

ORIGINAL

14-064

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION DEC 11 2014

This Section must be completed for all projects.

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility/Project Identification

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

Applicant /Co-Applicant Identification

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

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

Type of Ownership of Applicant/Co-Applicant

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

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

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

Primary Contact

[Person to receive ALL correspondence or inquiries]

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

Additional Contact

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

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

Post Permit Contact

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

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

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	The University of Chicago Medical Center
Address of Site Owner:	5841 S. Maryland Avenue, Chicago, IL 60637
Street Address or Legal Description of Site:	Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.
APPEND DOCUMENTATION AS ATTACHMENT 2 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Operating Identity/Licensee

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

Exact Legal Name:	The University of Chicago Medical Center		
Address:	5841 S. Maryland Avenue, Chicago, IL 60637		
<input checked="" type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental
<input type="checkbox"/>	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship
		<input type="checkbox"/>	Other
<ul style="list-style-type: none"> o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership. 			
APPEND DOCUMENTATION AS ATTACHMENT 3 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Organizational Relationships

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

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

Flood Plain Requirements

[Refer to application instructions.]

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

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

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

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

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

DESCRIPTION OF PROJECT**1. Project Classification**

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

Part 1110 Classification:

- Substantive
 Non-substantive



December 10, 2014

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

Re: University of Chicago Medical Center ("UCMC", the "Medical Center")
Adult Emergency Department Modernization and Relocation (the
"Project")
Application for Permit

Dear Chairwoman Olson:

We are pleased to submit our permit application to modernize, relocate and expand our comprehensive Adult Emergency Department ("Adult ED") – an essential, safety-net resource for our community.

Our ED remains an important point of entry for patients without other means of access to medical care. The Project would enable UCMC to provide better and timelier care to our Adult ED population, to reduce lengths of stay and to accommodate future growth. The Project also has the full support of the medical leadership of the EMS System in the City of Chicago (Region XI).

Description of Proposed Project

On May 20, 2008, the Review Board granted us a permit for to construct a new hospital pavilion – the Center for Care & Discovery ("CCD") which has replaced Mitchell Hospital as the core of our clinical operations. Several critical functions, however, remain in Mitchell Hospital, including some Medical/Surgical and ICU beds and the Adult ED. For UCMC to maintain its standards of patient care and to continue to provide access to emergency medical services commensurate with demand, we need to relocate and expand the Adult ED closer to our the new center of clinical operations on our campus.

In recent permit applications to the Board, we have relocated more clinical operations from Mitchell to in and around the CCD. For example, on August 2014, the Review Board approved project #14-013 to build out two floors of shell space in the CCD, which when complete, will enable the CCD to house 92% of UCMC's adult beds, including most of the remaining Medical/Surgical Beds and all of the ICU beds.

Relocation of Adult ED to Clinically Superior Location

This Project would move the Adult ED closer to the CCD, which now serves as the clinical hub of our Medical Center. Medical care in an emergency department is unique due to the unplanned nature of patient arrivals and because emergency

departments treat a broad range of illnesses and injuries, many of which are life-threatening and demand immediate attention. This is even more true for us because of our status as both a STEMI-Receiving Center and a Comprehensive Stroke Center. We have specialized teams available around the clock to open blocked arteries within 90 minutes of arrival for patients with the most serious heart attacks, including those known as “widow makers,” and the resources and clinical teams to accurately diagnose stroke and initiate treatment in situations where every second counts. We are also recognized as an Ebola Resource Hospital and must remain prepared to receive the sickest patients.

While EDs are critical points of entry, what matters most is where these patients go after the ED. The existing Adult ED is located in Mitchell Hospital, which was our main adult, acute care hospital prior to the construction of the CCD. The Adult ED and the CCD are separated by 1500 feet and two elevator rides, which means long travel times for physicians and long transport times for patients who need critical access to the operating rooms, invasive cardiology laboratories, and the Neurology ICU. By relocating our Adult ED to near the CCD, the proposed Project would reduce transport times from the Adult ED to the operating rooms or procedure rooms from more than 15 minutes to approximately 5 minutes. It would thereby enable us to locate our most critical patients closer to the life-saving care in the CCD that they need. This Project also would include specialized isolation and treatment rooms for infectious disease and an onsite biohazard decontamination unit. Ambulances would be able to pull into a covered and contained structure, with doors that can be closed and sealed, instead of the current outdoor ambulance bay. Isolation rooms would be located within feet of the ambulance entrance. In this way, UCMC would be better equipped to safely and effectively provide medical care to patients during catastrophic events.

Even without relocating the Adult ED this department would still need to be modernized. Modernizing Mitchell would be more expensive and would not resolve the current concerns about travel times to and from the CCD. Additionally, while UCMC has already successfully reduced its rate of EMS diversion by approximately 80% and has significantly improved operational efficiency in the current Adult ED, we cannot make additional physical improvements in the current space. The current space is undersized and is not laid out to efficiently sustain a busy, urban emergency room, whereas the proposed Project would resolve these suboptimal design issues.

The efficient layout proposed for the new Adult ED means that more patients could be examined and treated in less time. One goal for this Project is to substantially reduce the time patients must wait to be seen and to reduce the number of patients who leave without being seen (“LWBS”) to zero. UCMC also seeks to decrease the average length of stay (“ALOS”) for patients treated and discharged from the Adult ED, as well as patients admitted to UCMC to the 50th percentile for federal CMS benchmarks.

Addition of Treatment Stations.

With this Project, we propose to increase the number of our treatment stations by six to 42, including stations to better accommodate isolation for infectious disease, such as pandemic flu or Ebola, as well as stations equipped to treat behavioral health and bariatric patients.

Our ED patient volume fluctuates considerably and our Adult ED is frequently at capacity, with long wait times and high occupancy. Given continued visit growth, our ED Project is necessary to eliminate dangerous overcrowding. The trend over the past six years shows an annual increase in demand for Adult ED visits of 5.3%, which we project to continue through 2019. In recent years almost 6,000 patients annually who come into our ED leave without being seen, mostly because of long wait times. With a more efficient ED layout, we hope to timely take care of all these patients so that none leave without being seen. Moreover, a survey conducted by the American College of Emergency Physicians earlier this year showed that a majority of emergency physicians saw an increase in ED visits since January 1, 2014, when expanded coverage under the Affordable Care Act took effect. That study is consistent with the increased emergency department utilization from the expansion of Medicaid and health care reform seen in other studies published this year. We also project a separate and substantial surge in utilization that routinely follows the construction of new emergency department.

Given these factors, during the busiest hours of the day for our Adult ED (10 am – 10 pm), we calculate that we would regularly fill between 42-60 treatment stations. Additionally, the average daily volume of patients seen in our ED for FY2014 is 147 patients per day, but has recently peaked at 191 patients per day. In order to accommodate this uneven flow of patients in the ED, we must take into account the substantial variation in patient arrival in planning for the emergency service. As a result, UCMC's request for 42 treatment stations is reasonable, and we expect to meet target utilization for all 42 treatment stations within two years of Project completion.

Relocation of Imaging Facilities.

We do not propose to add any imaging capacity as a result of this Project, but instead, we propose to relocate two radiographic imaging rooms and one CT room from their current location in Mitchell to the new Adult ED that would be dedicated to serving emergency room patients. The current Adult ED is adjacent to Radiology in Mitchell so patients can be quickly transported for imaging. While the new Adult ED location brings patients twice as close to the critical services in the CCD, if unchanged, imaging services would no longer be as conveniently located as they are now. For this reason, we also need to relocate these imaging rooms within the new Adult ED to enable quick turnaround of critical imaging studies and to minimize patient transports.

Ms. Kathy J. Olson, Chairwoman
Adult ED Modernization & Relocation
December 10, 2014
Page 4

The Project Puts Patients First

The Project will result in a superior clinical location for the Adult ED at a lower cost than renovating the current space in Mitchell. It also better meets the growing clinical needs of UCMC's patient community, which relies heavily on emergency departments for care. The incidence of diabetes, hypertension, heart disease and stroke in our community is higher than in other parts of the city and the state, which puts patients at greater risk for ED visits. Eighty two percent of our Adult ED patients reside in the immediate area, and Medicaid and indigent patients account for 51% of our Adult ED population.

UCMC's Adult ED sustained a \$23 million dollar operating loss last fiscal year. Despite this financial cost, we seek to expand access to and increase our subsidy of high-quality emergency medical care for those who need it most, and we are doing so at a time when other hospitals in the area have either closed or have significantly scaled back their emergency services. This Project demonstrates our enduring commitment to low-income and other vulnerable populations, and our Adult ED is an anchor for the South Side communities.

We respectfully request your support of our Project because our patients and our community need the care your approval can provide.

Very truly yours,


Sharon O'Keefe
President

112112258.4

2. Narrative Description

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

This project proposes to relocate, modernize and expand the Adult Emergency Department ("Adult ED") at the University of Chicago Medical Center ("UCMC").

On May 20, 2008, the Illinois Health Facilities and Services Review Board ("Review Board") approved permit #07-153 for UCMC to construct a new hospital pavilion, the Center for Care and Discovery ("CCD"). The CCD is now the center of our hospital's clinical operation and houses medical-surgical beds, ICU beds, general surgical rooms, a GI Procedure Unit, Interventional Radiology, Neurology and other support services. At the time the CCD opened, many functions were transferred from UCMC's existing adult, acute care hospital on campus – Mitchell Hospital ("Mitchell") – but several functions remain at Mitchell, including the Adult Emergency Department, which is now a 15-minute walk from the CCD.

The Project proposes to relocate the Adult ED from Mitchell to near the CCD. We propose to increase the number of ED treatment stations from 36 to 42, and to equip the Adult ED with imaging equipment dedicated to serving emergency room patients. Specifically, two radiographic rooms and one CT room would be relocated from Mitchell and the total number of imaging devices would remain the same. The purpose of the Project is to better meet the growing clinical needs of UCMC's patient community, which relies heavily on emergency departments for the provision of care, in a location that is clinically superior and more efficient than the current space.

The Project would consist of 43,985 departmental gross square feet (dgsf) for both clinical and non-clinical space. Projected utilization of the treatment stations will meet or exceed the Review Board's target occupancy standard by the second full year after project completion.

The Project has robust community support, and an initial letter of support for this Project from the medical directors of the Emergency Medical System (EMS) for the City of Chicago (Region XI) is included as Exhibit 1 to this narrative. The total project cost is expected to be \$35,915,000 and will be funded with cash and securities.

The project is classified as "non-substantive" based upon definitions in the Planning Act and does not establish or discontinue a facility or category of service or change the hospital bed count.

The Project is expected to be complete by March 31, 2020.



December 10, 2014

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

Re: University of Chicago Medical Center CON Application – Adult ED Relocation & Expansion

Dear Ms. Avery:

As the medical leadership of the EMS System in the City of Chicago (Region XI), we are writing to explain how significant UCMC's Project to relocate and expand its Adult Emergency Department would be to our EMS Region and to the patients we serve. Our joint mission is to assure that every citizen and visitor of Chicago receives prompt emergency care in an effective, efficient and timely manner from the most competent and knowledgeable EMS personnel.

UCMC's proposed Adult ED would have an entrance off of Cottage Grove Avenue, a major thoroughfare, which is more easily accessible for ambulances than the current, side-street entry and would reduce the amount of time it takes for EMS personnel to unload patients requiring emergency care. The Adult ED ambulance entrance would also be equipped for biohazard containment and infection control, which would make it safer to bring patients suspected of having highly contagious illnesses to UCMC for care. Further, the expanded footprint of the new Adult ED would enable patients to be examined and treated by providers more quickly and would also help UCMC to maintain the huge reductions we've seen in diversion despite an increase in UCMC's emergency room visits. Moreover, as ED physicians, we are aware that the overall demand for emergency medical services has been trending upward over the past 12 months; and we know the addition of six treatment stations at UCMC, including specialized stations for behavioral health patients, will help to meet the growing demand at a local level.

As we mentioned in a previous letter to this Board, UCMC has demonstrated a commitment to reducing overcrowding in its Adult ED and the amount of time that it has spent on diversion; Further, because the pre-hospital and hospital components of the EMS System are integrated, when diversion at UCMC is lower and the amount of time that it takes patients to see an ED doctor is reduced, the entire EMS System benefits. We believe that this project will enable UCMC build upon these prior successes to better serve its community.

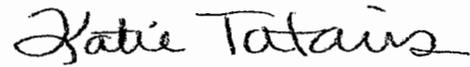
The additional capacity in UCMC's Adult ED, as well as more efficient design, would improve access to emergency medical care throughout our City, which is an important public health benefit, and we support the approval of this important project for our EMS Region.

Please feel free to contact us directly at if you need additional information. Thank you very much for your attention to this issue.

Sincerely,



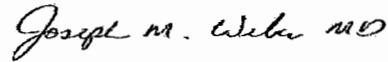
Kenneth Pearlman, MD
Chair, Region XI EMS Medical Directors Consortium
EMS Medical Director
Northwestern Memorial Hospital
kpearlman@mac.com



Katie Tataris, MD, MPH
EMS Medical Director
University of Chicago Medical Center
ktataris@medicine.bsd.uchicago.edu



Eddie Markul, MD
EMS Medical Director
Advocate Illinois Masonic Medical Center
eddie.markul@advocatehealth.com



Joseph Weber, MD
EMS Medical Director
John H. Stroger Jr., Hospital of Cook County
jweber@cookcountyhhs.org

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	\$104,090	\$37,005	\$141,095
Site Survey and Soil Investigation	15,861	5,639	21,500
Site Preparation	379,800	135,024	514,824
Off Site Work			
New Construction Contracts	13,907,832	4,944,397	18,852,229
Modernization Contracts			
Contingencies	1,182,166	420,273	1,602,439
Architectural/Engineering Fees	1,275,105	329,787	1,604,892
Consulting and Other Fees	688,341	134,659	823,000
Movable or Other Equipment (not in construction contracts)	11,614,429	48,496	11,662,925
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized	573,116	118,980	692,096
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	\$29,740,740	\$6,174,260	\$35,915,000
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	\$29,740,740	\$6,174,260	\$35,915,000
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$29,740,740	\$6,174,260	\$35,915,000
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AS ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

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

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

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.	
Indicate the stage of the project's architectural drawings:	
<input type="checkbox"/> None or not applicable	<input type="checkbox"/> Preliminary
<input checked="" type="checkbox"/> Schematics	<input type="checkbox"/> Final Working
Anticipated project completion date (refer to Part 1130.140): <u>March 31, 2020</u>	
Indicate the following with respect to project expenditures or to obligation (refer to Part 1130.140):	
<input type="checkbox"/> Purchase orders, leases or contracts pertaining to the project have been executed.	
<input type="checkbox"/> Project obligation is contingent upon permit issuance. Provide a copy of the contingent "certification of obligation" document, highlighting any language related to CON Contingencies	
<input checked="" type="checkbox"/> Project obligation will occur after permit issuance.	
APPEND DOCUMENTATION AS ATTACHMENTS, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

State Agency Submittals

Are the following submittals up to date as applicable:
<input checked="" type="checkbox"/> Cancer Registry
<input checked="" type="checkbox"/> APORS
<input checked="" type="checkbox"/> All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted
<input checked="" type="checkbox"/> 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.**

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

APPEND DOCUMENTATION AS ATTACHMENTS IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization

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

FACILITY NAME: The University of Chicago Medical Center		CITY: Chicago			
REPORTING PERIOD DATES: From: October 1, 2013 to: September 30, 2014					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	338	16,491	102,145	0	338
Obstetrics	46	1,919	6,232	0	46
Pediatrics	60	2,833	13,854	0	60
Intensive Care	126	4,022	29,967	0	126
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care	47	743	14,347	0	47
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify))					
TOTALS:	617	26,008	166,545	0	617

CERTIFICATION

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

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

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

Sharon O'Keefe
 SIGNATURE
Sharon O'Keefe
 PRINTED NAME
President
 PRINTED TITLE

Jennifer Hill
 SIGNATURE
Jennifer Hill
 PRINTED NAME
Secretary
 PRINTED TITLE

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

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

Cassandra Cole
Signature of Notary

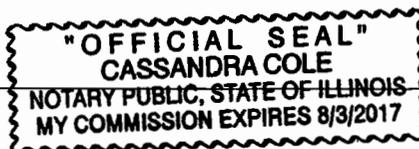
Cassandra Cole
Signature of Notary

Seal

*Insert



Seal



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

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

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

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

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

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

PURPOSE OF PROJECT

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

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

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

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

ALTERNATIVES

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

Alternative options **must** include:

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

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

APPEND DOCUMENTATION AS ATTACHMENT 6, 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 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

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

Service	# Existing Key Rooms	# Proposed Key Rooms
<input checked="" type="checkbox"/> Adult Emergency	36	42
<input checked="" type="checkbox"/> Radiology - CT	8	8
<input checked="" type="checkbox"/> Radiology - Gen. Rad.	20	19

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

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

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

VIII. - 1120.120 - Availability of Funds

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

\$35,915,000.00	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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.
\$35,915,000.00	TOTAL FUNDS AVAILABLE	

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

IX. 1120.130 - Financial Viability

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

Financial Viability Waiver

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

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

See Section 1120.130 Financial Waiver for information to be provided

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

X. 1120.140 - Economic Feasibility

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

A. Reasonableness of Financing Arrangements

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

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

B. Conditions of Debt Financing

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

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

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

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

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

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

XI. Safety Net Impact Statement

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

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

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

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

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

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

Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT 25, 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 25, 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:

INDEX OF ATTACHMENTS		
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2	Site Ownership	29-55
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	55-57
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	58-59
5	Flood Plain Requirements	60-66
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18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	
	Service Specific:	
20	Medical Surgical Pediatrics, Obstetrics, ICU	
21	Comprehensive Physical Rehabilitation	
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28	Selected Organ Transplantation	
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30	Subacute Care Hospital Model	
31	Children's Community-Based Health Care Center	
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Section I, Type of Ownership of Applicant/Co-Applicant

Attachment 1

The University of Chicago Medical Center (“UCMC”) is an Illinois not-for-profit corporation, incorporated on October 1, 1986. A copy of UCMC’s Good Standing Certificate dated December 3, 2014 is attached.



To all to whom these Presents Shall Come, Greeting:

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

THE UNIVERSITY OF CHICAGO MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON OCTOBER 01, 1986, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 3RD day of DECEMBER A.D. 2014

Jesse White

SECRETARY OF STATE

Authentication #: 1433702624

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

Section I, Site Ownership

Attachment 2

An attached copy of the Lease Agreement between the University of Chicago (“Lessor”) and the University of Chicago Medical Center (“Lessee”), dated as of January 23, 2013, shows that UCMC has control of the site.

This instrument was prepared by
And after recording return to:

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

SPACE ABOVE THIS LINE
FOR RECORDER'S USE

NEW HOSPITAL PAVILION GARAGE LEASE AGREEMENT

THIS LEASE AGREEMENT dated as of January 23, 2013 (herein, together with all supplements and amendments hereto made or entered into at any time hereafter, referred to as this "Lease") is made by and between THE UNIVERSITY OF CHICAGO (the "Lessor"), an Illinois not-for-profit corporation, and THE UNIVERSITY OF CHICAGO MEDICAL CENTER (the "Lessee"), an Illinois not-for-profit corporation, who hereby mutually covenant and agree as follows:

ARTICLE I

DEFINITIONS

- 1.1 "Affiliation Agreement." Affiliation Agreement shall mean the Affiliation Agreement dated October 1, 1986 entered into between Lessor and Lessee, as the same may be amended, modified or supplemented from time to time.
- 1.2 "Default Interest Rate." Default Interest Rate shall mean the Corporate Base Rate as posted by JPMorgan Chase Bank, N.A., or its successor, each day.
- 1.3 "Improvements." Improvements shall mean, at any time, all buildings and any other improvements comprising or located on the premises.
- 1.4 "Loan Agreements." Loan Agreements shall mean collectively (i) the Bond Purchase and Loan Agreement dated as of January 1, 2013 among the Lessee, the Authority and Bank of America, N.A. related to the Illinois Finance Authority Revenue Bonds, Series 2013A (The University of Chicago Medical Center) (the "Series 2013A Bonds") and (ii) any Continuing Covenant Agreement (as defined in such Bond Purchase and Loan Agreement) for the Series 2013A Bonds or any subseries thereof, which is initially the Continuing Covenant Agreement dated as of January 1, 2013 between the Lessee and Bank of America, N.A., or its successors and assignees.

1.5 **“Premises.”** Premises shall mean the real property set forth in the legal description contained in EXHIBIT A-1 and depicted as the Leased Premises in EXHIBIT A-2, together with all buildings, appurtenances and fixtures located thereon.

1.6 **“Affiliated Leases.”** Affiliated Leases shall mean each of:

- (i) the Lease Agreement, between Lessor and Lessee and dated as of June 30, 1987, as heretofore amended and as may be amended from time to time (the “1987 Lease”);
- (ii) the Center For Advanced Medicine and Pritzker Building Lease Agreement, between Lessor and Lessee and dated as of June 21, 1993, as heretofore amended and as may be amended from time to time (the “DCAM Lease”);
- (iii) the Comer Children’s Hospital Lease Agreement, between Lessor and Lessee and dated as of June 29, 2001, as heretofore amended and as may be amended from time to time (“Comer Lease”); and
- (iv) the New Hospital Pavilion Lease Agreement, between Lessor and Lessee and dated as of August 20, 2009, as heretofore amended and as may be amended from time to time (“NHP Lease”).

ARTICLE II

DEMISE

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

ARTICLE III

TITLE, CONDITION AND USE OF THE LEASED PREMISES

3.1 **Title and Condition.**

- (a) Except for the express warranty set out in Section 3.1 (b), the Premises are demised and let in their condition as in effect at the commencement of the lease term relating thereto, “as is,” and without any representation or warranty by Lessor of any kind as to any matter whatsoever express or implied (including, without limitation, the physical condition thereof).
- (b) Lessor represents and warrants that, as of the date of this Lease, Lessor is the fee owner of the Premises and holds title to such land and Improvements as, and subject to the qualifications and exceptions, shown on the Commitments for Title Insurance (the “Title Reports”) prepared by Chicago Title Insurance Company, copies of which have been furnished to Lessor and Lessee, as they may be subsequently revised with the agreement of the parties.

(c) LESSOR HAS NOT MADE AN INSPECTION OF THE PREMISES OR OF ANY PROPERTY, FIXTURE, EQUIPMENT OR OTHER ITEM CONSTITUTING A PORTION THEREOF, AND LESSOR MAKES NO WARRANTY OR REPRESENTATION, EXPRESS OR IMPLIED OR OTHERWISE, WITH RESPECT TO THE SAME OR THE LOCATION, USE, DESCRIPTION, DESIGN, MERCHANTABILITY, FITNESS FOR USE FOR ANY PARTICULAR PURPOSE, CONDITION OR DURABILITY THEREOF, OR AS TO THE QUALITY OF THE MATERIAL OR WORKMANSHIP THEREIN, OR OTHERWISE. THE PREMISES ARE BEING LEASED "AS IS." ALL WARRANTIES ARE EXPRESSLY WAIVED BY LESSEE. THE PROVISIONS OF THIS SECTION 3.1 ARE INTENDED TO BE A COMPLETE EXCLUSION AND NEGATION OF ANY AND ALL WARRANTIES (EXCEPT ONLY THE EXPRESS WARRANTY CONTAINED IN SECTION 3.1.(b)) BY LESSOR, EXPRESS OR IMPLIED, WITH RESPECT TO THE PREMISES AND ALL PROPERTY, FIXTURES, EQUIPMENT AND OTHER ITEMS CONSTITUTING A PORTION THEREOF.

- 3.2 Use of Premises. Lessee shall manage and operate the facilities on the Premises in a manner consistent with the Affiliation Agreement. The Premises, and every part thereof, shall be used and occupied only for the purpose of building and operating a parking garage, not-for-profit hospital and related outpatient clinics, each of which is supportive of the Lessor's academic and research mission. Lessee may operate certain facilities incidental to the operation of these facilities, unless prohibited from so doing pursuant to Sections 3.3 and 3.4 below.
- 3.3 Certain Uses Prohibited. Except to the extent that such violation will not materially adversely affect the business or financial position or ability to operate of either Lessee or Lessor, Lessee shall not use or occupy the Premises, or any part thereof, or permit the Premises, or any part thereof, to be used or occupied: contrary to any statute, law, rule, order, ordinance, requirement, regulation, covenant, condition or restriction of record applicable thereto; or in any manner which would violate any certificate of occupancy affecting the same, or which would cause major damage to the improvements. Lessee shall not use or occupy the Premises for any unlawful purpose, or in any manner which would cause, maintain or permit any nuisance or anything against public policy in or about the Premises or any part thereof. Except as necessary for Lessee to conduct its ordinary business as contemplated under this Lease, Lessee will not keep or use on the Premises or any part thereof any inflammable or explosive liquids or materials. Lessee will not commit or suffer to be committed any waste in, upon or about the Premises, or any part thereof. Lessee shall not permit persons under its control to engage in any unlawful activity in or about the Premises, and shall endeavor to prohibit any activity from being conducted on the Premises which is prohibited by the Affiliation Agreement.
- 3.4 Prohibition of Use. If the use or occupancy of the Premises, or any part thereof, should at any time during the term of this Lease be prohibited by law or by ordinance or other governmental regulation, or prevented by injunction, this Lease shall not be thereby terminated, nor shall Lessee be entitled by reason thereof to surrender the premises, nor shall the respective obligations of the parties hereto be otherwise affected.

- 3.5 Requirement of Continued Use. Lessee shall continuously during all of the Lease Term conduct and carry on the uses permitted by Section 3.2 hereof in the Premises in a first class, high quality, reputable manner. The provisions of this Section 3.5 obligating the Lessee to occupy and use the Premises at all times shall not apply when Lessee is prevented from doing so by strikes, lockouts or other causes and acts of God beyond the reasonable control of Lessee.
- 3.6 Agreements Affecting the Premises. Lessee shall keep, observe, perform and comply with all covenants, conditions and restrictions in any endowments or instruments of gift or bequest which affect the Premises.
- 3.7 Lessor's Right to Terminate Lessee's Occupancy Upon Abandonment. If Lessee should, for any reason other than a major renovation of the Premises or other than any of the reasons set out in the last sentence of Section 3.5, at any time cease to occupy or use for the uses permitted by Section 3.2 hereof for any period exceeding 90 consecutive days (or for any 90 days within any 120-day period) all or substantially all of any building which comprises part of the Premises, then Lessor has the right (but no obligation), upon written notice to Lessee, to terminate this Lease with respect to such Abandoned Premises (the "Abandoned Premises"), and by such notice to Lessee, such Abandoned Premises shall automatically cease to be a part of the Premises and shall permanently revert to the Lessor, and thereafter, Lessee shall have no rights or obligations with respect to the Abandoned Premises; provided, however, that until receipt of Lessor's notice pursuant to this Section 3.7, Lessee shall have full liability for all obligations under this Lease with respect to the Abandoned Premises.

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

ARTICLE IV

TERM

- 4.1 Lease Term. The term of this Lease (the "Lease Term") shall commence on January 23, 2013. The Lease Term shall end upon the earliest of the following events: (a) the termination of the Affiliation Agreement or any extensions thereof; (b) the expiration of the Affiliation Agreement as a result of an exercise of the election not to renew for additional 10 year terms; (c) Lessor's assumption of Lessee's obligations under the Loan Agreements and any of Lessee's loan agreements with the Illinois Finance Authority and related documents referred to in the definition of "loan agreements" in any of the Affiliated Leases; (d) termination of this Lease otherwise in accordance with its terms.
- 4.2 Possession. At any time during the Lease Term, Lessee shall have the right (subject to the terms and conditions of this Lease) to enter upon, occupy, possess and peaceably and quietly have, hold and enjoy the Premises, provided that Lessor shall retain the right to enter upon the Premises at any time in order to make inspections or to exercise any other rights of Lessor hereunder and further provided that except in the case of emergency, any entry by

Lessor pursuant to this Section 4.2 shall not unreasonably interfere with Lessee's use of the Premises.

ARTICLE V

RENT

- 5.1 Basic Rent. Lessee covenants to pay Lessor rent ("Basic Rent") for the Premises for the entire Lease Term in the amount of \$10.00, due and payable on the date hereof.
- 5.2 Additional Rent.
- (a) Lessee covenants to pay and discharge when the same shall become due or payable, as additional rent hereunder, all of the following (collectively, "Impositions"): each and every cost, tax, assessment and other expense on or with respect to the Premises or any part thereof, or for the payment of which Lessor or Lessee is liable pursuant to any provision of this Lease or by reason of any rights or interest of Lessor or Lessee in this Lease, or any portion thereof or relating to the Premises or any portion thereof, or the operation, maintenance, insurance, alteration, repair, rebuilding, possession, use or occupancy of the Premises or any portion thereof, or by reason of or in any manner connected with or relating to this Lease, or for any other reason whether similar or dissimilar to the foregoing, foreseen or unforeseen, together with every fine, penalty, interest and cost which may be added for nonpayment or late payment thereof; provided, however, that nothing herein shall require Lessee to pay any franchise, transfer, Federal net income, Federal profits, single business or other taxes of Lessor determined on the basis of Lessor's income or revenue, unless such tax is in lieu of or a substitute for any other tax or assessment upon or with respect to the Premises, which if such other tax or assessment were in effect, would be payable by Lessee hereunder.
 - (b) Lessee covenants to pay, as additional rent hereunder, all amounts, charges or costs required to be paid by Lessee under this Lease, all in accordance with the provisions of this Lease. All such additional rent, together with all Impositions are sometimes referred to collectively herein as "Additional Rent" and all Additional Rent and Basic Rent are sometimes referred to collectively herein as "Rent."
 - (c) In the event of any failure by Lessee timely and fully to pay any Rent when due or to discharge any of the foregoing, Lessor shall have all rights, powers and remedies provided herein, by law, or otherwise, and in addition thereto the right (but without any obligation) to pay and to perform any and all of Lessee's obligations and covenants under this Lease and to receive on demand from Lessee repayment thereof, with interest at the Default Interest Rate.
- 5.3 Net Lease. This is intended to be a completely "net" lease to Lessor, and the Rent and all other sums payable hereunder by Lessee shall be paid without demand, and without set-off, counterclaim, abatement, suspension, credit, deduction, deferment, defense, diminution or reduction of any kind or for any reason.

ARTICLE VI

IMPOSITIONS AND OTHER LIENS

6.1 Payment by Lessee.

- (a) At Lessee's request, Lessor will apply for real estate tax exemptions for those portions of the Premises which are not exempt from such taxes and will charge the expenses of obtaining the exemption to the Lessee.
- (b) Lessee shall cooperate with Lessor in filing or causing to be filed any documentation required to retain the Premises' status as exempt from real estate taxes and shall pay prior to delinquency, as additional rent for the Premises, its share (based on a reasonable allocation thereof determined by Lessor and acceptable to Lessee as between the Premises and any other property on which such taxes or impositions were levied, assessed, or charged, but if the parties cannot agree, the amount allocated to Lessee shall be based on Lessee's proportionate share of the square footage of the premises covered by such taxes or Impositions) of any and all taxes and assessments (general and special), and water rates and other Impositions (ordinary and extraordinary), of every kind and nature whatsoever, which are levied, assessed, charged or imposed upon or with respect to the Premises, or any part thereof, or which become payable during the Lease Term, or any ad valorem taxes assessed thereon or on or in connection with any personal property used in connection therewith which Lessor shall be required to pay, becoming due and payable during or with respect to the term of this Lease.
- (c) Lessee shall also be responsible for and shall pay prior to delinquency any and all taxes, whether or not customary or now within the contemplation of the parties hereto and regardless of whether imposed upon Lessor or Lessee: (i) levied against, upon, measured by or reasonably attributable to any and all equipment, furniture, fixtures and other personal property located in or upon the Premises; (ii) upon or with respect to the possession, leasing, operation, management, maintenance, alteration, repair, use or occupancy by Lessee of the Premises or any portion thereof; or (iii) upon this transaction. If, at any time during the term, any of the foregoing taxes are included with any tax bills to Lessor or upon or relating to the Premises, then Lessee shall promptly upon notice by Lessor reimburse Lessor for any and all such taxes and such tax or assessment shall for purposes of this Lease be deemed to be taxes or assessments under this Section 6.1 payable by Lessee; provided, however, that if such taxes are included in a bill which also covers property owned by Lessor or property other than the Premises or property other than that within or upon the Premises, Lessee shall pay its share of such tax or assessment based on a reasonable allocation proposed by Lessor and acceptable to Lessee, but if the parties cannot agree, the amount allocated to Lessee shall be based on Lessee's proportionate share of the square footage of the premises covered by such tax or assessment; and provided further, that if the activity of one of the parties alone has resulted in the imposition of the tax or assessment, then that party shall pay the full cost of such tax or assessment.

- (d) If under applicable law any Imposition may at the option of the taxpayer be paid in installments, Lessee may exercise such option, as long as Lessee pays all finance charges, installment payment fees or charges, and similar amounts.
- (e) There shall be excluded from Impositions all Federal or state income taxes, Federal or state excess profit taxes, franchise, capital stock and Federal or state estate or inheritance taxes imposed upon Lessor except insofar as the same may be included within the definition of Additional Rent under Section 5.2.

6.2 Alternative Taxes.

- (a) If at any time during the term of this Lease the method of taxation prevailing at the commencement of the Lease Term hereof shall be altered so that any new tax, assessment, levy, imposition or charge, or any part thereof, shall be measured or be based in whole or in part upon the Lease or Premises, or the Rent, or other income therefrom and shall be imposed upon the Lessor, then all such taxes, assessments, levies, impositions or charges, or the part thereof reasonably allocated by Lessor to this Lease or the Premises, to the extent that they are so measured or based, shall be deemed to be included within the term Impositions for the purposes hereof, to the extent that such Impositions would be payable if the Premises were the only property of Lessor subject to such Impositions, and Lessee shall pay and discharge the same as herein provided in respect of the payment of Impositions.
- (b) Without limiting the generality of the preceding Section 6.2(a), if at any time during the Lease Term a tax, excise, assessment or imposition on rents or income or the privilege of leasing (as lessor or as lessee) real or personal property or other tax however described (a "Rent Tax") is levied or assessed by any governmental unit or taxing authority, on account of the rents payable or receivable hereunder or the interest of Lessor under this Lease or the privilege of leasing (as lessor or as lessee) real or personal property or otherwise, then Lessee agrees to reimburse Lessor on account thereof for the full amount thereof reasonably allocated by Lessor to this Lease or the Premises.

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

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

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

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

- 6.6 Liens. Lessee shall not permit the Premises to remain subject to any mechanics', laborers', materialmen's or similar lien on account of labor, service or material furnished to, or claimed to have been furnished to, or for the benefit of Lessee or the Premises, except if payment for such labor, service or material is not yet due under the contract in question and except to the extent such lien is being contested in accordance with the terms of Section 6.7 hereof.
- 6.7 Permitted Contests. Lessee shall not be required to pay any Imposition, or to remove any lien, charge or encumbrance required to be removed under Sections 6.5 and 6.6 hereof, or to comply with any law, ordinance, rule, order, decree, decision, regulation or requirement referred to in Section 3.3 hereof, so long as Lessee shall, in good faith and at its sole cost and expense, be actively contesting the amount or validity thereof, in an appropriate manner and by appropriate legal proceedings which shall operate during the pendency thereof to prevent the sale, estate or interest therein, and further provided, that no such contest shall subject Lessor to the risk of any loss or liability. Lessee will indemnify, defend and save Lessor harmless from and against any and all losses, judgments, decrees, liabilities, claims and costs (including, without limitation, attorneys' fees and expenses in connection therewith) which may relate to or result from any such contest.
- 6.8 Notice. Lessor shall promptly deliver to Lessee any notice, bill, assessment or other documentation received by Lessor requiring payment of any tax, imposition or other payment required by this Article VI.

ARTICLE VII

CONSTRUCTION OF NEW HOSPITAL PAVILION GARAGE

Lessor and Lessee understand that Lessee anticipates building the New Hospital Pavilion Garage (the "NHP Garage") on the Premises. The NHP Garage will include: an eight (8) story, approximately 875,000 square foot parking structure with approximately 1800 parking stalls, lower level loading docks, a ground level oxygen tank farm, and approximately 60,000 square feet of empty shelled space for future development.

ARTICLE VIII

INSURANCE

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

Any insurance procured and maintained pursuant to this Article VIII may be obtained jointly by Lessor and Lessee or separately by either party. To the extent insurance is obtained jointly or by Lessor, Lessor shall allocate, on an equitable basis consistent with past practice or acceptable to Lessee, the cost of such policies or self-insurance as between Lessor and Lessee, and Lessee shall pay to Lessor, as Additional Rent, the portion of the cost of such policies or self-insurance so allocated to Lessee by Lessor. To the extent Lessee procures and maintains insurance policies covering the Premises, the entire cost and expense of such policies shall be paid by Lessee and considered to be Additional Rent.

