 3 classification.

Collaterolized Securities and Other – This class encompasses collateralized bond obligations, collateralized loan obligations, collateralized mortgage obligations, and any other asset backed securities, including government asset backed securities. The fair value of collateralized obligations classified as Level 2 was determined using techniques consistent with the market and income approach, such as discounted cash flows and matrix pricing. Significant observable inputs include prepayment spreads, discount rates, reported trades, benchmark yield curves, volatility measures and quotes. Significant unobservable inputs may be used including bid or ask/offer quotes that are uncorroborated, which results in a Level 3 classification.

U.S. and International Equity Securities – The fair value of U.S. and foreign equity securities classified as Level 2 was primarily determined using the calculated NAV at the valuation date under a market approach. This includes investments in commingled funds that invest primarily in domestic and foreign equity securities whose underlying values are based on Level 1 inputs. The NAV is often corroborated through ongoing redemption or subscription activity. Certain common and preferred stocks held by Rush under this classification may not have available current market quotes and were primarily valued using techniques consistent with the market approach utilizing significant observable inputs, such as mid, bid, and ask or offer quotes.

World Asset Allocation Mutual Funds – This class includes investments in fund of funds that seek to provide both capital appreciation and income by investing primarily in both traditional and alternative asset classes. The asset allocation is driven by the fund manager's long range forecasts of asset-class real returns. Investments representing approximately 86% of the fair value in this category, which are invested in mutual funds, are priced as of the New York Stock Exchange (NYSE) close on each day the NYSE is open. The remaining investments in this category, which are invested in a multi-strategy hedge fund, are priced on the last business day of each calendar month. Redemption proceeds for approximately 50% of these investments is daily. Redemption proceeds for the remaining 50% of these investments is monthly and requires at least 14 business days advance notice.

Hedge Fund of Funds – This class includes diversified investments in hedge fund of funds with diverse strategies, including equity long/short, credit long/short, event-driven, relative value, global opportunities, and other multi-strategy funds. Hedge fund of funds investments are valued based on Rush's ownership interest in the NAV of the respective fund as estimated by the general partner, which approximates fair value. Rush routinely monitors and assesses methodologies and assumptions used in valuing these interests. The values for underlying investments are estimated either internally or by an external fund manager based on many factors, including operating performance, balance sheet indicators, growth, and other market and business fundamentals. Hedge fund investments also include certain liquidity restrictions that may require 65 to 95 days advance notice for redemptions. Due to significant unobservable inputs used in estimating the NAV and liquidity restrictions, Rush classifies all hedge fund investments as Level 3.

Beneficial Interest in Trusts – The fair value of beneficial interests in perpetual and charitable trusts classified as Level 3 was determined using an income approach based on the present value of expected future cash flows to be received from the trust or based on Rush's beneficial interest in the investments held in the trust measured at fair value. Since Rush is unable to liquidate the funds held and benefits only from the distributions generated off of such investments, the interest in such trusts are all shown in Level 3.

Interest in Cash Collateral Pools and Obligation to Return Collateral Under Securities Lending Program – The fair value of interests in cash collateral pools under the securities lending program and the corresponding liability to return collateral held classified as Level 2 were determined using the calculated NAV. The collateral held under this program is placed in commingled funds that invest primarily in government securities, asset-backed and mortgage-backed securities, and corporate debt, all of which are subject to quality and liquidity guidelines established by the fund. The underlying investments were valued using techniques consistent with the market approach, which utilizes significant observable market inputs, such as available trades, quotes, and benchmark yield curves.

Obligations Under Interest Rate Swap Agreements – The fair value of Rush's obligations under interest rate swap agreements classified as Level 2 are valued using a market approach. The valuation is based on a determination of market expectations relating to the future cash flows associated with the swap contract using sophisticated modeling based on observable market-based inputs, such as interest rate curves. The fair value of the obligation reported in Rush's consolidated balance sheets includes an adjustment for the Obligated Group's credit risk but may not be indicative of the value Rush would be required to pay upon early termination of the swap agreements.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while Rush believes that its methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value at the reporting date.

Level 3 Rollforward

A rollforward of the amounts in the consolidated balance sheets for financial instruments classified by Rush within Level 3 of the fair value hierarchy, are as follows:

	Hedge Fund of Funds	Corporate Bonds	Asset Backed Securities & Other	Beneficial Interest in Trusts	Total Assets at Fair Value
Fair value — June 30, 2009	$ 21,790	$ 679	$ 364	$ 22,075	$ 44,908
Actual return on plan assets — Realized and unrealized gains	2,643	129	294	1,245	4,311
Purchases, sales, and settlements — net	-	-	(285)	-	(285)
Transfers in and/or out of Level 3	-	(439)	89	-	(350)
Fair value — June 30, 2010	24,433	369	462	23,320	48,584
Actual return on plan assets — Realized and unrealized gains	1,948	15	89	4,216	6,268
Purchases, sales, and settlements — net	5,881	(384)	(551)	-	4,946
Transfers in and/or out of Level 3	-	-	-	-	-
Fair value — June 30, 2011	$ 32,262	$ -	$ -	$ 27,536	$ 59,798

For the year ended June 30, 2011, realized and unrealized gains pertaining to Level 3 investments include $128 reported within excess of revenue over expenses and $1,924 and $4,216 reported within temporarily and permanently restricted net assets under investment gains, respectively. For the year ended June 30, 2010, realized and unrealized gains pertaining to Level 3 investments include $483 reported within excess of revenue over expenses and $2,583 and $1,245 reported within temporarily and permanently restricted net assets under investment gains, respectively.

Investments in Entities that Report Fair Value Using NAV

Included within the fair value table above are investments in certain entities that report fair value using a calculated NAV or its equivalent, and are classified as Level 2 or Level 3 investments. The following table summarizes the attributes relating to the nature and risk of such investments as of June 30, 2011:

Entities that Report Fair Value Using NAV	Fair Value (In Thousands)	Unfunded Commitments	Redemption Frequency (If Currently Eligible)	Redemption Notice Period
International equity securities (equity commingled trust)	$13,820	None	Daily	1 – 7 days
World asset allocation mutual funds	$42,902	None	Weekly; Monthly	1 – 14 days
Hedge fund of funds	$26,329	None	Quarterly	65 – 95 days
Fixed income mutual funds	$73,664	None	Daily	1 – 7 days

7. ENDOWMENT FUNDS

Rush's endowment consists of over 300 individual funds, which are established for a variety of purposes. As required by GAAP, net assets associated with endowment funds are classified and reported based on the existence or absence of donor-imposed restrictions.

Interpretation of Relevant Law

Rush has interpreted the Uniform Prudent Management of Institutional Funds Act (UPMIFA) as requiring preservation of the original value of the gift as of the gift date absent explicit donor stipulations to the contrary. As a result of this interpretation, Rush classifies as permanently restricted net assets (a) the original value of gifts donated to the permanent endowment, (b) the original value of any subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable gift instrument at the time the accumulation is added to the fund. The portion of the donor-restricted endowment fund that is not classified as 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 standards of prudence under UPMIFA. In accordance with UPMIFA, Rush considers the following factors in making a determination to appropriate or accumulate donor restricted funds:

a. The duration and preservation of the fund
b. The purposes of the organization and the donor-restricted endowment fund
c. General economic conditions
d. The possible effect of inflation and deflation
e. The expected total return from income and the appreciation of investments
f. Other resources of the organization
g. The investment policies of the organization

Endowment Investment and Spending Policies

Rush has adopted endowment investment and spending policies to preserve purchasing power over the long-term and provide stable annual support to the programs supported by the endowment, including professorships, research and education, free care, and student financial aid, scholarships, and fellowships. Approximately 17% of Rush's endowment is available for general purposes.

The Investment Committee of the Board is responsible for defining and reviewing the investment policy to determine an appropriate long-term asset allocation policy. The asset allocation policy reflects the objective with allocations structured for capital growth and inflation protection over the long-term. The current asset allocation targets and ranges as well as the asset allocation as of June 30, 2011 and 2010, are as follows:

	Target Allocation and Range		Percentage of Endowment Assets	
Asset Class	June 30, 2011	June 30, 2010	2011	2010
Domestic equity	30%(+/-5%)	45%(+/-5%)	31 %	44 %
International equity	15%(+/-5%)	10%(+/-5%)	14	8
Global asset allocation	10%(+/-5%)	None	10	-
Alternatives (Hedge Funds/Private Equity)	15%(+/-5%)	15%(+/-5%)	19	21
Fixed income	30%(+/-5%)	30%(+/-5%)	26	27

To achieve its long-term rate of return objectives, Rush relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized) and current income (interest and dividends). The expected long-term rate of return target of the endowment given its current asset allocation structure is approximately 8.8% based on historical returns. Actual returns in any given year may vary from this amount. Rush has established market-related benchmarks to evaluate the endowment fund's performance on an ongoing basis.

The Finance Committee of the Board approves the annual spending policy for program support. In establishing the annual spending policy, Rush's 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 4.0% and 3.5% for the fiscal years ended June 30, 2011 and 2010, respectively, and income from the endowment fund provided $15.6 million and $14.1 million of support for Rush's programs during the fiscal years ended June 30, 2011 and 2010, respectively. The spending rate is based on a three-year moving average of ending market values for pooled assets.

Composition of Endowment Fund and Reconciliation

The endowment net asset composition by type of fund as of June 30, 2011, consisted of the following:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 207,523	$ 227,736	$ 435,259
Board-designated endowment funds	4,715	-	-	4,715
Total funds	$ 4,715	$ 207,523	$ 227,736	$ 439,974

Changes in endowment net assets for fiscal year ended June 30, 2011, consisted of the following:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets — beginning of year	$ 4,155	$ 162,105	$ 214,282	$ 380,542
Investment return:				
Investment (loss) income	(103)	6,750	-	6,647
Replenishment of endowment impairment	-	-	(2,446)	(2,446)
Net appreciation (realized and unrealized)	663	53,823	6,662	61,148
Total investment return	560	60,573	4,216	65,349
Contributions	-	-	9,238	9,238
Transfer of unrestricted endowment appreciation	-	(15,155)	-	(15,155)
Endowment net assets — end of year	$ 4,715	$ 207,523	$ 227,736	$ 439,974

The endowment net asset composition by type of fund as of June 30, 2010, consisted of the following:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Donor-restricted endowment funds	$ -	$ 162,105	$ 214,282	$ 376,387
Board-designated endowment funds	4,155	-	-	4,155
Total funds	$ 4,155	$ 162,105	$ 214,282	$ 380,542

Changes in endowment net assets for fiscal year ended June 30, 2010, consisted of the following:

	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Endowment net assets — beginning of year	$ 3,054	$ 142,714	$ 205,084	$ 350,852
Investment return:				
Investment (loss) income	(70)	5,747	-	5,677
Replenishment of endowment impairment	-	-	(3,622)	(3,622)
Net appreciation (realized and unrealized)	271	27,345	4,867	32,483
Total investment return	201	33,092	1,245	34,538
Contributions	900	-	7,953	8,853
Transfer of unrestricted endowment appreciation	-	(13,701)	-	(13,701)
Endowment net assets — end of year	$ 4,155	$ 162,105	$ 214,282	$ 380,542

Fund Deficiencies

Rush monitors the accumulated losses on permanently restricted investments to determine whether the endowment corpus has been impaired and restores these losses through unrestricted net assets as necessary. During the years ended June 30, 2011 and 2010, $2,446 and $3,622, respectively, was recovered and replenished through unrestricted net assets representing accumulated losses on permanently restricted investments incurred during fiscal years 2010 and 2009, respectively.

8. PROPERTY AND EQUIPMENT

Property and equipment as of June 30, 2011 and 2010 consisted of the following:

	2011	2010
Land and buildings	$ 1,048,648	$ 1,010,438
Equipment	382,155	363,904
Construction in progress	545,648	355,741
	1,976,451	1,730,083
Less accumulated depreciation	(789,273)	(727,204)
Property and equipment, net	$ 1,187,178	$ 1,002,879

9. LONG-TERM DEBT AND CREDIT ARRANGEMENTS

Rush's long-term debt is issued under a Master Trust Indenture which established an Obligated Group comprised of Rush and RCMC. The Obligated Group is jointly and severally liable for the obligations issued under the Master Trust Indenture. Each Obligated Group member is expected to pay its allocated share of the debt issued on its behalf. Total Obligated Group debt as of June 30, 2011 and 2010 was $618,920 and $627,786, respectively. As of June 30, 2011 and 2010, such issuances are secured by a pledge of gross receipts and a mortgage on primary healthcare facilities, as defined, of the Obligated Group members.

A summary of Rush's long-term debt as of June 30, 2011 and 2010, is as follows:

	Interest Rates	Final Maturity Date	Amount Outstanding at June 30, 2011	2010
Illinois Finance Authority Revenue Bonds:				
Fixed rate revenue bonds:				
Series 2009C/D	6.375% to 6.625%	November 1, 2039	$ 173,800	$ 173,800
Series 2009 A/B	5.0% to 7.25%	November 1, 2038	176,265	176,265
Series 2006B	5.0% to 5.75%	November 1, 2028	67,050	67,050
Series 1998A	5.0% to 5.25%	November 1, 2024	60,550	60,550
Total fixed rate debt			477,665	477,665
Variable rate revenue bonds :				
Series 2008A	Average of 0.22% and 0.25% in FY2011 and FY2010, respectively.	November 1, 2045	50,000	50,000
Series 1989A	Average of 0.26% and 0.25% in FY2011 and FY2010, respectively.	October 1, 2010	-	4,600
Series 1985 C, D, and F	Average of 1.58% and 1.59% in FY2011 and FY2010, respectively.	February 28, 2011	-	2,993
Total variable rate debt			50,000	57,593
Total par value of debt			527,665	535,258
Less current portion of long-term debt			(4,550)	(7,593)
Net discount and premium			(5,336)	(5,505)
Long-term debt			$ 517,779	$ 522,160
Estimated fair value based on quoted market prices and other relevant information			$ 567,317	$ 604,061

Under its various indebtedness agreements, the Obligated Group is subject to certain financial covenants, including maintaining a minimum historical debt service coverage and maximum annual debt service coverage ratios; maintaining minimum levels of days cash on hand; maintaining debt to capitalization at certain levels; limitations on selling, leasing, or otherwise disposing of Obligated Group property; and certain other nonfinancial covenants. The Obligated Group was in compliance with its debt covenants as of June 30, 2011 and 2010.

Annual maturities of outstanding long-term debt, adjusted to reflect the refinancing of the amounts borrowed on a taxable line of credit (described below), are as follows:

Years Ending June 30	
2012	$ 4,550
2013	5,905
2014	11,320
2015	12,140
2016	6,320
Thereafter	487,430
Total	$ 527,665

Letters of Credit Arrangements

The Obligated Group's variable rate revenue bonds are subject to remarketing provisions that require the Obligated Group to repurchase the bonds if they cannot be sold to a third party. The Obligated Group entered into letters of credit with commercial banks to provide funding for such repurchases, as necessary. Any amounts borrowed under these letters of credit are due and payable more than one year from the date of such borrowing. The letters of credit related to the Series 1989A variable rate revenue bonds and the Series 1985 C, D, and F pool loans expired during fiscal year 2011 when the final principal payment was made on each series. The letter of credit related to the Series 2008A Variable Rate Demand Bonds (the "Series 2008A Bonds") expires in December 2012. In the absence of such agreement, the Obligated Group would be required to replace it with a similar credit arrangement, convert the related debt from variable to fixed interest rate, or fund required repurchases from available funds. Draws are routinely made from the letter of credit to pay off principal and interest and are reimbursed to the commercial bank on the following business day. As of June 30, 2011 and 2010, there were outstanding draws against the letter of credit related to the Series 2008A Bonds representing interest paid to the bondholders on July 1, 2011 and 2010 of $6 and $10, respectively.

Recent Financing Activity

On July 29, 2009, the IFA issued $173,800 of Series 2009C Fixed Rate Revenue Bonds, allocated to Rush, and $26,200 of Series 2009D Fixed Rate Revenue Bonds, allocated to RCMC, on behalf of the Obligated Group (collectively, the "Series 2009C/D Bonds"). Proceeds from the Series 2009C/D Bonds were used to reimburse the Obligated Group for capital expenditures, establish a project fund for Rush, refinance $19,800 in borrowings under a taxable line of credit used to reimburse RCMC for prior capital expenditures, and provide financing for costs of issuance and a debt service reserve fund. The Series 2009C/D Bonds are due on November 1, 2039, and are secured by a mortgage on certain real property and a pledge of the gross receipts of the Obligated Group.

Lines of Credit Arrangements

The Obligated Group had a $50 million short-term line of credit with a bank as of June 30, 2011 and 2010. This line of credit was extended, during fiscal year 2011 through December 2012. As of June 30, 2011, the Obligated Group had no amounts outstanding on this line of credit.

The Obligated Group also had a $100 million short-term line of credit with a bank as of June 30, 2011 and 2010. This line of credit was extended, during fiscal year 2011 through December 2013. Any borrowings on this short-term line of credit are due and payable in 180 days. As of June 30, 2011 and 2010, the Obligated Group had no amounts outstanding on this line of credit.

10. DERIVATIVES

Derivatives Policy

The Obligated Group uses derivative instruments, specifically interest rate swaps, to manage its exposure to changes in interest rates on variable rate borrowings. The use of derivative instruments exposes the Obligated Group to additional risks related to the derivative instrument, including market risk, credit risk, and termination risk, as described below, and the Obligated Group has defined risk management practices to mitigate these risks.

Market risk represents the potential adverse effect on the fair value and cash flow of a derivative instrument due to changes in interest rates or rate spreads. Market risk is managed through ongoing monitoring of interest rate exposure based on set parameters regarding the type and degree of market risk that the Obligated Group will accept. Credit risk is the risk that the counterparty on a derivative instrument may be unable to perform its obligations during the term of the contract. When the fair value of a derivative contract is positive (an asset to the Obligated Group), the counterparty owes the Obligated Group which creates credit risk. Credit risk is managed by setting stringent requirements for qualified counterparties at the date of execution of a derivative transaction and requiring counterparties to post collateral in the event of a credit rating downgrade or if the fair value of the derivative contract exceeds a negotiated threshold. Termination risk represents the risk that the Obligated Group may be required to make a significant

payment to the counterparty if the derivative contract is terminated early. Termination risk is assessed at onset by performing a statistical analysis of the potential for a significant termination payment under various scenarios designed to encompass expected interest rate changes over the life of the proposed contract. The test measures the ability to make a termination payment without a significant impairment to the Obligated Group's ability to meet its debt or liquidity covenants.

Board approval is required to enter or modify any derivatives transaction. Management periodically reviews existing derivative positions as its risk tolerance and cost of capital changes over time.

Interest Rate Swap Agreements

The Obligated Group has two interest rate swap agreements (the "Swap Agreements"), which were designed to synthetically fix the interest payments on the Series 2006A Bonds, which were later refinanced. Under the Swap Agreements, the Obligated Group makes fixed rate payments equal to 3.945% to the swap counterparties and receives variable rate payments equal to 68% of LIBOR (0.186% as of June 30, 2011 and 0.237% as of June 30, 2010) from the swap counterparties, each calculated on the notional amount of the Swap Agreements. As of June 30, 2011 and 2010, the Swap Agreements had a notional amount of $96,750 outstanding ($48,375 in notional amount with each counterparty). The Swap Agreements each expire on November 1, 2035, and amortize annually commencing in 2012. The Swap Agreements are secured by obligations issued under the Master Trust Indenture.

Following the refinancing of the Series 2006A Bonds, the Obligated Group used $50,000 in notional amount of the Swap Agreements to synthetically fix the interest on the Series 2008A Bonds. Rush's share of the Swap Agreements had a fair value of $(9,366) and $(10,808) as of June 30, 2011 and 2010, respectively, reported in other long-term liabilities in the accompanying consolidated balance sheets. The fair value of the Swap Agreements reported in Rush's balance sheet as of June 30 2011 and 2010 includes an adjustment for the Obligated Group's credit risk and may not be indicative of the termination value that Rush would be required to pay upon early termination of the Swap Agreements.

Management has not designated the Swap Agreements as hedging instruments. Amounts recorded in the accompanying consolidated statements of operations and changes in net assets for the Swap Agreements allocated to Rush for the fiscal years ended June 30, 2011 and 2010, were as follows:

		Fiscal Year Ended June 30	
	Reported As	2011	2010
Change in fair value of interest rate swaps	Nonoperating income (expense)	$ 1,442	$ (2,956)
Net cash payments on interest rate swaps	Interest expense	(2,528)	(2,523)

The Swap Agreements also require either party to post collateral in the form of cash and certain cash equivalents to secure potential termination payments. The amount of collateral that is required to be posted is based on the relevant party's long-term credit rating. Based on its current rating, the Obligated Group was not required to post any collateral as of June 30, 2011.

11. OBLIGATIONS UNDER CAPITAL LEASE AND DEFERRED FINANCING ARRANGEMENTS

Rush is a party to certain long-term deferred financing arrangements with respect to facilities, equipment, and services with unrelated third parties. Rush is also party to an arrangement with a third party to lease a medical office building adjacent to ROPH for a remaining period of 13 years. Under the terms of this arrangement, the annual expense, excluding maintenance and repairs, taxes, and other operating expenses was approximately $4,122 and $4,012 for the years ended June 30, 2011 and 2010, respectively, and increases each year by 2.75%.

In September 2005, Rush entered into a long-term contract with a vendor for the licensing, implementation, and maintenance of a clinical, patient management, and patient accounting system. Under terms of the contract, Rush pays licensing fees over an initial 6.25-year term, and at the end of the initial term, Rush has the right to convert the arrangement to a perpetual license for a fee. The arrangement has been treated in the manner of a capital lease, with the present value of future license payments included in property and equipment and the related obligation included in obligations under capital lease on the accompanying consolidated balance sheets. The asset has a net book value of approximately $3,224 and $4,473 as of June 30, 2011 and 2010, respectively. In addition to licensing fees, Rush pays maintenance fees for support services received under terms of the agreement, which are recognized as expenses when incurred. Maintenance fees were not significant to the consolidated financial statements during the years ended June 30, 2011 and 2010.

Rush is also party to certain capital lease arrangements relating to medical and office equipment. Expiration of leases ranges from 2012 to 2013. Assets acquired under capital lease arrangements are included in property and equipment, net on the accompanying consolidated balance sheets.

Future minimum lease payments under noncancelable capital leases and other financing arrangements are as follows:

Years Ending June 30	
2012	$ 6,268
2013	5,560
2014	4,935
2015	4,762
2016	4,741
Thereafter	31,286
Total minimum payments	57,552
Less amount representing interest	(19,648)
Net present value of obligations under capital lease and other financing arrangements	37,904
Less current portions included in accounts payable	(3,277)
Long-term portion of obligations under capital lease and other financing arrangements	$ 34,627

12. PENSION AND OTHER POSTRETIREMENT BENEFIT PLANS

Rush and its subsidiaries maintain defined benefit pension plans, defined contribution plans, and other postretirement benefit plans that together cover substantially all of Rush's employees.

Rush has two defined benefit pension plans, the Retirement Plan and the Pension Plan (collectively, the "Defined Benefit Pension Plans"), covering substantially all of its employees. Benefits are based on the years of service and the

employee's final average earnings, as defined. The Defined Benefit Pension Plans' assets and obligations are measured as of June 30 (the "Measurement Date") each year. Employer contributions were $34,427 and $35,144 during fiscal years 2011 and 2010, respectively. The actuarial cost method used to compute the Defined Benefit Pension Plans' liabilities and expenses is the projected unit credit method. Effective December 31, 2011, the Pension Plan, representing certain union employees, will be amended to freeze benefit accruals for all participants. No additional benefits will accrue, and no additional individuals will become plan participants in the Pension Plan as of January 1, 2012. Effective January 1, 2012, the Retirement Plan will be amended to include eligible union members previously covered by the Pension Plan. The amendments were signed on August 1, 2011.

In addition to the pension programs, Rush also provides postretirement healthcare benefits for certain employees (the "Postretirement Healthcare Plans"). Further benefits under the Postretirement Healthcare Plans have been curtailed.

Obligations and Funded Status

The table below sets forth the accumulated benefit obligation, the change in the projected benefit obligation, and the change in the plan assets of the Defined Benefit Pension Plans and Postretirement Healthcare Plans (collectively, the "Plans"). The table also reflects the funded status of the Plans as of the Measurement Date and amounts recognized in Rush's consolidated balance sheets as of June 30, 2011 and 2010, respectively.

