#23-011

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name:	The University of Chicago Medical Center – New Cancer Hospital		
Street Address:	5654 South Drexel Avenue		
City and Zip Code:	Chicago, IL 60637		
County:	Cook	Health Service Area: 6	Health Planning Area: A-03

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name:	The University of Chicago Medical Center
Street Address: :	5841 S. Maryland Avenue
City and Zip Code:	Chicago, IL 60637
Name of Registered Agent: :	John Satalic
Registered Agent Street Address:	5841 S. Maryland Avenue
Registered Agent City and Zip Code:	Chicago, IL 60637
Name of Chief Executive Officer:	Thomas Jackiewicz
CEO Street Address:	5841 S. Maryland Avenue
CEO City and Zip Code:	Chicago, IL 60637
CEO Telephone Number:	(773) 702-6240

Type of Ownership of Applicants

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

- Corporations and limited liability companies must provide an **Illinois certificate of good standing.**
- Partnerships must provide the name of the state in which they are 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:	Joe Ourth
Title:	Partner
Company Name:	Saul Ewing, LLP
Address:	161 N. Clark Street, Suite 4200, Chicago, IL 60601
Telephone Number:	(312) 876-7815
E-mail Address:	joe.ourth@saul.com
Fax Number:	(312) 876-6215

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

Name:	
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

Post Permit Contact

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

Name:	Carla Gazes
Title:	Associate General Counsel, Office of Legal Affairs
Company Name:	The University of Chicago Medical Center
Telephone Number:	(773) 702-8184
E-mail Address:	carlagazes@uchospitals.edu
Fax Number: :	(773) 702-9310

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 the Site:

Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, 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

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

- Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.
- Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.
- **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 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 #2006-5 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 #2006-5 (http://www.hfsrb.illinois.gov). **NOTE:** A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.

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 1110.20 and Part 1120.20(b)]

Part 1110 Classification :

☒ Substantive

☐ Non-substantive

2. Narrative Description

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

On March 15, 2022, the Illinois Health Facilities & Services Review Board (the "Review Board") approved the University of Chicago Medical Center's ("UCMC") application for a Master Design Permit (Project #22-004) for the architectural services required to develop a free-standing, dedicated cancer hospital on UCMC's Hyde Park Campus on the South Side of Chicago. The Review Board's approval allowed UCMC time to engage its community in this planning effort, alongside the architects, and to refine the design based on the community's input.

UCMC now seeks authority from the Review Board for the actual construction of the cancer hospital at 5654 South Drexel Avenue, Chicago, Illinois (the "Project"). Specifically, UCMC proposes the construction of a seven (7) story cancer hospital with eighty (80) private inpatient beds, including sixteen (16) ICU beds and sixty-four (64) medical/surgical beds and space for a comprehensive program of ambulatory care services. The building would consolidate many cancer services currently dispersed throughout the campus and would be connected to existing structures on the UCMC campus with tunnels and bridges.

The Project would also include a Radiology Suite consisting of two (2) MRI, two (2) CT Scanners, two (2) general ultrasound rooms, two (2) procedure rooms with mobile C-arm/fluoroscopy, and one (1) X-ray. The design includes a comprehensive Breast Center containing five (5) mammography rooms for both screening and diagnostic mammography, two (2) automated whole breast rooms (ABUS) for the screening of women with dense breast tissue, (1) stereotactic biopsy room, and (2) rooms for ultrasound guided breast biopsies as well as 18 exam/consult rooms dedicated for breast cancer clinic visits. The facility would include ninety (90) exam and consult rooms for a broad range of cancer specialty clinic visits. UCMC additionally proposes 67 general Cancer Infusion spaces, 12 Outpatient Cellular Therapy infusion spaces, and an eight (8) bay Oncology Rapid Assessment Clinic ("ORAC") that functions as a cancer urgent care clinic. The Project would include space to support clinical trials research and reserve shell space for future expansion.

The total project square footage of the proposed inpatient and outpatient tower would be 575,000 BGSF.

The total project cost is $815,112,669.

UCMC anticipates the completion date of the Project to be April 30, 2028.

Pursuant to 77 Ill. Adm. Code 1120.20(b), the Project is classified as "Substantive" because it proposes a change in bed capacity.

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 be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	**REVIEWABLE**	**NONREVIEWABLE**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation	$210,000	$490,000	$700,000
Site Preparation	$4,075,214	$9,508,832	$13,584,046
Off Site Work	$1,442,100	$3,364,901	$4,807,001
New Construction Contracts	$141,343,067	$329,548,365	$470,891,432
Modernization Contracts		$2,863,539	$2,863,539
Contingencies	$14,134,307	$33,241,190	$47,375,497
Architectural/Engineering Fees	$7,454,09	$17,392,782	$24,846,831
Consulting and Other Fees	$8,833,335	$20,611,116	$29,444,451
Movable or Other Equipment (not in construction contracts)	$71,463,795	$27,073,900	$98,537,695
Bond Issuance Expense (project related)	$1,216,701	$2,838,968	$4,055,669
Net Interest Expense During Construction (project related)	$20,257,800	$47,268,200	$67,526,000
Fair Market Value of Leased Space or Equipment			
Other Costs to Be Capitalized	$15,144,152	$35,336,356	$50,480,508
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$285,574,521	$529,538,149	$815,112,669
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$128,074,521	$237,038,149	$365,112,669
Pledges			
Gifts and Bequests			
Bond Issues (project related)	$157,500,000	$292,500,000	$450,000,000
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$285,574,521	$529,538,149	$815,112,669

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

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

Land acquisition is related to project x☐ Yes ☐ No
Purchase Price: $_____
Fair Market Value: $ $19,556,863
*Indirectly, See Lease in Attachment 2

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

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

Estimated start-up costs and operating deficit cost is $ 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:

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

Anticipated project completion date (refer to Part 1130.140): April 30, 2028

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

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

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

State Agency Submittals [Section 1130.620(c)]

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

Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (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 departments or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Not Reviewable Space [i.e., non-clinical]: *means an area for the benefit of the patients, visitors, staff, or employees of a health care facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; newsstands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers.* [20 ILCS 3960/3]

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

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

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is 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: 7/1/22**		**to: 6/30/22**	
Category of Service	**Authorized Beds***	**Admissions**	**Patient Days**	**Bed Changes**	**Proposed Beds**
Medical/Surgical	481	20,693	153,459	64	545
Obstetrics	46	3,126	8,674	-	46
Pediatrics	60	3,990	15,159	-	60
Intensive Care	142	5,664	40,902	16	158
Comprehensive Physical Rehabilitation	-	-	-	-	-
Acute/Chronic Mental Illness	-	-	-	-	-
Neonatal Intensive Care	53	811	17,681	-	53
General Long-Term Care	-	-	-	-	-
Specialized Long-Term Care	-	-	-	-	-
Long Term Acute Care	-	-	-	-	-
Other ((identify)	-	-	-	-	-
TOTALS:	782	34,284	235,875	80	862
* Authorized bed information based on Alteration of Project #16-008 The University of Chicago Medical Center, approved on September 16, 2021					

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD APPLICATION FOR PERMIT- 06/2022 - Edition

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

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

This Application 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 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 fee required for this application is sent herewith or will be paid upon request.**

SIGNATURE

Thomas Jacklewicz

President

Notarization:
Subscribed and sworn to before me
this 31st day of January

Signature of Notary

Seal

"OFFICIAL SEAL"
CASSANDRA COLE
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 8/3/2025

SIGNATURE

Jennifer Hill

Treasurer

Notarization:
Subscribed and sworn to before me
this 31st day of January

Signature of Notary

Seal

"OFFICIAL SEAL"
CASSANDRA COLE
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 8/3/2025

*Insert the exact legal name of the applicant

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

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

1110.110(a) – Background of the Applicant

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 listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.

3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners, and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.

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

    b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted, or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction, and submit any police or court records regarding any matters disclosed.

    c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.

    d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.

    e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.

4. 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.**

5. 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 that the information was 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 can 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.

Criterion 1110.110(b) & (d)

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 relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the 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 the age and condition of the project site, as well as 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 Staff 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** the alternatives to the proposed project:

Alternative options **must** include:

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

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

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

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

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

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

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

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

Criterion 1110.120 - 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 and it shall include the basis used for determining the space and the methodology applied.**

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 and certified by the facility's Medical Director.

    b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.

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

    d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

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**	**MEET 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 (GSF) 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 is available; and
   b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

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

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

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

SECTION V. - MASTER DESIGN AND RELATED PROJECTS

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

Criterion 1110.235(a) - System Impact of Master Design

Read the criterion and provide documentation that addresses the following:

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

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

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

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

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

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

1. The anticipated completion date(s) for the future construction or modernization projects; and

2. Evidence that the proposed number of beds and services is consistent with the need assessment provisions of Part 1100; or documentation that the need for the proposed number of beds and services is justified due to such factors, but not limited to:

   a. limitation on government funded or charity patients that are expected to continue.

   b. restrictive admission policies of existing planning area health care facilities that areexpected to continue.

   c. the planning area population is projected to exhibit indicators of medical care problems such as average family income below poverty levels or projected high infant mortality.

3. Evidence that the proposed beds and services will meet or exceed the utilization targets established in Part 1100 within two years after completion of the future construction of modernization project(s), based upon:

   a. historical service/beds utilization levels.
   b. projected trends in utilization (include the rationale and projection assumptions used in such projections).
   c. anticipated market factors such as referral patterns or changes in population characteristics (age, density, wellness) that would support utilization projections; and anticipated changes in delivery of the service due to changes in technology, care delivery techniques or p hysician availability that would support the p r ojected utilization levels.

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

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

1. Schematic architectural plans for all construction or modification approved in the master design permit.

2. The estimated project cost for the proposed projects and also for the totalconstruction/modification projects approved in the master design permit.

3. An item-by-item comparison of the construction elements (i.e., site, number of buildings, numberof floors, etc.) in the proposed project to the approved master design project.

4. A comparison of proposed beds and services to those approved under the master design permit.

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

SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

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

A. Criterion 1110.200 - Medical/Surgical, Obstetric, Pediatric and Intensive Care

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

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

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

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (Formula calculation)	X		
1110.200(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.200(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.200(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.200(b)(5) - Planning Area Need - Service Accessibility	X		
1110.200(c)(1) - Unnecessary Duplication of Services	X		
1110.200(c)(2) - Maldistribution	X	X	
1110.200(c)(3) - Impact of Project on Other Area Providers	X		
1110. 200(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.200(d)(4) - Occupancy			X

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(e) - Staffing Availability	X	X	
1110.200(f) - Performance Requirements	X	X	X
1110.200(g) - Assurances	X	X	

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

M. Criterion 1110.270 - 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
☐		
☐		
☐		

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

1APPEND DOCUMENTATION AS ATTACHMENT 31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

N.
APPEND DOCUMENTATION AS ATTACHMENT-33, 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)**

VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document those 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]:**

$365,112,669	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to: 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion.
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated timetable 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 timetable of receipts.
$450,000,000	d)	Debt – a statement of the estimated terms and conditions (including the debt time, variable or permanent interest rates over the debt time, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including: 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated. 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate. 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc. 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment. 5) For any option to lease, a copy of the option, including all

	terms and conditions. e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent. f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt. g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
$815,112,669	**TOTAL FUNDS AVAILABLE**

APPEND DOCUMENTATION AS ATTACHMENT 34, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VIII. 1120.130 - FINANCIAL VIABILITY – NOT APPLICABLE

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

Financial Viability Waiver

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

1. "A" Bond rating or better
2. All the project's 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 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

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

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

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

Variance

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

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

SECTION IX. 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 the cash and equivalents must be retained in the balance sheet asset accounts 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	Cost/Square Foot Mod.	Gross Sq. Ft. New	Gross Sq. Ft. Circ.*	Gross Sq. Ft. Mod.	Gross Sq. Ft. Circ.*	Const. $ (A x C)	Mod. $ (B x E)	
Contingency									
TOTALS									
* Include the percentage (%) of space for circulation									

D. Projected Operating Costs

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

E. Total Effect of the Project on Capital Costs

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

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

SECTION X. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, ***including the impact on racial and health care disparities 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 each community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all 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 37.

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

Outpatient			
Total			

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

SECTION X. CHARITY CARE INFORMATION

Charity Care information MUST be furnished for ALL projects [1120.20(c)].

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 39.

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

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

SECTION XI -SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM

In accordance with Executive Order 2006-5 (EO 5), the Health Facilities & Services Review Board (HFSRB) must determine if the site of the CRITICAL FACILITY, as defined in EO 5, is in a mapped floodplain (Special Flood Hazard Area) or a 500-year floodplain. All state agencies are required to ensure that before a permit, grant or a development is planned or promoted, the proposed project meets the requirements of the Executive Order, including compliance with the National Flood Insurance Program (NFIP) and state floodplain regulation.

1. Applicant: University of Chicago Medical Center, 5841 S. Maryland Avenue
   (Name) (Address)
   Chicago Illinois 60637
   (City) (State) (ZIP Code) (Telephone Number)

2. Project Location: 5654 South Drexel Avenue Chicago, Illinois 60637
   (Address) (City) (State)
   Cook
   (County) (Township) (Section)

3. You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (https://msc.fema.gov/portal/home) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the ***Go to NFHL Viewer*** tab above the map. You can print a copy of the floodplain map by selecting the  icon in the top corner of the page. Select the pin tool icon  and place a pin on your site. Print a FIRMETTE size image.

   If there is no digital floodplain map available select the **View/Print FIRM** icon above the aerial photo. You will then need to use the Zoom tools provided to locate the property on the map and use the **Make a FIRMette** tool to create a pdf of the floodplain map.

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA: Yes___ No X?

IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN?

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance.
If the determination is being made by a local official, please complete the following:

FIRM Panel Number:_____ Effective Date:_____

Name of Official:_____ Title: _____

Business/Agency:_____ Address:_____

(City) (State) (ZIP Code) (Telephone Number)

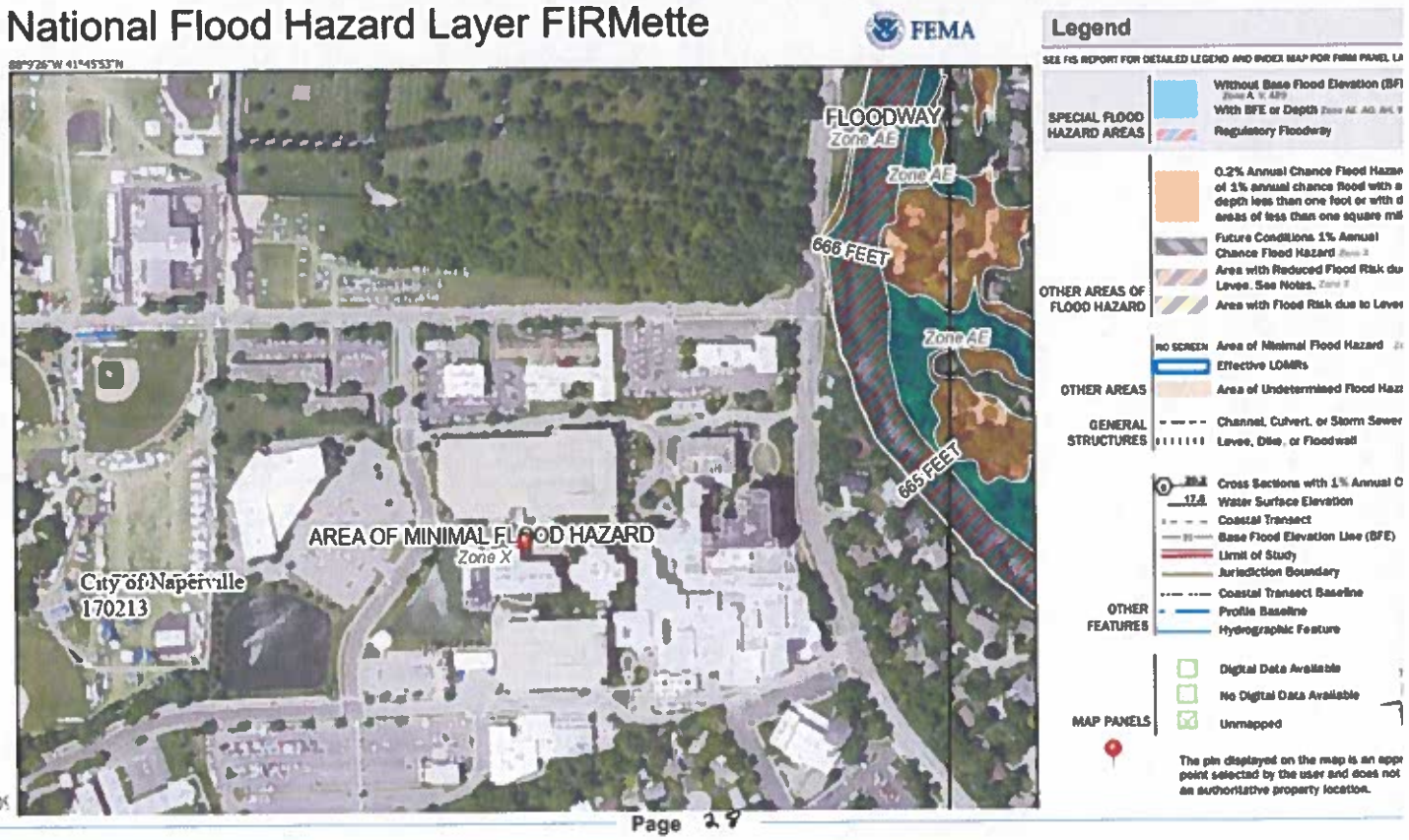
Signature:_____ Date: _____

NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

If you need additional help, contact the Illinois Statewide Floodplain Program at 217/782-4428

Floodplain Map Example

The image below is an example of the floodplain mapping required as part of the IDPH swimming facility construction permit showing that the swimming pool, to undergo a major alteration, is outside the mapped floodplain.



After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS

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. A copy of UCMC's Good Standing Certificate is attached.

File Number 5439-757-7

STATE OF ILLINOIS

OFFICE OF THE SECRETARY OF STATE

To all to whom these Presents Shall Come, Greeting:

I, **Alexi Giannoulias,** *Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I 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* 23RD *day of* JANUARY *A.D.* 2023 .

Authentication #: 2302304554 verifiable until 01/23/2024
Authenticate at: https://www.ilsos.gov

SECRETARY OF STATE

Attachment 1

Section I, Site Ownership

Attachment 2

Attached is a signed lease in which The University of Chicago will lease the property to The University of Chicago Medical Center.

This instrument was prepared by
And after recording return to:
Robert Rush
The University of Chicago
Office of Legal Counsel
5801 S. Ellis Avenue, Suite 619
Chicago, Illinois 60637

SPACE ABOVE THIS LINE
FOR RECORDER'S USE

LEASE AGREEMENT
(CANCER CENTER)

THIS LEASE AGREEMENT dated as of August 22, 2022 (the "Effective Date") (such Lease Agreement, 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:

1 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 [Reserved].

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");

ATTACHMENT 2

(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");

(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"); and

(v) the New Hospital Pavilion Garage Lease Agreement, between Lessor and Lessee and dated as of January 23, 2013, as heretofore amended and as may be amended from time to time ("NHP Garage Lease").

2 **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.

3 **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.

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 purposes of building and operating a 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 acts of God, strikes, lockouts, actions of labor unions, general shortage of labor, governmental action or inaction, orders of government, pandemics, sabotage or any cause, whether similar or dissimilar to the foregoing, not within their 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.

(a) Follwing substantial completion of the Project (as defined in Article VII hereof), 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.

(b) Should Lessee fail to commence vertical construction of the Project by thirty-six (36) months from the Effective Date (the "Construction Commencement Date"), Lessor shall have the right to terminate this Lease upon 30 days written notice to Lessee, which notice must be delivered, within 30 days of the Construction Commencement Date. In the event of such termination: (i) possession of the Premises, including all Improvements located thereon shall be surrendered by Lessee and delivered to Lessor, with all of Lessee's furniture, machinery, trade fixtures and other items of personal property removed from the Premises; and (ii) Lessor shall have the right, but not the obligation, to elect to remove any of Lessee's Improvements from the Premises at Lessee's sole cost, which election shall be made within 30 days of Lessor's notice of termination.

Where Lessor does not so elect to remove any Lessee Improvements pursuant to Subsection 3.7(b)(ii), Lessor shall Lessor shall pay to Lessee, an amount equal to all Basic Rent paid by Lessee to Lessor prior to such termination.

Where Lessor does so elect to remove any Lessee Improvements pursuant to Subsection 3.7(b)(ii):

In the event the cost of removal of Lessee's improvements is less than the amount of Basic Rent paid by Lessee to Lessor prior to the termination of the Lease, Lessor shall pay to Lessee, within 30 days of its completion of such removal, an amount equal to all Basic Rent paid by Lessee to Lessor prior to such termination, less the cost to Lessor of the removal of any Lessee property and Improvements from the Premises.

In the event the cost of removal of Lessee's improvements is greater than the amount of Basic Rent paid by Lessee to Lessor prior to the termination of the Lease, Lessee shall pay to Lessor, within 30 days of its completion of such removal, an amount equal to the cost to Lessor of the removal of any Lessee property and Improvements from the Premises less the amount of all Basic Rent paid by Lessee to Lessor prior to such termination.

(c) Should Lessee fail to substantially complete construction (so as to permit building

ATTACHMENT 2

occupancy) of the Project by seventy-two (72) months from the Construction Commencement Date (the "Substantial Completion Date") Lessor shall have the right to terminate this Lease upon 30 days written notice to Lessee, which notice must be delivered, if at all, within 30 days of the Substantial Completion Date. In the event of such termination: (i) possession of the Premises, including all Improvements located thereon shall be surrendered by Lessee and delivered to Lessor, with all of Lessee's furniture, machinery, trade fixtures and other items of personal property removed from the Premises; and (ii) Lessor shall have the right, but not the obligation, to elect to remove any of Lessee's Improvements from the Premises at Lessee's sole cost, which election shall be made within 30 days of Lessor's notice of termination.

In the event the cost of removal of Lessee's improvements is less than the amount of Basic Rent paid by Lessee to Lessor prior to the termination of the Lease, Lessor shall pay to Lessee, within 30 days of its completion of such removal, an amount equal to all Basic Rent paid by Lessee to Lessor prior to such termination, less the cost to Lessor of the removal of any Lessee property and Improvements from the Premises.

In the event the cost of removal of Lessee's improvements is greater than the amount of Basic Rent paid by Lessee to Lessor prior to the termination of the Lease, Lessee shall pay to Lessor, within 30 days of its completion of such removal, an amount equal to the cost to Lessor of the removal of any Lessee property and Improvements from the Premises less the amount of all Basic Rent paid by Lessee to Lessor prior to such termination.

4 ARTICLE IV – TERM

4.1 Lease Term. The term of this Lease (the "Lease Term") shall commence on the Effective Date. 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) 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 with reasonable notice in order to make inspections or to exercise any other rights of Lessor hereunder and further provided that except in the case of emergency, any entry by Lessor pursuant to this Section 4.2 shall not unreasonably interfere with Lessee's use of the Premises; and (b) Lessor shall with reasonable notice to Lessee, retain the right to enter upon and occupy certain portions of the Premises in order to install and maintain conduits for utility services (including but not limited to gas, water, sewer, electricity and telecommunications services) through and under the Premises, provided that no such access, use or occupancy shall materially interfere with or materially impair the Lessee's operation of the Premises.

5 ARTICLE V - RENT

5.1 Basic Rent. Lessee covenants to pay Lessor rent ("Basic Rent") for the Premises: (i) $19,556,863.09, plus (ii) the amount of $10.00 per year during the Lease Term.

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.

6 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

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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 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.

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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.

7 ARTICLE VII – CONSTRUCTION OF PROJECT

7.1 Lessor and Lessee understand that Lessee shall commence and complete the construction of a mixed-use medical project upon the Premises that is anticipated to include up to one million one hundred fifty thousand (1,150,000) gross square footage and a minimum building height of sixty-five (65) feet and no more than two hundred forty-five (245) feet (the "Project"). Landlord agrees to reasonably cooperate with Tenant in obtaining any approvals required for the Project.

8 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).

9 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 Permitted Alterations (defiend below) and the demolition and construction involved in the initial construction of the Project ("Alterations"), *provided, however*, that Lessee shall have the right, from time to time during Term, to make Permitted Alterations (defined below) withour consulting with Lessor. "Permitted Alterations" shall mean alterations and modifications to the interior of the Project that do not result in material alterations or structural changes to the Project, including expanding a building's size or materially altering a building's configuration, extertior, structure, or systems.

Notwithstanding the foregoing, 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 request by Lessor, Lessee shall provide Lessor with access to such completion and close-out 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.

10 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.

11 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.

12 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.

13 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.

14 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.

15 ARTICLE XV – SURRENDER

15.1 Surrender. Upon the expiration or earlier termination of this Lease for any reason, Lessee shall peaceably leave and surrender the Premises to Lessor in 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, equipment, and other personal property removed from the Premises by Lessee prior to the expiration or termination of this Lease), 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.

16 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:

(a) Lessee fails to pay, within 60 days after written notice to Lessee that the same is due and payable, any amount of Rent (including, without limitation, Additional Rent) due hereunder;

(b) Lessee fails to pay, within 60 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;

(c) 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 60 days after notice thereof in writing to Lessee; provided, however, that if such matter cannot be cured within 60 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;

(d) 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;

(e) 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;

(f) 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);

(g) 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;

(h) 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;

(i) 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 [Reserved].

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.

17 ARTICLE XVII – MISCELLANEOUS

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

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

hereof thereafter to be performed in the same manner and to the same extent as the same are herein covenanted to be performed by Lessee.

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

IF TO LESSOR:

The President
The University of Chicago
5801 South Ellis Avenue
Chicago, Illinois 60637

with a copy to:
The General Counsel
The University of Chicago
5801 South Ellis Avenue
Chicago, Illinois 60637

IF TO LESSEE:

The President
The University of Chicago Medical Center
5841 South Maryland Avenue
Chicago, Illinois 60637

with a copy to:
The General Counsel
The University of Chicago Medical Center
5841 South Maryland Avenue
Chicago, Illinois 60637

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

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

17.5 Attorneys' Fees. In the event that either party retains an attorney to enforce this Lease or any term, covenant or condition hereunder or to collect any Rent or any other amount due or payable under this Lease or to recover possession of the Premises, or files any action or proceeding under or relating to this Lease, the non-prevailing party shall pay the prevailing party's reasonable attorneys' fees and court costs incurred in connection therewith.

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

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

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

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

[*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.

THE UNIVERSITY OF CHICAGO	THE UNIVERSITY OF CHICAGO MEDICAL CENTER
MaryFrances McCourt	Tom Jackiewicz
Chief Financial Officer	President

ATTACHMENT 2

LEASE AGREEMENT

(CANCER CENTER)

EXHIBIT A-1

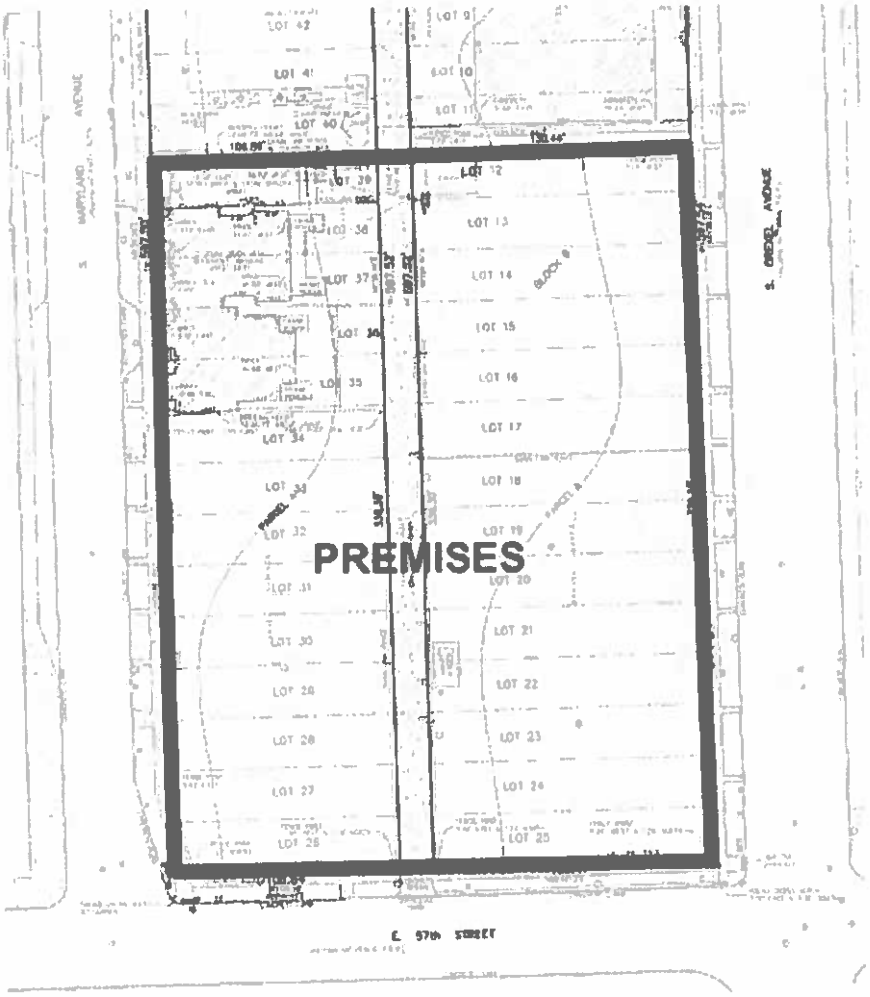
THE PREMISES

PARCEL A

LOTS 12 THROUGH 25 AND LOTS 26 THROUGH 39, BOTH INCLUSIVE, IN BLOCK 6 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, IN COOK COUNTY, ILLINOIS.

CONTAINING 79,795 SQUARE FEET OR 1.831 ACRES MORE OR LESS.

LEASE AGREEMENT
(CANCER CENTER)
EXHIBIT A-2
THE PREMISES



ATTACHMENT 2

Section I, Operating Identity/Licensee

Attachment 3

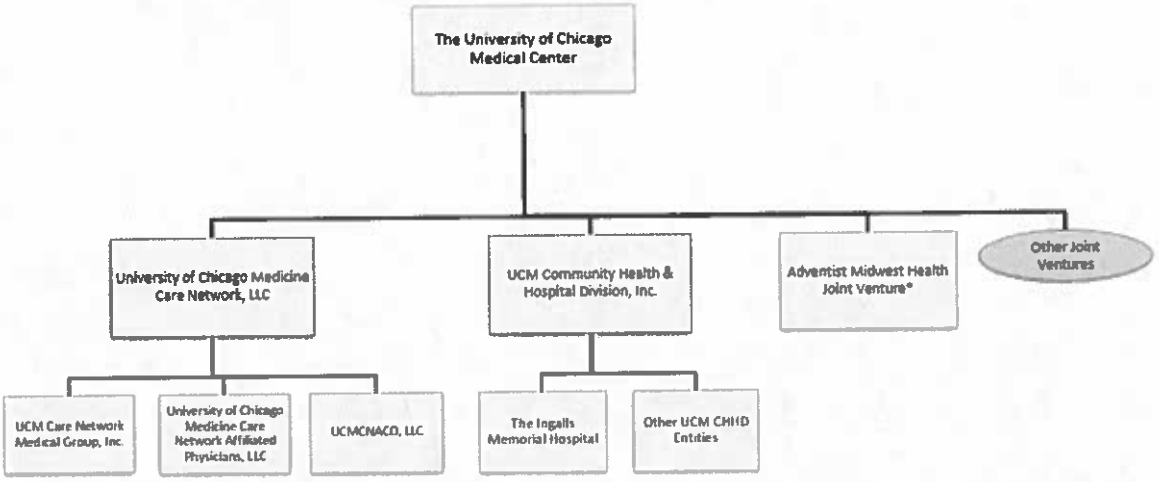
The University of Chicago Medical Center is an Illinois not-for-profit corporation and will be the operating entity and licensee.