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

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

ARTICLE IX

MAINTENANCE AND ALTERATIONS

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

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

9.2 Alterations.

- (a) Lessee shall consult with Lessor's Facilities Services department from time to time and apprise them of modifications, alterations, or additions to space or demolishing facilities within the Premises, other than the demolition and construction involved in building the NHP Garage ("Alterations"), and Lessee shall not make any major alterations that have a substantial effect on the nature of activities on the Premises, without the consent of Lessor, which shall not be unreasonably withheld. Lessee shall review plans for such alterations with the Lessor's Facilities Services department to confirm that they conform to reasonable, established architectural criteria for the University campus.
- (b) Lessee shall, subject to the right to contest as set forth in Section 6.7 hereof, at Lessee's expense; make such repairs and alterations, if any, on the Premises as are expressly required by any governmental authority or which may be made necessary by the act or neglect of Lessee, its employee's agents or contractors, or any persons, firm or corporation, claiming by, through or under Lessee; provided, however, that to the fullest extent permitted by applicable law or governmental order, all such work shall be done pursuant to the notice, review and approval provisions set forth in Section 9.2 (a).
- (c) Any Alterations, repairs and replacements performed or made by Lessee shall be performed or made in a good, workmanlike manner with good quality, new materials, in accordance with all applicable laws and ordinances, and lien-free.
- (d) Upon completion of any such work by or on behalf of Lessee, Lessee shall provide Lessor with access to such documents as Lessor may reasonably require (including, without limitation, a certificate of occupancy, if such certificates are then issued by the appropriate governmental agency or agencies with respect to projects or work of the type so performed by or on behalf of Lessee, an architect's certificate of completion, and sworn contractors' and subcontractors' statements and supporting final lien waivers) evidencing completion of the work in compliance with applicable laws (and, if relevant, with plans and specifications approved by Lessor) and payment in full for such work, and "as built" working drawings.

9.3 Title to Alterations. All improvements and Alterations installed pursuant to this Lease shall be deemed part of the Premises and the property of Lessor (subject only to Lessee's rights

hereunder during the Lease Term); provided, however, that upon expiration of this Lease, Lessee may remove from the Premises, in accordance with the provisions of Section 15.2 hereof, any trade fixtures and personal property which are owned by Lessee.

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

ARTICLE X

ASSIGNMENT AND SUBLETTING

10.1 Consent Required.

- (a) Lessee shall not, without Lessor's prior written consent (which Lessor may withhold in Lessor's sole discretion): (i) assign, sell, transfer, convey, pledge, encumber or mortgage this Lease or any interest herein or hereunder; (ii) allow or permit to occur or exist any assignment, sale, transfer, conveyance, pledge, encumbrance or mortgage of, or lien upon or security interest in, this Lease or any part of Lessee's interest herein or hereunder, whether by operation of law or otherwise; (iii) sublet, or cause or permit to occur or exist any subletting of, the Premises or any part thereof; or (iv) permit the use or occupancy of the Premises or any part thereof by anyone other than Lessee, provided however, that if this Lease is assigned to any person or entity pursuant to the provisions of the United States Bankruptcy Code, 11 U.S.C. 101 *et seq.* (the "Bankruptcy Code"), any and all monies and other consideration of any kind whatsoever payable or otherwise to be delivered in connection with such assignment shall be paid or delivered to Lessor, shall be and remain the exclusive property of Lessor and shall not constitute property of Lessee or of the estate of Lessee within the meaning of the Bankruptcy Code. Any and all monies or other consideration constituting Lessor's property under the preceding sentence not paid or delivered to Lessor shall be received and held in trust for the benefit of Lessor and shall be promptly paid to or turned over to the Lessor. It is understood that, by sublease or other agreement between the parties, Lessee may make available for occupancy by Lessor certain portions of the Premises for specified periods of time under arrangements for payment of maintenance costs and other services furnished by Lessee to Lessor.
- (b) No assignment or subletting, whether or not permitted hereunder, shall relieve Lessee of any of Lessee's obligations, covenants, or agreements hereunder and Lessee shall continue to be liable as a principal and not as a guarantor or surety, to the same extent as though no assignment or subletting had been made. Any person or entity to whom this Lease is assigned or to whom a sublease is made pursuant to the provisions of the United States Bankruptcy Code shall be deemed without further act or deed to have personally assumed, and agreed personally to be liable for, all of the obligations of the Lessee arising under this Lease on and after the date of such assignment or sublease. Any such assignee or sublessee shall, upon demand, execute and deliver to Lessor an instrument expressly confirming such assumption.

ARTICLE XI

UTILITIES

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

ARTICLE XII

INDEMNITY AND WAIVER

- 12.1 Indemnity. Lessee will protect, indemnify and save harmless Lessor and Lessor's agents from and against all liabilities, obligations, claims, damages, penalties, causes of action, judgments, costs and expenses (including without limitation, attorneys' fees and expenses) imposed upon or incurred by or asserted against Lessor by reason of: (a) any failure on the part of the Lessee to perform or comply with any of the terms or provisions of this Lease to be performed by Lessee; or (b) performance of any labor or services or the furnishing of any materials or other property at the request of and on behalf of Lessee or any other person (except only Lessor) in respect of the Premises or any part thereof. In case any action, suit or proceeding is brought against Lessor or Lessor's trustees, officers, agents, or employees by reason of any such occurrence, Lessee will, at Lessor's election and Lessee's expense, resist and defend such action, suit or proceeding, or cause the same to be resisted and defended, and Lessor shall also have the right to defend and resist the same by its own attorneys. Lessee will not settle or compromise any such matter without Lessor's written consent. Upon demand, Lessee shall reimburse Lessor for any cost incurred as a result of or in connection with any such action, suit or proceeding.
- 12.2 Waiver of Certain Claims. Lessee waives all claims it may have against Lessor and Lessor's trustees, officers, agents, or employees for damage or injury to person or property sustained by Lessee or any persons claiming through Lessee or by any occupant, patient, visitor, invitee or licensee of Lessee or the Premises, or any part thereof, or by any other person, occurring at, upon, within or about, or resulting from the condition of, any part of the Premises or resulting directly or indirectly from any act or omission of Lessee to the fullest extent permitted by law; provided, however, that nothing contained herein shall relieve Lessor from liability for its own negligence or willful misconduct. The foregoing waiver shall include, without limitation, damage or injury caused by water, snow, frost, steam,

excessive heat or cold, sewage, gas, odors or noise, or caused by bursting or leaking of pipes or plumbing fixtures or unsafe conditions, and shall apply equally whether any such damage or injury results from the act or omission of Lessee or of any other person and whether such damage be caused by or result from any thing or circumstance whether of a like nature or of a wholly different nature. All personal property belonging to Lessee or any other person other than Lessor that is in or on any part of the Premises shall be there at the risk of Lessee or of such other person only, and Lessor shall not be liable for any damage thereto or for the theft or misappropriation thereof.

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

ARTICLE XIII

INSPECTION

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

ARTICLE XIV

LESSEE'S COVENANTS

- 14.1 Covenants. Lessee hereby covenants and agrees that:
- (a) Lessee shall: permit access by the Lessor to, and allow the Lessor to copy and make extracts from, the books and records of the Lessee at any time; and permit the Lessor to inspect the properties and operations of the Lessee at any time.
 - (b) Lessee shall not enter into any agreement containing any provision which would be violated or breached by the performance of any of its obligations hereunder or under any instrument or document delivered or to be delivered by it hereunder or in connection herewith.

ARTICLE XV

SURRENDER

- 15.1 **Surrender.** Upon termination of this Lease for any reason, Lessee will at once surrender and deliver up the Premises to Lessor in good condition and repair, reasonable wear and tear excepted. Lessee shall deliver to Lessor keys to all doors on the Premises. All hardware, fixtures (other than trade fixtures), and improvements, in or upon the Premises, shall become Lessor's property and shall remain upon the Premises upon any termination of this Lease, without compensation, allowance or credit to Lessee.
- 15.2 **Removal of Lessee's Property.** Upon the termination of this Lease, if Lessee is not in default hereunder, Lessee may remove Lessee's trade fixtures, personal property and equipment; provided, however, that Lessee shall repair any injury or damage to the Premises which may result from such removal. Any of Lessee's furniture, machinery, trade fixtures and other items of personal property which Lessee fails to remove from the Premises by the end of the Lease Term may, at Lessor's option, be removed by Lessor and delivered to any other place of business of Lessee or any warehouse, and Lessee shall pay the reasonable cost of such removal (including the repair of any injury or damage to the Premises resulting from such removal), delivery and warehousing to Lessor on demand, with interest at the Default Interest Rate from the tenth day after the demand until paid in full; or Lessor may treat such property as having been conveyed to Lessor with the Lease as a Bill of Sale, without further payment or credit by Lessor to Lessee.
- 15.3 **Holding Over.** Any holding over of the Premises by Lessee after the expiration of this Lease shall operate and be construed to be a tenancy from month to month only. During any such extended term of this Lease, all of the provisions hereof (including without limitation, those obligating Lessee to pay all Additional Rent) shall govern and apply, except that Lessee shall pay Base Rent to Lessor for such period at the rate of \$100,000.00 per month. Nothing contained in this Section 15.3 shall be construed to give Lessee the right to hold over after the expiration of this Lease, and Lessor may exercise any and all remedies at law or in equity to recover possession of the Premises.

ARTICLE XVI

DEFAULTS AND REMEDIES

- 16.1 **Defaults.** Lessee agrees that the occurrence of any one or more of the following events shall constitute an Event of Default for all purposes of this Lease:
- (i) Lessee fails to pay, within 30 days after written notice to Lessee that the same is due and payable, any amount of Rent (including, without limitation, Additional Rent) due hereunder;
 - (ii) Lessee fails to pay, within 30 days after written notice to Lessee that the same is due and payable, any other amount or charge required to be paid by Lessee hereunder;

- (iii) Lessee fails in any material respect to keep, observe or perform any of the other covenants or agreements herein contained to be kept, observed and performed by Lessee, and Lessee fails to completely and fully cure such default within 30 days after notice thereof in writing to Lessee; provided, however, that if such matter cannot be cured within 30 days, then no Event of Default shall be deemed to have occurred with respect thereto so long as cure is commenced immediately and Lessee diligently proceeds to complete cure within a reasonable period of time, and provided further, that no cure period whatsoever shall apply with respect to a hazardous or emergency condition;
- (iv) Lessee shall become insolvent or shall admit in writing its inability to pay its debts, or shall make a general assignment for the benefit of creditors;
- (v) Lessee shall file, institute or commence any case, proceeding or other action seeking reorganization, arrangement, adjustment, liquidation, dissolution or composition of it or its debts under any law relating to bankruptcy, insolvency, reorganization or relief of debtors, or seeking appointment of a receiver, trustee, custodian or other similar official for it or for all or any substantial part of its property;
- (vi) Lessee shall take any corporate or other action to authorize any of the actions set forth above in either of the preceding paragraphs (iv) or (v);
- (vii) Any case, proceeding or other action against the Lessee or any of its property shall be filed, instituted or commenced seeking to have an order for relief entered against it as debtor, or seeking reorganization, arrangement, adjustment, liquidation, dissolution or composition of it or its debts under any law relating to bankruptcy, insolvency, reorganization or relief of debtors, or seeking appointment of a receiver, trustee, custodian or other similar official for it or for all or any substantial part of its property, and such case, proceeding or other action results in the entry of an order for relief against it which is not fully stayed within 30 days after the entry thereof or remains undismissed for a period of 60 days;
- (viii) All or any material part of the interest or estate of Lessee under this Lease is levied upon under execution or is attached under process of law;
- (ix) An Event of Default shall have occurred under any of the Affiliated Leases.

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

by operation of law. Upon termination of this Lease, Lessor shall be entitled to recover as damages all Rent (including, without limitation, Additional Rent) and other sums due and payable by Lessee on the date of termination or for or with respect to the period ending on the effective date of such termination, plus interest at the Default Interest Rate, plus the cost of performing any other covenants or obligations Lessee should have performed on or before the effective date of such termination. Lessor may relet all or any part of the Premises and none of the rents or other amounts received by Lessor as a result of any such reletting shall reduce, or be a credit or offset against, the damages and other amounts required to be paid by Lessee to Lessor hereunder with respect to such termination or otherwise, except as required by law.

- 16.3 Assumption of Loan Agreement Obligations. Notwithstanding anything else contained in this Lease including, without limitation, the provisions of Sections 3.7, 4.1 and 16.2 hereof, the Lessor or the Lessee shall not be entitled to terminate this Lease for any reason or to exercise its option not to renew the Affiliation Agreement for an additional ten year term upon completion of its initial term unless prior to or concurrently with the termination of the Lease or end of the Lease Term under Section 4.1 hereof as a result of such non-renewal, the Lessor shall have assumed and agreed to perform the obligations of the Lessee under the Loan Agreements in the manner and to the extent provided in the Loan Agreements.
- 16.4 Lessee's Waiver of Statutory Rights. In the event of any termination of the term of this Lease or any repossession of the Premises pursuant to this Article XVI, Lessee, to the fullest extent permitted by law, waives (a) any notice of re-entry, (b) any right of redemption, re-entry or repossession, and (c) the benefits of any laws now or hereafter in force exempting property from liability for rent or for debt.
- 16.5 Remedies Cumulative. No right or remedy of Lessor shall be considered to exclude or suspend any other remedy. All rights and remedies of the Lessor shall be cumulative and shall be in addition to every other remedy. Every such power, right and remedy may be exercised from time to time, together or successively, and so often as Lessor chooses.
- 16.6 No Waiver. No delay or omission of Lessor to exercise any right, remedy or power shall impair any such right, remedy or power or be construed to be a waiver thereof or of any default or any acquiescence therein. No waiver of any breach of any of the covenants of this Lease shall be a waiver of any other breach or waiver, acquiescence in or consent to any further or succeeding breach of the same covenant. The acceptance by Lessor of any payment of Rent or other charges hereunder after the termination of this Lease shall not restore this Lease or Lessee's right to possession hereunder, but rather shall be construed only as a payment on account, and not in satisfaction, of damages due from Lessee to Lessor.

ARTICLE XVII

MISCELLANEOUS

- 17.1 Lessor's Right to Cure. Lessor may, but shall not be obligated to, cure any default by Lessee or failure of Lessee to perform any of its obligations hereunder, including Lessee's failure to pay Impositions, obtain or maintain appropriate insurance, make repairs or satisfy lien claims; and whenever Lessor so elects, all costs and expenses paid by Lessor in curing such

- 17.5 Attorneys' Fees. In the event that either party retains an attorney to enforce this Lease or any term, covenant or condition hereunder or to collect any Rent or any other amount due or payable under this Lease or to recover possession of the Premises, or files any action or proceeding under or relating to this Lease, the non-prevailing party shall pay the prevailing party's reasonable attorneys' fees and court costs incurred in connection therewith.
- 17.6 No Brokers. Lessor and Lessee each represents and warrants to the other that it has dealt with no broker in connection with this transaction. Each party hereto agrees to indemnify and hold the other harmless from and against any and all damage, liability, loss, expense and claims arising from the incorrectness of this warranty.
- 17.7 Entire Agreement. This Lease (including any Exhibits hereto, which are made a part hereof), the agreement concerning the provision of steam described in Section 11.1 hereof, and any other agreement specifically identified or described in this Lease, contains all of the understandings and agreements between the parties hereto with respect to the Premises and the subject matter hereof.
- 17.8 Applicable Law. This Lease shall be governed by, and construed and enforced in accordance with, the laws of the State of Illinois.
- 17.9 Covenants Binding on Successors; No Third Party Beneficiaries. All of the covenants, agreements, conditions and undertakings contained in this Lease shall extend and inure to the benefit of, and be binding upon, the parties hereto and their respective successors and assigns; provided, however, that this sentence shall not be construed as restricting or limiting in any way the provisions of Article X hereof, which shall govern and control over any inconsistent provisions of this Section 17.9. No person, firm, corporation, entity, or governmental authority other than the parties hereto and their respective successors and assigns shall have or may enforce any right, benefit, claim or privilege under or as a result of this Lease or any covenants, agreement, condition or undertaking in this Lease, it being the express intention of the parties that there not be any third party beneficiaries of this Lease or any provision hereof. Notwithstanding the other provisions of this Section 17.9, the other parties to the Loan Agreements (as that term may be amended from time to time) and their respective successors and assigns, so long as either of the Loan Agreements is in effect and amounts are payable thereunder, shall be third party beneficiaries solely with respect to the provisions of Section 16.3 hereof.

[Signature page follows.]

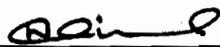
IN WITNESS WHEREOF, Lessor and Lessee have executed and delivered this Lease as of the day and year first above written, pursuant to proper authority duly granted.

Lessor:

THE UNIVERSITY OF CHICAGO

ATTEST:

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

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

Lessee:

THE UNIVERSITY OF CHICAGO MEDICAL
CENTER

ATTEST:

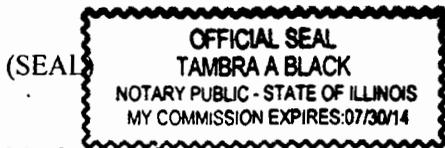
By: _____
Name: Jennifer A. Hill
Its: Secretary

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

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

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

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



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

My Commission Expires: 7/30/14

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

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

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

(SEAL)

Notary Public in and for Cook County, Illinois

My Commission Expires:

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

Lessor:

ATTEST:

THE UNIVERSITY OF CHICAGO

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

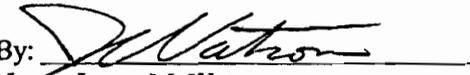
By: _____
Name: Nimalan Chinniah
Its: Executive Vice President for
Administration and Chief Financial Officer

Lessee:

ATTEST:

THE UNIVERSITY OF CHICAGO MEDICAL
CENTER

By: 
Name: Jennifer A. Hill
Its: Secretary

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

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

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

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

(SEAL)

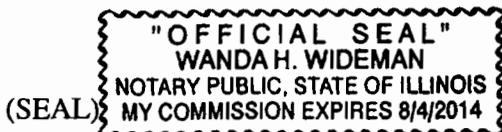
Notary Public in and for Cook County, Illinois

My Commission Expires:

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

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

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



Wanda H. Wideman

Notary Public in and for Cook County, Illinois

My Commission Expires: August 4, 2014

NEW HOSPITAL PAVILION GARAGE LEASE AGREEMENT

EXHIBIT A-1

LOTS 9 THROUGH 20, BOTH INCLUSIVE, AND THE SOUTH HALF OF LOT 8, AND LOTS 26 THROUGH 42, BOTH INCLUSIVE, AND THAT PART OF LOT 43 LYING SOUTH OF THE NORTH 13.00 FEET THEREOF IN BLOCK 5 IN MCKICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN, TOGETHER WITH LOTS 1, 2, AND 3 IN THE RESUBDIVISION OF LOTS 21 THROUGH 25, BOTH INCLUSIVE, IN BLOCK 5 OF MCKICHAN AND MASON'S SUBDIVISION AFORESAID, TOGETHER WITH THAT PART OF THE 16 FOOT WIDE ALLEY LYING NORTH OF THE NORTH LINE OF EAST 57TH STREET, AND LYING SOUTH OF THE SOUTH LINE, EXTENDED EAST, OF THE NORTH 13.00 FEET OF LOT 43 IN BLOCK 5 IN MCKICHAN AND MASON'S SUBDIVISION OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST, OF THE THIRD PRINCIPAL MERIDIAN, ACCORDING TO THE ANTE-FIRE PLAT THEREOF RECORDED OCTOBER 22, 1868, ALL IN COOK COUNTY, ILLINOIS.

SAID PARCEL CONTAINS 2.439 ACRES OF 106,255 SQUARE FEET, MORE OR LESS.

CITY ATLASES INDICATE UNDERGROUND POLICE AND FIRE ALARM CABLES ON COTTAGE GROVE AND 57TH. EXACT LOCATION COULD NOT BE DETERMINED.

NEW HOSPITAL PAVILION GARAGE LEASE AGREEMENT

EXHIBIT A-2

PLAT OF BOUNDARY AND TOPOGRAPHIC SURVEY
 PART OF THE WEST HALF OF THE NORTHWEST QUARTER OF SECTION 14, TOWNSHIP 38 NORTH, RANGE 14 EAST OF THE THIRD PRINCIPAL MERIDIAN

CONTRACTOR:
ARMORE ASSOCIATES
 3150 S. MICHIGAN AVE.
 CHICAGO, IL 60607-3101
 312-799-1400

UTILITY STRUCTURE DATA TABLE

02.1.017
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WATER VAULTS

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NOTES: ALL UTILITIES SHOWN ARE BASED ON RECORD DRAWINGS AND FIELD SURVEY. THE LOCATION OF UTILITIES IS SUBJECT TO CHANGE WITHOUT NOTICE. THE SURVEYOR ASSUMES NO LIABILITY FOR DAMAGES TO UTILITIES OR PERSONS OR PROPERTY CAUSED BY THE CONSTRUCTION OF THE PROJECT. THE SURVEYOR'S RESPONSIBILITY IS LIMITED TO THE ACCURACY OF THE SURVEY DATA AND THE LOCATION OF UTILITIES SHOWN ON THIS PLAN.

THE UNIVERSITY OF CHICAGO
 ARCHIVE CENTER
 CHICAGO, ILLINOIS

PROJECT: UCM - NORTH GARAGE

DATE: 01/13/13 SCALE: 1" = 30'

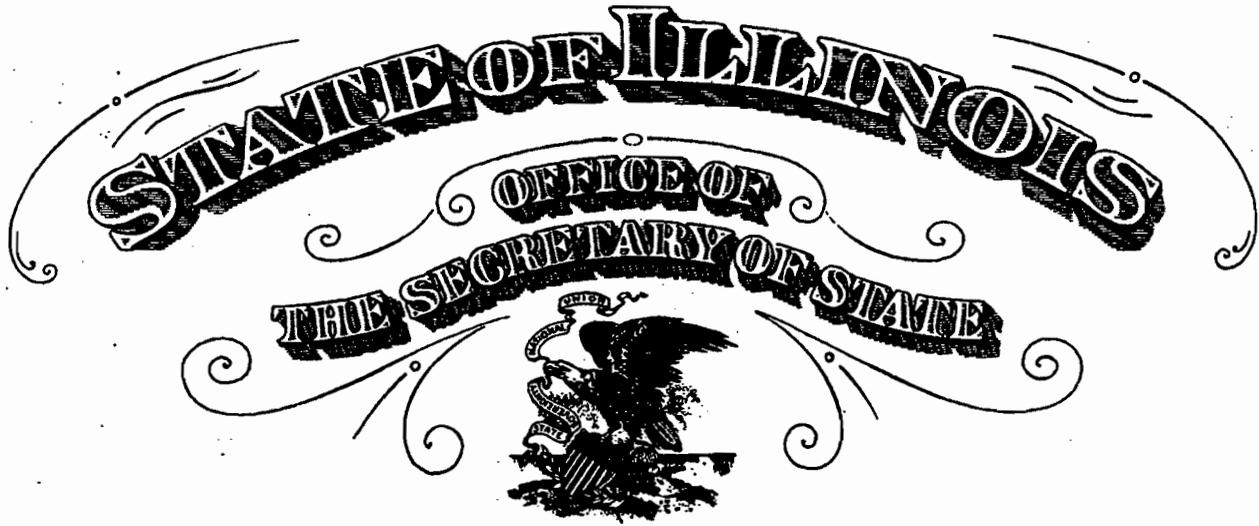
OWNER: UCM
 DRAWN BY: [Name]
 CHECKED BY: [Name]
 DATE: 01/13/13 SHEET No. 2
 OF 2 SHEETS

Section I, Operating Identity/Licensee

Attachment 3

The University of Chicago Medical Center (“UCMC”) is an Illinois not-for-profit corporation, incorporated on October 1, 1986. A copy of UCMC’s Good Standing Certificate dated December 3, 2014 is attached.

File Number 5439-757-7



To all to whom these Presents Shall Come, Greeting:

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

THE UNIVERSITY OF CHICAGO MEDICAL CENTER, A DOMESTIC CORPORATION, INCORPORATED UNDER THE LAWS OF THIS STATE ON OCTOBER 01, 1986, APPEARS TO HAVE COMPLIED WITH ALL THE PROVISIONS OF THE GENERAL NOT FOR PROFIT CORPORATION ACT OF THIS STATE, AND AS OF THIS DATE, IS IN GOOD STANDING AS A DOMESTIC CORPORATION IN THE STATE OF ILLINOIS.



Authentication #: 1433702624

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

In Testimony Whereof, I hereto set my hand and cause to be affixed the Great Seal of the State of Illinois, this 3RD day of DECEMBER A.D. 2014 .

Jesse White

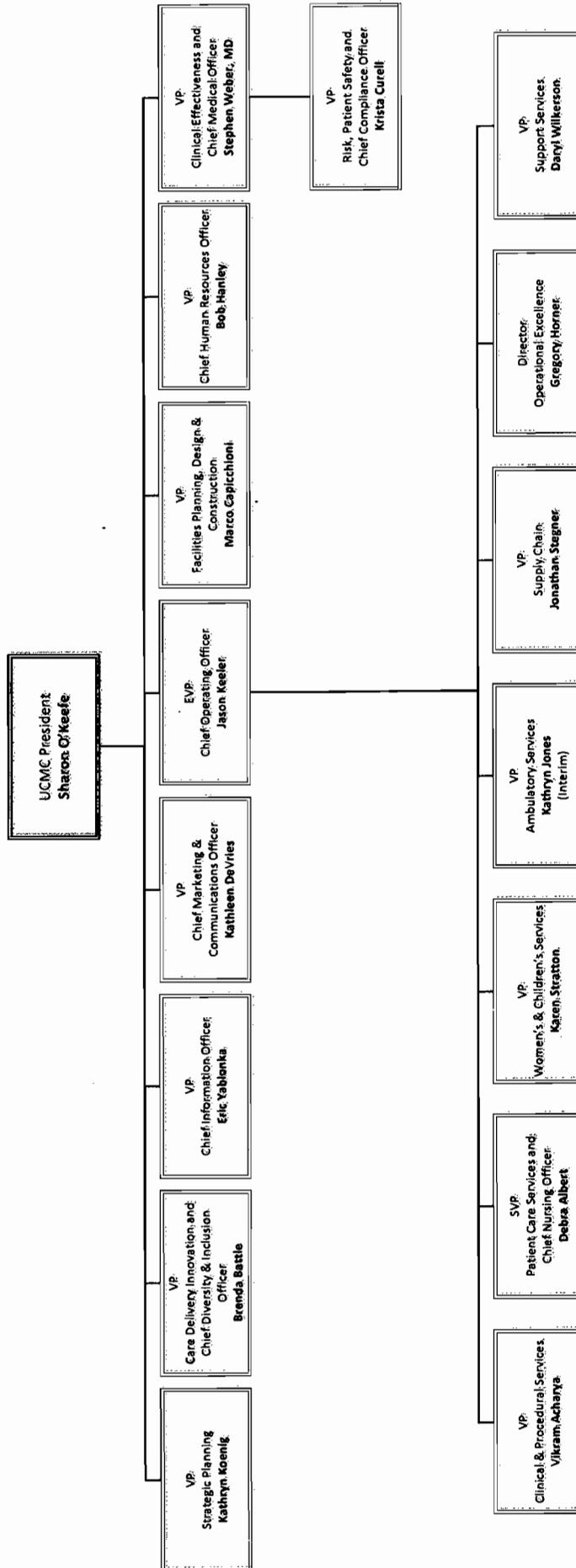
SECRETARY OF STATE

Section I, Organizational Relationships

Attachment 4

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

University of Chicago Medical Center Administration



Revised 9/15/14

Section I, Flood Plain Requirement

Attachment 5

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



December 10, 2014

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

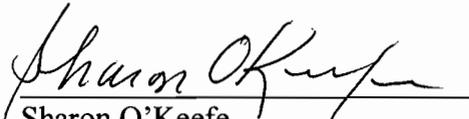
In Re: Flood Plain Requirements

Dear Ms. Avery:

We hereby attest that our proposed project complies with the requirements of Illinois Executive Order #2005-5 pertaining to construction activities in special flood hazard areas. The accompany map from www.illinoisfloodmaps.org indicates that the site of our project is judged "Area of Minimal Flood Hazard"

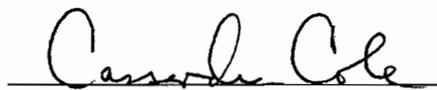
Sincerely,

The University of Chicago Medical Center


Sharon O'Keefe
President

Notarization:

Subscribed and sworn to before me
This 10th day of December, 2014


Signature of Notary Public

Seal



// Make spelling changes

Cook County Map Panels

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

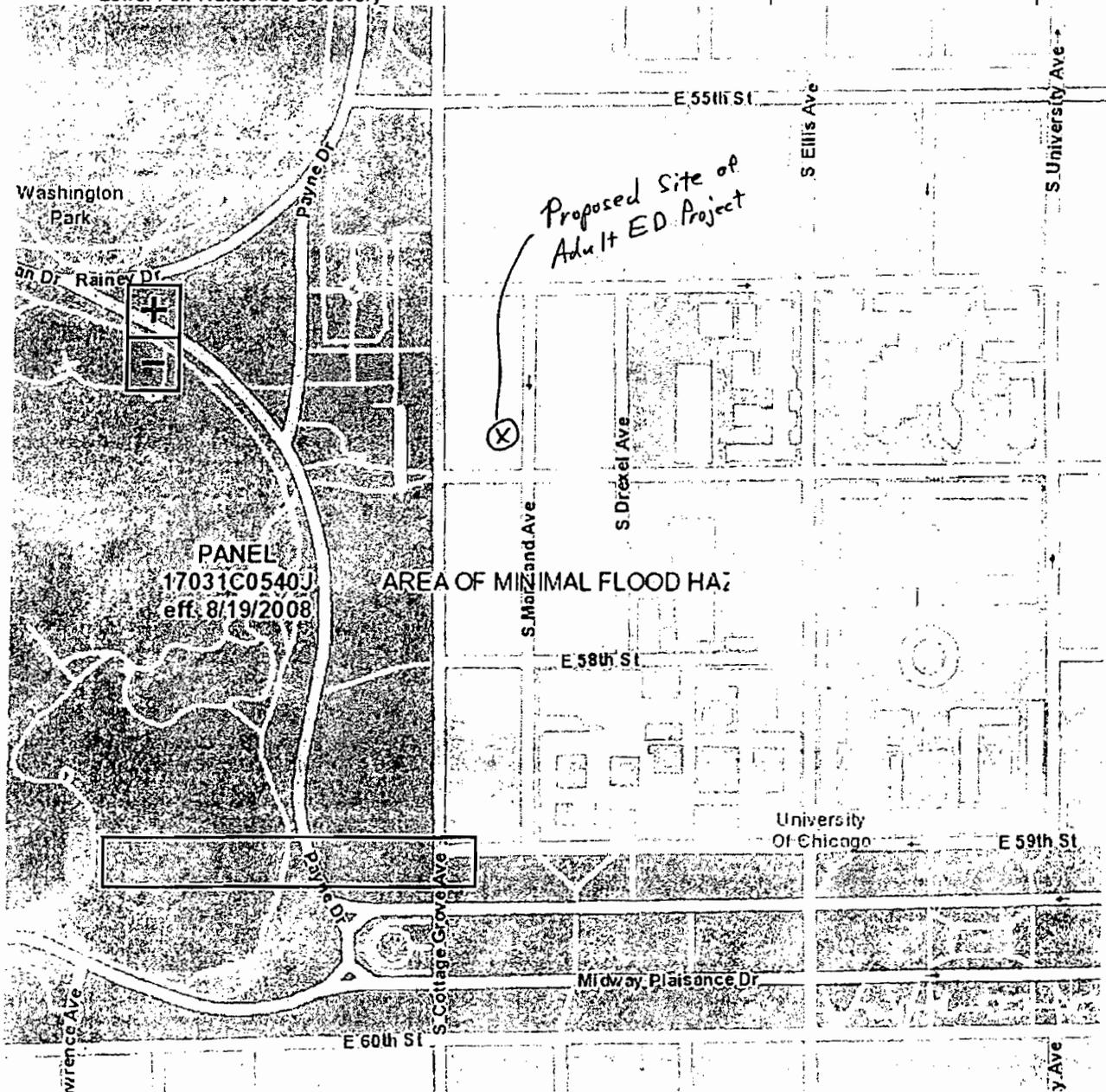
... even more!

Below are links to resources pertaining to Cook County

- Chicago River Watershed Discovery
- Des Plaines Watershed Discovery
- Lower Fox Watershed Discovery

What is a DFIRM?

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





2006-05

**CONSTRUCTION ACTIVITIES
IN SPECIAL FLOOD HAZARD AREAS**

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

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

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

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

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

2. All State Agencies engaged in any development within a Special Flood Hazard Area shall undertake such development in accordance with the following:
 - A. All development shall comply with all requirements of the National Flood Insurance Program (44 C.F.R. 59-79) and with all requirements of 92 Illinois Administrative Code Part 700 or 92 Illinois Administrative Code Part 708, whichever is applicable.
 - B. In addition to the requirements set forth in preceding Section A, the following additional requirements shall apply where applicable:
 1. All new Critical Facilities shall be located outside of the floodplain. Where this is not practicable, Critical Facilities shall be developed with the lowest floor elevation equal to or greater than the 500-year frequency flood elevation or structurally dry floodproofed to at least the 500-year frequency flood elevation.
 2. All new buildings shall be developed with the lowest floor elevation equal to or greater than the Flood Protection Elevation or structurally dry floodproofed to at least the Flood Protection Elevation.
 3. Modifications, additions, repairs or replacement of existing structures may be allowed so long as the new development does not increase the floor area of the existing structure by more than twenty (20) percent or increase the market value of the structure by fifty (50) percent, and does not obstruct flood flows. Floodproofing activities are permitted and encouraged, but must comply with the requirements noted above.
3. State Agencies which administer grants or loans for financing development within Special Flood Hazard Areas shall take all steps within their authority to ensure that such development meets the requirements of this Order.
4. State Agencies responsible for regulating or permitting development within Special Flood Hazard Areas shall take all steps within their authority to ensure that such development meets the requirements of this Order.
5. State Agencies engaged in planning programs or programs for the promotion of development shall inform participants in their programs of the existence and location of Special Flood Hazard Areas and of any State or local floodplain requirements in effect in such areas. Such State Agencies shall ensure that proposed development within Special Flood Hazard Areas would meet the requirements of this Order.
6. The Office of Water Resources shall provide available flood hazard information to assist State Agencies in carrying out the responsibilities established by this Order. State Agencies which obtain new flood elevation, floodway, or encroachment data developed in conjunction with development or other activities covered by this Order shall submit such data to the Office of Water Resources for their review. If such flood hazard information is used in determining design features or location of any State development, it must first be approved by the Office of Water Resources.

I. For purpose of this Order:

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

Examples of critical facilities where flood protection should be required include:

Emergency Services Facilities (such as fire and police stations)

Schools

Hospitals

Retirement homes and senior care facilities

Major roads and bridges

Critical utility sites (telephone switching stations or electrical transformers)

Hazardous material storage facilities (chemicals, petrochemicals, hazardous or toxic substances)

Examples of critical facilities where flood protection is recommended include:

Sewage treatment plants

Water treatment plants

Pumping stations

- B. "Development" or "Developed" means the placement or erection of structures (including manufactured homes) or earthworks; land filling, excavation or other alteration of the ground surface; installation of public utilities; channel modification; storage of materials or any other activity undertaken to modify the existing physical features of a floodplain.
- C. "Flood Protection Elevation" means one foot above the applicable base flood or 100-year frequency flood elevation.
- D. "Office of Water Resources" means the Illinois Department of Natural Resources, Office of Water Resources.
- E. "Special Flood Hazard Area" or "Floodplain" means an area subject to inundation by the base or 100-year frequency flood and shown as such on the most current Flood Insurance Rate Map published by the Federal Emergency Management Agency.
- F. "State Agencies" means any department, commission, board or agency under the jurisdiction of the Governor; any board, commission, agency or authority which has a majority of its members appointed by the Governor; and the Governor's Office.

7. State Agencies shall work with the Office of Water Resources to establish procedures of such Agencies for effectively carrying out this Order.
8. **Effective Date.** This Order supersedes and replaces Executive Order Number 4 (1979) and shall take effect on the first day of.

Rod R. Blagojevich, Governor

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

Section I, Historic Resources Preservation Act Requirements

Attachment 6

Attached is a letter from the Illinois Historic Preservation Agency dated May 28, 2014 noting that the Project meets the Secretary of the Interior's "Standard for Rehabilitation and Guidelines for Rehabilitation of Historic Buildings" and will not result in any adverse effect.



**Illinois Historic
Preservation Agency**

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

FAX (217) 524-7525

www.illinoishistory.gov

Cook County

Chicago

Relocation of Labor, Delivery and Recovery Department

Existing - Mitchell Hospital at 5815 S. Maryland Ave., Proposed - Comer Center for Children and Specialty Care at 5730 S. Drexel Ave.