Obligations and Funded Status	Defined Benefit Pension Plans		Postretirement Healthcare Plans	
	2011	2010	2011	2010
Actuarial present value of benefit obligations — accumulated benefit obligation	$796,003	$780,775	$ 8,730	$ 9,049
Change in projected benefit obligations:				
Projected benefit obligation — beginning of measurement period	$798,568	$614,299		
Service costs	17,648	13,636		
Interest costs	42,732	41,089		
Plan amendments	(14,657)	-		
Actuarial (gains) losses	(18,599)	154,181		
Benefits paid	(28,372)	(24,637)		
Projected benefit obligation — end of measurement period	$797,320	$798,568		
Change in plan assets:				
Fair value of plan assets — beginning of measurement period	$575,670	$483,624	$ -	$ -
Actual return on plan assets	84,603	81,539	-	-
Employer contributions	34,427	35,144	459	529
Plan participant contributions	-	-	560	555
Benefits paid	(28,372)	(24,637)	(1,019)	(1,084)
Fair value of plan assets — end of measurement period	$666,328	$575,670	$ -	$ -
Accrued benefit liability	$130,992	$222,898	$ 8,730	$ 9,049

The components of net periodic pension cost for the Plans were as follows:

Components of Net Periodic Pension Cost Year Ended June 30	Defined Benefit Pension Plans		Postretirement Healthcare Plans	
	2011	2010	2011	2010
Net periodic pension cost comprised the following:				
Service cost	$ 17,648	$ 13,636	$ 159	$ 101
Interest cost on projected benefit obligation	42,732	41,089	474	608
Expected return on plan assets	(47,408)	(40,156)	-	-
Amortization of prior service cost and other actuarial amounts	(165)	(165)	(294)	(294)
Recognized actuarial loss (gain)	20,390	11,390	(1,075)	(1,703)
Net periodic pension cost (credit)	$ 33,197	$ 25,794	$ (736)	$ (1,288)

In accordance with FASB guidance regarding accounting for defined benefit pension and other postretirement plans, all previously unrecognized actuarial losses and prior service costs are reflected in the consolidated balance sheets. The postretirement related charges other than net periodic benefit cost related to the pension and postretirement healthcare plans are included as a separate charge to unrestricted net assets and total $89,800 and $(103,106) for fiscal years 2011 and 2010, respectively. For fiscal year 2011, this amount includes actuarial gains arising during fiscal year 2011 of $56,286, unrecognized prior service cost of $14,657, and a reclassification adjustment for losses reflected in periodic expense in fiscal year 2011 of $18,857. For fiscal year 2010, this amount includes actuarial losses arising during fiscal year 2010 of $(112,336) and a reclassification adjustment for losses reflected in periodic expense in fiscal year 2010 of $9,230.

The table below sets forth the change in the accrued benefit liability of the Plans.

Accrued Benefit Liability	Defined Benefit Pension Plans		Postretirement Healthcare Plans	
	2011	2010	2011	2010
Accrued benefit liability — beginning of year	$222,898	$130,675	$ 9,049	$ 9,333
Fiscal year activity:				
Net periodic pension cost	33,197	25,794	(736)	(1,288)
Employer contributions	(34,427)	(35,144)	(459)	(529)
Unrecognized prior service cost	(14,657)	-	-	-
Postretirement-related changes other than net periodic postretirement cost:				
Actuarial (gain) loss	(55,794)	112,799	(492)	(463)
Reclassification adjustment for losses reflected in periodic expense	(20,225)	(11,226)	1,368	1,996
Accrued benefit liability — end of year	$130,992	$222,898	$ 8,730	$ 9,049
Recognized in the consolidated balance sheets as follows:				
Accrued expenses	$ -	$ -	$ 818	$ 719
Noncurrent liabilities	130,992	222,898	7,912	8,330
	$130,992	$222,898	$ 8,730	$ 9,049

Assumptions

The actuarial assumptions used to determine benefit obligations at the measurement date and net periodic benefit cost for the Plans are as follows:

Assumptions Used to Determine Benefit Obligations and Net Periodic Benefit Cost	Defined Benefit Pension Plans		Postretirement Healthcare Plans	
	2011	2010	2011	2010
Discount rate — benefit obligation	5.50 %	5.45 %	5.50 %	5.45 %
Discount rate — pension expense	5.45	6.85	5.45	6.85
Rate of increase in compensation levels	5.38/4.89*	5.47/4.95*	-	-
Expected long-term rate of return on plan assets	7.75	7.75	-	-
Health care cost trend rate (initial)	-	-	8.00	8.10

* Represents rate of increase in compensation levels on the Retirement Plan and Pension Plan, respectively.

The discount rate used is based on a spot interest rate yield curve based on a broad group of corporate bonds rated AA or better as of the Measurement Date. Rush uses this yield curve and the estimated payouts of the Plans to develop an aggregate discount rate. The estimated payouts are the sum of the payouts under the Defined Benefit Pension Plans and the Postretirement Healthcare Plans.

Rush's overall expected long-term rate of return on assets is 7.75% for 2011 and 2010. The expected long-term rate of return is based on the total portfolio of the Defined Benefit Pension Plans' investments rather than the accumulation of returns on individual asset categories. For the years ended June 30, 2011 and 2010, the actual rate of return on plan assets was 15.3% and 17.6%, respectively.

Plan Assets

Rush's investment objective for its Defined Benefit Pension Plans is to achieve a total return on plan assets that meets or exceeds the return on the plan's liability over a full market cycle with consideration of the plan's current funded status. Investment risk is effectively managed through diversification of assets for a mix of capital growth and capital protection across various investment styles. The asset allocation policy reflects this objective with allocations to return generating assets (e.g. equity and alternative investments, consisting of hedge funds and limited partnerships) and interest rate hedging assets (e.g. fixed income securities).

All of the plan's assets are measured at fair value, including alternative investments. Fair value methodologies used to assign plan assets to levels of FASB's valuation hierarchy are consistent with the inputs described in Note 6. Fair value methodologies used to value interests in private equity limited partnerships that hold restricted securities and are not publicly traded are based on Rush's ownership interest in the NAV of the respective fund as estimated by the general partner, which approximates fair value. Rush routinely monitors and assesses methodologies and assumptions used in valuing these interests. Due to significant unobservable inputs used in estimating the net asset value of private equity limited partnerships, Rush classifies all such investments as Level 3.

The fair value of the Defined Benefit Pension Plan assets as of June 30, 2011 and 2010 are as follows:

	Level 1	Level 2	Level 3	Total Fair Value
Fair Value Measurements as of June 30, 2011				
Cash, cash equivalents, and short-term investments	$ 3,675	$ 5,562	$ -	$ 9,237
Fixed income securities:				
U.S. government securities	-	127,183	-	127,183
International government securities	-	17,228	-	17,228
Corporate bonds	-	205,958	1,868	207,826
Collateralized securities and other	-	28,496		28,496
U.S. equity securities	129,192	-	-	129,192
International equity securities	16,389	48,716	-	65,105
World asset allocation mutual funds		18,847	7,119	25,966
Alternative investments:				
Hedge fund of funds	-	-	28,434	28,434
Private equity partnerships (a)	-	-	22,795	22,795
Accrued interest and other	1,060	3,795	11	4,866
Total plan assets	$ 150,316	$ 455,785	$ 60,227	$ 666,328
Fair Value Measurements as of June 30, 2010				
Cash, cash equivalents, and short-term investments	$ -	$ 4,022	$ -	$ 4,022
Fixed income securities:				
U.S. government securities	-	29,005	-	29,005
International government securities	-	18,694		18,694
Corporate bonds	-	270,899	479	271,378
Collateralized securities and other	-	8,018	-	8,018
U.S. equity securities	140,091	16,019	-	156,110
International equity securities	20,960	14,457	-	35,417
Alternative investments:				
Hedge fund of funds	-	-	26,390	26,390
Private equity partnerships	-	-	21,106	21,106
Accrued interest and other	1,455	4,075	-	5,530
Total plan assets	$ 162,506	$ 365,189	$ 47,975	$ 575,670

(a) This class includes investments in funds with diverse strategies, including approximately 42% in buyout and growth capital, 24% in diversified fund of funds, 17% in distressed debt and special situations, 16% in venture capital, and 1% in co-investment private equity funds.

A rollforward of the amounts in the Plans for financial instruments classified by Rush within Level 3 of the fair value hierarchy, are as follows:

Rollforward of Level 3 Investments	Corporate Bonds and Accrued Interest and Other	Asset-Backed Securities & Other	Hedge Fund of Funds	Private Equity Partnerships	Total Assets at Fair Value
Fair value at June 30, 2009	$ 993	$ 1,387	$ 23,541	$ 17,018	$ 42,939
Actual return on plan assets:					
Realized and unrealized gains (losses)	189	40	2,849	2,636	5,714
Purchases, sales, and settlements	466	(1,427)	-	1,452	491
Transfers in and/or out of Level 3	(1,169)	-	-	-	(1,169)
Fair value at June 30, 2010	479	-	26,390	21,106	47,975
Actual return on plan assets:					
Realized and unrealized gains	182	-	2,106	648	2,936
Purchases, sales, and settlements	-	-	7,057	1,041	8,098
Transfers in and/or out of Level 3	1,218	-	-	-	1,218
Fair value at June 30, 2011	$ 1,879	$ -	$ 35,553	$ 22,795	$ 60,227

Cash Flows

Rush expects to make estimated contributions to and benefit payments from its Defined Benefit Pension Plans and Postretirement Healthcare Plans, for the years ending June 30 as follows:

	Defined Benefit Pension Plans	Postretirement Healthcare Plans
Expected contributions in 2012	$ 38,151	$ 818
Estimated Benefit Payments		
2012	$ 31,722	$ 818
2013	35,297	888
2014	38,708	898
2015	43,185	894
2016	47,330	868
2017 through 2021	282,031	3,746
Total	$ 478,273	$ 8,112

Other Postretirement Benefit Plans

Rush maintains a voluntary tax-deferred retirement savings plan. Under this plan, employees may elect to contribute a percentage of their salary, which may be matched in accordance with the provisions of the plan. Other provisions of the plan may provide for employer contributions to the plan based on eligible earnings regardless of whether the employee elects to contribute to the plan. Maximum annual contributions are limited by federal regulations. Employer contributions to this plan were $9,172 and $8,778 in the years ended June 30, 2011 and 2010, respectively.

Rush also sponsors a noncontributory defined contribution plan covering selected employees ("457(b) Plan"). Contributions to the 457(b) Plan are based on a percentage of qualifying compensation up to certain limits as defined by the provisions of the 457(b) Plan. The 457(b) Plan assets and liabilities totaled $9,586 and $7,090 as of June 30, 2011 and 2010, respectively, and are included in investments – less current portion and other long-term liabilities on the

accompanying consolidated balance sheets. The assets of the 457(b) Plan are subject to the claims of the general creditors of Rush.

Rush also sponsors a supplemental retirement plan for certain management employees ("Supplemental Plan"). The Supplemental Plan is noncontributory and annual benefits are credited to each participant's account based on a percentage of qualifying compensation as defined by the provisions of the plan. Assets set aside to fund the Supplemental Plan amounted to $11,172 and $8,371 as of June 30, 2011 and 2010, respectively, and are included in investments – less current portion on the accompanying consolidated balance sheets. This supplemental retirement plan is currently funded at 100% of benefits accrued.

Rush also maintains a frozen nonqualified supplemental defined benefit retirement plan for certain management employees, which is unfunded. Benefits under the supplemental defined benefit plan, which were curtailed as of December 31, 2004, are paid when incurred from operating funds.

It is Rush's policy to meet the requirement of the Employee Retirement Income Security Act of 1974 and the Pension Protection Act of 2006.

13. CONCENTRATION OF CREDIT RISK

Rush grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of net patient accounts receivable from patients and third-party payors as of June 30, 2011 and 2010, was as follows:

	2011	2010
Medicare	10 %	10 %
Medicaid	13	14
Managed care	65	63
Commercial	3	2
Self-pay	9	11
Total	100 %	100 %

The Chicago metropolitan market has experienced consolidation in the managed care market that has impacted the Obligated Group. Products sponsored by Blue Cross Blue Shield of Illinois, the largest health insurer in the market, accounted for 37.5% of managed care net patient accounts receivable and 24.3% of net patient accounts receivable of Rush for the fiscal year ended June 30, 2011.

14. COMMITMENTS AND CONTINGENCIES

Professional Liability

Rush maintains insurance programs, including both self-insured and purchased insurance arrangements, for certain professional liability claims. Self-insured risks are retained in varying amounts according to policy year and entity. For the years ended June 30, 2011 and 2010, Rush retained self-insured risk of $20,000 on the first case, $15,000 on the second case, and $10,000 on any additional cases. Rush also maintains excess liability insurance coverage with combined limits of $80,000 per occurrence and in the aggregate. Rush has an established trust fund to pay claims and related costs.

Rush has employed an independent actuary to estimate the ultimate costs of claim settlements. Self-insured liabilities are based on the actuarial estimate of losses using Rush's actual payout patterns and various other assumptions. Rush's self-insured liabilities of $173,447 and $204,594 as of June 30, 2011 and 2010, respectively, are recorded as noncurrent and current liabilities on the accompanying consolidated balance sheets, as appropriate, and based on the estimated present value of self-insured claims that will be settled in the future. If the present value method was not used, Rush's

liability for self-insured claims would be approximately $30,652 and $44,263 higher than the amounts recorded on the consolidated balance sheets as of June 30, 2011 and 2010, respectively. The discount rates used in calculating the present value by organization was 4% for fiscal years ended June 30, 2011 and 2010.

During fiscal years 2011 and 2010, actual experience on Rush's self-insured claims was better than projected. Rush has experienced significant reserve adjustments in its self-insurance liability each fiscal year since 2006 as a result of favorable claims experience. The amount of the reserve adjustments were $29,297 and $6,412 in the years ended June 30, 2011 and 2010, respectively, which reduced insurance expense in the consolidated statements of operations and changes in net assets in each respective year.

Rush is subject to various other regulatory investigations, legal proceedings, and claims which are incidental to its normal business activities. In the opinion of management, the amount of ultimate liability with respect to professional liability matters and other actions will not have a material adverse effect on the consolidated financial position or results of operations of Rush.

Self-Funded Medical Benefit Plans

Effective January 1, 2005, Rush began sponsoring self-funded medical benefit plans covering substantially all of their employees and their dependents. The medical benefit expense is based on actual medical and prescription claims paid, administration fees, and provisions for unpaid and unreported claims at year-end. As of June 30, 2011 and 2010, the estimated liability for unpaid and unreported claims was $7,738 and $7,082, respectively, and included in accrued expenses on the accompanying consolidated balance sheets. The medical benefit expense was $53,349 and $47,456 for the years ended June 30, 2011 and 2010, respectively, and included in salaries, wages, and employee benefits in the accompanying statement of operations and changes in net assets.

Obligations under Operating Leases

Rush is party to various noncancelable operating leases with third parties. Rental expense was approximately $9,935 and $10,845 for the years ended June 30, 2011 and 2010, respectively, and was included in supplies, utilities, and other expenses in the accompanying consolidated statements of operations and changes in net assets. Total minimum payments under noncancelable operating leases as of June 30, 2011, are as follows:

Years Ending June 30	
2012	$ 9,515
2013	7,216
2014	4,572
2015	3,185
2016	2,402
Thereafter	12,248
Total	$ 39,138

15. CAMPUS TRANSFORMATION COMMITMENTS

In fiscal year 2004, Rush began a Campus Transformation project that currently includes the addition of new facilities, including a new hospital and the renovation of existing facilities. The project is driven by a redesign of patient care processes to improve efficiency and patient safety and to provide a more inviting environment to physicians, patients, and visitors. The project is estimated to cost approximately $1,139,000 to complete over a 13-year period (fiscal year 2004 to fiscal year 2016). As of June 30, 2011, $822,435 has been spent on the campus redevelopment plan, and construction commitments outstanding were $102,452.

16. PROMISES TO CONTRIBUTE

Included in assets limited by donor or time restriction are the following unconditional promises to give which are discounted at rates of 0.02% and 0.12% applied to new pledges given during the years ended June 30, 2011 and 2010, respectively:

	2011	2010
Capital campaign	$ 65,556	$ 61,699
Restricted to future periods	1,887	2,054
Unconditional promises to give before unamortized discount and allowance for uncollectibles	67,443	63,753
Less unamortized discount	(4,808)	(6,747)
Less allowance for uncollectibles	(1,723)	(1,610)
Net unconditional promises to give	$ 60,912	$ 55,396
Amounts due in:		
Less than one year	$ 27,241	$ 14,480
One to five years	22,695	29,207
More than five years	17,507	20,066
Total unconditional promises to give	$ 67,443	$ 63,753

In addition, Rush has received conditional promises to contribute that are not recognized as assets in the consolidated balance sheet as of June 30, 2011. The total is not considered material to the consolidated financial statements as of June 30, 2011.

17. TEMPORARILY AND PERMANENTLY RESTRICTED NET ASSETS

Temporarily and permanently restricted net assets were available for the following purposes as of June 30, 2011 and 2010:

	2011	2010
Temporarily Restricted Net Assets:		
Construction and purchase of equipment	$ 30,020	$ 42,051
Health education	6,357	4,406
Research, charity, and other	262,817	215,233
Unappropriated endowment appreciation available for operations	44,054	36,279
Total temporarily restricted net assets	$ 343,248	$ 297,969
Permanently Restricted Net Assets, income from which is expendable to support:		
Health education	$ 141,246	$ 139,140
Research, charity, and other	54,889	45,362
Operations	31,601	29,780
Total permanently restricted net assets	$ 227,736	$ 214,282

During fiscal years 2011 and 2010, net assets were released from donor restrictions for purchasing property and equipment of $34,870 and $18,773, respectively, and incurring expenses of $29,398 and $30,497, respectively, both of which satisfied the restricted purposes of the donors. Net assets released from restriction used in operations are included in other revenue in the accompanying consolidated statements of operations and changes in net assets.

18. JOINT VENTURES AND OTHER AFFILIATIONS

Rush has affiliations with and interests in other organizations which are not consolidated. These organizations primarily operate inpatient and outpatient health services and managed care contracting services.

Investments in unconsolidated joint ventures, accounted for on the equity method, totaled $2,190 and $12,158 as of June 30, 2011 and 2010, respectively, and are included in other assets in the accompanying consolidated balance sheets. Income (loss) recognized from these joint ventures, reported in other revenue, was $(44) and $630 during the years ended June 30, 2011 and 2010, respectively.

RML Health Providers, Limited Partnership (RML) was a limited partnership between Rush and Loyola University Medical Center (Loyola) that operated RML Specialty Hospital, a 174-licensed bed, long-term acute care hospital in Hinsdale, Illinois. Both Rush and Loyola owned a 49.5% limited partnership interest in RML. RMLHP Corporation (RMLHP) held a 1% interest as the general partner of RML, and Rush and Loyola were equal members of RMLHP. Rush received a $560 annual distributions from RML Specialty Hospital during fiscal year 2010. Effective July 1, 2010, Advocate Health and Hospitals Corporation (Advocate) purchased limited partnership interests from Rush and Loyola resulting in Advocate, Loyola, and Rush each holding 33% limited partnership interests in RML. Advocate also became a member of RMLHP. As a result, RML then became the operator of both RML Specialty Hospital and Advocate Bethany Hospital. Effective August 1, 2010, Rush recognized an option to sell its remaining partnership share in RML and received a $6,617 promissory note. This promissory note was received on August 1, 2011.

19. FUNCTIONAL EXPENSES

Expenses related to the patient care, education, and research services provided by RUMC for the years ended June 30, 2011 and 2010, were as follows:

	2011	2010
Healthcare	$ 1,078,965	$ 1,057,314
University services, including research	193,474	175,935
General and administrative	58,978	57,209
Illinois Medicaid hospital assessment	26,306	26,306
Total	$ 1,357,723	$ 1,316,764

20. FICA TAX REFUND SETTLEMENT

Rush has historically paid FICA tax on medical residents as if they were employees. In March 2010, the IRS made an administrative determination that teaching hospitals and medical residents are exempt from paying FICA taxes under the student exception for time spent in a residency program between 1994 and April 1, 2005, when new IRS regulations imposing a specific FICA requirement for medical residents were put into place. Teaching hospitals and residents are eligible for a refund of FICA taxes paid, plus interest. As of June 30, 2010, Rush recorded a FICA tax receivable of $19,690, representing the recovered cost of FICA taxes previously paid and expensed, which was reported in other accounts receivable as of June 30, 2010 since the amount was expected to be collectible within one year. As of June 30, 2011, no amounts were received related to the FICA refund and the receivable of $19,690 was reclassified to other assets in the accompanying consolidated balance sheets since Rush no longer expects that the receivable will be collectible within one year. The FICA refund was reported in salaries, wages, and employee benefits in the accompanying consolidated statements of operations and changes in net assets during fiscal year 2010.

Rush has elected not to record any income related to the interest component of the FICA refund and will recognize the interest when received.

21. ASSET SALES

During fiscal year 2010, Rush completed construction of a new ambulatory building designed to house the orthopedic practices at Rush and certain hospital support functions. A portion of this building was sold to a private physician practice for $26,079.

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Appendix D

2011 Community Benefits Report

RUSH UNIVERSITY MEDICAL CENTER

Rush University Medical Center
Community Benefit Report
Fiscal Year 2008

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I. Introduction

The Community Benefits Act of 2003 mandated that not-for-profit hospitals report on the benefits provided to their communities. Academic medical centers (AMCs) are unlike their community-based counterparts because AMCs attend to the sickest patients and prepare the next generation of health care workers. AMC's also engage in research on new ways to prevent, diagnose and treat illness, thus helping to shape the future of medicine. While Rush University Medical Center is no exception in this regard, its organizational structure is unique. All AMCs in the Chicago area are affiliated with a medical school. The hospital and the medical school are separate corporate entities that support one another via formal operating agreements. Rush is unique in that all components of the enterprise constitute one corporate entity called Rush University Medical Center. The hospital and all patient care activities and Rush University fall under the leadership of one individual, Larry J. Goodman, MD, president and chief executive officer of Rush University Medical Center. This report includes all of the community benefits of Rush University Medical Center, and including both health care and academic missions.

II. Organizational Information: Rush University Medical Center

Rush University Medical Center is an academic medical center that encompasses a hospital for adults and children with 623 staffed beds (including Rush Children's Hospital), the 58-bed Johnston R. Bowman Health Center for older adult and rehabilitative care, and Rush University. It also operates Rush Oak Park Hospital.

Rush brings together clinical care and research to address major health problems, including arthritis and orthopedic disorders, cancer, heart disease, neurological disorders and diseases associated with aging. In the recent *U.S. News & World Report* annual Best Hospitals issue, 7 Rush programs are ranked among the nation's top 50.

Rush has received Magnet status twice, first in 2002 and again in 2006. The American Nurses Credentialing Center (ANCC) Magnet Recognition Program is the highest recognition given for nursing excellence. Rush was the first medical center in Illinois caring for adults and children to receive this prestigious four-year Magnet designation for a second time.

Rush University is home to Rush Medical College, one of the oldest medical schools in the Midwest, and to the College of Nursing, one of the nation's top-ranked nursing colleges. Rush University also offers undergraduate and graduate programs in allied health and management through the College of Health Sciences, and programs in basic sciences through the Graduate College. The Medical Center offers more than 65 highly selective postgraduate residency and fellowship programs in medical and surgical specialties and subspecialties.

Rush is also a thriving center for basic and clinical research, with physicians and scientists involved in hundreds of research projects developing and testing the effectiveness and safety of new therapies and medical devices.

With a history spanning more than 170 years, Rush has been part of the Chicago landscape longer than any other health care institution in the city. Rush Medical College received its charter on March 2, 1837, two days before the city of Chicago was incorporated. Its oldest hospital component, St. Luke's Hospital, was founded in 1864.

Mission

The Mission of Rush University Medical Center is to provide the very best care for our patients. Our education and research endeavors, community service programs and relationships with other

hospitals are dedicated to enhancing excellence in patient care for the diverse communities of the Chicago area, now and in the future.

Vision
Rush University Medical Center will be recognized as the medical center of choice in the Chicago area and among the very best clinical centers in the United States.

Values
Rush University Medical Center's core values — innovation, collaboration, accountability, respect and excellence — are the roadmap to our mission and vision. These five values, known as our I CARE values, convey the philosophy behind every decision Rush employees make. Rush employees also commit themselves to demonstrating these values with compassion. This translates into a dedication shared by all members of the Rush community to provide the highest quality of patient care.

Guided by our shared values and mission, Rush is dedicated to enhancing patient care through research, education and community service. Rush maintains a strong commitment to the community by reaching out to Chicago neighborhoods through projects such as the Rush Community Services Initiatives Program, an umbrella for several student-led outreach programs designed to address the social and health care needs of residents in neighboring communities. The Medical Center's community service efforts also include the Science and Math Excellence Network, a public-private partnership to improve the science and math skills of inner-city children by providing scientific equipment, teacher training and a variety of hands-on experiences. Through this program, students of the West and Southwest side neighborhoods of Chicago receive the same opportunities to learn math and science as are available to students in more affluent areas.

III. Framework and Summary of Rush University Medical Center Community Benefits Report

Within this community benefits report, Rush University Medical Center (Rush) and Rush Oak Park Hospital (ROPH) assign a financial value to various predefined community benefits categories, as well as provide a sense of the breadth and scope of the various community benefit activities inherent in the Rush mission. Rush's mission lends itself to a framework upon which operational and strategic decisions can be based while taking into account the needs of the community.

This report details a number of community benefit activities that fall into each of the four components of Rush's mission statement:

1) To provide the very best patient care for the diverse communities of the Chicago area now and in the future
2) To provide education endeavors to enhance excellence in patient care for the diverse communities of the Chicago area now and in the future
3) To provide research endeavors to enhance excellence in patient care for the diverse communities of the Chicago area now and in the future
4) To provide community service programs and build relationships with other hospitals to enhance excellence in patient care for the diverse communities of the Chicago area now and in the future

1) **To provide the very best patient care for the diverse communities of the Chicago area now and in the future:**

Rush University Medical Center is widely recognized as one of the leading providers of patient care in the Chicago area, as exhibited through national recognition for various programs by many entities, such as the *U.S. News & World Report* and the University HealthSystem Consortium (UHC). This year, the annual UHC study examined 88 academic medical centers from across the country and ranked Rush University Medical Center among the top five centers in the nation based on high performance in quality and safety. The study was guided by six elements of care-patient safety, timeliness, effectiveness, equity of care, efficiency and patient centeredness. Additionally, for the fourth consecutive year, Rush received a perfect score of 100 percent in the category of "equity of care," indicating that Rush's safety and quality of care does not vary regardless of the patient's gender, race or socioeconomic status. Rush focuses on ensuring that all patients, regardless of their ability to pay, receive access to the highest level of patient care.