Section I, Organizational Relationships

Attachment 4

A copy of The University of Chicago Medical Center organizational chart is attached.

UChicago Medicine Organization Structure



* Joint Venture between The University of Chicago Medical Center (Class A Member with controlling interest) and Adventist Health System/Sunbelt, Inc. (Class B Member) in which Adventist Midwest Health holds a non-controlling interest. Includes Advent LaGrange Hospital, Advent Bolingbook Hospital, Advent Glen Oaks Hospital and Advocate Hinsdale Hospital.

ATTACHMENT 4

Section I, Flood Plain Requirement

Attachment 5

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

SECTION XI -SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM

In accordance with Executive Order 2006-5 (EO 5), the Health Facilities & Services Review Board (HFSRB) must determine if the site of the CRITICAL FACILITY, as defined in EO 5, is located in a mapped floodplain (Special Flood Hazard Area) or a 500-year floodplain. All state agencies are required to ensure that before a permit, grant or a development is planned or promoted, the proposed project meets the requirements of the Executive Order, including compliance with the National Flood Insurance Program (NFIP) and state floodplain regulation.

1. Applicant: University of Chicago Medical Center, 5841 S. Maryland Avenue
(Name) (Address)
Chicago IL 60637
(City) (State) (ZIP Code) (Telephone Number)

2. Project Location: 5654 South Drexel Ave Chicago IL 60637
(Address) (City) (State)
Cook
(County) (Township) (Section)

3. You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (https://msc.fema.gov/portal/home) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the *Go To NFHL Viewer* tab above the map. You can print a copy of the floodplain map by selecting the icon in the top corner of the page. Select the pin tool icon and place a pin on your site. Print a FIRMETTE size image.

If there is no digital floodplain map available select the View/Print FIRM icon above the aerial photo. You will then need to use the Zoom tools provided to locate the property on the map and use the **Make a FIRMette** tool to create a pdf of the floodplain map.

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA: Yes___ No X

IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN? No

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance.
If the determination is being made by a local official, please complete the following:

FIRM Panel Number:_____ Effective Date:_____

Name of Official:_____ Title:_____

Business/Agency_____ Address:_____

(City) (State) (ZIP Code) (Telephone Number)

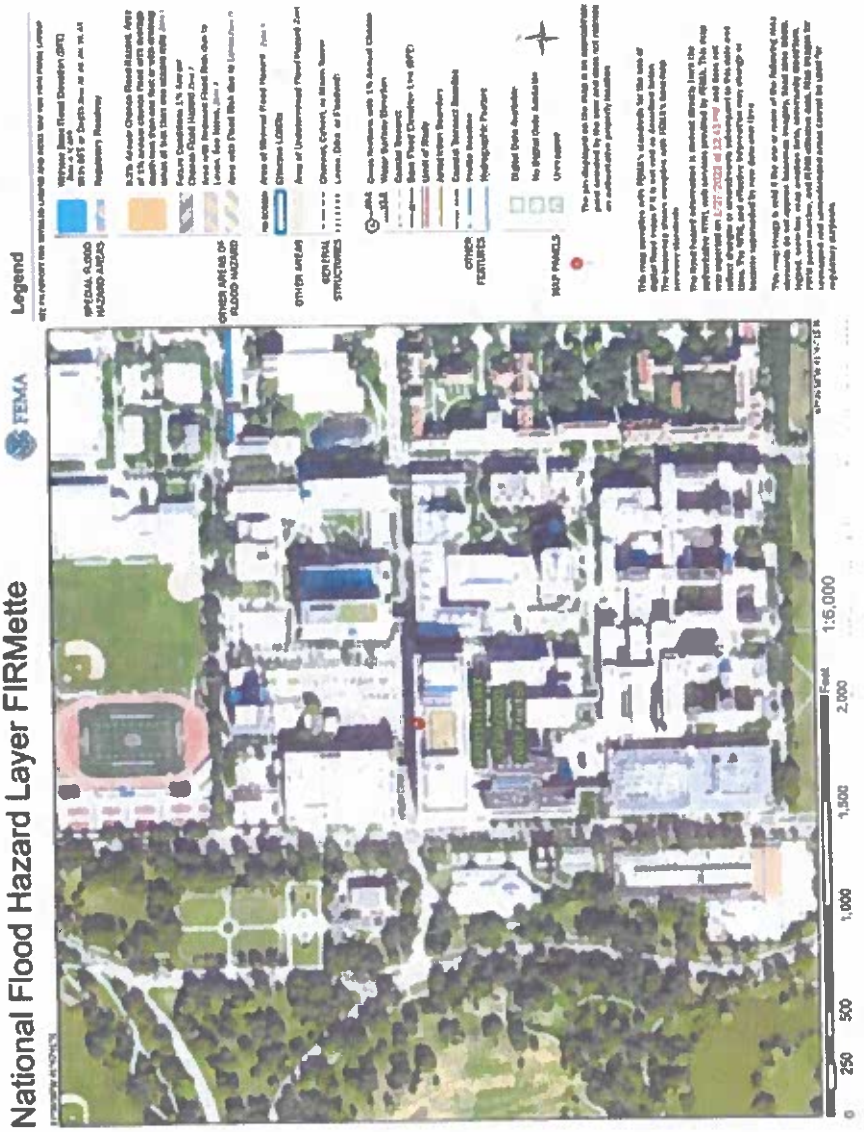
Signature:_____ Date:_____

NOTE: The finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

If you need additional help, contact the Illinois Statewide Floodplain Program at 217/782-4428

39413609.4

ATTACHMENT 5


National Flood Hazard Layer FIRMette
FEMA
Legend
SPECIAL FLOOD HAZARD AREAS
OTHER AREAS OF FLOOD HAZARD
OTHER AREAS
GENERAL STRUCTURES
OTHER FEATURES
MAP PANELS
1:6,000
Feet
0
250
500
1,000
1,500
2,000

Section I, Historic Resources Preservation Act Requirements

Attachment 6

Attached is a letter from the Illinois Department of Natural Resources indication that no historic, architectural or archaeological sites exist within the Project area.

ILLINOIS DEPARTMENT OF NATURAL RESOURCES

Illinois Department of
Natural Resources

One Natural Resources Way Springfield, Illinois 62702-1271
www.dnr.illinois.gov

JB Pritzker, Governor
Colleen Callahan, Director

Cook County
Chicago
5654 South Drexel Avenue
IHFSRB
New construction, cancer hospital - University of Chicago Medical Center

PLEASE REFER TO: SHPO LOG #001021022

February 23, 2022

Joe Ourth
Saul Ewing Arnstein & Lehr LLP
161 N. Clark, Suite 4200
Chicago, IL 60601

Dear Mr. Ourth:

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

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

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

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

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

If further assistance is needed please contact Jeff Kruchten, Chief Archaeologist at 217/785-1279 or jeffery.kruchten@illinois.gov.

Sincerely,

Carey L. Mayer

Carey L. Mayer, AIA
Deputy State Historic
Preservation Officer

ATTACHMENT 6

Section I, Project Costs and Source of Funds

Attachment 7

Section 1120.110, Project Costs and Sources of Funds

Project Costs and Sources of Funds			
USE OF FUNDS	**REVIEWABLE**	**NONREVIEWABLE**	**TOTAL**
Preplanning Costs			
Site Survey and Soil Investigation	$210,000	$490,000	$700,000
Site Preparation	$4,075,214	$9,508,832	$13,584,046
Off Site Work	$1,442,100	$3,364,901	$4,807,001
New Construction Contracts	$141,343,067	$329,548,365	$470,891,432
Modernization Contracts		$2,863,539	$2,863,539
Contingencies	$14,134,307	$33,241,190	$47,375,497
Architectural/Engineering Fees	$7,454,09	$17,392,782	$24,846,831
Consulting and Other Fees	$8,833,335	$20,611,116	$29,444,451
Movable or Other Equipment (not in construction contracts)	$71,463,795	$27,073,900	$98,537,695
Bond Issuance Expense (project related)	$1,216,701	$2,838,968	$4,055,669
Net Interest Expense During Construction (project related)	$20,257,800	$47,268,200	$67,526,000
Fair Market Value of Leased Space or Equipment			
Other Costs to Be Capitalized	$15,144,152	$35,336,356	$50,480,508
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	$285,574,521	$529,538,149	$815,112,669
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**
Cash and Securities	$128,074,521	$237,038,149	$365,112,669
Pledges			
Gifts and Bequests			
Bond Issues (project related)	$157,500,000	$292,500,000	$450,000,000
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	$285,574,521	$529,538,149	$815,112,669

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

	Cost Detail Total	Cost Detail Clinical	Cost Detail Non-Clinical
Preplanning Comments			
In Master CON			
Site Survey and Soil Investigation			
Soil Testing	$ 700,000	$ 210,000	$ 490,000
	$ 700,000	$ 210,000	$ 490,000
Site Preparation			
Earthwork	$ 1,120,050	$ 336,015	$ 784,035
Hardscape	$ 1,113,846	$ 334,154	$ 779,692
Landscaping	$ 2,475,050	$ 742,515	$ 1,732,535
Other	$ 8,875,100	$ 2,662,530	$ 6,212,570
	$ 13,584,046	$ 4,075,214	$ 9,508,832
Off Site Work			
Network & Pneumatic Tube Connection	$ 4,807,001	$ 1,442,100	$ 3,364,901
	$ 4,807,001	$ 1,442,100	$ 3,364,901
New Construction	$ 470,891,432	$ 141,343,067	$ 329,548,365
Modernization	$ 2,863,539		$ 2,863,539
Contingencies	$ 47,375,497	$ 14,134,307	$ 33,241,190
Architectural Engineering Fees	$ 24,846,831	$ 7,454,049	$ 17,392,782
Consulting and Other Fees			
Capitalized Staff Salaries	$ 11,703,858	$ 3,511,157	$ 8,192,701
Project Management	$ 1,980,000	$ 594,000	$ 1,386,000
Cost and Peer Review	$ 764,500	$ 229,350	$ 535,150
Public Relations	$ 440,000	$ 132,000	$ 308,000
Utility	$ 137,500	$ 41,250	$ 96,250
Legal	$ 1,595,000	$ 478,500	$ 1,116,500
Donor/Philanthropy	$ 605,000	$ 181,500	$ 423,500
Testing/Inspections	$ 3,194,114	$ 958,234	$ 2,235,880
Commissioning	$ 2,899,116	$ 869,735	$ 2,029,381
IT Consulting	$ 658,177	$ 197,453	$ 460,724
Landscaping	$ 269,501	$ 80,850	$ 188,651
Signage and Wayfinding	$ 363,756	$ 109,127	$ 254,629
Medical Equipment Planning	$ 460,955	$ 138,287	$ 322,669
Vertical Transportation Consulting	$ 152,417	$ 45,725	$ 106,692
Acoustical/Vibration Consulting	$ 136,695	$ 41,009	$ 95,687
Lighting Consulting	$ 596,881	$ 179,064	$ 417,817
Hardware Consulting	$ 17,545	$ 5,264	$ 12,282
Permit Expeditor	$ 55,825	$ 16,748	$ 39,078
Exterior Enclosure Consulting	$ 301,455	$ 90,437	$ 211,019
Misc. Consulting	$ 2,924,250	$ 877,275	$ 2,046,975
Sustainability - LEED Consulting	$ 187,906	$ 56,372	$ 131,534
	$ 29,444,451	$ 8,833,335	$ 20,611,116

Moveable and Other Equipment			
Medical Equipment			
Inpatient	$ 6,736,117	$ 6,736,117	
Imaging	$ 19,088,699	$ 19,088,699	
Breast Center	$ 6,677,308	$ 6,677,308	
Exam Rooms	$ 1,469,605	$ 1,469,605	
Infusion	$ 3,216,467	$ 3,216,467	
ORAC	$ 783,905	$ 783,905	
Pharmacy	$ 7,797,464	$ 7,797,464	
Phlebotomy	$ 110,358	$ 110,358	
Rehab/Nutrition	$ 254,518	$ 254,518	
HTRC & Biofluids	$ 1,161,691	$ 1,161,691	
Furniture	$ 13,778,285	$ 4,133,486	$ 9,644,800
Artwork/Graphics	$ 1,017,500	$ 305,250	$ 712,250
Support Services Equipment	$ 1,265,000	$ 379,500	$ 885,500
IT Equipment Management	$ 1,949,746	$ 1,072,360	$ 877,386
Network Equipment	$ 19,357,800	$ 10,646,790	$ 8,711,010
Clinical Systems	$ 8,861,441	$ 4,873,793	$ 3,987,648
Technology Devices	$ 5,011,792	$ 2,756,486	$ 2,255,306
	$ 98,537,695	$ 71,463,795	$ 27,073,900
Other Costs to be Capitalized			
Air Monitoring	$ 253,000	$ 75,900	$ 177,100
Utility Usage	$ 4,713,038	$ 1,413,911	$ 3,299,127
Electric Service	$ 2,970,000	$ 891,000	$ 2,079,000
Security	$ 6,118,640	$ 1,835,592	$ 4,283,048
Mock-ups	$ 2,722,500	$ 816,750	$ 1,905,750
Transition/Activation	$ 8,442,500	$ 2,532,750	$ 5,909,750
Other	$ 2,685,582	$ 805,675	$ 1,879,907
Permit Fees	$ 2,493,618	$ 748,085	$ 1,745,533
Technology Infrastructure	$ 5,624,960	$ 1,687,488	$ 3,937,472
Master Antenna/RFID	$ 5,088,710	$ 1,526,613	$ 3,562,097
Security Systems	$ 4,443,230	$ 1,332,969	$ 3,110,261
Facilities Systems	$ 1,424,900	$ 427,470	$ 997,430
Technology Project Management	$ 3,499,830	$ 1,049,949	$ 2,449,881
	$ 50,480,508	$ 15,144,152	$ 35,336,356

Section I, Cost Space Requirements

Attachment 9

Cost Space Requirements

Reviewable	Cost	BGSF Existing	BGSF Proposed	BGSF New	BGSF Modernization	As-Is	BGSF Vacated Space
Medical / Surgical	$80,754,936	0	58,085	58,085	0	0	0
ICU	$22,151,840	0	14,864	14,864	0	0	0
General Radiology	$24,885,249	0	14,722	14,722	0	0	0
Breast Center	$11,015,404	0	7,923	7,923	0	0	0
Outpatient Clinics	$54,113,301	0	38,316	38,316	0	0	0
Infusion Therapy	$41,759,583	0	28,994	28,994	0	0	0
Outpatient Cell Therapy (OCT)	$8,197,791	0	4,850	4,850	0	0	0
ORAC	$14,351,335	0	8,318	8,318	0	0	0
Phlebotomy	$2,372,430	0	1,777	1,777	0	0	0
Wellness	$5,455,051	0	4,074	4,074	0	0	0
Cancer Ancillaries	$20,517,599	0	12,898	12,898	0	0	0
Total Reviewable	$285,574,521	0	194,820	194,820	0	0	0
Non-Reviewable							
Building Support	$185,454,257	0	103,960	103,960	0	0	0
Staff Support	$40,577,589	0	33,566	33,566	0	0	0
Public	$134,844,587	4,091	88,749	88,749	4,091	0	0
Administrative Offices	$3,645,068	0	3,215	3,215	0	0	0
Shell	$153,914,866	0	135,739	135,739	0	0	0
Bridges	$8,295,636	0	2,204	2,204	0	0	0
Tunnel	$2,806,146	0	1,258	1,258	0	0	0
Total Non-Reviewable	$529,538,148	4,091	368,691	368,691	4,091	0	0
Project Totals:	$815,112,669	4,091	563,511	563,511	4,091	0	0

Section III, Background of Applicant

Attachment 11

Section 1110.230, Background, Purpose of the Project and Alternatives

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

   UCMC's full general hospital license #0003897, effective July 1, 2022, issued by the Illinois Department of Public Health ("IDPH"), is attached. UCMC's most recent accreditation letter from the Joint Commission is attached.

   UCMC also owns Ingalls Memorial Hospital ("Ingalls Hospital") and Ingalls Same Day Surgery Center, an ambulatory surgery treatment center ("Ingalls ASTC").

   Ingalls Hospital's full general hospital license is #0001099, effective January 1, 2022.

   Ingalls ASTC's ambulatory surgery treatment center license #7001043, effective June 18, 2021.

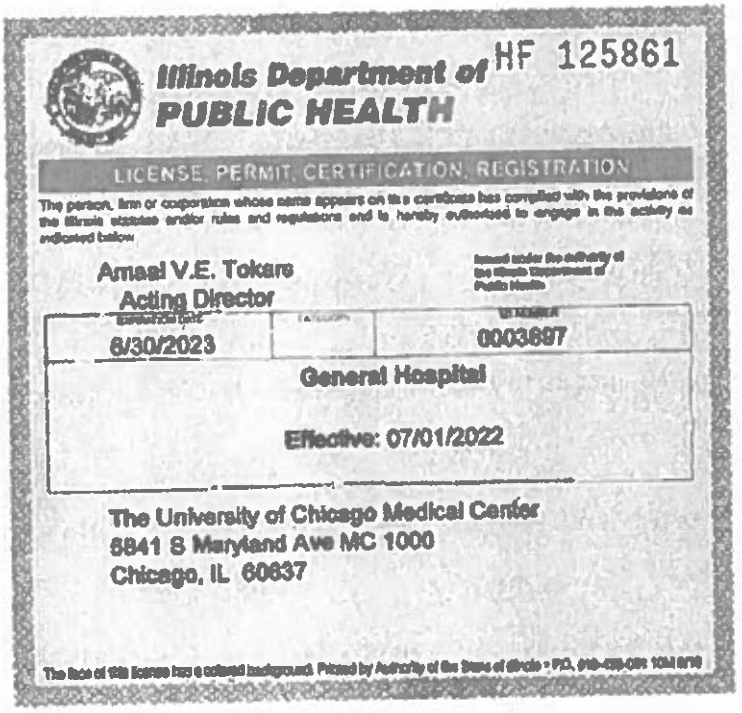
   Effective January 1, 2023, UCMC is also an owner in a joint venture, Adventist Midwest Health, which owns Advent LaGrange Hospital, Advent Bolingbrook Hospital, Advent Hinsdale Hospital and Advent Glen Oaks Hospital

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

   By signature of this application, UCMC certifies that there has been no adverse actions taken against UCMC within the prior three years.

3. **Authorization permitting HFSRB and DPH access to documents necessary to verify the information submitted, including, but not limited to: official records of DPH or other State agencies; the licensing or certification records of other States; when applicable; and the records of nationally recognized accreditation organizations.**

   By its signature to this application, UCMC grants the Review Board and the IDPH access to information to verify information in the application.



Illinois Department of PUBLIC HEALTH

HF 125861

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

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

Amaal V.E. Tokars
Acting Director

Issued under the authority of the Illinois Department of Public Health

Expiration Date: 6/30/2023

License Number: 0003697

General Hospital

Effective: 07/01/2022

The University of Chicago Medical Center
5841 S Maryland Ave MC 1000
Chicago, IL 60637

The face of this license has a colored background. Printed by Authority of the State of Illinois • P.O. 018-039-001 10M 6/19

← DISPLAY THIS PART IN A CONSPICUOUS PLACE

Exp. Date 6/30/2023

Lic Number 0003697

Date Printed 6/30/2022

The University of Chicago Medical Cen

5841 S Maryland Ave MC 1000
Chicago, IL 60637

FEE RECEIPT NO.

ATTACHMENT 11

The Joint Commission

October 17, 2022

Krista Curell, JD, RN
Associate Vice President, Integrity
University of Chicago Medical Center
5841 South Maryland Avenue
Chicago, IL 60637

Re: # 7315
CCN: # 140088
Deemed Program: Hospital
Accreditation Expiration Date: July 16, 2025

Dear Ms. Curell:

This letter confirms that your July 11, 2022 - July 15, 2022 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on October 6, 2022 and the successful unannounced Medicare Deficiency follow-up event conducted on August 24, 2022, the area of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of July 16, 2022. We congratulate you on your effective resolution of these deficiencies.

§482.51 Surgical Services

The Joint Commission is also recommending your organization for continued Medicare certification effective July 16, 2022. Please note that the Centers for Medicare and Medicaid Services (CMS) Medicare Administrative Contractor (MAC) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following location(s):

University of Chicago Hospitals and Health Systems
5841 South Maryland Avenue, Chicago, IL, 60637

Outpatient Senior Health Center at South Shore
7101 S. Exchange Avenue, Chicago, IL, 60637

University of Chicago Hospitals and Health Systems
d/b/a Comer Children's Hospital
5721 South Maryland Avenue, Chicago, IL, 60637

The Joint Commission

Joliet Cancer Center - Physician Office
1850 Silver Cross Blvd., New Lenox, IL, 60451

UCMC Orland Park Center for Advanced Care
14290 South La Grange Road, Orland Park, IL, 60462

UCMC South Loop
1101 South Canal Street Suit 201 & 202 Chicago, IL, Chicago, IL, 60607

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

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations

cc: CMS/Baltimore Office/Survey & Certification Group/Division of Acute Care Services
CMS/SOG Location 5 /Survey and Certification Staff

www.jointcommission.org

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

ATTACHMENT 11

Illinois Department of PUBLIC HEALTH

HF 123993

LICENSE, PERMIT, CERTIFICATION REGISTRATION

Ngozi O. Ezike, M.D.
Director

12/31/2022		0001099

General Hospital

Effective: 01/01/2022

Ingalls Memorial Hospital
1 Ingalls Drive
Harvey, IL 60426

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Exp. Date 12/31/2022
Lic Number 0001099

Date Printed 10/12/2021

Ingalls Memorial Hospital
1 Ingalls Drive
Harvey, IL 60426

FEE RECEIPT NO.

ATTACHMENT 11

Section III, Purpose of Project

Attachment 12

Executive Summary

- **A dedicated comprehensive cancer facility (inpatient hospital and outpatient ambulatory) will enhance access to a broad continuum of cancer care and prevention on the South Side of Chicago where the incidence and mortality from cancer is disproportionately high and the available resources are disproportionately low.**

A half-century ago, a cancer diagnosis seemed unbeatable. Despite remarkable advances in detection and treatment during this time, the benefits have not been distributed equally, and the prognosis for many cancers, and many populations with cancer, remains poor, with residents on the South Side having some of the worst outcomes . People who live on the South Side of Chicago are twice as likely to die from cancer than those who live just about anywhere else in America.

Cancer is the second leading cause of death on the South Side. The problem is expected to worsen in the years ahead, with the incidence of cancer projected to grow 19% in the next five years on the South Side compared to only 9.1% in the five collar counties surrounding the City. Currently, 67% of South Side residents leave their communities to get cancer care. Compared to North Side residents, South Siders in some neighborhoods have a 30-year lower life expectancy. Black women are also 40% more likely than white women to die from the same cancer.

Residents on the South Side of Chicago face many health care injustices, and UCMC recognizes the problem not just as one of biology, but largely a problem of zip code, which accounts for many social determinants of health.

- **UCMC knows that the war on cancer is a team effort. Robust community and patient engagement has been at the core of the design process.**

Throughout the Master Design process, UCMC engaged effectively with not just architects and consultants, but also current and former patients, community hospitals and health centers, as well as scientists and direct health care providers, as UCMC seeks to enhance not just cancer care but the entire level of care on the South Side.

UCMC has fostered strong relationships with civic leaders, community organizations, health care providers and residents to improve health and access to quality care on the South Side of Chicago, culminating in its work to bring Adult Level I Trauma to the South Side four years ago. UCMC actively reached out to all of the community hospitals in its Planning Area A-03 prior to submitting its application for a Master Design Permit. Support from community hospitals and religious and civic leaders remains strong, and UCMC is pleased that this application will be followed by their letters of support.

In a community where cervical cancer mortality is almost as high of several of the poorest nations in the world, UCMC knows it cannot fight for health equity without the community at its side, and that it cannot build a patient-centered dedicate, comprehensive cancer facility without the voice of its patients at the core.

- **Cancer is not a single disease, but a collection of hundreds of diseases, and no two patients' cancers are the same.**

Traditional therapies for cancer, or "one size fits all" approach, such as surgery, chemotherapy and radiation, underestimate the aggressiveness and heterogeneity of cancer. Precision and personalized medicine ("PPM") is the future of cancer therapy, which means the development of specialized treatments for each type of cancer that can be tailored to specific targets based on an understanding of a patient's genetic data. More and more, it is possible to identify the cancer treatments that are likely to be most effective, minimizing damage to healthy tissues as well as harsh side effects, which may include targeted antibodies, cancer vaccines, and T-cell therapies, for which UCMC has been a national leader.

- **UCMC seeks to build a world-class, comprehensive cancer facility that has not been built before with a data-driven design that facilitates interdisciplinary collaboration both in the lab and at the patient's bedside, whether in the clinic or in the hospital, and care delivery that is compassionate and empowering.**

Whether from its own community, or drawn regionally, nationally, or internationally, UCMC's patients and their families inspire its scientists on the mission of discovery. Bringing care to those who need it most takes scientific discovery and advanced technology, but it also takes heart and vision to see beyond what is visible.

Renowned for treating some of the most complex medical cases, UCMC brings the very latest medical treatments to patients in Chicago and continues to invest in the capital resources necessary to maintain this effort. Chimeric antigen receptor T-cell therapy (CAR-T Therapy) is one prime example of UCMC's pioneering efforts and is one of the biggest advances in cancer treatment in recent years. Viral-vector based gene therapies and the potential to manufacture such viral vectors on its campus is another.

One of the major challenges to harnessing the power of personalized medicine is the interpretation of enormous amounts of data, for which special technology, a robust computing infrastructure and data processing algorithms play a major role. The new cancer facility will create an environment wired to consume and analyze rich stores of patient data to better flex a "molecule to medicine" approach, to improve outcomes for patients and, ultimately, to save lives.

Yet cutting-edge, clinical excellence is not enough – UCMC wants every patient and family member who comes through the doors of this facility to feel they have come to the right place. This means professionalism in approach, sensitivity to needs, and depth of expertise offering answers to the most complex and difficult questions.

UCMC's path to transformative cancer care is not just a physical structure but a dynamic, healing environment that centered around the patient, bringing clinical and supportive services to the patients, leveraging technology, and integrating the latest research for the best outcomes.

- **UCMC seeks to build a comprehensive cancer facility that is dedicated to cancer prevention and screening.**

UCMC understands that a comprehensive cancer facility means more to the community than treatments and medication for when they get sick but a place to help them stay well. For this reason, UCMC transformed the design of the ground floor of the building to be a mainstay of health and wellness for all comers by providing a healing environment to welcome patients along all stages of their treatment journey. It proposes a community hub for cancer prevention, screening and diagnoses with healthy lifestyle and wellness classes and other educational resources. The facility will include amenities to support the treatment and experience including comforts during extended stays, psycho-social and spiritual support, navigation and resource support.

Section III, Purpose of Project
Attachment 12

Overview

Purpose of Project. The purpose of the Project is to construct a dedicated comprehensive cancer facility (inpatient and ambulatory) on the University of Chicago Medical Center's ("**UCMC**") Hyde Park campus on the South Side of Chicago following a strategic and inclusive design phase. As a National Cancer Institute ("**NCI**") designated Comprehensive Cancer Center, UCMC knows that the war on cancer is a team effort. Cancer is not a single disease, but a collection of hundreds of diseases, and there is no single solution to get over the finish line.

As a critical first step, UCMC received approval for a Master Design Permit to expend funds in excess of the capital threshold for activities such as architectural services and site preparation. The primary costs were for determining and developing the vision and design of a dedicated cancer hospital to optimize care for the future. With the Master Design Permit, UCMC engaged effectively with the representation of the entire team, not just architects and consultants, but also current and former patients, community hospitals and health centers, as well as scientists and direct health care providers. UCMC seeks to enhance not just cancer care but the entire level of care on the South Side necessary to keep patients healthy and to save lives.

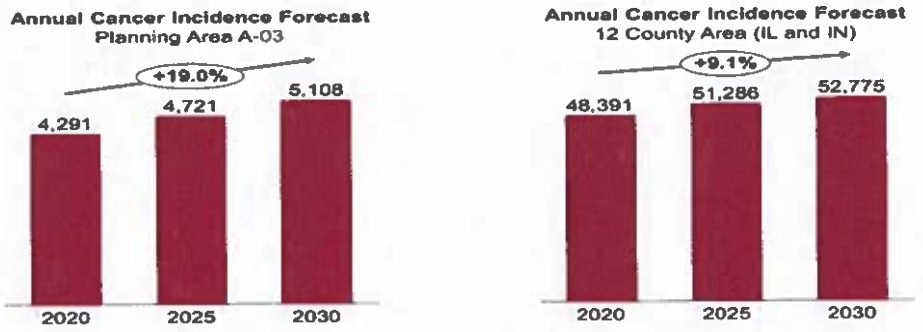
The purpose of a dedicated comprehensive cancer facility is to enhance access to the full continuum of cancer care to the South Side of Chicago in communities where the incidence and mortality from cancer is disproportionately high and the available resources are disproportionately law. With 50 years as an NCI-designated cancer center, UCMC seeks to further its mission by building a world-class comprehensive cancer facility to continue to address the disparate distribution of high-quality health care resources in the communities that UCMC serves.

For decades, the 900,000 residents of the South Side of Chicago have experienced health disparities ranging from materially higher disease incidence and comorbidities to significantly lower life expectancy. These health disparities reflect a history of racial inequities and underinvestment – both of which have contributed to a fragmented healthcare delivery landscape with limited resources. Today, over 50% of all adult South Side residents leave the South Side to receive their care and almost two-thirds of all adult South Side residents specifically leave for cancer care.

These trends have been both caused and been compounded by insufficient, inadequate and declining medical services in both primary and specialty care: there is a stark shortage of primary care and OB providers; the CMS star rating for most hospitals on the South Side falls below the national average; and there has been over a dozen inpatient service or hospital closures in the past ten years – all contributing to the large number of South Side residents leaving their community for care. Paradoxically, this dearth of care has partly contributed to overutilization as high as 60% in expensive emergency and inpatient settings, including at UCMC, even as local hospitals continue to see occupancy of less than 60% due to outmigration. The end result of these care delivery challenges is a staggering disparity in health outcomes: compared to North Side

residents, South Siders in some neighborhoods have a 30 year lower life expectancy, the problem is expected to grow worse in the years ahead, with the incidence of cancer projected to grow 19% in Planning Area A-03 in the next ten years compared to 9.1% in the 12 county metropolitan area over the same time frame. These tolls have been further exacerbated by the COVID-19 pandemic, as evidenced in the highly disparate unemployment and death rates relative to white residents and North Side neighborhoods.