IHPA Log #030050714

May 22, 2014

John R. Beberman

The University of Chicago Hospitals

Capital Budget and Control

MC 0953

850 E. 58th St.

Chicago, IL 60637-1459

Dear Mr. Beberman:

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

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

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

Sincerely,

Anne E. Haaker

Deputy State Historic

Preservation Officer

Section I, Project Costs and Source of Funds

Attachment 7

Section 1120.110, Project Costs and Sources of Funds

			<u>TOTAL</u>	<u>CLINICAL</u>	<u>NON-CLINICAL</u>
PREPLANNING COSTS					
	Kaizan Activities	\$77,550			
	Mockups	63,545			
			\$141,095	\$104,090	\$37,005
SITE SURVEY AND SOIL INVESTIGATION					
		21,500	21,500	15,861	5,639
SITE PREPARATION					
	Earthwork	122,361			
	Paving	213,306			
	Demolition	79,157			
	Landscaping	50,000			
	Other	50,000			
			514,824	379,800	135,024
NEW CONSTRUCTION					
	Construction	18,087,229			
	Material Testing	50,000			
	DAS/WLAN Systems	450,000			
	Signage	175,000			
	Keys, Locksets	15,000			
	Com Ed Vault Relocation	75,000			
			18,852,229	13,907,832	4,944,397

CONTINGENCIES		1,602,439	1,602,439	1,182,166	420,273
ARCHITECTURAL/ ENGINEERING FEES		1,604,892	1,604,892	1,275,105	329,787
CONSULTING AND OTHER FEES					
	Legal	50,000			
	Program Manager	50,000			
	Equipment Planner	225,000			
	CON Consultant	40,000			
	CON Fee	76,000			
	Scheduling Consultant	50,000			
	Traffic Consultant	15,000			
	Technology, Security Consult.	75,000			
	Vibration Consultant	35,000			
	Code Consultant	30,000			
	Other Consultants	60,000			
	Developer Manager	12,000			
	City Permit Fees	35,000			
	IDPH Review Fees	40,000			
	Builders Risk Insurance	30,000			
			823,000	688,341	134,659
MOVABLE AND OTHER EQUIPMENT					
	Adult Emergency	8,290,872			
	Radiology	3,323,557			
	Staff/Support	48,496			
			11,662,925	11,614,429	48,496

OTHER COSTS TO BE CAPITALIZED					
	Environmental Services	51,000			
	Movers	75,000			
	Plant Shutdowns	55,000			
	Art Work	30,000			
	Capitalized Staff Salaries	481,096			
			692,096	573,116	118,980
TOTAL COSTS			\$35,915,000	\$29,740,740	\$6,174,260

ADULT ED EQUIPMENT	
Patient monitors	\$2,149,875
IT applications, hardware	2,040,199
Headwalls	1,050,000
Nurse call integration	551,250
Desks, chairs, other furnishings	315,000
Omnicell drug cabinets	288,750
Patient beds	239,400
Exam lights, booms	210,000
Desktop computers, printers	187,110
Pneumatic tube equipment	168,000
Linen, fluid tall carts	119,700
Bedside tables	91,770
Ice makers, water dispensers	66,282
Defibrillators for crash carts	63,000
Blanket warmers w/IV warmers	63,000
Glidescopes	47,250
Overhead med gas, monitor booms	42,000
LED procedure lights	35,280
Blanket warmers	31,500
Recliner chairs w/table, IV stand	31,500
Kanban board with tablet	31,500
Tray tables	29,925
Dopplers	22,050
Equipment rails w/accessories	21,420
White boards	21,000
Overhead surgical lights	21,000
Patient lift/scale	21,000
Ceiling patient lift	21,000

Procedure carts	18,900
Isolation carts	18,900
Ophtho/Otosopes	18,375
Dynampap bp monitors	15,750
Crash carts	14,700
Patient bay restock carts	12,600
Other, small equipment	<u>211,885</u>
ADULT ED EQUIPMENT TOTAL	\$8,290,872

RADIOLOGY EQUIPMENT	
CT scanner	\$1,995,000
Radiographic Units	1,121,400
IT applications/hardware/install.	107,379
CT injector	47,250
IT equipment for Radiology	44,541
Desktop computers, printers, furn.	<u>7,987</u>
RADIOLOGY EQUIPMENT TOTAL	\$3,323,557
STAFF SUPPORT	
Desk, chairs, other furnishings	\$33,250
Desktop computers, printers	15,246
Staff Support Equipment Total	<u>48,496</u>
EQUIPMENT GRAND TOTAL	\$11,662,925

Section I, Cost Space Requirements

Attachment 9

Cost Space Requirements

<u>Department/Area</u>	<u>Cost</u>	<u>Gross Square Feet</u>		<u>Amount of Proposed Total GSF</u>			<u>Vacated</u>	<u>Re-</u>
		<u>Existing</u>	<u>Proposed</u>	<u>New</u>	<u>Modern.</u>	<u>As Is</u>		
				<u>Constr.</u>			<u>Space</u>	<u>assign</u>
Reviewable:								
Adult Emergency	\$25,054,339	16,517	27,019	27,019			16,517	0
Radiology	4,686,401	117,306	116,891	1,585			2,000	
Total Reviewable	\$29,740,740	133,823	143,910	28,604	0	0	18,517	
Nonreviewable:								
Bldg. Systems	\$5,217,961	957,040	970,302	13,262		957,040		
Staff/Support	956,299	69,645	71,764	2,119		69,645		
Total Nonreviewable	\$6,174,260	1,026,685	1,042,066	15,381	0	1,026,685		
Grand Total	\$35,915,000	1,160,508	1,185,976	43,985	0	1,026,685	18,517	0



Illinois Department of PUBLIC HEALTH

HF106029

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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 indicated below.

Lamar Hasbrouck, MD, MPH
Acting Director

Issued under
the authority of
the Illinois Department of
Public Health

EXPIRATION DATE	CATEGORY	ID NUMBER
6/30/2015	General Hospital	0003897
Effective: 07/01/2014		

Exp. Date 6/30/2015

Lic Number 0003897

Date Printed 6/5/2014

The University of Chicago Medical Center
5841 South Maryland
MC 1112
MC 1112
Chicago, IL 60637

The University of Chicago Medical Cen
5841 South Maryland
MC 1112
Chicago, IL 60637

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FEE RECEIPT NO.



July 12, 2013

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

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

Dear Ms. O'keefe:

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

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

- Comprehensive Accreditation Manual for Hospitals

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

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

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

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

Sincerely,

Mark G. Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations



December 10, 2014

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

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

Dear Ms. Avery:

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

Sincerely,

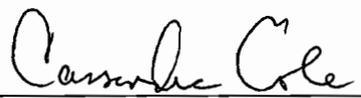
The University of Chicago Medical Center


Sharon O'Keefe
President

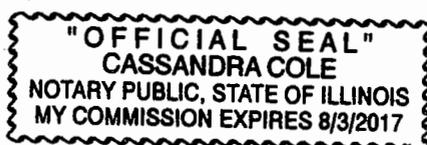
Notarization:

Subscribed and sworn to before me

This 10th day of December, 2014


Signature of Notary Public

Seal





THE UNIVERSITY OF
CHICAGO
MEDICINE

Sharon O'Keefe
President

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

December 10, 2014

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

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

Dear Ms. Avery:

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

Sincerely,

The University of Chicago Medical Center

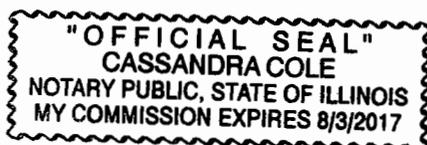
Sharon O'Keefe
President

Notarization:

Subscribed and sworn to before me
This 10th day of December, 2014

Signature of Notary Public

Seal



Section III, Purpose of Project

Attachment 12

Section 1110.230(b), Purpose of Project

Overview of Purpose

The University of Chicago Medical Center (“UCMC”) proposes to relocate its Adult Emergency Department (“Adult Ed”) from its current location in Mitchell Hospital to space adjacent to its Center for Care & Discovery (“CCD”) (the “Project”).

The purpose of the Project is to relocate the Adult ED nearer to the CCD, the hub of clinical care at UCMC, thereby enabling UCMC to provide better and timelier care to its Adult ED population, to accommodate existing patient demand and projected future growth, and to enhance UCMC’s preparation for large-scale, pandemic events.

Specifically, the Project would: (i) relocate and reconfigure UCMC’s Adult ED, (ii) add 6 new treatment stations, for a total of 42 treatment stations, and (iii) simultaneously move two Radiographic imaging rooms and one CT room from Mitchell Hospital closer to the CCD. The Project also includes separate entrances for EMS providers and patients, a rapid assessment unit for lower acuity patients, and an on-site bio containment unit for infectious disease.

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

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

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

Over the past several years, UCMC has experienced sustained, high demand for its adult emergency medical services. Adult ED visits have increased steadily from 40,137 visits in 2009 to 51,852 in 2014, an average annual increase of 5.3%. Additionally, each year approximately 6,000 patients come to UCMC's Adult ED, but leave without being seen.

UCMC's Adult ED capacity constraints come at a precarious time in health care delivery on the South Side of Chicago, which has seen its hospital inventory contract by more than half over the past 25 years as other hospitals have reduced their emergency medical services. UCMC is a valuable resource on the South Side of Chicago for both community hospitals and patients, and its Adult ED is an important point of entry into the health care system for many patients.

UCMC has consistently and consciously worked to optimize efficiency within the footprint of its existing Adult ED. For instance, UCMC recently achieved its lowest diversion rates in history. Between 2011 and 2013, UCMC's annual diversion hours averaged 1,799. One of the reasons for this high diversion rate was due to a shortage of inpatient beds that caused backups in the Adult ED. As a result of this bed shortage, UCMC frequently had to divert ambulances. In August 2013, the Review Board approved UCMC's application for an additional 38 Medical/Surgical beds pursuant to project #14-013. These new beds helped to reduce UCMC's diversion rate to 535 hours in 2014, a 70% improvement. In fact, during the spring of 2014 there was nearly a 3 consecutive month period with no ambulance diversion. The Review Board's support of UCMC's application for an increase in beds was crucial for this achievement.

Despite this success, UCMC is still unable to fully address capacity constraints within its current Adult ED's physical space. For example, in 2013, the average time a patient who was ultimately

discharged from the Adult ED spent there was 7 hours, and for patients who were ultimately admitted to an inpatient bed, the length of time in the Adult ED averaged 13.2 hours. Although these wait times were reduced to 6.5 hours and 10.9 hours, respectively, UCMC believes such delays are unacceptable. The industry benchmark for academic medical centers for emergency room wait times are 4.5 hours for those patients who will be discharged and 8 hours for those who will be admitted. Although UCMC is committed to reaching these benchmarks so that its patients have timely access to quality emergency care services, its existing Adult ED's space constraints frustrates these efforts. UCMC is, therefore, proposing to relocate and modernize its Adult ED.

By relocating its Adult ED closer to the CCD, UCMC will be able to reduce patient transport times, thereby improving critically ill patients' access to life saving resources and care. Such a relocation will also allow UCMC to reconfigure and modernize its Adult ED to decrease patient wait times and the number of patients who leave before being seen, as well as continue to shorten diversion rates. The move will also allow UCMC to construct an on-site bio-containment unit which will make it better equipped to handle pandemic emergencies. For those and other reasons the Project will improve the delivery of health care to residents of the South Side of Chicago and overall well-being of the neighborhood.

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

As a major national academic medical center, UCMC essentially has two market areas. First, it serves much of the South Side of the City of Chicago, primarily in Planning Area A-03. (Planning Area A-03 is roughly bounded by Roosevelt Road (12th Street) to the north, Cicero Avenue to the west, 127th Street to the south, and Lake Michigan/Indiana State line to the east.) In addition, for its highly specialized tertiary and quaternary services, UCMC serves much of the metropolitan area, the state and the Midwest, and even includes international patients.

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

A. Insufficient Treatment Capacity

UCMC's current Adult ED is frequently at capacity, with long wait times and high occupancy. Adult ED visits have increased steadily from 40,137 visits in 2009 to 51,852 in 2014, an average annual increase of 5.3%. Additionally, each year approximately 6,000 patients come to UCMC's Adult ED, but leave without being seen because of long wait times. UCMC projects that these trends will continue through 2019. UCMC also anticipates continued increased emergency department utilization as a result of the Affordable Care Act and the expansion of Medicaid and projects a separate and substantial surge in utilization that routinely follows the construction of new emergency department. Despite recent improvements in operational efficiency in its current Adult ED, UCMC's average lengths of stay for both patients treated and discharged and treated and admitted exceed the 50th percentile for CMS benchmarks.

In addition to relocating its Adult ED, UCMC also proposes to increase its number of treatment stations from 36 to 42.

The majority of UCMC's existing treatment stations were created by partitioning a larger space into curtained cubicles, which are smaller than Review Board standards and do not offer as much patient privacy as separate rooms. Increasing the number of treatment stations will allow UCMC to reduce its long wait times and provide more timely access to emergency care services. It will also allow UCMC to better accommodate isolation for infectious disease, such as pandemic flu or Ebola, as well as ensure that there are stations equipped to treat behavioral health and bariatric patients.

B. Lack of Proximity to Diagnostic and Treatment Facilities

UCMC proposes to enhance patient safety by relocating its Adult ED from Mitchell Hospital to a building adjacent to the CCD.

The majority of UCMC's clinical operations are now housed in or near the CCD. For instance, UCMC's Operating Rooms, Interventional Radiology, Cardiac Catherization Labs, Electrophysiology Labs, and GI Procedure Area are all located in the CCD.

The Adult ED and the CCD are separated by 1500 feet and two elevator rides, which means long transport times for patients who need critical access to the operating rooms and other facilities and services located at the CCD. UCMC is a Comprehensive Stroke Center. UCMC's stroke teams work in the CCD's Neurology patient unit. When a stroke patient arrives in the Adult ED the stroke team must rush from the CCD all the way to Mitchell Hospital. For stroke and other critically ill patients time is of the essence.

The remoteness of the current Adult ED also affects staff efficiency. The time spent by physician, nurses, and technicians accompanying the patient along with multiple items of equipment to support the patient significantly reduces treatment capacity and disrupts operations. The Adult ED is also remote from UCMC's inpatient beds in the CCD, where many patients are hospitalized following their ED admission.

The present Adult ED is, however, well located in that it is adjacent to the inpatient Radiology area. Patients needing to be imaged can be transported there quickly. Because the location of the new Adult ED would be a 6 to 7 minute trip from radiology facilities in the CCD and because there will be sufficient volume in the Adult ED to support dedicated imaging services, UCMC proposes to simultaneously locate 2 radiographic rooms and 1 CT room in the new Adult ED. Corresponding rooms in Mitchell Radiology would be discontinued, so there would be no change in equipment counts. This will allow patients to continue to benefit from being near imaging equipment.

By relocating the Adult ED near the CCD, the Project would reduce patient transport times from 15 minutes to less than 5 minutes which, for critically ill patients, is important. Similarly, by simultaneously moving imaging equipment, UCMC will ensure that patients, maintain the benefit of having such equipment nearby.

C. Existing Layout Contains Clinical Inefficiencies

As part of relocating its Adult ED from Mitchell Hospital to adjacent to the CCD, UCMC also plans to utilize a more efficient and patient-friendly floor plan, designed to reduce wait times and to treat patients in settings according to the nature and severity of their illness.

Even if UCMC were not proposing to relocate its Adult ED, it would still need to modernize Mitchell Hospital's facilities. The Adult ED has been renovated three times over the past 31 years. The current space is undersized and not efficiently structured to best support general emergency activity. Given space and structural constraints, UCMC cannot make additional physical improvements in the current space. The new layout at the new location would resolve these suboptimal design issues.

There are three separate treatment zones in UCMC's Adult ED, which are difficult to operate effectively, since attending physicians and the charge nurses who direct the physicians and nurses do not have visual contact between the zones. As part of the relocation UCMC can address this issue thereby improving patient care and clinical efficiencies. Another issue which will be addressed is the lack of support staff space. In order to gain space to add treatment stations over the years, support space has been taken over. Thus, storage for supplies and equipment has been sacrificed. As a result, more time is spent gathering supplies than is optimal for patient care. Additional support space will be included in the new floor plan to alleviate this issue.

Finally, both walk-in patients and EMS providers enter the Adult ED through one doorway. The result is that the most acute patients and the least urgent patients are mixed together in both the waiting rooms and treatment areas. This complicates triage and treatment. By creating separate entrances UCMC will be able to expedite patient care and improve patients' experience.

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

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

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

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

A. Clinically Superior Location

The Project would enable UCMC to locate its most critical patients closer to the life-saving resources and care in the CCD in order to achieve the best clinical outcomes for these patients. By reducing patient transport times from the Adult ED to the operating rooms or procedure rooms from approximately 15 minutes to approximately 5 minutes, patients, for whom time is of the essence, will be in close proximity to the advanced diagnostic, treatment and ancillary services available in the CCD. Additionally, need for clinical staff to round on their patients over a wide area will also be reduced, further increasing clinical capacity.

B. Increased Treatment Capacity to Meet Patient Demand

The Project is designed to better meet the growing clinical needs of UCMC's patient community, which relies heavily on emergency departments for the provision of care. UCMC's ED remains an important point of entry for those without other means of access to medical care.

The new Adult ED will have six more treatment rooms for a total of 42, including 2 rooms for isolation, 4 psychiatric rooms and 1 bariatric room. The treatment stations will be separate rooms and will offer more privacy and noise control than the curtained cubicles that they will be replacing. Patients needing psychiatric attention can be a challenge for emergency departments, particularly for hospitals such as UCMC that do not operate inpatient psychiatric beds. The

addition of 4 psychiatric rooms will assist UCMC in caring for this population while at the same time keeping them from disturbing other patients and the provision of care.

UCMC expects to meet target utilization for all 42 treatment stations within two years of Project completion.

C. Efficient Care Delivery and Patient-Friendly Design

The new Adult ED's layout is designed to help UCMC to substantially reduce wait times for patients overall and the left without being seen rate to zero.

The newly configured Adult ED will have separate entrances for ambulatory/walk-in patients and those patients being transported by ambulance. Currently both types of patients enter through the same door, which can complicate triage and treatment. Separating entrances will reduce time to treatment and improve health outcomes. Specifically, the new Adult ED will contain a rapid assessment unit adjacent to the entrance for patients needing minor stabilizing treatment prior to discharge.

The new facility will also have additional treatment stations and a more efficient layout which will further improve care and efficiency. Sized to meet growing demand, designed for efficient use of space and optimally located from a clinical perspective the facility will assist in the coordinated treatment of patients. Additionally, all of the rooms will be private, which is better for patient privacy and infection control.

With this Project, UCMC seeks to decrease the average length of stay ("ALOS") for patients treated and discharged from the ED from 7 hours to 4.5 hours, which is the 50th percentile for CMS benchmarks. Similarly, UCMC seeks to decrease the ALOS for patients admitted to UCMC from 13 hours to 8 hours.

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

This Project involves the relocation of UCMC's Adult ED from Mitchell Hospital to new construction adjacent to UCMC's CCD and the addition of 6 treatment stations for a total of 42.

UCMC's prevailing objective is access to high-quality medical care – both through increased capacity, reduced wait times and operational efficiency. Specifically, the goals of the Project are:

- To concentrate clinical operations for the most acutely ill patients in or near the CCD, alongside the ancillary diagnostic and treatment modalities required for their medical care, and to improve clinical efficiency throughout UCMC's medical campus.
- To alleviate strain on UCMC's current resources that arise due to long lengths of stay and unpredictable volume of Adult ED patients and to decrease the number of LWBS patients who leave because of long wait times.
- To create clinical efficiencies and capacity for additional growth by modestly expanding UCMC's Adult ED and by streamlining the delivery of emergency medical care to UCMC's patients and to the community.
- To enhance local and regional emergency preparedness through state of the art facilities for isolation and bio containment.

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

Section III, Alternatives

Attachment 13

1. Alternatives

A. Project of Greater or Lesser Scope and Cost

One alternative which UCMC considered was expanding the current Adult ED in Mitchell Hospital. Renovations would have added 18,000 dgsf to the current 16,517 dgsf plus 5,000 dgsf for swing space for a total of 39,517. Although some of the additional area is currently vacant, the other areas are occupied and the cost of relocating those occupants was expensive. Because Mitchell Hospital is 31 years old any renovations would also likely require infrastructure improvements (HVAC, electrical, plumbing, IT systems). A substantial construction contingency would, therefore, have also been required thereby significantly increasing the costs. In order to maintain present operations, the work would require many phases, which also adds to cost. Due to the inherent difficulties of expanding and renovating in place while continuing to operate the ED, renovating would not only be expensive but would also potentially negatively affect patient care. While the square footage would be similar to the proposed relocated space, constraints means that the resulting renovated space would not be as advantageous as the proposed space. For example, the present ambulance bay/public drop-off area share the same entrance. The cost of separating this into two entrances, one for more urgent patients transported by ambulance and another for walk-in patients, would be prohibitively expensive. Thus, even with a remodel, a suboptimal single entrance would remain.

Total cost for renovations would have been \$38.2 million, which exceeds the \$35.9 million for the proposed Project. The most important reason, however, that this alternative was rejected is that the renovated Adult ED would still remain too far from key inpatient services such as Operating Rooms, Interventional Radiology, Cardiac Catheterization Labs, Neuroscience Patient Unit, and GI Procedures Unit. This would still mean patient transports of up to 15 minutes from Mitchell Hospital to the CCD, as opposed to a 5 minute trip from the proposed relocated site of the Adult ED.

B. Joint Venture with Other Providers

A joint venture with another provider was also considered.

Emergency departments are often run at a loss owing to relatively low reimbursement for outpatient services. UCMC incurred a loss of \$23 million in the last year for its Adult ED. Assuming a 50/50 sharing of costs and revenues, the cost to UCMC would only have been 18 million instead of 35.9 million. Few, if any, health care providers desire to split such losses without any potential gains. For this reason, it is not likely that a joint venture would be possible. Joint ventures are typically arranged for services that are remunerative, but not for ones that have large losses. An economic case could be made for two facilities, each with small volumes, to be combined as one more efficient operation, but at 52,000 annual visits, expected to grow to 85,000, UCMC's Adult ED is a large operation. 16% of Illinois's 153 hospitals offering emergency services operate at 50,000 or more annual visits. Thus, finding another provider to partner with was unlikely.

UCMC, however, recognizes that its Adult ED serves a vital role in its community's healthcare delivery services and, despite the losses it incurs in the provisions of such care, UCMC is committed to remaining a resource for its patient communities. As a result, UCMC rejected the idea of a joint venture and instead has fully committed itself to dedicating the funds necessary to provide the best emergency care services it can.

C. Utilize Other Available Health Resources

Another alternative UCMC considered was utilizing other available health resources. Each of the other 8 hospitals in Planning Area A-03, where UCMC is located offers emergency services. Based on 2013 survey information, the number of stations in each facility ranges from 11 to 33. Overall, these facilities average 1,492 visits per station. No single facility could absorb UCMC's annual 52,000 visits, which on average would result in 3,855 visits per station per year. Another area hospital would itself have to have increased its own capacity in order to accommodate UCMC's excess patients at a cost of approximately \$22 million.

Alternatively, UCMC's 52,000 annual visits could be divided equally among all other Planning Area A-03 providers. Mathematically, this would bring each provider up to 1,786 visits per station which is within the Review Board's Adult standard of 2,000. First, it is unlikely that such an even distribution would occur. Second, the nature of emergency care is that the patient is in critical condition requiring immediate care. Diverting patients to other hospitals which may be further away could negatively affect health outcomes. UCMC has always been and continues to be, committed to ensuring that its patients have access to care in their community. Relegating these patients to other providers outside of their neighborhoods is not something UCMC or the community desires.

While a good portion of emergency care is of a primary or secondary nature, the patients UCMC serves tend toward a higher acuity of care. The ESI Triage Research Team, LLC developed a triage algorithm that is commonly used to score patients. There are five categories in this system. During a recent 12 month period, 45% of the patients were in the two highest emergency categories. 23% of patients arriving at UCMC Adult ED are hospitalized. In this respect, UCMC's ED is not simply the destination for care, but a gateway to the tertiary level of services offered at UCMC. Many of these services are not offered, or at least not to the same extent, at the other Planning Area A-3 hospitals. For these reasons, the alternative of having the UCMC's Adult ED patients cared for at neighboring emergency departments was not pursued.

D. Proposed Alternative

The proposed Project is the alternative selected. Within UCMC's medical campus, the location is most proximal to the inpatient services located in the CCD. Of the locations evaluated at UCMC and among the other arrangements discussed above, the proposed project achieves the best combination of the quality patient services for the cost.

2. Comparison of Alternatives

Alternative	Cost	Pros	Cons
Project of Lesser Scope	\$38M	Does not utilize valuable space near the CCD.	More costly.
		Continue to use existing ambulance bays.	Lacks critical adjacencies.
			Combined entrance.
Joint Venture	\$36M	Shared risk/losses.	Others reluctant to share in losses.
		Integrated with area providers.	Emergency Department not likely for joint venture service.
Utilize Existing Facilities	\$22M	No capital cost.	May not be possible to accommodate +50K emergency department visits elsewhere on South Side.
		Save operating losses.	
Proposed Project	\$36M	Closer to critical inpatient services.	Uses valuable space near the CCD space.
		Optimal design.	
		Easier access.	

Section IV, Project Scope, Utilization, and Unfinished/Shell Space

Attachment 14

Section 1110.234, Project Scope, Utilization and Unfinished/Shell Space

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED	STATE	DIFFERENCE	MET
	BGSF/DGSF	STANDARD		STANDARD?
Adult Emergency	27,019	37,800	(10,781)	Yes
Radiology	1,585	4,400	(2,815)	Yes

The Total proposed square footage for the relocated Adult ED is 27,019 departmental gross square feet (dgsf). This is below the Review Board maximum area of 37,800 (42 stations of 900 dgsf each) by 10,781 dgsf.

With the opening of the 13-story CCD nearly 2 years ago, many vital inpatient services that were located in Mitchell Hospital are now a 12 to 15 minute, two elevator trip away from the Adult ED. The lengthy transport time to such services as Operating Rooms, GI Procedures, Interventional Radiology, Cardiac Catheterization Labs, ICU's and acute care beds, and notably the Neurological Unit for stroke victims is the primary driver for this Project. In addition to patient transport time the separation from key physicians and caregivers located at the CCD is also a concern. For example, as a comprehensive stroke center, UCMC's stroke teams must travel from the CCD to the Adult ED which is almost 15 minutes away. Time is of the essence. Delays due to the location of the Adult ED in comparison the location of the stroke teams and CCD's life saving resources is unacceptable. As UCMC's remaining ICU and most of the Medical/Surgical beds are moved to the CCD over the next several years as part of project 14-013 it becomes increasingly imperative for the Adult ED to be relocated.

New Location Promotes Better Patient Care

The proposed new Adult ED location would be on 57th Street to the north of the CCD and would be connected to the CCD by both a tunnel and a 2nd floor bridge.

Currently patients, whether arriving by ambulance or in a personal vehicle, must drive two blocks into the heart of UCMC's busy clinical campus center and parking is difficult to find. The proposed new location is directly off Cottage Grove Avenue, a major arterial route, which is the western boundary of UCMC's campus. Obviously, parking arrangements for persons arriving by private vehicle will be improved since the ED will be located near parking.

New Ambulance Drop-Off is Superior for Infection and Biohazard Containment

UCMC's existing ambulance bay is outdoors. The proposed Project would include a covered ambulance bay within the structure. Automatic doors will open as the ambulance approaches. Given the increased concern over infectious diseases, such as Ebola, this covered and contained approach is a marked improvement over UCMC's current outdoor ambulance bay arrangement. If a suspected highly contagious patient is brought in by ambulance, the doors can be closed and the area sealed for disinfecting. The Project also proposes a better arrangement for biohazard containment. Currently this function is located in a trailer situated in the UCMC's existing Adult ED parking lot. In the new Adult ED, these functions would be inside the ambulance drop-off area. Again, because the two large doors to the drop-off area could be closed, the area could be sealed off for containment and quick decontamination.

Specifically, the new ambulance entrance is the drop-off area on the west side. Within 50 feet of the ambulance entrance is an isolation room for patients, which minimizes potential exposure to the majority of the Adult ED space. On the east side, off of Maryland Avenue, is the drop-off for private vehicles, with an entrance into the reception/waiting area. Less than 15 feet from the reception/waiting area is another isolation room, again minimizing contact with a possibly infectious patient.

Public Area

The public waiting area in the relocated Adult ED will have 46 seats for friends and family. The

expectation is that except in very busy moments patients will be either in treatment rooms, imaging, or a 12-seat Internal Disposition Area for low acuity patients. Just off the public waiting area will be a family room to serve multiple family members in a more private setting. Public rest rooms and a vending area complete the reception area.

Treatment of Lower Acuity Patients

The Rapid Assessment Unit is served by 7 treatment rooms and a 12-seat internal waiting area for patients needing minor treatment just prior to release, for example, nebulizer treatment for a patient suffering an asthma attack. To streamline operations less acute patients will be seen in this Rapid Assessment Unit adjacent to the public entrance where such patients are most likely to arrive. Quickly consolidating these low acuity patients in one location will help improve triage functions and wait times.

Improved Triage and Treatment of Emergent Patients

Emergent patients will be served by 35 treatment rooms. The majority of these rooms range from 140 to 167 net square feet (nsf) and will be universal rooms. In other words, such rooms will have identical layouts, supply arrangements, exam tables, etc. so that caregivers will be immediately familiar with each room. Two of these rooms will be large exam rooms of 249 nsf each for cases when many physicians, nurses, and technicians might need to be involved with the patient. There will also be 1 bariatric room for extremely large-sized patients and a bariatric bathroom. As mentioned earlier, there will be 2 isolation rooms for infectious patients.

Psychiatric Treatment Area

Patients needing psychiatric attention can be a challenge for emergency departments, particularly for hospitals such as UCMC that do not operate inpatient psychiatric beds. After a patient is stabilized, arranging for him or her to be transported to a hospital with an open psychiatric bed can take time. Often these patients are disruptive to other patients. In a separate area in the center of the floor, closed off from the main clinical area will be 4 psychiatric treatment rooms. Having these patients segregated not only ensures they are appropriately cared for but also helps to minimize potential distraction to the rest of the department if such psychiatric patients were cared for in regular treatment rooms. An attendant would be stationed within this designated

area and the patients would be confined to the treatment rooms. The entry doors to this psychiatric sub-area will have controlled access. Although this specialized area may result in less than optimal room utilization, it is important to make these special provisions for psychiatric patients.

Team Work Stations Ideally Situated

The majority of the treatment rooms served by three Team Stations, where physicians and nurses share work space. It is important to locate these work spaces together to facilitate communication. Treatment rooms will be on either side of the Team Stations so caregivers have visual views of these rooms and the ability to communicate orally in order to readily understand where assistance is needed. The Charge Nurse station will be located so that he or she has direct sightlines to 30 of the ED's treatment rooms. Again, this is of critical importance so that the Charge Nurse can quickly ascertain where help is needed during the free flowing and often hectic activity of a busy emergency department.

Support Areas

Due to the need to maximize treatment space, over the years space for support functions in Mitchell Hospital was co-opted for treatment space. As a result, the current Adult ED has insufficient space for support services. The new layout of the relocated Adult ED would include space for storage rooms for supplies and equipment, storage alcoves for smaller, portable devices such as EKG machines, medication rooms with dispensing machines, clean and soiled utility rooms, a staff conference room, an EMS radio room, administrative offices located just outside the main department and a break room and small locker room.

Efficiency of Design

UCMC has engaged Moody Nolan, an architectural firm with a 25 person healthcare team, to design the Project. This firm designed projects for the Ohio State University Wexner Medical Center, the University of Illinois Hospital and Health Sciences System, and the Children's Hospital of Philadelphia (planned for a different firm by an architect who is now the Senior Planner on UCMC's Adult ED project). The firm considers UCMC's design highly efficient and compact. Circulation space is only 15% of the clinical area. The proposed project square

footage is 29% below the State standard for maximum size, another indication of the efficient design.

Use of Vacated Space

Once vacated, UCMC’s existing Adult ED facility, equaling 16,517 dgsf in Mitchell Hospital, will likely become the new home for a Student Care Center, serving students attending the University of Chicago. This location is readily accessible from the street and only two blocks from the main quadrangle of the University of Chicago campus.

1. Radiology

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED	STATE	DIFFERENCE	MET
	BGSF/DGSF	STANDARD		STANDARD?
Radiology				
- General radiographic (2)		2,600		
- CT (1)		1,800		
Total	1,585	4,400	(2,815)	Yes

The Project proposes a total of 1,585 dgsf for Radiology space. This is below the Review Board standard of norm of 4,400 (2 general radiographic rooms 1,300, plus 1 CT room at 1,800) by 2,815 dgsf and thus the Project meets the standard. The design is very efficient, being 64% below the Review Board maximum standard.

The key rooms for Radiology will be 2 Radiographic rooms and 1 CT room located near the middle of the clinical space. When the new Adult ED begins operations, 2 Radiographic and one CT room in Mitchell Hospital will be decommissioned. Thus, there will be no increase in imaging rooms, only a relocation of existing imaging rooms. In addition to these radiology rooms there will be a 130 nsf waiting area, as well as a 240 nsf Reading Room.

Section IV, Size of Project

Attachment 14

Section 1110.234, Project Scope, Utilization and Unfinished/Shell Space

Room #	Room Description	Emergency Department Clinical	Square Footage	Radiology Clinical	Non-Clinical Staff/Public	Non-Clinical Building Support
Level 1 - Emergency Department			Square Footage			
1200	R.A. TEAMING STATION		163			
1200A	CORRIDOR		743			
1200B	CORRIDOR		852			
1202	P.T.		48			
1203	IWA CHECK-IN		40			
1210	INTERNAL WAITING AREA		170			
1211	IWA		53			
1212	IWA		52			
1213	IWA		52			
1214	IWA		52			
1215	IWA		52			
1216	IWA		53			
1220	INTERNAL WAITING AREA		169			
1221	IWA		53			
1222	IWA		52			
1223	IWA		53			
1224	IWA		52			
1225	IWA		51			
1226	IWA		52			
1300	TOILET		42			

1300A	CORRIDOR		405			
1301	POC SOILED		101			
1340	CLEAN SUPPLY		397			
1360	P.T.		48			
1400	SOILED		56			
1400A	PSYCH CORRIDOR		329			
1400A	CORRIDOR		536			
1400B	CORRIDOR		241			
1401	S.T.		53			
1404	RED BAG		44			
1405	EVS		68			
1406	HLD		70			
1407	EMS RADIO		100			
1408	S.T.		56			
1409	R.T.		89			
1410	LINEN		10			
1412	PSYCH STORAGE		90			
1414	PSYCH NURSE STATION		229			
1422	REGISTRATION/BILL PAY		234			
1500A	CORRIDOR		511			
1500B	CORRIDOR		1,090			
1500C	CORRIDOR		571			
1500D	CORRIDOR		2,250			
1500E	CORRIDOR		1,070			
1500F	CORRIDOR		386			
Emergency Department Key Rooms:						
1230	EXAM RM 1		139			
1231	EXAM RM 2		139			
1232	EXAM RM 3		139			
1233	EXAM RM 4		128			
1234	EXAM RM 5		148			
1235	EXAM RM 6		148			

1204	EXAM RM 7		140			
1533	EXAM RM 8 Iso		172			
1534	EXAM RM 9		154			
1535	EXAM RM 10		154			
1536	EXAM RM 11		154			
1537	EXAM RM 12		154			
1540	EXAM RM 13		148			
1541	EXAM RM 14		148			
1542	EXAM RM 15		148			
1543	LARGE EXAM 16		253			
1544	LARGE EXAM 17		254			
1501	EXAM RM 18 Iso		146			
1502	EXAM RM 19		146			
1503	EXAM RM 20		143			
1507	EXAM RM 21		156			
1508	EXAM RM 22		156			
1509	EXAM RM 23		156			
1510	EXAM RM 24		156			
1511	EXAM RM 25		156			
1512	EXAM RM 26		156			
1513	EXAM RM 27		156			
1514	EXAM RM 28		156			
1516	EXAM RM 29		157			
1517	EXAM RM 30		162			
1518	EXAM RM 31		163			
1520	EXAM RM 32		162			
1521	EXAM RM 33		162			
1522	EXAM RM 34		162			
1523	EXAM RM 35		162			
1524	EXAM RM 36		162			
1525	SANE RM 37		159			
1530	BARIATRIC 38		208			
1413	PSYCH 39		154			

1415	PSYCH 40		154			
1416	PSYCH 41		154			
1417	PSYCH 42		156			
1501A	ANTE		41			
1501B	P.T.		45			
1505	EMS		115			
1506	EMS STO		89			
1515	DECON		119			
1519	P.T.		54			
1525A	P.T.		62			
1526	EQUIP.		215			
1527	EVS		88			
1528	RED BAG		49			
1529	SOILED		46			
1531	MEDS.		94			
1532	LINEN		20			
1533A	ANTE		47			
1533B	P.T.		52			
1538	BARIATRIC P.T.		49			
1539	MEDS.		134			
1550	TEAM STATION A		105			
1551	TEAM STATION B		117			
1552	TEAM STATION C		93			
1553	TEAM STATION D		124			
1554	TEAM STATION E		95			
1555	TEAM STATION F		108			
1556	CHARGE NURSE STATION G		223			
1557	TEAM STATION H		218			
1558	TEAM STATION I		232			
1559	TEAM STATION J		201			
1560	TEAM STATION K		200			
1561	TEAM STATION L		209			

Level 1 – Radiology						
Radiology Key Rooms:						
1350	C.T.			413		
1310	X-RAY			260		
1320	X-RAY			260		
1329	IMAGING EQUIPMENT STORAGE			96		
1330	RAD WAITING			108		
1331	CONT.			138		
1350A	EQUIP ROOM			70		
1632	READING			240		
Level 1 - Non-Clinical Staff Support for Emergency						
1504	BREAK ROOM				298	
1504A	STAFF LOCKERS				371	
1504B	S.T.				42	
1504C	S.T.				42	
1506A	OFFICE				150	
Level 1 - Emergency Intake/Waiting						
1100	WAITING		695			
1100A	CORRIDOR		344			
1160	FEMALE TOILET		163			
1170	MALE TOILET		160			
1171	GREETER		90			
1172	SECURITY		44			
1173	W.C.STORAGE		33			
1174	VEND		89			
1201	FAMILY ROOM		94			
1506B	EMS DROP-OFF		3,495			

Level 1 - Non-Clinical Building Support						
1000A	VESTIBULE					108
1000B	SERVICE ELEVATOR LOBBY					163
1150	VESTIBULE					129
1200A	VESTIBULE					85
1200A	VESTIBULE					161
1361	CHUTES					75
1361A	COND. PUMP					33
1402	ELEC					95
1403	MECH.					40
1418	ELEC					89
1420	SECURITY PANELS					22
1500A	VEST.					80
1500D	EXIT VESTIBULE					42
1500H	CORRIDOR					450
1500H-1	VESTIBULE					61
1504	4-HR VESTIBULE					35
1E90	ELEVATOR 151					115
1E91	ELEVATOR 150					99
Level 1 - Subtotal			27,019	1,585	903	1,882

Level 1.5 Non-Clinical Building Support						
1600	LEVEL 1.5 CORRIDOR					4,390
1601	LEVEL 1.5 ACCESS CORRIDOR					74
1620	IT ROOM					197
1621	ATS ROOM					457
1622	SWITCHGEAR ROOM					489
1624	MECHANICAL LEVEL 1.5					2,264
1631	BAS CLOSET					65
1669	IT ROOM					199
Level 1.5 Non-Clinical Staff Support for Emergency						
1600A	HALLWAY				215	
1623	HOTELING WORKSTATIONS				107	
1625	OFFICE				100	
1626	OFFICE				80	
1627	OFFICE				100	
1628	CONFERENCE				237	
1629	OFFICE				100	
1630	OFFICE				100	
1633	ON-CALL				100	
1634	STAFF TOILET				77	
Level 1.5 - Subtotal			-	-	1,216	8,135
Upper Levels - Non-Clinical Building Support						

Level 2 Non-Clinical Building Support						
2000	ELEVATOR LOBBY					386
2000A	4 HOUR VESTIBULE					44
200B	LEVEL 2 BRIDGE					794
200C	HOSPITAL VESTIBULE					150
2002	ELEVATOR MACHINE ROOM					151
2003	MECHANICAL SHAFT					140
Level 3 Non-Clinical Building Support						
3000	MECHANICAL SHAFT					494
Level 4 Non-Clinical Building Support						
4000	MECHANICAL SHAFT					281
Level 5 Non-Clinical Building Support						
5000	MECHANICAL SHAFT					293
Level 6 Non-Clinical Building Support						
6000	MECHANICAL SHAFT					512
Upper Levels - Subtotal			-	-	-	3,245
TOTAL (DGSF)			27,019	1,585	2,119	13,262
GRAND TOTAL (DGSF)						43,985

Section IV, Project Services Utilization

Attachment 15

Section 1110.Appendix B, Project Services Utilization

1. Adult Emergency Department

UTILIZATION					
	DEPT./	HISTORICAL	PROJECTED	STATE	MET
	SERVICE	UTILIZATION	UTILIZATION	STANDARD	STANDARD?
		(VISITS)			
	Adult ED			2,000/station	
2009		40,137			
2010		42,887			
2011		45,715			
2012		46,434			
2013	36 stations	48,039			No
2014	36 stations	51,852			No
2015	36 stations		54,577		
2016	36 stations		57,445		
2017	36 stations		60,464		
2018	42 stations		79,592		
2019	42 stations		83,774		Yes
2020	42 stations		84,854		Yes

Note: Year end 9/30 except 2020 which ends 1/1.