During fiscal year 2008, Rush and ROPH provided $113.15 million in unreimbursed care to its patients. Unreimbursed care consists of charity care provided to patients who lack the means to pay for services (at cost), bad debt (at expected payment, not charges), and unreimbursed costs for Medicaid and Medicare services. Rush recognizes the need to simplify charity policies and to expand assistance to the growing population of uninsured and underinsured individuals. To assist patients in their hospital bill, Rush offers the following financial assistance programs:

- **Paid in Full Charity Care:** Patients qualify for the Rush Charity Care program if their income level is at or below 250 percent of the federal poverty line. That means that individuals qualify if they earn less than $53,000 and are supporting a family of four. These patients are eligible for a full write-off of their bill.
- **Discounts for Limited Income:** Rush also assists those families with limited incomes, defined as less than $85,000 annual income, who are eligible for a write-off of up to 70 percent of the bill.
- **Discounts for Self-Pay Patients:** Rush also offers an automatic 50 percent discount for individuals who do not have a health insurance plan. For patients who cannot pay their portion of the bill at the time of service, financial counselors work closely with them to set up monthly installments payment plans with no interest at an amount that the patient is comfortable with.
- **State and Federal Programs:** Financial counselors work with patients and alert them if they qualify for one of a handful of state and federal programs such as the state's Medical Assistance program (MANG) or the Social Security Disability program (SSDI). Because the paperwork required for these programs can be overwhelming, Rush has specialists on site who assist patients in the application process. Through these efforts, we have qualified individuals for a social security disability who are not age 65, while at the same time ensuring payment for their hospital bill.
- **Payment plans:** If requested, interest-free payment plans are available to patients. Payments can be made over at most, 24 months. Rush does not assess interest on unpaid balances.

Rush also maintained a patient eligibility service throughout fiscal year 2008 at a cost of $375K. This service focuses on providing patients who arrive at Rush without insurance with the coverage they are entitled to under various federal and state programs. During fiscal year 2007, an additional financial counselor was hired in order to reach out within the hospital to more patients and expedite the process. Coverage was obtained for 539 patients who were initially classified as uninsured, representing more than $34 million in charges. In addition to achieving

insurance coverage for these patients' medical bills, this eligibility service also obtains eligibility for SSI or SSA benefits, which assist patients beyond their hospital stay.

Rush provides a full range of medical services to the community, including an emergency department that is never closed and is open to everyone regardless of the ability to pay, and numerous services that operate at a loss. The emergency department is a key driver of providing care to the uninsured in a hospital setting. Rush continues to emphasize on primary and preventive care for uninsured individuals and families. Through this approach, which relies on the services provided within physician clinics at Rush as well as the community service projects operated by patient care staff, Rush hopes to have an impact on the health of patients before they get to the point of visiting the emergency department. During fiscal year 2008, Rush subsidized $8 million in losses at physician clinics incurred from treating uninsured patients and those covered by Medicaid and Medicare.

Additionally, Rush provided cutting-edge neurological services to the community through a new transfer system that facilitates neurological emergency transfers from community hospitals to Rush within 45 minutes, 24 hours a day. In FY08, this program saw approximately 15% Medicaid patients and roughly 11% uninsured patients.

To ensure that Rush is delivering on its patient care mission to the diverse communities of Chicago, Rush incurred $251K in costs to maintain a staff of employees acting as Spanish language interpreters, and another $187K in costs to maintain a staff of other-language and sign language interpreters. These financial commitments are critical to provide the best patient care to the diverse communities of the Chicago area.

2) **To provide education endeavors to enhance excellence in patient care for the diverse communities of the Chicago area now and in the future**

Rush is committed to providing programs to educate and train the health care workforce of the future. It is widely recognized that workforce demands in health care will rapidly escalate as the U.S. population ages. To help meet this need, Rush maintains programs to train future physicians, nurses and allied health professionals. During fiscal year 2008, Rush provided $36 million in unreimbursed costs to maintain these education programs. It is an essential part of Rush's corporate mission that education programs continue to receive this operational support to supply highly trained physicians, nurses and allied health professionals, not only to Rush, but to the larger health care community.

Rush University is a recognized leader in life sciences education in Chicago and around the country and is nationally ranked by the *U.S. News & World Report* as a provider of top graduate programs. Each of the four colleges, the Rush Medical College, the College of Nursing, the College of Health Sciences and the Graduate College, supports the research and patient care endeavors of the Medical Center.

Rush Medical College
Daniel Brainard, MD, a native of New York educated in Philadelphia, founded Rush shortly after his arrival to Chicago. The new college received its charter in March 1837, two days before the city of Chicago was chartered. Brainard named Chicago's first medical college, one of the first in the region, in honor of Benjamin Rush, MD, a physician-statesman who signed the Declaration of Independence.

The medical college provides educational opportunities in an environment that emphasizes competence and compassion in the provision of patient care. The medical college is committed to attracting candidates from diverse backgrounds who will make the physician population more representative of the national population. As an academic medical center, Rush University Medical Center is able to provide a unique learning experience for its students. For example, Rush is the primary academic affiliate of the John H. Stroger Jr. Hospital of Cook County (Stroger Hospital). Stroger Hospital is one of the busiest and most venerable public hospitals in the nation, and provides a valuable training ground for Rush medical students. In addition, the patient population at Stroger Hospital benefits from access to Rush specialists. Each year, more than 400 Rush students and postgraduate residents receive training at Stroger Hospital, in areas ranging from vascular surgery to breast cancer. (The collaboration with Stroger Hospital is covered in more detail on pg. 20)

To continue the spectrum of medical education, Rush has over 60 graduate medical education (GME) programs. The mission for GME at Rush is to develop and provide educational training programs of the highest quality for resident physicians and fellows (medical school graduates seeking advanced training and board certification in a medical specialty area) with the ultimate aim to develop physician competencies and improve and promote patient health care. A key goal of the GME programs is to link Rush's considerable academic resources with those of affiliated institutions in order to provide a widely diverse and representative educational environment and patient mix. Rush is committed to maintaining excellence in the GME programs and to providing our house staff physicians an environment conducive to outstanding clinical experience, expert teaching and personal well-being.

In addition, the Rush Community Service Initiatives Program (RCSIP) provides a forum for Rush Medical College students to become involved in meeting the social and health care needs of the Chicago population. The specifics of the RCSIP program will be discussed in more detail in section 4 of the summary portion of this report.

College of Nursing (CON)

The mission of the College of Nursing is to respond to the health needs of a diverse society by preparing future generations of highly qualified clinician nurse leaders, to generate and disseminate knowledge that advances the scientific basis of nursing practice and to provide innovative leadership in nursing education. This mission supports and sustains the goals of Rush University Medical Center and the education of nurses who improve clinical outcomes through evidence-based, patient-centered care.

The heritage of the College of Nursing dates back to 1885, when the college's first antecedent, the St. Luke's Hospital Training School of Nursing, opened to offer diploma education to nurses. In 1903, the Presbyterian Hospital School of Nursing accepted its first students. From 1956 to 1968, nurses were taught at the merged Presbyterian-St. Luke's School of Nursing. Before the establishment of the College of Nursing in 1972, more than 7,000 nurses had graduated from these schools. More than 5,800 baccalaureate, masters and doctoral students have graduated from the College of Nursing since then. The College of Nursing consistently ranks among the top 5 percent of U.S. nursing schools, according to the *U.S. News & World Report*.

As discussed above, Rush has been recognized as a "Magnet Hospital," by the American Nurses Credentialing Center (ANCC), a testament to the excellence of the nursing program. Many of the individuals responsible for achieving this important designation are also responsible for training future nurses enrolled in the Rush College of Nursing.

College of Health Sciences (CHS)
The College of Health Sciences, founded in 1975, is responsible for education and research in the allied health professions. More than six of every ten health care workers in the United States work in an allied health field, and the demand for these professionals is expected to increase significantly because of the aging population. More than 50 categories of professionals make up this largest segment of the health care workforce.

Faculty members of the College of Health Sciences serve the Medical Center as practitioner-teachers. Nearly all have patient care or service responsibilities while concurrently filling roles as teachers and investigators. Through the faculty, Rush University students have access to managers in a dynamic academic medical center with skilled clinicians employing the latest treatment and practice patterns.

The Graduate College
The primary mission of the Graduate College is to promote and assure excellence in educational programs in selected disciplines of the medical sciences. The Graduate College promotes cooperative efforts in achieving high quality education and research programs to prepare students for successful careers and lifelong professional development. The essence of the college, which provides doctoral education in the basic sciences, is the excitement of discovery and conveying that excitement to other scholars.

Recent records indicate that nearly 15 percent of Rush Medical College graduates practice in the Chicago area. This statistic reflects the importance of Rush in the community. Additionally, over 75 percent of Rush College of Nursing graduates begin their careers in the Chicago area and continue to contribute to the community. Both medical and nursing graduates go on to provide outstanding patient care at Rush and other institutions, and all draw on the exceptional education and experience through their involvement with Rush University Medical Center.

3) To provide research endeavors to enhance excellence in patient care for the diverse communities of the Chicago area now and in the future

Rush is committed to advancing medical care through translational research that aims to bring advances and improvements gained in research as rapidly as possible to the bedside of patients. Investigators at Rush are involved in numerous clinical studies to test the effectiveness and safety of new therapies and medical devices, as well as many basic research studies designed to expand scientific and medical knowledge. Like the academic affiliation between Rush and Stroger Hospital, there is similar collaboration within research activities. Joint research projects in basic science, clinical science and services and epidemiology look for new ways to improve the health of vulnerable communities and bridge the widening gaps in the health care system. As an academic medical center, Rush brings together individuals from diverse backgrounds with varying experience, with the intention of uncovering new advances in patient care. In this way, Rush is able to act as an incubator for noteworthy breakthroughs in medicine. In recognition of this important mission, during fiscal year 2008, Rush supported $10.1 million in unreimbursed costs to maintain these research activities.

The following three examples of current research activities at Rush illustrate the wide array of community-based and clinical research:

Alzheimer's Disease Community-Based Epidemiologic Studies
The Rush Institute for Healthy Aging (RIHA) and the Rush Alzheimer's Disease Center (RADC) were created around 1990 to conduct research into the causes and treatment of age-related

neurological diseases and conditions, including the increasingly common and devastating, Alzheimer's disease. Rush research includes multiple, longitudinal community-based cohorts (large, distinct groups of people) in the city of Chicago and nationwide, including:

- The Chicago Health and Aging Project (CHAP), established in 1993, is a geographically-defined, epidemiologic study of four Chicago neighborhoods (60% black, 40% white) that includes over 10,400 study participants aged 65 years and older. The study includes data linkage to the National Death Index, Medicare data, and the Chicago Department of Public Health data on elder abuse. CHAP and its ancillary studies provide information on study participants, including exercise, smoking, health history, neighborhood characteristics, physical disability, genetics, biochemical measures, care giving, psycho-social information, behavioral symptoms, and medication use.
- The Religious Orders Study, started in 1993, includes 1,131 older priests, nuns and brothers in 40 sites around the country and nearly 390 in the metropolitan area of Chicago.
- The Memory and Aging Project, started in 2000, has a cohort that includes 1,241 Chicago older residents of retirement communities.
- The Minority Aging Retirement Study begun in 2003 and studies 354 older community-dwelling African Americans in Chicago.

The high community participation and high rates of follow-up are due in part to the respectful and personal approaches used to engage the communities and the practice of sending Rush research personnel to participants' homes for all data collection. No research participant has to travel to the Medical Center for any component of the studies. The studies involve yearly interviews and/or clinical evaluations, imaging, blood drawing, and for two of the studies, the donation of after death of brains and spinal cords, and neuro-pathological analysis of the tissue. The RADC also provides patient care and support services, conducts randomized clinical trials in disease treatment and in care-giver behavioral interventions, and sponsors a multicultural outreach program to engage the Chicago community in research. The program supports two community outreach workers who network with community organizations to learn about health and other concerns of the organization's constituents, and to inform the organizations and constituents about best practices for managing disease and the importance of research. Clinicians, along with community and basic scientists meet periodically to discuss best clinical practice and methods for dissemination of these practices to clinical staff, patients and caregivers, and the broader community.

Chicago Parenting Program

The Chicago Parenting Program, led by the College of Nursing, was developed in 2002 with NIH funding to support parenting skills and prevent behavior problems in young children. The 12-week program, which is offered through day care centers serving low-income African-American and Latino communities in Chicago, equips parents of children between the ages of 2 and 4 with new parenting skills and positive child discipline strategies. The instruction offered through the Chicago Parenting Program helps decrease child misbehavior. The study examines incentives, such as offering the program in Spanish and providing a discount in the parent's portion of their childcare fee. The impact of the Chicago Parenting Program is growing nationally and the program is now being used across the country and in Chicago Head Start. Fourteen Chicago Parent Program groups have been led in 6 Chicago Head Start sites since beginning this initiative in 2006, benefiting 124 families and approximately 248 children.

Behavioral Interventions and Cardiovascular Disease
The Rush Department of Preventive Medicine has a long history of community research, teaching, and training dating back to the 1970's. Since 1990, the Department has received $50 million in National Institute for Health (NIH) funding to conduct community-based translational research. The Department is one of the 40 clinical sites for the Women's Health Initiative, which involves a volunteer sample of 2300 post-menopausal women from Chicago and its suburbs, of whom 65% are minority. The study includes three clinical trials and an observational study designed to determine optimum treatments for post-menopausal women to prevent major chronic illnesses including heart disease, cancer and osteoporosis. Investigators participating in the study represent an array of disciplines from the basic sciences and clinical medicine to the population sciences. The Women's Health Initiative recently published studies that changed traditional beliefs about the benefits of hormone replacement therapy in women, and subsequently affected the medical treatment of Chicago women and women nationwide. The study reported no benefit in receiving hormones for the prevention of heart disease, and increased the risk of breast cancer, stroke and cognitive decline. The Department is also one of seven sites of the SWAN study of the natural history of the menopausal transition. The Chicago site includes 868 African American and Caucasian women and is studying the early pathogenesis of cardiovascular disease in women. Identification of modifiable risk factors translates into clinical trials aimed at reducing cardiovascular risk. Just completed is the HART trial, the largest behavioral trial in patients with heart failure ever funded by NIH.

4) **To provide community service programs and build relationships with other hospitals to enhance excellence in patient care for the diverse communities of the Chicago area now and in the future**

In addition to dedicating resources to patient care, education and research activities, Rush has historically placed emphasis on community service activities and relationships with other health care organizations. During fiscal year 2008, Rush provided more than $1.9 million in other community benefit programs as well as an $2.2 million of volunteer time for various community service projects. In addition, Rush made $400,000 in direct donations to various community and medical organizations throughout the Chicago area. In total, Rush contributed $4.5 million of quantifiable community benefit to numerous programs that are summarized below.

Community Service Projects
Rush's educational mission drives the organization to expose its students to the numerous public health disparities in Chicago, while also giving students the opportunity for hands-on learning and experience. Detailed below are a number of programs that demonstrate the institution's commitment to improving the health of the Chicago community.

Office of Community and Global Health (OCGH): In FY08, the Rush University Office of Community and Global Health was established in order to promote, create and organize interdisciplinary community service learning activities across the university. The office and its staff work closely with Rush's administration, faculty, and students as well as with community contacts throughout Chicago and overseas. Educational and scholarly initiatives within community outreach programs do not only fulfill Rush's mission to provide optimal care to its diverse communities, but exceptional education to its many colleges as well.

The establishment of such an office will advance the stated institutional mission surrounding patient care and provide a "home" for the numerous volunteer activities already taking place, while allowing for further community work development. The OCGH provides oversight for the Rush Community Service Initiative Program (RCSIP).

The Rush Community Service Initiatives Program (RCSIP) was established in 1991 to create a network of community service programs that match Rush Medical College student interest and initiative with the social and health care needs of the Chicago population. Students have the opportunity to participate in any of the 24 clinical and non-clinical community service programs, which are administered through the RCSIP office and overseen by attending physicians at Rush.

RCSIP's mission is to do the following:

a) Identify services in the Chicago area that could benefit from the voluntary assistance of Rush students.
b) Match these service needs with students' desire to be part of an active community service experience.
c) Coordinate activities to the mutual benefit of all parties involved.
d) Evaluate the effects of community service experiences on the students' learning and development.

RCSIP aspires to be a model for academic medical centers that wish to develop innovative ways to train future health care professionals in community health, social and behavioral medicine, as well as primary care.

Student participation in RCSIP is strictly voluntary, and students do not receive academic credit for their involvement. However, they do receive valuable experience by serving the poor and disenfranchised as well as by collaborating with community representatives and working closely with Rush Medical College faculty, fellow students, and agency staff. Electives, research fellowships and faculty assistance with student projects are offered to qualified participants. Leadership opportunities are also available and tend to be competitive for the clinical programs. Opportunities exist for students to develop special projects in conjunction with ongoing programs or to establish new programs. Approximately 90 percent of Rush Medical College students volunteer in one or more activities.

RCSIP programs allow students to apply the knowledge gained in the lecture hall to real-life settings. By participating in RCSIP, medical students are exposed to the challenges of serving disadvantaged populations as well as to community health, social and behavioral medicine, and primary care. The hope is that students exposed to such diverse populations and settings will become more culturally competent as providers, which will serve them well as future physicians. **RCSIP programs are detailed below:**

<u>RCSIP Clinical Programs:</u>

- ***Clinic at Franciscan House of Mary & Joseph:*** The Franciscan House of Mary & Joseph on Chicago's Near West Side provides a meal, a shower and a safe place to sleep for up to 235 men and 35 women each night. The shelter is located about one mile west of Rush, and is the largest overnight shelter in Chicago. The Clinic at Franciscan House of Mary & Joseph is the major source of medical care for many of the shelter's residents. In serving each patient, the medical students complete an initial interview, perform the physical examination, and present the patient information to the attending physician. The team then explains the patient' individual treatment plan and provides any necessary medications to the patient. Staffed exclusively by Rush students and physicians on Tuesday evenings, the clinic serves the primarily English-speaking patient population. In fiscal year 2008, 277 volunteers provided triage, took histories and provided physicals and distributed medications to 1,915 patients.

RCSIP Clinical Programs (Continued):

- ***Clinical Training Program:*** Trained by senior nursing students, 1st year medical students who volunteer in health-related events and health fairs learn how to give flu shots and vaccines. In FY08, 128 individuals received medical services from 20 1st year medical students.

- ***Community Health Clinic:*** The Community Health Clinic is a nonprofit volunteer organization providing free preventive and primary health care services to members of the community who cannot afford or are ineligible for medical insurance. One evening each week, students and physicians from Rush help to staff the clinic, located 10 minutes north of the Medical Center.

  The clinic offers services ranging from routine physicals and immunization programs to a full laboratory and pharmacy. First- and second-year medical students triage patients, inquire about the nature and course of the patient's illness, perform laboratory procedures, and observe and participate while patients are examined and treated. Third- and fourth-year medical students examine patients, diagnose and recommend a treatment plan under the close supervision of attending physicians. In addition, Rush students work with an otolaryngologist at Rush who is scheduled on a monthly basis. This clinic has a multilingual population with the majority Spanish-speaking and a significant Polish-speaking contingent. In fiscal year 2008, the medical students at Community Health Clinic evaluated 589 patients.

- ***Door of Hope:*** At a Southside Chicago mission, students triage patients, addressing basic needs including but not limited to athlete's foot, headaches and colds. Students also administer flu vaccines during flu season and in fiscal year 2008, it reached out to 400 individuals through this endeavor.

- ***Freedom Center (Formerly the Pilsen Homeless Health Services):*** Freedom Center provides free health care for men, women and children in the Pilsen community. Pilsen, located a few miles south of Rush, is a neighborhood composed primarily of Mexican immigrants. It is a self-contained community, with Spanish as the predominant language. When Freedom Center opened its doors for the first time in October 1994, its main intent was to serve the homeless community in Pilsen. Since then, the clinic has earned the trust of the community and has been serving a wider range of people.

  First- and second-year medical students take histories, examine patients and present their cases to the attending physician. Students then discuss the diagnosis with the patient and administer medication, if prescribed. In fiscal year 2008, 460 people received services at the Freedom Center.

- ***Medical Mobile Van (Formerly the Medical Outreach Van):*** This RCSIP program offers a unique opportunity to work with underserved populations directly on the streets of Chicago. The medical mobile van is a mobile health care delivery unit that provides medical care free of charge to the homeless and disenfranchised. As part of this program, students visit two principal locations: 16th and Cicero and Lower Wacker Drive. At 16th and Cicero, the majority of patients are former or currently active drug users. The residents of Lower Wacker Drive are homeless. Through the experience of observing and interacting with these populations, students gain a better understanding of some of the social and health care challenges faced by these groups. In fiscal year 2008, 215 people benefited from this program.

RU Caring Interdisciplinary Student Program: Through the RU Caring program, students from across Rush University work to combine the expertise of various disciplines to create an interdisciplinary community service program. The program involves students from Rush Medical College, the College of Nursing, and the College of Health Sciences (including programs in such areas as occupational therapy, clinical nutrition, health systems management, audiology, and clinical laboratory sciences). Similar to RCSIP initiatives, this program is voluntary and student-led, and gives students an opportunity to provide community service; develop and hone clinical, interpersonal and leadership skills; and work with students from other health disciplines, while simultaneously taking care of patients in underserved communities in the greater Chicago metropolitan area. RU Caring exposes medical students to an interdisciplinary, team approach to medicine. By working directly with students from other disciplines, such as nursing, occupational therapy, audiology, nutrition and health systems management, medical students develop a better understanding of the role different disciplines play and how the separate disciplines complement each other to create the optimal patient care experience.

The students work together to conduct monthly health-related events and health fairs using an interdisciplinary approach. This program engages all students and faculty within the university. The RU Caring programs served 800 people in fiscal year 2008.

- ***20/20:*** 20/20's mission is to provide free vision services to underserved populations. Student volunteers apply their clinical and non-clinical skills to screen adults and children for eye diseases, such as glaucoma, cataracts, amblyopia, and strabismus. In fiscal year 2008, 420 individuals benefited from this program.

RCSIP Non-Clinical Programs:

- ***A Day In the Life of Rush University:*** Rush Medical College held an event that invited high school students from throughout Chicago to experience an interdisciplinary approach to medicine. This program exposed 120 students to the many facets of being a physician at an academic medical center. Participants "managed" fictitious patients in various areas of the hospital and were given the opportunity to ask questions of the interdisciplinary panel at the end of the day.

- ***BUDDIES Program:*** The BUDDIES program, working in cooperation with the Department of Pediatrics and the Department of Family Medicine, matches Rush medical student volunteers with chronically ill children. Student volunteers become special "buddies" for the children. Students do not administer any medical care or advice but rather act as mentors, advocates and, most important, friends. In the last fiscal year, 60 pediatric patients were helped by this program.

- ***Casa Juan Diego Tutoring:*** Casa Juan Diego is a youth center located in nearby Pilsen. Sponsored by St. Pius Catholic Church, the center provides Latino youth from the ages of five to 17 with academic, recreational and religious activities. Rush students volunteer to do interactive, hands-on science experiments with groups of young children to encourage their interest in science. In addition, medical students assist older students with their homework or English language skills. During fiscal year 2008, 35 students received tutoring or other assistance services.

RCSIP Non-Clinical Programs (Continued):

- ***Chicago Christian Industrial League (CCIL):*** CCIL was established in 1909 with the mission of providing the resources, opportunities, and support necessary so that poor and homeless Chicagoans can return to the workforce and lead independent lives. A new partnership with Chicago CCIL occurred in FY08 and together they provide bi-monthly clinical services which include, triage, histories and physicals and distribution of medication. In FY08, 100 individuals were helped by this program.

- ***Community Education and Outreach:*** A new program as of fiscal year 2007 is located at the Salvation Army's Temple Corp where Rush students tutor and mentor the children who attend the Army's after school program. Since the start of this weekly program, approximately 400 students have been assisted in their scholastic goals as of fiscal year 2008.

- ***Health Educators/ASAP:*** Health Educator volunteers visit elementary and middle schools in nearby Chicago communities to teach kids the basics of sexual and reproductive health, nutrition, hygiene and puberty. ASAP—The Adolescent Substance Abuse Prevention (ASAP) curriculum is based upon the premise that in order for children to make healthy choices, they must be equipped with the knowledge and skills to understand the consequence of their choices. To achieve this goal, ASAP builds upon children's natural curiosity to teach important facts and develop resistance skills to avoid drug use. Volunteers teach at least one session each academic year. Each one-hour course session covers age-appropriate topics for students who range from third to eighth grade. This program reached 500 children over the course of the last fiscal year.

- ***Henry Horner Tutoring Program:*** The Major Adams Academy, a short drive from Rush and close to the United Center, serves children who live in the surrounding housing development. The community is currently going through intense upheaval as families' homes are being torn down and neighbors are being relocated due to a Housing Urban Development (HUD) rehabilitation plan.