Cancer Incidence Forecast



Incidence of cancer is expected to grow 9.1% in the 12 County Metro Area, and 19.0% in the A-03 Planning Area over 10 years

AT THE FOREFRONT UChicagoMedicine

Source: Advisory Board Cancer Incidence Estimator, based on incidence rates from NCI SEER Program

The Federal Government declared a war on cancer a little more than 50 years ago with the passage of the National Cancer Act (the "**Act**") and created the National Cancer Institute to promote and to coordinate the significant nexus of cancer research, treatment and community engagement. The NCI was charged with establishing cancer centers throughout the United States and to bringing treatment closer to a patient's home. This milestone recognizes years of growth in cancer prevention, diagnostics and treatment and reinvigorates the need for specialized cancer centers to coordinate the full spectrum of cancer research, from the most basic to the most applied, to improve the implementation of therapies, and to help patients live longer and healthier lives.

Although the 50th Anniversary of the Act recognized the progress that has been made during this time, there is a long way to go to reduce the burden of cancer for everyone. The understanding of cancer is dramatically different than it was a few decades ago. At a fundamental level, it starts with the understanding of genes; some of this information has been translated into improving lives, and the outcome is far better than before. It is clear that no two patients' cancers are the same, and the standard of care therapies, or "one size fits all" approach, such as surgery, chemotherapy and radiation underestimate the aggressiveness and heterogeneity of cancer.[1] Precision and personalized medicine ("PPM") is the future of cancer care, which means the

[1] **The growing role of precision and personalized medicine for cancer treatment** Paulina Krzyszczyk, Alison Acevedo, Erika J. Davidoff, Lauren M. Timmins, Ileana Marrero-Berrios, Misaal Patel, Corina White, Christopher Lowe, Joseph J. Sherba, Clara Hartmanshen, Kate M. O'Neill, Max L. Balter, Zachary R. Fritz, Ioannis P. Androulakis, Rene S. Schloss & Martin L. Yarmush; Technology 2018:06:79-100.

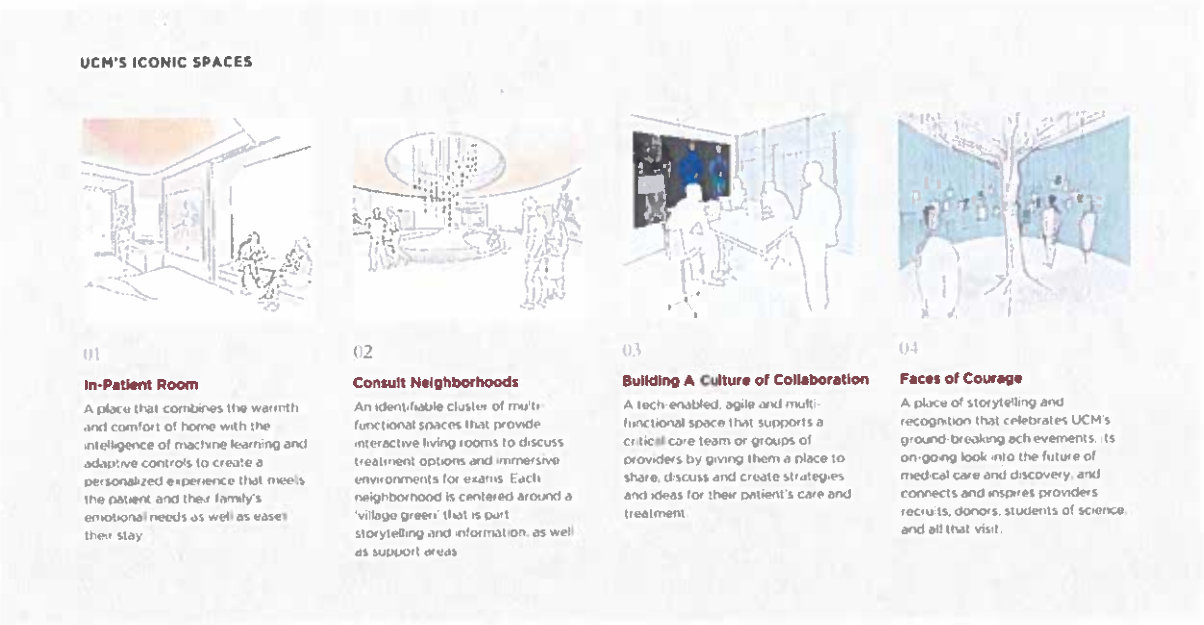
development of specialized treatments for each type of cancer that can be tailored to specific targets based on an understanding of a patient's genetic data.

One of the major challenges to harnessing the power of PPM is in the interpretation of these enormous data sets, for which special technology, a robust computing infrastructure and data processing algorithms play a major role. More and more, it is possible to identify the cancer treatments that are likely to be most effective, minimizing damage to healthy tissues as well as harsh side effects, which may include targeted antibodies, cancer vaccines, and T-cell therapies, for which UCMC has been a national leader.

UCMC believes it is the responsibility of a NCI-designated comprehensive cancer center to continue to push the envelope in the delivery of cancer care, a move taken by many of UCMC's peer institutions in the U.S. that built cancer centers within the past ten years. But UCMC is not seeking to build a facility comparable to its peers, it seeks to build a facility that has not been built before – one that recognizes the revolution underway in cancer therapies because of the understanding of cancer at the molecular level, that is ready to grow with the future of cancer research, and that can optimize the delivery of cutting-edge treatment.

A cancer diagnosis is complicated, and patients are understandably anxious and looking for solutions. The science behind cancer is also complicated, and a lot more is learned about cancer each year. While many facets of a cancer diagnosis are complex, UCMC wants to design a facility that makes navigating the continuum of cancer care cancer as simple, welcoming and efficient as possible. The proposed comprehensive cancer facility would put patients and their families first and strive to provide a full-service, personalized experience – from the environment of care to the cancer therapy itself. UCMC also recognizes a comprehensive cancer facility means more to them than treatments and medication but a place to help its community stay well. For this reason, UCMC transformed the design of the ground floor of the building to be a mainstay of health and wellness for all comers by providing a healing environment to welcome patients along all stages of their treatment journey.

UCMC wants every patient and family member who comes through the doors of this facility to feel they have come to the right place. This means professionalism in approach, sensitivity to needs, and depth of expertise offering answers to the most complex and difficult questions. UCMC's path to transformative cancer care is not just a physical structure but a dynamic, healing environment of "iconic spaces" that center around the patient, bringing clinical and supportive services to the patients, leveraging technology, and integrating the latest research for the best outcomes.



UCMC is not waiting until the cancer facility is built to reduce the burden of a cancer diagnosis or the inequities in access to treatment. The American Cancer Society ("ACS") just awarded the University of Chicago Medicine Comprehensive Cancer Center (UCCCC) a multi-year grant for a program to enhance oncology patient navigation and to address barriers to individualized, timely and equitable care for cancer patients and their families, one of only 14 hospitals to receive the grant across the nation. Patient navigation is one of the only evidence-based interventions to eliminate health disparities and improve health equity in cancer care.

Navigation is a crucial component of cancer care, from prevention through treatment and survivorship. By providing individualized assistance to patients, families and caregivers, navigation ensures high-quality health and psychosocial care, creating positive health outcomes for patients. Ultimately, UCMC hopes to use this reimagined oncology navigation model in its new dedicated, comprehensive cancer facility to support all of its patients.

Whether from its own community, or drawn regionally, nationally, or internationally, UCMC's patients and their families inspire its scientists on the mission of discovery. Bringing care to those who need it most takes scientific discovery and advanced technology, but it also takes heart and vision to see beyond what is visible.

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.

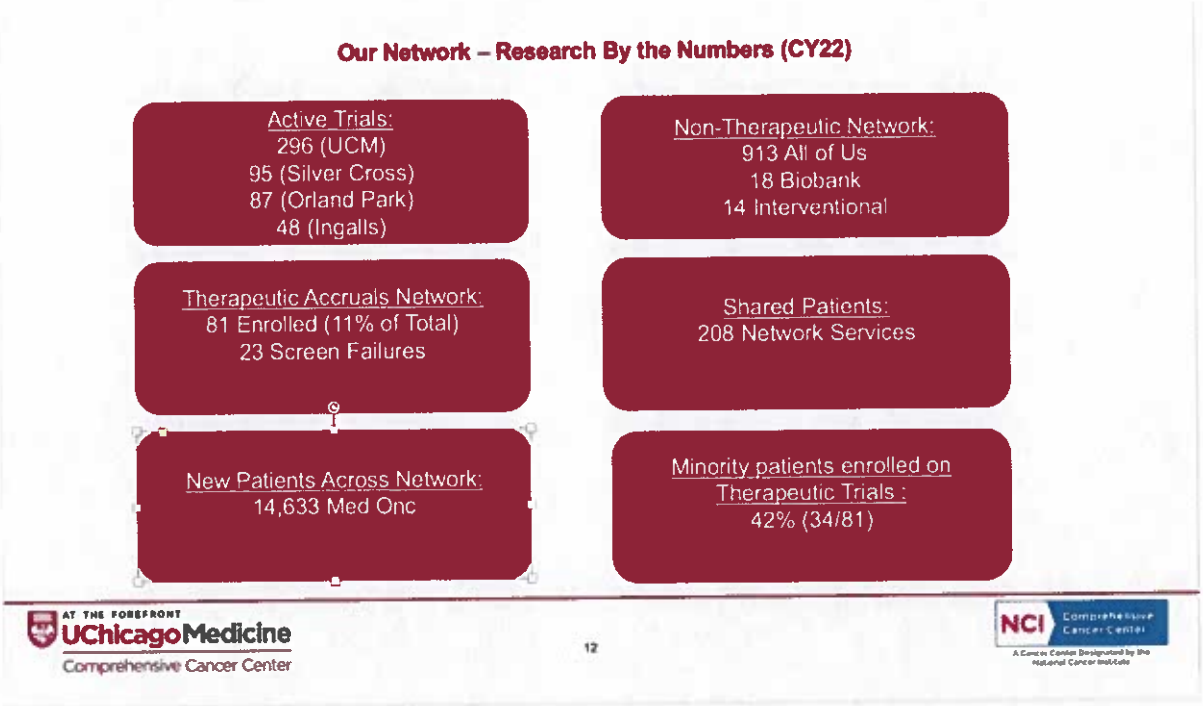
UCMC has been serving the City of Chicago since 1927 and is one of the nation's leading academic medical institutions. Its mission is to provide superior health care in a compassionate manner, ever mindful of each patient's dignity and individuality. To accomplish this mission, UCMC relies upon the skills and expertise of all who work together to advance medical innovation, serve the health needs of the community and further the knowledge of those dedicated to caring for patients.

ATTACHMENT 12

UCMC is a nationally recognized leader in patient care, research and medical education and is the primary teaching hospital for the University of Chicago, Pritzker School of Medicine. UCMC is the sole academic medical center on the South Side of Chicago. It is the closest support for the surrounding community hospitals, offering a full array of tertiary and quaternary patient services otherwise not available in the planning area. Renowned for treating some of the most complex medical cases, UCMC brings the very latest medical treatments to patients in Chicago 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. Through the Project, UCMC seeks to facilitate access to integrated, interdisciplinary ambulatory and inpatient cancer care, to reduce wait times to treatment initiation and for ongoing appointments, and to minimize travel distances for existing patients who currently leave the planning area for care.

The mission of the Comprehensive Cancer Center is three-fold: to discover what leads to cancer and to expand screening, prevention and treatment, train the next generation of cancer clinicians and researchers and bring advances in cancer to the surrounding community. The Medical Center's cancer care program was again recognized in 2022 by the Quality Oncology Practice Initiative (QOPI®), an affiliate of the American Society of Clinical Oncology. This three-year certification means that its outpatient hematology-oncology practice meets the highest standards for quality and care delivery to cancer patients.

The Medical Center and its more than 200 cancer researchers and physicians are committed to developing innovative ways to prevent and reduce cancer's devastating effects. Over the past three years, UCMC participated in 321 clinical trials for cancer treatment and accrued over 4,000 patients to those trials, including 1,341 minority patients. Additionally, during this same time period, UCMC faculty published more than 1300 peer-reviewed, journal articles with their research findings. In 2021, even in midst of the public health emergency, faculty published 441 scholarly articles, and a representative list of these publications has been included at the end of this section. In 2022, UCM's Cancer Network, which includes UCMC, Ingalls, and its Joint Venture at Silver Cross, saw 14,633 new medical/oncology patients.



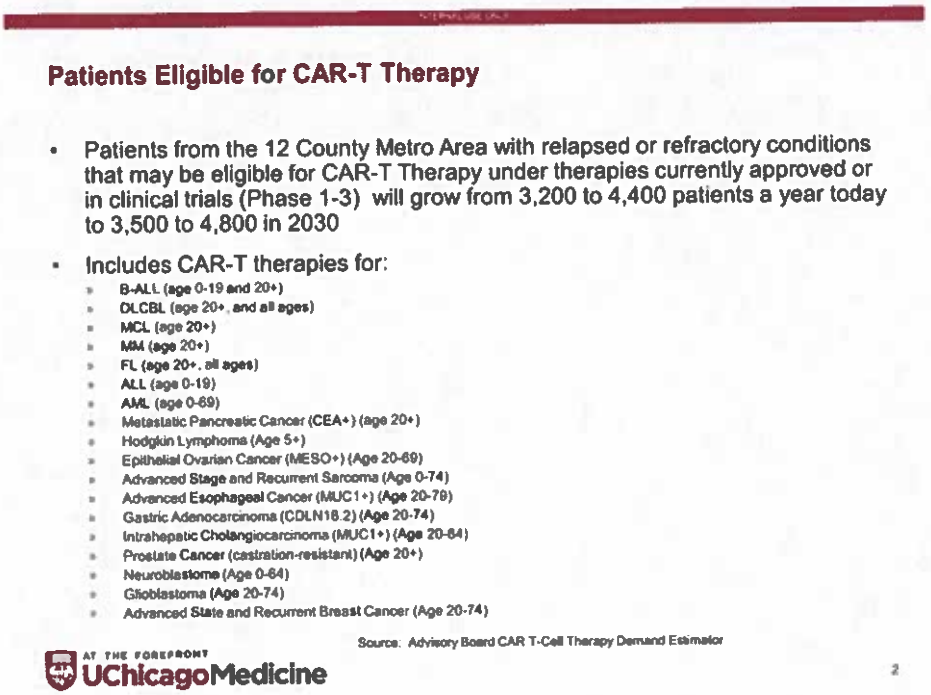
UCMC's aspiration is that the proposed comprehensive cancer facility will be a conduit towards a cure for cancer and knows its patients and their families inspire its scientists on the mission of discovery. Renowned for treating some of the most complex medical cases, UCMC brings the very latest medical treatments to patients in Chicago and continues to invest in the capital resources necessary to maintain this effort. Chimeric antigen receptor T-cell therapy (CAR-T Therapy) is one prime example of UCMC's pioneering efforts and is one of the biggest advances in cancer treatment in recent years. It is an approach to cellular therapy where cells are collected from a patient, modified in a lab so that they can find and destroy cancer cells, and returned to the patient's body to do this important work.

UCMC was the first hospital in Illinois and one of the first few in the country to offer CAR-T Therapy. UCMC started to offer CAR-T in 2016 in clinical trials. Since then, UCMC has done over 250 adult cell therapy infusions of commercial products and clinical trials. UCMC was the first center in the country to offer Novartis's Kymriah® for all three of its indications and the second center to offer Kite's Yescarta®. UCMC also has one of the largest cell therapy clinical trial portfolios in the US with trials in leukemia, lymphoma, multiple myeloma, and several solid tumors (breast, cervical, melanoma, NSCLC, GI malignancies, and H&N cancers).

UCMC has also built a state- of-the-art cell therapy lab to be able to offer CAR-T and other cellular therapies. UCMC has demonstrated both the ability to take care of cancer patients and the ability to work with pharmaceutical partners with product development as part of the clinical trial process for CAR-T therapy – highlighting its basic and translational research. UCMC continues to offer twice as many clinical trials for CAR-T therapies than any other hospital in Illinois, and has the most doctors recognized for their research in cellular therapy. UCMC is currently offering therapies not available elsewhere in Illinois, and that are only available at five (5) to six (6) medical centers across the US.

ATTACHMENT 12

CAR-T therapy is used for patients with relapsed and refractory cancers, where conventional cancer treatments have not been effective. Multiple Myelomas are one of the focus areas for CAR-T therapy, which is a disease that disproportionately affects African American populations. CAR-T therapies are currently being developed for other tumor areas, particularly for solid organ tumors, and will require utilization of inpatient beds for treatment, which the new cancer hospital would offer. In addition to inpatient care, cellular therapies will also be partially offered using "day hospital" ambulatory care, which will also be included in the new cancer hospital. New therapies will require inpatient beds, cellular therapy lab space, day hospital treatment space, and resources to be able to perform cellular manipulation in the clinical care areas. UCMC anticipates significant growth in the number of people with relapsed or refractory conditions that will be eligible for CAR-T therapy through 2030.



Another example of UCMC's pioneering efforts is with its Theranostics program launched earlier this year. Theranostics is a personalized approach to treatment using radioactive drugs uniquely combined to sequentially diagnose and deliver therapy to specific targets that may be present on cells. If the targets are present, a radioactive drug is used to target the cancer cells while avoiding healthy areas. Theranostics is currently used to treat neuroendocrine tumors, and UCMC has the highest volume of neuroendocrine ("NET") patients in Illinois, representing a 19% market share in FY21. UCMC also has the only medical cyclotron in the region to create diagnostic tracers, which means the availability of clinical trials not available elsewhere, and plans to flex its partnership with Argonne Labs to develop treatments for future indications including bone metastases, thyroid, liver, and pediatric neuroblastoma.

Through some of its most pre-eminent researchers, UCMC is also seeking to flex its unique capabilities in immuno-engineering by working towards manufacturing clinical-grade vectors

and immune cells for gene therapy on its campus. Viral vectors have generally proven to be efficient tools for targeted gene delivery to cells and tissue, a critical aspect of effective therapy. UCMC has already developed a cellular cGTP (FDA current Good Tissue Practice) therapy and transplant facility in its adult hospital, which is key to cellular transplant and CAR-T therapies. It will also debut the initial phase of a cGMP (FDA current Good Manufacturing Practice) facility on the University of Chicago campus in February 2023 for the manufacture of viral vectors, with a second phase to open the following year. Such cGTP and cGMP facilities will expand cutting-edge immunotherapy clinical trials and, ultimately, the pipeline of new treatment options for some of the most aggressive cancers.

1. 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, as well as South Suburbs. UCMC is targeting a service area spanning 15 zip codes and approximately 900,000 residents on Chicago's South Side, The A-03 planning area was approximated using the 15 zip codes.

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In addition, for its highly specialized tertiary and quaternary services, and other services necessary for the coordinated delivery of specialty medicine, UCMC serves much of the Chicago metropolitan area, the state and the Midwest, as well as patients throughout the nation and the world. UCMC seeks to provide greater access and an enhanced patient experience on UCMC's main campus in Hyde Park by bringing these services closer to the patient.

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

A. People who live on the South Side of Chicago are twice as likely to die from cancer than those who live just about anywhere else in America. In fact, cancer is the second leading cause of death on the South Side.

- Inequities in the burden of cancer are largely driven by the social determinants of health (including financial stability, healthy food, education and strong community resources), including access to cancer prevention, screening and care.
- The problem is expected to grow worse in the years ahead, with the incidence of cancer projected to grow 19% in Planning Area A-03 in the next ten years compared to 9.1% in the 12 county metropolitan area over the same time frame.
- The Centers for Disease Control and Prevention ("CDC") predicts overall cancer rates will increase by 49% from 2015 to 2050.
- Vulnerable communities have less access based on a variety of factors including access to screening technology to detect, diagnose and treat cancer, such as broadband technology and mobile tools, and over-employment, with limited ability to take time off work for preventative screenings.
- Life expectancy, disease burden and the utilization of health care services (*e.g.*, routine wellness, procedures, surgeries, and costs) all vary significantly depending on where one lives, leading the Robert Wood Johnson Foundation to conclude that when it comes to health and health care, "zip code is more important than genetic code."[2] UCMC recognizes that cancer injustice is not a problem of biology, technology or even necessarily genetics, but a larger socioeconomic problem.

B. Over Half of Adult South Side Patients Today Leave the Area for Care They Need.

- The South Side of Chicago has insufficient, inadequate and declining medical resources. There has been over a dozen inpatient service or hospital closures in the past ten years on the South Side residents.
- Over Two-Thirds (67%) of Adult South Side cancer inpatients were treated outside of A-03 in 2020, up from 62% in 2019 (pre-Covid), with a significant amount of medical care provided to residents of the South Side of Chicago delivered in other regions of the city and in the suburbs.
- Five (5) hospitals treated 50% of the outflowing adult cancer patients from the A-03 planning area in 2019 and 2020 (Advocate Christ, Northwestern, Rush, UIC and Stroger).

[2] RWJF Commission to Build a Healthier America. Improving the health of all Americans by focusing on communities. Robert Wood Johnson Foundation. Accessed May 29, 2019. https://www.rwjf.org/en/library/research/2013/06/improving-the-health-of-all-americans-by-focusing-on-communities.html

C. UCMC is almost always full and operates at capacity 90% of the time

- Too frequently, UCMC operates under "surge" conditions because of a full hospital coupled with backup of critically ill patients waiting for admission in its emergency departments. In fact, UCMC called "surge" more than 50% of the time over the past few months.
- UCMC's patients are 45% sicker than patients that occupy the same beds in other hospitals in the planning area. When UCMC is operating at capacity, it limits the ability for safety net hospitals to transfer patients who need UCMC's specialized services and a higher level of care.

D. Community hospitals lack the investments and resources they need to meet the needs of local patients.

- Residents on the South Side are a medically-underserved population with a limited medical infrastructure. As a result, patients elect to go elsewhere.
- Over the past 25 years, Planning Area A-03 has seen seven of 16 hospitals close and inpatient capacity decrease by more than 54%.
- Of the remaining safety net hospitals, the average daily census in Planning Area A-03 decreased from 2015-2019 by 7% to as much as 48% except for UCMC and Provident (which was closed for a period of time).

E. Cancer Care is dispersed throughout several buildings on UCMC's Campus

- Cancer Care at UCMC is currently fragmented and patients have to visit multiple buildings to receive their full spectrum of cancer care.
- Inpatient oncology patients are currently admitted to the Bernard Mitchell Hospital (BMH) located at 5815 South Maryland Avenue and the Center for Care and Discovery (CCD) building located at 5700 South Maryland Ave in Chicago.
- Most if not all outpatient clinical and diagnostic services, such as imaging, lab, rehabilitative therapy services, infusion and interventional radiology are in the DCAM located at 5758 South Maryland or the BMH.
- Clinical trials research and care administration at 860 East 59TH Street in Chicago.

F. Rapid advances in cancer care have far outpaced the facilities available to deliver them to patients.

- Huge amounts of data are consistently being generated in health care and existing medical buildings may not have been constructed to process the data effectively. It is tedious and cost-prohibitive to retrofit existing buildings with an adequate technology infrastructure.
- The cancer care journey is increasingly complex for both patients and providers. Not only is the number of cancer diagnoses rising each year but cancer patients have to coordinate care with more specialists involved in their care.

G. Inequities in clinical trial population exist and may discourage underrepresented populations from using new therapies or treatments.

- One study that looked at more than 20,000 studies over two decades reported that less than 44% of trials report race/ethnicity data, with 21% of clinical trials reporting zero Black enrollees.[3] Other studies show between 80%-90% of clinical trials skew heavily white.[4]
- Even if researchers work to diversify studies, recruitment may be difficult because minority populations are skeptical and may not have the trust necessary to join a study given a long history of exploitative and unethical studies.

3. 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. UCMC also relied upon data its own records, UCMC 2020-2022 CHNA, 2020 Annual Report of its NCI-CCC, PubMed Open Source publications.

4. Detail how the project will address or improve the previously referenced issues or problems.

A. A dedicated comprehensive cancer facility will increase access and help to address healthcare disparities

- With 67% of South Side residents leaving their communities to get cancer care, adding a dedicated, comprehensive cancer facility on the South Side will dramatically increase access and reduce time traveled. Research has established that patients living farther from healthcare facilities have worse health outcomes, longer lengths of hospital stay, non-attendance at follow-up visits, higher rates of chronic disease-related deaths, lower five-year cancer survival rates, and increased overall disease burden.

  - A dedicated comprehensive cancer facility will allow UCMC to effectively and efficiently provide increased access to world-class cancer care. As a Comprehensive Cancer Center, UCMC sees a higher volume of patients with rare cancer diagnoses. For example, UCMC's Radiation Oncology program conducted a study evaluating the outcomes of patients diagnosed with a rare brain cancer – glioblastoma and found that patients who received care at high volume Cancer Center – such as UCMC – were found to have more favorable outcomes than a patient who went to a low volume institution.[5]

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[3] https://www.sciencedaily.com/releases/2022/04/220410205932.htm

[4] https://www.scientificamerican.com/article/clinical-trials-have-far-too-little-racial-and-ethnic-diversity/.

[5] Association between hospital volume and receipt of treatment and survival in patients with glioblastoma Matthew Koshy[1,2], David J Sher[3], Michael Spiotto[4,5], Zain Husain[6], Herb Engelhard[7], Konstantin Slavin[7], Martin K Nicholas[8], Ralph R Weichselbaum[4,5], Chad Rusthoven[9] J Neurooncology 2017 Dec;135(3):529-534. DOI: 10.1007/s11060-017-2598-2

- A dedicated cancer facility is critical to rectifying the demand in screening and treatment that has gone unmet as a result of the COVID-19 pandemic, with the most dramatic reduction in screening occurring in medically underserved communities. This has led to decreases in diagnosis and treatment and is expected to result in thousands of preventable deaths. According to the CDC, the screening rates for breast and cervical cancers fell by more than 80%, with the most severe declines occurring in populations of low-income women of color.
- The threat of worsening cancer outcomes has been recognized by the international cancer research community as a leading priority. Early projections showed that if these trends continue, mortality for these cancer types is expected to increase by nearly 10,000 in the next 10 years in the U.S. alone as a result of missed cancer screenings and treatment.
- The dedicated comprehensive cancer facility would provide equitable cancer care to vulnerable groups, but it would also be dedicated to cancer prevention. In response to input from our community, the cancer hospital would offer a range of services to help our community learn how to reduce its cancer risk or to detect cancer early - when it's most treatable.

B. Enhanced Access to High Quality Cancer Care on the South Side will provide greater choice to patients and the option to receive care closer to home .

- Adding a dedicated comprehensive cancer facility to UCMC's Hyde Park campus will further strengthen UCMC's work in improving these disparities for the Southside communities. UCMC's cancer faculty have conducted research on the impact of healthcare disparities and access to quality cancer care and have found that if a patient has to travel a long distance for cancer care – it will often lead to poor outcomes for that patient. UCMC's commitment to investing in the Southside of Chicago will help reduce travel time for the communities it serves and increase access to world class cancer care.[6]

C. A dedicated comprehensive cancer facility will increase capacity for the entire spectrum of world-class cancer services and will be a treatment home for patients in its community and around the world.

- The cancer facility will provide dedicated capacity for inpatients and 40% more capacity for ambulatory operations at UCMC. This increased access will allow UCMC's complex patient population to begin their personalized treatment plans faster, including the likelihood that treatment is initiated within 30 to 6- days of diagnosis.

[6] https://pubmed.ncbi.nlm.nih.gov/29932220/ Racial and Ethnic Disparities in Travel for Head and Neck Cancer Treatment and the Impact of Travel Distance on Survival Evan M Graboyes 1 2, Mark A Ellis 1, Hong Li John M Kaczmar 4, Anand K Sharma 5, Eric J Lentsch 1, Terry A Day 1, Chanita Hughes Halbert

- With the additional bed capacity, the proposed cancer hospital has the potential to reduce disparities in access to essential medical services and to transform the way life-saving medical care is providing in the community
- The new cancer facility will enhance access to care for the South Side's most vulnerable residents and help to break down barriers including transportation and supply gaps. Additionally, with the recent ACS navigation grant, the UCCCC seeks to reduce fragmentation of services for patients and caregivers, especially among vulnerable patients such as those with significant social needs, high symptom burdens or those requiring complex multi-modal and -team care (surgery, chemotherapy and/or radiation). UCMC plans to invest in innovative approaches to integrate both in-person and digital resources to improve the navigation experience for both patients and caregivers. Particular attention will be paid to addressing digital access and digital literacy to ensure equitable access across the health system.

D. <u>The commitment to building a dedicated, comprehensive cancer facility is an investment in the resources of the entire healthcare community of the South Side of Chicago.</u>

- In an unprecedented initiative, UCMC has joined 12 other South Side providers to develop a South Side Healthy Community model to serve over 900,000 residents with better, more seamless and more accessible care. This collaborative will be better able to serve the community with additional primary care and OB providers and dedicated access to nearly 50 priority specialists, 250 community healthcare workers and coordinators, and a connected and integrated care technology platform.
- The scope and scale of the SSHCO is both comprehensive and transformative, and the effort in parallel with a dedicated comprehensive cancer facility will constitute a major step in reversing the longstanding health and economic disparities of Chicago's South Side.
- The availability of care is generally enhanced when different elements of the healthcare delivery system work together. Patients deserve access to both community hospitals and complex care. Community hospitals play a critical role in providing convenient and affordable access to care to vulnerable and low-income populations for primary and secondary care. UCMC also plays a critical role in caring for the sickest and most complex patients. The healthcare missions of UCMC and community hospitals are aligned: Provide patients access to the care they need when and where they need it.

E. <u>The new facility will move the broader cancer care continuum under one roof</u>

- A key objective of a dedicated comprehensive cancer facility is to reduce fragmentation and improve coordination of care and services. Not only is this a dissatisfier for patients, it leads to a disjointed delivery of care. This fragmentation today drives high wait times, results in avoidable utilization of higher-acuity settings, and contributes to the outmigration for care. The new facility will put the broader care continuum under one roof, unlike any other center in the Chicagoland arda, creating synergies that will improve patient's outcomes and experience.