In the year ending September 30, 2014 UCMC's Adult ED provided care through 51,852 visits. During this same period 6,052 patients who came to the Adult ED for care, were seen by the intake staff, but left before receiving treatment. The long waits experienced by these patients are the most likely cause for them leaving. Although this is a problem experienced in many emergency departments in urban and suburban areas, it is nonetheless unacceptable that patients seeking care choose to leave before obtaining it. One of the goals of the Project is to relocate and reconfigure the Adult ED in a manner that reduces the number of these disappointed and inconvenienced patients to zero.

Ongoing Effort to Increase Adult ED Capacity

UCMC's Adult ED was opened in 1983 as part of the construction of Mitchell Hospital. Throughout the years there has been a concerted effort to improve the efficiency of operations and reduce the long waiting times and lessen bottlenecks. Initially there were 18 stations, 6 of which were located in a single large room and cordoned off by cubicle curtains. In subsequent years 3 stations were added by sacrificing support space such as supply storage and the break room. The space was slightly expanded in 2005 by filling in the ambulance pull-in area and using former patient parking lot to create 5 ambulance bays. This captured area allowed UCMC to increase stations to 30. In 2012, space from the adjacent Radiology department was used to expand the Adult ED to its current 36 stations. This gradual growth over the past 31 years has expanded capacity, but has done so at a cost to the original efficient layout of the facility.

The main area housing the 32 treatment stations is bifurcated by a set of fire doors, which must be closed at all times. The third area is across a public corridor to the west and has 4 stations. This creates operating difficulties since the caregivers cannot see from one area to the next. This diminished sightline makes it difficult to determine where staff is most needed.

Five Year Growth of 5.3% Per Year

Despite the shortcomings of UCMC's present Adult ED space, it has nonetheless, accommodated an increasing number of visits. As indicated in the chart above and also in the table later in this section entitled Adult Emergency Visit Forecast, visits to UCMC's Adult ED have increased steadily from 40,137 in 2009 to 51,852 in 2014, an average annual rate of increase of 5.3%. Based on this historic rate of growth, UCMC projects that over the next 5 years visits will reach 60,464 in 2017.

Additional Inpatient Beds Support Visit Growth

In August, 2013 the Review Board approved UCMC's application for an additional 38 Medical/Surgical beds. One of the reasons UCMC cited for the need for additional beds was that a shortage of beds was causing backups in the Adult ED which frequently necessitated diversion of ambulances. Between 2011 and 2013, annual diversion hours averaged 1,799. Once the

additional beds were opened this diversion rate was reduced to 535 hours, a 70% improvement. In fact, during the spring of 2014 there was nearly a 3 consecutive month period with no ambulance diversion. The Review Board's support of this bed addition was crucial to this achievement.

Reduced Waiting Time Will Eliminate LWBS

In 2013, the average time a patient spent in UCMC's Adult ED was 7 hours. This is unacceptable and UCMC's goal is to reduce this to 4.5 hours, an industry accepted benchmark for a well-run academic medical center emergency department. In 2014, this 7 hour wait was reduced to 6.5 hours, so progress is being made, but more can be done. Similarly in 2013, for patients who were ultimately admitted from UCMC's Adult ED to an inpatient bed, the length of time in the ED averaged 13.2 hours. In 2014 this was improved to 10.9 hours, however, UCMC's next goal is 8 hours. Again, 8 hours is an industry benchmark of good performance that UCMC is intent on reaching in the next several years as the Adult ED moves into new and better space.

The new facility in many ways will enable this to happen, but operations can be improved and this is also being addressed. This includes establishing up-to-date treatment protocols both for nurses and physicians that are evidence-based to result in better patient outcomes. This will streamline patient treatment and make sure every caregiver is following rigorous methods that have been proven to improve quality and reduce errors and cost. Cleaning methods are also being studied. Specifically, UCMC is timing how long it takes the cleaning staff to reach a just-vacated room, how long it takes to finish the cleaning, and then how long until a nurse places a new patient in the cleaned room. Another operational efficiency being implemented is to bring a patient immediately to a treatment station be triaged by a nurse and then to a clerk to be registered. The expectation is that these and other processes will help reduce waiting times.

These ongoing operational improvements along with the addition of the recently approved 38 Medical/Surgical and 12 ICU beds have actually increased in ED visits. In forecasting to January 1, 2020, which is two years of operation after opening the new space in 2018, it is anticipated that no patients will leave without being seen (LWBS).

As shown in the Adult Emergency Visit Forecast table below, during the past 4 years LWBS patient totals ranged from 5,671 to 6,271, an average of 12.4% of the visits for treated patients. Applying this factor to 2018 visits when the facility will have been open for 9 months, it is expected that the improvements described above will mean improved treatment speed with patients being cared for much sooner after they arrive. Patients will no longer leave in frustration and disappointment after a lengthy wait.

ADULT EMERGENCY VISIT FORECAST									
Year End	Visits		LWBS			Stations	Visits per Station		
2009	40,137								
2010	42,887								
2011	45,715		5,671	}					
2012	46,434		6,271						
2013	48,039		5,800		12.4%	36	1,334		
2014	51,852		6,052			36	1,440		
		Add LWBS	Add One Time Increase						
2015	54,577					36			
2016	57,445					36			
2017	60,464					36			
2018	79,592	5,914	10,037			42	begin operations		
2019	83,774					42	1,995		
2020	84,854					42	2,020		

Notes/Assumptions:

- Annual average rate of increase in visits 2009 to 2014 is 5.3% per year, assumed for 2015-2020.

- Operations to begin 1/1/18. 2020 above is for the year ending 1/1/20, two years of operations.
- LWBS is Left Without Being Seen, patients who were registered but left without being treated.
- LWBS 2011 to 2014 was 12.4% of visits. These visits added due to more capacity in 2018.
- One Time Increase is a 16.6% first year increase seen in a survey of 8 recent ED projects at academic medical centers.

One-Time Surge in Utilization for New Facilities

During UCMC's planning for this Project, UCMC staff visited other hospitals and had discussions with peers at academic medical centers that had recently rebuilt their emergency departments. Many of these hospitals experienced a phenomenon of a surge in visits between the year before opening to the year after. The reasons for this increase could include a new facility attracting patients who use to go elsewhere, increased treatment capacity, and reduced waiting time. Through the auspices of the University Hospital Consortium UCMC surveyed 6 academic hospitals that had recently replaced their emergency departments. The respondents were asked to subtract LWBS patients from their base year visits for a consistent comparison to UCMC's data. UCMC was also aware of 2 other recent emergency room projects and included visit data for these projects to the group. The change in visits for the year after the new facility was in operation ranged from a 10% loss to a 51.5 % increase. The average utilization increase for the 8 hospitals was 16.6%. This factor was applied to UCMC's projections for the first year of operation, 2018. By the second year of operation for UCMC's Adult ED, expected visits reach 84,854 for 42 stations, an average per station of 2,020. This meets the Review Board's standard of 2,000 visits per station.

Change in ED Visits First Year After Opening

<u>Hospital</u>	Visits		<u>Change</u>
	Year Before	Year After	
	<u>Opening</u>	<u>Opening</u>	
Univ. of Arizona Med Center	59,525	90,157	51.5%
Anonymous	69,801	75,760	8.5%
Eskanazi Health, Indianapolis	103,000	92,686	-10.0%
Anonymous	109,456	109,041	-0.4%
UAMS Med Center, Arkansas	39,430	51,681	31.1%
Anonymous	23,479	24,601	4.8%
Univ. of Colorado Hospital	68,000	88,000	29.4%
Rush University Med Center	51,093	60,095	17.6%
		Total	16.6%

2. Radiology Department

UTILIZATION					
	DEPT./	HISTORICAL	PROJECTED	STATE	MET
	SERVICE	UTILIZATION	UTILIZATION	STANDARD	STANDARD?
		(EXAM)			
	Radiology				
	Radiographic			8,000/unit	
2012	18 units	116,090			No
2013	20 units	114,111			No
2014	19 units		119,565		
2015	19 units		122,212		
2016	19 units		122,156		
2017	19 units		125,698		

2018	19 units		130,708		
2019	19 units		135,223		
2020	19 units		135,236		No
	CT			7,000/unit	
2012	7 units	47,434			Yes
2013	8 units	49,760			Yes
2014	8 units		51,679		
2015	8 units		52,896		
2016	8 units		53,130		
2017	8 units		54,347		
2018	8 units		56,273		
2019	8 units		57,865		
2020	8 units		57,869		Yes

Dedicated Imaging Facilities Within Proposed ED

The proposed relocated and reconfigured Adult ED will include 2 Radiographic imaging rooms and 1 CT room. UCMC’s current Adult ED is adjacent to the Radiology facilities in Mitchell Hospital so patients can be quickly transported for imaging. While this proposed location is advantageous in that patients will be twice as close to the lifesaving resources in the CCD, the present imaging services will no longer be as conveniently located. To ensure that patients’ access to radiology services remains efficient, UCMC is proposing to simultaneously build and equip imaging rooms dedicated to the Adult ED within the ED space. Thus patients will benefit not only from quick transports and greater access to the CCD’s lifesaving resources, but also will maintain the benefit of fast turnaround of imaging studies. However, this also contributes to lower efficiency in how imaging services can be provided.

Maximizing Imaging Efficiency Versus Convenience and Safety

Hypothetically, to maximize the use of imaging assets, imaging equipment would be placed in one central location for maximum use. Unfortunately, UCMC similar to most of other large medical centers has patients in multiple buildings, so patients would be inconvenienced by

having to walk or be transported to a central imaging center. At UCMC, patients are spread between Mitchell Hospital, Gilman-Smith Hospital, Duchossois Center for Advanced Medicine, Comer Children's Hospital, Comer Center for Pediatric and Specialty Care, and the CCD. To reduce waiting times and inconvenience to say nothing of the risks of lengthy transports over the long distances between these buildings and imaging facilities, most of these buildings have imaging equipment located within them. In some cases, particularly departments that use imaging frequently, such as Orthopedics, Surgery, and Women's Care, the imaging equipment is within the department. The fact that multiple imaging devices are located in multiple building means that each piece of equipment is used less intensely. However, this is the trade-off between efficient operations and safety and convenience, and privacy for the patients.

General Radiology

UCMC's General Radiology department operates 20 rooms presently and does not meet the Review Board's historic use rate standard of 8,000 procedures per room per year. Nor will it meet the standard in 2020, two years after the new Adult ED's operations begin. Yet, UCMC believes that the fact that patients can be taken quickly and safely to a dedicated imaging area within the Adult ED for fast service and reduced waiting time outweighs any benefits that could be achieved by centralizing radiology equipment to increase utilization of specific equipment.

CT

Owing to their large size and high cost, CT scanners are less dispersed than other imaging equipment. CT scanners are currently located in four buildings at UCMC. Consequently, the Review Board standard of 7,000 exams per room per year is met both historically, using the CON convention of rounding up to the next highest integer, as well as based on projections through 2020.



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December 10, 2014

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

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

Dear Ms. Avery:

This letter attests to the fact that if this Project is approved by the Illinois Health Facilities and Services Review Board, University of Chicago Medical Center understands that it is expected to achieve and maintain the occupancy for its emergency department specified in §1110.234(e)(1) by the second year of operation after project completion. The University of Chicago Medical Center reasonably expects to meet this occupancy. Our ability to maintain this occupancy level could be affected by various factors, however, such as natural disasters, regulatory changes in healthcare, interruption of necessary utilities, physical plant problems, or other unexpected issues outside of our control which could have a direct or indirect effect upon our occupancy rate.


Sharon O'Keefe
President

Notarization:

Subscribed and sworn to before me
This 10th day of December, 2014


Signature of Notary Public

Seal



Section VII, Clinical Service Areas Other Than Categories of Service

Attachment 34

Section 1110.3030(d), Clinical Services Other Than Categories of Service

Service	# Existing Key Rooms	# Proposed Key Rooms
Adult Emergency	36	42
Diagnostic Imaging	3	3

1. Necessary Expansion

A. Adult Emergency

Physical Deficiencies of Current Department

The existing Mitchell Adult ED was opened in 1983 with 18 adult stations. Of these, 6 were located in one room and divided by cubicle curtains. Three stations were added in 2004 by using support space such as supply rooms and staff support space. In 2005, an ambulance back-in area was filled in to permit an expansion to 30 stations and the public parking area was reduced substantially to create parking bays for 6 ambulances. In more recent years two areas in adjoining space to the west have allowed an increase to the present 36 stations. Existing area totals 16,891 dgsf or 459 per station, half of the State standard and inadequate in many ways. The gradual addition of stations over three decades has helped serve visit growth, but has resulted in a floor plan that is a challenge to operate effectively.

In the 31 years in the Mitchell space, the station capacity was doubled but the construction had to take place while allowing the operation to continue. The various projects have resulted in the present layout in which there are 3 separate clinical zones. The main space is separated by fire doors with 14 stations on the north and 18 on the south. There are 4 stations to the west, behind 2 sets of doors. These 3 separate treatment zones are difficult to operate effectively, since

attending physicians and the charge nurse who direct the physicians and nurses do not have visual contact between the zones. In well-designed space, these people could easily see where additional help is needed very quickly. The nature of emergency services is that patients come unexpectedly, the atmosphere can be chaotic and staffing needs ever-changing, so it is important that there be a few key vantage points where oral and visual communication can happen readily to adjust to the changing needs.

Patients enter the ED through one doorway, mixing the most acute and emergent patients with the least urgent/ambulatory patients. Ideally there would be separate entrances depending on severity which would streamline how patients are handled and provide more privacy for the patients and family members.

The waiting area is in an open area that can be very hectic. During the peak hours of the day, generally between 10 a.m. and 10 p.m., the waiting area fills up. If the treatment stations are full, the patients and accompanying family and friends must wait in this public area. Efforts to improve operations and make the best use of the present facilities have been underway for the past several years, but there is a limit to how much can be done short of addressing the physical facility itself.

As more treatment stations have been added over the years, one way to gain space has been to reduce support space. Thus, storage for supplies and equipment has been sacrificed. As a result, more time is spent resupplying from farther away. The lack of storage space also hampers some steps to streamline operations. For example, point-of-care lab testing could be instituted, but this requires storage space for the supplies and counter space for the instruments. So instead specimens continue to be collected and sent to the central lab, which adds to processing time.

The majority of treatment stations are separated only by cubicle curtains. A few treatment rooms have pull curtains across the entrance and walls on the other sides. These arrangements result in a lack of privacy and inadequate noise control.

There are 2 pneumatic tube stations for transport of lab specimens and medications. Because the clinical area is broken up, these stations are not always convenient to the staff. The tendency is

for a staff member to accumulate several orders before taking them to the nearest tube station, to make the best use of their time. But this comes at the expense of quicker handling of the patients. When orders arrive at the tube stations, the staff may not be located where they can see that something has arrived. Again, this contributes to longer wait times for the patients than if the tube stations were more conveniently located.

Insufficient Treatment Capacity

With 36 stations and visits in the 12 months ending September 30th of 48,039 in 2013 and 51,852 in 2014, UCMC averaged 1,387 visits per station per year. This is less than the State standard of 2,000. However, the State standard does not take into account the peak activity periods that are important to facility operation. Peak periods are between 10 a.m. and 10 p.m. each day. A recent one month survey showed that the number of patients in the ED during this period ranged from 43.8 to 75.7, indicating that the 36 stations were insufficient to accommodate this busy half of the day.

Treatment capacity has many determinants, both physical in terms of number of stations, effectiveness of the floor plan, adequacy of storage to name a few, but also operational factors. Are staffing levels adequate? Are the staff working at high levels of productivity? Are support departments such as laboratory, imaging, environmental services handling the ED's work responsively? It is acknowledged that the length of time ED patients spend in the department are higher than benchmarks for well-run academic medical center EDs. For 2013, ambulatory patients who were discharged from the ED averaged 7 hours in the ED. The goal is to lower this period of time to 4.5 hours, the benchmark for academic medical centers. For 2013, patients admitted to an inpatient service from the ED spent 13.2 hours in the ED before being admitted. The benchmark is 8 hours. In 2013, concerted efforts were begun to improve operations and reduce these lengths of stay. Good progress has been made in the past year, reducing discharged ED patients stay time to 6.5 hours, a 7 percent improvement. For patients admitted, the length of time before admission was reduced to 10.9 hours from 13.2, a 17 percent gain. One factor that was crucial in this improvement was an increase of 38 Med/Surg beds approved by the IHFSRB in August, 2013. If the IHFSRB approves this project, the new facility will help reduce patient waiting time. But UCMC will continue to pursue operating improvements and expects to reach the benchmarks by the time the new ED opens.

The proposed new ED will increase stations from 36 to 42. The additional stations are needed to handle continued growth in ED visits. Since 2009, visits have grown from 40,137 in 2009 to 51,852 in 2014 (year ending September 30th). This is an average annual increase of 5.3 percent. An additional amount of growth is expected by reducing patient waiting time which should result in the elimination of patients who come for care but leave without being treated. This has averaged 12.4 percent of total visits for the last 4 years. Finally, as seen with other academic medical centers that have opened new EDs, there is an expected one-time increase in visits the first year the new facility is opened of 16.6 percent. By the second full year of operation, 2020, it is expected that visits will reach 84,854, necessitating the requested increase of 6 stations to 42.

Relocation of Majority of Adult Services to CCD Negatively Impacts ED

The relocation of the majority of adult patient units to the new Center for Care and Discovery (CCD) makes the present location of the ED problematic. The Operating Rooms, Interventional Radiology, Cardiac Catheterization Labs, Electrophysiology Labs, and GI Procedure Area are located in the CCD. Transport time ranges from 12 to 15 minutes and necessitates two elevator rides and several blocks in distance. Because 23 percent of the patients seen in the ED are admitted to an inpatient unit, these transports happen frequently. The time spent by physician, nurses, and technicians accompanying the patient along with multiple items of equipment to support the patient is costly and reduces treatment capacity. There is also the problem of physicians, primarily working in the CCD traveling to see patients in the ED. UCMC is a Comprehensive Stroke Center. Because the Stroke Team works in the CCD Neurology patient unit, they must quickly come to the ED when a patient suffering a stroke arrives. Time is of the essence in minimizing damage and achieving the best outcomes.

Parking is Problematic

The Mitchell ED is located in the heart of the medical center campus. During the daytime street parking is extremely tight within a 3 block radius for people who drop off a patient at the ED. The logistics can also be complicated and trying when the patient needs the help and emotional support of the person who drove them to the ED.

Patient Transport Time for Inpatient Services Will be Reduced by Half

With the opening of the 13-story Center for Care and Discovery (CCD) nearly two years ago, many vital inpatient services that were located in Mitchell Hospital are now a 12 to 15 minute, two elevator trip from the Adult ED. The lengthy transport time to such services as Operating Rooms, GI Procedures, Interventional Radiology, Cardiac Catheterization Labs, ICU's and acute care beds, and notably the Neurological Unit for stroke victims is a primary driver for this project, equal in importance to the insufficiency of the current space. It is expected that transport time to CCD services will be reduced to 6 to 7 minutes from the new location. The Parking Garage on 57th street is expected to be completed in March, 2015. There will be a dedicated elevator to take patients from the ground level ED to the 2nd floor bridge into the CCD. They would then travel to the restricted patient elevators to the 5th and 6th floors for invasive procedures or the inpatient units on the other 5 clinical floors.

The transport time for the patients is one factor but the separation from key physicians and caregivers now working in the CCD is a concern. For example, as a comprehensive stroke center, the Stroke Team must travel from the CCD and for these patients time is of the essence to minimize the effect of a stroke. As the remaining ICU beds in Mitchell and most of the Medical/Surgical beds are moved to the vacant 3rd and 4th floors of the CCD in the next several years, it becomes imperative for the Adult ED to be relocated to minimize the distance from the CCD.

New Location is Better for Vehicular Access

The proposed new ED location will be in a parking garage being constructed for completion in the spring of 2015. It is across 57th Street to the north of the CCD and will be connected by tunnel and a 2nd floor bridge. This is a better location for the busy Adult ED. Currently patients arriving by ambulance or a personal vehicle must drive two blocks into the heart of the busy center of the clinical campus. Parking is very tight. The new location is directly off Cottage Grove Avenue, a major arterial route, which is the western boundary of the medical center campus. Obviously, parking arrangements for persons arriving by private vehicle will be improved since the ED will be located inside a large parking garage.

New Ambulance Drop-Off is Superior for Infection and Biohazard Containment

Ambulances can pull into a driveway into the structure and unload the patient. There are doors that can be opened automatically as the ambulance approaches. This covered and contained approach is a design improvement over the current outdoor ambulance bay arrangement with increased concern about infectious disease, such as Ebola virus disease. If a suspected highly contagious patient is brought in by ambulance, the doors can be closed and the area sealed for disinfecting. There would also be a better arrangement for biohazard containment. Currently this function is located in a trailer situated in the Adult ED parking lot. In the new ED, these functions would be inside the drop-off area. Again, because the two large doors to the drop-off area can be closed, the area can be sealed off for quick decontamination.

The ambulance entrance is just off the drop-off area on the west side. Within 50 feet of the ambulance entrance is an isolation room for the patient, which minimizes exposure to the majority of the ED space. On the east side, off of Maryland Avenue is the drop off for private vehicles, with an entrance into the reception/waiting area. No more than 15 feet from this area is another isolation room, again minimizing contact with a possibly infectious patient.

Public Area is More Accommodating

The public waiting area has 46 seats for friends and family, with the expectation that except in very busy moments the patients will be in treatment rooms, imaging, or a 12-spot Internal Disposition Area for low acuity patients. Just off the public waiting area will be a family room to serve multiple family members in a more private setting. Public restrooms and a vending area complete the reception area.

Treatment of Lower Acuity Patients is Streamlined

The Rapid Assessment Unit is served by 7 treatment rooms and a 12 seat Internal Disposition area for patients needing minor treatment just prior to release, for example nebulizer treatment for a patient suffering an asthma attack. To streamline the operation the less acute patients will be seen in this Rapid Assessment Unit adjacent to the public entrance where such patients are most likely to arrive. Consolidating these low acuity patients helps rationalize staffing.

Treatment Rooms for Emergent Patients More Numerous and Specialized

The more emergent patients will be served by the 42 treatment rooms. The majority of these rooms range from 140 to 167 net square feet (nsf) and will be universal rooms. That is, all having the same layout, supply arrangements, exam table, etc. so that all caregivers will be familiar with each room. There will be two large exam rooms of 249 nsf each for cases when many physicians, nurses, and technicians might need to be involved with the patient. There will be one bariatric room for extremely large-sized patients and a bariatric bathroom. As mentioned earlier, there will be 2 isolation rooms for infectious patients.

Separated Psychiatric Treatment Area

In a separate area in the center of the floor, closed off from the main clinical area are 4 psychiatric treatment rooms. Patients needing psychiatric attention can be a challenge for emergency departments, particularly for hospitals such as UCMC that do not operate inpatient psychiatric beds. The patient can be stabilized to the extent possible, but arranging for him to be transported to a hospital with an open psychiatric bed can take considerable time to accomplish. Often these patients are disruptive so having this cordoned off area will cause less disruption to the rest of the department rather than caring these patients among the general patient population. An attendant is stationed within this designated area and the patients are confined to the treatment rooms. The entry doors to this psychiatric sub-area will have controlled access. While this specialized area can result in less than optimal utilization of the rooms, it is important to make these special provisions for psychiatric patients.

Team Work Stations Ideally Situated

The majority of the treatment rooms are served by three Team Stations, where physicians and nurses share work space. It is important to locate them together to help communication. The treatment rooms are on either side of the Team Stations so caregivers can have good visual and oral communication to these rooms and readily see where assistance is needed. The Charge Nurse station is located so that there are direct sightlines to 30 of the ED's treatment rooms. Again, this is of critical importance to quickly ascertain where help is needed during the free flowing and often hectic activity that occurs in a busy ED.

Support Areas Are Sufficient

Support areas include storage rooms for supplies and equipment, storage alcoves for smaller, portable devices such as EKG machines, medication rooms with dispensing machines, clean and soiled utility rooms, a staff conference room, an EMS radio room, administrative offices located just outside the main department and a break room and small locker room. This will remedy the inadequacies of support space in the current ED.

Radiology

The present ED is well located by being adjacent to the inpatient Radiology area. Patients needing to be imaged can be transported there quickly, however they must be worked into the inpatient Radiology schedule which adds to waiting time. The busiest time of the day for the ED is 10 a.m. to 10 p.m. and much of the time that Radiology is busy is the prime work hours of 8 a.m. to 5 p.m. Because the location of the new ED would be a 6 to 7 minute trip from radiology facilities in the CCD and because there is sufficient volume in the ED to support dedicated imaging services, it was decided to locate 2 radiographic rooms and 1 CT room in the ED itself. Corresponding rooms in Mitchell Radiology would be discontinued, so there would be no change in room counts. (We do expect to reduce Radiographic rooms by 1 in the coming year, unrelated to this project.) Transport time within the ED should be no more than 1 or 2 minutes.

2. Utilization of Service or Facility

A. Adult Emergency

UTILIZATION					
	DEPT./	HISTORICAL	PROJECTED	STATE	MET
	SERVICE	UTILIZATION	UTILIZATION	STANDARD	STANDARD?
		(VISITS)			
	Adult ED			2,000/station	
2009		40,137			
2010		42,887			
2011		45,715			

2012		46,434			
2013	36 stations	48,039			No
2014	36 stations	51,852			No
2015	36 stations		54,577		
2016	36 stations		57,445		
2017	36 stations		60,464		
2018	42 stations		79,592		
2019	42 stations		83,774		Yes
2020	42 stations		84,854		Yes

Note: Year end 9/30 except 2020 which ends 1/1.

Ongoing Effort to Increase ED Capacity

The current ED was opened in 1983 as part of the construction of Mitchell Hospital. Initially there were 18 stations, 6 of which were located in a single large room and cordoned off by cubicle curtains. In subsequent years 3 stations were added by sacrificing support space such as supply storage and the break room. The space was slightly expanded in 2005, filling in the ambulance pull-in area and using the former patient parking lot for 5 ambulance bays. This captured area allowed the increase to 30 stations. In 2012, some space from the adjacent Radiology department was used to expand to the present 36 stations. This gradual growth over the past 31 years has expanded capacity, but has done so at a cost to the original efficient layout. The main area housing 32 stations is bifurcated by a set of fire doors, which must be closed at all times. There is an area to the west, separated by a public corridor that houses 4 treatment stations. This creates operating difficulties since the caregivers cannot see from one of the 3 separated areas to the next so the free flow of staff to areas where they are most needed is difficult and communication is limited.

Five Year Growth of 5.3% Per Year

Despite the shortcomings of the present ED space, it has been able to accommodate an increasing number of visits. As indicated in the chart above and also in the table later in this section entitled Adult Emergency Visit Forecast, visits have increased steadily from 40,137 in 2009 to 51,852 in 2014, an average annual rate of increase of 5.3 percent. This factor has been used to project future visits over the next 5 years, reaching 60,464 in 2017. In recent years there has been a

concerted effort to improve the efficiency of operations and reduce the long waiting times and lessen bottlenecks.

Additional Inpatient Beds Support Visit Growth

In August, 2013 the IHFSRB approved the addition of 38 Medical/Surgical beds. One argument for the bed increase was that a shortage of beds was causing backups in the ED which frequently necessitated diversion of ambulances. Between 2011 and 2013, annual diversion hours averaged 1,799. Once the additional beds were opened this was reduced to 535, a 70 percent improvement. At one point in the spring of 2014 there were nearly 3 consecutive months with no ambulance diversion. The Board's support of the bed addition was crucial to this achievement.

Reduced Waiting Time Will Eliminate LWBS

There are initiatives to further reduce bottlenecks and subsequently waiting time. In 2013, the average time a patient who would be discharged from the ED spent at UCMC was 7 hours. The goal is to reduce this to 4.5 hours, a benchmark for well-run academic medical center EDs. In 2014, the 7 hours was reduced to 6.5 so progress is being made. For patients who are ultimately admitted from the ED to an inpatient bed, the length of time in the ED averaged 13.2 hours in 2013. In 2014 this was improved to 10.9 hours, with an eventual goal of 8 hours. Again, this is a benchmark of good performance that is a goal to be reached in the next several years as the ED moves into new and better space.

The new facility in many ways will enable this to happen, but operations can be improved and this is also being addressed. This includes establishing up-to-date treatment protocols both for nurses and physicians that are evidence-based to result in better patient outcomes. This will streamline patient treatment and make sure every caregiver is following rigorous methods that have been proven to improve quality and reduce errors and cost. The approach to cleaning rooms after each use is being studied. Envisioned is a timing system to record how long it takes the cleaning staff to reach a just-vacated room, how long it takes to finish the cleaning, and then how long until a nurse places a new patient in the cleaned room. Currently being explored is bringing the patient to a treatment room upon arrival, to be visited by a nurse to triage the patient and a clerk to register the patient. The expectation is that this will reduce waiting time.

Ongoing operational improvements and the addition of 38 Medical/Surgical and 12 ICU beds recently approved allow continued increases in ED visits since they result in capacity increases. In forecasting to January 1, 2020, which is two years of operation after opening the new space in 2018, the impact of the improved facility is taken into account. Because the operational improvements, the addition of 4 stations, a Radiology service within the ED, and improved space configuration, it is expected that the goal of 0 patient who leave without being seen (LWBS) will be fully realized. As shown in Adult Emergency Visit Forecast table below, LWBS patient totals ranged from 5,671 to 6,271 in the last 4 years, an average of 12.4 percent of the visits for treated patients. This factor is applied to the 2018 visits when the facility will have been open for 9 months. It is expected that the improvements described above will mean patients being cared for much sooner after they arrive, eliminating the experience of patients who tire of the long waits and leave in frustration and disappointment.

ADULT EMERGENCY VISIT FORECAST									
Year End							Visits per Station		
<u>9/30</u>	<u>Visits</u>		<u>LWBS</u>			<u>Stations</u>	<u>Station</u>		
2009	40,137								
2010	42,887								
2011	45,715		5,671	}					
2012	46,434		6,271						
2013	48,039		5,800		12.4%	36	1,334		
2014	51,852		6,052			36	1,440		
		Add LWBS	Add One Time Increase						
2015	54,577					36			
2016	57,445					36			
2017	60,464					36			
2018	79,592	5,914	10,037			42	begin operations		

2019	83,774					42	1,995		
2020	84,854					42	2,020		

Notes/Assumptions:

- Annual average rate of increase in visits 2009 to 2014 is 5.3% per year, assumed for 2015-2020.
- Operations to begin 1/1/18. 2020 above is for the year ending 1/1/20, two years of operations.
- LWBS is Left Without Being Seen, patients who were registered but left without being treated.
- LWBS 2011 to 2014 was 12.4% of visits. These visits added due to more capacity in 2018.
- One Time Increase is a 16.6% first year increase seen in a survey of 8 recent ED projects at academic medical centers.

One-Time Surge for New Facilities

In long range planning for this project, other hospitals were visited and discussions held with peers at other academic medical centers that have recently rebuilt their EDs. Many described the phenomenon of a surge in visits between the year before opening and the year after. The reason for this increase could include a new facility attracting patients who use to go elsewhere, increased treatment capacity, and reduced waiting times. Through the auspices of the University Hospital Consortium academic hospitals with recent ED replacement projects were surveyed and there were 6 respondents. The respondents were asked to subtract LWBS patients from their base year for a consistent comparison to UCMC data. There were also 2 other recent projects that we knew of and had visit data for that we added to the group. The change in visits for the year after the new facility began operation ranged from a 10 percent loss to a 51.5 percent increase. The average for the 8 hospitals was 16.6%. This factor was applied in the projection for the first year of operation, 2018. By the second year of operation for UCMC’s ED, expected visits reach 84,854 for 42 stations, an average per station of 2,020. This meets the State standard of 2,000 visits per station.

Change in ED Visits First Year After Opening

<u>Hospital</u>	<u>Visits</u>		<u>Change</u>
	<u>Year Before</u>	<u>Year After</u>	
	<u>Opening</u>	<u>Opening</u>	
Univ. of Arizona Med Center	59,525	90,157	51.5%
Anonymous	69,801	75,760	8.5%
Eskanazi Health, Indianapolis	103,000	92,686	-10.0%
Anonymous	109,456	109,041	-0.4%
UAMS Med Center, Arkansas	39,430	51,681	31.1%
Anonymous	23,479	24,601	4.8%
Univ. of Colorado Hospital	68,000	88,000	29.4%
Rush University Med Center	51,093	60,095	17.6%
		Total	16.6%

B. Radiology

UTILIZATION					
	DEPT./	HISTORICAL	PROJECTED	STATE	MET
	SERVICE	UTILIZATION	UTILIZATION	STANDARD	STANDARD?
		(EXAM)			
	Radiology				
	Radiographic			8,000/unit	
2012	18 units	116,090			No
2013	20 units	114,111			No
2014	19 units		119,565		
2015	19 units		122,212		
2016	19 units		122,156		
2017	19 units		125,698		
2018	19 units		130,708		

2019	19 units		135,223		
2020	19 units		135,236		No
	CT			7,000/unit	
2012	7 units	47,434			Yes
2013	8 units	49,760			Yes
2014	8 units		51,679		
2015	8 units		52,896		
2016	8 units		53,130		
2017	8 units		54,347		
2018	8 units		56,273		
2019	8 units		57,865		
2020	8 units		57,869		Yes

Dedicated Imaging Facilities Within Proposed ED

Located in the proposed new ED will be 2 Radiographic imaging rooms and 1 CT room. The current ED is adjacent to Radiology facilities in Mitchell Hospital so patients can be quickly transported for imaging. The new location will be on the ground floor of a parking garage currently under construction to the north of the nearly 2 year-old CCD. While this location is advantageous in that the ED patients will be twice as close to the critical services in the CCD, the imaging services will no longer be as conveniently located as at present. It was decided to build and equip imaging rooms dedicated to the ED within the space. The advantage is one of safety from transports minimized and quick turnaround of imaging studies. However, this also contributes to lower efficiency in how imaging services can be provided.

Maximizing Imaging Efficiency Versus Convenience and Safety

Hypothetically, to maximize the use of imaging assets, they would be placed in one central location for maximum use. The downside is that UCMC along with most other large medical centers serve patients in multiple buildings, so the patients would be inconvenienced by having to walk or be transported to a central imaging center. Specifically for UCMC, the patients are in Mitchell Hospital, Gilman-Smith Hospital, Duchossois Center for Advanced Medicine, Comer Children's Hospital, Comer Center for Pediatric and Specialty Care, and the Center for Care and

Discovery. To reduce waiting times and the inconvenience to say nothing of the risks of lengthy transports over the long distances between these buildings and imaging facilities, most of these buildings have imaging services located within them. In some cases, particularly departments that use imaging frequently, such as Orthopedics, Surgery, and Women's Care, the imaging equipment is within the department. This factor and the many clinical buildings mean that imaging equipment is less intensively used. This is a trade-off between efficient operations and convenience, privacy, and safety for the patients.