  In an attempt to offer some sense of stability and support, RCSIP is coordinating a tutoring program where medical students assist children from first through ninth grade with homework and other academic activities. This service program is unique in that it draws more on interpersonal skills than knowledge of science. Our past visits included helping with homework, completing supplementary worksheets, playing games, making masks for Halloween and playing in the gym.

  This program allows the children from Henry Horner Homes to develop a relationship with someone from outside their community, helping them to have varied life experiences and exposure to students in the health professions. In fiscal year 2008, 69 students received tutoring through this program.

- ***Marah's Place Health Education Program:*** Marah's Place is a shelter affiliated with Deborah's Place, an organization dedicated to moving women out of homelessness and into housing. The mission of Deborah's Place and Marah's Place is to help women by providing programs to enable them to become more self-sufficient, and includes art therapy, employment counseling and social services.

  Students involved in the Marah's Place Health Education Program prepare and present health education seminars to women who use the shelter's services. Seminar topics include mental

RCSIP Non-Clinical Programs (Continued):

health, cardiovascular health, breast health, pelvic health, diabetes and gastrointestinal health. The goal of the program is to expose students to the social and health issues of women who are homeless through one-on-one contact, while also providing an opportunity for students to learn more and teach others about various disease processes. Most important, students are able to help these women move toward self-reliance through education. In fiscal year 2008, 120 women benefited from this initiative.

- ***Maternal Advocates Program:*** The Maternal Advocates Program was reorganized during fiscal year 2008 in order to provide medical education classes to pregnant teens. During the last fiscal year, 150 mothers received the attention and comfort of the Maternal Advocates Program.

- ***Pipeline Programs:*** Through the Pipeline Programs Rush students reach out to younger students from Chicago grade schools through college in the hopes of exciting them about a career in healthcare. The participant tour of Rush Medical College includes: visiting the simulation lab where they learned how to assess a patient should a loved one fall ill; they also visit the anatomy lab to view healthy organs and see the impact of smoking, drugs and alcohol on the human anatomy. At the end of their visit, students and faculty hold a discussion on how to prepare for a career in healthcare. Rush provided 60 volunteers in fiscal year 2008 to work with 1,000 students city wide.

- ***Red Ribbon Friends (Formerly Pediatrics AIDS – Big Sib Program):*** In conjunction with Children's Memorial Hospital (CMH), this program matches medical students as big brothers and sisters with children affected directly or indirectly by HIV. In addition to spending time with the children and their families, this program allows students to work with the HIV team members, including social workers, child-life specialists and doctors, and to become familiar with CMH's special infectious disease clinic (HIV/AIDS).

  The focus of this program is not to learn the technical skills needed to be a doctor, but to learn how to observe and learn the personal skills needed to be a good doctor. The students interact with the patients in a non medical manner through trips to movies, walks in the park, and other outings such as theater viewings. The experience also provides a unique opportunity for students to build lasting relationships with special children and their families. In fiscal year 2008, 41 pediatric patients participated in the Red Ribbon Friends.

- ***Rush Remedy:*** In an effort to "go green," eco-conscious medical students and hospital staff at Rush have started Rush Remedy, a medical supply recovery and recycling program that collects unused medical supplies and equipment and provides them to overseas hospitals and clinics-in-need.

  Volunteers of this grassroots movement, which started in January 2008, have collected and donated over 12,000 pounds of unused medical supplies such as surgical packs, surgical gloves, gauze, bandages, sutures and catheters.

Science and Math Excellence Network (SAME Network)
The Science and Math Excellence Network (SAME Network) is a large-scale community service enterprise operated through the Department of Community Affairs at Rush. The SAME Network was developed to improve the science, math and reading test scores in Chicago schools

surrounding Rush's West and Southwest side neighborhoods. Formed in 1990, the SAME Network provides students in these neighborhoods with the same opportunities to learn math and science as are available to their peers in more affluent areas. Rush Community Affairs staff spearheaded the SAME Network's first effort to improve education in the area by raising funds from the Chicago business community to build state-of-the-art science laboratories in local schools that lacked these facilities. Since then, the SAME Network has grown to a collaboration between Rush and 43 elementary schools, six high schools and many local businesses.

Rush University Medical Center is dedicated to the delivery of high quality, compassionate, comprehensive health care. Our dedication to promoting a healthy community has fostered a strong Medical Center commitment to support the growth and development of our neighborhood as well. Reflecting this mission, the Department of Community Affairs at Rush conducts a variety of programs in collaboration with our neighbors to maintain the health and well-being of our community and its people through the following programs:

- ***College Internship Program:*** The College Internship Program support students as they matriculate through college. Eligible students receive scholarship assistance and academic support. The students are given an opportunity to work at Rush University Medical Center in an area close to their related career choice. The students return from colleges and universities across the United States during the holiday season and summer break to learn, work and interact with patients, peers, and management. College students receive mentoring through preceptor relationships with professionals at Rush University Medical Center. During fiscal year 2008, 17 college students benefited from this program.

- ***College Preparatory Enrichment Program (CPEP):*** SAME Network collaborated with Chicago Public Schools and Benedictine University, Lisle, Illinois on an enrichment program. The CPEP offers students an opportunity to participate in year-round after-school and summer learning activities. The intent of the CPEP is to provide students with the experiences they need to pique their interest in science and math, pursue college entrance and, potentially, a science-related career. Students who participate in the CPEP have the opportunity to become involved with SAME Network's High School Internship Program when they graduate from elementary school.

  The program is geared to students entering seventh grade that attend SAME Network schools. The students are recommended by their school principals and teachers because they show academic promise in the areas of science and math. During the summer, students are exposed to campus living, which provide them with the experience of living away from home. Coupled with campus life, the students receive instruction in math, science, and technology. Field trips to educational institutions in the western suburbs and fun outings are a part of the experience. Students work independently, collaboratively, and cooperatively on inquiry-based science tasks emphasizing high-order thinking skills while integrating math and technology. Families participate in a variety of activities throughout the year. In FY08, 24 students participated in this program.

- ***Educator Program (formerly Preschool Teachers' Program):*** Professional development workshops provide teachers opportunities to gain new skills in science, math, and technology and to hone existing skills. Workshops are a venue for teachers to network, share ideas, concerns, and problem solve. SAME Network teachers are provided with additional support in the form of coaching, mentoring, and one-on-one time as needed. Teachers that attend the workshops can receive State of Illinois Continuing Professional Development Units. During the course of fiscal year 2008, 146 educators participated in this program.

SAME Network Programs (Continued):

- ***High School Internship Program:*** In conjunction with Chicago Public Schools through the SAME Network, the program provides a variety of internship experiences to high school students. The objectives of SAME's internship program are to encourage students to pursue education and careers in math, science, and technology fields, provide students with hands-on experience, classes and mentoring; and develop good work habits, ethics and job readiness skills. A mentoring relationship was developed between the internship students and Rush's Health Systems Management faculty and staff. After graduating from high school, students are eligible to transition into the College Internship Program. Throughout high school, the students work at Rush University Medical Center in various departments. Over the last fiscal year, 23 students participated in the program.

- ***Preschool Program:*** In 1998, SAME Network developed this program to introduce preschool children to science, math, and literacy skills. The program currently operates in 26 public and private schools. The goal of the SAME Preschool Program is to provide a stimulating environment for guiding children in the development of science, math, and literacy skills by providing science labs and materials appropriate for young children. Children begin to understand fundamental science concepts and develop inquiry skills by using their natural curiosity to motivate exploration of their surroundings. The ultimate objective of the science program is to have the preschool children achieve science literacy, which is necessary for them to succeed in a world filled with science. SAME Network offers workshops to parents of children participating in SAME Network sponsored preschool program. SAME believes early parental involvement is crucial for children to be successful in school. During fiscal year 2008, this program reached 1,076 preschool children.

- ***Dr. Martin Luther King, Jr. Humanitarian Awards Banquet:*** The SAME Network sponsors an annual awards banquet to honor students for achieving excellence in math and/or science. The awards banquet is also an incentive for students to strive for academic excellence in preschool through college. Top students in the SAME Network schools and college students attend the black-tie affair and the Network pays for all expenses. In fiscal year 2008, 74 students were honored and there were a total of 540 people who attended the annual awards banquet.

- ***Rev. Dr. Martin Luther King, Jr. Memorial Service:*** An annual memorial tribute to the memory of the late Rev. Dr. King, Jr. is held in honor of his contribution to humanity and to keep his legacy alive for the young and old. This tribute is held at Rush University Medical Center during the MLK holiday and is attended by community residents and Medical Center's employees. During FY 08, approximately 150 people attended the memorial tribute.

- ***Senior Coalition:*** The Senior Coalition was established to address the health and social needs of seniors. Senior Coalition members belong to churches that are affiliated with the Rush Department of Community Affairs and participate in events sponsored by Rush's Johnston R. Bowman Center and the Department of Community Affairs. In fiscal year 2008, 473 seniors participated in this program.

Pediatric/Adolescent Community Health Programs: The following programs are provided by the Department of Pediatrics:

- ***Kids-Shelter Health Improvement Project (Kids-SHIP):*** The Chicago Coalition for the Homeless estimates that approximately 26,000 children and youths experience homelessness in Illinois over the course of a year. The majority of these children and adolescents have no primary care physician and no medical home. As such, they usually receive medical care on an intermittent basis, and treatment is usually sought only when medical problems become severe. Many of these children do not receive routine childhood immunizations and, because of the irregularity of their medical care, they have no record of their medical history. These pediatric populations are in desperate need of comprehensive health care tailored to their physical, emotional and logistical needs. This underserved population is the focus of the Kids-Shelter Health Improvement Project initiative and Rush has supported 8,500 patient visits since beginning this program in 1997.

  Kids-SHIP provides initial health care services to homeless children and adolescents through a medical outreach team and follow-up care, if needed, at the Kids-SHIP Clinic, housed in the Pediatric Primary Care Center at Rush. The medical outreach team is made up of an attending pediatrician from Rush, pediatric residents from multiple teaching institutions (including Rush Medical College, the John H. Stroger Hospital Jr. Hospital of Cook County and the University of Chicago), and medical students from Rush who travel to 9 homeless shelters on the West and South Side of Chicago to provide on-site medical services to children and adolescents facilities. (Four of the 13 facilities in fiscal year 2006 have closed in the last year due to government cuts.) In fiscal year 2008 the physicians of Kids-SHIP saw 500 patients. By initiating contact with homeless children, this program has reduced barriers to care for the homeless, improved the overall health status of this population and encouraged the use of available health care resources among homeless families.

- ***Rush University Medical Center Adolescent Family Center:*** The Rush (AFC) provides prenatal care, gynecological care, contraceptive services, STD testing and treatment and community education to Chicago area teens and young adults ages 12-23 years. All of the AFC's services are provided regardless of income or ability to pay for care. Pregnant uninsured patients are provided on-site assistance in enrolling in Medicaid for their prenatal care while uninsured patients who are not pregnant have their services completely funded through the clinic. Although the AFC draws patients from over 100 Chicago area zip codes, the majority of patients served reside in the Chicago West side communities of East Garfield Park, West Garfield Park, North Lawndale, Austin and the Near Westside. AFC staff also provide free community education on reproductive anatomy, contraception, pregnancy prevention, STD infection prevention and reproduction to Chicago area high school and middle school students as part of their school's sex education curriculum.

  During fiscal year 2008, the AFC provided a total of 3,492 direct medical care clinic visits to 1,143 patients. The AFC provided 1,603 prenatal care clinic visits to 220 pregnant teens and young adults almost all of which were covered by Medicaid. The AFC also provided 1,889 gynecological/contraceptive services clinic visits to 923 sexually active teens and young adults. Of the 1,889 contraceptive services visits 57% were no fee and 43% were funded through Medicaid.

  In addition program staff conducted 235 free community education presentations involving 6,944 teens in 12 Chicago area high schools and middle schools. For the year the AFC budget

totaled $540,011 with $77,309 of that total going to pay for free contraceptives, lab testing, diagnostic tests, medications and educational materials.

- ***Rush-Stroger Affiliation Agreement-Pediatrics:*** Rush provides Pediatric and Adult Subspecialty physicians services at or below cost to Stroger Hospital to provide advanced high quality subspecialty medical care to the patients at Stroger. The Pediatric subspecialty medical services include: Pediatric Allergy/Immunology; Pediatric Critical Care; Pediatric Endocrinology; Pediatric Gastroenterology; Pediatric Infectious Disease; Pediatric Neurology; Pediatric Pulmonary Medicine.

- ***Pediatric Infectious Disease Faculty Outreach:*** The Department of Pediatrics at Rush volunteers with the Chicago Department of Public Health to provide care for complex tuberculosis patients at West Town Neighborhood Health Centers for half days every other week. This provides immigrant, minority, and underserved populations with tuberculosis access to specialized medical expertise.

  The Department of Pediatrics recently began working with Children's Place to provide HIV care for children in Haiti. Physicians from Rush provide HIV evaluations and care for children adopted from foreign countries with HIV.

- ***Reach Out and Read:*** Established by a group of doctors at Boston City Hospital in 1989, Reach Out and Read was created to help low-income families develop the reading habits that promote early childhood literacy. Many children who come to Rush Children's Hospital are from low-income families. In the Rush Pediatric Care Group, 84% of the patients served receive public assistance and many are teenage parents. These patients can especially benefit from a program like Reach Out and Read at Rush. The Pediatric Primary Care Center became a participant in this national program at Rush in 1999. Pediatricians, nurses and pediatric residents discuss the importance of reading aloud to young children as a means to increase language skills and promote a life-long love of learning. The program allows pediatricians at Rush to utilize routine appointments to introduce and promote the value of reading to parents and their children, thereby promoting cognitive development activities that contribute to healthy child development. Since the inception of the Reach Out and Read program in 1999, the program has been sustained through the generosity of individuals and foundations committed to literacy promoting activities.

  New developmentally-appropriate and culturally-sensitive books are given to patients at health maintenance visits. Volunteer readers model good reading techniques in the office waiting room. The Rush Pediatric Primary Care Center has over 30,000 visits/year and will distribute more than 50,000 new books this year as well as thousands of gently-used books. In addition, the MedPeds Lifetime Medical Associates practice is also a Reach Out and Read Site.

- ***Rush University Medical Center Adolescent Clinic:*** Located in Evergreen Park, a southwest suburb bordering Chicago, the Adolescent Clinic provides gynecological care, contraception, family planning counseling, STD testing and treatment, STD/HIV risk assessment, education and counseling, pregnancy testing, counseling and referral, and community outreach education. All services are specifically tailored for adolescents and young adults in need of low/no-cost care regardless of income, medical insurance or ability to pay.

  Rush's Adolescent clinic's mission is to reduce unintended pregnancies and the transmission of sexually transmitted diseases (STDs) and HIV/AIDS in adolescents and young adults by

providing access to information and affordable reproductive healthcare including contraception regardless of income, medical insurance or ability to pay. Bridging the gap between pregnancy and STD, HIV/AIDS prevention education and services, the Adolescent Clinic provides young women and men with the means and motivation to make responsible choices about reproductive health and contraception, thus reducing the incidence of unwanted adolescent pregnancies and the prevention of sexually transmitted infections.

The Adolescent Clinic has been a program at Rush since 1991. It has, however, been providing services to area adolescents and young adults since 1974 and has been funded with federal Department of Health and Human Services Title X funds since its inception. In 1985 the Illinois Department of Human Services became the Grantee of Title X funds for the state of Illinois and the Adolescent Clinic became a delegate agency of the Illinois Department of Health and Human Service. In fiscal year 2008 the Adolescent clinic provided family planning services for 1,402 patients, over 97% of these patients were below poverty level and no fee was charged for services.

Other Community Service Programs and Collaborations:

- ***Cook County Bureau of Health Services:*** After many years of informal collaboration, Rush University Medical Center and neighboring John H. Stroger Jr. Hospital of Cook County, one of the busiest public hospitals in the nation, formally affiliated in 1994. With this partnership, Stroger Hospital became a primary training location for Rush Medical College students, and Stroger Hospital patients gained access to specialists from Rush. Each year, more than 400 Rush students and postgraduate residents receive training at Stroger Hospital in areas ranging from vascular surgery to breast cancer. Joint research projects in basic science, clinical science health services and epidemiology look for new ways to improve the health of vulnerable communities and bridge the widening gaps in the health care system.

  Rush and the Cook County Bureau of Health Services also collaborated to create the Ruth M. Rothstein CORE Center in 1998. The CORE Center is the nation's first public-private outpatient facility dedicated to the care of people with HIV/AIDS. Today, it is the largest, most comprehensive provider of HIV/AIDS treatment in the Midwest. The center also serves patients with tuberculosis, hepatitis and other infectious diseases. Clinical research projects at the center seek new answers in screening, treating and halting the spread of infectious diseases.

  Rush University Medical Center recognizes that Stroger Hospital is sometimes unable to meet the medical needs of its patient population given its limited resources and the demand for health services. In fiscal year 2007, Rush agreed to provide diagnostic colonoscopy services to Stroger Hospital patients free of charge. The wait times at Stroger Hospital often exceeded eighteen (18) months which has been substantially reduced by Rush gastroenterologists who perform screenings for cancer, anemia, etc at Stroger Hospital and then refer those who require endoscopy procedures to Rush for no charge. Rush's involvement provides quicker access which leads to earlier detection and treatment.

  Rush University Medical Center leadership also took an important role in the Cook County Bureau of Health Services Review Committee, providing recommendations for the governance and financial changes of this organization. This time was volunteered and continued in FY08.

- ***College of Nursing School-Based Health Centers:*** The College of Nursing operates school-based health centers in two Chicago Public High Schools: Richard T. Crane Technical Preparatory Common School and Rezin Orr Community Academy High School Campus. The Crane and Orr health centers increase adolescents' access to quality health care and provide comprehensive health services on school grounds, thereby contributing to a decrease in school time loss due to health problems. More than 95% of Crane and Orr students are enrolled in the health centers. The health centers provide comprehensive health care services, including risk assessments, health promotion, acute and chronic care, reproductive health services, school and sports physicals, laboratory services and immunization services. The centers also provide assistance with benefits enrollment in programs like KidCare and Women, Infants, and Children (WIC). Rush public health nurses at the centers provide high school students first-hand opportunities in advocating for their own health care. Last year Orr students traveled with their public health nurse to Springfield to advocate for increase funding for school-based health centers. Schools are penalized if they do not demonstrate 95 percent compliance for physicals and immunization requirements. Both Crane and Orr health centers report rates greater than 95% by the end of the year. While these school-based health centers enable health care access, they also serve as clinical sites, providing learning opportunities for Rush undergraduate and graduate nursing students as well as medical students and residents. During FY08, there were 2,038 student encounters at Crane, serving 556 students. At Orr 545 students had 1,907 encounters.

- ***Wellness Program with the Chicago Department on Aging (CDOA):*** The Rush Wellness Program with the Chicago Department on Aging (CDOA), which mainly serves minority older adults, has been in existence since 1985. Advanced practice nurses, dietitians, and pharmacists from Rush educate and care for older adults at three Chicago senior centers (one of them is only 4 blocks from Rush). During fiscal year 2008, 3,429 seniors were seen by these medical professionals and yielded 4,118 screenings such as blood pressure, bone density, glucose and diabetes and PSA levels. In addition to the health professionals' time, supplies and educational materials are donated to this program and further volunteer hours are spent at health fairs and other events associated with the senior centers.

- ***CarFit:*** Rush implemented CarFit in conjunction with the Mather Lifeways, Mercy Hospital, Age Options, AAA, and the American Occupational Therapy Association in fiscal year 2008. There were seven events with four Rush occupational therapists staffing the events in the Chicago area and surrounding suburbs. The purpose of the CarFit is to heighten driver awareness of their vehicle in relation to themselves in order to create a safer driving experience.

  The program is open to the community and is specifically targeted to older adults and those requiring related occupational therapy. Participants (drivers) bring their vehicles to a scheduled event, where staff volunteers review checklists with the drivers to ensure that the vehicles are the best "fit" they can be for the drivers. Drivers are taught how to adjust mirrors, seats, head rests and steering wheels properly, and the staff ensures that they know where primary and secondary controls are located(e.g., hazards, etc.). Drivers meet with an occupational therapist who examines the checklist for any "red flag" issues. They make recommendations for adaptations to the vehicle, or to the driver, that included equipment that will aid the driver in safely operating the vehicle.

- ***Anne Byron Waud Patient and Family Resource Center for Healthy Aging:*** For the past eight years, the Waud Center at Rush offers an array of programs and services open to the public that promote healthy aging. Patients and their families have the opportunity to receive

free consultations from licensed social workers on health and aging issues, attend social and support groups, participate in free computer training, and use the health library. The Center provides a feel that it is a place to turn in times of need. This past year the Waud Center served 2,200 patients, families, and community members through the above mentioned programs and the center staff look forward to expanding upon this success by serving more people.

The Waud Center and the services it provides have also been the inspiration and driving force behind the development of older adult programming throughout the Medical Center. One such program is Rush Generations, a free membership program that promotes health and well-being for older adults and those who care for them. Through twice monthly educational seminars on a wide range of topics related to health and aging, and the resources provided by the Waud Resource Center, Rush Generations has reached out to over 5,410 members and the number of people is continually growing. Some of the highlights in fiscal year 2008 are as follows:

- Provided over 21 educational programs and wellness classes
- Carried out one health fairs serving 400 older adults and family caregivers
- Conducted needs assessment of older adults in Near West Side of Chicago (one year grant from the Michael Reese Health Trust)
- The Enhanced Discharge Planning pilot project, which follows up with at-risk older adults being discharged from hospital, has helped ease the transition to the community for over 600 adults
- Participating in Administration on Aging grant to teach Chronic Disease Self-Management Program in Chicago area
- Carried out BRIGHTEN Depression Screening for 611 older adults in Rush primary and specialty care clinics

- ***Mothers' Milk Club:*** Breast milk is essential to the growth and development of premature infants as it provides protection against many of the conditions to which they are most susceptible. The Rush Mothers' Milk Club was developed to help eliminate the social, emotional and physiological barriers to breastfeeding for mothers of premature infants. These mothers are disproportionately low-income and/or African-American women. Mothers are provided, free of charge, with hospital-grade breast pumps, educational materials and post-discharge assistance at weekly meetings to help manage the lactation process. The Mothers' Milk Club receives financial support from Rush and a private foundation.

- ***Rush Preemie Picnic:*** The Rush Preemie Picnic is an annual community outreach event held in the summer that targets families of infants who were born prematurely and admitted to the Neonatal Intensive Care Unit (NICU). Families come from the Chicagoland area as well as out of state/country. The ages of the children who had spent from days to months in the Rush NICU after birth, range from a few weeks old to teenagers.

  Activities include entertainment, reconnecting with staff and other families, crafts and food. The educational venue included information on Child Safety, Breastfeeding Education and Support, March of Dimes, SIDS and Dental Hygiene. Many prizes were given to families by the Mother's Milk Club for dedication to providing breast milk to their babies. In FY08, 600 people attended the Preemie Picnic.

- ***Principal-For-A-Day Program:*** Over the past five years, Rush has developed a special relationship with William King Jr. Elementary School through its participation in the Mayor

and the Board of Education's Principal-For-A-Day Program. Projects that have been implemented include a tutorial program, educational programs on nutrition and obesity, essay contests, assistance with the school's security system, and annual donation of gloves and mittens during the holidays. Among a number of 2008 programs were the following:

- On January 24, 2008, Rush hosted 8th graders from King Elementary School to introduce them to five Rush faculty members featured in Who's Who in Black Chicago: Drs. Robert Higgins, Cynthia Boyd, Howard Strassner, Sharon Byrd, and Mr. Terry Peterson, with a special appearance by Rush President Dr. Larry Goodman. While Rush faculty spoke about the importance of education, King students and faculty enjoyed lunch.
- On January 29, Rush hosted 23 7th graders and faculty from King Elementary School. They toured the Simulation Lab, PT/OT, and the Anatomy Lab. Lunch was provided and additional staff was invited to lunch, including two staff from Volunteer Services, and two staff from the Office for Equal Opportunity.
- For 2008 Principal-For-A-Day Program, the Office for Equal Opportunity is sponsoring an essay contest at King Elementary School. Prizes will be movie passes and food coupons from Pompeii Bakery.

- ***You Care, the Rush Employee Community Grant Program:*** In recognition for all the outreach our employees do, Rush has created a grant program to support and stimulate employees' volunteer activities. Grants are awarded to not-for-profit, human services organizations where Rush employees volunteer. In fiscal year 2008, the following organizations received contributions from the You Care Program at Rush:

  - Women in Management received a $1,000 grant. Grant was applied towards a scholarship aimed at encouraging women to further their careers in management.
  - Boy Scout of America Troop 117 received a $1,000 grant towards troop packages for U.S. Military overseas.
  - Mission in Action Outreach program received a $985 grant.
  - Emmaus Ministries received a $1,000 grant to help support men with HIV.
  - Pilsen Homeless Services received a $1,000 grant to purchase medication and medical supplies for the homeless.
  - Marillac House received a $1,000 grant to purchase medical supplies and First Aid kits for seniors.

  Among other organizations who benefited from the You Care Program were Forest Park Middle School Boosters, Washington Irving Elementary School, Old Town School of Folk Music, Interfaith Council for the Homeless, Saint Rita of Cascia High School, St. Christopher School, the Chicago Christian Industrial League and Trialways Girl Scout Council. Overall, Rush's You Care Program donated a total of $13,480 to these organizations in fiscal year 2008.