- The proposed new comprehensive cancer facility will allow all providers to work under "one roof" and provide patients with a single destination to receive care from multiple disciplines. UCMC's Cellular Therapy provide a multi-disciplinary clinic ("MDC") care model for their geriatric Stem Cell Transplant population, which has led to improved outcomes. Expanding this MDC care model beyond the geriatric patient population is a priority, and a proposed new dedicated, comprehensive cancer facility will allow for all cancer disease groups to maximize the effectiveness of an MDC care model.[7]
- Another example of the success of MDC is a collaboration between UCMC's Medical Oncologists and Radiation Oncologists to determine whether patients with Head/Neck cancer that stem from HPV are better served by congruent radiation and chemo therapy regimen. As a result of the collaboration, they have been able to reduce the amount of radiation the patient is exposed to, reduce the chemo toxicities that often have a significant impact on the quality of life for patients, and to provide the best patient outcomes in the nation for this specific type of head/neck cancer.[8]

F. UCMC will bring a coordinated, state-of-the-art, technologically advanced, and healing building for the future of cancer services for patients and their families from the South Side of Chicago and from around the world.

- UCMC seeks to build a comprehensive cancer facility that has not been built before with a data-driven design that facilitates interdisciplinary collaboration both in the lab and beside the patient, whether in the clinic or at bedside. The design planning for the new cancer facility will contemplate an environment wired to consume and analyze rich stores of patient data to better flex a "molecule to medicine" approach and to improve outcomes for patients.
- UCMC anticipates a profound shift in its health care delivery model that is more data-centric than function-centric and that fuses the most advanced technology, medical research, and clinical care through real-time collaboration for the benefit of all cancer patients. The new cancer facility will be built around a "smart" core allowing researchers and clinicians to leverage big data, powerful computing and artificial intelligence ("AI"). UCMC cares for some of the most complex and rare cancer diagnosis and having a facility that leverages big data/AI will allow for more precise and personalized treatment plans.
- The new dedicated, comprehensive cancer facility will include a Translational Research Laboratory (TRL) will provide real-time analysis of detailed molecular/immunological/metabolic attributes of a patient's tumor.

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[7] Benjamin A. Derman, Keriann Kordas, Emily Molloy, Selina Chow, William Dale, Andrzej J. Jakubowiak, Jagoda Jasielec, Justin P. Kline, Satyajit Kosuri, Sang Mee Lee, Hongtao Liu, Peter A. Riedell, Sonali M. Smith, Michael R. Bishop, Andrew S. Artz, Recommendations and outcomes from a geriatric assessment guided multidisciplinary clinic prior to autologous stem cell transplant in older patients, Journal of Geriatric Oncology,Volume 12, Issue 4, 2021,Pages 585-591
https://reader.elsevier.com/reader/sd/pii/S1879406820304914?token=163EC6F583BCD01E5E51789C4022BBC85273AB4E3D9577E2C18CE78A9662E626289239981C919E35467A90E01E6634D0&originRegion=us-east-1&originCreation=20211202223054

[8] Oral Oncol. 2021 Nov;122:105566.doi: 10.1016/j.oraloncology.2021.105566. Epub 2021 Oct 18.Risk and response adapted de-intensified treatment for HPV-associated oropharyngeal cancer: Optima paradigm expanded experience Ari J Rosenberg[1], Nishant Agrawal[2], Alexander Pearson[3], Zhen Gooi[2], Elizabeth Blair[2], John Cursio[4], Aditya Juloori[5], Daniel Ginat[6], Adam Howard[2], Jeffrey Chin[3], Sara Kochanny[3], Corey Foster[7], Nicole Cipriani[8], Mark Lingen[8], Evgeny Izumchenko[3], Tanguy Y Seiwert[9], Daniel Haraf[5], Everett E Vokes[3]
https://pubmed.ncbi.nlm.nih.gov/34662771/

- UCMC's path to transformative cancer care is not just a physical structure but a dynamic, healing environment that centered around the patient, bringing clinical and supportive services to the patients, leveraging technology, and integrating the latest research for the best outcomes UCMC wants every patient and family member who comes through the doors of this facility to feel they have come to the right place.

G. As an NCI certified Comprehensive Cancer Center, UCM already prioritizes diverse enrollment in its clinical trials. The Project will further disrupt inequities in clinical trial participation.

- The new facility will include the space and resources UCMC needs to do groundbreaking research into cancer care and expand access to clinical trials, particularly for groups that have been underrepresented in cancer research.
- The new cancer facility will include dedicated space with highly specialized staff to further integrate the clinical and research enterprise. Examples include biobanking (real time collection and processing of patient specimen to be used in translational research and clinical trials); a clinical trials unit (to provide on-site counseling, education and enrollment in trials, and to provide innovative experimental therapies arising from the University of Chicago's scientific discoveries).

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

UCMC's prevailing objective is to increase access to comprehensive cancer care, throughout the life cycle of cancer and, preferably, its prevention. By building a dedicated comprehensive cancer facility on its Hyde Park Campus, UCMC seeks to increasing the availability of the full range of cancer from screening through remission in closer proximity to current and future patients and to help to mitigate persistent health care disparities.

- Stimulate and support collaborative, interdisciplinary basic and clinical cancer research, and bring the benefits of our breakthroughs to patients to provide them with superior, state-of-the-art care.
- Pioneer preventative strategies based on cutting-edge research.
- Develop and provide imaging techniques and technologies to enhance diagnostics, detect malignancies early in their development, and improve the accuracy of radiographs
- Improve quality of life for patients and provide convenient access to useful resources to support their physical, social and emotional needs
- Use clinical trials to test investigational drugs and identify effective new cancer therapies
- Apply the latest advances in imaging, molecular biology, information technology, genetics, genomics, systems biology and other disciplines to the study of human cancer.

- Provide education, training and career development for students, basic scientists, translational/clinical investigators, and healthcare professionals at all levels (from high school students to senior faculty).
- Ensure clinical trial access to community oncologists and minority populations directly and through enhanced relationships with a network of affiliated hospitals and health centers and bring science and research into FQHCs and community hospitals.
- Develop and implement outreach programs that educate local health professionals about current approaches and new advances in cancer prevention, early detection, and treatment

These goals are ongoing and material progress can be achieved within the timeframe for Project completion.

2021 University of Chicago Comprehensive Cancer Center Faculty Publications

Total = 463

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Section III, Alternatives

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Alternatives

Through many years of planning, UCMC rigorously evaluated several alternatives to expand capacity and to provide reliable access to high-quality cancer care for its underserved patient population. Additionally, during the Master Design phase of the Project, UCMC considered over 75 iterations of the Project ultimately proposed, with input from key stakeholders in the community, architects and engineers, technical consultants, and valuation firms. A few of the various alternatives that have been considered are listed below:

1. Doing Nothing

For decades, the 900,000 residents of the South Side of Chicago have experienced health disparities ranging from materially higher disease incidence and comorbidities to significantly lower life expectancy. These health disparities reflect a history of racial inequities and underinvestment – both of which have contributed to a fragmented healthcare delivery landscape with limited resources. Today, over 50% of all adult South Side residents leave the South Side to receive their care and almost two-thirds of all adult South Side residents specifically leave for cancer care. People who live on the South Side of Chicago are twice as likely to die from cancer than those who live just about anywhere else in America. In fact, cancer is the second leading cause of death on the South Side.

From 2014-2018, the residents on the South Side of Chicago were 28.6% more likely to receive a cancer diagnosis than residents in other parts of the City and 25.2% more likely than others in the state. Similarly, for similar periods of time, 14.9 deaths per 100,000 residents from breast cancer (2013-2017) compared to 12 in Illinois and 19.9 colorectal cancer deaths compared to 13 for Illinois.

UCMC has been unable to consistently meet community demand because of capacity challenges on an inpatient and outpatient level. This shortfall is visible in ongoing denials for inpatient transfers due to a lack of available inpatient beds and long waiting times for outpatient clinics. Currently, the delivery of cancer care on UCMC's campus is fragmented, with key portions of routine cancer care spread among several buildings on campus and multiple points of entry.

Maintaining the status quo would not require a capital expenditure, but it would not address the significant and ongoing access and service limitations confronted by the South Side of Chicago that results in a health care injustice. It also would not alleviate the extremely high rate of outmigration experienced in the planning area or the travel burden imposed upon cancer patients and their families, both of which have the potential to delay care and to diminish quality of life.

As an academic medical center, and designated NCI comprehensive cancer center, doing nothing is not a viable choice. UCMC views a dedicated facility for the delivery of advanced cancer care

as an imperative and understands its obligation to act to improve inequalities that have persisted in its service area.

2. **Project of Greater Scope and Cost**

a. Construction of a dedicated cancer hospital remote from UCMC and its Hyde Park medical campus

As part of UCMC's systematic review of its options to expand access to high-quality cancer care, UCMC considered the construction of a free-standing cancer hospital built off of UCMC's campus on a suburban, Chicagoland location. From a cost perspective, suburban construction may be less expensive for many reasons (better soil quality, less wind vibration) but the construction on a remote site would require UCMC to duplicate all ancillary services needed to run a hospital. Specifically, the new facility would have to be separately licensed as a hospital and meet all of the requirements under the Illinois Hospital Licensing Act, including having its own CLIA-certified clinical laboratory and an emergency department.

This option also would require the purchase of land (approximately 75 acres) and the construction of a 1,000 car parking deck. The list of central services that would need to be built include the following:

- Kitchen Services
- Clinical Labs
- Emergency Department
- Central Sterile processing
- Full Pharmacy Services
- Full Imaging Services
- Surgical Services
- Administrative and Faculty services
- Roadway improvements
- Power Plant for Heating and Cooling
- Parking lots and parking decks.
- Faculty offices
- Research Facilities

In addition to clinical services, the hospital would need an administrative infrastructure, including a governing body and executives needed to manage the medical staff, medical record, and nursing services. A new hospital would also need to independently enroll as a Medicare and Medicaid provider and to obtain a CIN.

UCMC estimates that this would require an additional 300,000 sq. ft. of physical space to replicate the centralized services already available on its Hyde Park campus. This would require additional, initial capital outlays and as well as material ongoing operational costs.

A new hospital in a suburban, Chicagoland location would allow for the construction of modern facilities to meet patient and provider needs and to deliver technologically advanced medical care. However, the site would not be in the heart of the South Side of Chicago where patients in

the Hyde Park area are struggling with some of the highest rates of cancer. The site would also not be able to take advantage of the rich academic environment of the University of Chicago Hyde Park campus, with the aim to embed the new cancer hospital in pipeline of innovation and discovery alongside the University of Chicago's physical sciences division, Pritzker school of molecular engineer, the data sciences division, biological sciences division and advanced photo sources. .

Given that the intent and scope of the Project is to increase access to cancer services in the community, UCMC rejected this option outright. Most importantly, it would not alleviate the maldistribution of resources within the City of Chicago and the healthcare disparities on the South Side. Additionally, it would require the duplication of services available on UCMC's Hyde Park campus for which there is not an independent or unmet need resulting in unnecessary expenses.

The total cost estimate for the 844,000 sq.ft. hospital, land and parking structure is $1.140 billion.

b. Comprehensive Renovation Mitchell Hospital with an addition

UCMC also considered a more comprehensive renovation of Mitchell Hospital than proposed previously along with the construction of an annex building.[1] The current renovation of Mitchell Hospital involves 113,452 sq.ft. of the building's total 450,000 sq.ft. The potential use of the Mitchell Hospital would require renovation of the remaining 336,548 sq.ft., additional upgrades to the 113,452 sq.ft., the demolition of an adjacent building and the construction of 188,000 sq.ft. of adjacent pace to support modern clinical needs and to replace the faculty office and research space lost to the demolition. This would also require UCMC to decrease its current bed capacity by 88 during the majority of the multi-year renovation.

This approach would allow the proposed cancer facility to continue to benefit from the available central support and ancillary services on UCMC's Hyde Park campus. It would also be available to serve the residents on the Southside of Chicago and to benefit from scientific collaboration available on the University of Chicago academic campus. However, the disadvantages of utilizing the dated, double-loaded corridor inpatient areas would not allow UCMC to provide a modern efficient experience for UCMC patients and staff. This would provide a suboptimal experience for UCMC patients and require excessive operating costs to properly staff the patient

[1] UCMC already considered a project of lesser scope in Mitchell in 2016 when it originally proposed a comprehensive renovation of Mitchell to repurpose it as a hospital primarily dedicated to a broad spectrum of clinical cancer care. During the public health emergency, UCMC learned that optimizing care for its immunocompromised cancer population couldn't be accomplished in Mitchell. One notable area highlighted by COVID-19 is air handling systems and UCMC's ability to make substantial infrastructure changes to an existing building in a cost-effective manner.

Among the other problems encountered were: insufficient space to efficiently design ICU rooms and meet infection control requirements, 12 foot floor-to-floor heights prevented rerouting of HVAC ductwork needed to change layout on the current nursing units, negative impact on clinical labs and radiology due to need for new elevators, necessary replacement of the entire Mitchell Exterior Curtain Wall that could not be selectively modified; the need to modify IT infrastructure in Mitchell to accommodate a proliferation of IT systems could only be achieved at an extraordinary cost.

care units. The construction would also entail about 10 years to complete due to the amount of phasing required to work on an occupied inpatient facility and would be more expensive than the alternative chosen.

The total involved space for this project would be 638,000 sq.ft. and cost about $992.0 M.

c. Joint Venture with Other Providers

UCMC already has entered into joint ventures with other providers in cancer care to bring advanced and investigational therapies to the community-hospital setting. The University of Chicago Cancer Center at Silver Cross Hospital opened in 2012 to operate an outpatient cancer treatment center in New Lenox, IL with two main services lines: An infusion/chemotherapy and oncology clinic and a radiation oncology clinic. It gives access to a leading academic medical center and research hospital for cancer treatment resulting in premier, community-based resource for cancer treatments, research and education and to bring world-class treatment to the suburban health care market and to treat patients closer to home.

AMITA Health and UCMC also joined forces to jointly bring the South Side academic health system's specialized cancer expertise, access to advanced therapies and innovative clinical trials, and greater cancer care options to a smaller, community hospital on Chicago's North Side. The new partnership is based at AMITA Health Saint Joseph Hospital Chicago, and includes radiation and medical oncology, as well as surgical oncology and research services. Patients can now be seen by UCMC oncology physicians at the AMITA Saint Joseph Chicago campus.

On January 1, 2023, UCMC and Adventist Health System Sunbelt Healthcare Corporation ("**AdventHealth**") closed an agreement to enter into a Joint Venture pursuant to which UCMC acquired a controlling interest in Advent Midwest Health, comprising the facilities and equipment of Advent Bolingbrook Hospital, in Bolingbrook, Illinois, Advent GlenOaks Hospital, in Glendale Heights, Illinois, Advent Midwest Health d/b/a La Grange Hospital, in La Grange, Illinois and Advent Midwest Health d/b/a Hinsdale Hospital, in Hinsdale, Illinois (the "**Acquired Assets**"). This JV is not focused on cancer care specifically but seeks to give existing and new patients a greater choice of physicians and locations and overall increased access to a full continuum of care, including quality community-based primary and specialty care and an expanded footprint for ambulatory services. As such, this alternative doesn't replace the need for a dedicated cancer facility.

A joint venture often is the only mechanism to bring comprehensive cancer care to a community that lacks ready access to academic medical centers and research institutions. Because cancer patients frequently require prolonged treatment over a number of weeks, having state-of-the-art treatment facilities closer to the patients' homes and patients' family members is optimal. Joint ventures may also provide a meaningful opportunity for a community to receive "cutting edge" care based on a relationship with academic medical centers or dedicated, comprehensive cancer facilitys and the latest research.

However, in this case, UCMC is, itself, a world-renowned academic medical center with a premier cancer program and seeks to improve the delivery of cancer care within the communities it already serves. UCMC rejected this option because a joint venture on UCMC's Hyde Park Campus is not necessary to achieve its goals.

d. Utilize Other Available Health Resources

UCMC considered whether it would be possible to simultaneously make improvements to its existing facilities to meet the demand for increased services in combination with a reliance on the resources and affiliations with neighboring hospitals. This option was rejected for several reasons. In particular, UCMC is the only academic medical center on the South Side of Chicago, where demand for cancer care is increasing and its population remains underserved. While the tertiary and quaternary care provided by UCMC and the primary and secondary care provided by community hospitals in the region are complementary, UCMC has no peer hospitals in the area. Instead, UCMC receives frequent requests for transfers from most of the other hospitals in its service areas.

This option would not increase capacity for more complex care for which there is unmet demand. The neighboring hospitals are not currently equipped to provide tertiary or quaternary care, and a shift in their care delivery model would require significant capital construction, training, and resources. Instead, UCMC has focused on developing relationships with 12 other hospitals and community health centers in the South Side Health Community project, where each of the providers can excel in what they do best to advance the South Side's entire ecosystem of health care.

Additionally, if UCMC were to rely on neighboring hospitals, it would not be able to provide the continuum of care and co-location of services that can be achieved by building a dedicated cancer facility on its own campus. Moreover, a fundamental motivation for UCMC's dedicated cancer facility would be to integrate its innovative research capabilities with its cutting-edge clinical capabilities. The development of a network of community hospitals would not achieve the synergies that UCMC seeks in putting research and clinical care in one building to optimize the delivery of cancer care.

Similarly, UCMC rejected an affiliation with a hospital outside of the service area because it would not address the current unmet demand in Planning Area A-03.

e. Proposed Alternative

UCMC first proposed a dedicated comprehensive cancer facility in its application for a Master Design Permit that was approved on March 15, 2022. While some of the details have changed, the purpose of a dedicated cancer facility remains the same – to enhance access to a broad continuum of cancer care on the South Side of Chicago in communities where the incidence of and mortality from cancer is disproportionally high and the available resources are disproportionately law. Through the master design process, UCMC worked hand-in-hand with its community to better calibrate the cancer facility to their needs, including making cancer prevention, screening and education a true cornerstone of the facility, and offering. Within the context of the current economic and inflationary pressures, and with knowledge of the need for future growth and adaptability, this building contains more shelled space to preserve the ability to expand in years to come.

With this alternative, UCMC will bring a coordinated, state-of-the-art, technologically advanced building for the future of cancer services for patients and their families to the South Side of Chicago for those who live here and those from around the world. UCMC already has a team of

exceptionally trained specialists whose practices are grounded in the latest research with one goal in mind – to help UCMC's patients achieve the best possible outcomes – and to augment the community's access to the finest cancer care by enhancing local capabilities.

UCMC further seeks to build a cancer facility that has not been built before with an innovative layout and a data-driven design that facilitates interdisciplinary collaboration both in the lab and beside the patient, whether in the clinic or at bedside.

Huge amounts of data are consistently being generated in health care and existing medical buildings may not be have been constructed to process the data effectively. It is tedious and cost-prohibitive to retrofit existing buildings with an adequate technology infrastructure, so the space planning for the proposed cancer hospital will account for this need up front. The design planning for the new cancer hospital will contemplate an environment wired to consume and analyze rich stores of patient data to better flex a "molecule to medicine" approach and to improve outcomes for patients.

UCMC anticipates a profound new health care delivery model that is data driven and patient-centric and that fuses the most advanced technology, medical research, and clinical care through real-time collaboration for the benefit of all cancer patients.

With UCMC's ongoing commitment to bring an even greater benefit to the communities it serves, including underserved and vulnerable populations, the alternative chose is the only option.

Alternative	Cost	Pros	Cons
Project of Greater Scope: New Hospital Apart from UCMC's main campus	$1.140 B	• Would provide modern facilities and an environment for technologically advanced care	• More expensive than alternative selected • Would duplicate services for which there is no demand • Would not address primary reason for project – to infuse underserved and at-risk population with high quality health care resources
Project of Greater Scope: Renovation of Mitchell/Construction of Annex	$992.0 M	• Location on main medical campus would bring additional resources to the South Side of Chicago • No need to duplicate ancillary services	• More expensive than alternative selected • Constrained by dated hospital floorplan and layout of nursing units; ability to retrofit building with necessary technological infrastructure is limited. • Construction would take up to 10 years because of phasing required to work

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			on occupied patient units
Joint Venture	N/A	• No material advantages	• Would unnecessarily complicate the delivery of health care in one of UCMC's premier service lines in its own community
Utilize Existing Facilities	N/A	• Potentially lower cost	• UCMC fills a unique role in its planning area and there is no reliable acute care capacity for specialized cancer care that can be filled by existing hospitals.
Proposed Project	$815.1 M	• Enhanced access to broad continuum of cancer care for medically underserved and at-risk population and improved outcomes at each stage of illness • Creation of technologically advanced and data-centric delivery model to facilitate multi-disciplinary collaboration of care providers • Shelled space provides opportunity for future expansion in response to anticipated growth in demand.	• More expensive than doing nothing • Inflationary pressure has increased costs of construction overall • Material expenditure for technologically advanced infrastructure • Requires significant site preparation and underground utility work

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

Attachment 14

Project Scope, Utilization and Unfinished/Shell Space

The amount of proposed physical space is necessary and not excessive.

SIZE OF PROJECT DEPARTMENT/SERVICE	PROPOSED DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
Acute Care:				
Medical-Surgical	899 DGSF	500-660 DGSF/Bed	+239 DGSF	No
Critical Care:				
Intensive Care ("ICU")	851 DGSF	600-685 DGSF/Bed	+166 DGSF	No
Radiology:				
(1) General Radiography	1,883 DGSF	1,300 DGSF/Unit	+583 DGSF	No
(2) Ultrasound	2,123 DGSF	900 DGSF/Unit	+323 DGSF	No
(2) CT	3,747 DGSF	1,800 DGSF/Unit	+147 DGSF	No
(2) MRI	4,216 DGSF	1,800 DGSF/Unit	+616 DGSF	No
Breast Center D&T:				
(5) Mammography	3,732 DGSF	900 DGSF/Unit	-768 DGSF	Yes
(2) Ultrasound	1,761 DGSF	900 DGSF/Unit	-39 DGSF	Yes

As summarized in the table above, there are state space standards for Medical-Surgical patient rooms, ICU patient rooms and Radiology.

1. **Medical/Surgical & ICU Beds**

With the driving functionality of universal design and flexible adaptable spaces, the inpatient areas will be organized in pods of 16 beds each intended to provide optimal visualization and efficiency. One floor will consist of three pods of 16 beds for a total of 48 acuity adaptable beds – 16 of which are requested to be ICU licenses. Another floor will include two pods of 16 beds for a total of 32 beds. The high degree of flexibility in this design is intended to accommodate varying levels of patient acuity as well as to maintain adequate nursing ratios.

To achieve exceptional patient care and safety the inpatient platform will be designed to provide flexible, high quality, evidence-based care. All patient rooms will be private with dedicated family space to accommodate overnight stays. Additionally, there will be on unit patient and family amenity spaces to include a family shower, laundry

accommodations, a family living room, and a multi-purpose room that can accommodate recreational therapy.

To reduce unnecessary steps and achieve a lean design, there will be a decentralized approach to the unit support. There will be (1) medication room, (1) clean supply room, (1) equipment room, and (1) nourishment room for every 16 beds. Nursing stations will also be decentralized at the ratio of 2 per 16 beds to maximize visibility to patient rooms – this is partnered with charting alcoves between every two (2) patient rooms.

An innovative, multi-disciplinary team will deliver exceptional patient care. To foster collaboration, there will be at least one (1) provider work room per 16 beds in addition to a staff collaboration hub on each floor. The staff innovation and collaboration hub is intended to provide space for teamwork, meeting space, and staff respite space while still being proximate to the patients.

The inpatient environment will promote healing through the connection to natural light and biophilic design. In addition to the patient and family amenity spaces, both inpatient floors will also integrate rehabilitative services through a dedicated gym.

Lastly the inpatient areas will feature technological support to connect patients and staff while maintaining a quiet and calming environment. Staff will utilize clinical communication devices to enhance communication and reduce the need for overhead paging. Patient rooms will also feature the ability for patients to control their environment for improved comfort and sense of personal control. The patient controls will include lighting, motorized blinds, temperature control, as well as patient entertainment.
The Medical-Surgical inpatient units are planned at a range of 763-899 DGSF/bed (827 DGSF/bed average) that is 239 DGSF/bed larger than the State Standard of 500-660 DGSF/bed. The ICUs are also larger than the State Standards by 166 DGSF.

The increased size for the Medical-Surgical and ICU beds is to support UCMC's mission as an Academic Medical Center (AMC) with intense integrated research and teaching. This requires additional medical staff space for students, Residents, Fellows as well as Clinical Research Coordinators. This academic and research component results in more staff coming into the patient room during clinical rounds. The workspaces and multidisciplinary work rooms on the floors also need to accommodate teaching rounds.

The patient bedrooms are patient-family focused with a sleeping sofa and family zone to work, read, and eat comfortably while staying with their family member. The oncology patients typically have a longer length of stay than the average Medical-Surgical patient that tends to require more storage space on the unit. UCMC encourages the patient's caregiver to stay for support and engagement during the admission as part of the care team. Family members often cannot go home due to the long distance that they traveled for care at UCMC.

Clearances around the bed meet the requirements under the Illinois Administrative Code as well as the 2018 FGI Guidelines. All of the patient bedrooms are designed to be

universal rooms that will also meet the clearance requirements for an ICU bed. This will allow the beds to flex from Medical-Surgical to ICU in the event of a future pandemic or increased acuity of patients. Each of the 16-bed nursing units are also self-sufficient and are designed with the required staff support spaces. In the event that the census is low, the Medical Center can reduce the number of open nursing units to reduce cost.

Another driver for the size and layout of the inpatient units is the learnings from the pandemic. UCMC has increased the percentage of negative pressure isolation rooms on each unit. This will allow us to continue to provide cancer care to patients who are being ruled out or are diagnosed with respiratory illnesses such as flu or Covid. The size of the room is also meant to accommodate the intense needs for managing personal protective equipment ("PPE") and other necessary supplies and trash in order to manage care during pandemics.

2. Diagnostic & Treatment

A. Radiology Department:

The first floor Radiology department will be designed to accommodate both inpatients and outpatients for future flexibility. The additional space in excess of the State Space Standard is due to the large amount of circulation space to separate inpatient and outpatient services. When the cancer facility first opens, the Radiology Department will be primarily focused on outpatient cancer patients. Inpatient cancer patients in this building can easily be transported across the proposed bridge connecting the Project with UCMC's Center for Care and Discovery on Level 5, which contains existing inpatient radiology services.

The Radiology Department in UCMC's proposed Project has (1) General Radiography Room, (2) Ultrasound Rooms, (2) CT Scan Rooms and (2) MRI Rooms. The individual modality areas for MRI, CT, Ultrasound and X-Ray exceed the State Standard requirements. There will also be two minor procedure rooms. The area overage is due to the suite serving both inpatients and outpatients which requires a large amount of circulation to separate the patient flows. The room sizes for the various modalities are designed to be larger than the equipment manufacturer's recommended size. The manufacturer's recommendations do not account for the complex needs of UCMC's high acuity patients and patients of size. As technology changes, UCMC also needs to be able to accommodate the latest equipment. Similarly, UCMC needs to make rooms that can accommodate a wide variety of manufacturers to ensure competitive pricing and the ability to provide its patients with the latest technology from any vendor.

B. Breast Center Screening, Diagnostic & Treatment:

Level 1 has a Breast Center that consists of two components: a breast cancer & prevention clinic (described below under Ambulatory) and a Screening/Diagnostic & Treatment service. The Breast Center will relocate services from UCMC's existing

Duchossois Center for Advanced Medicine ("DCAM") building (outpatient center) to the proposed cancer facility. The Screening and Diagnostic & Treatment component of the Breast Center has (5) mammography rooms for both screening and diagnostic mammography, (2) automated breast ultrasound (ABUS) whole breast ultrasound rooms for the screening of women with dense breast tissue, (1) stereotactic biopsy room, and (2) rooms for ultrasound guided biopsy. The design is also accommodating private changing space for accommodating male Breast Center patients. The reviewable portion of the Breast Center with State Standards is 3,701 DGSF for Mammography which meets the State Standards and 1,761 DGSF for Ultrasound which also meets the State Standards.

3. **Other Reviewable Program - Ambulatory**

Other reviewable spaces with no current State Standards include various outpatient ambulatory spaces.

A. **Outpatient Oncology Clinics:**

There are (3) outpatient oncology clinics on Level 2 and Level 3 with (90) exam rooms (24,364 DGSF). The oncology clinics contain typical clinical programming, such as clean and soiled rooms, medication rooms, equipment storage, treatment spaces, team work areas, physician offices and patient consult rooms. The proposed Project includes physician office space for an array of Biological Sciences Division ("BSD") Faculty who provide specialized services for cancer patients. The physician offices will include medical oncology, surgical oncology, and palliative and supportive oncology specialists.

Cancer care is increasingly occurring in the outpatient environment and that has remained the case at UCMC where the growth has been more substantial than in the inpatient environment. UCMC currently has 47 dedicated exam rooms in medical oncology and additional rooms spread throughout the DCAM for surgical oncology patients. The trend towards outpatient care is forecast to continue well into the next decade. Current growth projections anticipate an outpatient growth rate of 4.8% annually. Using the existing room utilization trends, 90 rooms would be insufficient to meet this demand. However, with additional space and efficiency gains from an optimized layout, UCMC anticipates that the room turns per day will increase from ~4.5 to ~7.0 room turns per room per day. This enhanced efficiency will allow UCMC to see all of its oncology patients within the requested 90 exam rooms.

B. **Breast Center Cancer & Prevention Clinic:**

The 10,162 DGSF Breast Center Cancer & Prevention Clinic contains exam and patient consult rooms. This area is reviewable but has no State Standard. It is located on the first floor of the proposed Project and will consist of screening mammography, diagnostic breast imaging, and physician office space. The Breast Center plans to bring together multidisciplinary care for breast cancer patients including medical oncology, surgical oncology, plastic surgery, and breast imaging all in the same suite. Finally the clinic portion of the suite will include (18) exam/consult rooms and appropriate support spaces.

The Prevention Center including a small clinic and resource library space. Community forums hosted by UCMC and its dedicated patient panels indicated that there is a significant demand to provide resources for community education, cancer screening, and cancer prevention clinics to include both genetics clinics and lifestyle clinics.

The Breast Center will co-locate specialists from medical and surgical oncology as well as Plastic & Reconstructive Surgery ("PRS"). Given the nature of breast cancer, many of these providers see patients on the same day—especially the Breast Surgeons and PRS team. These surgeons typically see more than seven patients per room per day and consequently will need more than 10 rooms between them. While the room turns per day are smaller for medical oncology providers, advanced practice providers, survivorship providers and other providers that will practice in this space, an additional eight (8) rooms are needed to accommodate these services throughout the course of the week.

C. <u>Outpatient Infusion Services:</u>

Infusion Services is 26,142 DGSF and consists of (67) total infusion positions. These (67) total infusion spaces are divided into two locations for general infusion therapy services – (18) rooms on Level 2 and (49) rooms on Level 3. The 49 rooms on level 3 will include (5) rooms for Theranostics infusions. The intention behind having infusion services on two floors is to co-locate infusion for hematologic malignancy patients near their clinic spaces for these patients on Level 2. Meanwhile, infusion for solid tumor patients will be located near their clinic location on Level 3. Distributing the infusion bays in this manner is intended to create neighborhoods for patients receiving care by tumor type, which will reduce patient movement and should increase patient satisfaction. Similarly, physicians, nurses, and other patients will have to travel shorter distances to see their patients who are receiving infusions and those being evaluated in clinic rooms. The Project will include all private infusion bays/rooms, which is a decision based on direct patient feedback regarding UCMC's current open bay model. Infusion Services include intravenous and catheter-based infusion for chemotherapy, targeted therapies, immunotherapy, blood transfusions, and fluids. Lastly, on Level 3, five of the rooms have been designed to be lead lined with private bathrooms to accommodate Theranostics therapy, which delivers a radioactive drug to treat tumors.