General Radiology

General Radiology operates 20 rooms presently and does not meet the State's historic use rate standard of 8,000 procedures per room per year. Nor does it meet the standard in the future, for 2020 two years after operations begin. However, for this project patients in the ED can be quickly and safely taken to a dedicated imaging area within the department for fast service and reduced waiting time.

CT

Owing to their large size and high cost, CT scanners are less dispersed, presently located in four buildings and more concentrated within those buildings. Consequently, the State standard of 7,000 exams per room per year is met both historically, using the CON convention of rounding up to the next highest integer. The standard is also met based on projections through 2020.

Section VIII, Availability of Funds

Attachment 36

Section 1120.120, Availability of Funds

UCMC's financial statements for the years June 30, 2012, 2013 and 2014 are attached.

**The University of Chicago
Medical Center**
Financial Statements
June 30, 2013 and 2012

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

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Independent Auditor's Report

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

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

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

Opinion

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

PricewaterhouseCoopers LLP

October 10, 2013

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

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

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

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

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

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

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

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

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

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

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

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

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

The University of Chicago Medical Center
Notes to Financial Statements
June 30, 2013 and 2012
(in thousands of dollars)

1. Organization and Basis of Presentation

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

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

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

2. Summary of Significant Accounting Policies

New Accounting Pronouncements

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

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

Use of Estimates

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

Community Benefits

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

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

Fair Value of Financial Instruments

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

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

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

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

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

Cash and Cash Equivalents

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

Inventory

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

Investments

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

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

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

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

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

Endowment Funds with Deficits

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

Investments Limited as to Use

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

Derivative Instruments

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

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

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

Property, Plant and Equipment

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

Asset Retirement Obligation

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

Pledges Receivable

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

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Other Assets and Liabilities

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

Net Assets

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

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

Gifts and Grants

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

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

Statement of Operations

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

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

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

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

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Net Patient Service Revenue, Accounts Receivable and Allowance for Doubtful Accounts

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

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

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

Hospital Assessment Program/Medicaid Provider Tax

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

Subsequent Events

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

3. Agreements and Transactions with the University

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

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

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

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

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

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

4. Community Benefits

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

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

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

5. Investments Limited as to Use

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

	2013				2012
	Endowments			Total	
	Separately Invested	TRIP	Other		
Investments carried at fair value:					
Cash Equivalents	\$ 19,024	\$ 13,250	\$ 505	\$ 32,779	\$ 15,423
Global Public Equities	79,915	95,132	-	175,047	235,444
Private Debt	-	21,328	-	21,328	22,848
Private Equity					
U.S. Venture Capital	4,187	28,667	-	32,854	33,918
U.S. Corporate Finance	-	32,022	-	32,022	33,196
International	353	37,767	-	38,120	40,233
Real Assets					
Real Estate	-	56,978	-	56,978	57,296
Natural Resources	-	58,786	-	58,786	59,953
Absolute Return					
Equity Oriented	-	36,155	-	36,155	28,983
Global Macro/Relative Value	-	35,143	-	35,143	40,235
Multi-Strategy	-	50,457	-	50,457	50,350
Credit-Oriented	-	16,376	-	16,376	11,214
Volatility-Oriented	-	11,227	-	11,227	9,975
Fixed Income					
U.S. Treasuries, including TIPS	66,151	38,718	-	104,869	149,665
Other Fixed Income	4,162	76,209	-	80,371	81,482
Funds in Trust	-	-	14,804	14,804	54,223
Total Investments	\$ 173,792	\$ 608,215	\$ 15,309	\$ 797,316	\$ 924,438

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

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

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

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

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

Fair Value of Financial Instruments

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

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

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

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

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

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

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

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

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	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	2013 Total Fair Value
Assets				
Investments:				
Cash Equivalents	\$ 32,779	\$ -	\$ -	\$ 32,779
Global Public Equities	95,960	50,134	28,953	175,047
Private Debt	-	-	21,328	21,328
Private Equity				
U.S. Venture Capital	-	-	32,854	32,854
U.S. Corporate Finance	-	-	32,022	32,022
International	-	-	38,120	38,120
Real Assets				
Real Estate	-	-	58,978	58,978
Natural Resources	-	-	58,788	58,788
Absolute Return				
Equity Oriented	6,369	6,169	23,617	36,155
Global Macro/Relative Value	6,125	5,740	23,278	35,143
Multi-Strategy	-	2,666	47,791	50,457
Credit-Oriented	-	-	16,376	16,376
Volatility-Oriented	-	11,227	-	11,227
Fixed Income				
U.S. Treasuries, including TIPS	58,129	46,740	-	104,869
Other Fixed Income	9,892	70,479	-	80,371
Funds in Trust	14,804	-	-	14,804
Total Investments	224,058	193,155	380,103	797,316
Other assets	3,045	-	-	3,045
Total assets at fair value	\$ 227,103	\$ 193,155	\$ 380,103	\$ 800,361
Liabilities				
Interest rate swap payable	\$ -	\$ 88,769	\$ -	\$ 88,769
Total liabilities at fair value	\$ -	\$ 88,769	\$ -	\$ 88,769

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

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

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

	Separately Invested	Invested in TRIP	2012 Total
Fair value, July 1, 2011	\$ 7,510	\$ 366,077	\$ 373,587
Realized gains	18	23,569	23,587
Unrealized gains (losses)	297	(3,815)	(3,518)
Purchases	80	48,080	48,160
Sales	(1,672)	(50,008)	(51,680)
Transfers	-	2,303	2,303
Fair value, June 30, 2012	<u>\$ 6,233</u>	<u>\$ 386,206</u>	<u>\$ 392,439</u>

The interest rate swap arrangement has inputs which can generally be corroborated by market data and is therefore classified within level 2.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while UCMC believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value at the reporting date.

The significant unobservable inputs used in the fair value measurement of UCMC's long-lived partnership investments include a combination of cost, discounted cash flow analysis, industry comparables and outside appraisals. Significant increases (decreases) in any inputs used by investment managers in determining net asset values in isolation would result in a significantly lower (higher) fair value measurement.

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UCMC has made investments in various long-lived partnerships and, in other cases, has entered into contractual agreements that may limit its ability to initiate redemptions due to notice periods, lockups and gates. Details on typical redemption terms by asset class and type of investment are provided below:

	Remaining Life	Redemption Terms	Redemption Restrictions and terms	Redemption Restrictions In Place at June 30, 2013
Cash	N/A	Daily	None	None
Global Public Equity:				
Separate accounts	N/A	Daily	None	None
Commingled funds	N/A	Daily to monthly with notice periods of 1 to 14 days	None	None
Partnerships	N/A	Quarterly to annually with notice periods of 30 to 180 days	Lock-up provisions ranging from 0 to 5 years, some investments have a portion of capital in side pockets with no redemptions permitted	None
Private debt	1 to 10 years	Redemptions not permitted	N/A	N/A
Private equity	1 to 19 years	Redemptions not permitted	N/A	N/A
Real assets	1 to 18 years	Redemptions not permitted	N/A	N/A
Absolute return:				
Partnerships	N/A	Monthly to annually with varying notice periods	Lock-up provisions ranging from 0 to 5 investments have a portion of capital in side pockets with no redemptions permitted	Approximately \$48.5 million of investments are in gated or liquidating funds
Drawdown partnerships	1 to 4 years	Redemptions not permitted	N/A	N/A
Fixed income:				
Separate accounts	N/A	Daily	None	None
Commingled funds	N/A	Daily	None	None
Partnerships	N/A	Quarterly with notice periods of 90 days	Only one-third capital available in any 12-month period	None
Funds held in trust	N/A	Daily	None	None

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6. Endowments

UCMC's endowment consists of individual donor restricted endowment funds and board-designated endowment funds for a variety of purposes plus the following where the assets have been designated for endowment: pledges receivable, split interest agreements, and other net assets. The endowment includes both donor-restricted endowment funds and funds designated by the Board of Trustees to function as endowments. The net assets associated with endowment funds including funds designated by the Board of Trustees to function as endowments, are classified and reported based on the existence or absence of donor imposed restrictions.

Illinois is governed by the "Uniform Prudent Management of Institutional Funds Act" (UPMIFA). The Board of Trustees of UCMC has interpreted UPMIFA as sustaining the preservation of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, UCMC classifies as permanently restricted net assets, (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by UCMC in a manner consistent with the standard of prudence prescribed by UPMIFA.

UCMC has the following donor-restricted endowment activities during the years ended June 30, 2013 and 2012 delineated by net asset class:

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	<u>Unrestricted</u> Funds Functioning	Temporarily Restricted	Permanently Restricted	2013 Total
Endowment net assets, beginning of year	\$ 796,105	\$ 67,279	\$ 6,072	\$ 869,456
Investment return:				
Investment income	38,437	3,518	-	41,955
Net appreciation (realized and unrealized)	21,351	1,086	-	22,437
Total investment return	<u>59,788</u>	<u>4,604</u>	<u>-</u>	<u>64,392</u>
Gifts and other additions	25,000	-	10	25,010
Appropriation of endowment assets for expenditure	(37,037)	(3,610)	-	(40,647)
Appropriation of endowment assets for capital	(134,707)			(134,707)
Other	(1,859)	361	-	(1,498)
Endowment net assets, end of year	<u>\$ 707,290</u>	<u>\$ 68,634</u>	<u>\$ 6,082</u>	<u>\$ 782,006</u>
	<u>Unrestricted</u> Funds Functioning	Temporarily Restricted	Permanently Restricted	2012 Total
Endowment net assets, beginning of year	\$ 810,184	\$ 67,857	\$ 6,072	\$ 884,113
Investment return:				
Investment income	36,192	3,140	-	39,332
Net appreciation (realized and unrealized)	(11,335)	(305)	-	(11,640)
Total investment return	<u>24,857</u>	<u>2,835</u>	<u>-</u>	<u>27,692</u>
Appropriation of endowment assets for expenditure	(37,343)	(3,792)	-	(41,135)
Other	(1,593)	379	-	(1,214)
Endowment net assets, end of year	<u>\$ 796,105</u>	<u>\$ 67,279</u>	<u>\$ 6,072</u>	<u>\$ 869,456</u>

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Description of amounts classified as permanently restricted net assets and temporarily restricted net assets (Endowments only) as of June 30, 2013 and 2012:

	Perpetual	Time- Restricted by Donor	Time- Restricted by Law	2013 Total
Restricted for pediatric health care	\$ 1,855	\$ -	\$ 15,580	\$ 17,435
Restricted for adult health care	1,925	-	50,715	52,640
Restricted for educational and scientific programs	2,312	-	2,339	4,651
	<u>\$ 6,092</u>	<u>\$ -</u>	<u>\$ 68,634</u>	<u>\$ 74,726</u>

	Perpetual	Time- Restricted by Donor	Time- Restricted by Law	2012 Total
Restricted for pediatric health care	\$ 1,835	\$ -	\$ 15,273	\$ 17,108
Restricted for adult health care	1,925	-	49,751	51,676
Restricted for educational and scientific programs	2,312	-	2,255	4,567
	<u>\$ 6,072</u>	<u>\$ -</u>	<u>\$ 67,279</u>	<u>\$ 73,351</u>

Investment and Spending Policies

UCMC has adopted endowment investment and spending policies that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of endowment assets. UCMC expects its endowment funds over time, to provide an average rate of return of approximately 6% annually. To achieve its long-term rate of return objectives, UCMC relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized gains) and current yield (interest and dividends). Actual returns in any given year may vary from this amount.

For endowments invested in TRIP, the Board of Trustees of UCMC has adopted the University's method to be used to appropriate endowment funds for expenditure, including following the University's payout formula. The University utilizes the total return concept in allocating endowment income. In accordance with the University's total return objective, between 4.5% and 5.5% of a 12-quarter moving average of the fair value of endowment investments, lagged by one year, is available each year for expenditure in the form of endowment payout. The exact payout percentage, which is set each year by the Board of Trustees with the objective of a 5% average payout over time, was 5% for the fiscal years ended June 30, 2013 and 2012. If endowment income received is not sufficient to support the total return objective, the balance is provided from capital gains. If income received is in excess of the objective, the balance is reinvested in the endowment.

For endowments invested apart from TRIP, UCMC calculates a payout of 4% annually on a rolling 24-month average market value. In establishing this policy, the Board considered the expected long term rate of return on its endowment.

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7. Property, Plant and Equipment

The components of property, plant and equipment as of June 30 are as follows:

	2013	2012
Land and land rights	\$ 36,008	\$ 36,008
Buildings and improvements	1,255,542	649,565
Equipment	576,374	479,832
Construction in progress	74,688	610,211
	<u>1,942,612</u>	<u>1,775,616</u>
Less accumulated depreciation	<u>(752,989)</u>	<u>(709,122)</u>
Total property, plant and equipment, net	<u>\$ 1,189,623</u>	<u>\$ 1,066,494</u>

UCMC's net property, plant and equipment cost includes \$10,600 representing assets under capital leases with the University, which are stated at the UCMC's historical cost. The cost of buildings that are jointly used by the University and UCMC is allocated based on the lease provisions. In addition, land and land rights includes \$19,200, which represents the unamortized portion of initial lease payments made to the University. UCMC entered into a services agreement in 2013 for the exclusive right to operate certain food service operations at the Medical Center, which includes a capital commitment in the amount of \$11,800 for equipment and renovations provided by the contractor. The amount outstanding as of June 30, 2013 was \$11,300.

The Center for Care and Discovery was placed into service in 2013; approximately \$134,800 was spent in 2013 related to the building. In 2013 and 2012, approximately \$0 and \$16,800 were capitalized related to software implementation of an electronic medical records system.

Capitalized interest costs in 2013 and 2012 were \$14,600 and \$10,000, respectively.

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8. Long-Term Debt

Long-term debt as of June 30 consists of the following:

	<u>Final fiscal year maturity</u>	<u>Interest rate</u>	<u>2013</u>	<u>2012</u>
Fixed rate:				
Illinois Health Facilities Authority:				
Series 2003	2015	5.0	\$ 14,530	\$ 21,235
Illinois Finance Authority:				
Series 2009A and B	2027	4.9	150,840	152,350
Series 2009C	2037	5.4	85,000	85,000
Series 2009D-1 and 2 (synthetically fixed rate)	2044	3.9	70,000	70,000
Series 2009E-1 and 2 (synthetically fixed rate)	2044	3.9	70,000	70,000
Series 2010 A and B (synthetically fixed rate)	2045	3.9	92,500	92,500
Series 2011 A and B (synthetically fixed rate)	2045	3.9	92,500	92,500
Series 2011C	2042	5.5	90,000	90,000
Series 2012A	2037	4.5	72,080	75,155
Unamortized premium			11,163	12,528
Total fixed rate			748,813	781,268
Variable rate:				
Series 2013A	2020	1.0	686	-
Illinois Educational Facilities Authority (IEFA)	2038	0.2	81,427	83,277
Total variable rate			82,113	83,277
Total notes and bonds payable			830,726	844,545
Less current portion of long-term debt			(10,385)	(11,290)
Long-term portion of debt			\$ 820,341	\$ 833,255

The fair value of long-term debt is based on the pricing of fixed-rate bonds of market participants, including assumptions about the present value of current market interest rates, and loans of comparable quality and maturity. The fair value of long-term debt would be a Level 2 hierarchy. The carrying value of long-term debt is below the estimated fair value of the debt by \$10,729 and \$34,439 as of June 30, 2013 and June 30, 2012, respectively, based on the quoted market prices for the same or similar issues.

Scheduled annual repayments for the next five years are as follows at June 30:

<u>Year</u>	<u>Amount</u>
2014	\$ 10,385
2015	10,050
2016	12,778
2017	13,255
2018	13,868

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Under its various indebtedness agreements, the Medical Center is subject to certain financial covenants, including maintaining a minimum debt service coverage ratio, maintaining minimum levels of days cash on hand, maintaining debt to capitalization at certain levels; limitations on selling, leasing, or otherwise disposing of Medical Center property; and certain other nonfinancial covenants. Each of the bond series is collateralized by unrestricted receivables under a Master Trust Indenture and subject to certain restrictions. The Medical Center was in compliance with its debt covenants as of June 30, 2013 and 2012.

Recent Financing Activity

In January 2013, the Medical Center entered into an issuance of a tax-exempt direct purchase loan with a financial institution, issued as \$75,000 of Series 2013A bonds, allocated to the Medical Center for the purpose of constructing a new parking garage. This bond functions similar to a construction loan with principal being drawn down as construction proceeds. Interest at LIBOR plus 60 basis points is payable each month based on the outstanding principal balance. A mandatory purchase date of repayment is established for January 24, 2020.

Letters of Credit

Payment on each of the variable rate demand revenue bonds is also collateralized by a letter of credit. The letters of credit that support the Series 2009D and the Series 2009E bonds were due to expire in August 2012. The Medical Center replaced the letter of credit that supports the Series 2009D bonds with a new letter of credit in June 2012, which expires in June 2017. The letter of credit that supports the 2009E bonds was extended subsequent to June 30, 2012 and now expires in December 2014. The letters of credit that support the Series 2010A and Series 2010B bonds expire in November 2015 and the letters of credit that support the Series 2011A and Series 2011B bonds expire in May 2016. The letters of credit are subject to certain restrictions, which include financial ratio requirements and consent to future indebtedness. The most restrictive financial ratio is to maintain a debt service coverage ratio of 1.25:1. UCMC was in compliance with all applicable debt covenants at June 30, 2013.

Payment on each of the IEFA bonds is collateralized by a letter of credit maturing November 2014. The letter of credit is subject to certain restrictions, which include financial ratio requirements. The most restrictive financial ratio is to maintain a debt service coverage ratio of 1.75:1. UCMC was in compliance with all applicable debt covenants at June 30, 2013.

Included in UCMC's debt is \$81,427 of commercial paper revenue notes and \$325,000 of variable rate demand bonds. In the event that UCMC's remarketing agents are unable to remarket the bonds, the trustee of the bonds will tender them under the letters of credit. Scheduled repayments under the letters of credit are between 1 and 3 years, beginning after a grace period of at least one year, and bear interest rates different from those associated with the original bond issue. Any bonds tendered are still eligible to be remarketed. Bonds subsequently remarketed would be subject to the original bond repayment schedules.

UCMC paid interest, net of capitalized interest, of approximately \$18,300 and \$13,000 in 2013 and 2012, respectively.

UCMC has a \$15,000 line of credit from a commercial bank. As of June 30, 2013 and 2012, no amount was outstanding under this line.

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9. Commitments

Leases

UCMC has capital and noncancelable operating leases for certain buildings and equipment. Future minimum payments required under noncancelable operating and capital leases as of June 30 are as follows:

	Operating	Capital
2014	\$ 2,232	\$ 303
2015	2,074	172
2016	2,102	-
2017	548	-
2018 and thereafter	6,808	-
Total minimum lease payments	<u>\$ 13,764</u>	<u>475</u>
Less - Amount representing interest		<u>11</u>
Present value of net minimum capital lease payments		<u>\$ 464</u>

The amount of total assets capitalized under these leases at June 30, 2013 and 2012, is \$3,000 and \$3,200 with related accumulated depreciation of \$2,400 and \$2,100, respectively. Rental expense was approximately \$5,500 and \$4,700 for the years ended June 30, 2013 and 2012, respectively, including a \$500 annual rental of a parking garage from the University.

10. Insurance

UCMC is included under certain of the University's insurance programs. Since 1977, UCMC, in conjunction with the University, has maintained a self-insurance program for its medical malpractice liability. This program is supplemented with commercial excess insurance above the University's self-insurance retention, which for the years ended June 30, 2013 and 2012 was \$7,500 per claim and unlimited in the aggregate. Claims in excess of \$7,500 are subject to an additional self-insurance retention limited to \$12,500 per claim and \$12,500 in aggregate.

The estimated liability for medical malpractice self-insurance is actuarially determined based upon estimated claim reserves and various assumptions, and represents the estimated present value of self-insurance claims that will be settled in the future. It considers anticipated payout patterns as well as interest to be earned on available assets prior to payment. The discount rate used to value the self-insurance liability is a risk-adjusted rate commensurate with the duration of anticipated payments. These inputs to the fair value estimate of the liability are considered Level 2 in the fair value hierarchy.

A comparison of the estimated liability for incurred malpractice claims (filed and not filed) and net assets for the combined University and UCMC self-insurance program as of June 30, 2013 and 2012, is presented below:

	2013	2012
Actuarial present value of self-insurance liability for medical malpractice	<u>\$ 254,328</u>	<u>\$ 246,700</u>
Total assets available for claims	<u>\$ 352,414</u>	<u>\$ 330,431</u>

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If the present-value method were not used, the ultimate liability for medical malpractice self-insurance claims would be approximately \$47,200 higher at June 30, 2013. The interest rate assumed in determining the present value was 4.5% for 2013 and 3.75% for 2012. The Medical Center has recorded its pro-rata share of the malpractice self-insurance liability as required under ASU 2010-24 in the amount of \$121,300 at June 30, 2013 and \$118,153 at June 30, 2012 with an offsetting receivable from the malpractice trust to cover any related claims.

The malpractice self-insurance trust assets consist primarily of funds held in TRIP.

UCMC recognizes as malpractice expense its negotiated pro-rata share of the actuarially determined normal contribution, with gains and losses amortized over six years, with no retroactive adjustments, as provided in the operating agreement. For fiscal year 2014, the Medical Center expense will be \$15,300 related to malpractice.

UCMC designated \$14,800 and \$12,400 as of June 30, 2013 and 2012, respectively, as a workers' compensation self-insurance reserve trust fund. The self-insurance program investments consist of 65% bonds and 35% marketable equities. The specifically identified claim requirements and actuarially determined reserve requirements for unreported workers' compensation claims were \$9,500 and \$8,200 as of June 30, 2013 and 2012, respectively. The University also charges UCMC for its portion of other commercial insurance and self-insurance costs.

11. Pension Plans

Active Plans

A majority of UCMC's personnel participate in the University's defined benefit and contribution pension plan. Under the defined benefit portion of this plan, benefits are based on years of service and the employee's compensation for the five highest paid consecutive years within the last ten years of employment. UCMC and the University make annual contributions to this portion of the plan at a rate necessary to maintain plan funding on an actuarially recommended basis. UCMC recognizes its share of net periodic pension cost as expense and any difference in the contribution amount as a transfer of unrestricted net assets. The reduction to net assets for 2013 was \$2,800. Contributions of \$32,500 and \$52,700 were made in the fiscal years ended June 30, 2013 and 2012, respectively. UCMC expects to make contributions of \$32,500 for the fiscal year ended June 30, 2014 that will be entirely expensed as net periodic pension costs.

Under the defined contribution portion of the plan, UCMC and plan participants make contributions that accrue to the benefit of the participants at retirement. UCMC's contributions, which are based on a percentage of each covered employee's salary, totaled approximately \$6,400 and \$6,100 for the years ended June 30, 2013 and 2012, respectively.

Plan Name	EIN	Contributions of UCMC	
		2013	2012
University of Chicago Retirement Income Plan for Employees	36-2177139-002	\$ 6,711	\$ 35,000
University of Chicago Pension Plan for Staff Employees	36-2177139-003	25,789	17,700
		<u>\$ 32,500</u>	<u>\$ 52,700</u>

The benefit obligation, fair value of plan assets and funded status for the University's defined benefit plan included in the University's financial statements as of June 30, are shown below:

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	2013	2012
Projected benefit obligation	\$ 795,133	\$ 780,797
Fair value of plan assets	<u>557,966</u>	<u>496,657</u>
Deficit of plan assets over benefit obligation	<u>\$ (237,167)</u>	<u>\$ (284,140)</u>

The weighted-average assumptions used in the accounting for the plan are shown below:

	2013	2012
Discount rate	4.9%	4.5%
Expected return on plan assets	7.0%	7.1%
Rate of compensation increase	3.5%	3.5%

The weighted average asset allocation for the plan is as follows:

	2013	2012
Domestic equities	29 %	27 %
International equity	15 %	16 %
Fixed income	<u>56 %</u>	<u>57 %</u>
	<u>100 %</u>	<u>100 %</u>

The pension and other postretirement benefit obligation considers anticipated payout patterns as well as investment returns on available assets prior to payment. The discount rate used to value the pension and other postretirement benefit obligation is a risk-adjusted rate commensurate with the duration of anticipated payments. These inputs to the fair value estimate are considered Level 2 in the fair value hierarchy.

Total benefits and plan expenses paid by the plan were \$36,200 and \$32,200 for the fiscal years ended June 30, 2013 and 2012, respectively.

Expected future benefit payments excluding plan expenses are as follows:

Fiscal Year

2014	42,109
2015	37,761
2016	40,072
2017	42,672
2018	45,160
2019-2023	265,818

Certain UCMC personnel participate in a contributory pension plan. Under this plan, UCMC and plan participants make annual contributions to purchase annuities equivalent to retirement benefits earned. UCMC's pension expense for this plan was \$4,900 and \$5,000 for the years ended June 30, 2013 and 2012, respectively.

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Curtailed and Frozen Plan

In June 2002, UCMC assumed sponsorship of the Louis A. Weiss Memorial Hospital Pension Plan (Employer Identification Number 36-3488183, Plan Number 003), which covers employees of a former affiliate. Participation and benefit accruals are frozen. All benefit accruals are fully vested.

Components of net periodic pension cost and other amounts recognized in unrestricted net assets include the following:

	Years Ended June 30,	
	2013	2012
Net periodic pension cost		
Interest cost	\$ 2,340	\$ 2,719
Expected return on plan assets	(2,860)	(2,921)
Amortization of unrecognized net actuarial loss	817	684
Net periodic pension cost	297	482
Other changes in plan assets and benefit obligations recognized in unrestricted net assets		
Liability for pension benefits	3,878	(2,659)
Total recognized in net periodic pension cost and unrestricted net assets	\$ (3,581)	\$ 3,141

The following tables set forth additional required pension disclosure information for this plan:

	Years Ended June 30,	
	2013	2012
Change in projected benefit obligation		
Benefit obligation at beginning of year	\$ 58,098	\$ 55,219
Interest cost	2,340	2,719
Net actuarial loss (gain)	(3,029)	3,425
Benefits paid	(3,319)	(3,264)
	54,090	58,099
Change in plan assets		
Fair value of plan assets at beginning of year	47,696	41,717
Actual return on plan assets	2,892	3,003
Employer contribution	1,091	6,240
Benefits paid	(3,319)	(3,264)
	48,360	47,696
Funded status at end of year	\$ (5,730)	\$ (10,403)

Amounts recognized in the balance sheet are included in noncurrent liabilities.

Accumulated plan benefits equal projected plan benefits. Assumptions used in the accounting for the net periodic pension cost were as follows:

The University of Chicago Medical Center
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	2013	2012
Discount rate	4.8 %	4.2 %
Expected return on plan assets	6.0 %	6.0 %
Rate of compensation increase	N/A	N/A

Weighted average asset allocations for plan assets are as follows:

	2013	2012
Cash	2 %	8 %
Fixed income	51	53
Domestic equities	34	28
International equities	13	11
	<u>100 %</u>	<u>100 %</u>

All plan assets are valued using level 1 inputs. The target asset allocation is 40% equities and 60% fixed income. The expected return on plan assets is based on historical investment returns for similar investment portfolios.

UCMC expects to make contributions of \$1,500 to the plan in the fiscal year ending June 30, 2014. Expected future benefit payments are:

Fiscal Year

2014	\$	3,565
2015		3,547
2016		3,535
2017		3,535
2018		3,559
2019-2023		18,206

12. Acquisitions

On September 30, 2011, the Medical Center entered into an Asset Purchase Agreement, whereby the Medical Center acquired the operations of Midwest Center for Hematology/Oncology, S.C. a professional service corporation that specializes in oncology. The purchase price was \$2,607 and there are no earn-out provisions with the agreements. The acquisition is accounted for under the purchase method of accounting and, accordingly, the cost has been allocated on the basis of estimated fair value of assets acquired and liabilities assumed. This resulted in \$746 of the purchase price being allocated to goodwill and \$905 being allocated to non-compete agreements. The non-compete agreements are amortized over a 5 year period.

13. Concentration of Credit Risk

As a hospital, UCMC is potentially subject to concentration of credit risk from patient accounts receivable and certain investments. Investments, which include government and agency securities, stocks, corporate bonds, real assets, absolute return, and private equities, are not concentrated in any corporation or industry or with any single counter-party. UCMC receives a

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significant portion of its payments for services rendered from a limited number of government and commercial third-party payors, including Medicare, Medicaid, and Blue Cross. For 2013 and 2012, Medicaid approximated 15% and 17% of the Medical Center's net revenue for the year. Medicaid represented 16% and 30% of UCMC's net accounts receivable at June 30, 2013 and 2012, respectively. Management does not anticipate any collection risk related to the Medicaid accounts receivable at June 30, 2013. UCMC has not historically incurred any significant credit losses outside the normal course of business.

14. Pledges

Pledges receivable at June 30 are shown below:

	2013	2012
Unconditional promises expected to be collected in:		
Less than one year	\$ 2,272	\$ 4,959
One year to five years	2,634	6,001
More than five years	-	-
	<u>4,906</u>	<u>10,960</u>
Less unamortized discount (discount rate 5.5%)	(197)	(527)
Total	<u>\$ 4,709</u>	<u>\$ 10,433</u>

15. Restricted Net Assets

Temporarily restricted net assets are available for the following purposes as of June 30:

	2013	2012
Pediatric health care	\$ 17,943	\$ 17,751
Adult health care	51,756	50,743
Educational and scientific programs	4,691	4,187
Capital and other purposes	7,581	22,664
Total	<u>\$ 81,971</u>	<u>\$ 95,345</u>

Income from permanently restricted net assets is restricted for:

	2013	2012
Pediatric health care	\$ 1,855	\$ 1,845
Adult health care	1,925	1,935
Educational and scientific programs	2,312	2,312
Total	<u>\$ 6,092</u>	<u>\$ 6,092</u>

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16. Functional Expenses

Total operating expenses by function are as follows for the years ended June 30:

	2013	2012
Health care services	\$ 1,177,672	\$ 1,103,904
General and administrative	80,938	66,819
Total	<u>\$ 1,258,610</u>	<u>\$ 1,170,723</u>

17. Contingencies

UCMC is subject to complaints, claims and litigation which have risen in the normal course of business. In addition, UCMC is subject to reviews by various federal and state government agencies to assure compliance with applicable laws, some of which are subject to different interpretations. While the outcome of these suits cannot be determined at this time, management, based on advice from legal counsel, believes that any loss which may arise from these actions will not have a material adverse effect on the financial position or results of operations of UCMC.

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Independent Auditor's Report

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

We have audited the accompanying financial statements of The University of Chicago Medical Center, which comprise the [consolidated] balance sheets as of June 30, 2014 and 2013, and the related statements of operations, of changes in net assets, and cash flows for the years then ended.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of The University of Chicago Medical Center at June 30, 2014 and 2013, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

PricewaterhouseCoopers LLP

October 15, 2014

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T: (312) 298 2000, F: (312) 298 2001, www.pwc.com/us*

The University of Chicago Medical Center
Balance Sheets
June 30, 2014 and 2013
(in thousands of dollars)

	2014	2013
Assets		
Current assets		
Cash and cash equivalents	\$ 79,698	\$ 164,504
Patient accounts receivable, less allowance for doubtful accounts for 2014 - \$41,874 and 2013 - \$29,612	184,765	204,279
Current portion of investments limited to use	11	11
Current portion of malpractice self-insurance receivable	19,305	22,502
Current portion of pledges receivable	2,598	2,243
Prepays, inventory and other current assets	34,176	35,176
Total current assets	<u>320,553</u>	<u>428,715</u>
Investments limited to use, less current portion	1,021,660	797,305
Property, plant and equipment, net	1,199,907	1,189,623
Pledges receivable, less current portion	1,893	2,465
Malpractice self-insurance receivable, less current portion	96,134	98,821
Other assets, net	16,895	15,722
Total assets	<u>\$ 2,657,042</u>	<u>\$ 2,532,651</u>
Liabilities and Net Assets		
Current liabilities		
Accounts payable and accrued expenses	\$ 115,093	\$ 131,206
Current portion of long-term debt	10,050	10,385
Current portion of other long-term liabilities	311	2,033
Current portion of estimated third-party payor settlements	89,805	51,836
Current portion of malpractice self-insurance liability	19,305	22,502
Due to University of Chicago	15,761	14,799
Total current liabilities	<u>250,325</u>	<u>232,761</u>
Other liabilities		
Worker's compensation self-insurance liabilities, less current portion	8,241	9,528
Malpractice self-insurance liability, less current portion	96,134	98,821
Long-term debt, less current portion	831,035	820,341
Interest rate swap liability	95,810	88,769
Other long-term liabilities, less current portion	33,595	44,741
Total liabilities	<u>1,315,140</u>	<u>1,294,961</u>
Net assets		
Unrestricted	1,245,856	1,149,627
Temporarily restricted	87,954	81,971
Permanently restricted	8,092	6,092
Total net assets	<u>1,341,902</u>	<u>1,237,690</u>
Total liabilities and net assets	<u>\$ 2,657,042</u>	<u>\$ 2,532,651</u>

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

The University of Chicago Medical Center
Statements of Operations
Years Ended June 30, 2014 and 2013
(in thousands of dollars)

	2014	2013
Operating revenues		
Net patient service revenue	\$ 1,409,095	\$ 1,303,787
Provision for doubtful accounts	<u>55,169</u>	<u>47,812</u>
Net patient service revenue after provision for doubtful accounts	1,353,926	1,255,975
Other operating revenues and net assets released from restrictions	<u>93,577</u>	<u>81,184</u>
Total operating revenues	<u>1,447,503</u>	<u>1,337,159</u>
Operating expenses		
Salaries, wages and benefits	627,588	595,968
Supplies and other	367,633	332,707
Physician services from the University of Chicago	204,586	191,862
Insurance	15,345	18,382
Interest	33,354	19,883
Medicaid provider tax	46,071	26,691
Depreciation and amortization	<u>83,563</u>	<u>70,466</u>
Total operating expenses	<u>1,378,140</u>	<u>1,255,959</u>
Total operating income	69,363	81,200
Nonoperating gains		
Investment income and unrestricted gifts, net	101,159	57,137
Derivative ineffectiveness gain	<u>535</u>	<u>2,993</u>
Excess of revenues over expenses	171,057	141,330
Other changes in net assets		
Transfers to University of Chicago	(72,749)	(74,544)
Net assets released for capital purchases	2,462	14,277
Liability for pension benefits	1,337	3,878
Changes in valuation of derivatives	(5,914)	36,713
Other, net	<u>36</u>	<u>56</u>
Increase in unrestricted net assets	<u>\$ 96,229</u>	<u>\$ 121,710</u>

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

The University of Chicago Medical Center
Statements of Changes in Net Assets
Years Ended June 30, 2014 and 2013
(in thousands of dollars)

	2014	2013
Unrestricted net assets		
Excess of revenues over expenses	\$ 171,057	\$ 141,330
Transfers to University of Chicago	(72,749)	(74,544)
Net assets released for capital purchases	2,462	14,277
Liability for pension benefits	1,337	3,878
Changes in valuation of derivatives	(5,914)	36,713
Other, net	36	56
Increase in unrestricted net assets	<u>96,229</u>	<u>121,710</u>
Temporarily restricted net assets		
Contributions	4,007	3,137
Net assets released from restrictions used for operating purposes	(4,860)	(4,621)
Investment Income	9,298	4,604
Net assets released for capital purchases	(2,462)	(14,277)
Other	-	(2,217)
Increase (decrease) in temporarily restricted net assets	<u>5,983</u>	<u>(13,374)</u>
Permanently restricted net assets		
Contributions and other	<u>2,000</u>	<u>-</u>
Increase in net assets	104,212	108,336
Net assets at beginning of year	<u>1,237,690</u>	<u>1,129,354</u>
Net assets at end of year	<u>\$ 1,341,902</u>	<u>\$ 1,237,690</u>

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

The University of Chicago Medical Center
Statements of Cash Flows
Years Ended June 30, 2014 and 2013
(in thousands of dollars)

	2014	2013
Cash flows from operating activities		
Increase in net assets	\$ 104,212	\$ 108,336
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Net change in unrealized gains on investments	(65,113)	(1,075)
Transfers to University of Chicago	72,749	74,544
Restricted contributions and other changes	(4,008)	(921)
Realized gains on investments	(45,346)	(60,665)
Net change in valuation of derivatives	7,041	(47,103)
Pension and other changes in unrestricted net assets	(36)	(3,934)
Loss on disposal of assets	1,071	935
Depreciation and amortization	83,170	70,329
Increase (decrease) in cash resulting from a change in		
Patient accounts receivable, net	19,514	4,727
Other assets	(862)	26,429
Accounts payable and accrued expenses	(10,582)	11,545
Due to the University of Chicago	962	(794)
Estimated settlements with third-party payors	39,859	24,504
Self-insurance liabilities	(1,287)	1,312
Other liabilities	(3,153)	11,061
Net cash provided from operating activities	<u>198,191</u>	<u>219,230</u>
Cash flows from investing activities		
Purchases of property, plant and equipment	(100,571)	(209,359)
Uses of construction/capitalized interest funds	19	14,730
Purchases of investments	(422,420)	(224,580)
Sales of investments	308,505	371,690
Net cash used in investing activities	<u>(214,467)</u>	<u>(47,519)</u>
Cash flows from financing activities		
Proceeds from issuance of long-term debt	24,020	686
Payments on long-term obligations	(24,026)	(14,343)
Transfers paid to the University of Chicago, net	(72,749)	(74,544)
Restricted contributions	4,225	6,646
Net cash used in financing activities	<u>(68,530)</u>	<u>(81,555)</u>
Net increase (decrease) in cash and cash equivalents	(84,806)	90,156
Cash and cash equivalents		
Beginning of year	164,504	74,348
End of year	<u>\$ 79,698</u>	<u>\$ 164,504</u>

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

The University of Chicago Medical Center
Notes to Financial Statements
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1. Organization and Basis of Presentation

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

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

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

2. Summary of Significant Accounting Policies

New Accounting Pronouncements

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

Use of Estimates

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

Community Benefits

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

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

The University of Chicago Medical Center
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support education, clinical research and other community programs for the years ended June 30, 2014 and 2013, are reported in Note 4.