- ***2 BigHearts:*** Founded by Jim Clarke, a man who lost both his wife and sister-in-law within hours of each other to a grave heart condition, the 2BigHearts Foundation is an organization whose mission is to heighten awareness of heart disease among women by communicating the tragic story of these women and by working with the health care community to educate individuals and families about the causes and prevention of heart disease in women. Rush's partnership with 2BigHearts is a logical step in the effort to inform the Chicago community, specifically women who have not had previous cardiac care, of the need to be tested for heart irregularities and to receive proper heart health education.

The alliance has given rise to a number of community screening events at Rush, two in fiscal year 2008, and many more to come in the future. Rush nurses, techs and physicians work at a reduced cost when performing the exams which include an echocardiogram, cholesterol screening, lipid panel, weight management and a cardiologist consult. All aspects of the exam, which would typically result in a bill in excess of $4,000 per participant, are provided free of charge. Administrative and marketing support is also unfunded. In fiscal year 2008, 190 women were screened and 60% were found to have a lipid abnormality indicating a need to change lifestyle and diet, and 6% were found to have previously undiagnosed and potentially serious heart irregularity and were advised to seek follow-up care with a personal physician.

- ***Blood-Drives:*** In collaboration with the American Red Cross, Rush hosted five blood drives in FY08. Through the provision of a location and employee time for coordination and administrative purposes, Rush has supplied blood for people within the city of Chicago and beyond its borders.

- ***McCormick Foundation Center for Advanced Emergency Response:*** The Health Resources and Services Administration (HRSA) Bioterrorism Hospital Preparedness Program is designed to improve local hospitals' ability to manage an event where bioterrorism is involved. Rush University Medical Center is a City of Chicago Center of Excellence (COE) for Bioterrorism Preparedness and as such provides a medical link to the military teams that would be in service during a disaster and would further assist in civilian support measures. As a COE, Rush has given great consideration to the population that enters the emergency room doors. With grant funds Rush has implemented the MedBridge software which instantaneously increases the ability to communicate with patients. Through its bioterrorism preparedness initiatives, Rush provides a benefit to the local community as well as to the city as a whole. Collaborating with the city in order to prepare the community for a bioterrorism event is a continuing goal for Rush and will be pursued further in fiscal year 2009.

- ***Partnership with Chicago Bulls' Read to Achieve Program:*** Rush University Medical Center is a proud partner of the Chicago Bulls and their Read to Achieve program. Initially launched in the fall of 2001, the National Basketball Association's (NBA)'s Read to Achieve program is a year-round campaign to help young people develop a lifelong love for reading and encourage adults to read regularly to children. Reaching millions of children a year, Read to Achieve is the most extensive educational outreach initiative in the history of professional sports. The program's goal is to inspire young children to develop strong reading habits and build a genuine interest in learning through literacy. The Chicago Bulls have established dedicated Reading Learning Center/rooms decorated by the Chicago Bulls and stocked with books and other learning materials at Rush Children's Hospital as well as five Chicago public schools or community centers.

- ***Job Development:*** An Employment Opportunity plan was developed at Rush to be implemented in FY09. (See next page under Community Benefit Plan FY09 for a description of the Dawson Technical Institute Apprenticeship Program).

Rush University Medical Center
Community Benefits Plan FY09

I. Goals & Objectives for FY09

Complete Health Assessment & Community Benefits Plan: Expand the Community Needs Assessment to identify areas of need that align with Rush's existing program strengths. Additionally, a group will be convened to evaluate the effectiveness (health status measures) and reach (# of lives touched) of Rush's current community benefit programs. A plan will be developed to provide guidance for existing community service programs and principles for creating new initiatives that provide the most benefit to community health status.

Partnership with Malcolm X College: Malcolm X College and Rush University Medical Center will develop a partnership to assist in the development of a continuing education path in the healthcare field. Rush will establish clinical slots for MXC students, provide lecturers and teaching staff to programs where possible, assist in the development of new programs and proposals and provide assistance in writing studies for accreditation and letters of support.

Partnership with the Larry King Cardiac Foundation: The Larry King Cardiac Foundation and Rush University Medical Center will join forces to provide life-saving cardiac care for patients who have no insurance or limited means. The goal is to bring critical care to people who have run out of options.

Cardiologists and heart surgeons at Rush will donate their time and perform surgeries at no cost to the patient. The Larry King Cardiac Foundation provides funding to compensate the hospital for materials used.

In addition to providing free care, Rush will work with the Foundation's Health Across America campaign to raise awareness about heart disease and provide testing to those who would not normally have access to this support. Addressing risk factors such as high cholesterol, high blood pressure, diabetes, obesity, physical inactivity, unhealthy diet and smoking greatly reduces the risk for illness and death from heart disease.

Community Workforce Hiring: Rush University in collaboration with Malcolm X College and the Mayor's Office of Workforce Development will conduct annual vendor fairs where residents of Rush's immediate areas are invited to apply for positions. Rush will invite about 20% of applicants for interviews.

Dawson Technical Institute Apprenticeship Program: A one-time grant of $25,000 will be provided to Dawson Technical Institute to fund an apprenticeship program to assist community residents and other unemployed city residents to be trained in a trade field.

New Partnership with Community Organizations: The Rush Community Services Initiatives Program (RCSIP) will expand to two additional initiatives in FY09:

- Keep It Fit Chicago (KIFC) will be an extension of the RU Caring Program. Partnering with the Salvation Army, Rush students will work with families in a multidisciplinary team approach to help them achieve a better understanding of nutrition and how changed behavior and increased physical activity plays into a healthier lifestyle. The activity will take place at the Army's Red Shield located at 945 West 69th Street.

- New Partner for Maternal Advocates- Students will partner with Simpson Academy High School for Young Women located at 1321 South Paulina. This is the last remaining school in Chicago for pregnant teens. There are only three in the nation. Our students will be working with the young women to teach them health education and will share information on how best to bond with and teach their children. Rush students will also tutor the young women, encouraging them to finish school and pursue college.

Center for Urban Health: The purpose of the Rush Center for Urban Health, a partnership with John Stroger Hospital of Cook County, is to coordinate and facilitate the growth of research addressing the challenges to health encountered in an urban setting, such as around the Rush campus.

The objectives are:

a) To raise the level of public awareness and understanding of biomedical and behavioral research related to health and the role the public can play in the research;
b) To increase scientists' awareness of the importance of public engagement; and
c) To provide a forum to educate researchers and communities how to successfully implement health research.

The Center will support innovative activities designed to improve public understanding of biomedical and behavioral research, develop strategies for promoting collaboration between scientists and the community to improve the health of the public, and to identify the conditions (e.g., settings and approaches) that will enhance the effectiveness of such activities.

Expansion of the RTSC Community Network: Using the Rush Alzheimer's Disease Center model created for its multicultural outreach program, the Rush Translational Science Consortium (RTSC) will build on its existing network of community connections (complete listing of current relationships in Appendix B) by establishing new partnerships within the community. This program supports community outreach workers who network with other community organizations to learn about health-related concerns of the organizations' constituents. The outreach workers provide education, health screening, and health information. They also recruit participants for ongoing research studies. By creating new partnerships, RTSC can continue to collect important data from the population studies and patient visits. This will be used to inform local officials and community organizations about health and environmental disparities of their constituencies. RTSC will then work with them to improve health outcomes.

Health Surveillance Collaborative Workshop & Plan for Building a Healthier Chicago: Rush University Medical Center and the Rush Translational Sciences Consortium have received an HHS grant to conduct a 2-day needs assessment workshop on health surveillance and a pre- and post-meeting assessment through web-based surveys and interviews. Rush has committed additional support beyond the grant to conduct the needs assessment. Co-Directors and principle investigators of the proposed project are Dr. Martha Claire Morris from Rush University Medical Center and Dr. Robert A. Weinstein from John H Stroger Hospital. The goal is to provide a comprehensive report and a strategic health surveillance plan for the city. Attendees of the workshop will include community researchers from academic medical colleges (Rush/County, University of Chicago, University of Illinois at Chicago, Northwestern University, Loyola University), public health officials (Chicago Department of Health, Illinois Department of Public Health), and directors of community health clinics (e.g. CCBHS clinics, Access Community Health Network, Alivio Medical Center).

II. Geographical Boundaries of "Community"

As an academic medical center, Rush performs many community benefit activities in neighborhoods within and surrounding the Illinois Medical District (IMD) and throughout Chicago. While it is difficult to define set boundaries for the Rush "community," for the purposes of this plan and future planning initiatives, Rush defines its community using the recognized Chicago Community Areas of: a) 24 – West Town, b) 27 – East Garfield Park and c) 28 – Near West Side (Maps in Appendix A). These geographical areas encompass the location of the Medical Center in addition to the locations of clinics that are the sites for a significant number of community benefit projects. Additionally, as Rush engages with its partners in the Chicago Department of Planning and Development, among other departments, it will facilitate easier demographic and other analyses because there will be a common understanding of the area in question.

Despite these boundaries, Rush does not plan to discontinue those activities currently undertaken outside the aforementioned community areas. For example, the Science and Math Excellence Network supports mathematics and science educational efforts in Chicago Public Schools across the city in more than 40 schools. In addition, Rush's financial assistance policies apply to all patients in the Chicago metropolitan area.

III. Integration with Chicago Department of Public Health's Strategic Plan 2006-2011

Chicago, like any large urban city, surveys the health services it provides to its citizens. Over the course of the last year, the Chicago Department of Public Health (CDPH) engaged in a strategic planning exercise aimed to focus the energies of the department, set organizational priorities and guide the allocation of public health resources.

The CDPH's strategic plan shows the department's seven strategic priorities over the next five years. They are as follows:

1. Prevent chronic disease and promote health for all Chicagoans.
2. Assure access to needed physical and mental health services.
3. Ensure the health, safety and well-being of children and youth.
4. Ensure that Chicago is prepared to quickly and effectively respond to epidemics and public health emergencies.
5. Increase the visibility and awareness of CDPH and public health among the public, other stakeholders and policymakers.
6. Excellence in management.
7. Reduce disparities in health status.

Many of the community benefit activities undertaken by Rush University Medical Center address these strategic priorities. While the Rush Center of Excellence for Bioterrorism Preparedness continues to contribute to strategic priority #4, several other Rush community benefits programs are aligned with strategic priorities #1, #2, and #3. These include the Clinic at Franciscan House of Mary & Joseph, the Community Health Clinic, the Health Educators/ASAP program, Marah's Place, Red Ribbon Friends, the Maternal Advocates Program, and the Rush Adolescent Family Center. Rush performed a preliminary community needs assessment during FY08. A formal planning process will be initiated in FY09 to ensure that future community benefit efforts are aligned with the needs of the community.

IV. Data Sources

With many of Rush University Medical Center's clinical and research departments maintaining close relationships with community organizations, improvements upon Rush's existing community benefits are ongoing. Information provided by community organizations, internal data sources and publicly available information provided by the Chicago Department of Public Health and the Metropolitan Chicago Healthcare Council are used to generate a comprehensive community benefits plan.

V. FY08 Consolidated Financial Information

Community Benefits Report Component	RUMC	ROPH	Total Reportable Entity	Footnote References
True Charity Care (Cost)	8,210,042	706,296	8,916,338	Footnote 1, 4, 5, 6
Language Assistant Services	438,118	0	438,118	
Government Sponsored Indigent Health Care				
Medicare Program	33,675,373	5,153,224	38,828,597	Footnote 1,
Medicaid Program	26,452,078	3,025,54	29,477,618	Footnote 1, 2,
Donations	394,500	7,383	401,883	
Volunteer Services	2,057,780	144,519	2,202,299	
Education:				
Graduate Medical Education	35,515,877	0	35,515,877	
Other	514,119	0	514,119	
Research	10,114,000	0	10,114,000	
Subsidized Health Services				
Physician Practices	7,986,822	0	7,986,822	
Bad Debts	28,380,893	7,546,263	35,927,156	Footnote 3
Other Community Benefits	1,739,633	171,984	1,911,617	
Total	**155,479,235**	**16,755,209**	**172,234,444**	

Footnote #1:
The computation of charity care (cost) is based on the filed 2008 Medicare cost report. The Medicare loss and Medicaid loss is based on a discrete ratio of cost to charges utilizing Rush's cost accounting software. These amounts will differ from the amounts in the footnotes to the audited financial statements as this report reflects more recent and updated costs.

Footnote #2:
During FY 2008, Rush received payments related to a renewed Provider Assessment Program which was approved by CMS and administered through the Illinois Department of Health and Family Services. The three-year program (2006 – 2008) was designed to improve Medicaid payments to hospitals. Rush received a net benefit of $14,818,691 annually. Without the Provider Assessment Program additional reimbursement, the FY 2008 unreimbursed cost of the Medicaid program would have been $44.3 million

Footnote #3:
The amount of bad debt reported for purposes of the Community Benefit filing includes uncompensated care write-offs within Rush University Medical Group, Rush University Hospital and Rush Oak Park Hospital. This amount is valued at expected payments written off and not charges.

Footnote #4:
The amount of charity care reported for purposes of the Community Benefit filing includes only uncompensated care meeting the strict definition of charity care as defined by the Office of the Attorney General as part of the 'Community Benefits Act Compliance Information'. As defined in the 'Community Benefits Act Compliance Information', "Only the portion of a patient's account that meets the organization's charity care criteria is recognized as charity. Although it is not necessary for the entity to make this determination upon admission or registration of an

individual, at some point the entity must determine that the individual meets the established criteria for charity care." Under this definition, if Rush has not received information from the patient that is required to determine eligibility for charity care under Rush's policy, any uncollected amount cannot be included in charity care per the Community Benefits Act compliance information.

Footnote #5:
In the discussion of the Medical Center's provision of charity care to our patient population there are several factors which must be considered in addition to the charity care number provided for purposes of the Community Benefits filing, to obtain a full understanding of the breadth of charity provided. These factors are outlined as follows:

Through utilization of a patient eligibility service the Medical Center is extremely proactive in enrolling patients, who arrive at Rush without insurance coverage, into various state and federal programs that provide health insurance coverage. During FY2008, this service was able to obtain coverage for 539 patients who initially were classified as uninsured, representing approximately $34 million in gross charges. The maintenance of this service for our patients has a significant impact on decreasing the amount of charity care provided. In addition to achieving appropriate, available coverage for our patients' medical services, this eligibility service also obtains eligibility for SSI or SSA benefits for applicable patients. Guiding the patient through this often time consuming and arduous process is extremely beneficial to the patient, as once SSI/SSA eligibility is approved, the patient will begin receiving a monthly assistance check that provides a benefit well beyond their health care at Rush.

Because of the process that the Rush and other hospitals must go through to prove a patient's eligibility for charity care, the amount of charity care often can be undistinguished from other categories of uncompensated care. Without the cooperation of the patient to provide appropriate documentation, Rush cannot correctly distinguish patients that meet the defined charity care policies and who should appropriately be counted as charity write-offs. Instead, these patient cases are frequently classified as bad debt write-offs due to a lack of information to support qualification/classification for charity care. This creates a reported charity care amount that is not representative of the true amount of care provided to low income and indigent patients. During FY2006 Rush started preparing a detailed analysis of patients who completed charity care applications and the results of the application process. A summary of this analysis for Rush University Medical Center only in FY 2008 follows:

	Approved Patient Applications	Pending Patient Applications	No Response Patient Applications
Charity Care (100% write-off)			
Number of Patients	1,349	876	79
Write-Off Amount	$20,601,822		
Limited Income (50% write-off)			
Number of Patients	203	0	4
Write-Off Amount	$660,586		

The above amounts represent charges written off. Only the cost of providing these services can be included as charity care per the definition required in this filing.

Footnote 6:
In recognition of the need to simplify policies and to expand assistance to the growing population of uninsured, in FY07 Rush increased the discount for all patients without insurance from 40 percent to 50 percent. This discount is immediately given to all individuals without insurance regardless of whether a request was made for financial assistance. In addition, the discount under the limited income program was increased from 50 percent to 70 percent, and a catastrophic policy for patients with large medical bills was added with discounts up to 70 percent. Rush also formalized an annual review of these policies, implemented a formal communication plan to all staff at Rush, and assigned accountability for communication to patients.

Rush Oak Park Hospital
Community Benefit Report
Fiscal Year 2008

BACKGROUND AND ORGANIZATIONAL INFORMATION

Rush Oak Park Hospital (ROPH) is a Catholic community hospital consisting of 296 beds located in Oak Park, Illinois and affiliated with Rush University Medical Center, Chicago, IL and Wheaton Franciscan Healthcare, Inc., in Wheaton, IL.

BUILDING ON A CENTURY OF SERVICE

Building on a Century of Service is ROPH's commitment to providing benefits beyond traditional medical care to the communities and individuals it serves. ROPH community benefits are programs and services to residents of Cook and surrounding counties that address identified health care needs.

2007 was a centennial celebration for the Hospital, employees and the community. This has been carried forward into 2008 through our surgical, rehabilitation, diagnostic, diabetic and endocrine care and emergency services ROPH is meeting the growing needs of the communities we serve.

As part of Rush Oak Park's faith-based mission, emanating from the sponsorship of the Wheaton Franciscan Sisters, we are constantly striving to improve quality of care, safety and the patient experience. Our affiliation with Rush University Medical Center (RUMC) provides patients with access to advanced medical treatments without having to leave their neighborhoods. Growth from the past 100 years is sure to be matched, if not surpassed, over the next century. ROPH is committed to balancing clinical excellence with compassionate care and greater community outreach programs in order to provide a lifetime of care for individuals and their entire family.

MISSION AND VISION STATEMENT

Mission
Rush Oak Park Hospital's mission, as a member of Wheaton Franciscan Healthcare, Inc., is committed to living out the healing ministry of Jesus by providing exceptional and compassionate health care service that promotes the dignity and well-being of the people we serve.

Vision
Our health ministry at Rush Oak Park Hospital will be recognized in the community we serve for superior and compassionate patient service, clinical excellence, as the health care employer of choice and the preferred partner of physicians.

Values
Our commitment to our mission is our top priority. To assist all those who participate in the work of our health care ministry, we have core values that serve as guideposts for us as we do our day-to-day work.

- R – Respect: We value each person as sacred, created in the image and likeness of God, which gives worth and meaning to each person's life.

- I – **Integrity:** We value honesty, and works and actions that build trust.
- D – **Development:** We value personal and professional growth that combines the physical, emotional, spiritual and relational aspects of life and work.
- E – **Excellence:** We value superior performance in our work and service.
- S – **Stewardship:** We value our responsibility to use human, financial and natural resources entrusted to us for the common good, with special concern for those who are poor.

FOCUSING ON QUALITY / ENHANCING CARE

In 2007 and 2008, Rush Oak Park Hospital has made significant strides towards improving the quality of patient care, garnering national recognition for excellence in total knee replacement, joint replacement and inpatient diabetes care. Practice Greenhealth also recognized us with its 2008 "Partner for Change" award for the environmental conservation work we conducted.

Rush Oak Park Hospital strives every day to provide patients with a safe environment and high-quality care. The Hospital has increased its efforts in recent years, reporting to the Centers for Medicare and Medicaid Services core measures including the percentage of heart attack patients given aspirin at arrival and the percentage of pneumonia patients given an oxygenation assessment. Focusing efforts on preventing patient falls and moving patients quickly through the Emergency Department to inpatient beds are two projects that have shown improvements.

The Hospital was recognized in 2007 when it became the 2nd in the country and the 1st in Illinois to earn the **Joint Commission's Gold Seal of Approval for Inpatient Diabetes Management.** ROPH follows evidence-based guidelines and standards developed by the Joint Commission and the American Diabetes Association in caring for hospitalized patients with diabetes. This continuum of care means that from admission to discharge, all patients receive the best all-around care, and those utilizing the Center for Diabetes and Endocrine Care (CDEC) receive the benefits of a complete diabetes education.

More than an obligation or a list of programs, community outreach at Rush Oak Park Hospital is an essential part of its beginnings, its history and traditions, and its identity today.

TO BENEFIT OUR COMMUNITIES

Rush Oak Park Hospital is located among communities of various ethnicities, as well as families of all ages and economic backgrounds. Many in the community, however, still cannot easily get the medical care they need because they cannot afford health insurance, are unemployed, or are frail, elderly or indigent. ROPH is committed to ensuring these individuals, and any others who need help, get the health care they need and deserve.

Rush Oak Park Hospital defines Community Benefit as – services and activities that address community health needs primarily through disease prevention, health promotion and education, improving access to services and working with others to improve individual and community health status.

Community benefit activities highlighted in this report include:

- Charity Care
- Education for Community Health

- Services and Medical Specialties
- Community Outreach/Special Events
- Community Service Activities

CHARITY CARE

ROPH is committed to providing needed medical services to all in the community at all times, regardless of patients' ability to pay. Those needing care that are without health insurance or funds to pay for their care are never turned away. This community benefit includes financial losses recorded as charity care and the financial losses associated with participation in Medicaid and other government programs.

In addition to these shortfalls, ROPH also experiences significant losses due to underpayment for Medicare patients and bad debt for patients who cannot pay for their care. While businesses generally consider bad debt—a debt that is not collectable—as one of the costs of doing business, ROPH faces a challenge at the time of admission to identify those who need care, but are unwilling or unable to pay for it.

Going beyond community programs, the Hospital's generous charity care policy ensures that individuals who cannot pay for treatments and medications can still receive the care they need. For individuals without insurance, an automatic 50% discount is given after services are completed.

ROPH maintains records to identify and monitor the indigent and charity care we provide. These records include the amount of charges foregone for services and supplies provided under the charity care policy. During Fiscal Year 2008, Rush Oak Park Hospital provided approximately $706,000 in charity care (at cost), underwrote $8.2 million in expenses that were not fully reimbursed by Medicare and Medicaid, and wrote off $7.5 million in bad debts.

REACHING OUT TO THE COMMUNITY

AGE-WISE Clinic

The mission of Rush Oak Park's AGE-WISE program is to offer older adults and their families a comprehensive resource for current information and support of health-related issues. The approach is holistic and includes health education classes, support groups and screenings for common health problems to prevent, detect and treat diseases early.

Identifying unmet health care needs in the community is another mission of the program. Clinical health screenings range from diabetes, prostate, cholesterol and thyroid blood tests to glaucoma, skin cancer and bone density. The tests are a benefit to long-term health and the free lab work is a financial boon for an uninsured person who would normally have to pay out of pocket. Follow-up for those with abnormal results has led to early intervention for many. In addition, AGE-WISE is a referral source for information regarding unmet needs in the community such as transportation, caregivers, nursing homes and state and county services. In FY2008, 3,906 people within the community attended various health related AGE-WISE seminars, screenings and support groups.

In FY2009, the goal at ROPH is to grow AGE-WISE by an additional 15% of people served in the community for their health care needs.

Upcoming AGE-WISE programs are listed in the free quarterly newsletter entitled Aging Wisely, and at http://www.roph.org/calendar/. Further information is available by calling (708) 660-4636.

Diabetes Fair

Rush Oak Park Hospital conducts an annual health fair on diabetes. This health fair provides blood pressure, a fasting glucose and lipid profile blood test, optional foot screening and a healthy breakfast for every participant. In addition, a dozen or more pharmaceutical and other vendors are present to give away free literature and share information about diabetes care and related matters. Test results are mailed to participants with a recommendation to follow up with their respective physician in the case of an abnormal result. Each year, people benefit from early detection of the disease, some of whom were not previously receiving regular health care.

Early Detection Screening Mammograms aid Proviso Women

For the second consecutive year, Rush Oak Park Hospital received grant funding from the Westlake Health Foundation to provide free screening mammograms for the underserved and uninsured women in the community. The American Cancer Society states that the earlier breast cancer is detected the more treatment options are available and the more likely it is that the patient's treatment will be successful. Screening mammograms are so important, but especially for women who are uninsured and underinsured, and often cannot afford the cost of a breast cancer screening.

The Hospital used the grant funds to provide nearly 300 free screening mammograms to women in Oak Park, River Forest and Proviso Township in late 2007. Twenty-one women were scheduled for follow-up procedures. Due to the free mammograms provided, one of the women who came for a free mammogram was recommended to have a biopsy and a malignancy was found. She was referred for further treatment.

As part of the healing ministry of Jesus, the Breast Center at ROPH promotes good breast health among all women by helping them overcome the economic and physical obstacles that sometimes prevent them from being screened every year.

COMMUNITY SERVICE ACTIVITIES

Rush Oak Park Hospital promotes and encourages volunteerism among its physicians, employees and auxilians. Each year, our staff and physicians volunteer their time, manpower and other resources to make a positive impact and to build strong, safe and healthy communities. Examples of this are as follows:

Through the August *Back-to-School Drive*, employees had an opportunity to donate school supplies that were filtered to families of grandparents raising grandchildren.

Human Resources and Nursing Administration staff participate in numerous *Career Planning & Job Fairs* throughout the year.

ROPH's Annual Thanksgiving *Food Drive* helped to deliver food to families at St. Eulalia, a Catholic parish and elementary school in Maywood, IL. Through the December *Toy Drive*, employees donated items that helped benefit Sarah's Inn, a sanctuary for women and children, in Oak Park, IL and the non-profit organization, Toys for Tots.

Geographical Boundaries of "Community"

Rush Oak Park Hospital primarily serves residents in Oak Park, IL and its surrounding communities. These communities include but are not limited to River Forest, Forest Park, Elmwood Park, North Riverside and Berwyn, IL. ROPH directs community outreach strategies toward the target population, but our health care services are available to all who are in need.