In its current state, UCMC has 54 infusion bays for oncology patients on the Hyde Park campus. With the 4.7% annual growth rate in the outpatient patient environment, UCMC will quickly surpass the need for 67 infusion locations. However, UCMC anticipates more efficient use of the infusion bays than in the current state. First, while the vast majority of services within these bays are infusion treatments, other services do take place in the existing infusion bays. This includes bone marrow procedures, apheresis procedures and lumbar punctures. These procedures will be able to take place in procedure rooms in the proposed Project. Second, UCMC anticipates that more efficient layouts and staffing plans will enable the practice to see slightly more patients per bay per day. The team will be able to see roughly 2.6 patients per bay per day compared to

the current 2.3 patients per bay per day. Finally, to better meet the needs of working patients, UCMC anticipates that it will offer weekend hours in the proposed cancer facility.

D. Outpatient Cellular Therapy ("OCT"):

The outpatient cellular therapy unit is located on Level 2 and is 4,279 DGSF. There are (12) private rooms for this outpatient program. These rooms, co-located next to the general infusion bays for Hematologic malignancies, are designed for Hematopoietic Stem Cell Transplantation (HSCT) and Apheresis services. This space is also where bone marrow biopsies will be performed.

Over the past decade, the volume of Cellular Therapy treatments (Bone marrow transplants, Car-T, etc.) completed at UCMC has grown substantially. UCMC's existing outpatient cellular therapy footprint consists of five private bays. Over the next decade, it is anticipated that cellular therapy volume will nearly double. Historically, cellular therapy offerings have been limited to treating blood cancers. While that will continue to be the case, it is also anticipated that solid tumor cancer diagnoses will also increasingly have cellular therapy options as the standard of care in the future. As a result of this growth, plus the anticipated shift of apheresis services and bone marrow biopsies to this area, UCMC expects that 12 rooms will be needed to meet this patient demand.

E. Cancer Urgent Care - Oncology Rapid Assessment Clinic ("ORAC"):

For the cancer facility to be able to support cancer patients through every stage of their disease, UCMC needs to be prepared for when its patients have an acute need to be assessed and treated. UCMC is proposing to build an eight (8) bay Oncology Rapid Assessment Clinic "ORAC". This unit will offer patients an option other than the emergency room when cancer or treatment-related side effects surface. Cancer patients, who are immunocompromised, are at enhanced risk of infection in an emergency room environment. Helping redirect these patients from UCMC's emergency room to a more controlled environment will also help create capacity in UCMC's emergency department. Side effects such as fever, fatigue, nausea, vomiting, dehydration, diarrhea, mouth sores, and skin rashes need to be addressed promptly. Having a unit like ORAC for patients experiencing these symptoms outside of their regularly-scheduled treatment and clinic appointments has demonstrated a reduction in unexpected admissions and readmissions for oncology patients. ORAC will also improve the infusion and clinic throughput and waiting times. ORAC will reduce the number of same day, add-on patients in existing clinic schedules, creating a more predictable schedule and overall improved patient experience. All support spaces, including medication, clean supply, soiled and nutrition will be included in the unit so that it is self-sufficient. Equipment alcoves will be distributed throughout the care area to provide timely, convenient access from any location. This ambulatory clinic is 7,339 DGSF.

In the current state, UCMC uses roughly three ORAC bays per day. The existing location is not proximate to other areas where cancer patients are being treated, which limits on the acuity of the patients that are seen in this space. Additionally, limited hours have created an environment where infusions and other treatments that may last several hours may not be offered as the patients would not be able to have their treatments completed prior to ORAC closing. In the proposed Project, UCMC will operate ORAC as a 24-hour per day service. These extended hours will enable to UCMC to increase the number of services that are offered within this space and to better meet the needs of its patient population.

F. Phlebotomy:

Phlebotomists will be deployed throughout the proposed facility to collect specimens. Outpatients may have their blood draws completed in the outpatient departments or they can stop by the dedicated phlebotomy chairs on their way in or out of the facility. Inpatient blood draws will be done at the bedside by phlebotomists. When clinically viable, the inpatient and outpatient blood draws will transport the specimen through the pneumatic tube system to the existing central Lab located in the Mitchell Hospital building. UCM has allocated 1,568 DGSF for blood draw and processing space on Level 2.

G. Wellness Center:

The Oncology Patient Support Center includes supportive and integrative therapies. This space will include consultation rooms and rehabilitation gym equipment for the delivery of supportive outpatient services to support the cancer patient and family members during cancer treatment. Services include palliative care, cancer nutrition, physical and occupational therapy, social work services, psychology/psychiatry services, patient education, support groups, acupuncture, and massage. UCM has allocated 3,705 DGSF on Level 1 for this program.

H. Pharmacy:

The Project is proposing a Pharmacy on Level 5 which will be responsible for providing first dose medications, stat medications, routine doses, IV preparations, and compounding for the adult cancer patient population. The Pharmacy will have chemotherapy, immunotherapy, and oncology supportive care (IV nutrition, narcotics, etc.) production located in the cancer building to minimize the time between testing and treatment for the patient. The Pharmacy's location is on Level 5 proximate to the bridge connecting the Dedicated, comprehensive cancer facility to UCM's Center for Care and Discovery (CCD) to allow for easy access and distribution of medications from the central receiving pharmacy location in the CCD. The Pharmacy plans to utilize pharmacy technicians, pneumatic tube system and potentially autonomous delivery robots to efficiently prepared and distribute medications. The pharmacy will be fitted with the latest technologies including medication carousels to increase capacity and ensure compliance with all

regulatory agencies including USP 797/800 clean room standards. The Pharmacy is planned for maximum flexibility and adaptability given the rapid changes in cancer drug approvals and pharmacology, as well as future growth. An investigational drug pharmacy to support research activities will be included in the overall footprint of 10,106 DGSF. This Pharmacy will include a gene therapy clean room, and USP 797 and 800 clean rooms. In accordance with best practice, research medications will be stored and prepared separately from standard of care treatments. The Pharmacy is customized to service the patient population and research conducted at UCMC. In order to maximize efficiency, inpatient and ambulatory pharmacy have been combined in the proposed Project. By doing so, the Pharmacy has been able to reduce the clean room footprint in comparison to separate clean rooms built for each area. Hoods, fridges, freezers, and drug storage cart space are based on current equipment needs with a recommended proportional increase based on future growth. As shelled space is developed, Pharmacy will have the necessary space to add additional hoods and other required equipment. The Pharmacy has been thoughtfully designed based on federal clean room regulations, published pharmacy best practices, interviews with other large academic cancer centers, clinical research, and the need for future adaptability.

I. Human Tissue Resource Center (HTRC)/Biofluids Lab:

Patients who are on clinical trials may have a number of monitoring requirements as part of the protocols of the trial. Requirements can include vitals monitoring, EKGs, and/or providing multiple specimen samples. These samples need to be processed and either mailed out to the Primary Investigator lab or sent to a University of Chicago research lab. Approximately 1,696 DGSF on Level 3 of the proposed Project is being planned for a biobanking specimen lab space dedicated for the processing of these specimens for clinical research trials. The space is co-located near the Level 3 infusion space to allow for enhanced collaboration and reduced waits between the collection of specimen and the processing of specimen.

This space is needed to serve two specific functions. First, UCMC currently has HTRC and Biofluids being processed at two different areas of its medical campus. Given the nature of these services, the samples that need transported are usually transported by foot. It is a neglect of human talent to have them travelling to divergent parts of the campus to drop off samples. Additionally, the increased footprint is necessary to meet the anticipated growth of the proposed cancer facility. Increasingly, UCMC patients are interested in innovative and personalized treatment options. As a result, UCMC is anticipating a significant increase in the number of trials that are needed for its patients and furthermore, UCMC anticipates that the complexity of the trials it offers will continue to increase as well. This expanded footprint will enable these needed services to occur in an area that is proximate to where patients are being seen and will reduce the number of wasted steps that the care team has to take in order to deliver specimens to their existing processing labs.

4. Non-Reviewable Program

There are no State Guidelines for the non-clinical components of the Project. In determining the square footage for these components, UCMC's planning team members, architects, and consultants utilized existing functional standards and incorporated experience from other developments in the healthcare system.

A. Shell Space

The proposed Project will provide 124,318 DGSF of shelled space for future expansion. The shelled space is intended to enable growth and provide flexibility for the medical campus, particularly for the Cancer Service line where new drugs and clinical therapies will continue to emerge for future treatments. In addition to the shelled space included in the building, the Project will also include the structural support to allow for vertical expansion of the building in the future. Future shelled space may include Radiation Oncology, additional outpatient clinics, infusion space, inpatient beds and research. Planning for expansion space will be submitted under a future Certificate of Need application.

B. Building Support

(a) Building Support (94,524 DGSF) consists of mechanical, electrical, IT and other types of building support spaces such as Biomedical Support, EVS and Materials Management. These spaces are non-reviewable.

(b) The Biomedical Support department will have a space in the lower level of the Dedicated, comprehensive cancer facility. The Biomedical Support department is responsible for evaluating, repairing and maintaining clinical equipment in the facility.

(c) Housekeeping services for both clinical and non-clinical areas. EVS responsibilities include stocking areas with soap, hand sanitizer, and paper products as well as the removal of waste and recycling for disposal. EVS is co-located with other support services in the lower level of the building which provides efficient sharing of staff support spaces and easy access to the tunnel that will connect the proposed facility to UCMC's Dock B, which will be the primary pathway for supplies and waste coming in and out of the cancer building. The EVS space in the lower level will include appropriate storage for cleaning supplies, paper products, large equipment and equipment not used on a daily basis. Housekeeping carts and floor care machines will be deployed in EVS housekeeping closets on each floor of the building. Trash and linen chutes will also be integrated into the building which will allow a great deal of efficiency and ensure a hygienic workflow by eliminating the transport of waste and soiled linens in elevators.

(d) The Patient Transportation department will have satellite space in the lower level of the proposed cancer facility in order to store patient

stretchers and wheelchairs as well as provide a space assigned to staff that is proximate to the cancer patients in this building.

(e) The Supply Chain/Materials Management department is responsible for purchasing, shipping & receiving, inventory control, and distribution services for the facility. Supply Chain space in the lower level will benefit from direct access to the tunnel connecting the Cancer Building to UCM's Dock B location. Supply Chain space will include a breakdown room, medical gas tank storage, bulk supply storage, clean linen storage, soiled linen holding, biohazard waste holding, and trash holding. Clean linen space includes the building and holding of exchange carts which consists of linen from off-site commercial laundry processing.

C. Staff Support

Staff Support spaces (30,410 DGSF) are non-reviewable. Each floor of building will have staff locker rooms, toilets, lounges, and lactation/wellness rooms. These facilities will be shared by the departments located on each floor. Expanded staff collaboration and respite spaces are also available on Levels 2, 3, 4, and 6. In this era of healthcare worker shortages and staff burnout the proposed project aspires to keep in mind care of the caregivers by providing additional space for collaboration, nourishment, rest and respite in the building. Conference rooms will be dispersed throughout the building for Faculty and staff utilization. These rooms are planned for use across multiple departments for staff meetings and education. In addition to these conference spaces there is a community education center on Level 1 that will include a conference area for community education and support groups as well as an attached teaching kitchen for hands on healthy eating classes and nutritional education. Additionally the teaching kitchen can support the University of Chicago Pritzker School of Medicine Medical Education lecture series which is embracing the impact of food as medicine.

D. Public/Waiting / Retail

Public spaces (80,311 DGSF) include all of the Level 1 and Level 2 circulation and waiting areas, the chapel, the lobby café, the Image Shop, public restrooms and general corridors throughout the building that are not part of a suite. These spaces are not reviewable. The proposed Project will have two public entry and reception spaces – the first will be on Level 1 at the point of drop of and valet services on Drexel Avenue and the second is on Level 2 where the facility will connect via sky bridge to existing UCMC's Parking Garage B on the corner of Maryland Avenue and 57th Street. Both entrances will include a small reception desk and seating areas as well as aspire to be bright sun-lit spaces that overlook the outdoor pocket park which will be on the corner of 57th Street and Drexel Avenue. UCMC is reserving space in the building for future third party vendors providing retail services that will support the patients, families, and staff in the building. There is 1,230 DGSF held on Level 1 for a café space and an additional 1,700 DGSF square feet on Level 2 for a gift shop and cancer patient boutique. As a result of conducting multiple town hall and community engagement sessions the feedback helped shape the vision for a community accessible main lobby on the first floor

which includes community education space, resource lobby, prevention and screening spaces. This vision was also supported in a campus design workshop to create a welcoming environment to bring community, clinical, research and teaching into one building. This approach is very different than the Center for Care and Discovery (CCD) that contains a Sky Lobby on Level 7 that was designed for surgical waiting and visitors to the CCD building and not meant for the public.

E. Administrative Offices

Administrative Offices (2,945 DGSF) are located on Level 5 and are non-reviewable. A small, dedicated administrative suite will be provided for the clinical and administrative leadership. This space will also accommodate faculty managing the research staff in the dedicated, comprehensive cancer facility. This suite is in addition to the offices that are needed to be proximate to patients and staff areas and are thus embedded in the clinical departments.

F. Gardens

The proposed comprehensive cancer facility will include a pocket park on the corner of 57th Street and Drexel Avenue. UCMC would like to both provide world-class patient centered cancer care as well as achieving beauty and connectivity befitting of the campus, the institution, and the community. In addition to providing beauty and connectivity to the campus and community, there are significant benefits for patients having access to green spaces. The inclusion of these spaces will help provide a high-caliber patient experience, enhances sustainability and overall contributes to the quality of the campus as a community resource. The outdoor spaces are non-reviewable.

G. Tunnel, Bridges & Renovated Spaces

There is a planned tunnel that connects from the sub-basement of Garage B to the sub-basement of the proposed Project. The loading dock for the cancer facility exists in parking garage B and this tunnel will be the primary connection for moving materials into and out of the cancer facility. This tunnel is 1,134 DGSF and is non-reviewable. There is 1,322 DGSF of renovated space in Garage B associated with the new connection.

There are two bridges in the project. One bridge is at Level 2 (941 DGSF) and connects the proposed cancer facility to Garage B. There is 2,261 DGSF of renovation in Garage B associated with this connection. The second bridge is located at Level 5 and connects the proposed cancer facility to the Center for Care and Discovery ("CCD"). This bridge is 1,136 DGSF and there is 170 DGSF of renovation associated with this connection.

H. Overall Building Design

The building is designed into three distinct pods that surround a central core area. Each of the three pods are designed to be able to accommodate inpatient, outpatient, research and other future needs. The pods are also adaptable for future conversion should we need to

convert inpatient to outpatient or vice versa or even introduce research onto a previously occupied pod. The core design allows access directly from either the visitor or staff elevators to each of the pods. This avoids have unnecessary traffic through pods and provides the necessary privacy and separation. The core also provides robust services for mechanical, electrical, plumbing and IT infrastructure to accommodate a wide variety of future needs.

I. MEP Systems

The building is designed for flexibility of changes in clinical protocols in the future including the ability to convert spaces from inpatient to outpatient to research depending on how the needs change. The large building core helps facilitate flexibility of use by supporting increased MEP and IT infrastructure

a. Energy Performance:

The proposed Project will be designed to meet LEED v4 Gold Certification and the City of Chicago energy code requirements. National benchmarking and energy modeling will be referenced to develop building energy goals.

b. Mechanical

Hydronic and Steam Systems
The building will be cooled by a chilled water system served by a chiller plant on the 8th floor with an N+1 design and pipe sizing for the building's possible future expansion. The chilled water will be available 24/7/365 and will serve air handling unit cooling coils, fan coil units serving IT closets and electrical rooms, imaging and medical equipment such as CT Scanners, and MRI's. The chilled water system will be cross connected to CCD for redundancy and enabling greater efficiency in maintenance.

The heating system supplied will utilize high pressure steam from the University's central plant steam loop and enter the building via a new utility tunnel. The steam will be utilized to generate heating hot water via vertical flooded heat exchangers which will then serve air handling unit preheat coils and perimeter heating devices such as radiant ceiling panels and finned tube. A heat recovery system will generate heating hot water via heat recovery chillers during the summer time for energy efficiency.

Ventilation System
The proposed cancer facility will be provided with indoor air handling units located within the mechanical room on Level 8 and air handling unit zones are divided in accordance with program. In order to provide greater redundancy and resiliency, air handling unit systems are manifold together such that critical spaces continue to operate at the required air changes, temperature, humidity and differential pressure even if one unit fails or is down for

maintenance. This results in a greater first costs but brings greater operational efficiencies for the facility.

Some of the specialized ventilation systems will be a separate post event smoke removal exhaust fans to help fire fighters remove smoke out of the building post a fire event and hazardous exhaust fans for functions such as laboratory, patient isolation rooms and pharmacy including chemotherapy hoods, will be located on the roof with stacks.

In preparation for any future expansion, all systems requiring relocation when the vertical expansion is built will be provided with appropriate caps, valves, and dampers to enable vertical expansion of the building and relocation of exhaust fans and cooling towers in the future. Space is allocated for air handling units to serve fit out of shell spaces.

Building Automation and Temperature Controls
The building automation system will be a direct digital control system and be capable of fully monitor and controlling all critical mechanical, electrical, and piping systems used throughout the project. Local and remote alarming will be provided for the optimization of staff to maintain and respond to equipment failures. The system will be used to track KPI's and optimize building energy performance.

c. **Electrical:**
A minimum of two separate 12.47kV ComEd primary service feeders will be provided to the building, should a single feeder be taken out of service, the remaining feeder(s) will be able to support the entire facility.

The building's utility and emergency power sources such as the UPS room, generator room, switchgear room and ATS room will be located within Level 8 mechanical room. Emergency power will be supplied by three diesel generators in parallel. Space for a fourth future generator will be provided in the generator room to serve the future expansion of the building.

Normal Power System
The primary service feeders will be extended to a transformer vault located on level 8 and are sized to support mechanical and program loads located in the basement through level 8, as well as roof mounted equipment. Transformers installed in the vault will allow for 2N operation, ie, should one transformer be taken out of service the remaining transformers will be able to support the entire load of the facility. In order to provide greater resiliency, two sources of power will be extended to mechanical spaces with loads split between the two to avoid full system shutdown if one source is taken out of service.

Electrical rooms on each floor will include distribution panels, step-down transformers, and panel boards. Dry type transformers for conversion of

480V to 208Y/120V will serve panel boards in electrical rooms for branch circuits and general 120V lighting and receptacle loads. Each electrical room will also provide space for lighting control panels.

Emergency/Essential Power System
The emergency power system will include three diesel generators in the mechanical space on the 8th floor of the building. This arrangement will include a system of conductors, disconnecting means and overcurrent protective devices, transfer switches, and all control, supervisory, and support devices from the EPS up to and including the load terminals of the transfer equipment needed in order for the system to operate as a safe and reliable source of electric power. Secondary distribution from the emergency power system will be of radial design with multiple risers serving floors and areas to minimize building impact if a riser is taken out of service.

The generator system will fueled by two bulk underground diesel tanks to serve emergency loads continuously for 96 hours and are exterior to the building and pumped to the generator day tanks. For maintenance and testing purposes a permanent load bank will be located on the roof in order to perform required testing of the generators

Technology room loads will be connected to emergency power and will be backed up by a 2N, battery UPS system and served by dedicated panels in each technology closet.

A fully addressable fire alarm system will be installed. Fire alarm control panel will be located on Level 1.

d. Plumbing/Medical Gas

Medical Gas Systems
Oxygen service will be supplied by central bulk oxygen system and cross connected to the existing bulk system located in CCD via parking B tunnel for additional resiliency and as a redundant source. Medical vacuum and compressed air systems will be provided in the building. Appropriate medical gas alarm panels will be provided and located in the building.

Plumbing Systems
The proposed cancer facility's plumbing systems will include domestic water systems, waste and vent systems, storm system, subsoil drainage, and elevator sump pump systems. Dual incoming water lines will enter the building in the lower level.

Domestic hot water will be produced by duplex, water to water heat exchangers and will be pre-heated by a heat recovery source from mechanical equipment heat recovery chillers. The pre-heated water will be generated by

duplex plate and frame heat exchangers with a design outlet temperature of 120°F.

The hot water system temperature will be maintained by recirculating the hot water through a continuous loop with an in-line circulating pump. Localized heat exchanges for each pressure zone shall recirculate the hot water return and rewarm the water via use of a constant flow hot water recirculating line from the high-pressure side of the base building system.

e. Technology

The Dedicated, comprehensive cancer facility will be served from campus and external communication services brought into the facility via primary/entrance rooms on the Lower Level. The main technology room (MTR) will be located in the lower level of the building and telecom rooms will be stacked through the floors. The project will contain a universal structured cabling system including backbone fiber optic and copper cabling as well as horizontal Cat6A cabling, fit out of MTR/TR/BAS rooms, wireless network infrastructure, television signal distribution system, emergency responder and cell phone distributed antenna system, access control and duress system, security video system, intrusion detection system, overhead paging system, medical systems including nurse call and wireless telemetry, intercom systems, two way emergency communications system and synchronized clock systems per UCM standards.

f. Fire Protection

Two combined incoming water service lines will be brought into the building and made ready for connection to the fire pump and building systems. From this dual incoming water service arrangement, at the fire line, shall be provided a City of Chicago approved double detector check assembly with meter bypass that will supply the fire pump, standpipes, and sprinkler systems in the Phase 1 Dedicated, comprehensive cancer facility building and be sized to properly serve the vertical expansion.

A UL Listed centrifugal fire pump sized to adequately meet minimum fire protection demands will be provided in the lower level of the building. The fire pump will be sized in accordance with NFPA 13, NFPA 14, and NFPA 20. Current water supply flow test data will be obtained from the City Water Department in order to determine the required pressure rating of the fire pump.

A pre-action sprinkler system will be installed to protect the Main Technology Room (MTR).

g. Structural System

The structural system of the building is based on deep foundations utilizing caissons with a concrete core and structural steel columns and beam structure.

This system has been designed for the future possibility of a three floor expansion resulting in larger steel members and additional concrete structure therefore providing expansion capabilities if needed in the future. The floor structures for the shelled floors will be designed with increased capacity in order to maximize future flexibility for inpatient, outpatient, procedural, diagnostic and research purposes. The floor heights from the second to the fourth floor have been increased a total of 10 feet in order to minimize the necessary sloping of the bridge from the 5th floor of the Dedicated, comprehensive cancer facility to the 5th floor of the CCD to enable patients to be transported between the 2 buildings. This will minimize staff fatigue.

Section IV, Project Services Utilization

Attachment 15

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	MEET STANDARD?
YEAR 1					
YEAR 2					

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

Detailed projection rationale is provided in Attachment 19 and Attachment 31. Projections are provided through CY29, 2 years after projection completion.

Department	Historical Utilization 2022	Projected Utilization 2029	State Standard	Meets Standard?
Medical Surgical	153,459	178,710	178,038	Yes
ICU	40,902	45,395	34,314	Yes
CT	85,415	181,513	>70,000	Yes
MRI	26,526	35,546	>27,500	Yes
Ultrasound	16,421	21,874	>27,900	No
X-Ray	184,899	271,888	>136,500	Yes
Mammography	16,525	21,024	>20,000	Yes
OP Clinic Exam Rooms	62,618	86,363	N/A	N/A
OP Breast Center Clinic Exam Rooms	4,688	6,466	N/A	N/A
OP Infusion Therapy	23,944	33,691	N/A	N/A
OP Cellular Therapy	147	298	N/A	N/A

The following services are the current estimates of what the net impact on services with specific review criteria will be when the new dedicated, comprehensive cancer facility building is complete:

- 64 additional Medical-Surgical Beds
- 16 additional ICU Beds
- 30,000 square feet of shell space in the basement of the facility reserved for a potential future project to move Radiation Oncology into the building – while subject to UCM Board and future CON approval, the initial vision for a future Radiation Oncology department includes:
    - 4 LINAC (linear accelerator) vaults – a form of radiation therapy, these machines deliver high-energy particles to specific tumor sites
    - 2 CT simulators – which provide precise three-dimensional imaging of tumor sites for treatment planning
    - 1 High Dose Radiation room with afterloader – provides precisely targeted high dose radiation to specific tumor sites and significantly reduces the potential for personnel radiation exposure
- Relocation of Mammography and Breast Ultrasound equipment from the current location in UCMC's ambulatory center
- Two additional MRI units
- Two additional CT Scan units
- Two additional Ultrasound units
- One additional X-Ray/Radiography/Fluoroscopy unit
- One additional Mammography units

Evidence will be summarized below for the services above that are a net increase: Medical-Surgical Beds, ICU Beds, MRI, CT scan, Ultrasound, Radiography / Fluoroscopy, and Mammography. The other services noted above will be relocated from current locations on campus, either moving current equipment, or retiring current equipment and replacing with new equipment. When there will be no net increase in the number of machines, evidence for an increase in utilization will not be addressed in this application.

According to the Inventory of Health Care Facilities and Services and Need Determination released in October 2021, Planning Area A-03 has a combined excess of 518 medical surgical and pediatric beds. However, the Medical-Surgical beds across the planning area are not interchangeable, and the raw bed numbers provide an incomplete picture of the need for inpatient capacity in Planning Area A-03. The acuity mix of UCMC is more than 45% higher than that of any other hospital in the Planning Area, meaning that UCMC's Medical-Surgical and ICU beds are used for more acutely ill patients. UCMC also sees a higher volume of patients. In 2021, UCMC had close to 25,000 admissions with the next highest hospital in its planning area had only a fourth as many admissions. In 2022, UCMC had more than 25,000 admissions even when excluding pediatric and obstetric patients. And these admissions do not account for the hundreds of transfer requests from nearby safety net hospitals that UCMC must turn down because of its shortage of available beds.

As part of the ongoing renovation of Mitchell Hospital as part of CON Project 16-008, UCMC has not staffed the full complement of licensed Medical-Surgical beds as units are opened and closed for renovation work. The number of staffed beds has gone up in stages, starting in May 2018 through December 2021. During this bed expansion over time, with the exception of the first three months at the beginning of the COVID-19 pandemic in spring 2020, the staffed Medical-Surgical beds ran above 90% utilization each month. Similarly, the full complement of ICU beds has not yet been opened during renovation, yet ICU beds ran at greater than 60% utilization of the licensed number of beds from 2017 to present, even during 2020 when the onset of COVID-19 caused the cancellation of elective procedures and inpatient stays. In the summer and fall of 2021, ICU occupancy often exceeded 90% utilization. Bed utilization data is presented in detail in the next section of this application. Planning Area A-03 is still an underserved area, especially when compared to the outmigration in its area.

The rate of cancer is increasing overall, with the incidence higher in the South Side communities than elsewhere in the city and state, but the demand for cancer treatment is not felt equally among providers. The increased demand for cancer care may soon outpace capacity of hospitals and inhibit their ability to provide timely treatment. Both the high acuity that UCMC treats and the incidence of cancer on the South Side, contribute to the pressing need for additional beds. A recently retrospective, hospital-level study using data from the National Cancer Database from January 1, 2007, to December 31, 2016, found that patient volume increased more rapidly at NCI-designated and academic centers than at community hospitals, with particularly high growth at referral centers at NCI-designated facilities. Specifically, in this study sample that included more than four million patients treated at 1351 hospitals, patient volume increased 40% at NCI centers, 25% at academic centers, and 8% at community hospitals. The mean annual patient volume growth rate was 45.2 patients at NCI hospitals and 13.9 patients at academic hospitals compared with 2.0 patients at community hospitals [1]

The study also found that, for most of the cancers studied, TTI increased regardless of hospital type. This trend may partially reflect the increasing complexity of treatment decisions and a desire to consider the results of molecular testing when making frontline treatment decisions. Because of the potential association of such delays with emotional distress and survival, continued efforts to ensure timely cancer treatment are warranted.

The health care needs of the population in Planning Area A-03 are also unique, with some of the highest rates of disease and mortality, which has only been compounded by the COVID-19 public health emergency. This incidence of disease isn't accounted for the bed utilization predicted for the future and only amplifies the critical need for additional resources.

It has been over two years since the COVID-19 pandemic created an unprecedented public health crisis throughout the world. Although the threat of COVID-19 has decreased due to vaccination efforts, its devastating effects will be felt for years to come. Especially concerning is the drop in cancer screening rates, with the most dramatic reduction in screening occurring in medically

[1] Frosch ZAK, Illenberger N, Mitra N, et al. Trends in Patient Volume by Hospital Type and the Association of These Trends With Time to Cancer Treatment Initiation. *JAMA Netw Open*. 2021;4(7):e2115675. doi:10.1001/jamanetworkopen.2021.15675

underserved communities. This has led to decreases in diagnosis and treatment and is expected to result in thousands of preventable deaths.

According to the Centers for Disease Control and Prevention, the screening rates for breast and cervical cancers fell by more than 80%, with the most severe declines occurring in populations of low-income women of color.

The threat of worsening cancer outcomes has been recognized by the international cancer research community as a leading priority. In a June 2020 editorial, the director of the National Cancer Institute, expressed concerns about the mortality related to breast and colorectal cancer in particular. Early projections showed that if these trends continue, mortality for these cancer types is expected to increase by nearly 10,000 in the next 10 years in the U.S. alone as a result of missed cancer screenings and treatment, assuming a disruption of 6 months. However, the pandemic has lasted far longer than anyone anticipated, so the effects could be greater. It is not surprising that the underserved communities comprising Black and Hispanic people are disproportionately affected.

Both due to the high acuity that UCMC treats and the incidence of disease, including cancer on the South Side, contribute to the pressing need for additional beds to ensure timely access to care.
The addition of beds will not cause any duplication of services because of the different roles served by UCMC as an academic medical center providing tertiary and quaternary care and the community hospitals with a primary and secondary care focus.

The proposed project will include 80 total beds at the Medical Center, comprised of 64 Medical-Surgical beds and 16 ICU beds. The addition of these beds will be used to house Cancer patients who would otherwise be placed in other Medical-Surgical units across the hospital. These units will be included in a state-of-the-art comprehensive Cancer facility that provides a premier patient experience, streamlines the delivery of Cancer care, and continues the Medical Center's tradition of impeccable quality and safety.

While these units will be physically designed to suit the unique requirements of Cancer patients, there will also be significant care delivery benefits. Condition-specific units, like those in this center, will ensure that the patient care team develops the specialized skillsets needed to address all of the components of Cancer care.

Evidence that the utilization of the proposed beds and services will meet or exceed the utilization targets established in 77 Ill. Adm Code 1100 within 2 years after completion of the future construction or modification projects. Documentation shall include:

a. Historical service/bed utilization levels;
b. Projected trends in utilization, including the rationale and projection assumptions used in those projections;

ATTACHMENT 15

c. Anticipated market factors such as referral patterns or changes in population characteristics (age, density, wellness) that would support utilization projections; and
d. Anticipated changes in the delivery of the service due to changes in technology, are delivery techniques or physician availability that would support the projected utilization levels.