Fair Value of Financial Instruments

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

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

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

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

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

Cash and Cash Equivalents

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

Inventory

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

Investments

Investments are recorded in the consolidated financial statements at estimated fair value. If an investment is held directly by the Medical Center and an active market with quoted prices exists, the market price of an identical security is used as reported fair value. Reported fair values for shares in mutual funds are based on share prices reported by the funds as of the last business day of the fiscal year. The Medical Center's interests in alternative investment funds such as private debt, private equity, real estate, natural resources, and absolute return are generally reported at the net asset value (NAV) reported by the fund managers, which is used as a practical expedient to estimate the fair value, unless it is probable that all or a portion of the investment will be sold for an amount different from NAV. As of June 30, 2014 and 2013, the Medical Center had no plans to sell investments at amounts different from NAV.

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A summary of the inputs used in valuing the Medical Center's investments as of June 30, 2014 and 2013 is included in Note 5.

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

A summary of the inputs used in valuing the Medical Center's investments as of June 30, 2014 and 2013 is included in Note 5.

Endowment Funds with Deficits

From time to time, the fair value of assets associated with individual donor-restricted endowment funds may fall below the value of the initial and subsequent donor gift amounts (deficit). When donor endowment deficits exist, they are classified as a reduction of unrestricted net assets. As of June 30, 2014 and 2013, there were no endowments in a deficit position.

Investments Limited as to Use

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

Derivative Instruments

In August 2006, UCMC entered into a forward starting swap transaction against contemplated variable rate borrowing for the Center for Care and Discovery. This is a cash flow hedge against interest on the variable rate debt. The fair value of these swap agreements is the estimated amount that the Medical Center would have to pay or receive to terminate the agreements as of the consolidated balance sheet date, taking into account current interest rates and the current creditworthiness of the swap counterparty. The swap values are based on the London Interbank Rate ("LIBOR"). The inputs to the fair value estimate are considered Level 2 in the fair value hierarchy. The effective date of the swap was August 2011. In July 2011, UCMC novated the original swap agreement to divide the original notional amount in two equal parts between financial institutions. The fair value of the terminated portion of the hedge on the date of the novation was recorded in net assets in the amount of \$35,123 and is being amortized into interest expense over the life of the related debt, commencing on February 23, 2013, the date the Center for Care and Discovery was placed into service. The new agreement is being accounted for as a hedge. The combined notional amount of the swap is \$325,000 and the effective start date was August 2011. Management determined that the interest rate swaps are effective, and have qualified for hedge accounting. Management has recognized a net recovery of ineffectiveness of approximately \$500 and \$3,000 in 2014 and 2013. This movement reflects the spread between tax exempt interest rates and LIBOR during the period. The effective portion of these swaps is included in other changes in unrestricted net assets. The interest rate swaps terminate on February 1, 2044. Cash settlement payments related to the swaps for 2013 were \$7,900. These payments were accumulated in net assets while the Center for Care and Discovery was under construction, and are being amortized into depreciation expense over the life of the building. Amortization

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commenced on February 23, 2013, the date the Center for Care and Discovery was placed into service. Cash settlement payments after the Center for Care and Discovery was placed into service are recorded in interest expense. These payments were \$4,300 and \$12,400 for 2013 and 2014, respectively.

UCMC is required to provide collateral on one of the interest rate swap agreements when the liability of that swap exceeds \$50,000. At June 30, 2014 and 2013 \$0 was held as collateral. If UCMC's credit rating were to be downgraded one level; collateral would need to be provided under the swap with JP Morgan when the liability of that swap exceeds \$40,000 and under the Wells Fargo swap when the liability of that swap exceeds \$60,000. Upon further downgrade, the collateral requirements increase.

Property, Plant and Equipment

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

Asset Retirement Obligation

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

Pledges Receivable

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

Other Assets and Liabilities

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

The University of Chicago Medical Center
Notes to Financial Statements
June 30, 2014 and 2013
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Net Assets

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

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

Gifts and Grants

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

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

Statement of Operations

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

UCMC recognizes changes in accounting estimates related to third-party payor settlements as more experience is acquired. Adjustments to prior year estimates for these items resulted in an increase in net patient service revenues of \$10,700 in 2014 and \$3,700 in 2013.

In 2013, UCMC recognized a gain of \$2,400 related to the unwinding of the Weiss Liquidation Trust and received \$16,000 in cash from the liquidation.

In 2014, UCMC recognized a gain of \$2.5 million from the sale of its investment in VHS Acquisition Subsidiary No. 3, Inc. and received \$2.5 million in cash. The investment had been fully reserved at the time that it was acquired.

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

Net Patient Service Revenue, Accounts Receivable and Allowance for Doubtful Accounts

UCMC maintains agreements with the Social Security Administration under the Medicare Program, Blue Cross and Blue Shield of Illinois, Inc. (Blue Cross), and the State of Illinois under the Medicaid Program and various managed care payors that govern payment to UCMC for services rendered to

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patients covered by these agreements. The agreements generally provide for per case or per diem rates or payments based on allowable costs, subject to certain limitations, for inpatient care and discounted charges or fee schedules for outpatient care.

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

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

Hospital Assessment Program/Medicaid Provider Tax

In December 2008, the State of Illinois, after receiving approval by the federal government, implemented a hospital assessment program. The program assessed hospitals a provider tax based on occupied bed days and provided increases in hospitals' Medicaid payments. In 2014, the federal government also approved the enhanced Medicaid Assessment Program retroactive to June 10, 2012. The program, including the enhanced assessment program, results in a net increase of \$30,200 in income from operations, which represents \$76,300 in additional Medicaid payments offset by \$46,100 in Medicaid provider tax for 2014. For 2013, the assessment program resulted in a net increase of \$28,300 in operating income, which represents \$55,000 in additional Medicaid payments offset by \$26,700 in Medicaid provider tax.

Subsequent Events

UCMC has performed an evaluation of subsequent events through October 15, 2014, which is that date the financial statements were issued, and none were identified.

3. Agreements and Transactions with the University

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

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

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

UCMC purchases various services from the University, including certain employee benefits, utilities, security, telecommunications and insurance. In addition, certain UCMC accounting records are maintained by the University. During the years ended June 30, 2014 and 2013, the University charged UCMC approximately \$31,100 and \$25,200, respectively, for utilities, security, telecommunications, insurance and overhead.

The University's Division of Biological Sciences ("BSD") provides physician services to UCMC. In 2014 and 2013, UCMC recorded approximately \$204,600 and \$191,900, respectively, in expense related to these services.

UCMC's Board of Trustees adopted a plan of support under which it would provide annual net asset transfers to the University for support of academic programs in biology and medicine. All commitments under this plan are subject to the approval of UCMC's Board of Trustees and do not represent legally binding commitments until that approval. Unpaid portions of commitments approved by the UCMC Board of Trustees are reflected as current liabilities. UCMC recorded net asset transfers of \$71,750 in 2014 and 2013 for this support.

4. Community Benefits

The unreimbursed cost of providing care under the Financial Assistance Policy, along with the unreimbursed cost of government sponsored indigent healthcare programs, unreimbursed cost to support education, clinical research and other community programs for the years ended June 30, 2014 and 2013, are as follows:

	Years Ended June 30,	
	2014	2013
Uncompensated care:		
Medicaid sponsored indigent healthcare	\$ 55,371	\$ 50,124
Medicare sponsored indigent healthcare - Cost Report	64,671	44,782
Medicare sponsored indigent healthcare - Physician Services	27,365	20,737
Total uncompensated care	<u>147,407</u>	<u>115,643</u>
Provision for doubtful accounts	13,591	12,297
Charity care	25,468	25,731
	<u>186,466</u>	<u>153,671</u>
Unreimbursed education and research:		
Education	78,823	78,917
Research	48,000	48,309
Total unreimbursed education and research	<u>126,823</u>	<u>127,226</u>
Total community benefits	<u>\$ 313,289</u>	<u>\$ 280,897</u>

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

5. Investments Limited as to Use

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

	2014				2013
	Endowments Separately Invested	TRIP	Other	Total	
Investments carried at fair value:					
Cash Equivalents	\$ 8,492	\$ 18,900	\$ 295	\$ 27,687	\$ 32,779
Global Public Equities	130,120	128,945	-	259,065	175,047
Private Debt	-	23,055	-	23,055	21,329
Private Equity					
U.S. Venture Capital	3,834	38,994	-	42,828	32,853
U.S. Corporate Finance	-	35,858	-	35,858	32,022
International	283	44,442	-	44,725	38,120
Real Assets					
Real Estate	-	59,020	-	59,020	56,978
Natural Resources	-	66,979	-	66,979	58,786
Absolute Return					
Equity Oriented	-	55,327	-	55,327	36,154
Global Macro/Relative Value	-	46,685	-	46,685	35,143
Multi-Strategy	-	60,708	-	60,708	50,457
Credit-Oriented	-	21,035	-	21,035	16,377
Protection-Oriented	-	12,287	-	12,287	11,227
Fixed Income					
U.S. Treasuries, including TIPS	77,600	49,502	-	127,102	104,869
Other Fixed Income	32,905	89,274	-	122,179	80,371
Funds in Trust	-	-	17,131	17,131	14,804
Total Investments	\$ 253,234	\$ 751,011	\$ 17,426	\$ 1,021,671	\$ 797,316

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

	2014	2013
Current portion of investments limited to use	\$ 11	\$ 11
Investments limited to use, less current portion	1,021,660	797,305
Total investments limited to use	\$ 1,021,671	\$ 797,316

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

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	2014	2013
Interest and dividend income, net	\$ 14,638	\$ 13,311
Realized gains on sales of securities	27,097	43,120
Unrealized gains on securities	<u>59,424</u>	<u>706</u>
	<u>\$ 101,159</u>	<u>\$ 57,137</u>

Outside of TRIP, UCMC also invests in private equity limited partnerships. As of June 30, 2014, UCMC has commitments of \$1,700 remaining to fund private equity limited partnerships.

Fair Value of Financial Instruments

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

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

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

The absolute return portfolio is comprised of investments of limited partnership interests in hedge funds and drawdown private equity style partnerships whose managers have the authority to invest in various asset classes at their discretion, including the ability to invest long and short. The majority of the underlying holdings are marketable securities. The remainder of the underlying holdings is held in marketable securities that trade infrequently or in private investments, which are valued by the manager on the basis of an appraised value, discounted cash flow, industry comparables, or some other method. Most hedge funds that hold illiquid investments designate them in special side pockets, which are subject to special restrictions on redemption.

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

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

The Medical Center believes that the reported amount of its investments is a reasonable estimate of fair value as of June 30, 2014 and 2013. Because of the inherent uncertainties of valuation, these estimated fair values may differ significantly from values that would have been used had a ready market existed.

	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	2014 Total Fair Value
Assets				
Investments:				
Cash Equivalents	27,687	-	-	27,687
Global Public Equities	149,741	79,272	30,052	259,065
Private Debt	-	-	23,055	23,055
Private Equity				
U.S. Venture Capital	249	-	42,579	42,828
U.S. Corporate Finance	-	-	35,858	35,858
International	-	-	44,725	44,725
Real Assets				
Real Estate	1,164	-	57,856	59,020
Natural Resources	-	-	66,979	66,979
Absolute Return				
Equity Oriented	7,861	13,099	34,367	55,327
Global Macro/Relative Value	5,554	11,547	29,585	46,686
Multi-Strategy	-	6,666	54,042	60,708
Credit-Oriented	-	-	21,035	21,035
Protection-Oriented	-	12,288	-	12,288
Fixed Income				
U.S. Treasuries, including TIPS	59,014	68,087	-	127,101
Other Fixed Income	122,179	-	-	122,179
Funds in Trust	17,130	-	-	17,130
Total investments	390,579	190,959	440,133	1,021,671
Other assets	3,675	-	-	3,675
Total assets at fair value	\$ 394,254	\$ 190,959	\$ 440,133	\$ 1,025,346
Liabilities				
Interest rate swap payable	\$ -	\$ 95,810	\$ -	95,810
Total liabilities at fair value	\$ -	\$ 95,810	\$ -	\$ 95,810

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	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	2013 Total Fair Value
Assets				
Investments:				
Cash Equivalents	32,779	-	-	32,779
Global Public Equities	95,960	50,134	28,953	175,047
Private Debt	-	-	21,329	21,329
Private Equity				
U.S. Venture Capital	-	-	32,853	32,853
U.S. Corporate Finance	-	-	32,022	32,022
International	-	-	38,120	38,120
Real Assets				
Real Estate	-	-	56,978	56,978
Natural Resources	-	-	58,786	58,786
Absolute Return				
Equity Oriented	6,369	6,169	23,617	36,155
Global Macro/Relative Value	6,125	5,740	23,278	35,143
Multi-Strategy	-	2,666	47,791	50,457
Credit-Oriented	-	-	16,376	16,376
Volatility-Oriented	-	11,227	-	11,227
Fixed Income				
U.S. Treasuries, including TIPS	58,129	46,740	-	104,869
Other Fixed Income	9,892	70,479	-	80,371
Funds in Trust	14,804	-	-	14,804
Total investments	224,058	193,155	380,103	797,316
Other assets	3,045	-	-	3,045
Total assets at fair value	\$ 227,103	\$ 193,155	\$ 380,103	\$ 800,361
Liabilities				
Interest rate swap payable	\$ -	\$ 88,769	\$ -	88,769
Total liabilities at fair value	\$ -	\$ 88,769	\$ -	\$ 88,769

During 2014 there were no transfers between investment Levels 1 and 2. During fiscal year 2014 and 2013, transfers occurred between investment levels 2 and 3 as a result of changes in observable market data and/or redeemability. Changes to the reported amounts of investments measured at fair value using unobservable inputs (Level 3) as of June 30, 2014 and 2013 are as follows:

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	Separately Invested	Invested in TRIP	2014 Total
Fair value, July 1, 2013	\$ 4,540	\$ 375,563	\$ 380,103
Realized gains	-	34,920	34,920
Unrealized gains	774	30,467	31,241
Purchases	30	44,344	44,374
Sales	(1,226)	(49,053)	(50,279)
Transfers	-	(225)	(225)
Fair value, June 30, 2014	<u>\$ 4,118</u>	<u>\$ 436,016</u>	<u>\$ 440,134</u>
	Separately Invested	Invested in TRIP	2013 Total
Fair value, July 1, 2012	\$ 6,233	\$ 386,206	\$ 392,439
Realized gains	-	33,429	33,429
Unrealized gains	166	(23,415)	(23,249)
Purchases	-	29,498	29,498
Sales	(1,859)	(50,278)	(52,137)
Transfers	-	123	123
Fair value, June 30, 2013	<u>\$ 4,540</u>	<u>\$ 375,563</u>	<u>\$ 380,103</u>

The interest rate swap arrangement has inputs which can generally be corroborated by market data and is therefore classified within level 2.

The methods described above may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, while UCMC believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different estimate of fair value at the reporting date.

The significant unobservable inputs used in the fair value measurement of UCMC's long-lived partnership investments include a combination of cost, discounted cash flow analysis, industry comparables and outside appraisals. Significant increases (decreases) in any inputs used by investment managers in determining net asset values in isolation would result in a significantly lower (higher) fair value measurement.

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UCMC has made investments in various long-lived partnerships and, in other cases, has entered into contractual agreements that may limit its ability to initiate redemptions due to notice periods, lockups and gates. Details on typical redemption terms by asset class and type of investment are provided below:

	Remaining Life	Redemption Terms	Redemption Restrictions and Terms
Cash	N/A	Daily	None
Global Public Equities:			
Index Funds	NA	Daily	None
Separate Accounts	N/A	Daily with notice periods of 1 to 7 years	Lock-up provisions ranging from 0 to 1 year
Partnerships	N/A	Daily to triennial with notice periods of 2 to 90 days	Lock-up provisions ranging from 0 to 5 years, some investments have a portion of capital held in side pockets with no redemptions permitted
Private Debt:			
Partnerships	N/A	Redemptions not permitted	Capital held in side pockets with no redemption permitted
Drawdown partnerships	1 to 10 years	Redemptions not permitted	N/A
Private Equity	1 to 19 years	Redemptions not permitted	N/A
Real Estate:			
Drawdown partnerships	1 to 18 years	Redemption not permitted	N/A
Separate accounts	N/A	Daily with notice period of 5 days	None
Natural resources	1 to 17 years	Redemptions not permitted	N/A
Absolute Return:			
Partnerships	N/A	Monthly to annually with varying notice periods.	Lock-up provisions ranging from 0 to 5 years, some investments have a portion of capital in side pockets with no redemptions permitted
Drawdown Partnerships	1 to 3 years	Redemptions not permitted	N/A
Fixed Income:			
Separate Accounts	N/A	Daily to monthly with notice periods of 1 to 30 days	None
Commingled Funds	N/A	Daily to monthly with notice periods of 1 to 10 days	None
Partnerships	N/A	Quarterly with notice periods of 10 days	Only one-third capital available in any 12-month period
Funds Held in Trust:	N/A	Daily	None

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6. Endowments

UCMC's endowment consists of individual donor restricted endowment funds and board-designated endowment funds for a variety of purposes plus the following where the assets have been designated for endowment: pledges receivable, split interest agreements, and other net assets. The endowment includes both donor-restricted endowment funds and funds designated by the Board of Trustees to function as endowments. The net assets associated with endowment funds including funds designated by the Board of Trustees to function as endowments, are classified and reported based on the existence or absence of donor imposed restrictions.

Illinois is governed by the "Uniform Prudent Management of Institutional Funds Act" (UPMIFA). The Board of Trustees of UCMC has interpreted UPMIFA as sustaining the preservation of the original gift as of the gift date of the donor-restricted endowment funds absent explicit donor stipulations to the contrary. As a result of this interpretation, UCMC classifies as permanently restricted net assets, (a) the original value of gifts donated to the permanent endowment, (b) the original value of subsequent gifts to the permanent endowment, and (c) accumulations to the permanent endowment made in accordance with the direction of the applicable donor gift instrument at the time the accumulation is added to the fund. The remaining portion of the donor-restricted endowment fund that is not classified in permanently restricted net assets is classified as temporarily restricted net assets until those amounts are appropriated for expenditure by UCMC in a manner consistent with the standard of prudence prescribed by UPMIFA.

UCMC has the following donor-restricted endowment activities during the years ended June 30, 2014 and 2013 delineated by net asset class:

	<u>Unrestricted</u>			
	Funds	Temporarily	Permanently	2014
	Functioning	Restricted	Restricted	Total
Endowment net assets, beginning of year	\$ 707,290	\$ 68,634	\$ 6,082	\$ 782,006
Investment return:				
Investment income	37,212	1,207	-	38,419
Net appreciation (realized and unrealized)	63,947	8,092	-	72,039
Total investment return	101,159	9,299	-	110,458
Gifts and other additions	87,500	-	2,000	89,500
Appropriation of endowment assets for expenditure	(40,272)	(3,850)	-	(44,122)
Replenishment of endowment assets for capital	67,215			67,215
Other	(1,196)	385	-	(811)
Endowment net assets, end of year	<u>\$ 921,696</u>	<u>\$ 74,468</u>	<u>\$ 8,082</u>	<u>\$ 1,004,246</u>

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	<u>Unrestricted</u> Funds Functioning	Temporarily Restricted	Permanently Restricted	2013 Total
Endowment net assets, beginning of year	\$ 796,105	\$ 67,279	\$ 6,072	\$ 869,456
Investment return:				
Investment income	38,437	3,518	-	41,955
Net appreciation (realized and unrealized)	18,700	1,086	-	19,786
Total investment return	57,137	4,604	-	61,741
Gifts and other additions	25,000	-	10	25,010
Appropriation of endowment assets for expenditure	(37,037)	(3,610)	-	(40,647)
Appropriation of endowment assets for capital	(132,056)			(132,056)
Other	(1,859)	361	-	(1,498)
Endowment net assets, end of year	<u>\$ 707,290</u>	<u>\$ 68,634</u>	<u>\$ 6,082</u>	<u>\$ 782,006</u>

Description of amounts classified as permanently restricted net assets and temporarily restricted net assets (Endowments only) as of June 30, 2014 and 2013:

	Perpetual	Time- Restricted by Donor	Time- Restricted by Law	2014 Total
Restricted for pediatric health care	\$ 1,845	\$ -	\$ 16,918	\$ 18,763
Restricted for adult health care	1,925	-	54,780	56,705
Restricted for educational and scientific programs	4,312	-	2,769	7,081
	<u>\$ 8,082</u>	<u>\$ -</u>	<u>\$ 74,467</u>	<u>\$ 82,549</u>

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	Perpetual	Time- Restricted by Donor	Time- Restricted by Law	2013 Total
Restricted for pediatric health care	\$ 1,855	\$ -	\$ 15,580	\$ 17,435
Restricted for adult health care	1,925	-	50,715	52,640
Restricted for educational and scientific programs	2,312	-	2,339	4,651
	<u>\$ 6,092</u>	<u>\$ -</u>	<u>\$ 68,634</u>	<u>\$ 74,726</u>

Investment and Spending Policies

UCMC has adopted endowment investment and spending policies that attempt to provide a predictable stream of funding to programs supported by its endowment while seeking to maintain the purchasing power of endowment assets. UCMC expects its endowment funds over time, to provide an average rate of return of approximately 6% annually. To achieve its long-term rate of return objectives, UCMC relies on a total return strategy in which investment returns are achieved through both capital appreciation (realized and unrealized gains) and current yield (interest and dividends). Actual returns in any given year may vary from this amount.

For endowments invested in TRIP, the Board of Trustees of UCMC has adopted the University's method to be used to appropriate endowment funds for expenditure, including following the University's payout formula. The University utilizes the total return concept in allocating endowment income. In accordance with the University's total return objective, between 4.5% and 5.5% of a 12-quarter moving average of the fair value of endowment investments, lagged by one year, is available each year for expenditure in the form of endowment payout. The exact payout percentage, which is set each year by the Board of Trustees with the objective of a 5% average payout over time, was 5.5% for the fiscal years ended June 30, 2014 and 2013. If endowment income received is not sufficient to support the total return objective, the balance is provided from capital gains. If income received is in excess of the objective, the balance is reinvested in the endowment.

For endowments invested apart from TRIP, UCMC calculates a payout of 4% annually on a rolling 24-month average market value. In establishing this policy, the Board considered the expected long term rate of return on its endowment.

7. Property, Plant and Equipment

The components of property, plant and equipment as of June 30 are as follows:

	2014	2013
Land and land rights	\$ 36,008	\$ 36,008
Buildings and improvements	1,288,213	1,255,542
Equipment	515,713	576,374
Construction in progress	58,313	74,688
	<u>1,898,247</u>	<u>1,942,612</u>
Less accumulated depreciation	<u>(698,340)</u>	<u>(752,989)</u>
Total property, plant and equipment, net	<u>\$ 1,199,907</u>	<u>\$ 1,189,623</u>

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UCMC's net property, plant and equipment cost includes \$10,600 representing assets under capital leases with the University, which are stated at the UCMC's historical cost. The cost of buildings that are jointly used by the University and UCMC is allocated based on the lease provisions. In addition, land and land rights includes \$17,800 and \$19,200 for 2014 and 2013, respectively, which represents the unamortized portion of initial lease payments made to the University. UCMC entered into a services agreement in 2013 for the exclusive right to operate certain food service operations at the Medical Center, which included a capital commitment in the amount of \$11,800 for equipment and renovations provided by the contractor. In 2014 UCMC terminated this food service operation agreement and settled all outstanding balances, including the capital commitment. The amount outstanding under this commitment as of June 30, 2014 and 2013 was \$0 and \$11,300, respectively.

The Center for Care and Discovery was placed into service in 2013; approximately \$134,800 was spent in 2013 related to the building.

Capitalized interest costs in 2014 and 2013 were \$60 and \$14,600, respectively.

8. Long-Term Debt

Long-term debt as of June 30 consists of the following:

	Final fiscal year maturity	Interest rate	2014	2013
Fixed rate:				
Illinois Health Facilities Authority:				
Series 2003	2015	5.0	\$ 7,410	\$ 14,530
Illinois Finance Authority:				
Series 2009A and B	2027	4.9	149,330	150,840
Series 2009C	2037	5.4	85,000	85,000
Series 2009D-1 and 2 (synthetically fixed rate)	2044	3.9	70,000	70,000
Series 2009E-1 and 2 (synthetically fixed rate)	2044	3.9	70,000	70,000
Series 2010 A and B (synthetically fixed rate)	2045	3.9	92,500	92,500
Series 2011 A and B (synthetically fixed rate)	2045	3.9	92,500	92,500
Series 2011C	2042	5.5	90,000	90,000
Series 2012A	2037	4.5	70,325	72,080
Unamortized premium			9,797	11,163
Total fixed rate			736,862	748,613
Variable rate:				
Series 2013A	2020	3.1	24,706	686
Illinois Educational Facilities Authority (IEFA)	2038	0.1	79,517	81,427
Total variable rate			104,223	82,113
Total notes and bonds payable			841,085	830,726
Less current portion of long-term debt			(10,050)	(10,385)
Long-term portion of debt			\$ 831,035	\$ 820,341

The fair value of long-term debt is based on the pricing of fixed-rate bonds of market participants, including assumptions about the present value of current market interest rates, and loans of comparable quality and maturity. The fair value of long-term debt would be a Level 2 hierarchy. The carrying value of long-term debt is below the estimated fair value of the debt by \$37,400 and \$10,729 as of June 30, 2014 and June 30, 2013, respectively, based on the quoted market prices for the same or similar issues.

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Scheduled annual repayments for the next five years are as follows at June 30:

<u>Year</u>	<u>Amount</u>
2015	\$ 10,050
2016	12,778
2017	13,255
2018	13,868
2019	14,513

Under its various indebtedness agreements, the Medical Center is subject to certain financial covenants, including maintaining a minimum debt service coverage ratio, maintaining minimum levels of days cash on hand, maintaining debt to capitalization at certain levels; limitations on selling, leasing, or otherwise disposing of Medical Center property; and certain other nonfinancial covenants. Each of the bond series is collateralized by unrestricted receivables under a Master Trust Indenture and subject to certain restrictions. The Medical Center was in compliance with its debt covenants as of June 30, 2014 and 2013.

Recent Financing Activity

In January 2013, the Medical Center entered into an issuance of a tax-exempt direct purchase loan with a financial institution, issued as \$75,000 of Series 2013A bonds allocated to the Medical Center for the purpose of constructing a new parking garage. This bond functions similar to a construction loan with principal being drawn down as construction proceeds. Interest at LIBOR plus 60 basis points is payable each month based on the outstanding principal balance. A mandatory purchase date of repayment is established for January 24, 2020.

Letters of Credit

Payment on each of the variable rate demand revenue bonds is also collateralized by a letter of credit. The letters of credit that support the Series 2009D and the Series 2009E bonds were due to expire in August 2012. The Medical Center replaced the letter of credit that supports the Series 2009D bonds with a new letter of credit in June 2012, which expires in June 2017. The letter of credit that supports the 2009E bonds was extended subsequent to June 30, 2012 and now expires in December 2014. The letters of credit that support the Series 2010A and Series 2010B bonds expire in November 2015 and the letters of credit that support the Series 2011A and Series 2011B bonds expire in May 2016. The letters of credit are subject to certain restrictions, which include financial ratio requirements and consent to future indebtedness. The most restrictive financial ratio is to maintain a debt service coverage ratio of 1.25:1. UCMC was in compliance with all applicable debt covenants at June 30, 2014.

Payment on each of the IEFA bonds is collateralized by a letter of credit maturing November 2017. The letter of credit is subject to certain restrictions, which include financial ratio requirements. The most restrictive financial ratio is to maintain a debt service coverage ratio of 1.75:1. UCMC was in compliance with all applicable debt covenants at June 30, 2014.

Included in UCMC's debt is \$79,500 of commercial paper revenue notes and \$325,000 of variable rate demand bonds. In the event that UCMC's remarketing agents are unable to remarket the bonds, the trustee of the bonds will tender them under the letters of credit. Scheduled repayments under the letters of credit are between 1 and 3 years, beginning after a grace period of at least one year, and bear interest rates different from those associated with the original bond issue. Any

The University of Chicago Medical Center
Notes to Financial Statements
June 30, 2014 and 2013
(in thousands of dollars)

bonds tendered are still eligible to be remarketed. Bonds subsequently remarketed would be subject to the original bond repayment schedules.

UCMC paid interest, net of capitalized interest, of approximately \$33,500 and \$18,300 in 2014 and 2013, respectively.

UCMC has a \$15,000 line of credit from a commercial bank. As of June 30, 2014 and 2013, no amount was outstanding under this line.

9. Commitments

Leases

UCMC has capital and noncancelable operating leases for certain buildings and equipment. Future minimum payments required under noncancelable operating and capital leases as of June 30 are as follows:

	Operating	Capital
2015	\$ 2,074	\$ 147
2016	2,102	-
2017	548	-
2018	559	-
2019 and thereafter	6,249	-
Total minimum lease payments	<u>\$ 11,532</u>	<u>147</u>
Less - Amount representing interest		<u>2</u>
Present value of net minimum capital lease payments		<u>\$ 145</u>

The amount of total assets capitalized under these leases at June 30, 2014 and 2013, is \$2,300 and \$3,000 with related accumulated depreciation of \$2,000 and \$2,400, respectively. Rental expense was approximately \$5,500 and \$5,500 for the years ended June 30, 2014 and 2013, respectively, including a \$500 annual rental of a parking garage from the University.

10. Insurance

UCMC is included under certain of the University's insurance programs. Since 1977, UCMC, in conjunction with the University, has maintained a self-insurance program for its medical malpractice liability. This program is supplemented with commercial excess insurance above the University's self-insurance retention, which for the years ended June 30, 2014 and 2013 was \$5,000 per claim and unlimited in the aggregate. Claims in excess of \$5,000 are subject to an additional self-insurance retention limited to \$12,500 per claim and \$12,500 in aggregate.

The estimated liability for medical malpractice self-insurance is actuarially determined based upon estimated claim reserves and various assumptions, and represents the estimated present value of self-insurance claims that will be settled in the future. It considers anticipated payout patterns as well as interest to be earned on available assets prior to payment. The discount rate used to value the self-insurance liability is a risk-adjusted rate commensurate with the duration of anticipated payments. These inputs to the fair value estimate of the liability are considered Level 2 in the fair value hierarchy.

The University of Chicago Medical Center
Notes to Financial Statements
June 30, 2014 and 2013
(in thousands of dollars)

A comparison of the estimated liability for incurred malpractice claims (filed and not filed) and net assets for the combined University and UCMC self-insurance program as of June 30, 2014 and 2013, is presented below:

	2014	2013
Actuarial present value of self-insurance liability for medical malpractice	\$ 238,552	\$ 254,328
Total assets available for claims	\$ 332,592	\$ 352,414

If the present-value method were not used, the ultimate liability for medical malpractice self-insurance claims would be approximately \$43,100 higher at June 30, 2014. The interest rate assumed in determining the present value was 4.25% for 2014 and 4.5% for 2013. The Medical Center has recorded its pro-rata share of the malpractice self-insurance liability as required under ASU 2010-24 in the amount of \$115,400 at June 30, 2014 and \$121,300 at June 30, 2013 with an offsetting receivable from the malpractice trust to cover any related claims.

The malpractice self-insurance trust assets consist primarily of funds held in TRIP.

UCMC recognizes as malpractice expense its negotiated pro-rata share of the actuarially determined normal contribution, with gains and losses amortized over five years, with no retroactive adjustments, as provided in the operating agreement. For fiscal year 2015, the Medical Center expense will be \$16,800 related to malpractice.

UCMC designated \$17,100 and \$14,800 as of June 30, 2014 and 2013, respectively, as a workers' compensation self-insurance reserve trust fund. The self-insurance program investments consist of approximately 60% bonds and 40% marketable equities. The specifically identified claim requirements and actuarially determined reserve requirements for unreported workers' compensation claims were \$8,200 and \$9,500 as of June 30, 2014 and 2013, respectively. The University also charges UCMC for its portion of other commercial insurance and self-insurance costs.

11. Pension Plans

Active Plans

A majority of UCMC's personnel participate in the University's defined benefit and contribution pension plan. Under the defined benefit portion of this plan, benefits are based on years of service and the employee's compensation for the five highest paid consecutive years within the last ten years of employment. UCMC and the University make annual contributions to this portion of the plan at a rate necessary to maintain plan funding on an actuarially recommended basis. UCMC recognizes its share of net periodic pension cost as expense and any difference in the contribution amount as a transfer of unrestricted net assets. The reduction to net assets for 2014 and 2013 was \$1,000 and \$2,800, respectively. Contributions of \$32,500 were made in the fiscal years ended June 30, 2014 and 2013. UCMC expects to make contributions of \$32,500 for the fiscal year ended June 30, 2015 that will be entirely expensed as net periodic pension costs.

Under the defined contribution portion of the plan, UCMC and plan participants make contributions that accrue to the benefit of the participants at retirement. UCMC's contributions, which are based on a percentage of each covered employee's salary, totaled approximately \$6,700 and \$6,400 for the years ended June 30, 2014 and 2013, respectively.

The University of Chicago Medical Center
Notes to Financial Statements
June 30, 2014 and 2013
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Plan Name	EIN	Contributions of UCMC	
		2014	2013
University of Chicago Retirement Income Plan for Employees	36-2177139-002	\$ 7,920	\$ 6,711
University of Chicago Pension Plan for Staff Employees	36-2177139-003	24,580	25,789
		<u>\$ 32,500</u>	<u>\$ 32,500</u>

The benefit obligation, fair value of plan assets and funded status for the University's defined benefit plan included in the University's financial statements as of June 30, are shown below:

	2014	2013
Projected benefit obligation	\$ 916,791	\$ 795,133
Fair value of plan assets	<u>671,793</u>	<u>557,966</u>
Deficit of plan assets over benefit obligation	<u>\$ (244,998)</u>	<u>\$ (237,167)</u>

The weighted-average assumptions used in the accounting for the plan are shown below:

	2014	2013
Discount rate	4.3 %	4.9 %
Expected return on plan assets	6.5 %	6.5 %
Rate of compensation increase	3.5 %	3.5 %

The weighted average asset allocation for the plan is as follows:

	2014	2013
Domestic equities	28 %	29 %
International equity	16 %	15 %
Fixed income	<u>56 %</u>	<u>56 %</u>
	<u>100 %</u>	<u>100 %</u>

The pension and other postretirement benefit obligation considers anticipated payout patterns as well as investment returns on available assets prior to payment. The discount rate used to value the pension and other postretirement benefit obligation is a risk-adjusted rate commensurate with the duration of anticipated payments. These inputs to the fair value estimate are considered Level 2 in the fair value hierarchy.

Total benefits and plan expenses paid by the plan were \$39,300 and \$36,200 for the fiscal years ended June 30, 2014 and 2013, respectively.

Expected future benefit payments excluding plan expenses are as follows:

The University of Chicago Medical Center
Notes to Financial Statements
June 30, 2014 and 2013
(in thousands of dollars)

Fiscal Year

2015	70,010
2016	46,975
2017	48,850
2018	50,719
2019	52,682
2020-2024	306,906

Certain UCMC personnel participate in a contributory pension plan. Under this plan, UCMC and plan participants make annual contributions to purchase annuities equivalent to retirement benefits earned. UCMC's pension expense for this plan was \$5,000 and \$4,900 for the years ended June 30, 2014 and 2013, respectively.

Curtailed and Frozen Plan

In June 2002, UCMC assumed sponsorship of the Louis A. Weiss Memorial Hospital Pension Plan (Employer Identification Number 36-3488183, Plan Number 003), which covers employees of a former affiliate. Participation and benefit accruals are frozen. All benefit accruals are fully vested.

Components of net periodic pension cost and other amounts recognized in unrestricted net assets include the following:

	Years Ended June 30,	
	2014	2013
Net periodic pension cost		
Interest cost	\$ 2,485	\$ 2,340
Expected return on plan assets	(2,794)	(2,860)
Amortization of unrecognized net actuarial loss	675	817
Net periodic pension cost	<u>366</u>	<u>297</u>
Other changes in plan assets and benefit obligations recognized in unrestricted net assets		
Liability for pension benefits	<u>1,337</u>	<u>3,878</u>
Total recognized in net periodic pension cost and unrestricted net assets	<u>\$ (971)</u>	<u>\$ (3,581)</u>

The following tables set forth additional required pension disclosure information for this plan:

The University of Chicago Medical Center
Notes to Financial Statements
June 30, 2014 and 2013
(in thousands of dollars)

	Years Ended June 30,	
	2014	2013
Change in projected benefit obligation		
Benefit obligation at beginning of year	\$ 54,090	\$ 58,098
Interest cost	2,485	2,340
Net actuarial loss (gain)	3,237	(3,029)
Benefits paid	<u>(3,402)</u>	<u>(3,319)</u>
	<u>56,410</u>	<u>54,090</u>
Change in plan assets		
Fair value of plan assets at beginning of year	48,360	47,696
Actual return on plan assets	6,693	2,892
Employer contribution	1,500	1,091
Benefits paid	<u>(3,402)</u>	<u>(3,319)</u>
	<u>53,151</u>	<u>48,360</u>
Funded status at end of year	<u>\$ (3,259)</u>	<u>\$ (5,730)</u>

Amounts recognized in the balance sheet are included in noncurrent liabilities.