Certain community programs at Rush Oak Park Hospital have different target audiences due to the average age of the residents in the community, the types of services the Hospital provides, or the nature of the programs themselves. According to the Oak Park Health Department, those 55 and older now represent 27% of the Oak Park population, with the 55 and older group projected to represent 40% of the population by the year 2015.

COMMUNITY BENEFIT DATA SUMMARY

Charity Care (at cost)	$	706,296
Unpaid Costs of Medicare	$	5,153,224
Unpaid Costs of Medicaid	$	3,025,540
Bad Debts	$	7,546,263
Community Health Services	$	144,519
Subsidized Health Services	$	171,984
Donations	$	7,383
Total	**$**	**16,755,209**

Community benefit calculations of financial assistance, Medicare and Medicaid are based on uncompensated cost of care, not charges.

WEB SITE

www.roph.org is Rush Oak Park Hospital's official web site. The site features information about hospital programs and services, upcoming screenings and health care classes, a comprehensive employment section, an online database of physicians and an informative newsroom of current health care articles and events.

OUR COMMITMENT – The Heart of the Mission

Community Benefits are about more than just numbers, they are a testimony to the value of focused, advanced medical care in the community. Every resident who benefits from a program or service improves their quality of life, and in turn, the quality of the community as a whole.

Our mission is to work to positively impact the overall health of the communities we serve. Education, outreach and community service allow us to broaden our impact beyond the walls of our facilities.

ROPH management is committed to the task of a successful community program. Steps for FY09 include the following:

- Utilize our mission and values statements to set the framework for the community benefit program.

- Integrate a strategic plan for community benefits incorporating attention to the community needs, required resources and commitment.
- Hold leaders accountable for meeting community benefit goals and make it integral to their work.
- Finally, reflect a culture that welcomes people of all economic, racial and ethnic backgrounds.

Organization of Community Benefits Task Force:

Maintaining the level of community involvement is critical to addressing the future needs of the Rush Oak Park Hospital community. ROPH has formed an internal Community Benefit Task Force comprised of representatives from key departments to help steer the organization's community benefit program. The Chairperson of the Community Benefits Task Force is Deborah Wilberding, Controller for ROPH, appointed by Bruce Elegant, President and Chief Executive Officer of ROPH. The Task Force is comprised of representatives from the following departments:

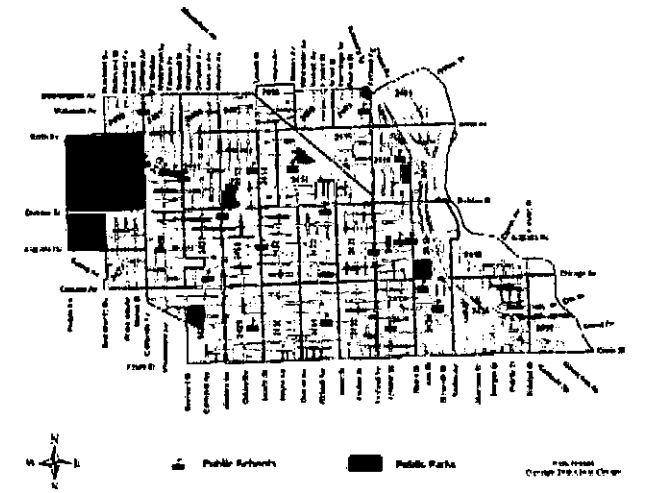
Marketing	Pastoral Care	Hospital Operations
Patient Care	Finance	

In FY09, this workgroup will monitor implementation of community benefit programs, participate in evaluations of the program, be advocates and help to tell the community benefit story as it is related to ROPH.

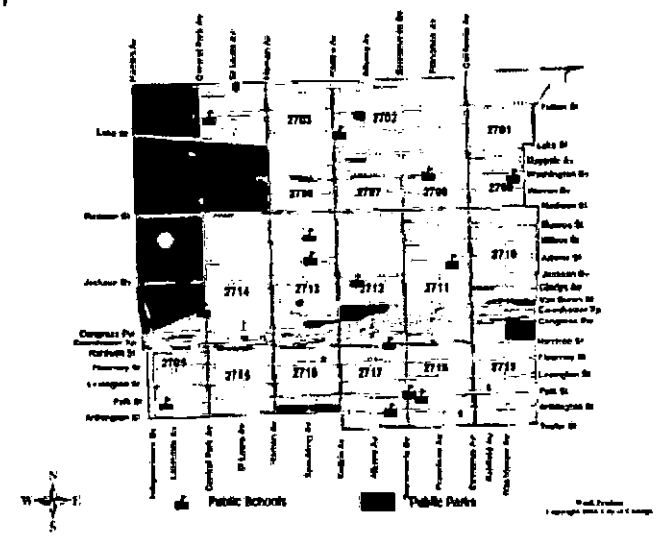
In addition, the Chairperson of this Task Force is responsible for coordinating the efforts associated with the filing of the annual Community Benefit Report with the initiatives at Rush University Medical Center.

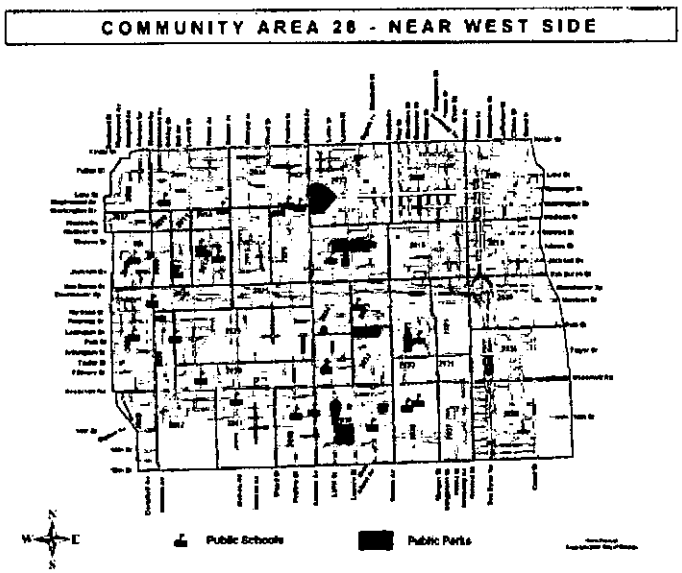
APPENDIX A

COMMUNITY AREA 24 - WEST TOWN



COMMUNITY AREA 27 - EAST GARFIELD





Source: Chicago Department of Planning and Development

APPENDIX B
ESTABLISHED PARTNERSHIPS OF THE RUSH CONSORTIUM

Organization	Location	Population Served	Partnership
AAA-Chicago Motor Club	Chicago, IL	All Ages	Education, training
AARP	222 N La Salle St # 710 Chicago, IL	Adults 50+	Education, training
Access Community Health Network	1501 South California Avenue Chicago, Illinois	All Ages	Research
Accolade Adult Day Services Catholic Charities of Chicago	112 Humphrey Oak Park, IL	older adults with physical or cognitive impairments	Clinical service, Research
Ada S. McKinley/Evelyn Wright Renaissance Center	7939 S. Western Avenue	Low Income Adults	Training, Education
Adult Christian Care Center	314 W. Valiette Elmhurst, IL	older adults with physical or cognitive impairments	Clinical service, Research
Advocate Christ Medical Center	4440 W. 95th Street Oak Lawn, IL	Adults with heart failure	Research
Advocate Lutheran General Hospital	1775 Dempster Street Park Ridge, IL	Adults with heart failure	Research
Advocate Lutheran General Older Adult Services	9375 Church St. Des Plaines, IL	older adults with physical or cognitive impairments	Clinical service, Research
AgeOptions	1048 Lake St, Suite 300 Oak Park, Illinois 60301	Seniors	Research, Education, Training
Ald. Rugai's office	Chicago's 19th Ward	All Ages	Education, Training
Alivio Medical Center	966 W 21st St	Latino	Education, Training
Alzheimer's Family Care Center	6141 N. Cicero Ave.	older adults with physical or cognitive impairments	Clinical service, Research, Training
American Indian Center	1630 W Wilson	Native Americans	Education
American Indian Health Service of Chicago, Inc. (AIHS)	4081 N. Broadway	American Indians	Clinical Service
American Medical Association	515 N. State Street Chicago, IL 60610	All Ages	Research
Bethel New Life/Senior Services	4950 W. Thomas	older adults with physical or cognitive impairments, African American	Clinical service, Research
Beverly Kiwanis Club	W. 111th Street	Men 55+	

Organization	Location	Population Served	Partnership
Beverly Men of Leisure	W. 111th Street	Seniors	Training, Education
Bluhm Cardiovascular Institute	201 East Huron Street	Adults with heart failure	Research
Cardiovascular Risk Reduction Center (CRRC)	8816 W. Dempster St. Niles, IL	Adults with heart failure	Research
Cardiovascular Associates of Glenbrook	2501 Compass Drive Glenview, IL	Adults with heart failure	Research
Casa Juan Diego After School Program	2020 S Blue Island Ave	Latino school age children	Clinical Service, Training, Education
Central DuPage Hospital	25 N. Winfield Rd. Winfield, IL	Adults with heart failure	Research
Centro Comunitario Juan Diego	8812 S Commercial	Latino	Education, Research
Centro San Bonifacio	4145 W Armitage	Latino adults and children	Education, Research
Centro Sin Fronteras	4811 W. Armitage Chicago	Latino	Research
Cherished Place Adult Day Services c/o Lutheran Home & Services	800 W. Oakton Arlington Heights, IL	older adults with physical or cognitive impairments	Clinical service, Research
Chicago Christian Industrial League	123 South Green St.	Homeless	Clinical Services, Training, Education
Chicago Commons	1258 W. 51st St.	older adults with physical or cognitive impairments, African American	Clinical service, Research
Chicago Commons/Guadalupano Family Center	1814 S. Paulina Chicago, IL	Latino	Training, Education
Chicago Dept. on Aging Portage Park Senior Wellness Center	4200 North Long Ave	Seniors	Clinical Services, Education
Chicago Dept. on Aging Central West Regional Center	2102 W Ogden Ave	Seniors	Research, Education
Chicago Dept. on Aging Atlas (Southeast) Center	1767 E. 79th Street	Seniors	Research, Education
Chicago Dept. on Aging Southwest Regional Center	6117 S. Kedzie	Seniors	Research, Education

Organization	Location	Population Served	Partnership
Chicago Dept. on Aging' Caregiver Advisory Board	Chicago	geriatric	Education, Clinical service
Chicago Dept. on Aging' Grandparents Raising Children Task Force and Advisory Board	Chicago	geriatric	Education
Chicago Dept. on Aging Well Being Task Force	30 N. LaSalle	Seniors	Education
Chicago Department of Health	2045 W Washington Blvd,	Latino	Education
Chicago Christian Industrial League	123 South Green St.	General	Clinical Service
Chicago Department of Public Health	DePaul Center, Rm. 200 333 S. State St. Chicago, IL 60604	All Ages	Research
Chicago Hispanic Health Coalition	2600 S. Michigan Ave, Suite 104	Latino	Research
Chicago Lighthouse	1850 West Roosevelt Rd.	Disabled children	Clinical Services, Training, Education
Chicago Public Library	Theodore Roosevelt Branch 1101 W. Taylor Street Chicago, IL 60607	All Ages	Education, Research
Chicago Public Schools (Mexican American Problem Solving Program)	125 South Clark	Immigrant Mexican women and their 4th and 5th graders	Education, Research, Training
Chicago Police Department	Chicago	All Ages	Education
Chicago Reach	4501 W Augusta	African American, geriatric	Clinical Services, Training
Children's Memorial Hospital	2300 N Childrens Pl Chicago, IL	African American and Latino children impacted by HIV/AIDS	Clinical Service, Training, Education
Chinese American Service League	2141 S. Tan Court	Chinese	Education
Christian Evangelical Church	3253 W Wilson Ave	African American adults and children	Clinical Service, Training, Education
Church of God True Believers	Chicago	Adults and Children	Training
Clara's House	1650 W 62nd St.	Homeless	Clinical service, Training

Organization	Location	Population Served	Partnership
CLESE (Coalition for Limited English Speaking Elderly)	53 W. Jackson, suite 1301 Chicago, IL 60604	Seniors	Research
Community Adult Day Care	501 Main St. Downers Grove, IL	older adults with physical or cognitive impairments	Clinical service, Research
Community Health Clinic	2611 W Chicago Ave	Adult immigrants, Polish and Latino	Clinical Service, Training, Education, Research
Community Renewal Society's Senior Ministry Advisory Board	Chicago	geriatric	Education, Research, Clinical service
Cong. Davis Senior Citizens Task Force	Congressman Davis District	geriatric	Education
Cook County Bureau of Health Services	1900 W Polk Chicago, IL 60612	Latino	Education
Cook County/ Stroger Hospital	Chicago	All Ages	Research
CORE	2100 W. Harrison	All Ages	Clinical Service
Crane School-Based Clinic	2245 W. Jackson	Children	Clinical Service
Day care centers-Chicago Parenting Program	City wide	Low income, Hispanic and African American	Research, Training
Dr. Dwenzar Howard	24 Joliet St. Dyer, IN	Adults	Clinical Services
Dunbar High School	3000 S. MLK Dr. Chicago, IL	Adolescents	Clinical Services, Education
Ecumenical Adult Day Services	305 W. Jackson Naperville, IL	older adults with physical or cognitive impairments	Clinical service, Research
Edward Hospital	801 S. Washington Naperville, IL	Adults with heart failure	Research
Erie Neighborhood House	1701 W. Superior St. Chicago, IL	Low Income Adults	Training, education
ESSE Adult Day Services	515 S. Wheaton Wheaton, IL	Older adults with physical or cognitive impairments	Clinical service, Research

Organization	Location	Population Served	Partnership
Evanston Northwestern Healthcare	2650 Ridge Ave Evanston	Children with asthma in Chicago	Research
Excellent Way	2510 E 79th St, 60649	Homeless	Clinical service, Training
Fourth Presbyterian Church	North Michigan Ave At Delaware Pl & Chestnut Ave	All Ages	Education
Franciscan House of Mary and Joseph	2715 W Harrison St	African American	Clinical Service, Training, Education
Franciscan Outreach	1645 W Le Moyne	Homeless adults and children	Research
Great Hope Family Center	2622 W Cermak	Homeless	Clinical service, Training
God's Helping Hands	5820 W Chicago	Homeless	Clinical service, Training
Good Samaritan Hospital	3825 Highland Ave. Downers Grove, IL	Adults with heart failure, Uninsured of DuPage County	Research, Clinical Services, Training, Education
Great Opportunities ADS/Presbyterian Homes	4555 Church St. Skokie, IL	older adults with physical or cognitive impairments	Clinical service, Research
Harmony Village	7750 S Kingston #1B	Homeless	Clinical service, Training
Health and Medicine Policy Research Group	29 E. Madison St. Suite 602 Chicago, IL 60602	All Ages	Research
Heartland Hospice	4415 W Harrison, Hillside	geriatric	Clinical Services, Training
Hektoen Institute CORE Center	2100 W. Harrison	HIV/AIDS patients	Clinical Services, Training
Henry Horner After School Program	123 N. Hoyne Ave	African American school age children	Clinical Service, Training, Education
Hispanic Provider Council	Chicago	Latino geriatric	Clinical service, Education
Holy Family church	1019 S. May	All Ages	Education, Research
Holy Name of Mary Catholic Church	1423 W 112th St, Chicago	Seniors	Education, training
Hope Village	7852 S Essex	Homeless	Clinical service, Training

Organization	Location	Population Served	Partnership
House of Welcome Adult Day Services of the North Shore Senior Center	1779 Winnetka Rd. Winnetka	older adults with physical or cognitive impairments	Clinical service, Research
Hugenie Crane School Based Health Center	2245 West Jackson	Inner city poor adolescents	Clinical Services, Training, Education
Humboldt Park Community of Wellness	Chicago	Residents of Humboldt Park	Research
Illinois Department on Aging	160 N. LaSalle St. Suite N-700 Chicago, IL 60601	Seniors	Research, Education
Illinois department of Public Health	122 S. Michigan Ave Chicago, IL 60603	All Ages	Research, Education
Infant Welfare Society	3600 West Fullerton	Hispanic poor women	Clinical Services, Training, Education
Interfaith Council for the Homeless	Sanctuary Place 642 North Kedzie	Homeless adult women	Clinical Services, Training, Education
Interfaith House	1111 N Wells	Homeless adults and children	Research, Clinical, Education
Laurance Armour Day School (LADS)	630 South Ashland	Preschool children	Clinical Services, Training, Education
Lakefront Housing	3150 N Racine	Homeless adults and children	Research
Lene Washington Center	1609 S Homan	Homeless	Clinical service, Training
Levy Center	300 Dodge Evanston, IL	Adults with heart failure	Research
Lighthouse for the Blind School	Roosevelt Road Chicago	Impaired children and Young Adults	Clinical Services, Education
Little Company of Mary Hospital Adult Day Care Center	2800 W. 87th St.	older adults with physical or cognitive impairments	Clinical service, Research
Malcolm X College	1900 W Van Buren	African American, White, Latino	Education, Research
Marah's Place	1456 West Oakdale	Homeless	Clinical Service, Training, Education
Marillac House	212 S. Francisco	Low Income Adults	Training, Education

Organization	Location	Population Served	Partnership
Mary Crane Center	2905 N Leavitt St Chicago, IL	Adults and Children	Training
Mather Life Ways	Chicago	Seniors	Education, Training
Mercy Hospital	2525 South Michigan Ave.	HS Students, adults and children	Clinical Services, Training, Education
Merwick & Associates.	533 W. North Ave. Elmhurst	Adults	Clinical Services, Training
Metro Seniors in Action	220 S. State Street	Seniors	Research, education
Metropolitan Family Services	Chicago	All Ages	Research
Mt Greenwood Park	3724 W. 111th St	Women 65+	Education, training
Mount Sinai Baptist Church	2841 W. Washington Blvd	All Ages	Education
Morgan Park Women's Club	Morgan Park, IL	Senior Women	Education
New Birth Church of God in Christ	1500 W. 69th Street	All Ages	Education
Nia Family Center	744 N. Monticello Ave. Chicago, IL	Low Income Adults	Training, Education
North Avenue Day Nursery	2001 W Pierce Ave Chicago, IL	Low Income Adults	Training, Education
North Shore Senior Center	161 Northfield Rd Northfield, IL 60093	Senior	Education
Northside Housing and Supportive Services	835 West Addison	Homeless adult men	Clinical Services, Training, Education
Northside Shelter	835 W. Addison Chicago, IL	Homeless Adult Men	Clinical Services, Education
Northwestern University Settlement House	1400 Augusta Blvd. Chicago, IL	Adults and children	Training
OARS Adult Day Care	712 E. Elm Ave. La Grange, IL	older adults with physical or cognitive impairments	Clinical service, Research
Onward Neighborhood House	600 N. Leavitt Street Chicago, IL	Adults and Children	Training
Oaklawn Federal	Oaklawn, IL	Retired Seniors	Education
Orr High School	730 S. Pulaski	Adolescents	Clinical Services, Education

Organization	Location	Population Served	Partnership
Paulo Freire Child Care Center	1653 West 43rd Street Chicago, IL	Low income Adults	Education, Training
Pilsen Homeless Services	731 W 17th St, 60616	Latino homeless	Clinical services, Education
Phillips High School	224 E. Pershing Rd. Chicago, IL	Adolescents	Clinical Services, Education
Portage Park Senior Wellness Center	4200 N. Long Ave.	Seniors	Clinical Service
Prime Center	4241 W Washington	Homeless	Clinical service, Training
PRO Center	2650 W Hirsch	Homeless	Clinical service, Training
Proviso Adult Day Health Center	439 Bohland Bellwood, IL	older adults with physical or cognitive impairments, African American	Clinical service, Research
Puerto Rican Community Center	2739 W Division	Latino	Research
Rainbow House	Confidential address	Homeless	Clinical service, Training
Renaissance Adult Day Services Inc.	7920 S. Greenwood	older adults with physical or cognitive impairments, African American	Clinical service, Research
Respiratory Health Association of Metropolitan Chicago (formerly American Lung Association)	1440 W Washington Blvd	All Ages	Education
Resurrection Project	1818 S Paulina	Latino	Education, Training
Resurrection Health Care	Chicago	All Ages	Education
Retirement Research Foundation	8765 W. Higgins Rd Suite 430 Chicago, IL 60631	Seniors	Education
Rezin Orr School Based Health Center.	730 North Pulaski	Inner city poor adolescents	Clinical Services, Training, Education
Ridgeland	6822 S Ridgeland, #1E	Homeless	Clinical service, Training

Organization	Location	Population Served	Partnership
Roth & Zucker	Highland Lakes, Suite 130 246 Janata Blvd. Lombard, IL	Women	Clinical Services, Training
Salem Baptist Church of Chicago	11816 S. Indiana Ave	All Ages	Education
Salvation Army	5040 N. Pulaski Road	Low income	Clinical Service, Training, Education
Sanctuary Place	642 N. Kedzie	Women and Children	Clinical Services, Education
Senior Fair at Mt. Greenwood Park	3724 W. 111th St	Seniors 55+	Education, Training
Senior Housing ASSIST	Chicago	geriatric	Education, Research
Senior Service Coalition of SE Chicago	Southeast Chicago	geriatric	Clinical service, Education, Research
SE Provider Council for CDOA	Southeast Chicago	geriatric	Education, Research
Southside Dementia Consortium	Chicago	geriatric	Education, Clinical service
South Short United Methodist Child Care Center	Chicago	All Ages	Training
South Suburban Hospital	17850 S. Kedzie Hazel Crest, IL	Adults with heart failure	Research
St. Christina	11005 S Homan Ave Chicago, IL	Seniors 65+	Education, Training
St.Phillip Lutheran Church	1609 Phingston Road Glenview, IL	Adults with heart failure	Research
St. Vincent DePaul Day Care Center	2145 N. Halsted St. Chicago, IL 60614	Low Income Adults	Educetion, Training
TAB House	2678 W Washington	Homeless	Clinical service, Training
Theresa House	5017 S Hermitage	Homeless	Clinical service, Training
Third Baptist Church	1551 W 95th St, Chicago, IL	Seniors 55+	Education, Training
UIC Department of Family Medicine	1919 W Taylor St	Students	Research, Education
UIC School of Public Health	1603 W. Taylor St	All Ages	Research, Education

Organization	Location	Population Served	Partnership
Webster Elementary School	4055 W Arthington St	African American school age children	Clinical Service, Training, Education
Westside Coalition for Seniors	West Chicago	geriatric	Clinical service, Education, Research
West Side Health Authority	5437 W Division	African American	Research, Clinical Service
White Crane Wellness Center	1355 West Foster Chicago, IL 60640	Seniors	Research, Education
Why Wait Clinic	3815 Highland Ave Downers Grove, IL	Women	Clinical Services

RML Specialty Hospital
Community Benefits Report FY2008

Table of Contents

1. Illinois Attorney General "Annual Non-Profit Hospital Community Benefits Plan Report" Form
2. Attachments
    - A. Mission Statement
    - B. Community Benefits Plan
    - C. Detailed Report of Community Benefits
        - i. Community Benefits by Category
        - ii. Footnotes
    - D. Community Benefits Narrative
    - E. Charity Care Policy
    - F. Audited Financial Statements

Annual Non-Profit Hospital Community Benefits Plan Report

Hospital or Hospital System: RML Specialty Hospital

Mailing Address: 5601 S. County Line Road (Street Address/P.O. Box) Hinsdale, IL 60521 (City, State, Zip)

Physical Address (if different than mailing address):

(Street Address/P.O. Box) (City, State, Zip)

Reporting Period: 06 / 01 / 2007 (Month / Day / Year) through 05 / 31 / 2008 (Month / Day / Year) **Taxpayer Number:** 36-4113692

If filing a consolidated financial report for a health system, list below the Illinois hospitals included in the consolidated report.

Hospital Name	Address	FEIN #

1. **ATTACH Mission Statement:** See Attachment A
The reporting entity must provide an organizational mission statement that identifies the hospital's commitment to serving the health care needs of the community and specify the date it was adopted.

2. **ATTACH Community Benefits Plan:** See Attachment B
The reporting entity must provide its most recent Community Benefits Plan and specify the date it was adopted. The plan should be an operational plan for serving health care needs of the community. The plan must:
   1. Set out goals and objectives for providing community benefits including charity care and government-sponsored indigent health care.
   2. Identify the populations and communities served by the hospital.
   3. Disclose health care needs that were considered in developing the plan.

3. **REPORT Charity Care:** See Attachment C for details
Charity care is care for which the provider does not expect to receive payment from the patient or a third-party payer. Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other federal, State, or local indigent health care programs, eligibility for which is based on financial need. In reporting charity care, the reporting entity must report the actual cost of services provided, based on the total cost to charge ratio derived from the hospital's Medicare cost report (CMS 2552-96 Worksheet C, Part 1, PPS Inpatient Ratios), and not the actual charges for the services.

Charity Care..... $ 0

ATTACH Charity Care Policy: See Attachment E
Reporting entity must attach a copy of its current charity care policy and specify the date it was adopted.

REPORT Community Benefits actually provided other than charity care:
See instructions for completing Section 4 of the Annual Non Profit Hospital Community Benefits Plan Report.