Historical and Projected Utilization – Medical-Surgical Beds

UCMC is currently renovating beds in the Mitchell Hospital as part of CON project 16-008, which was altered in September 2021, and is now licensed for 481 Medical-Surgical beds. UCMC opened the Center for Care and Discovery in 2013, which was licensed for 300 Medical-Surgical beds at the time. Thirty-eight (38) additional Medical-Surgical beds were then added as part of CON project 13-025 in October 2013, which reactivated beds in Mitchell Hospital. CON project 16-008 was then approved in May 2016, and an alteration was approved in September 2021.

UCMC anticipates that 80 additional inpatient bed licenses (64 of which are Medical-Surgical and 16 of which are ICU) are being requested as part of this application, which would bring total Medical-Surgical beds to 545.

While *licensed Medical-Surgical* beds demonstrate an occupancy below the state standard of 90%, it is important to note that the Medical Center's Medical-Surgical beds available for *staffing* (see: staffed Medical-Surgical beds), consistently have greater than 90% utilization. In the last twelve months, from January 2022 to January 2023, the average occupancy of staffed Medical-Surgical beds has been at 96% utilization at morning census. As staffing shortages are addressed and procedural cases are ramped up to pre-pandemic levels, it is anticipated that utilization figures will follow suit.

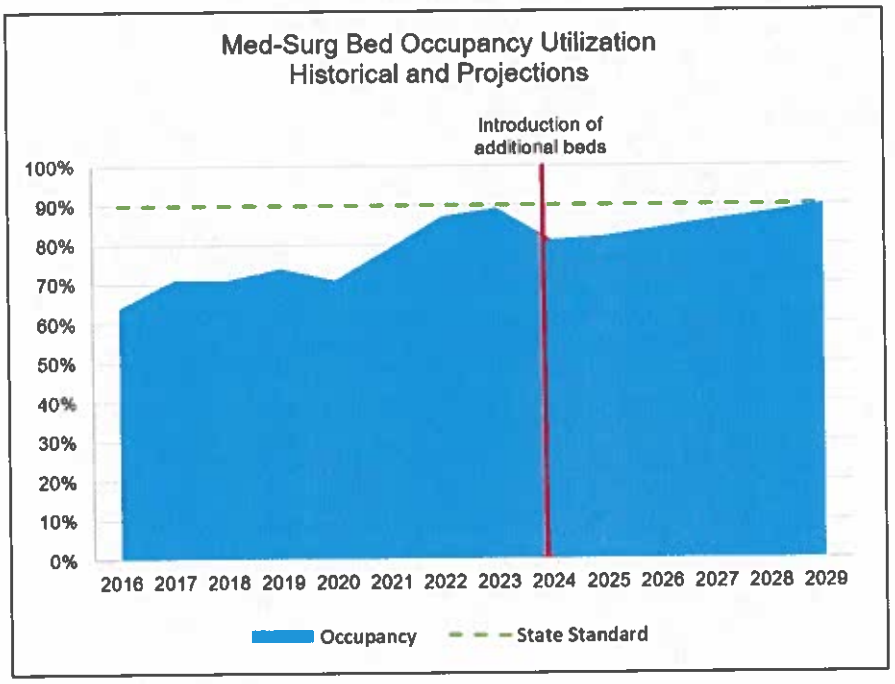
Utilization – Medical-Surgical only (FY2016-FY2029)					
	Dept/Service	**Historical Utilization**	**Projected Utilization**	**State Standard**	**Meet Standard?**
Year	**Medical-Surgical Beds**			**90% Occupancy**	
2016	506	118,273		64%	No
2017	506	130,516		71%	No
2018	506	130,347		71%	No
2019	506	136,794		74%	No
2020	506	130,516		71%	No
2021	506	146,524		79%	No
2022	481	153,459		87%	No
2023	481		156,835	89%	
2024	545		160,285	81%	
2025	545		163,812	82%	
2026	545		167,416	84%	

ATTACHMENT 15

2027	545		171,099	86%	
2028	545		174,863	88%	
2029	545		178,710	90%	Yes

Source: EPIC ADT Patient Census Data

Medical-Surgical bed utilization has historically seen a compound annual growth rate of 4.4% between FY2015 and FY2022. Applying this growth rate would meet the states 90% utilization threshold in one year's time. However, the growth estimates shown in the table above are more conservative to account for any future volatility in inpatient volumes, largely to account for any pandemic-related disruptions. A projected growth rate of 2.2% was applied from FY2023 onward. Historical utilization is inclusive of standard inpatients and observation patients treated in licensed Medical-Surgical beds.



Historical and Projected Utilization – Intensive/Critical Care Beds

UCMC is currently renovating beds in Mitchell Hospital as part of CON Project 16-008, which was altered in September 2022, and is now licensed for 142 ICU beds. UCMC opened the Center for Care and Discovery in 2013, which was licensed for 114 ICU beds at that time. Twelve ("12") additional ICU bed licenses were added as part of CON Project 14-013 in August 2014, which was a project to build out the shelled space on the 3rd and 4th floors of the Center for Care and Discovery, relocate beds to those floors, and add ICU beds. CON Project 16-008 was then approved in May 2016, and an alteration was approved in September 2021.

UCMC has exceeded 60% utilization for ICU beds each year since 2017, based on a license for 146 ICU beds, which has since been reduced to 142. The 37,663 patient days seen in FY21 would justify 172 ICU beds at 60% utilization

ATTACHMENT 15

UCMC is requesting an additional 16 ICU bed licenses, which would bring the total ICU bed licenses up to 158. The requested number is lower than the 172 justified above.

Utilization – ICU Only (FY2016-FY2029)					
	Dept/Service	Historical Utilization	Projected Utilization	State Standard	Meet Standard?
Year	ICU Beds			60% Occupancy	
2016	146	31,114		58%	
2017	146	32,629		61%	
2018	146	35,254		66%	
2019	146	36,348		68%	
2020	146	35,000		66%	
2021	146	37,663		71%	Yes
2022	142	40,902		79%	Yes
2023	142		41,516	80%	
2024	158		42,138	73%	
2025	158		42,770	74%	
2026	158		43,412	75%	
2027	158		44,063	76%	
2028	158		44,724	78%	
2029	158		45,395	79%	Yes

Source: EPIC ADT Patient Census Data

While ICU utilization has seen a historical compound annual growth rate of 4.7% between FY2016 and FY2022, the growth estimates shown are more conservative to account for any future volatility in ICU volumes. A projected growth rate of 1.5% was applied from FY2023 onward. Note that ICU utilization is inclusive of all ICU beds, agnostic of adult or pediatric designation. NICU beds are not included in this analysis.

Medical-Surgical Bed to ICU Bed Ratio Comparison

To better understand UCMC's current and future bed composition, an analysis was completed to compare bed counts and types across Chicago's academic medical centers. UCMC's ratio of Medical-Surgical beds to ICU beds is on par with other academic medical centers in the region, and the requested revisions to the bed licenses will not change the ratios drastically.

Hospital	Medical-Surgical Beds	ICU Beds	Ratio (M/S-ICU Beds)
Northwestern Memorial Hospital	506	139	4.0
Rush University Medical Center	506	132	2.7
University of Illinois Hospital and Clinics	506	65	3.7
UCMC Beds (Current + Requested)			
Hospital	**Medical-Surgical Beds**	**ICU Beds**	**Ratio (M/S-ICU Beds)**
University of Chicago Medical Center (Current Bed Count)	481	142	3.4
University of Chicago Medical Center (Current + Requested Bed Count)	545	158	3.7

Source: Illinois Annual Hospital Questionnaire 2020

Historic Growth Even Amidst the COVID-19 Pandemic

Over the past four years, Medical-Surgical admissions have grown by nearly 10% and bed days have grown by nearly 20%. UCMC had observed an even stronger upward trajectory in the days before March 2020, but the COVID-19 pandemic had an outsized impact in dropping admissions and procedures for the following 12-24 months. At current, UCMC has been able to rebound from those volume declines and is returning to pre-pandemic volumes.

The key to this growth has been two-thronged, with steady growth in emergency admissions in the past two years as well as UCMC's intentional investments in key service lines (like Cancer, Digestive Diseases, Heart and Vascular, Musculoskeletal, Neurosciences, and Transplant).

Below is a graph that describes UCMC's anticipated growth across all service lines. Using annual growth rates from before the COVID pandemic (3.0%), during the height of the COVID pandemic (-1.6%), and currently (2.2%), a model was created to estimate the expected number of patient admissions should patient volumes move along the trajectories of any of the three scenarios. At its current rate, the Medical Center is expected to see a total of 11.3% growth in admissions in the following four years.

The anticipated inpatient admission growth drives UCMC's need to expand its inpatient capacity. With the movement of Cancer patients to a dedicated building with service-specific inpatient units, we will use existing capacity for new backfill opportunities. Several key service lines have grown in both program size and patient demand over the past few years, with UCMC Neurosciences volumes expanding nearly 35% between 2018-2022 and Heart & Vascular growing nearly 15% in the same time period. We fully expect to fill other inpatient capacity that is opened up as a result of this project.

A more detailed analysis of utilization is included in Attachments 19 and 31.

Section IV

Attachment 16, Unfinished Shell Space

1. The total gross square footage of the proposed shell space at the UCM dedicated, comprehensive cancer facility is 135,739 BGSF.

2. The proposed shell space has been located on the following floors:
   a. Lower Level – 29,710 BGSF for a future Radiation Oncology department that is planned for (4) Linear Accelerator vaults and various patient and staff support spaces.
   b. Level 5 – 36,300 BGSF for future medical/surgical inpatient units that would include (32) patient beds plus various family and staff support spaces.
   c. Level 6 – 13,454 BGSF for a future medical/surgical inpatient unit that would include (16) patient beds plus various family and staff support spaces.
   d. Level 7 – 56,275 BGSF for future medical/surgical inpatient units that would include (32) patient beds plus various family and staff support spaces. Other shell space on Level 7 might include a cGMP Facility that would be directly involved with cancer treatment and research performed in the Dedicated, comprehensive cancer facility.

3. The proposed shell space is planned for the experienced increase in the need for both inpatient beds and space needs for Radiation Oncology.

Med-Surg and ICU Beds

UCMC has experienced continued growth in Med-Surg bed and ICU bed utilization. Between FY2016 and FY2022, UCMC compound annual growth rates were 4.4% for Med-Surg beds and 4.7% for ICU beds.

	M/S Beds	ICU Beds
Years	Patient Days	Patient Days
2016	118,273	31,114
2017	130,516	32,629
2018	130,347	35,254
2019	136,794	36,348
2020	130,516	35,000
2021	146,524	37,663
2022	153,459	40,902
Annual Growth Rate (FY16-FY22)	4.4%	4.7%

ATTACHMENT 16

Radiation Therapy

In the past 6 years, UCMC's Radiation Therapy volume has stabilized year over year, largely due to UCMC's offsite ambulatory locations meeting the needs of the growth.

	Radiation Therapy
Years	Treatments
2018	17,724
2019	18,396
2020	17,472
2021	16,044
2022	16,584
Annual Growth Rate (FY18-FY22)	-1.6%

UCMC currently has (4) existing Linear Accelerator vaults in the outpatient building DCAM whose size is limited for newer equipment. The shell space would accommodate the space required for modern Linear Accelerators in addition to potential new technologies not currently identified.

4. **Provide:**
   a. **Historical utilization for the area for the latest five-year period for which data is 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.**

Med-Surg and ICU Beds

The utilization projection shows continued growth for both Medical-Surgical beds and intensive care beds. With current growth trajectory, by 2029 the volume would justify 569 Med-Surg beds and 214 ICU beds, based on current state standards.

Projected Days				
	M/S Beds		ICU Beds	
Years	Patient Days	Justified Beds	Patient Days	Justified Beds
2016	118,273		31,114	
2017	130,516		32,629	
2018	130,347		35,254	
2019	136,794		36,348	
2020	130,516		35,000	
2021	146,524		37,663	
2022	153,459		40,902	
2029	178,710	545	45,395	208
2030	182,642	556	46,076	211
2031	186,660	569	46,767	214

ATTACHMENT 16

M/S Beds justified at 90% occupancy = 186,660/365/0.9 = 569
ICU Beds justified at 60% occupancy = 46,767/365/0.6 = 214

	M/S Beds	ICU Beds	Total
Potential Total Incremental Justified Beds	24	56	80

Radiation Therapy

A key objective of the Dedicated, comprehensive cancer facility is to reduce fragmentation and improve coordination of care and services across different disciplines. The Dedicated, comprehensive cancer facility will allow all providers to work under "one roof" and provide patients with a single destination to receive cancer care. Co-locating Radiation Therapy in the Dedicated, comprehensive cancer facility along with other disciplines is a long term vision of UCMC.

In FY22, there were 16,584 radiation therapy treatments at UCMC. Based on Sg2's forecast, radiation therapy will experience a modest growth in the next 10 years (4%) as new and expanded use of combination treatments of immune and radiation becomes common. Volume projections based on Sg2's 10-year growth rate of 4%, show the utilization to be at a similar level as FY22 in FY32. While we do not anticipate needing an additional Linear Accelerator in the future, we may leverage the shell space for new therapies and technologies we have not identified.

Projected Utilization		
	Radiation Therapy	
Years	**Treatments**	**Accelerator**
2018	17,724	4
2019	18,396	4
2020	17,472	4
2021	16,044	4
2022	16,584	4
2031	17,191	4
2032	17,259	4

Section IV

Attachment 17, Assurances

1. The University of Chicago Medicine 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. We anticipate that the shell space will be developed in phases which will depend on demand and types of services needed.

2. The estimated date by which the first subsequent CON application (to develop and utilize the subject shell space) will be submitted is April 30, 2029.

Section V Master Design and Related Projects 1110.5235(c)

Attachment 18

Relationship to Previously Approved Master Design

In March 2022, HFSRB granted UCMC's request for a CON Master Facility Plan (Project #22-004), which allowed UCMC time to engage its broader community in this planning effort, alongside the architects, and to refine the design based on the community's input.

On the South Side of Chicago, where people are twice as likely to die from cancer than those who live just about anywhere else in American, and cervical cancer mortality rivals that of several of the poorest nations in the world, UCMC knew it could not build a patient-centered cancer hospital without the community at its side.

The approval of the Master Design Permit enabled UCMC to do just this -- to strategically plan the design and development of a world-class, dedicated cancer hospital in partnership with its community. Robust community and patient engagement was at the core of UCMC's design process to allow input not from only its architectural and engineering professionals, but also from current patients and cancer survivors. Over the past ten (10) months, UCMC actively sought out the voice of its community by conducting a community telephone poll, sending out over 200,000 community engagement surveys, convening its Community Advisory Council four times, hosting two town hall meetings, and meeting with community hospital, political and faith leaders. UCMC learned that its community supports the development of a world-class cancer in their neighborhood as a destination for those with cancer from near and far, and their input dramatically shaped the building's design.

UCMC also learned from the community that a cancer hospital means more to them than treatments and medication for when they get sick but a place that can help them stay well. For this reason, UCMC transformed the design of the ground floor of the building to be a mainstay of health and wellness for all comers by providing a healing environment to welcome patients along all stages of their treatment journey. The community described it as a possible "town center" or "village square" that serves as a community hub for cancer prevention, screening and diagnoses with healthy lifestyle and wellness and other educational resources. For this reason, UCMC has included a teaching kitchen and education space to host healthy eating and cooking classes. The wellness areas and resource library where the community, patients, and families can be connected with education and resources are designed to both support a journey through cancer treatment but also to reduce the risks associated with cancer including smoking cessation aids, exercise classes, mindfulness and stress management amongst others. The wellness space is also the home of the Cancer Risk and Prevention Clinic area which will help patients assess their potential genetics risks, discuss early detection, and coordinate preventative screenings.

Nothing about a cancer diagnosis is simple, but UCMC now better understands that access to services, information and education and a means to support quality of life during cancer care should be as simple as possible for patients on this journey. In the words of UCMC's own patients, "providers cannot be so focused on saving lives that [they] don't think about the quality

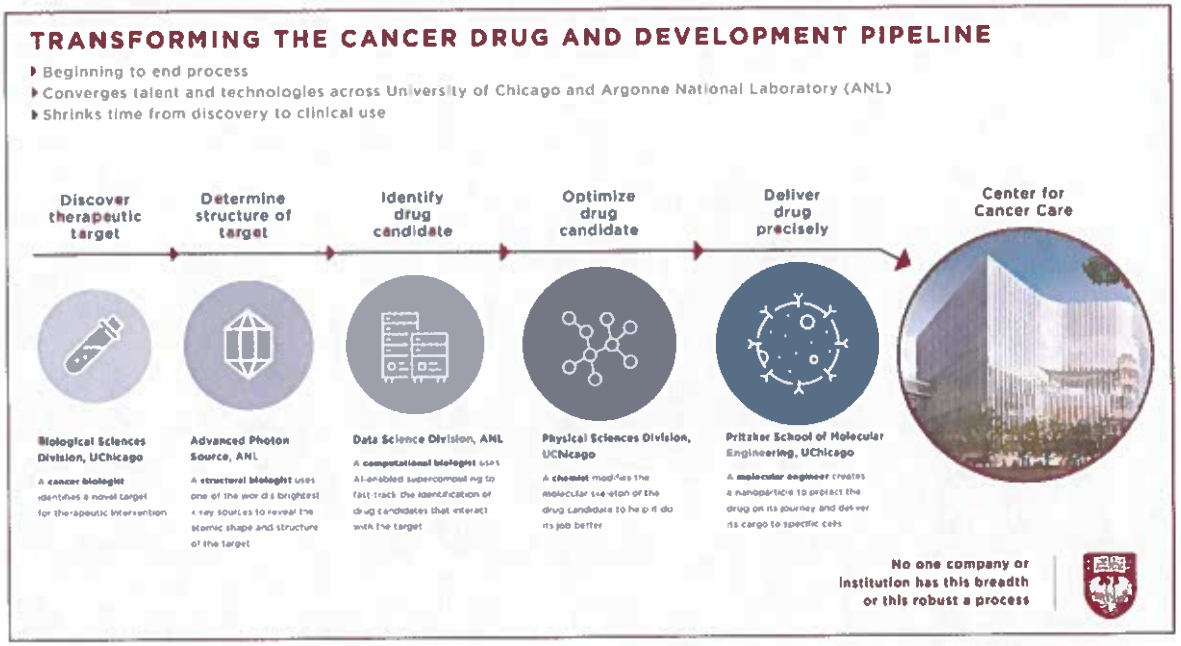
of life." Part of the design of this building is to enhance quality of life for cancer patients and their families to the greatest extent possible.

Additionally, UCMC heard from both its patients and its providers the need for research to be a part of the building. This project will support a wide range of cutting edge research advancements and clinical trials that are already happening at UCMC but will also facilitate UCMC's vision for transforming the cancer drug and development pipeline – from drug discoveries to patient delivery. The aspiration of creating a new and innovate oncology pipeline means discovering and developing therapies for innovative treatments. This means providing space for researchers to interact with patients, their families and other clinical staff where patients are receiving clinical services, such as consultation space to educate patients and families on available clinical trials. The participation in clinical trials also requires space on the inpatient and outpatient units to manage the extensive research-related testing in protocols sponsored by pharmaceutical companies. Additionally, clinical trials require space to maintain all of the research kits and drugs needed throughout the trial. Research is an integral part of every part of the proposed dedicated, comprehensive cancer facility's design and is crucial to helping find a cure for cancer.

UCMC's patients and their families are the inspiration for its scientists on their mission of discovery. As UCMC treats patients today, its scientists will be researching developmental biology and genetics, cellular biology, cytogenetics, tumor immunology, transplant biology, pharmacogenetics, and protein targeting to develop the treatments of tomorrow. Much of UCMC's basic research carries over into clinical studies. With the scientific discoveries made in basic science research, both with scientists at the University of Chicago as well as with industry partners, UCMC dedicated to expanding access to clinic trials, particularly for groups that have historically been underrepresented in cancer research.

Integrating Cancer Research and Patient Care in the New Cancer Center

We have a vision for transforming the cancer drug and development pipeline – from drug discovery to patient delivery.



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UCMC's path to transformative cancer care is not just a physical structure but a dynamic, healing environment that centers around the patient, bringing clinical and supportive services to the patients, leveraging technology, and integrating the latest research for the best outcomes.

UCMC believes the Project for which it now seeks approval represents the thoughtful collaboration of key stakeholders, including residents in our planning area, not just for the construction of a new building, but also for a model of groundbreaking cancer care – and cancer prevention – established upon the principles of access, equity, dignity and innovation.

Table 1. The Master Design Permit granted UCMC more opportunities to engage the community and gather their input through town halls, community events, and a robust surveying tool. Some of the key community engagement activities are listed below:

Event	Date	Notes	Exhibit
South Side Poll	April 22-28, 2022	• Conducted by Impact Research on Behalf of UCMC as a live phone and text to web survey.	Exhibit 1. Poll Findings
Community Survey	July 11 – October 31, 2022	Pushed to >200,000 persons through QR codes, online access points, community events, email blasts, social media promotion, Chicago Sky partnership, etc. Questions focused on how to build a patient-centric	Exhibit 2. Community Survey Findings

ATTACHMENT 18

		cancer center that meets the needs of the community.	
Community Webcast	August 1, 2022	"At the Forefront: Cancer Center of the Future" part of a series of complex health at social issues, featuring Brenda Battle (SVP Community Health Transformation), Sonali Smith, MD, (Section Chief, Hem/Onc) and Candace Henley. (Survivor, Patient Advocate)	Exhibit 3. Link to webcast
Zoom Town Halls	July 27, 2023 August 30, 2023	Featured: Candace Henley (Member CAC) Tom Jackiewciz (UCMC President) Kunle Odunsi, MD, PhC (Director of UCM Comprehensive Cancer Center) Sonali Smith, MD (Section Chief, Hematology/Oncology) Brenda Battle, (SVP of Community Health Transformation and Chief DEI Officer) Marco Capicchion, (VP For Cancer Center Facilities) Cannon Design Attended by more than 100 residents of the South Side Community.	Exhibit 4a. Slides from July 27, 2023 Meeting. Exhibit 4b. Slides from August 30, 2023 Meeting.
Community Advisory Council	Quarterly Meetings	Brenda Battle, (SVP of Community Health Transformation and Chief DEI Officer) Marco Capicchioni (VP For Cancer Center Facilities) Discussion of Cancer Center plan & Community Health Needs Assessment	Exhibit 5. Community Advisory Council
Harper Lecture, Kunle Odunsi, MD PhD, Director of UCM Comprehensive Cancer Center	May 11, 2022	"Changing the Future of Cancer Health Disparities"	Exhibit 6. Slides from Harper Lecture
Faith Leaders' Breakfast	August 13, 2022	Over 50 Attendees from faith-based organizations on the South Side of Chicago	
Community Events	Various	Hosted and/or Attended more than 50 community health related events; grant making; and other research-related activities through the Office of Community Engagement and Cancer Health Equity	Exhibits 7a, b, c. Community education, OCECHE mini-grants, community research, and other events.

UCM has regularly engaged in efforts to provide cancer screening and prevention for its community members, and it is not waiting for the new building to undertake these activities. In tandem with those screening activities, UCMC engages in talks and presentations to its underserved populations, including the Black and Latinx community, to educate them on cancer risks and prevention. In the past year, UCMC has hosted the following community events:

- 11 Community Events and Health Fairs
  - » Black Women's Expos

ATTACHMENT 18

- » African Festival For the Arts
- » Distribute information about cancer screenings and HPV vaccination
- » Chicago Family Health, SALUD Center, South Shore Cultural Center, churches, Vincennes Senior Center, Salvation Army, DePaul College, etc.

- 12 Talks and Presentations
  - » Cancer-focused community health worker training
  - » Basic cancer education, HPV, breast density, colorectal and lung cancer
  - » Participants earned certificate of completion
- 5 Cancer Health Equity "Webinar Wednesdays"
  - » Topics — gynecologic cancer, blood cancer, sexual healing after cancer, prostate cancer, caring for your spirit
- 21 Other Health Events
  - » 8 on women's health — breast cancer screening, genetic testing, wellness
  - » 13 on men's health — prostate cancer, wellness, prevention, screening

UCMC already maintains many avenues for communication –

- Community Advisory Council: broad representation of South Side
- Community e-newsletter: weekly distribution to 12,000 residents
- WVON Community Health Hour: radio program each Saturday
- Social media: target by ZIP codes
- Flyers: at gathering places like churches, barbershops, etc.
- Standing community meetings: drop-in as a guest presenter

And the content UCMC creates get distributed to the community in the following ways:

- Owned channels: TV show, website, social media, e-newsletters, magazines
- Earned media: research papers, clinical innovation, patient stories
-

Table 2. Comparison of Master Design CON to Construction CON

Design Attributes	Master Design CON	Construction CON
Connectivity to other Buildings	Three bridges and one tunnel to existing medical campus buildings	• Two bridges and one tunnel to existing medical campus buildings.
Inpatient Services	• Inpatient services included: o 128 inpatient beds • Inpatient and chemo pharmacy	• Research supportive environments • Inpatient services included: o 80 inpatient beds • Inpatient and chemo pharmacy
Outpatient Services	• Outpatient services included: o Clinical exam rooms	• Outpatient services include: o Clinical exam rooms

	○ Infusion treatment space ○ Phlebotomy ○ Urgent care for cancer patients ○ Imaging and diagnostic services • Radiation Oncology	○ Infusion treatment space ○ Phlebotomy ○ Urgent care for cancer patients ○ Imaging and diagnostic services ○ Breast Center ○ Research supportive environments ○ Pharmacy Supportive services, including education and wellness, for healthy lifestyles both for cancer prevention and during cancer treatment
Cancer Research Support	○ Not Included	Extensive environments supportive of research and clinical trial participation ○
Shelled Space	○ 30,000 gsf	○ 135,739 gsf

Table 3. Graphical Comparison of Master Design CON versus Construction CON

Table 3. Master Design CON v Construction CON

Size & Investment	Master Design CON 544,000 GSF $633.3 M	Construction CON 575,000 GSF $815.1M
Building Financing Shelled Floors	$633.3 M	$630.5 M $71.6 M $113.0 M
Construct	• 5 stories (incl. 128 beds) • 1 lower level • 1 mechanical penthouse	• 7 stories (incl. 80 beds) • 1 lower level • 1 mechanical penthouse
Build-Out	• Floors 1 - 5 • LL for support services • Mechanical penthouse	• Floors 1 – 7* • LL for support services • Mechanical penthouse
Shelled in Spaces	• 1 pod of exam rooms • 1 pod of infusion bays	• Radiation Oncology • Equivalent of two floors
Future Vertical Expansion	• 4 additional floors & 1 mechanical penthouse • Designed for a wide variety of future uses.	• 3 additional floors & 1 mechanical penthouse • Designed for a wide variety of future uses.

*See Final Shell Space Configuration diagram at right for placement of shell space

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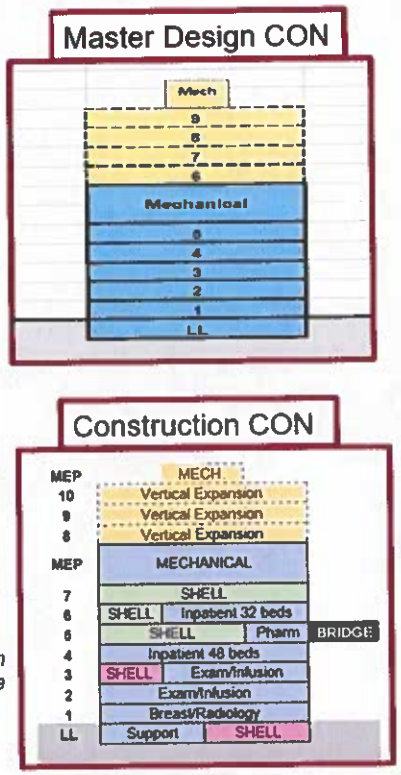

Throughout the past 10 months, UCMC relentlessly sought out the input of its community, which, dramatically shaped the building's design. The Project UCMC now proposes is similar to the one approved under the Master Design Permit, but better tailored to the depth and breadth of the community's needs and to account for increased demand for cancer services in the coming years. While the Project is incrementally larger, with a cost increase and an increase in square footage, the increases are commensurate with the anticipated demand for a cancer hospital dedicated to both treating and preventing cancer.

The current Project has changed from the Project described in the Master Design Permit in the following ways:

» **The increase in cost:**

- Hyperinflation experienced since the original estimate made in the spring of 2021 is over $100 M. While consumer price index may show a slowing of inflation we continue to see pressure with the producer price index for manufactured goods. Construction sector seems to lag the others with price decreases.
- Number of built occupied floors from 6 to 7 and total capacity of from 10 to 11 floors with future vertical expansion.

ATTACHMENT 18

- Future flexibility of the building to accommodate the role of academic medical centers to manage the most acute patients. Despite the trends of ambulatory services shifting to retail and inpatient services to outpatient, the number of acute care beds for academic medical centers and UChicago continue to climb.
- Shift from Silver to Gold LEED certification.
- Increased resiliency of the building to weather storms including potential flooding events. Virtually all critical mechanical, electrical and technology infrastructure has been moved to the building penthouse and out of the lower level.
- City of Chicago continues to update and enhance their code requirements especially with respect to wind and seismic events. Evaluation of soil conditions revealed design enhancements that needed to be made to the foundation, structural and the exterior shell of the building to ensure its structural integrity.
- Due to the extreme uncertainty of the last two years the UCMC's Board of Directors requested that we employ more conservative cost estimating methodology.

» **The Increase in the number of floors**

The increase in the number of floors was the result of UCMC's efforts under the Master Design Permit, and the realization of the limited space on the campus to expand the adult medical campus. Due to the physical constraints of a densely populated urban area, we sought to maximize the utilization of the air space on the land. The Master Design Permit also outlined the eventual need to replace Mitchell Hospital that was built in 1983 and will be 45 years old when the new Dedicated, comprehensive cancer facility building opens.

» **The Reduction in the number of inpatient beds**

The reduction in the number of inpatient beds from 128 to 80 was a direct response to managing the escalated cost of the overall Project. Balancing the factors impacting the cost of the project UCMC determined it was prudent to only build out of the portion of the inpatient beds and created shelled space for future expansion. At this time, UCMC determined it was best to defer moving the surgical oncology patients to the new building since the operating rooms for surgical oncology patients will remain in the Center for Care and Discovery (CCD).

» **Increase in shelled space**

The increased amount of shell space from 30,000 gsf to 161,000 gsf was driven by a change in strategy necessitated by the impact of hyper-inflation and other factors mentioned before. Here are some of the specifics:

- 30,000 gsf of radiation oncology was shelled since we believe that ultimately it should be included in the dedicated, comprehensive cancer facility. On the other hand the high cost of building the vaults now with no increase in volume did not seem prudent.
- 50,500 gsf was attributable to the reduction in the number of beds being built out (80 vs 128).