Accumulated plan benefits equal projected plan benefits. Assumptions used in the accounting for the net periodic pension cost were as follows:

	2014	2013
Discount rate	4.2 %	4.8 %
Expected return on plan assets	6.0 %	6.0 %
Rate of compensation increase	N/A	N/A

Weighted average asset allocations for plan assets are as follows:

	2014	2013
Cash	1 %	2 %
Fixed income	56	51
Domestic equities	29	34
International equities	<u>14</u>	<u>13</u>
	<u>100 %</u>	<u>100 %</u>

All plan assets are valued using level 1 inputs. The target asset allocation is 40% equities and 60% fixed income. The expected return on plan assets is based on historical investment returns for similar investment portfolios.

UCMC expects to make contributions of \$1,500 to the plan in the fiscal year ending June 30, 2015. Expected future benefit payments are:

The University of Chicago Medical Center
Notes to Financial Statements
June 30, 2014 and 2013
(in thousands of dollars)

Fiscal Year		
2015	\$	3,635
2016		3,611
2017		3,607
2018		3,609
2019		3,637
2020-2024		18,349

12. Concentration of Credit Risk

As a hospital, UCMC is potentially subject to concentration of credit risk from patient accounts receivable and certain investments. Investments, which include government and agency securities, stocks, corporate bonds, real assets, absolute return, and private equities, are not concentrated in any corporation or industry or with any single counter-party. UCMC receives a significant portion of its payments for services rendered from a limited number of government and commercial third-party payors, including Medicare, Medicaid, and Blue Cross. Medicaid approximated 16% of the Medical Center's net revenue for 2014 and 2013. Medicaid represented 21% and 17% of UCMC's net accounts receivable at June 30, 2014 and 2013, respectively. Management does not anticipate any collection risk related to the Medicaid accounts receivable at June 30, 2013. UCMC has not historically incurred any significant credit losses outside the normal course of business.

13. Pledges

Pledges receivable at June 30 are shown below:

	2014	2013
Unconditional promises expected to be collected in:		
Less than one year	\$ 2,420	\$ 2,272
One year to five years	2,142	2,634
More than five years	-	-
	<u>4,562</u>	<u>4,906</u>
Less unamortized discount (discount rate 5.5%)	<u>(71)</u>	<u>(197)</u>
Total	<u>\$ 4,491</u>	<u>\$ 4,709</u>

The University of Chicago Medical Center
Notes to Financial Statements
June 30, 2014 and 2013
(in thousands of dollars)

14. Restricted Net Assets

Temporarily restricted net assets are available for the following purposes as of June 30:

	2014	2013
Pediatric health care	\$ 19,541	\$ 17,943
Adult health care	56,505	51,756
Educational and scientific programs	4,774	4,691
Capital and other purposes	7,134	7,581
Total	<u>\$ 87,954</u>	<u>\$ 81,971</u>

Income from permanently restricted net assets is restricted for:

	2014	2013
Pediatric health care	\$ 1,855	\$ 1,855
Adult health care	1,925	1,925
Educational and scientific programs	4,312	2,312
Total	<u>\$ 8,092</u>	<u>\$ 6,092</u>

15. Functional Expenses

Total operating expenses by function are as follows for the years ended June 30:

	2014	2013
Health care services	\$ 1,285,218	\$ 1,177,672
General and administrative	92,922	78,287
Total	<u>\$ 1,378,140</u>	<u>\$ 1,255,959</u>

16. Contingencies

UCMC is subject to complaints, claims and litigation which have risen in the normal course of business. In addition, UCMC is subject to reviews by various federal and state government agencies to assure compliance with applicable laws, some of which are subject to different interpretations. While the outcome of these suits cannot be determined at this time, management, based on advice from legal counsel, believes that any loss which may arise from these actions will not have a material adverse effect on the financial position or results of operations of UCMC.

Section IX, Financial Viability

Attachment 37

Section 1120.130, Financial Viability

UCMC's most recent bond ratings from Fitch Ratings (AA-), Standard & Poor's (AA-) and Moody's (Aa3) are attached.

FitchRatings

33 Whitehall Street
New York, NY 10004

T 212 908 0500 / 800 75 FITCH
www.fitchratings.com

September 25, 2014

Ms. Ann McColgan
Vice President, Chief Treasury Officer
University of Chicago Medical Center
8201 S. Cass Avenue
Darien, IL 60561

Dear Ms. McColgan:

Fitch Ratings has assigned one or more ratings and/or otherwise taken rating action(s), as detailed in the attached Notice of Rating Action.

In issuing and maintaining its ratings, Fitch relies on factual information it receives from issuers and underwriters and from other sources Fitch believes to be credible. Fitch conducts a reasonable investigation of the factual information relied upon by it in accordance with its ratings methodology, and obtains reasonable verification of that information from independent sources, to the extent such sources are available for a given security or in a given jurisdiction.

The manner of Fitch's factual investigation and the scope of the third-party verification it obtains will vary depending on the nature of the rated security and its issuer, the requirements and practices in the jurisdiction in which the rated security is offered and sold and/or the issuer is located, the availability and nature of relevant public information, access to the management of the issuer and its advisers, the availability of pre-existing third-party verifications such as audit reports, agreed-upon procedures letters, appraisals, actuarial reports, engineering reports, legal opinions and other reports provided by third parties, the availability of independent and competent third-party verification sources with respect to the particular security or in the particular jurisdiction of the issuer, and a variety of other factors.

Users of Fitch's ratings should understand that neither an enhanced factual investigation nor any third-party verification can ensure that all of the information Fitch relies on in connection with a rating will be accurate and complete. Ultimately, the issuer and its advisers are responsible for the accuracy of the information they provide to Fitch and to the market in offering documents and other reports. In issuing its ratings Fitch must rely on the work of experts, including independent auditors with respect to financial statements and attorneys with respect to legal and tax matters. Further, ratings are inherently forward-looking and embody assumptions and predictions about future events that by their nature cannot be verified as facts. As a result, despite any verification of current facts, ratings can be affected by future events or conditions that were not anticipated at the time a rating was issued or affirmed.

Fitch seeks to continuously improve its ratings criteria and methodologies, and periodically updates the descriptions on its website of its criteria and methodologies for securities of a given type. The criteria and methodology used to determine a rating action are those in effect at the time the rating action is taken, which for public ratings is the date of the related rating action commentary. Each rating action commentary provides information about the criteria and methodology used to arrive at the stated rating, which may differ from the general criteria and methodology for the applicable security type posted on the website at a given time. For this reason, you should always consult the applicable rating action commentary for the most accurate information on the basis of any given public rating.

Ratings are based on established criteria and methodologies that Fitch is continuously evaluating and updating. Therefore, ratings are the collective work product of Fitch and no individual, or group of individuals, is solely responsible for a rating. All Fitch reports have shared authorship. Individuals identified in a Fitch report were involved in, but are not solely responsible for, the opinions stated therein. The individuals are named for contact purposes only.

Ratings are not a recommendation or suggestion, directly or indirectly, to you or any other person, to buy, sell, make or hold any investment, loan or security or to undertake any investment strategy with respect to any investment, loan or security or any issuer. Ratings do not comment on the adequacy of market price, the suitability of any investment, loan or security for a particular investor (including without limitation, any accounting and/or regulatory treatment), or the tax-exempt nature or taxability of payments made in respect of any investment, loan or security. Fitch is not your advisor, nor is Fitch providing to you or any other party any financial advice, or any legal, auditing, accounting, appraisal, valuation or actuarial services. A rating should not be viewed as a replacement for such advice or services.

The assignment of a rating by Fitch does not constitute consent by Fitch to the use of its name as an expert in connection with any registration statement or other filings under US, UK or any other relevant securities laws. Fitch does not consent to the inclusion of its ratings nor this letter communicating our rating action in any offering document.

It is important that you promptly provide us with all information that may be material to the ratings so that our ratings continue to be appropriate. Ratings may be raised, lowered, withdrawn, or placed on Rating Watch due to changes in, additions to, accuracy of or the inadequacy of information or for any other reason Fitch deems sufficient.

Nothing in this letter is intended to or should be construed as creating a fiduciary relationship between Fitch and you or between us and any user of the ratings.

In this letter, "Fitch" means Fitch, Inc. and Fitch Ratings Ltd and any subsidiary of either of them together with any successor in interest to any such person.

We are pleased to have had the opportunity to be of service to you. If we can be of further assistance, please feel free to contact us at any time.

Jeff Schaub
Managing Director, Operations
U.S. Public Finance /
Global Infrastructure & Project Finance

JS/mb

Enc: Notice of Rating Action
(Doc ID: 194310)

Notice of Rating Action

Bond Description	Rating Type	Action	Rating	Outlook/ Watch	Eff Date	Notes
Illinois Finance Authority (IL) (University of Chicago Medical Center) rev bonds ser 2009C	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	
Illinois Finance Authority (IL) (University of Chicago Medical Center) rev bonds ser 2011C	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	
Illinois Finance Authority (IL) (University of Chicago Medical Center) rev bonds ser 2012A	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	
Illinois Finance Authority (IL) (University of Chicago Medical Center) rev rfdg bonds ser 2009A	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	
Illinois Finance Authority (IL) (University of Chicago Medical Center) rev rfdg bonds ser 2009B	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	
Illinois Finance Authority (IL) (University of Chicago Medical Center) var-rate demand rev bonds ser 2009D-1	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	
Illinois Finance Authority (IL) (University of Chicago Medical Center) var-rate demand rev bonds ser 2009D-2	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	
Illinois Finance Authority (IL) (University of Chicago Medical Center) var-rate demand rev bonds ser 2009E-1	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	
Illinois Finance Authority (IL) (University of Chicago Medical Center) var-rate demand rev bonds ser 2009E-2	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	
Illinois Finance Authority (IL) (University of Chicago Medical Center) var-rate demand rev bonds ser 2010A (LOC: Bank of America, N.A.)	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	1
Illinois Finance Authority (IL) (University of Chicago Medical Center) var-rate demand rev bonds ser 2010B (LOC: Wells Fargo Bank, N.A.)	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	1
Illinois Finance Authority (IL) (University of Chicago Medical Center) var-rate demand rev bonds ser 2011A (LOC: Bank of America, N.A.)	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	1
Illinois Finance Authority (IL) (University of Chicago Medical Center) var-rate demand rev bonds ser 2011B (LOC: Wells Fargo Bank, N.A.)	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	1
Illinois Health Facilities Authority (IL) (The University of Chicago Hospitals and Health System) rev bonds ser 2003	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	
University of Chicago Medical Center (IL) (Bank Bonds) bank bonds ser 2009D-1	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	
University of Chicago Medical Center (IL) (Bank Bonds) bank bonds ser 2009D-2	Long Term	Affirmed	AA-	RO:Sta	03-Jun-2014	

Key: RO: Rating Outlook, RW: Rating Watch; Pos: Positive, Neg: Negative, Sta: Stable, Evo: Evolving

Notes

1 The rating is an underlying rating, given without consideration of credit enhancement.



**STANDARD & POOR'S
RATINGS SERVICES**
McGRAW HILL FINANCIAL

130 East Randolph Street
Suite 2900
Chicago, IL 60601
tel 312-233-7000
reference no.: 40258212

November 13, 2014

University of Chicago Medical Center
8201 South Cass Avenue
Darien, IL 60561
Attention: Ms. Ann M. McColgan, Treasurer

Re: *University of Chicago Medical Center, Illinois, Hospital Revenue Bonds, Various Series*

Dear Ms. McColgan:

Standard & Poor's Ratings Services ("Ratings Services") hereby affirms its rating of "AA-" for the above-referenced obligations and stable outlook. A copy of the rationale supporting the rating and outlook is enclosed.

This letter constitutes Ratings Services' permission for you to disseminate the above rating to interested parties in accordance with applicable laws and regulations. However, permission for such dissemination (other than to professional advisors bound by appropriate confidentiality arrangements) will become effective only after we have released the rating on standardandpoors.com. Any dissemination on any Website by you or your agents shall include the full analysis for the rating, including any updates, where applicable.

To maintain the rating, Standard & Poor's must receive all relevant financial and other information, including notice of material changes to financial and other information provided to us and in relevant documents, as soon as such information is available. Relevant financial and other information includes, but is not limited to, information about direct bank loans and debt and debt-like instruments issued to, or entered into with, financial institutions, insurance companies and/or other entities, whether or not disclosure of such information would be required under S.E.C. Rule 15c2-12. You understand that Ratings Services relies on you and your agents and advisors for the accuracy, timeliness and completeness of the information submitted in connection with the rating and the continued flow of material information as part of the surveillance process. Please send all information via electronic delivery to pubfin_statelocalgovt@standardandpoors.com. If SEC rule 17g-5 is applicable, you may post such information on the appropriate website. For any information not available in electronic format or posted on the applicable website,

Please send hard copies to:

Standard & Poor's Ratings Services
Public Finance Department
55 Water Street
New York, NY 10041-0003

PF Ratings U.S. (7/19/14)

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The rating is subject to the Terms and Conditions, if any, attached to the Engagement Letter applicable to the rating. In the absence of such Engagement Letter and Terms and Conditions, the rating is subject to the attached Terms and Conditions. The applicable Terms and Conditions are incorporated herein by reference.

Ratings Services is pleased to have the opportunity to provide its rating opinion. For more information please visit our website at www.standardandpoors.com. If you have any questions, please contact us. Thank you for choosing Ratings Services.

Sincerely yours,

A handwritten signature in cursive script that reads "Standard & Poor's".

Standard & Poor's Ratings Services

gc
enclosure

MOODY'S INVESTORS SERVICE

7 World Trade Center
250 Greenwich Street
New York, NY 10007
www.moody's.com

November 8, 2013

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

Dear Mr. Watson:

We wish to inform you that Moody's Investors Service has affirmed The University of Chicago Medical Center's Aa3 rating on bonds issued through the Illinois Finance Authority and Illinois Health Facilities Authority. The outlook is revised to negative.

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

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

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

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

Sincerely,



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

MP:rl

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

Section X, Economic Feasibility

Attachment 39

Section 1120.140, Economic Feasibility

A. Reasonableness of Financing Arrangements.

The Project will be financed through cash on hand. A letter attesting to the reasonableness of the financing arrangement is attached.

B. Conditions of Debt Financing.

This Project is being paid for through cash and securities and therefore, these criteria do not apply.

C. Reasonableness of Project and Related Costs.

Department	COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE							H	Total
	A	B	C	D	E	F	G		
(list below)	Cost/Sq. Foot		Gross Sq. Ft.		Gross Sq. Ft.		Const. \$	Mod. \$	Costs
	New	Mod.	New	Circ.	Mod	Circ.	(A x C)	(B x E)	(G + H)
Reviewable:									
Adult Emergency	483.32		27,019				\$13,058,944		\$13,058,944
Radiology	535.58		1,585				848,888		848,888
Reviewable Total	\$486.22		28,604	15%			13,907,832		13,907,832
Non-reviewable:									
Bldg. Systems	317.86		13,262				4,215,487		4,215,487
Staff/Support	343.99		2,119				728,910		728,910
Non-reviewable Total	\$321.46		15,381	0%			4,944,397		4,944,397
Contingency	\$36.43						1,602,439		1,602,439
TOTALS	\$465.04		43,985	10%			\$20,454,668		\$20,454,668

D. Project Operating Costs.

Projected Operating Costs		
		<u>Adult ED</u>
Compensation		\$14,588,100
Supplies		2,398,039
Services and Other		361,504
Total Operating Costs		\$17,347,643
Workload Units (visits) 2019		77,739
Annual Operating Cost Per Unit		\$223
2014 dollars		

E. Total Effect of Project on Capital Costs.

		<u>Year 2017</u>
Annual Depreciation		\$2,492,744
Equivalent Patient Days		531,348
Capital Cost Per Equivalent Day		\$7.98



THE UNIVERSITY OF
CHICAGO
MEDICINE

James M. Watson
Chief Financial Officer

December 10, 2014

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

***Re: The University of Chicago Medical Center, Reasonableness of Financing Arrangements
1120.140(a)(1)***

Dear Ms. Avery:

The total estimated project costs and related costs will be funded in total with cash and equivalents. Available for funding this project, as of June 30, 2014 audited financial statements is \$79.7 million from Cash and Cash Equivalents and \$1.022 billion from Investments Limited to Use, Less Current Portion.

Sincerely,

James Watson

Chief Financial Officer

Notarization:

Subscribed and sworn to before me
This 10th day of December, 2014

Signature of Notary Public

Seal



Section XI, Safety Net Impact Statement

Attachment 40

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

The University of Chicago Medical Center (“UCMC” or the “Medical Center”) is an established provider of safety net services, and is, itself, an essential, safety-net resource for the communities that it serves. At a time when many other hospitals have reduced the scope of their emergency medical services or closed entirely, UCMC’s intent to invest in its facilities and to create additional emergency room capacity is a demonstration of its enduring commitment to low-income and other vulnerable populations and to anchor the South Side communities in which they make their homes. UCMC recognizes that financial and other barriers to healthcare are endemic to its constituency and seeks to remove crowding in its emergency department as potential obstacle to their timely receipt of quality health care in the community.

The proposed relocation and expansion of the Adult ED will make more accessible the services that UCMC has historically provided to the communities that comprise its primary service area. The UCMC service area consists of a large, medically underserved, low income population on Chicago's South Side, a community that is among one of the most economically challenged communities in the State of Illinois and that has a critical need for quality healthcare. The population of the South Side is approximately 87 percent African American, 6 percent White and 4 percent Hispanic. The South Side is relatively poor compared to the City of Chicago as a whole with 29 percent of community residents reporting family incomes below the poverty level compared with 20 percent for the city as a whole. In addition, just under half of the South Side community lives below 200 percent of the poverty level. (Source: *Serving Chicago's Underserved: Regional Health System Profiles*, Chicago Department of Public Health, Chicago Health and Health Systems Project (Oct. 20, 2005).)

The South Side community is one of the unhealthiest in Cook County, with high rates of diabetes, asthma, hypertension and other chronic conditions. In fact, the target communities in

UCMC's service area have some of the highest chronic disease and mortality rates in Chicago. UCMC is one of the few hospitals—and the only academic medical center—located in the South Side of Chicago. At the same time, hospitalization rates in UCMC's service area are much higher than the metropolitan average. The South Side of Chicago has the highest incidence in Chicago of admissions through the emergency room; at UCMC, approximately 23% percent of the visits becoming inpatient admissions. These high rates of admission through emergency departments may be attributed to the high number of uninsured, underinsured and low income residents in the community which leads to a lack of access for these residents to primary care services.

UCMC remains the largest provider of Medicaid services (by admissions and patient days) on the South Side of Chicago and one of the largest in the State of Illinois. Notably, patients Medicaid or who are uninsured comprise almost one-half of UCMC's emergency department population.

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

UCMC's proposed relocation and expansion of its Adult ED should not impact the ability of other providers or health care systems to cross-subsidize safety net services. The project does not include any increases in market share or market reach; rather the purpose of the project is an attempt to keep pace with current and increasing demand for emergency medical services from the community and to position these patients closer to the ancillary medical services that they will need once at UCMC. Many of the patients that will use the new Adult ED either have been served by UCMC in the past or would have been served but for UCMC's capacity constraints (e.g., patients that left without being seen from UCMC's Adult ED because of long wait times).

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

Not applicable.

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

UCMC already provides a substantial amount of care for which it does not receive payment. For fiscal year, 2012, as filed in its IRS Form 990, UCMC provided \$20,179,000 in care for which it did not expect to receive compensation, incurred losses on government programs of \$78,872,000 and losses on education of \$86,263,000, provided research support of \$48,000,000 and \$1,179,000 for other programs, and incurred uncompensated charges—or bad debt—of \$11,917,000.

However, the community benefit provided by UCMC goes well beyond the number of charity care and Medicaid patients treated at the University of Chicago Medical Center. For example, UCMC’s mission is to provide superior health care in a compassionate manner, ever mindful of each patient’s dignity and individuality. To accomplish its mission, the Medical Center calls upon the skills and expertise of all who work together to advance medical innovation (patient care), service the health needs of the community (community service) and to further the knowledge of those dedicated to caring (research and education).

A. Patient Care and Research

The University of Chicago Medical Center (“UCMC”) is a nationally recognized leader in patient care, research and medical education. Renowned for treating some of the most complex medical cases, UCMC brings the very latest medical treatments to patients in Chicago’s South Side community, and throughout the world. In this way, UCMC furthers its commitment to patient care, clinical practice and community health. UCMC partners with the University of Chicago physicians and the Pritzker School of Medicine to educate the next generation of physicians and other health care professionals. The Medical Center is a leading provider of complex care and routinely ranks among the top providers of Medicaid services (based on admissions and inpatient days) in the state of Illinois.

THE CENTER FOR CARE & DISCOVERY AND BERNARD A. MITCHELL HOSPITAL

Completed in 2013, the Center for Care & Discovery is UCMC's new hospital, a 10-story "hospital for the future" that provides a home for complex specialty care with a focus on cancer, gastrointestinal disease, neuroscience, advanced surgery and high-technology medical imaging. The new hospital also has space for 28 operating rooms with leading-edge technology; and an integrated diagnostic and interventional platform including cardiac, gastrointestinal, neurological and vascular services.

Built in 1983, Bernard A. Mitchell Hospital was UCMC's primary adult inpatient facility until the construction of the Center for Care and Discovery, and includes the Emergency Department and the Arthur Rubloff Intensive Care Tower. The tower houses the University of Chicago Medical Center Burn Unit and Electrical Trauma Unit and remains an integral hub for intensive care and medical/surgical patients.

UCMC houses one of only two burn units in Chicago, at which UCMC provides care to critically-injured adult and pediatric patients, many of whom spend months in this intensive care facility.

UCMC admitted more than 19,440 adult patients in fiscal year 2012 with more than 409,000 visits to the outpatient ambulatory care facility. In addition, UCMC's Mitchell Hospital contains state-of-the-art obstetrical and gynecological facilities and has a leading program in reproductive endocrinology and infertility. The facilities include eight labor rooms, three delivery rooms, and two birthing rooms, as well as a 17-bed gynecology unit and four obstetric operating rooms. Over 1,400 babies were delivered at UCMC during FY 2012, many to women with high-risk pregnancies.

The Medical Center offers world-class transplantation programs in several areas, including transplantation of the liver, kidney, pancreas, lung, heart, bone marrow and other tissues, multiple-organ transplantation, and research in transplant immunology. UCMC performed 106 organ transplants in FY 2012 and 148 bone marrow or stem cell transplant procedures for treatment of various cancers.

UCMC's Emergency Department is open 24 hours a day, 7 days a week and in FY 2012, UCMC provided almost 47,000 adult ED visits, making it the busiest emergency room on Chicago's South Side. In addition, UCMC serves as a Resource Hospital for one of the emergency medical system ("EMS") regions in Illinois. UCMC is one of three (3) Resource Hospitals in Chicago and represents Chicago South. As a Resource Hospital, UCMC has authority and responsibility over the entire EMS regional system, including the clinical aspects, operations and educational programs. UCMC provides the entire budget for its participation as a Resource Hospital and spends over \$300,000 per year on this service. As a Resource Hospital, UCMC also is responsible for replacing medical supplies and providing for equipment exchange in participating EMS vehicles. UCMC spends approximately \$30,000 per year on replacement and restocking.

CHICAGO COMER CHILDREN'S HOSPITAL

As a major tertiary referral center, the University of Chicago Comer Children's Hospital sees children with medical problems that range from some of the most common to some of the most complex in its 155 bed, seven-story facility, which opened in February 2005. Families of these pediatric patients can stay at the 30,000 square-foot Ronald McDonald House on campus, which UCMC built and opened in December 2007, nearly doubling the size of the prior Ronald McDonald House. More than 4,700 children were admitted as patients to Comer Children's Hospital in fiscal year 2012 from the Chicago area, the Midwest, and around the world. In FY 2012, UCMC's outpatient clinics accommodated more than 44,000 general pediatric and specialty visits in its ambulatory care facility and more than 29,500 visits were made to the Comer pediatric emergency room.

Comer Children's Hospital is staffed by more than 100 physicians from the Department of Pediatrics at the University, as well as specialty nurses and caring support staff. The teams of healthcare professionals—including medical students, residents and fellows—work together to provide general and specialty medical care for newborns to young adults. At Comer Children's

Hospital and through its outpatient clinics, children and teens receive advanced therapies in virtually all clinical areas.

Comer Children's Hospital is a pediatric Level-I trauma center that treats children with severe injuries for emergency trauma care. UCMC also cares for critically ill and injured children in its technologically advanced Pediatric Intensive Care Unit ("PICU"). The 30-bed PICU is fully equipped to treat children with multiple traumas, complex medical problems, and conditions requiring major surgery, including cardiac, transplant, and neurosurgery. In fiscal year 2012, over 1,000 children were cared for in the PICU.

In addition, 47 designated tertiary care (Level III) beds in the Neonatal Intensive Care Unit and 18 convalescent (Level II) beds in the Transitional Care Unit provide premature and critically ill infants with the most advanced medical care and life support systems.

At the Comer Children's Hospital, infants who spend time in the NICU receive specialized follow-up care after they are discharged at its Center for Healthy Families ("Center"). The Center uses a multidisciplinary care approach that includes general pediatricians, neonatologists, nurse educators, pediatric social workers, registered dietitians, occupational therapists, physical therapists, speech therapists and home health nurses. The Center also draws on the expertise of other pediatric specialists as needed. The team addresses a host of concerns, including medical and physical needs, development, motor skills, speech, growth, nutrition, and the home environment. Team members are available by pager 24 hours a day and also teach parents how to give medications, monitor symptoms, and take other steps to meet their child's special needs. Sometimes, team members even visit the child's home to help parents and caregivers adapt to the physical and emotional environment to support the child's needs.

Comer Children's Hospital serves as the Center of a Regional Perinatal Network that is responsible for the administration and implementation of the Illinois Department of Public Health's ("IDPH") regionalized perinatal health care program. In this role, UCMC provides nine area hospitals with consultation as well as transport services for approximately 16,000 babies born in network hospitals, more than one-third of them considered high-risk. The network is committed to reducing fetal and infant mortality throughout the surrounding urban, suburban,

and rural communities. UCMC also provides leadership in the design and implementation of IDPH's Continuous Quality Improvement program and participates in continuing education for other health professionals.

More than 60% of all care provided at Comer Children's Hospital is provided to children covered by the Medicaid program. Comer Children's Hospital has a strong commitment to its community and sponsors a number of programs and services that extend beyond its walls. For example, Comer Children's Hospital takes primary care to children in its surrounding neighborhoods through the Pediatric Mobile Medical Unit (the "Mobile Unit"), which features two fully equipped exam rooms and a team comprised of a physician, a nurse practitioner and a community health advocate. The 40-foot-long Mobile Unit provides a full array of pediatric primary care services to children ages 3 to 19 who may not receive healthcare on a regular basis and brings medical resources to the children's school so parents or guardians don't have to work through obstacles, such as transportation.

At schools throughout the community, the Mobile Unit provides such services as immunizations; physicals for school and sports; screenings for vision, hearing, lead poisoning, and anemia; urine tests; and blood draws. At high schools, the Mobile Unit offers health education and treatment for minor injuries. When appropriate, children are referred for follow up care and specialty services to manage conditions such as asthma, diabetes, or mental health problems.

B. Community Service

UCMC's South Side community lacks needed health care services. Chicago's South Side has lost seven hospitals since 1985 – including most recently, the closure of Michael Reese Hospital in 2009 – and more than 2,000 beds in the past decade alone. Most recently, Roseland Community Hospital has been identified as another South Side hospital in trouble. This has resulted in a "shortage" of critical medical services and an increased demand for preventative care. Rooted in the firm belief that all patients should have access to the health care services they need, UCMC has partnered with other healthcare providers that serve this community to coordinate resources.

UCMC is committed to building strong and meaningful relationships with the surrounding community and recognizes that these relationships will help improve health outcomes on the South Side of Chicago.

One of UCMC's innovative approaches to addressing the health care shortage in its community is a program called the Urban Health Initiative ("UHI"). Under the UHI, UCMC pursues meaningful partnerships with other providers in the community to improve the long-term health of patients and to conduct important community-based clinical research, including research on the diseases that have the greatest impact in the South Side community (e.g., diabetes, renal failure, asthma, etc.).

Under the UHI, UCMC established, and continues to expand, a series of relationships with other health care providers throughout the South Side to help patients establish a permanent "medical home" and to ensure that more patients are guided to the most suitable providers for the care they need. Research has shown that when patients have a medical home in the community, they can manage their health issues on a more consistent basis and get more effective care for the prevention and treatment of non-urgent conditions, routine care and management of health issues, and referrals to specialists or hospitals for more complex care as needed.

One of the key components of the UHI is the South Side Healthcare Collaborative (SSHCC). The SSHCC was established in 2005, with assistance from a two-year Healthy Communities Access Program grant from the United States Department of Health and Human Services, to help emergency room patients who report not having a primary care physician find appropriate care at a medical home where the patient can establish an ongoing relationship with a community clinic or physician. After the government grant ended, UCMC undertook the continued funding of the SSHCC operations.

To help patients connect with community health resources, UCMC staffs its Emergency Department with patient advocates whose goal is to meet with patients who have come to the emergency department and do not otherwise have a primary care provider. In addition, the program provides comprehensive social service assessments and referrals through social workers

in the Emergency Department. Since 2005, UCMC has given information to more than 27,000 patients about available SSHCC resources and more than 16,000 of those patients have been connected to community resources.

Under the UHI, UCMC recently developed an ER Community Portal, a web-based site that gives SSHC physicians the ability to access the medical records of patients referred from UCMC's pediatric and adult emergency rooms. The Portal is aimed at helping to lower medical costs by reducing the need to re-order redundant tests; reducing medical errors by giving community physicians a more comprehensive view of patients' medical histories; and improving outcomes by providing better continuity of care. The Portal is just one of the many steps geared towards creating a seamless network of interconnected health care and social service agencies on the South Side.

UCMC also provides community residents with sub-specialty care through a number of additional programs. For example, in an effort to expand the availability of high quality medical care in the community, under the UHI, UCMC has placed specialty care providers at a federally qualified health center ("FQHC") in the South Side. This clinic aims to increase specialty services available to patients living in the community, as the absence of specialty care can lead to greater morbidity and perhaps mortality among patients from their underlying medical conditions.

UCMC has partnered with the public health system on the IRIS for Kids program, which is designed to expand access to pediatric specialty care and diagnostic services. This automated, Internet-based scheduling system allows parents to book specialty care appointments for children at the public hospital. Often the wait for these appointments is lengthy on the South Side and this system provides much-needed additional capacity.

UCMC provides grants to community health care providers under the UHI to help them expand their capabilities to serve more patients with more resources. UCMC develops partnerships with community hospitals to help make the best use of resources in underutilized hospitals. In addition, UCMC physicians often provide care at these community providers and hospitals.

As part of the UHI, UCMC has undertaken research initiatives that engage South Side residents in finding innovative, community-based solutions to ongoing health care needs. For example, UHI has launched a Center for Community Health and Vitality (“CCHV”), which provides a community base for UHI to offer University data and research resources to the community and to facilitate research and demonstrations done by University investigators in collaboration with South Side residents.

One of the major CCHV initiatives is the South Side Health and Vitality Studies (the “Studies”). The Studies are guided by the fundamental premise that scientific inquiry in service to community priorities and in collaboration with community partners is needed to eliminate the most impenetrable barriers to health and vitality. The South Side Health and Vitality Studies focus on social, environmental and technological determinants of health.

More specifically, the Studies aim to track several thousand South Side households over a generation to discover ways to ensure long-term health and wellness. These discoveries will inform effective health policy and action. The first of these studies is a Community Asset Mapping project that engages community members in keeping current information about the availability and distribution of commercial, healthcare, social and civic resources in all thirty-four (34) South Side communities. The goal of the Community Asset Mapping project is to give area residents reliable information to help them find quality services, to identify gaps in such services, and to inform new community investments. Residents may view and give feedback on the Community Asset Mapping project at SouthSideHealth.org. This interactive website also provides professionals with detailed information about available resources for health and human services in Chicago’s South Side.

UCMC provides financial incentives to encourage alumni to practice in surrounding, underserved communities through UCMC’s funding of a program called Repayment for Education to Alumni in Community Health, or REACH. REACH encourages up to five graduates a year from the Medical School to practice medicine at a federally qualified health clinic or community hospital on the South Side of Chicago, once they have completed a residency. In exchange, students receive financial help, which can be used for education loan repayment, of \$40,000 a year.

COMMUNITY OUTREACH AND EDUCATION

As a member of a diverse neighborhood, UCMC is involved in a variety of activities with community groups, faith-based organizations, community leaders and residents. To this end, UCMC has launched a series of initiatives to build partnerships with local communities and engage directly in providing information and solutions that enhance healthcare in the neighborhoods surrounding UCMC.

UCMC routinely holds community events on specific diseases and diagnoses and invites community residents to participate through outreach efforts via churches and other community-based organizations. At these community events, UCMC clinical and administrative personnel speak directly to members of the community about a variety of issues, including how to manage particular medical issues and the importance of having a medical home.

On a bi-annual basis, UCMC holds a UHI Summit, which brings together UCMC physicians, administrators and staff; public healthcare officials; representatives of various community organizations; and the media to discuss ways to advance health in the community.

In addition, UCMC and the University of Chicago's Comprehensive Cancer Center are focused on addressing the gap between advances in cancer care and patient accessibility. To achieve the desired cancer prevention and control outcomes, the Comprehensive Cancer Center's priority is to identify the parts of Chicago most affected by cancer and provide resources that maximize the impact of its services. This includes improving the quality of life for cancer patients and survivors, reducing risk factors, increasing access to care, reducing tobacco use and increasing participation in cancer research. To this end, UCMC and the University of Chicago initiated the Community Engagement Centering on Solutions ("CECOS") program, with a goal of enhancing public awareness of cancer prevention, early cancer detection and control, and the role of genetics in cancer. The program also strives to provide sustained engagement with the South Side community to increase local awareness of the latest advances in cancer research.

UCMC also provides Best of the Best Tours to children and teens in grades 6 through 12. The Best of the Best Tours provide a hands-on look at what goes on inside the Medical Center and a personal introduction to the many job opportunities available at UCMC, one of the South

Side's largest employers. Students visit an array of critical areas where they look at human organs to learn about disease; they learn about the impact of exercise on the body; and they see how technology is used in all facets of medical care — both diagnostically and administratively. It's a day of fun and inspiration as students learn about careers as sterile technicians, pathologists, nurses, phlebotomists, information systems analysts, human resources specialists and other job roles. Since 2003, the Medical Center has provided between three and ten Best of the Best tours per year.

C. Research and Education

UCMC dedicates resources to a variety of clinical, research and education initiatives that are designed to promote better health results for the communities it serves. UCMC works with the University to conduct a wide array of externally and internally funded biologic research with the aim of finding solutions to some of the country's most critical health problems. Hundreds of clinical research projects are being conducted at UCMC facilities at any one time and are available to nearly every type of patient UCMC treats. As a result, UCMC provides the only comprehensive set of clinical trials to patients in the South Side of Chicago.

For example, the Center for Interdisciplinary Health Disparities Research focuses on achieving a trans-disciplinary approach to understanding population health and health disparities and the elimination of group differences in health. Currently the Center for Interdisciplinary Health Disparities Research is focused on understanding why African American women develop breast cancer at a younger age and have a higher incidence of mortality from breast cancer than do white women.

UCMC also invests in research conducted under a Clinical and Translational Science Award (CTSA) – funded by federal grants to the University with additional investment by UCMC – to provide more effective community health care by helping to translate basic science research into programs that benefit the community. The CTSA initiative is led by the National Center for Research Resources at the National Institutes of Health and is aimed at improving the way biomedical research is conducted across the country, reducing the time it takes for laboratory discoveries to become treatments for patients, engaging communities in clinical

research efforts, and training the next generation of clinical and translational researchers. In an effort to marshal available intellectual resources, this research includes the involvement of University social scientists and social workers to help researchers and practitioners better understand how to overcome social and/or cultural hurdles and improve community health.

UCMC is deeply committed to providing health care solutions and services for patients, the community and the region. With a continued focus on its three critical missions – patient care, research and education – UCMC strives to be a leader in complex care and to have a lasting impact on the health and vitality of Chicago’s South Side.

The community benefit services are described in detail in the FY 2012 Community Benefit Report, included in this Attachment 40.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	2011	2012	2013
Inpatient	597	655	759
Outpatient	15,021	20,446	22,720
Total	15,618	21,101	23,479
Charity (cost in dollars)			
Inpatient	\$7,721,000	\$7,524,000	\$10,633,000
Outpatient	6,706,000	9,096,000	11,367,000
Total	\$14,427,000	\$16,620,000	\$22,000,000
MEDICAID			
Medicaid (# of patients)	2011	2012	2013
Inpatient	6,969	7,414	7,215
Outpatient	88,942	88,211	88,065
Total	95,911	95,625	95,280
Medicaid (revenue)			
Inpatient	\$162,810,000	\$171,224,000	\$165,714,000
Outpatient	43,554,000	44,182,000	44,274,000
Total	\$206,364,000	\$215,406,000	\$209,988,000



THE UNIVERSITY OF
CHICAGO
MEDICINE

AT THE FOREFRONT OF MEDICINE™

AT THE FOREFRONT OF OUR COMMUNITY

The University of Chicago Medicine's
2012 Report to the Community



Kicking Off a Big Year on the South Side

The past year has been an exciting one for the University of Chicago Medicine. As we moved ahead with monumental changes under health care reform, we also completed a new hospital that rivals any medical facility in the world.