Community Benefit Type	See Attachment C for details See Attachment D for narrative	
Language Assistant Services		$ 107
Government Sponsored Indigent Health Care		$ 861,713
Donations		$ 30,380
Volunteer Services		
a) Employee Volunteer Services	$ 131,238	
b) Non-Employee Volunteer Services	$ 0	
c) Total (add lines a and b)		$ 131,238
Education		$ 27,998
Government-sponsored program services		$ 0
Research		$ 53,677
Subsidized health services		$ 448,511
Bad debts		$ 291,388
Other Community Benefits		$ 2,020,202
	TOTAL	$ 3,865,214

Attach a schedule for any additional community benefits not detailed above.

5. **ATTACH Audited Financial Statements for the reporting period.** See Attachment F

Under penalty of perjury, I the undersigned declare and certify that I have examined this Annual Non Profit Hospital Community Benefits Plan Report and the documents attached thereto. I further declare and certify that the Plan and the Annual Non Profit Hospital Community Benefits Plan Report and the documents attached thereto are true and complete.

James R. Prister, President & CEO
Name / Title (Please Print)

630-286-4120
Phone: Area Code / Telephone No.

Signature

November 17, 2008
Date

Ken Pawola
Name of Person Completing Form

630-286-4458
Phone: Area Code / Telephone No.

kpawola@rmlsh.org
Electronic / Internet Mail Address

630-286-4130
FAX: Area Code / FAX No.

Attachment A

RML SPECIALTY HOSPITAL
MISSION STATEMENT

To provide exceptional health services to unique patients with long-term acute care needs.

We are focused on:

- Delivering quality care measured by clinical outcomes and patient satisfaction;
- Meeting each patient's individualized needs with compassion;
- Delivering highly effective and efficient services;
- Recognizing the value of every staff member; and
- Supporting the specialized needs of our community.

Approved by the RML Specialty Hospital Board of Directors on July 30, 2007

Attachment B

RML Specialty Hospital
Community Benefits Plan – FY2007 AND FY2008

Part 1: Goals and Objectives

The goals of RML Specialty Hospital's community benefit activities are to:

- Support the charitable missions of its Partner (Sponsor) organizations – Rush University Medical Center and Loyola University Medical Center.
- Support the specialized health care needs of RML's defined community (see part 2).
- Identify, promote, and organize volunteer activities to support health care and well-being in our community, with a focus on opportunities related to our core line of business, (i.e., long-term acute care)

Part 2: Community

RML Specialty Hospital's community is not the same as that of a typical community hospital. RML serves over 65 referral sources throughout Northeast Illinois; the vast majority of patients admitted to RML are not from the Hinsdale area. For the purposes of community benefit, RML considers its community to consist of:

- Our Partner (Sponsor) organizations.
- Our top five referral sources that are not Partner organizations (i.e., Hinsdale, Good Samaritan, Northwestern Memorial, Christ, and MacNeal Hospitals).
- The Village of Hinsdale and the surrounding communities (e.g., Burr Ridge, LaGrange, Western Springs).
- The communities where our employees live.

Part 3: Health Care Needs Considered

As a small organization with a regional geographic service area, RML does not believe that it is cost-effective or relevant to conduct an in-depth study of the health care needs of its local geographic community or to develop programs of its own. Instead, RML will trust in the experience and knowledge of charitable organizations in our local geographic community in order to have the greatest impact it can. Specifically, RML will:

- Support the well-conceived charitable mission and community benefit activities of its Partner organizations.
- Support community benefit activities organized by other charitable organizations that take into account identified community needs.
- Look for opportunities to partner with other charitable organizations that have a similar focus as ours, especially in respiratory care.
- Contribute to medical knowledge and best practices through constant support of research in RML's core competencies (ventilator weaning, wound care, complex rehab, infectious diseases)
- Foster the development of medical professionals through support of clinical education and hands-on experience opportunities for students

Adopted by RML Board of Directors
Approved 11/19/2007

Attachment C

RML Specialty Hospital
FY2008 Community Benefits Report

RML Community Benefit – Total FY2008	**$ 3,685,214**
RML Net Revenue – FY2008	**$ 46,225,934**
Community Benefit as a Percentage of Net Revenue – FY2008	**8.4 %**

Community Benefit Categories

A.	Community Health Services [1-11]		$ 194,232
B.	Health Professions Education [12-17]		$ 27,998
C.	Subsidized Health Services [18-19]		$ 361,739
D.	Research [20-22]		$ 53,677
E.	Contributions [23-25]		$ 40,750
F.	Community Building Activities [26-27]		$ 4,924
G.	Community Benefit Operations [28]		$ 8,591
H.	Charity Care [29]		$ 0
I.	Government Sponsored Health Care		$ 1,153,101
	Medicaid [30]	$ 861,713	
	Bad Debt [31]	$ 291,388	
J.	Other [32]		$ 2,020,202

RML Community Benefit – Total FY2008	**$ 3,685,214**

Approved by the RML Board of Directors on 11/17/2008

Attachment C

RML Specialty Hospital
FY2008 Community Benefits Report

Footnotes

(1) All calculations involving RML employees use the average salary for a class of employees and include an indirect cost factor of 0.4527 derived from the methodology approved by the VHA and Catholic Health Association (CHA).

(2) RML provided chaplain services for patients and families.

(3) Several members of RML's management team contributed approximately 750 hours working with CMS in the development of a post-acute patient management tool.

(4) Several RML employees conducted educational programs for local community centers on lung health and general health promotion as well as participated in back-to-school fairs and COPD screens at senior centers.

(5) RML management employees participated on several committees to improve the health of the community.

(6) RML's clinical psychologists conducted weekly support groups for patients' families.

(7) RML held three blood drives during the year attracting a total of 72 donors.

(8) RML contracted with translation services to provide language assistance.

(9) RML employees donated over 35 hours of service to Christmas Caroling for patients.

(10) RML employees contributed nearly 500 hours building "Memory Bears" and lap blankets for clients of Vitas Hospice.

(11) RML assisted families in need with transportation, lodging, and meals assistance while visiting their loved ones at RML.

(12) 85 nursing students from Morton College, College of DuPage, and Joliet Junior College performed clinical rotations at RML.

(13) Three pharmacy students from Midwestern University performed full-time, 6-week clinical rotations at RML.

(14) A respiratory therapy student from College of DuPage performed a part-time, 12-week clinical rotation at RML.

(15) One Speech Therapy student from Illinois State University and one from Governors State University received a total of 200 hours of clinical experience at RML.

(16) 10 Occupational Therapy Students from Governors State University, Midwestern University, Northwestern University, and Northern Illinois University spent a combined 772 hours performing clinical rotations at RML.

(17) A University of Michigan graduate student in the School of Public Health was mentored by a member of the RML executive team.

(18) RML operates a level-4 emergency room, which means that RML is required to treat, stabilize, and transfer patients (if necessary) requiring emergency care. 38 patients received emergency care during the year; none were admitted to RML and none were charged a fee.

(19) RML operated an outpatient pulmonary rehabilitation unit at a loss due to insufficient payment from Medicare.

(20) RML participated in nine clinical research studies on the treatment and care of long-term ventilated patients with physicians from Loyola University Medical Center. RML is the first and only long-term acute care hospital in the country to be included in a grant from the National Institutes of Health (NIH) for research.

(21) RML dietitians, pharmacists, and physical therapists published research articles in health journals.

(22) RML maintains an active Institutional Review Board (IRB) to ensure the ethical performance of all research activities. RML also provides space and administrative / office support for researchers.

Attachment C

RML Specialty Hospital
FY2008 Community Benefits Report

Footnotes (continued)

(23) RML contributed nearly $20,000 to the charitable foundations of several local health care providers.

(24) RML employees volunteered on RML time to raise funds and distribute goods for the RML Annual Holiday Drive that raises clothes, food, and toys for community charities, the American Heart Association's Heart Walk, the Christmas in July food drive, and a Nurses Week bake sale.

(25) RML contributed to fund-raising events for local not-for-profit organizations.

(26) Members of RML's management team provided assistance to the local Chamber of Commerce and participated on a local Aging Well Committee.

(27) Several RML employees and their families participated in Earth Day activities during the spring and fall at local forest preserves.

(28) RML operates a Community Benefits Council made up of RML employees to organize and promote volunteer opportunities in the community for its employees. The Community Benefits Council also organizes, promotes, and supports the RML Annual Holiday Drive and Christmas in July food drive.

(29) RML has a charity care policy that conforms to Illinois Hospital Association guidelines.

(30) RML's cost to treat Medicaid patients in FY2008 was $1,776,597. RML was reimbursed $914,884 for the care provided.

(31) Bad debt expense is calculated monthly.

(32) RML's Board of Directors approved the distribution of $1,000,000 each to Rush University Medical Center and Loyola University Medical Center and $20,202 to RMLHP Corporation in support of each organization's charitable mission.

Attachment D

RML SPECIALTY HOSPITAL:
A VALUABLE PARTNER FOR THE CHICAGOLAND COMMUNITY

RML Specialty Hospital is Chicagoland's center of excellence for long-term acute care and the largest single ventilator weaning hospital in the nation. Our work in ventilator weaning, complex medical rehabilitation, and wound care focuses on patients who require intensive, specialized care as they recover from debilitating disease and injury. At RML we recognize that these patients and their families need a high level of clinical expertise and compassionate care in an environment that gives them the time they need to heal.

As a not-for-profit organization, we also embrace the responsibility we have to those in our "community". Through both local programs and far-reaching initiatives, RML Specialty Hospital's unique presence is felt throughout the Chicago area and beyond, even by people who have never heard of our facility. The following narrative summarizes our community benefits activities for fiscal year 2008 (June 1, 2007 to May 31, 2008).

Partnering for better community health

Beyond our work with our long-term acute patients, RML Specialty Hospital's primary community benefit is the special relationship we have with our partners, Rush University Medical Center and Loyola University Medical Center. Through contributions back to these nationally recognized institutions, we invest in the missions of both systems — helping to provide care and health resources to thousands of people throughout the Chicago area each year. In addition, RMLHP Corporation oversees the charitable mission of RML Specialty Hospital, ensuring timely and appropriate aid to local organizations in need.

Conducting research for medical advancement

Clinical research is imperative to uncovering the root causes of conditions, determining alternative treatments, and improving patient outcomes. RML conducts and participates in numerous clinical research studies on the treatment and care of long-term ventilated patients, as well as those with infectious diseases and medically complex conditions. We are the first and only long-term acute care hospital in the country to be included in a research grant from the National Institute of Health (NIH). There were a total of nine active studies underway at RML during 2008. Following are several examples of studies being conducted jointly by RML Specialty Hospital, Loyola University, and Hines VA Hospital this year:

- Weaning from Prolonged Mechanical Ventilation, Amal Jubran, MD principal investigator. (Funded by National Institute of Health, National Institute of Nursing Research).
- The Correlation between Rehabilitation Therapy Intensity, Therapy Frequency, and Functional Performance in a Long Term Acute Care Hospital.
- Measurement and Outcomes Post severe Brain Injury.

In addition, RML employees have contributed to the body of research knowledge concerning patients requiring RML's specialized care in the areas of dietetics, pharmacy, and rehabilitation therapy.

RML maintains an active Institutional Review Board (IRB) to ensure the ethical performance of all research activities and provides space and administrative/office support for researchers.
For the past two years, RML has partnered with The Research Triangle Institute (RTI) in a CMS-led effort to develop a patient management tool for post-acute care. RML will be instrumental in pilot testing the new tool in 2009.

Educating the caregivers of the future

Many studies have pointed to a shortage of qualified health professionals in the not-too-distant future. At RML Specialty Hospital, we provide opportunities for hands-on clinical experience that ensure well-trained caregivers will be available for our community. Each year, we welcome dozens of nursing students as well as students of other health care disciplines to sample, study and continue RML's brand of quality, compassionate care for those who need it most. In 2008:

- 85 nursing students from Morton College, College of DuPage, and Joliet Junior College performed clinical rotations.
- 15 Pulmonary Fellows were trained.
- 16 students received training in pharmacy, respiratory therapy, occupational therapy, and speech therapy.

Offering health education and resources to our community

RML Specialty Hospital provides a number of additional benefits to our community, including lung function testing, health education for the students of local schools, and support groups for the grieving families of seriously ill patients. In addition, RML employees volunteer countless hours in many community events such as back-to-school fairs and Earth Day projects. In these ways and many more, RML Specialty Hospital stands as a vital health resource to our patients, their families, our own employees and our neighbors. These programs are an honor to provide, and an essential part of our mission. In 2008,

- RML's clinical psychologists conducted weekly support groups for patients' families.
- RML held three blood drives during the year, attracting a total of 72 donors.
- Staff members participated in morale-boosting activities, such as Christmas caroling for patients, around the holidays.
- RML employees participated in local senior fairs and back-to-school fairs.
- RML respiratory therapists conducted screening tests for pulmonary disease and provided lung-health education at several community centers.
- Sensitive to individual beliefs and traditions, RML's Chaplains provided emotional and spiritual support services to those in need.

Supporting local and far-reaching initiatives through volunteerism and donations

In 2008, RML built on its recognized status as an organizational leader in the community. This past year,

- RML's annual Holiday Drive and Christmas in July collected nearly 600 pounds of food and scores of toys, hats and mittens and other clothing items.
- Employees volunteered to raise funds for and participated in the American Heart Association's Heart Walk.
- Employees donated to the RML fund, which provided for taxi services, hotel stays, and meals to support families with loved ones in the hospital.
- RML staff created 40 Memory Bears that were given to families receiving support from VITAS Hospice in remembrance of their loved ones.

- Community members volunteered over 425 hours of their time and efforts at RML this year. They visited with patients, assisted at nursing stations, participated on the President's Advisory Board and took part in community awareness and fundraising projects.
- RML operates a Community Benefits Council made up of RML employees and physicians to organize and promote volunteer opportunities in the community for its employees.

Providing charity care to those in need

In 2008, RML provided charitable health care services to the community in several ways:

- Medicaid – RML Specialty Hospital provided unreimbursed health care services to Medicaid patients.
- Debt forgiveness – RML provided unreimbursed services to several individuals in the community who were unable to fully finance their hospital expenses.
- Charity care - Charity Care was extended to all who needed and applied.
- Emergency care – RML's Level 4 emergency room provided 27 patients emergency care at no charge; patients were treated, stabilized, then transferred to local hospitals.

Attachment E

RML SPECIALTY HOSPITAL

DEPARTMENT: ADMINISTRATION		NUMBER: ADM 1507
TITLE: CHARITY CARE		PAGE 1 OF 4
EFFECTIVE DATE: 06/1997 REVISED DATE: 08/1999, 01/2007 REVIEW DATE: 01/2005	APPROVED BY: Signatures on File 01/2007 President & CEO	
DISTRIBUTION: All Departments	APPROVED BY: _____ Vice President Finance & CFO	

POLICY

RML Specialty Hospital (RML) is organized for the purpose of providing health care services, which includes the provision of care to those patients who are financially unable to pay the full cost of the health care services they receive. Patients who earn less than 150% of the Federal Poverty Guideline will receive health care at no cost while those who earn up to 350% of the Federal Poverty Guideline may be eligible for a sliding scale partial discount.

PURPOSE

The purpose of providing charity care and partial discounts to self-pay uninsured patients is to insure the hospital fulfills its mission of serving the community by assisting patients based upon medical necessity who are financially indigent or experiencing temporary financial hardship. This policy reflects RML's responsibility as a not-for-profit health care organization.

PROCEDURE

A. COMMUNICATION

The availability of hospital financial assistance as defined under this policy shall be widely communicated to patients including but not limited to:

1) Posting a sign in areas of the hospital commonly utilized for admission and registration of patients with the following notice:

"You may be eligible for financial assistance under the terms and conditions the hospital offers to qualified patients. For more information, please contact either the Director of Patient Financial Services or the Admitting Manager."

The sign shall be in English and in any other language that is the primary language of at least 5% of the patients served by RML annually as defined by RML's 5/31 fiscal year.

2) Availability of financial assistance must be prominently displayed on RML's public website including a description of the financial assistance application process and a copy of the financial assistance application.

3) Written material shall be available regarding RML's financial assistance program in areas of the hospital commonly utilized for admission and registration of patients.

B. INPATIENT CARE

Due to the nature of RML Specialty Hospital as a long-term specialty hospital, all inpatient admissions are referred to RML from other area hospitals for specialty care. Each patient referred shall be evaluated clinically prior to admission to insure the patient meets clinical inpatient admission criteria.

The Patient Financial Services Department (PFS) prior to admission shall review each patient's source of insurance and ability to pay. A financial representative from PFS will explain to self-pay uninsured patients RML's payment policy and discuss a payment plan for the proposed admission. Patients who are not able to comply with the payment will then be evaluated for possible Medicaid eligibility and spend down requirements. RML will either initiate the Medicaid application or direct the patient to the Public Aid Office whenever it appears the patient could qualify. Patients will not be extended financial assistance if they fail to cooperate with either the Medicaid application process or any other document request of the patient as stated in this policy. Should a patient not have sufficient insurance or lack the ability to pay for services out of pocket, each case shall be independently evaluated for charity care eligibility depending upon the following:

1) The hospital will insure charity care is rendered only to those who are indigent and in true need of financial assistance by reviewing a referred patient's financial assets, liabilities, and sources of income. The following documents will be required of the patient to apply for charity care:

   A. A copy of the previous year W2, 1040 tax return, and any other applicable tax forms that were filed.
   B. Copies of the last 3 most recent paycheck stubs from the employer or a letter from the employer if the employee is paid cash stating the amount paid weekly.
   C. Copies of Social Security checks if the patient receives one.
   D. Copy of last statement for all checking, investment, and savings accounts.
   E. Complete and signed financial disclosure attestation wherein the patient lists all known assets, liabilities, and income sources along with authorization for RML to perform credit checks and inquiries validating the attestation.

2) The availability of unoccupied patient rooms.

A determination of charity care will be made by comparing a referred patient's annualized income to the Federal Poverty Guidelines taking into consideration available assets such as cash and investments but not the patient's primary home residence or automobile.

In addition to the provision of charity care to financially indigent patients, the hospital may also offer partial discounts from charges on a patient's bill. Some examples of such discounts from charges offered are as follows.

1) The hospital is a participating provider in the State of Illinois Medicaid program and has agreed to accept the state's fee schedule for long term specialty hospitals as payment in full, which does not cover the full cost of care.

2) The hospital maintains contracts with managed care organizations and insurance companies, which extend discounted pricing arrangements.

3) The hospital will offer sliding scale partial discounts to self-pay uninsured patients who do not qualify for 100% charity care and who's immediate family incomes are 350% or less of the Federal Poverty Guideline. These patients shall be subject to the same documentation eligibility criteria in this policy as charity care patients in order to determine the level of discount defined below.

% of Federal Poverty Level	Discount From Billed Charges
>150% and <= 200%	90%
>200% and <= 250%	80%
> 250% and <= 300%	70%
> 300% and <= 350%	60%

C) EMERGENCY CARE

The hospital maintains a standby emergency department, and triages and stabilizes all patients regardless of the ability to pay. If a patient is unable to pay for health care services rendered, a determination for charity care shall be made in a similar manner as inpatient admissions by reviewing the financial history of the patient to insure charity care is extended to those who are indigent and are in need of financial assistance.

D) COLLECTION PRACTICE GUIDELINES

When a patient is deemed eligible for a partial discount due to income/assets at or below 350% of the Federal Poverty Guideline, a Patient Accounts Representative will work with the patient to establish a reasonable payment plan that takes into consideration available income and assets, the amount of the discounted bill(s), and any prior payments. The patient will be advised as to their responsibilities to RML including making a good faith effort to timely make payments according to the plan and notifying RML of any changes in financial ability to pay.

RML will not pursue legal action for non-payment of bills against patients offered partial discounts who have clearly demonstrated they no longer have neither the sufficient income nor assets to meet their financial obligations.

Legal action, including the garnishment of wages may be taken by RML to enforce the terms of the payment plan when there is evidence the patient or responsible party offered a partial discount has sufficient income and/or assets to meet his or her obligation. Such actions shall be in compliance with administrative policy PFS004 – Self Pay Collections including appropriate written authorization from either the President & CEO or the Vice President Finance & CFO.

RML will not place a lien on a partial discount patient's primary residence if this is the patient's sole real asset unless the value of the property clearly indicates an ability to assume significant financial obligations. The hospital will not execute a lien for the purpose of forcing the sale or foreclosure of the patient's primary residence to pay for an outstanding medical bill.

RML will refrain from using aggressive collection practices such as body attachment to require the patient or responsible party to appear in court.

RML will notify external collection agencies of the collection procedures outlined in this policy for discounted patients and require compliance.

Developed by: Vice President Finance & CFO
Committee Approval: RML Board of Directors January 22, 2007

RML Health Providers, L.P.

Financial Statements as of and for the Years Ended May 31, 2008 and 2007, and Independent Auditors' Report

RML HEALTH PROVIDERS, L.P.

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INDEPENDENT AUDITORS' REPORT

To the Board of Directors of
RML Health Providers, L.P.:

We have audited the accompanying balance sheets of RML Health Providers, L.P. (the "Partnership") as of May 31, 2008 and 2007, and the related statements of operations and changes in partners' equity, changes in partners' equity, and cash flows for the years then ended. These financial statements are the responsibility of the Partnership'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 Partnership'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 financial statements present fairly, in all material respects, the financial position of the Partnership as of May 31, 2008 and 2007, and the results of its operations and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Deloitte & Touche LLP

July 7, 2008

Member of
Deloitte Touche Tohmatsu

RML HEALTH PROVIDERS, L.P.

BALANCE SHEETS
AS OF MAY 31, 2008 AND 2007

	2008	2007
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 2,496,390	$ 2,993,500
Short-term investments (Note 3)	1,213,325	4,511,851
Current portion of assets limited as to use	29,610	164,346
Patient accounts receivable, less allowances for uncollectible accounts of $539,000 in 2008 and $660,000 in 2007	5,872,425	4,174,287
Other accounts receivable	9,099	63,314
Prepaid expenses	923,694	857,574
Other current assets	358,617	375,397
Total current assets	10,903,160	13,140,269
LONG-TERM INVESTMENTS (Note 3)	5,748,886	5,210,006
ASSETS LIMITED AS TO USE — Self-insurance trust (Note 8)	397,425	566,368
PROPERTY AND EQUIPMENT — At cost (Note 2):		
Leasehold improvements	14,101,909	12,792,298
Equipment and furniture	9,751,382	9,146,699
Construction in progress	153,995	144,551
Property and equipment — at cost	24,007,286	22,083,548
Less accumulated depreciation	(12,506,575)	(11,833,785)
Property and equipment — net	11,500,711	10,249,763
OTHER ASSETS	732,930	586,714
TOTAL	$ 29,283,112	$ 29,753,120
LIABILITIES AND PARTNERS' EQUITY		
CURRENT LIABILITIES:		
Accounts payable and accrued expenses	$ 4,024,011	$ 4,910,611
Partner distributions payable		2,020,202
Estimated settlements due to third-party payors	248,228	804,459
Due to affiliated corporation (Note 6)	253,789	188,093
Long-term debt — current portion (Note 7)	616,315	400,000
Total current liabilities	5,142,343	8,323,365
RESERVE FOR PROFESSIONAL LIABILITY CLAIMS (Note 8)	625,527	920,024
LONG-TERM DEBT — Noncurrent portion (Note 7)	3,926,488	3,533,333
OTHER NONCURRENT LIABILITIES	1,064,724	565,565
Total liabilities	10,759,082	13,342,287
PARTNERS' EQUITY:		
Limited partners:		
Rush University Medical Center	9,201,317	8,155,285
Loyola University Medical Center	9,201,317	8,155,285
General partner — RMLHP Corporation	121,396	100,363
Total partners' equity	18,524,030	16,410,833
TOTAL	$ 29,283,112	$ 29,753,120

See notes to financial statements.

RML HEALTH PROVIDERS, L.P.

STATEMENTS OF OPERATIONS AND CHANGES IN PARTNERS' EQUITY
FOR THE YEARS ENDED MAY 31, 2008 AND 2007

	2008	2007
REVENUE:		
Net patient service revenue (Note 2)	$44,635,067	$42,831,032
Contribution revenue (Note 2)	858,181	750,821
Other revenue (Note 2)	729,432	769,539
Realized gains (losses) on investments	3,254	(18,119)
Total revenue	46,225,934	44,333,273
EXPENSES (Note 9):		
Salaries, wages, and benefits	25,586,704	23,782,484
Purchased services	4,169,771	3,963,130
Supplies	4,946,167	4,452,616
Rental	1,338,733	1,217,921
Depreciation and amortization	1,671,898	1,618,157
Provision for bad debts	733,999	326,625
Interest	174,287	194,907
Utilities	498,358	475,175
Insurance	522,670	900,645
Other	1,951,859	2,903,302
Total expenses	41,594,446	39,834,962
INCOME FROM OPERATIONS	4,631,488	4,498,311
NONOPERATING EXPENSES — Loss on sale of assets — net	(97,523)	(38,232)
EXCESS OF REVENUE OVER EXPENSES	4,533,965	4,460,079
OTHER CHANGES IN PARTNERS' EQUITY:		
Net assets released from restrictions used for property acquisitions		50,870
Partner distributions	(2,020,202)	(5,050,505)
Unrealized gains (losses) in investments	(38,028)	94,474
Pension-related changes other than net periodic pension cost	(362,539)	
Total changes in unrestricted Partners' Equity	2,113,196	(445,082)
CHANGES IN TEMPORARILY RESTRICTED FUNDS:		
Temporarily restricted contributions		114,916
Net assets released from restrictions for operating purposes		(99,479)
Net assets released from restrictions used for property acquisitions		(50,870)
Total changes in temporarily restricted funds		(35,433)
CHANGE IN PARTNERS' EQUITY	$ 2,113,196	$ (480,515)

See notes to financial statements.