- 50,500 gsf of shell was added to the project in order to ensure future speed to market depending on future needs including inpatient, outpatient and research. Vertical additions require an extensive amount of time (four to five years) to construct versus the short lead time for building out shell space (two years).

UNIVERSITY OF CHICAGO MEDICINE
HYDE PARK CANCER CENTER

SCHEMATIC DESIGN DIAGRAMS FOR CON SUBMISSION
JANUARY 31, 2023

KEY

Reviewable

With Standards

Acute Care
-Med/Surg Inpatient Unit (500-660 DGSF/Bed)

Critical Care
- Intensive Care Service (600-685 DGSF/Bed)

Diagnostic & Treatment
- General Radiology (1,300 DGSF/Unit)
- Mammography (900 DGSF/Unit)
- Ultrasound (900 DGSF/Unit)
- CT Scan (1,800 DGSF/Unit)
- MRI (1,800 DGSF/Unit)

With No Standards

Ambulatory
- Exam Rooms
- Infusion Rooms / Bays
- Outpatient Cellular Therapy (OCT)
- Oncology Rapid Assessment Clinic (ORAC)
- Phlebotomy
- Wellness Center

Cancer Ancillaries
- Human Tissue Research Center (HTRC) & Biofluids Lab
- Pharmacy

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UNIVERSITY OF CHICAGO MEDICINE
HYDE PARK CANCER CENTER

SCHEMATIC DESIGN DIAGRAMS FOR CON SUBMISSION
JANUARY 31, 2023

KEY

Non-Reviewable

- Building Support (Mechanical, Support Services, EVS)
- Staff Support (Innovation, Collaboration, Work Areas)
- Public Space (Chapel, Retail, Waiting, Cafe)
- Administrative Offices
- Shell Space
- Tunnel, Bridges & Renovated Spaces

AT THE FOREFRONT UChicago Medicine

Turner

CANNONDESIGN

UNIVERSITY OF CHICAGO MEDICINE
HYDE PARK CANCER CENTER

SCHEMATIC DESIGN DIAGRAMS FOR CON SUBMISSION
JANUARY 31, 2023

LOWER LEVEL

AT THE FOREFRONT UChicago Medicine Turner CANNONDESIGN

UNIVERSITY OF CHICAGO MEDICINE
HYDE PARK CANCER CENTER

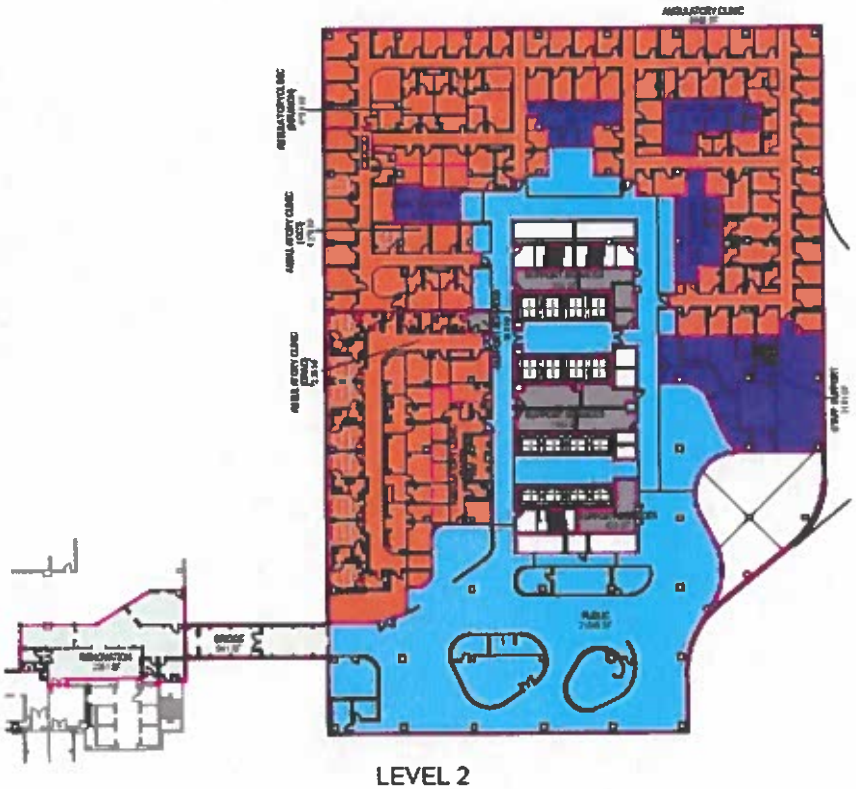
SCHEMATIC DESIGN DIAGRAMS FOR CON SUBMISSION
JANUARY 31, 2023

LEVEL 1

AT THE FOREFRONT UChicago Medicine Turner CANNONDESIGN

UNIVERSITY OF CHICAGO MEDICINE
HYDE PARK CANCER CENTER

SCHEMATIC DESIGN DIAGRAMS FOR CON SUBMISSION
JANUARY 31, 2023

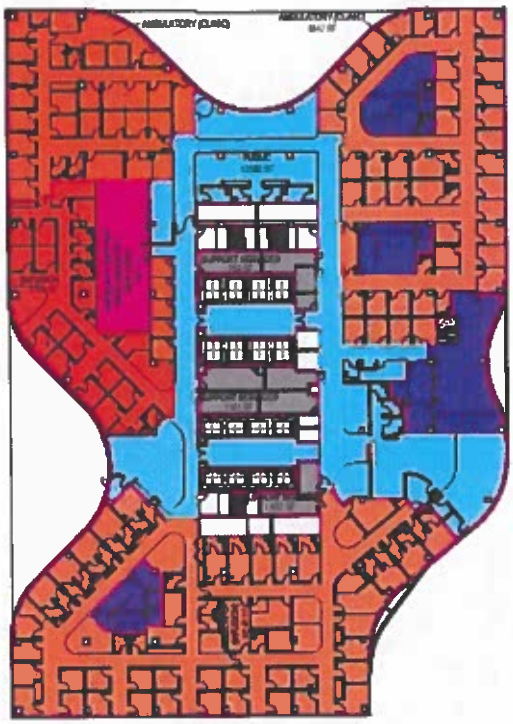


LEVEL 2

AT THE FOREFRONT UChicago Medicine Turner CANNONDESIGN

UNIVERSITY OF CHICAGO MEDICINE
HYDE PARK CANCER CENTER

SCHEMATIC DESIGN DIAGRAMS FOR CON SUBMISSION
JANUARY 31, 2023



LEVEL 3

AT THE FOREFRONT UChicago Medicine Turner CANNONDESIGN

ATTACHMENT 18

UNIVERSITY OF CHICAGO MEDICINE
HYDE PARK CANCER CENTER

SCHEMATIC DESIGN DIAGRAMS FOR CON SUBMISSION
JANUARY 31, 2023

LEVEL 4

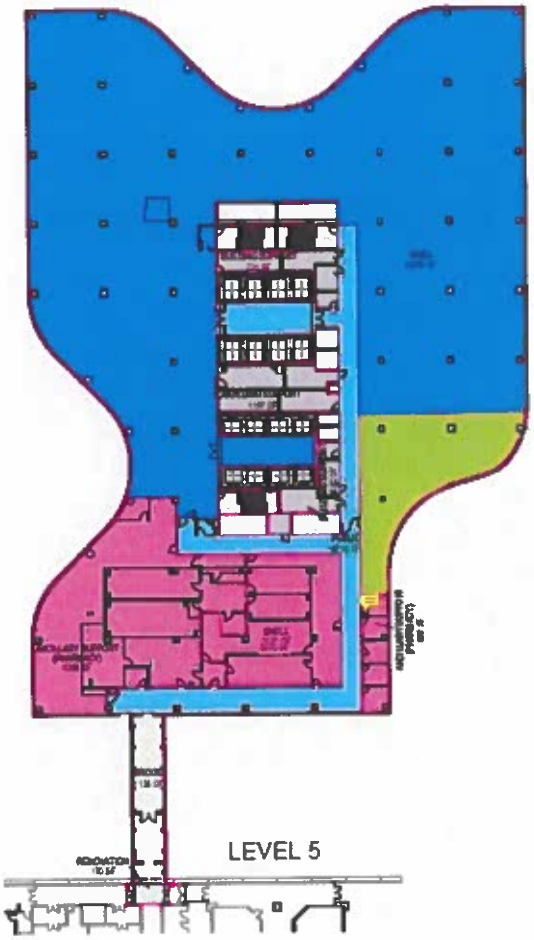
AT THE FOREFRONT UChicago Medicine

Turner

CANNONDESIGN

UNIVERSITY OF CHICAGO MEDICINE
HYDE PARK CANCER CENTER

SCHEMATIC DESIGN DIAGRAMS FOR CON SUBMISSION
JANUARY 31, 2023



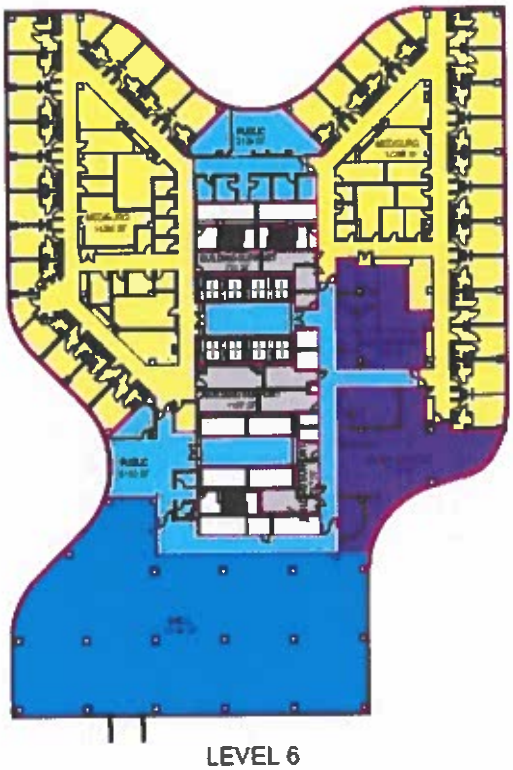
AT THE FOREFRONT UChicago Medicine

Turner

CANNONDESIGN

UNIVERSITY OF CHICAGO MEDICINE
HYDE PARK CANCER CENTER

SCHEMATIC DESIGN DIAGRAMS FOR CON SUBMISSION
JANUARY 31, 2023

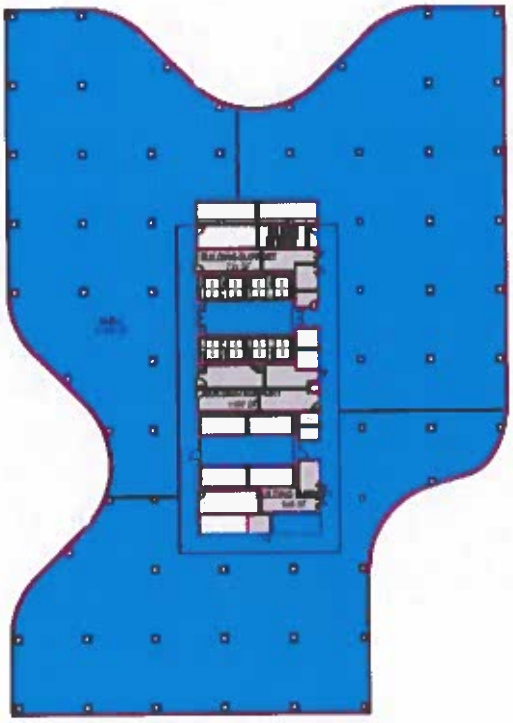


LEVEL 6

AT THE FOREFRONT UChicago Medicine Turner CANNONDESIGN

UNIVERSITY OF CHICAGO MEDICINE
HYDE PARK CANCER CENTER

SCHEMATIC DESIGN DIAGRAMS FOR CON SUBMISSION
JANUARY 31, 2023

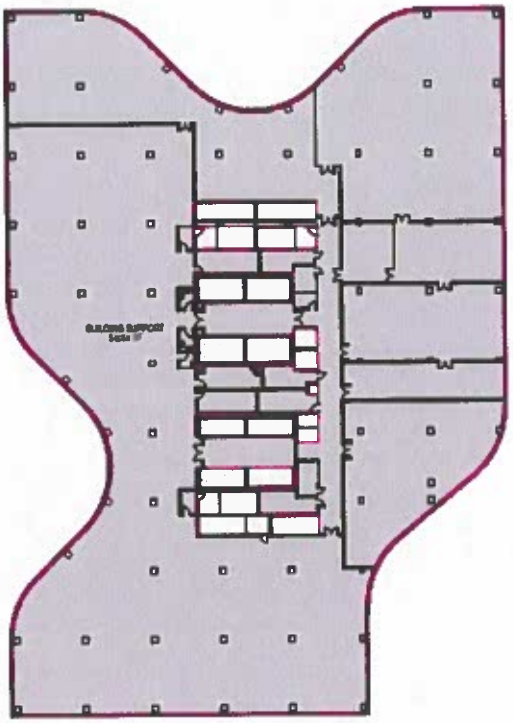


LEVEL 7

AT THE FOREFRONT UChicago Medicine Turner CANNONDESIGN

UNIVERSITY OF CHICAGO MEDICINE
HYDE PARK CANCER CENTER

SCHEMATIC DESIGN DIAGRAMS FOR CON SUBMISSION
JANUARY 31, 2023

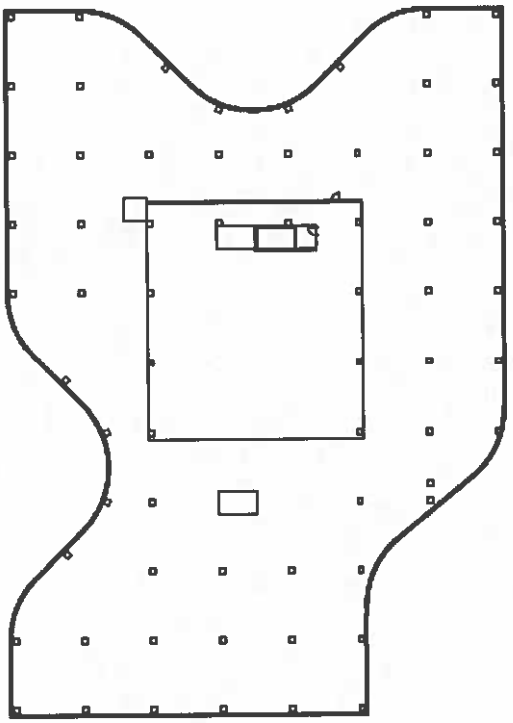


LEVEL 8

AT THE FOREFRONT UChicago Medicine Turner CANNONDESIGN

UNIVERSITY OF CHICAGO MEDICINE
HYDE PARK CANCER CENTER

SCHEMATIC DESIGN DIAGRAMS FOR CON SUBMISSION
JANUARY 31, 2023



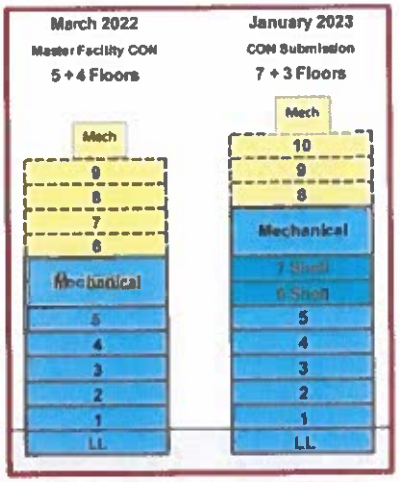
LEVEL 9 / ROOF

AT THE FOREFRONT UChicago Medicine Turner CANNONDESIGN

CONFIDENTIAL

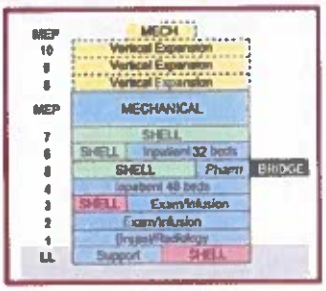
HFSRB March 2022 Approved v February 2023 Submission

Investment & Size	$633.3 M 544,000 BGSF	$801.1M 575,000 BGSF
Building Financing Shelled Floors	$633.3M	$630.5 M $57.6 M $113.0 M
Construct	• 5 stories (incl. 128 beds) • 1 lower level • 1 mechanical penthouse	• 7 stories (incl. 80 beds) • 1 lower level • 1 mechanical penthouse
Build-Out	• Floors 1 - 5 • LL for support services • Mechanical penthouse	• Floors 1 – 7* • LL for support services • Mechanical penthouse
Shelled In Spaces	• 1 pod of exam rooms • 1 pod of infusion bays	• 1 pod of exam rooms • 1 pod of infusion bays • Radiation Oncology • Equivalent of two floors
Future Vertical Expansion	• 3 additional floors & 1 mechanical penthouse • Designed for a wide variety of future uses.	• 4 additional floors & 1 mechanical penthouse • Designed for a wide variety of future uses.



See Final Shell Space Configuration diagram at right for placement of shell space

Final Shell Space Configuration



AT THE FOREFRONT UChicagoMedicine

IMPACT RESEARCH

June 8, 2022

To: Interested Parties
Fr: Brian Stryker / Oren Savir
Re: South Side Chicago Poll Findings

Residents of Chicago's South Side strongly support building a new, state of the art cancer care center on Chicago's South Side. Support is both broad and deep, with all demographic groups deeply favorable to the proposal.

Methodology:

Impact Research conducted a live phone and text-to-web survey commissioned by UChicago Medicine. Interviews were conducted April 22-28, 2022 among n=400 adults on Chicago's South Side in ZIP codes 60609, 60615, 60617, 60619, 60620, 60621, 60629, 60636, 60637, 60643, 60649, 60653, 60633, 60827 and 60655.

The margin of error for the full sample is +/- 4.9%; the margin of error for subgroups varies and is higher. 75% of interviews were conducted via cell phone.

Key Findings:

- **South Side residents support a new UChicago Medicine cancer center.** 83% of adults on the south side favor building a new cancer care center, with 72% saying they strongly favor one. Support is demographically broad, with 80% or more of all races and income levels favoring a new cancer center.

- **Residents like all of the new benefits that would come with the cancer center, and learning about these benefits increases support.** Every single one of the eight benefits tested was rated a "very big benefit" to residents and their community by at least three-fourths of residents. After hearing about these benefits, 89% of residents support the cancer center (78% strongly).

Cancer Center Proposals – % Very big benefit	
The new center will offer cancer treatment and all the things that go along with it. This includes help with medical finances and help managing symptoms that come from treatment and life after cancer.	79
It will have leading-edge technology and advanced care with some of the newest treatments available for cancer.	77
It will be patient and family-centered, making sure all services for cancer treatment are included in one place.	76
The new cancer center will offer world- class cancer care all in one place for patients, but here on the South Side.	75
It will focus on access for groups like Black Americans who have historically been excluded from cancer research.	75

It will have some of the newest research available into cancer care and increase access to clinical trials in the Chicago area.	74
Having beds just for cancer patients will free up some other beds for patients with other needs such as trauma care, organ transplants, and heart surgery.	74
It will create 500 new construction jobs with benefits on the South Side. 41 percent of jobs will go to a diverse workforce.	74

- **83% say they have gone out of the south side for medical care before.** This underscores the need for additional access to care on the South Side.

- **UCM's efforts to meet community needs and investments in community benefits are the strongest proof points to South Siders of UCM's efforts to strengthen access to care and address disparities in health outcomes.** They find the hospital's expansion of its emergency department and Adult Trauma Center as well as the $2.5 billion investment in charity care, community health prevention, and free health and wellness programs more impactful than data on the hospital's Medicaid coverage or its rankings as a national leader in racial inclusivity.

Next are initiatives and facts related to UChicago Medicine's efforts to provide the care the community needs. Please select the one you find most impactful:	Top Choice	Top Two Choices
UChicago Medicine has taken essential steps to better meet community needs, including a significant expansion of its Emergency Department and the opening of an Adult Trauma Center.	28	48
UChicago Medicine has invested over $2.5 billion over the past 5 years in community benefits ranging from charity care and community health research to violence prevention and offering free health and wellness programs.	24	47
UChicago medicine is the largest Medicaid provider in the state, outpacing all other Chicago hospitals.	13	27
The Lown Institute, a national leader on healthcare advocacy, recently released a study that found UChicago Medicine is sixth in the nation when it comes to racially inclusive hospitals.	9	19

About Impact Research:

Impact Research is a nationally recognized survey research firm. For more than 20 years, we have helped elect Democratic and progressive candidates at all levels – from the White House and Congress to state houses and city halls. We conduct polling and provide strategic advice for a wide range of national Democratic and progressive groups as well as labor unions, the Democratic Governors Association, DSCC, DCCC, Planned Parenthood, the AFL-CIO, AFSCME, SEIU, and many more. Our current clients include President Joe Biden, five governors, two U.S. Senators, and over 20 members of Congress.

University of Chicago Cancer Center
Community Engagement Survey 2022

V2 12/16/2022

Contents

High-level Insights

01 The community looks to UCM to provide a tailored set of solutions across a broad spectrum of needs. The UCM experience should not be considered as a one-size-fits-all approach.

02 Patients, family, and loved ones desire empathetic care- this starts with providing universal access through service delivery that exudes cleanliness, attention to details and enhanced communication.

03 Patients and their loved ones value having flexibility and options: Provide platforms for individuals to determine how they want to engage with UChicago Medicine's environment, operations, and services. Support diverse technology needs and accommodate preferences for check-in and how individuals communicate with their Care Team.

Demographics

Respondent Age

Age Group	% Respondents
20 - 29	2%
30 - 39	8%
40 - 49	11%
50 - 59	14%
60 - 69	19%
70 - 79	23%
80 - 89	23%

Are you a UChicago Medicine patient?

Current UCM Patient	Count
No	35%
Yes	65%

Do you work in the healthcare field?

Work in Healthcare	Count
No	77%
Yes	23%

Are you currently receiving cancer treatment?

Receiving treatment	Count
No	74%
Yes	26%

Have you had cancer care or cared for someone receiving cancer care?

Received cancer care / Caregiver	Count
No	27%
Yes	73%

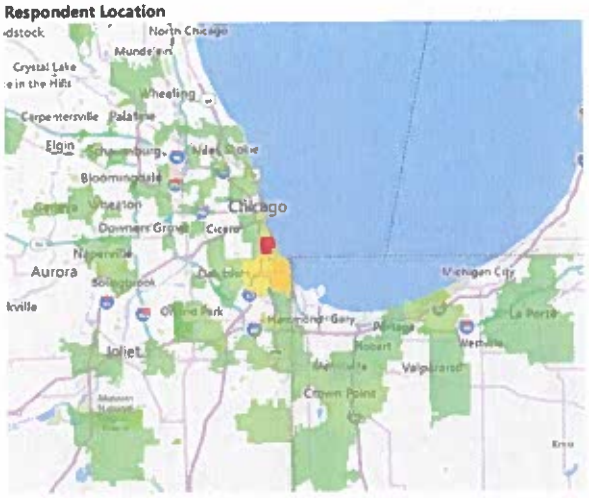
Have you or do you currently work at UChicago Medicine?

Worked at UChicago Medicine	Count
No, I have not	76%
Yes, I am a current or previous employee	24%

Do you have health insurance?

Insurance type	Count
Private	56%
Medicaid/Medicare	41%
Not insured	3%

Respondent Location



Building & Services

What is the most important thing when you first enter a healthcare facility?

When you are waiting for an appointment, how do want to spend your time?

Top choices in order of most often to least often selected:

Using personal devices (56%)
Access to nature and quiet (48%)
Sitting in department waiting areas (27%)
Library (16%)
Business Center (11%)
Dining Café (13%)
Gift shop (0.1%)

Respondents were not limited in how many options they could choose.

Please share good examples.

"Very clear signage that directs is where we need to go, access to wheelchairs that allow a weak person to still push, or wheelchair helpers. "

"River East location has large windows and comfortable chairs and a table with a USB charger.""

"Jefferson Health Abington Cancer Center and UCSD Cancer Center. State of the art facilities. They offer complimentary valet, open spaces, beautiful art, professional staff"

How do you prefer to check in at appointments?

Building & Services

What kinds of things do you want to have at a dining café?

Top choices in order of most often to least often selected:

Healthy options (68%)
Grab & Go (61%)
Snacks (33%)
Salad Bar (16%)
Grill (2.7%)
Rotating Pop-up (2.6%)
Baked Goods (2.2%)

Respondents were not limited in how many options they could choose

What kinds of products may be most helpful for cancer patients to manage physical effects from cancer?

Options included: wigs, hats, prosthetics, skincare, post surgical bras, and compression garments

81%

of respondents selected "all of the above"

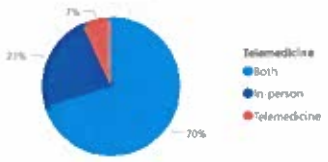
What supportive services are most beneficial to cancer patients?

Top choices in order of most often to least often selected:

Psychosocial Support (66%)
Nutrition Counseling (58%)
Support Groups (50%)
Meditation (41%)
Financial Counselor (40%)
Music Therapy (40%)
Pet Therapy (31%)
Spiritual Guidance (30%)
Yoga (25%)
Art Therapy (22%)

Respondents were not limited in how many options they could choose

What type of visits do you prefer?



Cancer Prevention & Programming

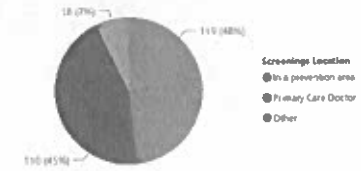
Whether or not you need access to cancer care, what following services and programs do you want from a healthcare provider?

Top choices in order of most often to least often selected:

Fitness Classes (67%)
Nutrition Education (60%)
Counseling (54%)
Health Education (55%)
Nutritional Support (41%)
Help Quitting Smoking (15%)
Other (0.4%)

Respondents were not limited in how many options they could choose

Where do you want to get cancer prevention testing and screenings?



What other services from your healthcare provider would interest you?

"Anger management counseling"

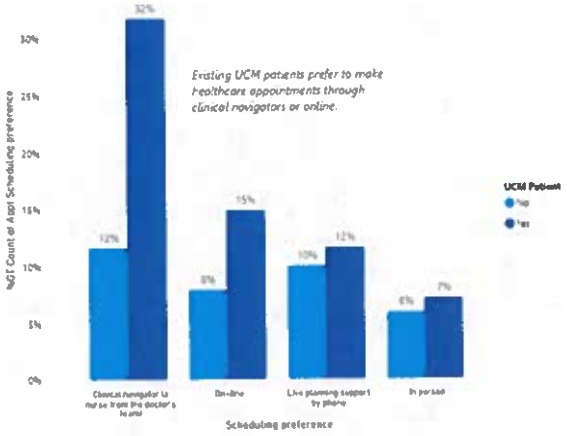
"OT/PT support onsite that is aligned with common needs of cancer patients"

"Financial counseling and assistance"

"Psychologists who specialize in oncology and practice full-time"

Care Planning & Communication

As a new patient, how do you want to make healthcare appointments?



For persons who had cancer or cared for someone who had cancer: What kinds of follow-up information were most helpful to you?

Top choices in order of most often to least often selected:

Counseling, Case Management, Caregiver Health, Support Groups, and Family Risk Screenings were ranked as top choices

Respondents were not limited in how many options they could choose

For persons who had cancer or cared for someone who had cancer: What kinds of information do you wish you were given?

Top choices in order of most often to least often selected:

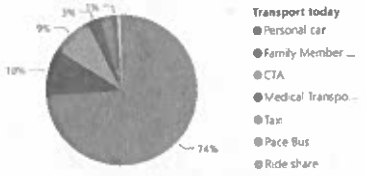
Counseling, Caregiver Health Information, Survivorship Support, Support Groups, and Family Risk Screening were ranked as top choices

Respondents were not limited in how many options they could choose

Counseling and support groups are the highest ranked ways that patients and caregivers prefer to receive information about cancer treatment.

Travel and Logistics

If you were traveling to UChicago Medicine Hyde Park, how would you plan your transportation?

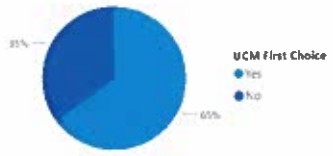


Do you prefer to self-park in the garage or utilize valet parking at UChicago Medicine?

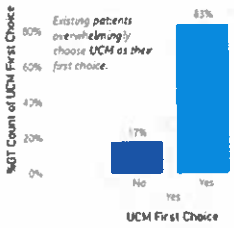
Do you feel good about how you are able to get to UChicago Medicine?

UChicago Perception and Planning Feedback

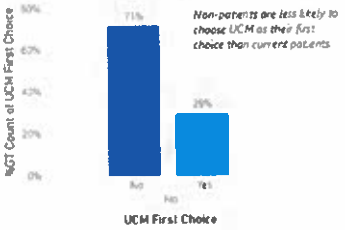
Is UChicago Medicine your first choice for Cancer Care?



Is UChicago Medicine your first choice for Cancer Care? (Patients only)



Is UChicago Medicine your first choice for Cancer Care? (Non-Patients)



Please share why or why not.

"The long delays in getting appointments and the lack of intra-department communication are frustrating."

"The doctors are top notch and my Medicare supplement insurance is thru U of C. If I need radiation or chemo for breast cancer I would go to Northwestern where many friends have gone, because it is cleaner and kinder."

"I am impressed at the professionalism of all workers at UChicago medicine. From the top cardiac doctors to the transportation and in-patient food service people, there is a respect for all."

"The different oncology specialties at U OF C are some of the most well known, smartest and assertive physicians in North America."