About 200 guests were on hand for the dedication of the Center for Care and Discovery on Jan. 14, 2013. From left: the University of Chicago Medicine patient Tony Palumbo; Sharon O'Keefe, Medical Center president; Dr. Kenneth Polonsky, executive vice president for medical affairs; Illinois Gov. Pat Quinn; Robert Zimmer, president of the University of Chicago; Rep. Barbara Flynn Currie; Sen. Kwame Raoul; Ald. Leslie Hairston; Rep. Christian Mitchell; and Ndong Azang-Njaah, Pritzker School of Medicine student.

The Center for Care and Discovery represents our mission of delivering top-notch care in a collaborative setting where a critical mass of expertise and world-class research gives patients of today and tomorrow hope and a place to heal. The new hospital also exemplifies our contributions to the economic vitality of the region, bringing jobs to residents and pumping dollars into the local economy.

While we are proud of the new hospital, our commitment to the community goes beyond brick and mortar. It also involves supporting the next generation of physicians, charity care, losses tied to Medicaid, and donations to community groups. It extends even further to cover medical research, Medicare underpayments, unrecoverable patient debt, interpreters and volunteer work.

Altogether, the University of Chicago Medical Center and the Biological Sciences Division provided \$254 million in benefits and services to the community in fiscal 2012.

This brochure highlights these community benefits and our plans to address health disparities. For details on how we work to improve the health of the South Side and beyond, visit us online at uchospitals.edu/community or call 773-702-0025 to get last year's Community Benefit Report.

Kenneth S. Polonsky, MD
Executive Vice President for Medical Affairs, University of Chicago
Dean, Biological Sciences Division and Pritzker School of Medicine

Sharon O'Keefe
President, University of Chicago Medical Center

ON THE COVER: Robert McGee Jr., president of *II in One Contractors Inc.* in the Archer Heights neighborhood, and his workers laid the foundation for the Center for Care and Discovery. (See his story inside.)

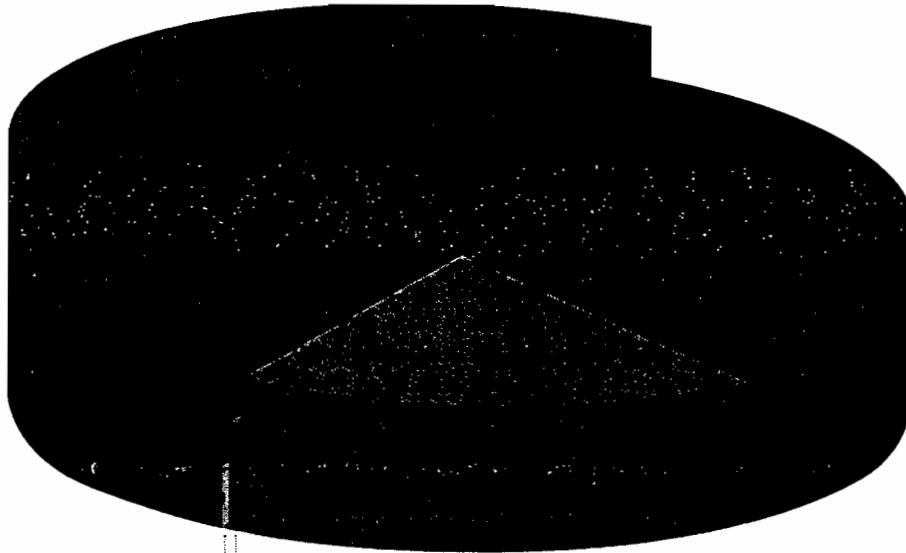
Photo by Bruce Powell

Providing Millions in Benefits and Services

\$254.1 MILLION

Community Benefits, Services in Fiscal 2012

21.7% of \$1.17 billion in total operating expenses



Total Uncompensated Care: \$122.5 million

Medicare program losses: \$50 million

Support to make up for Medicare and Medicaid reimbursement rates, which do not cover the cost of care. Medicare is a federal health insurance program for people 65 and older and those with certain disabilities. Medicaid is a federal-state program for those requiring financial assistance.

Medicaid program losses*: \$40.2 million

Charity care*: \$20.3 million

Cost of providing free or discounted services to qualified individuals

Unrecoverable patient debt: \$12 million

Amount absorbed when a hospital cannot collect expected payment for services

Medical Education: \$81.7 million

Cost to teach and train future health care professionals not covered by tuition, grants and scholarships

Medical Research: \$48 million

Funding to investigate ways to better prevent, detect and treat disease and to advance patient care

Uncategorized Community Benefits: \$1.2 million

Includes support for health improvement services, community activities, volunteers and language assistance

Cash and In-kind Contributions/Donations*: \$676,285

Gifts to community groups for health-related activities

*An IRS-defined category of community benefit Components of community benefit for fiscal year 2012 (measured at cost). Data prepared based on the Illinois Attorney General's and IRS guidelines for fiscal year ended June 30, 2012.

Creating Opportunities for the South Side



In December 2012, well before sunrise, Angela McGowan arrived at Apostolic Church of God in the Woodlawn neighborhood to apply for one of the roughly 300 permanent positions created to staff the Center for Care and Discovery.

The South Side native had been trying for years to land a job on the University of Chicago campus. So when she saw a flyer for a job fair posted at a nearby Family Community Resource Center, she was thrilled at the opportunity to meet recruiters face-to-face.

By 10:30 a.m. the day of the fair, more than 1,000 people were waiting with resumes in hand for the opportunity to work at the University of Chicago Medicine's newest hospital.

"When I think about all the people who were there, I feel extremely fortunate," said McGowan, one of the approximately 300 permanent hires who now work in the Center for Care and Discovery. "This is my foot in the door. I want to do my best here, go back to college soon, then pursue other opportunities the Medical Center has to offer."

About a month later, Robert McGee Jr. was walking around the new hospital's Sky Lobby on the 7th floor with a sense of awe as he looked out over the surrounding Hyde Park community and downtown skyline.

His concrete and rebar firm, II in One Contractors Inc., was one of about 100 minority- and women-owned firms that helped build the

"This is my foot in the door. I want to do my best here, go back to college soon, then pursue other opportunities the Medical Center has to offer."

- Angela McGowan,
food service worker at the new Center for Care and Discovery

\$700 million Center for Care and Discovery. He was there to represent them at the January 2013 dedication ceremony.

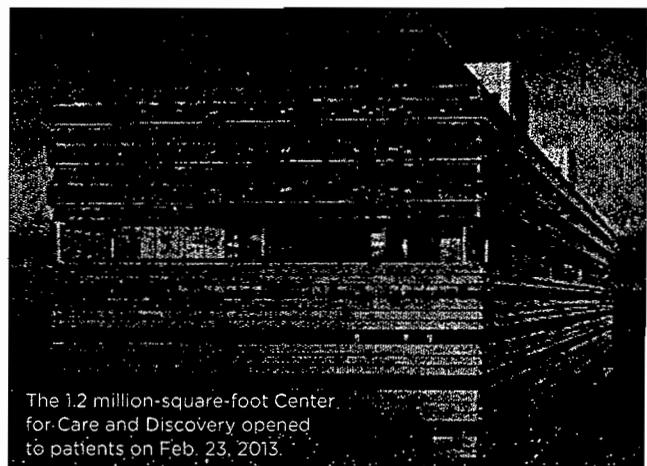
"I had a real sense of gratitude and thanksgiving that I was allowed to be a part of this project that is going to make such a profound difference in the lives of so many people," he said.

As South Side residents, both McGee and McGowan have common bonds to a community with a proud culture and rich heritage. Through the Center for Care and Discovery, they became part of a larger family sharing in the economic benefits and hope that the University of Chicago Medicine is bringing to its neighbors.

The ironworkers and laborers employed by McGee spent about 50,000 hours on the new hospital project, with more than two-thirds of the work going to minority and women workers. In fact, about 48 percent of the value of all construction contracts that were put out to bid for the 10-story facility went to certified women- and minority-owned businesses.

Construction of the 1.2 million-square-foot facility, which opened in February 2013, employed a total of 2,755 people over the four-year project. Roughly 42 percent were minority and women construction workers.

"In terms of dollars that trickled down to people in the community with the kind of participation in the workforce, it was huge," McGee said, adding he won other business from the contacts he made on the hospital job. "That's men and women feeding their families as a result of that project. It was not only good for my company; it was good for a lot of people in the African-American and other minority communities."



The 1.2 million-square-foot Center for Care and Discovery opened to patients on Feb. 23, 2013.

Center for Care and Discovery

Total Economic Impact of Hospital Project:

\$571.5 million

\$447.7 million
paid in contracts
that were open for bid

\$123.8 million
Economic value of total workforce
of 2,755 (wages, benefits, other)

Of that \$447.7 million:

Of a total workforce of 2,755:

48%
went to
**minority & women
business enterprises**
(MBE/WBE)

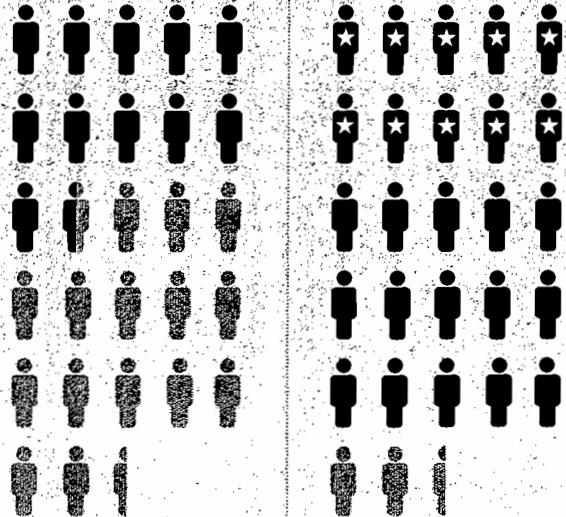


79%
went to
ILLINOIS firms



43%
went to
**MBE/WBE
IN ILLINOIS**

1 icon = 100



42% were
minority
and women
construction
workers

91% from Illinois

36% from Chicago

25% from the
South Side

Fostering Health and Opportunity in the Community

The University of Chicago Medicine is committed to strengthening the South Side by supporting programs and initiatives that improve health and well-being among the community and help boost the local economy. That philosophy touches every facet of the medical campus, including what types of health programs are supported and how business partners are selected. In 2012 and 2013, the University of Chicago Medicine was recognized for its contributions to the community.

CommunityHealth's Visionary Award

April 20, 2013 — The University of Chicago Medicine was awarded CommunityHealth's 2013 Visionary Award for its "extraordinary contributions and its commitment to bringing high-quality, comprehensive health care to Chicago's more undeserved South Side communities." The University of Chicago Medicine has provided staffing and financial support for initiatives that have helped CommunityHealth expand its role as a medical home on the South Side.

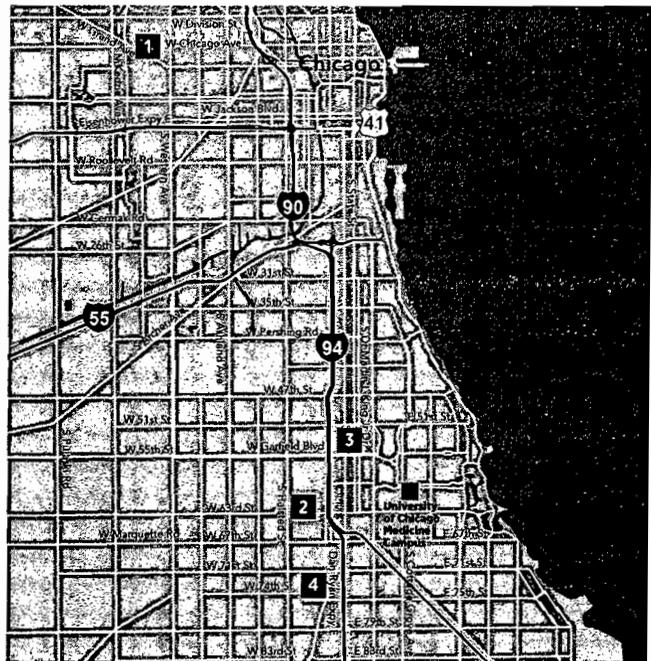
AAMC's Spencer Foreman Award

Nov. 3, 2012 — The University of Chicago Medicine was named a finalist for the Spencer Foreman Award for Outstanding Community Service from the Association of American Medical Colleges. The award honors medical schools and teaching hospitals with a longstanding commitment to communities that exceed the traditional role of academic medicine to address unmet health care needs. The University of Chicago Medicine's broad-based community collaborations, health education, patient care and prevention programs earned high marks among the 13 applicants for the award. The winner and other finalist were the University of California San Francisco School of Medicine and the University of Arizona College of Medicine, respectively.

UHC's Supplier Diversity Award

Sept. 14, 2012 — The University of Chicago Medicine was awarded the 2012 Supplier Diversity Leadership Award by UHC, an alliance of the nation's leading academic medical centers, for the development and implementation of an outstanding supplier diversity program. The award is based on several criteria, including the structure and strength of the organization's supplier diversity program, utilization of diversity contracts, senior leaders' involvement in supplier diversity, and community involvement and outreach to minority-, women- and veteran-owned businesses.

CommunityHealth's facilities are among the free clinics that the University of Chicago Medicine supports:



- 1. CommunityHealth West Town** — Faculty and medical students support a weekly clinic at this facility.
2611 W. Chicago Ave. | 773-395-9900
- 2. CommunityHealth Englewood** — Volunteer physicians, residents and medical students from the University of Chicago Medicine provide the bulk of services at this clinic.
641 W. 63rd St. | 773-994-1515
- 3. Washington Park Children's Free Clinic** — From 5:30 to 7:30 p.m. each Tuesday, medical students provide acute medical care, social services and referrals for children.
5350 S. Prairie Ave. | 773-924-0220 ext. 110
- 4. Maria Shelter Clinic** — Medical students and an attending physician provide care at this facility for homeless women and their children.
7320 S. Yale Ave. | 773-994-5350

Assessing Neighborhood Health Needs

In spring 2012, University of Chicago Medicine leaders set out to answer a question essential to the patient-focused mission of hospitals: How do we best leverage our knowledge and resources to make the greatest impact on health in the communities we serve?



Lolita Smith, a patient advocate at Comer Children's Hospital, offers assistance to a mother who is seeking a regular pediatrician for her young daughter.

While the health challenges facing many urban settings are known, developers of community initiatives on campus needed an evidence-based assessment of which issues South Side residents view as the most daunting and which untapped opportunities could drive significant improvements in those areas.

In pursuit of this data and as part of the requirements of the federal Affordable Care Act, the University of Chicago Medicine has conducted its most comprehensive assessment to date of health care concerns, behaviors and status across Chicago's South Side. An in-depth report called the Community Health Needs Assessment (CHNA), published in June in collaboration with the Metropolitan Chicago Healthcare Council, details the study's findings and provides a strategic compass for the health issues of the surrounding neighborhoods.



The analysis, conducted over an eight-month period, examined health status, barriers to care, demographics and socioeconomic factors that affect adults and children living in a dozen ZIP codes from 35th Street to 119th Street and east of Western Avenue. Insights gathered through numerous focus groups and phone interviews with residents, community leaders, public health experts and social service providers were weighted against metro Chicago health data from trusted sources including

the U.S. Department of Health and Human Services' Healthy People 2020 initiative and the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System.

The CHNA uncovered three health care priorities for adults and three for children. For adults, they are access to health care, breast and colorectal cancer, and diabetes. For children, the critical areas are access to care, obesity and asthma. The report includes a plan to advance outreach, prevention and education initiatives in those areas.

In addition to identifying the issues of greatest concern in the community, the assessment provided another valuable insight: Confirmation that much of the work under way by the University of Chicago Medicine is on the right path.

"It was encouraging to find that many of our targeted interventions at the community level are on the mark," said Brenda Battle, RN, BSN, MBA, assistant dean for diversity and inclusion and vice president for care delivery innovation. "But the report also pointed to areas where there's still work to do. The primary benefit of this exercise is that we're able to better prioritize the numerous programs in progress, which promotes stronger collaboration and innovation toward improved outcomes."

You will find a summary of the University of Chicago Medicine's plans to address these community health needs on the following pages.

For the complete Community Health Needs Assessment, please visit us online at uchospitals.edu/community-needs.

Assessing Community Health Needs: An Action Plan

Armed with new community insights and an arsenal of programs and research in development, the University of Chicago Medicine has crafted an aggressive plan to address the health needs identified in the Community Health Needs Assessment (CHNA). The priorities for adults and children and the plans to meet these needs are listed below and on the following page.

Adult-Focused Needs



Karen E. Kim, MD, professor of medicine, an expert on colon cancer prevention and screening methods, coordinates free colorectal cancer screenings, particularly for minority populations.

TARGET: Access to health care

Research increasingly points to a strong relationship with a primary care physician as the key to improved long-term health outcomes. The CHNA revealed that many South Side residents still lack an ongoing connection to frontline care and often seek treatment for chronic conditions in the emergency department (ED).

PLAN: Implement Medical Home Connection program

The University of Chicago Medicine is honing efforts to turn the tide on this longstanding concern through its Medical Home Connection program. First launched in 2005, the program has made significant strides toward reducing repeat visits to the ED for non-emergency health conditions and connecting patients with a regular doctor for preventive care, disease management, and referrals to specialists.



Patient advocates in the adult ED are central to this program. These specially trained staff members educate patients about the importance of having a regular doctor, and they schedule appointments with providers within the South Side Healthcare Collaborative, a network of 30 community health centers and two free clinics across Chicago's South Side. They also make reminder calls to help patients keep their appointments.

TARGET: Diabetes

Diabetes affects an estimated 23.6 million people in the United States and is the seventh-leading cause of death. Between 2007 and 2009, Cook County reported an annual average age-adjusted diabetes mortality rate of 22.7 deaths per 100,000 people. Of the adults in the CHNA survey area, 13.4 percent reported having been diagnosed with diabetes — compared to the Illinois average of 8.7 percent.

PLAN: Implement South Side Diabetes Project

The South Side Diabetes Project has set out to bring together local health systems with community organizations to improve the health and quality of life for people living with diabetes. The project works



with six South Side clinics to train providers in culturally-relevant diabetes management, promote improvements to quality systems and connect patients to community resources, including exercise programs, local food pantries and educational grocery-store tours.

TARGET: Breast and colorectal cancer

Respondents to the CHNA survey say cancer remains among their top health concerns. According to the National Cancer Institute's Surveillance, Epidemiology and End Results (SEER), African-Americans and Hispanics carry the heaviest burden of cancer in the U.S., with a death rate for all cancers nearly 25 percent higher than that observed in other ethnic groups.

PLAN: Enhance and implement current programs

The University of Chicago Medicine is responding to these disparities with a multifaceted plan to bring cancer prevention, early detection and treatment information to populations most at risk. Coordinators plan to leverage community relationships, research and expertise to launch outreach initiatives to help educate the community.

One example of these initiatives is the Breast Cancer Survivorship Program. Outreach coordinator Zakiya Moton, MPH, says that in her six years spearheading grassroots programs across Chicago's underserved neighborhoods, demand for information about breast cancer risk factors and early detection has increased. "I've seen improvements in health literacy each year, and people are reaching out more than ever for resources and information to aid them in becoming self-empowered for better health," said Moton, who speaks at health fairs, workplace programs and faith-based events. "Because of our efforts, people are getting screened and diagnosed with cancer in the earliest stages."

Pediatric-Focused Needs



Nurse practitioner Pamela Beauduy checks the vital signs of a student during a visit to a high school. In the 2011-12 school year, the Comer Children's Hospital Pediatric Mobile Medical Unit visited 25 schools, the majority of them on the South Side.

TARGET: Access to health care

Access to comprehensive, quality health care services is vital to achieving health equity and improving the quality of life and life expectancy, particularly among children. Nearly 38 percent of parents in the CHNA survey area reported some type of challenge or delay in obtaining health care for a child in the past year. That is more than 7 percentage points higher than the national average.

PLAN: Enhance and implement current programs

The Medical Home Connection program is expanding its reach to in-patient floors at the University of Chicago Medicine Comer Children's Hospital to help ensure more young patients have the follow-up care needed to minimize the chance of a repeat hospital stay.

To reach more underinsured and uninsured children, coordinators plan to expand the offerings of the Comer Children's Hospital Pediatric Mobile Medical Unit, which has been visiting South Side schools for more than a decade. They plan on visiting more schools and moving the "clinic on wheels" beyond physicals, screenings, immunizations and mental health assessments to offer a broad range of health education services, acute care and chronic illness management.

TARGET: Childhood obesity

Good nutrition and a healthy body weight are key to a child's development and to reducing the risk of developing many health conditions. About 40 percent of children in the CHNA survey area were found to be overweight or obese, nearly 9 percentage points higher than the national average.

PLAN: Enhance and implement current programs

To help address these startling statistics, the University of Chicago Medicine will tap its resources among community partners and researchers on the medical campus to develop programs focused on risk, prevention, weight management and culturally relevant nutrition education. It also will support Power-Up, an after-school program of activities for kindergarten through 6th grade at the Woodlawn Community School.

TARGET: Asthma

Asthma is the most common chronic illness affecting children in this country, and research confirms that children in underserved communities are more likely to experience asthma-related complications, ED visits and hospitalization. About 17 percent of children in the CHNA survey area have asthma, and almost 58 percent missed school because of asthma-related problems.

PLAN: Enhance and implement current programs

The University of Chicago Medicine's Asthma Care Coordination program is designed to reduce the occurrence of serious asthma episodes. The program, which involves patient and caregiver education along with specialized training for nurses, is aimed at increasing awareness of potential triggers and improving the ability to manage the condition at home. The initiative also connects frequent emergency department visitors with a medical home or regular primary care provider who will become familiar with the patient's needs. Community-based education and home assessments are on the horizon.

**MOBILE
CLINIC
IMPACT**

111
SITE VISITS

954
MEDICAL
ENCOUNTERS

196
MENTAL
HEALTH
ENCOUNTERS

For the complete Community Health Needs Assessment, please visit us online at uchospitals.edu/community-needs.

Making Headlines in Community-Related News

\$12 million in federal grants to help improve health outcomes

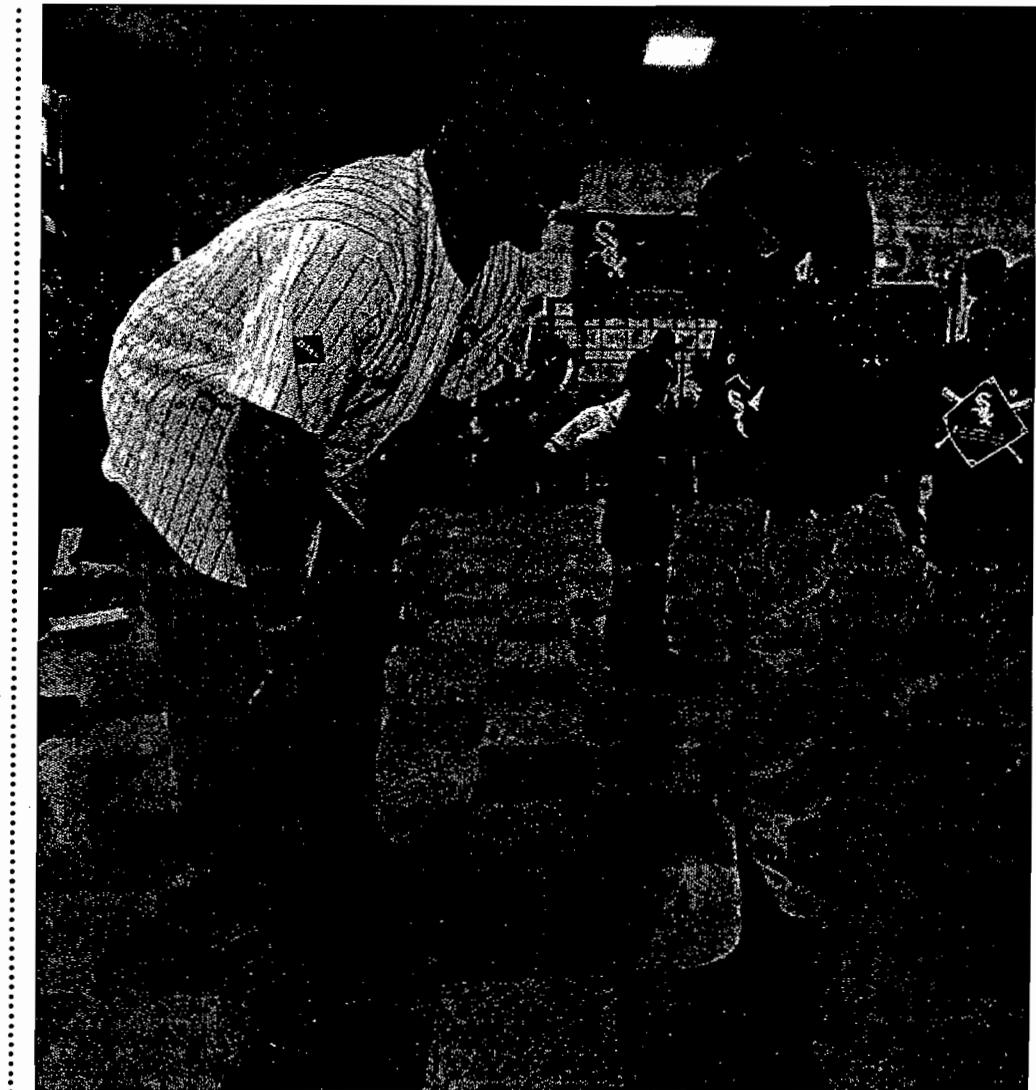
July 10, 2012 The U.S. Department of Health and Human Services awarded \$12 million to two University of Chicago Medicine-led programs: \$5.9 million to create an automated system that will provide information about community-based services and resources and \$6.1 million to test a comprehensive care physician model that seeks to improve health outcomes while also lowering costs.

The grants were part of the Centers for Medicare & Medicaid Services' Health Care Innovation Awards, a funding initiative under the Affordable Care Act that supports solutions to improve health outcomes and reduce medical costs. Of the nearly 3,000 applicants, the University of Chicago Medicine was one of 107 institutions, and the only academic medical center in Illinois, to get multiple grants in round one of the Innovation Awards.

The University of Chicago Medicine's South Side Health and Vitality Studies is leading the development of the CommunityRx system, a continuously updated database of health resources linked to the electronic health records of local safety net providers. In real time, the system processes data and prints out a "Health.eRx" for the patient, including referrals to community resources relevant to that person's condition and health status. The project is in partnership with the Chicago Health Information Technology Regional Extension Center and the Alliance of Chicago Community Health Services.

CommunityRx is expected to serve about 200,000 beneficiaries of the South Side, many of whom are covered by Medicare, Medicaid or the Illinois Comprehensive Health Insurance Plan.

"Our innovation helps people stay healthy and manage disease by connecting them to businesses and support organizations in their community," said Stacy Tessler Lindau, MD, associate professor of obstetrics and gynecology



Comer Children's Hospital, White Sox team up to target childhood obesity

Jan. 25, 2013 Comer Children's Hospital and the White Sox have joined forces to combat childhood obesity. Through a sponsorship of the team's "Family Sundays" along with the White Sox Kids Club, Comer Children's Hospital will teach families how to make healthy lifestyle choices using its repertoire of research-based programs.

at the University of Chicago Medicine and lead researcher for this project. "The outcome will be better and more efficient health care delivery and stronger, more vital communities."

The other Innovation Award will fund the study of a model that improves continuity of care for frequently hospitalized patients by providing them with a physician who will care for them both in clinic and in the hospital. The

goal is to address the issue of frequent hospitalizations by high-risk patients, who account for a disproportionate amount of health care spending in the United States. Under the model, a comprehensive care physician (CCP) will lead a team of nurse practitioners, social workers, care coordinators and other specialists to address the needs of frequently hospitalized patients. CCPs will carry a panel of approximately 200 patients at a time, serving as their

primary care physician during clinic visits and supervising their care while hospitalized. "Our goal will be to really understand patients' needs so that we can give them the care that they need," said lead investigator David Meltzer, MD, PhD, associate professor and chief of the Section of Hospital Medicine at the University of Chicago Medicine. "That should be better for them, and should ultimately be less costly for the health care system and produce better outcomes."

Other Community-Related News in 2012 and 2013



Taxi drivers offered free flu shots at O'Hare, Midway

Sept. 21, 2012 As part of an initiative to vaccinate some of Chicago's most vulnerable populations, University of Chicago Medicine nurses administered free flu shots to licensed taxicab drivers at O'Hare International Airport and at Midway International Airport.

University of Chicago Medicine, CeaseFire partner to address violence

Feb. 7, 2012 In an effort to address urban violence on the South Side, the University of Chicago Medicine is partnering with CeaseFire Chicago to sponsor a "Violence Interrupter" who will focus on monitoring, mediating and defusing disputes in neighborhoods that the medical campus serves. In addition, it has co-hosted media screenings of "It Shoudda Been Me," a play about youth violence written by Doriane Miller, MD, director of the Center for Community Health and Vitality.

Annual Day of Service and Reflection marks 10 years of giving to community

May 11, 2012 Hundreds of University of Chicago Medicine staff, faculty members, students, their family and friends mobilized across Chicago's South Side to tackle a host of

community projects as part of the 10th annual Day of Service and Reflection.

\$23 million NIH grant to boost transformative medical research

July 23, 2012 A \$23 million grant from the National Institutes of Health will energize the University of Chicago's efforts to harness innovative medical research for interventions that lead to better community health in Chicago and across the nation. The grant brings total NIH funding to the University's Institute for Translational Medicine (ITM) to more than \$50 million. Among projects the ITM has supported: development of an automated 3D imaging tool for measuring upper airway inflammation in sinusitis cases, and a program called the Thirty Million Words Project, which helps parents improve their children's language environment.

Diabetes initiative taps power of Rx pad

Aug. 15, 2012 The University of Chicago Medicine and Walgreens teamed up to launch "Food Rx," an initiative that helps people with diabetes improve their eating habits by overcoming two major hurdles when shopping for food: access and affordability. As part of the Improving Diabetes Care and Outcomes on the South Side of Chicago, a project based at the University of Chicago Medicine, diabetes patients who visit one of six South Side clinics can receive a prescription-like checklist of their doctor's food recommendations and a coupon for \$5 off \$20 worth of healthy food at participating Walgreens locations. Patients also can get a \$3 voucher for the weekly 61st Street Farmers Market in the Woodlawn neighborhood.

Annual event seeks to inspire diabetes patients, families

April 27, 2013 Sherri Shepherd, co-host of "The View," was the special guest speaker at the University of Chicago Medicine Kovler Diabetes Center's 7th annual Living Well with Diabetes event on April 27, 2013. Shepherd shared her personal struggle with weight loss and how she learned to enjoy life while managing her diabetes. Chef Jennifer Bucko Lamplough, star of Food Network's "Fat Chef" and author of blog FitFoodieChef, served up diabetes-friendly dishes and shared tips for healthful home-cooked meals. Living Well is a free annual event hosted by Kovler Diabetes Center to educate and inspire people living with diabetes.

Ci3's Game Changer Chicago earns MacArthur Foundation funding



April 10, 2013 Melissa Gilliam, MD, MPH, (above) heads the Center for Interdisciplinary Inquiry & Innovation in Sexual & Reproductive Health (Ci3), which received a \$500,000 grant from the MacArthur Foundation. The grant will help support the creation of the Design Lab for Game Changer Chicago, an initiative to investigate how playing and designing games can promote the social and emotional well-being of youth and improve sexual and reproductive health outcomes.

To read more about these news items, go to www.uchospitals.edu/news.



THE UNIVERSITY OF
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5841 S. Maryland Ave.
Chicago, IL 60637

About Us

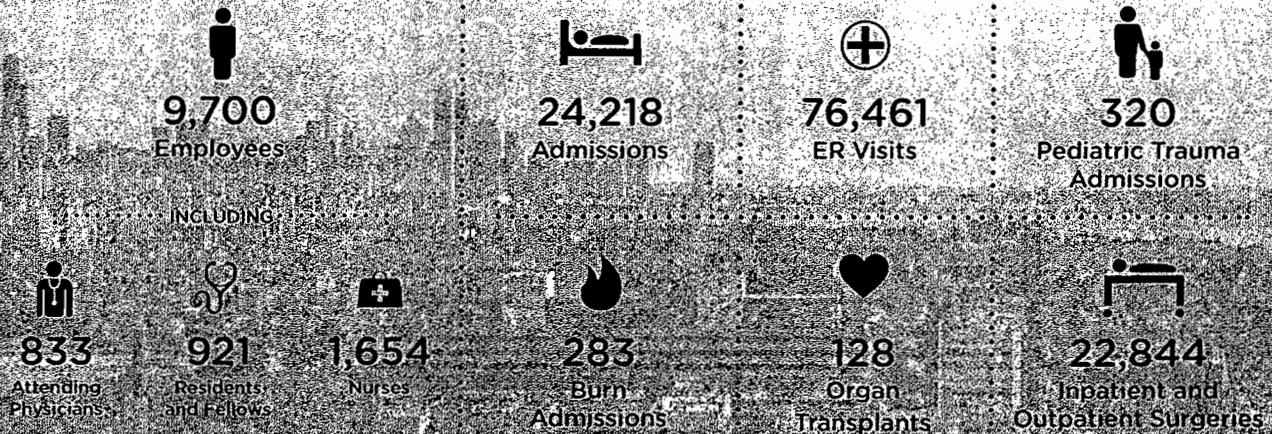
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- University of Chicago Biological Sciences Division
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IN FY2012



Medicaid Acute Care Days for Private Hospitals in Metro Chicago*

	Medicaid Days	Percent of Total Days		Medicaid Days	Percent of Total Days
1. University of Chicago Medical Center	40,107	29%	6. Mount Sinai Hospital	31,316	18
2. Advocate Christ Medical Center	38,388	21	7. Loyola University Medical Center	30,241	22
3. Northwestern Memorial Hospital	36,867	16	8. St. Mary and Elizabeth Medical Center	26,314	33
4. Rush University Medical Center	36,650	26	9. Advocate Lutheran General Hospital	20,735	17
5. Lurie Children's Hospital	33,041	33	10. Mercy Hospital & Medical Center	18,638	32

*Acute care is provided inpatient, where Illinois Medicaid is the primary insurer, excluding prenatal, postnatal, and rehabilitation days. Source: Illinois Department of Healthcare & Family Services, Medicaid cost reports filed for the state fiscal year ended June 30, 2011.

Section XII, Charity Care Information

Attachment 41

CHARITY CARE			
	2011	2012	2013
Net Patient Revenue	\$1,158,990,000	\$1,267,102,000	\$1,303,794,000
Amount of Charity Care (charges)	\$61,801,000	\$73,064,000	\$100,061,000
Cost of Charity Care	\$14,427,000	\$16,620,000	\$22,000,000
Ratio of Charity Care Cost to Net Patient Revenue	1.24%	1.31%	1.69%

Appendix 1

Letters of Support



December 10, 2014

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

Re: University of Chicago Medical Center CON Application – Adult ED Relocation & Expansion

Dear Ms. Avery:

As the medical leadership of the EMS System in the City of Chicago (Region XI), we are writing to explain how significant UCMC's Project to relocate and expand its Adult Emergency Department would be to our EMS Region and to the patients we serve. Our joint mission is to assure that every citizen and visitor of Chicago receives prompt emergency care in an effective, efficient and timely manner from the most competent and knowledgeable EMS personnel.

UCMC's proposed Adult ED would have an entrance off of Cottage Grove Avenue, a major thoroughfare, which is more easily accessible for ambulances than the current, side-street entry and would reduce the amount of time it takes for EMS personnel to unload patients requiring emergency care. The Adult ED ambulance entrance would also be equipped for biohazard containment and infection control, which would make it safer to bring patients suspected of having highly contagious illnesses to UCMC for care. Further, the expanded footprint of the new Adult ED would enable patients to be examined and treated by providers more quickly and would also help UCMC to maintain the huge reductions we've seen in diversion despite an increase in UCMC's emergency room visits. Moreover, as ED physicians, we are aware that the overall demand for emergency medical services has been trending upward over the past 12 months; and we know the addition of six treatment stations at UCMC, including specialized stations for behavioral health patients, will help to meet the growing demand at a local level.

As we mentioned in a previous letter to this Board, UCMC has demonstrated a commitment to reducing overcrowding in its Adult ED and the amount of time that it has spent on diversion; Further, because the pre-hospital and hospital components of the EMS System are integrated, when diversion at UCMC is lower and the amount of time that it takes patients to see an ED doctor is reduced, the entire EMS System benefits. We believe that this project will enable UCMC build upon these prior successes to better serve its community.

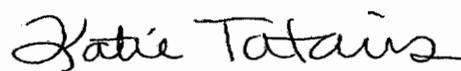
The additional capacity in UCMC's Adult ED, as well as more efficient design, would improve access to emergency medical care throughout our City, which is an important public health benefit, and we support the approval of this important project for our EMS Region.

Please feel free to contact us directly at if you need additional information. Thank you very much for your attention to this issue.

Sincerely,



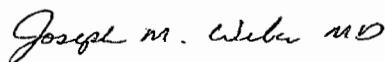
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