RML HEALTH PROVIDERS, L.P.

STATEMENTS OF CHANGES IN PARTNERS' EQUITY
FOR THE YEARS ENDED MAY 31, 2008 AND 2007

	Rush	Loyola	RMLHP Corp.	Temporarily Restricted Funds	Total
PARTNERS' EQUITY BALANCE — May 31, 2006	$ 8,375,600	$ 8,375,600	$ 104,715	$ 35,433	$ 16,891,348
Excess of revenue over expenses	2,207,739	2,207,739	44,601		4,460,079
Partner distributions	(2,500,000)	(2,500,000)	(50,505)		(5,050,505)
Temporarily restricted contributions				114,916	114,916
Net assets released from restrictions for operating purposes				(99,479)	(99,479)
Net assets released for property acquisitions	25,181	25,181	508	(50,870)	
Unrealized gains on investments	46,765	46,765	944		94,474
PARTNERS' EQUITY BALANCE — May 31, 2007	8,155,285	8,155,285	100,263	-	16,410,833
Excess of revenue over expenses	2,244,313	2,244,313	45,340		4,533,966
Partner distributions	(1,000,000)	(1,000,000)	(20,202)		(2,020,202)
Pension-related changes other than net periodic pension cost	(179,457)	(179,457)	(3,625)		(362,539)
Unrealized gains (losses) on investments	(18,824)	(18,824)	(380)		(38,028)
PARTNERS' EQUITY BALANCE — May 31, 2008	$ 9,201,317	$ 9,201,317	$ 121,396	$ -	$ 18,524,030

See notes to financial statements.

RML HEALTH PROVIDERS, L.P.

STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED MAY 31, 2008 AND 2007

	2008	2007
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in partners' equity	$ 2,113,196	$ (480,515)
Adjustments to reconcile change in partners' equity to net cash provided by operating activities:		
Depreciation and amortization	1,671,898	1,618,157
Provision for bad debts	733,999	326,625
Unrealized (gains) losses on investments	38,028	(76,355)
Realized (gains) losses on investments	(3,254)	
Pension-related changes other than net periodic pension cost	362,539	
Net realized losses on sale of assets	97,523	38,232
Partner distributions	2,020,202	5,050,505
Proceeds from restricted contributions		35,433
Changes in:		
Patient accounts receivable	(2,432,137)	2,929,017
Other accounts receivable	54,215	119,738
Prepaid expenses	(66,120)	(78,454)
Other current assets, noncurrent assets, and noncurrent liabilities	165,397	(28,838)
Accounts payable, accrued expenses, and reserve for professional liability claims	(3,045,541)	827,874
Due to affiliated corporation	65,696	29,361
Estimated settlements due to third-party payors	(556,231)	366,149
Net cash provided by operating activities	1,219,410	10,676,929
CASH FLOWS FROM INVESTING ACTIVITIES:		
Property and equipment additions	(3,176,126)	(2,064,451)
Proceeds from sale of investments	11,727,539	7,595,861
Purchases of investments	(8,857,201)	(9,139,057)
Net cash used in investing activities	(305,788)	(3,607,647)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Payment on long-term debt	(472,105)	(400,000)
Partner distributions	(2,020,202)	(5,050,505)
Proceeds from new debt issuance	1,081,575	
Proceeds from restricted contributions		15,437
Net cash used in financing activities	(1,410,732)	(5,435,068)
(DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS	(497,110)	1,634,214
CASH AND CASH EQUIVALENTS — Beginning of year	2,993,500	1,359,286
CASH AND CASH EQUIVALENTS — End of year	$ 2,496,390	$ 2,993,500
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION:		
Cash paid for interest	$ 174,287	$ 194,907
Noncash additions to property and equipment	$ -	$ 155,758

See notes to financial statements.

RML HEALTH PROVIDERS, L.P.

NOTES TO FINANCIAL STATEMENTS
AS OF AND FOR THE YEARS ENDED MAY 31, 2008 AND 2007

1. ORGANIZATION

RML Health Providers, L.P. (RML), an Illinois limited partnership between Rush University Medical Center (Rush) and Loyola University Medical Center (Loyola), each with a 49.5% interest, operates a 174-licensed bed, long-term acute-care hospital, providing certain specialty services such as acute ventilator, medically complex, and wound care. RMLHP Corporation (RMLHP), an Illinois not-for-profit corporation owned equally by Rush and Loyola, holds a 1% interest as the general partner of RML. Partnership excess of revenue over expenses is allocated to the partners based on their relative ownership.

2. SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation — The accompanying financial statements have been presented in conformity with accounting principles generally accepted in the United States of America as recommended in the audit and accounting guide for healthcare organizations published by the American Institute of Certified Public Accountants.

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, liabilities, revenue, and expenses and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates are used by management to record amounts relating to patient accounts receivable, estimated settlements due to third-party payors, reserves for professional liability claims, and for the supplement executive retirement plan, among others. Actual results could differ from those estimates.

Net Patient Service Revenue — Substantially all of net patient service revenue for 2008 and 2007, respectively, is derived from services rendered to beneficiaries under the Medicare, Medicaid, and Blue Cross programs, as well as several contractual arrangements with various health maintenance and preferred provider organizations. All charges are for inpatient, outpatient, and physician services.

Effective June 1997, the Centers for Medicare and Medicaid Services (CMS) granted RML status as a long-term acute-care hospital (LTCH) for Medicare reimbursement purposes. Effective June 1, 2003, Medicare reimbursement to RML changed from allowable costs calculated under Tax Equity & Fiscal Responsibility Act (TEFRA) reimbursement rules to a diagnosis-related grouping (DRG) prospective payment system (PPS) for inpatient LTCH services. The LTCH PPS DRG payment system was created by CMS as a final rule implementing Section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Act of 1999.

Blue Cross and Medicaid reimbursement is based upon per diem rates as defined by contract or promulgated by law. Health maintenance and preferred provider organizations' payments are based primarily on per diem amounts. RML has provided, by a charge against net patient service revenue, for differences between gross charges for patient services and estimated reimbursement from these third-party payor programs. Cost report settlements are accrued in the period the related services are rendered and adjusted in future periods as final settlements are determined. Laws and regulations

governing the Medicare program are extremely complex and subject to interpretation. As a result, there is a reasonable possibility recorded estimated settlements could change by a material amount in the near term.

In December 2006, CMS approved the Illinois Hospital Assessment Program covering the period from August 1, 2005 to June 30, 2008. The net loss to RML from this program in fiscal years 2008 and 2007 was $579,297 and $1,110,319, respectively. Due to the tax assessment provisions contained in the legislation, implementation of the program impacted both operating revenues and expense in the statements of operations. At May 31, 2008 and 2007, Medicaid supplement revenues of $426,699 and $817,838 respectively, were included in net patient service revenue and the provider assessment tax for fiscal years 2008 and 2007 of $1,005,996 and $1,928,157, respectively were included in other expense. Further legislative changes to Medicaid reimbursement provided to Illinois hospitals could have a material adverse effect on RML's operating results.

Contribution Revenue — Contribution revenue represents unrestricted donations and use of restricted donations for their intended purpose specific to operating activity. In fiscal years 2008 and 2007, RML received, from a single donor, unrestricted donations totaling $598,824 in 2008 and $582,717 in 2007.

Other Revenue — Other revenue includes interest income earned on investments and other miscellaneous income.

Cash and Cash Equivalents — Cash and cash equivalents includes investments in highly liquid financial instruments with original maturities of three months or less.

Investments — Investments are measured at their fair value and are recorded as such in the financial statements. Investment gains and losses (including interest, dividends, realized gains and losses, and other than temporary declines in investment fair values below cost, if any) are included in the excess of revenue over expenses. Unrealized gains and losses are excluded from the excess of revenue over expenses and are recognized as other changes in partners' equity. RML routinely monitors and evaluates the declines in the values of investments to determine whether other-than-temporary impairment losses have occurred. At May 31, 2008 and 2007, management does not believe that any of the declines in value of investments were other-than-temporary.

Inventories — Inventories are stated at the lower of cost or market, using the first-in, first-out method and are included in other current assets in the accompanying balance sheets.

Property and Equipment — RML depreciates property and equipment using the straight-line method over the asset's useful life, or in the case of leasehold improvements, over its useful life or the remaining term of the facility lease (including option period), whichever is shorter. Costs incurred to maintain or repair property, plant, and equipment that do not significantly enhance its useful life are expensed when incurred. One-half year's depreciation is recorded in the year of acquisition and in the year of retirement. Approximate average depreciable lives for financial statement purposes by classification are as follows:

Equipment and furniture	3–14 years
Leasehold improvements	5–14 years

Contributions — Temporarily restricted net assets are assets whose use has been limited by donors to a specific time period or purpose. Net assets released from restrictions that are used for operating purposes are reported in the statements of operations as other revenue. Net assets released from restrictions that

are used for property acquisitions are reported as increases in partners' equity in the statements of changes in partners' equity. RML's temporarily restricted net assets are restricted for spiritual and family needs.

Income Taxes — The Internal Revenue Service has determined that RML is exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code of 1986. Accordingly, income from operations of RML is generally not subject to federal or state income tax. However, income that is earned from activities that are unrelated to RML's tax-exempt purpose is subject to federal and state income tax.

Accounting for Uncertainty in Income Taxes — In June, 2006, the FASB issued FIN No. 48, *Accounting for Uncertainty in Income Taxes — an interpretation of FASB Statement No. 109.* FIN No. 48 prescribes a comprehensive model for how a company should recognize, measure, present, and disclose in its financial statements uncertain tax positions that the company has taken or expects to take on a tax return. RML adopted the provisions of FIN No. 48 on June 1, 2007. As a result of the implementation of FIN No. 48, RML recorded no liability for unrecognized tax benefits.

Concentrations of Credit Risk — RML grants unsecured credit to its patients, most of whom are Chicagoland area residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors as of May 31, 2008 and 2007, was as follows:

	2008	2007
Medicare	47 %	52 %
Managed care	41	35
Medicaid	8	8
Commercial	3	2
Self Pay	1	3
Total	100 %	100 %

Insurance Expense — The provision for professional and general liability claims, included in the accompanying statements of operations, includes estimates of the ultimate costs for both reported and incurred but not reported claims and premiums relating to purchased insurance coverage maintained during the year (see Note 8).

Fair Value of Financial Instruments — The carrying amounts of cash and cash equivalents, short-term investments, accounts receivable, accounts payable, and long-term debt approximate their related fair values.

Long-Lived Assets — RML continually evaluates whether circumstances have occurred that would indicate the remaining estimated useful life of long-lived assets may warrant revision or that the remaining balance of such assets may not be recoverable. When factors indicate that such assets should be evaluated for possible impairment, RML uses an estimate of the undiscounted cash flows over the remaining life of the asset in measuring whether the asset is recoverable. To date, no such impairments have been necessary.

Fair Value measurement – In September 2006, the FASB issued FASB Statement No, 157, *Fair Value Measurements*. This statement defines fair value, establishes a framework for measuring fair value, and expands disclosures about fair value measurements. The statement does not require any new fair value measurements, rather it provides guidance on how to perform fair value measurements as required or

permitted under other accounting pronouncements. To the extent required, this statement will be prospectively adopted by RML effective June 1, 2008. FASB Statement No. 157 is not expected to have a material impact on the RML's results of operations or financial condition.

In February 2007, the FASB issued FASB Statement No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities — Including an amendment of FASB Statement No. 115.* FASB Statement 159 permits entities that elect the fair value provisions of FASB Statement 157 to choose to measure many financial instruments and certain other items at fair value. It also provides the opportunity to mitigate volatility, in reported earnings caused by measuring related assets and liabilities differently, without having to apply complex hedge accounting provisions. Accordingly, unrealized gains and losses on items for which the fair value option has been elected will be reported in earnings. FASB Statement 159 is effective for years beginning after November 15, 2007. However, for RML, early adoption is permitted, provided RML also elects to apply the provisions of FASB Statement 157. RML is assessing the impact the application of FASB Statement 159 may have on the financial statements.

3. INVESTMENTS

Assets Limited as to Use and Investments — Assets limited as to use consist solely of investments held in a self insurance trust. Assets limited to use as of May 31, 2008 and 2007, are comprised of the following:

	2008	2007
Assets limited as to use — self-insurance trust:		
U.S. Government obligations	$ 24,515	$473,336
Certificates of deposit		158,000
Other debt securities	402,520	99,378
Total	$427,035	$730,714

Short-term investments as of May 31, 2008 and 2007, are comprised of the following:

	2008	2007
Short-term investments:		
U.S. Government obligations	$ 966,638	$2,588,164
Auction rate securities		1,650,000
Mutual funds	246,687	273,687
Total	$1,213,325	$4,511,851

Long-term investments as of May 31, 2008 and 2007, are comprised of the following:

	2008	2007
Long-term investments:		
U.S. Government obligations	$5,213,748	$4,948,293
Other debt securities	535,138	261,713
Total	$5,748,886	$5,210,006

RML held a $275,000 investment in auction rate securities as of May 31, 2008. On June 6, 2008, $200,000 was redeemed at par value. Management believes that the amounts presented in the balance sheets represents the best estimate of fair value as of May 31, 2008 and 2007.

Investment Income — Net investment income consists of interest and dividend income and net realized investment gains or losses. Net investment, interest and dividend income is reported as part of other revenue in the statements of operations. Total investment income and unrealized gains (losses) on investments for the years ended May 31, 2008 and 2007, is comprised of the following:

	2008	2007
Investment income:		
Interest and dividends	$478,468	$532,003
Net realized gains (losses) on sales of securities	3,254	(18,119)
Total	$481,722	$513,884
Net unrealized gains (losses) on investments	$ (38,028)	$ 94,474

4. LEASE COMMITMENTS

During fiscal year 1998, RML entered into a 10-year lease with the Suburban Cook County Tuberculosis Sanitarium District (the owner of the premises) ("Suburban") for the facilities. The facility lease contains provisions to extend the lease term for three successive additional periods of five years each under the terms and conditions of the current lease at the option of RML provided no event of default has occurred. In fiscal year 2006, RML executed its option to extend the facility lease for the first five-year renewal term. In July 2007 the County of Cook became the successor owner of the leased facility as a result of the dissolution of the Suburban Cook County Tuberculosis Sanitarium District. All terms, conditions, rights, and responsibilities of the lease remain the same and are assigned to the County of Cook.

RML paid $962,118 and $934,095 under this lease in 2008 and 2007, respectively. Future minimum lease payments under this facility lease as of May 31, 2008, are as follows:

Years Ending May 31	Amount
2009	$ 999,641
2010	1,029,630
2011	1,060,519
2012	1,092,334
Total	$4,182,124

5. RETIREMENT PLANS

RML sponsors a qualified defined contribution plan, the RML Health Providers Employees' 401(k) Savings Plan (the "Plan"). The Plan is available to employees on the first day of the month following 90 days from their date of hire. Employer contributions are made on a biweekly basis equal to the employees' percentage of contributions up to a maximum of 4%. For 2008 and 2007, RML contributed $638,131 and $664,196, respectively, to the Plan.

RML sponsors a 457(b) deferred compensation plan, the RML Health Providers L.P. Deferred Compensation Plan (the "457(b) Plan"). The 457(b) Plan is available to certain employees and physicians who can elect to defer a percentage of their compensation in accordance with the 457(b) Plan. Additionally, RML can elect to make an annual discretionary contribution to the 457(b) Plan as determined by the Board of Directors. For 2008 and 2007, RML contributed $66,731 and $62,751, respectively, to the 457(b) Plan. The 457(b) Plan assets remain the property of RML until paid or made available to participants and are subject to the claims of general creditors. As of May 31, 2008 and 2007, 457(b) Plan assets of $655,939 and $565,565, respectively, are included in other assets in the balance sheets. The 457 (b) Plan's assets are invested in stock and bond mutual funds at May 31, 2008 and 2007.

RML sponsors a supplemental executive retirement plan available to a select group of executives as determined by the RML Board of Directors. The plan effective November 1, 2007, is a nonqualified deferred compensation plan that is subject to the provisions of Sections 409A and 457(f) of the Internal Revenue Code. The following tables summarize the change in projected benefit obligations and changes in plan assets for the defined plan benefits during 2008 and the assumptions used in making these estimates.

The Company uses a May 31 measurement date.

Change in Benefit Obligation

Benefit obligation — beginning of year	$ -
Service cost	18,482
Interest cost	13,405
Actuarial (gain) loss	7,670
Plan amendments	369,228
Benefit obligation — end of year	$408,785
Accumulated benefit obligation — end of year	$ 56,458
Weighted-average assumptions used to determine benefit obligation at end of year:	
Discount rate	6.00 %
Rate of compensation increase	4.00

Funded Status — The funded status at the end of the year, and the related amounts recognized on the statement of financial position as of May 31, 2008, are as follows:

Funded status — end of year:	
Fair value of plan assets	$ -
Benefit obligations	408,785
Funded status	$ (408,785)
Amounts recognized in the statement of financial position consist of:	
Noncurrent asset	$ -
Current liability	
Noncurrent liability	(408,785)
	$ (408,785)
Amounts recognized in changes in partners' equity consist of:	
Net actuarial loss (gain)	$ 7,670
Prior service cost (credit)	354,869
	$ 362,539

The projected benefit obligation and fair value of plan assets for pension plans with a projected benefit obligation in excess of plan assets at May 31, 2008, were as follows:

Projected benefit obligation in excess of plan assets:	
Projected benefit obligation — end of year	$ 408,785
Fair value of plan assets — end of year	

The projected benefit obligation, accumulated benefit obligation, and fair value of plan assets for pension plans with an accumulated benefit obligation in excess of plan assets at May 31, 2008 and 2007, were as follows:

	May 31, 2008
Accumulated benefit obligation in excess of plan assets	
Projected benefit obligation — end of year	$ 408,785
Accumulated benefit obligation — end of year	56,458
Fair value of plan assets — end of year	

	May 31, 2008
Expected cash flows:	
Pension benefits:	
Expected employer contributions — 2008*	$ -
Expected benefit payments:	
2008	
2009	
2010	
2011	
2012	
2013–2017	272,888

*Expected contributions reflect amounts expected to be contributed to funded plans.

	May 31, 2007
Components of net periodic benefit cost:	
Service cost	$ 18,482
Interest cost	13,405
Amortization of prior service (credit) cost	14,359
Net period benefit cost	46,246
Other changes in plan assets and benefit obligations recognized in partners' equity:	
Curtailment effects	-
Settlements	
Current year actuarial (gain) loss	7,670
Amortization of actuarial gain (loss)	
Current year prior service (credit) cost	369,228
Amortization of prior service credit (cost)	(14,359)
Amortization of transition asset (obligation)	
Total recognized in other comprehensive income	362,539
Total recognized in net periodic benefit cost and other changes in partners' equity	$ 408,785
Weighted-average assumptions used to determine net periodic cost:	
Discount rate	6.00 %
Expected long-term rate of return on plan assets	N/A
Rate of compensation increase	4.00 %
The estimated amounts that will be amortized from accumulated Changes in partners' equity into net periodic benefit cost in 2008 are as follows:	Pension Benefits
Actuarial (gain) loss	$ -
Prior service (credit) cost	24,615
Total	$ 24,615

6. RELATED PARTIES

In the normal course of business, RML purchases certain of its services and supplies from the partners and their various affiliated organizations. RML purchased laboratory services, dialysis, blood, and certain other services totaling $1,923,093 and $1,598,400 in 2008 and 2007, respectively, from Loyola.

7. LONG-TERM DEBT

During 2002, RML issued $6,000,000 in tax-exempt debt through a Project Loan Agreement with the Illinois Finance Authority to refund RML for current and previous capital expenditures.

The principal portion of the loan is repaid monthly based on a 15-year amortization schedule with a balloon payment at the end of the three-year term. Effective April 1, 2004, the loan was extended for an additional three-year period under the same terms with a balloon payment for the outstanding principal due in March 2008. Effective April 1, 2007, the loan was extended an additional 4.75 years with a

balloon payment for the outstanding principal due now in December 2012. The tax-exempt interest rate is the 7-day Securities Industry and Financial Market Association (SIFMA) reset rate plus 1.05%. The effective interest rate, including related financing fees, was 4.81% and 5.20% during fiscal years 2008 and 2007, respectively. Management intends to negotiate additional term extensions to the existing note beyond the current expiration date in December 2012, when the balance of the outstanding principal is due and payable. The tax-exempt financing is backed by a letter of credit guaranteed equally by RML's partners. The letter of credit contains certain covenants to be maintained by both RML and its partners over the duration of the loan.

During 2008 RML entered into a two-year Term Loan Agreement for $1,081,575 to finance certain medical equipment. The principal is repaid on a straight-line basis and amortized over five years with a balloon payment for the outstanding principal due in January 2010. The interest rate for the two-year period is fixed at 3.75% on a taxable basis.

Future principal payments are as follows:

Years Ending May 31	Amount
2009	$ 616,315
2010	1,193,155
2011	400,000
2012	400,000
2013	1,933,333
Total	$4,542,803

Management believes RML was in compliance with all covenants under its loan agreements at May 31, 2008.

8. RESERVE FOR PROFESSIONAL LIABILITY CLAIMS

Prior to September 1, 1998, RML was self-insured for professional and general liability risks up to a self-insured retention of $1 million per occurrence and $3 million annual aggregate. As of May 31, 2008, there are no known loss exposures requiring reserves associated with this time period.

For the period of September 1, 1998 through February 28, 2002, RML purchased insurance coverage on an occurrence basis with no self-insured retention amount, in the amount of $1 million per occurrence and $3 million annual aggregate. In addition to this coverage, RML maintained general and professional liability excess insurance in the amount of $10 million per occurrence and annual aggregate.

Since March 1, 2002, RML has purchased insurance coverage on a claims-made basis with a $100,000 per claim and no aggregate self-insured retention amount, with insured limits of $1 million per occurrence and $3 million annual aggregate. Additionally, RML has purchased general and professional excess liability insurance coverage on a claims-made basis in the amount of $20 million per occurrence and annual aggregate. For both the self-insured retention including incurred but not reported risks, RML has established a trust fund and related reserve. The determination of the reserve is based upon an independent actuarial valuation. During 2008, RML's professional liability declined as a result of settled claims and positive claims development experience. As of May 31, 2007, RML had pledged $158,000 of

assets limited to use as collateral related to a letter of credit issued to RML's professional liability insurer. During 2008 RML's professional liability insurer terminated its requirement for a letter of credit and the associated pledged assets have been released.

In the opinion of management, the ultimate disposition of any professional or general liability exposure will not have a material adverse effect on the financial position or results of operations of RML.

9. FUNCTIONAL EXPENSES

RML provides long-term acute-care services to residents in the greater Chicagoland area. Expenses related to providing these services at May 31, 2008 and 2007, are as follows:

	2008	2007
Healthcare services	$36,082,359	$34,683,826
General and administrative	5,512,087	5,151,136
Total	$41,594,446	$39,834,962

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OFFICE OF THE ATTORNEY GENERAL
STATE OF ILLINOIS

Lisa Madigan
ATTORNEY GENERAL

August 12, 2005

Mr. Kenneth Pawola
Director of Operations and Planning
RML Specialty Hospital
5601 South County Line Road
Hinsdale, Illinois 60521

Re: RML Community Benefit Act Filing

Dear Mr. Pawola:

I am writing to confirm that in our phone conversation on July 25, 2005 we agreed to the following:

- RML Specialty Hospital would complete a report consistent with the format outlined in the Community Benefits Act for its fiscal year ending May 31, 2005;
- Both Rush University Medical Center and Loyola University Medical Center would attach RML Specialty Hospital's Community Benefits Act report to their own Community Benefits Act reports for their fiscal years ending June 30, 2005;
- Neither Rush nor Loyola may claim RML's quantified community benefit in their calculated totals; however, as 50% owners, they may foonote the fact that they are entitled to claim 50% of RML's quantified community benefit and refer readers to the attachment;
- RML Specialty Hospital is not required to submit a Community Benefit Act report under its own name;

- RML Specialty Hospital will follow this procedure in future years.

Sincerely,

Therese M. Harris, Chief
Charitable Trusts Bureau
100 West Randolph Street
Third Floor
Chicago, Illinois 60601
(312) 814-2533

RML
SPECIALTY HOSPITAL

November 25, 2008

Therese Harris
Chief, Charitable Trusts Bureau
Office of the Illinois Attorney General
100 W. Randolph Street, 12th Floor
Chicago, Illinois 60601-3175

Dear Therese:

I am writing to notify you that RML Specialty Hospital has completed its Community Benefits Report for fiscal year 2008 in compliance with the Illinois Community Benefits Act. A copy of the complete report has been forwarded to representatives at Rush University Medical Center and Loyola University Medical Center (our owners). Both medical centers will attach RML's report to their own fiscal year 2008 report. This is in accordance with our agreement reached in August 2005 (copy attached).

If you have any questions regarding RML's report, please call me at (630) 286-4458.

Sincerely,

Kenneth Pawola
Vice President, Operations and Planning
RML Specialty Hospital

5601 South County Line Road • Hinsdale, Illinois 60521 • *telephone*: 630-286-4000