Exhibit 3

UCMC Webcast that ran live on August 1, 2022 featuring Brenda Battle, Dr. Soni Smith, Candace Henley and patient panel member Lisa Cohen.

https://players.brightcove.net/719220616001/default_default/index.html?videoId=6309848633112

AT THE FOREFRONT
UChicago Medicine

Cancer Care Reimagined on Chicago's South Side

Community Advisory Council: Building the Cancer Center of the Future

AGENDA

- Welcome remarks by Candace Henley, Member, Community Advisory Council
- Cancer Center vision by Tom Jackiewicz, President of the University of Chicago Medical Center
- Disparities in cancer and innovation by Dr. Kunle Odunsi, Director of the University of Chicago Medicine Comprehensive Cancer Center
- Community engagement overview by Brenda Battle, Senior Vice President of Community Health Transformation and Chief Diversity, Equity and Inclusion Officer
- Facilities overview by Marco Capicchioni, VP for Cancer Center Facilities, Planning, Design and Construction, UChicago Medicine
- Facilitated discussion with Cannon Design
- Q&A

AT THE FOREFRONT UChicago Medicine

Speaker: Candace Henley

2

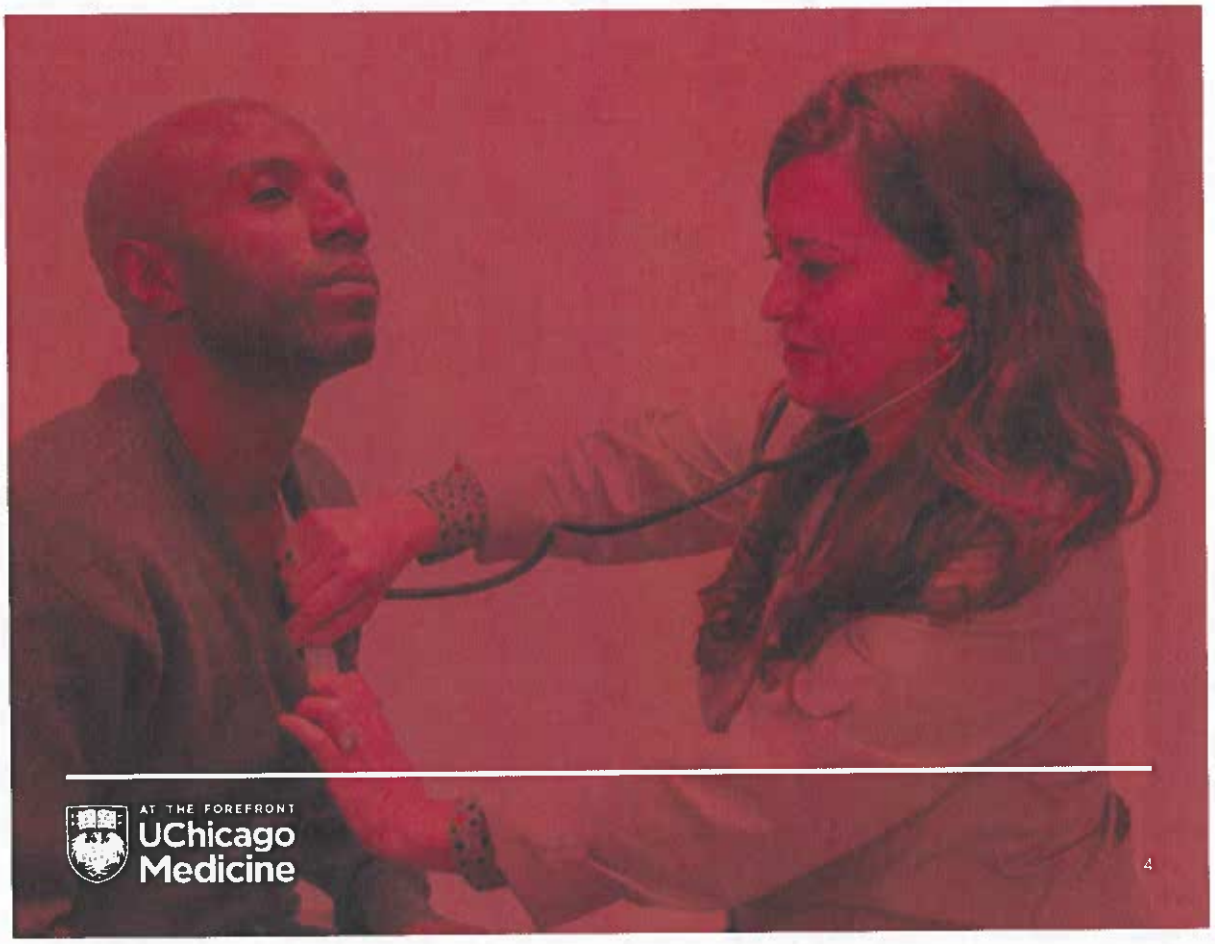
Community Advisory Council: Building the Cancer Center of the Future

- Participant microphones are muted to limit distraction
- All guests invited to join on camera
- Enter questions in the chat feature throughout the discussion
- When we get to the facilitated discussion, hit the "raise your hand" button to share your views

AT THE FOREFRONT UChicago Medicine

Speaker: Candace Henley

3


AT THE FOREFRONT
UChicago
Medicine
4

A $633M Reimagined Cancer Center for the Future

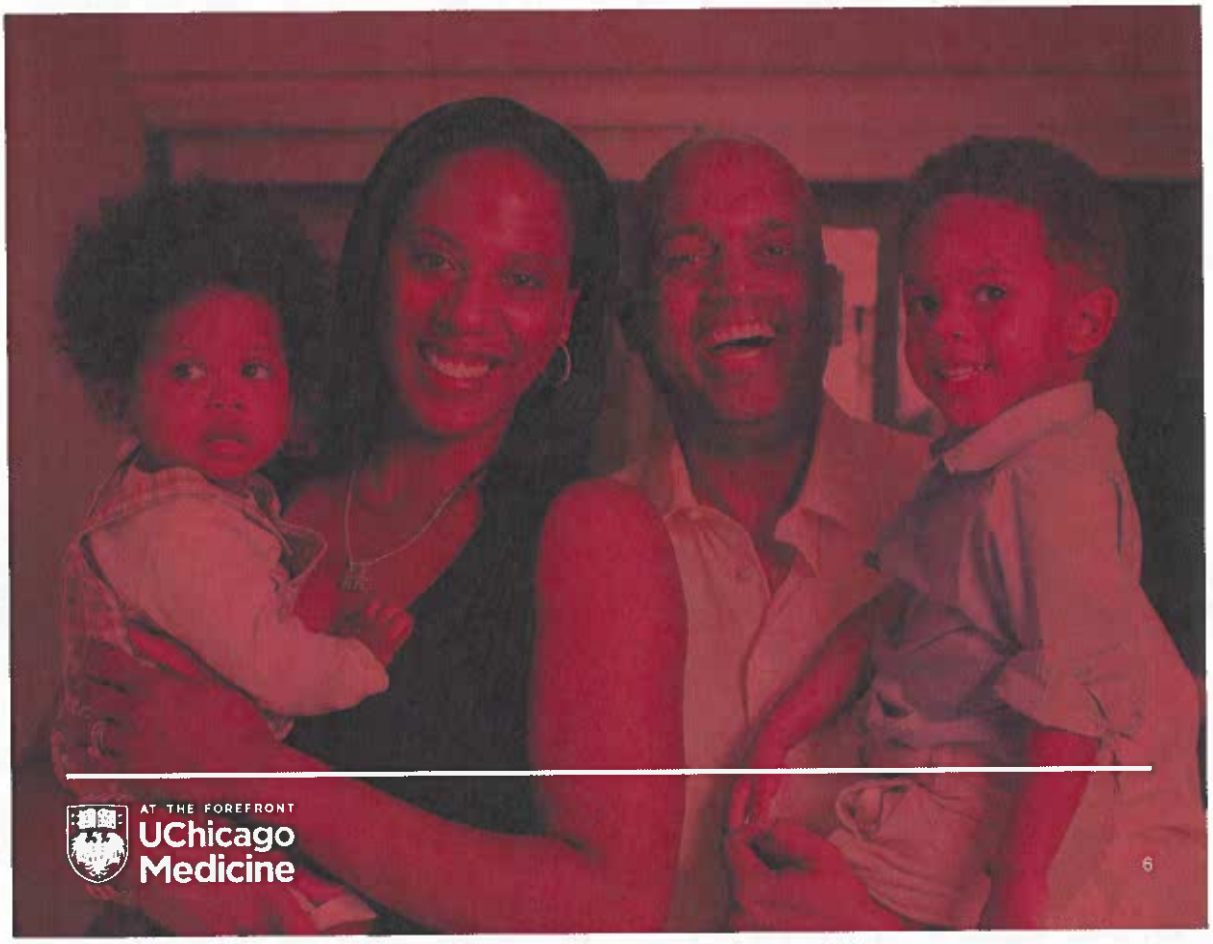
THE PROPOSED 425,000 SQUARE FOOT CENTER WILL INCLUDE:

- The first freestanding and dedicated comprehensive cancer center in Chicago.
- A unique approach to caring for the whole person, from addressing the financial matters of living with cancer to post acute care and managing life after a cancer diagnosis.
- A fully coordinated patient- and family-centric experience, ensuring all services across the continuum of care are located together.
- Multi-disciplinary, technologically advanced care with access to the newest diagnostics and treatment innovations which are anchored by pioneering basic & translational research.
- Ground-breaking science and efficient, compassionate care.

AT THE FOREFRONT UChicago Medicine

Speaker: Tom Jackiewicz

5


AT THE FOREFRONT
UChicago
Medicine
6

Disturbing Trends in Cancer on Chicago's South Side Are Expected to Grow Worse in Years Ahead

People who live on the South Side of Chicago are twice as likely to die from cancer than those who live just about anywhere else in America. In fact, cancer is the second leading cause of death on the South Side.

Inequities in the burden of cancer are largely driven by the social determinants of health, including access to cancer prevention and care.

12% The problem is expected to grow worse in the years ahead, with the incidence of cancer projected to **grow 12%** in the next ten years.

49% The CDC predicts **cancer rates will increase by 49%** from 2015 to 2050.

AT THE FOREFRONT UChicago Medicine

Speaker: Dr. Kunle Odunsi

7

A Commitment to Clinical Research & Innovation

The new facility will include the space and resources we need to do groundbreaking research into cancer care and expand access to clinical trials, particularly for groups that have historically been underrepresented in cancer research.

THE FOCUS ON CANCER RESEARCH WILL:

Put science on display and in play for patients

Embed research & discovery in the fabric of the center

Foster digital innovation & technology to enhance patient and provider experience

AT THE FOREFRONT UChicago Medicine

Speaker: Dr. Kunle Odunsi

8

A Holistic Approach to Addressing Inequities

Bringing our resources to bear to strengthen health of our community by:

- Addressing social determinants of health
- Strengthening access to prevention and screenings
- Caring for uninsured and underinsured
- Driving policy initiatives to promote sustainable change

AT THE FOREFRONT UChicago Medicine

Speaker: Brenda Battle

9

TIMELINE

MILESTONE	EST. DATE
Master Design Permit Application Filed	January 26-28, 2022
Public Hearing	Latter half of February 2022
CON Board Meeting	April 26, 2022
Initial Public Input Phase for Design Begins	Spring 2022
Full CON Application Filed	Late 2022
CON Board Vote on Full Application	2023
Groundbreaking	Late 2023 (pending CON approval)
Cancer Center Ribbon Cutting/Doors Open	2026

AT THE FOREFRONT UChicago Medicine

Speaker: Marco Capicchioni

ATTACHMENT 18

AT THE FOREFRONT
UChicago Medicine

Community Advisory Council

Winter Quarterly Meeting

January 24, 2022

Agenda

1. Welcome – *Pastor Julian DeShazier, Chair*
2. South Side Healthy Community Organization (Transformation Project) Update– *Brenda Battle*
3. UChicago Medicine Cancer Center Plan & Discussion – *Marco F. Capicchioni, PE, BSEME, MBA, Vice President, Cancer Center Facilities, Planning, Design, and* Construction
4. Community Health Need Assessment (CHNA) Community Health Needs Assessment Results, Discussion, and Prioritization. *Brenda Battle & Will Snyder, Metopio*
5. Next Steps/Adjourn, (5 minutes) *Pastor Julian DeShazier* , Chair

AT THE FOREFRONT
UChicago Medicine

AT THE FOREFRONT
UChicago Medicine

VERSION 3 1/11/21

Cancer Center Plan
Community Advisory Council

January 24, 2022

Delivering World-Class Cancer Care

UNIVERSITY OF CHICAGO MEDICINE IS:

- Ranked in the **50 top cancer hospitals** by the U.S. News & World Report and has the most Top Doctors in Illinois by Chicago Magazine for cancer
- **One of two NCI designated cancer centers in Illinois**
- One of 30 U.S. institutions selected as Lead Academic Participation Sites for the NCI's National Clinical Trials Network, with **>300 open therapeutic trials and >1,000 patients enrolled per year.**
- The first site in the USA to be **certified for FDA – approved Car-T cell therapies** for specific blood cancers in both adult and pediatric patients.

Our clinical teams are recognized leaders in delivering complex cancer care, a market leader in clinical trials and delivery of novel therapies; and a proven destination for cancer patients, despite working in a highly competitive and fragmented market comprised of several large scale academic and community health systems.

AT THE FOREFRONT
UChicagoMedicine

Disturbing Trends in Cancer on Chicago's South Side Are Expected to Grow Worse in Years Ahead

- **People who live on the South Side of Chicago are twice as likely to die from cancer than those who live just about anywhere else in America. Cancer is the second leading cause of death on the South Side.**
- **Inequities in the burden of cancer are largely driven by the social determinants of health, including access to cancer prevention and care.**

12% The problem is expected to grow worse in the years ahead, with the incidence of cancer projected to **grow 12%** in the next ten years.

49% The CDC predicts **cancer rates will increase by 49%** from 2015 to 2050.

- **Over half of South Side patients today leave the area for care they need**

A $633M Reimagined Cancer Center for the Future

In Phase 1, a capital investment of $633M, the Center will expand existing ambulatory capacity by 40% and inpatient capacity by 10% on the day it opens, allowing for additional expansion of clinical exam rooms, infusion bays, and two floors of inpatient beds in the future

- First freestanding comprehensive clinical Cancer Center in the Chicago market
- Will offer seven floors of world class clinical care in a marquee facility that is a true destination for cancer care, now and in the future.
- Will embody a patient and family centric experience, ensuring all services across the continuum of care are co-located, including ambulatory, radiation oncology, a full suite of imaging and diagnostic modalities, 128 dedicated cancer beds, and a clinical trials unit.
- Will deliver multi-disciplinary, technologically advanced care with access to the newest diagnostic and treatment innovations which are anchored by pioneering basic & translational research.
- Will be where ground-breaking science and efficient, compassionate care meet to provide an unrivaled approach to conquering cancer.

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The Cancer Center of the Future will help to reduce longstanding disparities in cancer by:

- Being unlike any other from a patient and family centric experience
- Providing a facility devoted to cancer research, prevention, detection, treatment and survival to address cancer disparities to improve health outcomes
- Offering access to new diagnostic and treatment innovations in cancer. Patients will benefit by having greater access to screening, clinical trials, and the latest therapies – anchored by pioneering research.
- Addressing health inequities with a two-pronged approach to support a healthcare ecosystem for the South Side that increases access to complex, specialty care and strengthens the continuity of care for the community
- Ensuring South Side patients the same access to healthcare as other communities in the city and should not have to leave their area to get the care they need

Vision & Guiding Principles: Cancer Center of the Future

Mission: To discover the determinants of cancer, to develop novel therapies for cancer, and to prevent cancer through innovative and collaborative research, compassionate patient care, education, and community engagement.

We are at the forefront of comprehensive cancer care distinguished by eminence in patient-centered care delivery, research, discovery, and training the next generation of cancer leaders

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International Destination Center for Cancer Care

- Consider cultures & communities beyond our current reach, with a focus on access for our South Side community
- Celebrate our diversity with our location as s source of strength.

AT THE FOREFRONT
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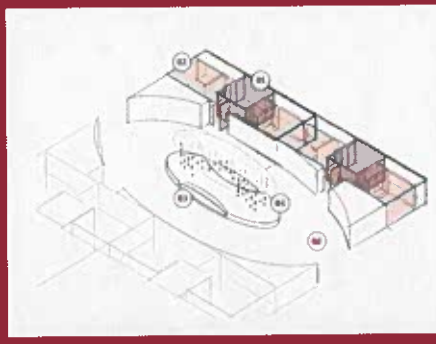
Key Differentiators: Reimagined Cancer Center of the Future

- **Ability to provide all Cancer Services under one roof**
- **Deliver cutting edge diagnostics & treatments for patients**
  - » Bench to bedside
  - » Leverage new modalities (e.g., Molecular Engineering, Cell Therapy)
- **Technological advances in care delivery**
  - » Center will address not only inpatient and ambulatory patient needs but also patient home healthcare needs
  - » Smart building will allow us to leverage big data and AI to improve patient's outcomes
- **Revolutionize care delivery and the patient experience**
  - » LAUNCH concept of a rapid multi-disciplinary care approach providing patients with personalized treatment options under one roof
  - » Arrival lounge & seamless check-in with dedicated patient navigation
  - » Enhanced consultation & exam rooms to be patient & family centric
  - » Collaborative tech-enabled team space giving teams a place to share, discuss and create strategies and ideas for patient
  - » Virtual & telehealth space to allow optimal flexibility
  - » Robots to enhance efficiency and operations



Conceptual image of proposed disease group neighborhoods, that will allow for synergies and individualized care plans for our patients.

AT THE FOREFRONT
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Personalized Innovative Therapies: Examples of Integration of Clinical and Research Enterprise

Put science on display and in play for patients
Embed research & discovery in the fabric of the center

Translational Research Laboratory (TRL)

Real time analysis of detailed molecular/immunological/metabolic attributes of a patient's tumor

Clinical Trials Unit

To provide innovative experimental therapies arising from UChicago's scientific discoveries; and on results from TRL

Destination for Innovative Cellular Therapy

Cellular Engineering and Therapy Unit

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General Site Plan

6-story building with a basement encompassing approximately 544,000 sf with the following program:

Ambulatory Services
- Infusion
- Oncology Clinics
- Urgent Care
- Outpatient Imaging

Inpatient Beds
- 128 Beds

Radiation Oncology
- Linear Accelerators
- CT's
- Clinics

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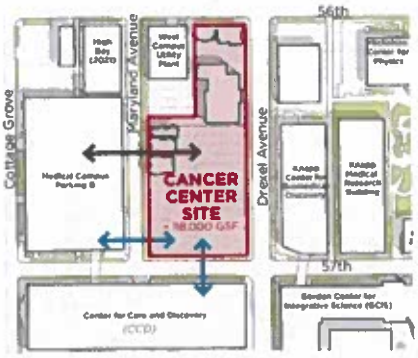
General Site Plan and Connections



The Cancer Center will require **bridged connections** to Garage B and the CCD and **one tunnel** connecting the new building and the loading docks at Garage B.

Connectivity to Other Buildings
Foster interactions within the medical ecosystem. Guided by gracious open spaces and easy to use internal connections (especially through the "bridge level") pedestrians should be able to easily access multiple buildings and access their needs.

Current Status and Schedule:

- Design work is in progress
- Demolition work Summer 2022
- Major Site Work Spring 2023
- Opening Summer 2026

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MWBE Utilization and Workforce Goals

- **Construction ($500 M total labor and materials)**
  - 35% certified MBE Participation
  - 6% certified WBE Participation
- **Workforce Goals ($155 M total labor):**
  - **Journeyworker and Apprentices**
    - Minority 30%
    - Women 5%
  - **Laborer**
    - Minority 40%
    - Women 5%
  - **City of Chicago Residency Goals:** 40%
  - **Community Hiring Initiative Zip Codes:** 60609, 60615, 60616, 60619, 60621, 60637, 60649 and 60653

Number of Workers on Site/City:

- **Preconstruction Period (2 Yrs)**
  Average: 75 workers
- **During Construction Period (3 Yrs)**
  Average: 193 workers
  Peak: 282 workers

Past 2020-2021

"Taking Care of Your Girls: Breast Cancer Awareness" Cedric McKoy, WVON - 10/17/20

"Taking Care of Your Girls, Pt. 2: Breast Cancer Awareness" SSF workshop - 10/24/20

"Defeat Cervical Cancer" - Ced McKoy, WVON - 1/16/21

"Colon Cancer" - Ced McKoy, WVON - 3/20/21

"Colon & Prostate Health" - SSF Workshop - " 5/24/21

"Prostate Cancer and Health Disparities" - Cedric McKoy, WVON - 6/19/21

"Breast Cancer Awareness" - SSF Workshop - 10/23/21

Past 2022

"Spread the Word, Cervical Cancer Is Preventable" – 1/22/22

"Colorectal Cancer, Striking Younger Adults" 3/19/22

SSF Workshop - Women's Health Panel Q&A – Various Cancer questions 4/23/22

SSF Workshop - Men's Health Panel Q &A – Prostate cancer 5/23/22

Upcoming 2022

Black Women's Expo – Cancer Panel & Cancer Outreach (Specific Topic TBD) 8/14/22

"Sex after Cancer" 8/20/22

Breast Cancer – WVON show 10/22 (Exact date TBD)

SSF Workshop - Breast Cancer Awareness 10/22/22

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UChicagoMedicine
Comprehensive Cancer Center

OCECHE
Office of Community Engagement and Cancer Health Equity

January 2022	Event	Resource we provide/provided
1/9	CFHC Cervical cancer awareness/HPV teacup distribution	UChicago branded HPV cards, teacups, honey straws and green tea
1/10	CCJD Health Fair	HPV information and snacks
February		
2/12	Equal Hope Galentine's Day	Teacups with HPV information
March		
3/2	CCJD – OLL Program- Spanish Language	Provided four cancer education modules in two sessions. Raffled gift cards and provided lunch.
April		
4/1	CSU Cancer Education Session	Breast density and HPV education and raffles.
4/3	CCJD Vaccination event	Cancer resource table, HPV, colorectal info, and snacks
4/7	Community Fair	Cancer info and PPE kits
4/9	LUCERO Health & Wellness Fair	Cancer resource table, Jesse White Tumbling team, photographer, tents/tables/chairs, snacks
4/13	SCNN Health Fair	Information, promo items
4/22	Community Psychology Conference	Breast density and cancer info, and PPE kits
4/30	SWIO Breast Cancer Walk	Cancer resource table and goodie bags
May		
1st	Equal Hope – Hope in Action -South Shore	Cancer research table, prostate cancer presentation, goodie bags
9th	Prostate Health Education Network Community	Cancer information, expert presentations, and gift cards
14th	Equal Hope – Hope in Action-Waukegan	Cancer research table, prostate cancer presentation, goodie bags
5/21	Church food giveaway	Cancer information and PPE kits
June		
6/10-6/12	Fiesta Back of the Yards	Cancer information table goodie bags, snacks
6/16	CCJD Men's Health event	CRC presentation, snacks, cancer information table
6/17	Far South Community Fest	Cancer resource table and goodie bags (PPE kits)
6/18	Comer Education Institute Fair	Cancer resource table and goodie bags (PPE kits)
6/18c	Church Food Giveaway	Cancer information and PPE kits
6/19	DuSable Museum Juneteenth Fair	Cancer resource table and goodie bags (PPE kits)

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AT THE FOREFRONT
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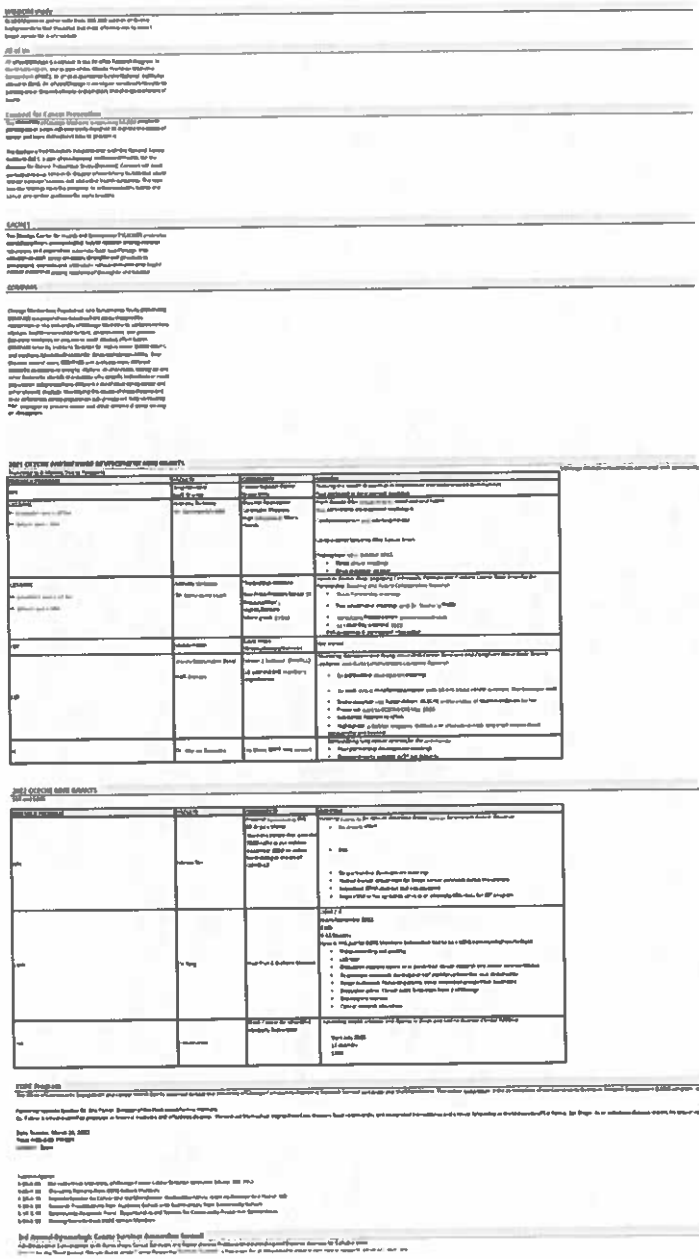
Comprehensive Cancer Center

OCECHE
Office of Community Engagement and Cancer Health Equity

6/19	Real Men Cook	Cancer resource table and goodie bags (PPE kits)
6/25	LUCERO Men's Health and Resource Fair	Information, photographer, ice cream truck, tent/tables/chairs, balloon artist, DJ, snacks for vendors
July		
7/10	CCJD Health Fair Under the Sun- Spanish Language	Cancer information table and prizes for Loteria
7/16	Englewood Health Fair	Cancer information table and PPE kits
7/21	Prostate Cancer Education and Clinical Trial Rally	Cancer information and raffles
7/26	Bench to Barbers Community-Academic Prostate Education	Cancer information, presentations, raffles
August		
8/13	10th Ward BTS Event	School supplies, cancer resource table, HPV vax?
8/13	Latino Back to School Family Health Fair	Cancer resource table, inflatable colon, goodie bags, HPV vax
8/26-8/28	Black Women's Expo	Caner resource table and goodies bags
8/27	CHHC Vive tu Vida	Cancer resource table, inflatable colon, goodie bags
September		
9/10/22	Southland Cancer Screening Fair with Ingalls	Cancer resource table, inflatable colon, goodie bags
9/17/22	Gynecologic Community – Researcher Summit	Cancer information and raffles
9/24/22	Prostate Cancer Awareness Month Community Education	Cancer information and raffles
9/30/22	Blood Cancer Awareness (Spanish Language)	Cancer information, expert presentations, and raffles
October		
TBD	4th Annual Cancer Disparities Research Symposium	Cancer information, expert presentations, and raffles
TBD	3rd Annual Diversity in Clinical Trials Forum	Cancer information, expert presentations, and raffles
TBD	4th Annual Chicago Bears Tackle Cancer Event	Cancer information, expert presentations, and raffles
TBD	Breast Cancer Awareness Event	Cancer information, expert presentations, and raffles
November		
TBD	Annual Lung Cancer Awareness Event	Cancer information, expert presentations, and raffles
TBD	Annual LUNGevity Lunch & Learn	Cancer information, expert presentations, and raffles
TBD	Annual White Ribbon Project Lung Cancer Awareness	Cancer information, expert presentations, and raffles
TBD	3rd Annual Diversity in Clinical Trials Forum	Cancer information, expert presentations, and raffles



SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

Attachment 19

This Section is applicable to all projects proposing the establishment, expansion, or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion, and modernization).

A. Criterion 1110.200 - Medical/Surgical, Obstetric, Pediatric and Intensive Care

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

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

	# of Existing Beds	# of Proposed Beds
☐ Medical/Surgical	481	545
☐ Obstetric		
☐ Pediatric		
☐ Intensive Care	142	158

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

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(b)(1) - Planning Area Need - 77 Ill. Adm. Code 1100 (Formula calculation)	X		
1110.200(b)(2) - Planning Area Need - Service to Planning Area Residents	X	X	
1110.200(b)(3) - Planning Area Need - Service Demand - Establishment of Category of Service	X		
1110.200(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service		X	
1110.200(b)(5) - Planning Area Need - Service Accessibility	X		
1110.200(c)(1) - Unnecessary Duplication of Services	X		

APPLICABLE REVIEW CRITERIA	Establish	Expand	Modernize
1110.200(c)(2) - Maldistribution	X	X	
1110.200(c)(3) - Impact of Project on Other Area Providers	X		
1110. 200(d)(1), (2), and (3) - Deteriorated Facilities			X
1110.200(d)(4) - Occupancy			X
1110.200(e) - Staffing Availability	X	X	
1110.200(f) - Performance Requirements	X	X	X
1110.200(g) - Assurances	X	X	

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

1110.200(b)(2) - Planning Area Need - Service to Planning Area Residents

Only a few decades ago, prognosis after a cancer diagnosis was bleak, and survival rates were low. But cancer care is transforming thanks to rapid advances in cellular biology, cancer diagnostics, precision medicine, immunotherapy and the discovery of new drugs. The proposed construction of a comprehensive, dedicated cancer facility on UCMC's main campus will strengthen the delivery of transformational cancer care by improving access to critical clinical services, participation in research, and supportive services for the whole patient. It proposes to be the first freestanding, full-service cancer hospital in the City of Chicago. With a singular focus on cancer, UCMC knows that dedicated cancer facilities, with their state- of-the-art therapies and research activities, often offer the greatest possibility of successful cancer treatment. Like these institutions, UCMC already provides multi-disciplinary cancer care, including diagnostic, surgical, medical, chemotherapy and radiation treatment, but it seeks to do so within a dedicated facility to further improve both outcomes and patient experience.

As stated above, the primary purpose of this Project is to enhance access to the full continuum of cancer care to the South Side of Chicago in communities where the incidence and mortality from cancer is disproportionately high and the available resources are disproportionately low.

In UCMC FY2022, 50% of all inpatients resided within the A-03 planning area, covering the immediate surrounding zip codes that are part of Chicago's South Side, Chicago's Southwest Side, and the Loop. 95% of all inpatients resided within the UCMC's Primary and Secondary Service Areas, composed of the City of Chicago, its suburbs and neighboring counties. 79% of inpatients resided within Cook County.

To dive more deeply, 54% of all adult med-surg patients are from within the A-03 Planning Area. 43% of ICU patients are from within the Planning Area. This is due in part to a large number of transfers into UCMC for patients who require a higher level of care. UCMC is a Level 1 Adult Trauma Center and a Level 1 Pediatric Trauma Center, so the ICU often sees patients from within the Medical Center's planning area and from other parts of Chicagoland.

Inpatient Origin (FY2022, Jul 2021-Jun 2022)	IP Volume % of Total
A-03 Planning Area - Immediate Surrounding Zip Codes	50%
Other Within UCMC Primary and Secondary Service Areas	45%
Beyond UCMC Service Areas	5%
Cook County	79%

The bulk of patients (~20K) resided in UCMC's immediate surrounding zip codes, encompassing Chicago's South Side. Granular volume detail by patient zip codes provided below.

Zip Codes (FY2022, Jul 2021-Jun 2022)	IP Volume
A-03 Planning Area	**19,281**
South Side	**18,257**
60609	906
60615	1,980
60616	661
60617	1,623
60619	2,646
60621	1,277
60628	1,112
60636	966
60637	3,151
60649	1,868
60653	2,067
Southwest Chicago	**881**
60629	599
60632	192
60638	90
Loop	**143**
60605	143
Other Within PSA	**15,795**
Outside of Service Area	**1,662**
Total	**36,738**

According to the Inventory of Health Care Facilities and Services and Need Determination released in October 2021, Planning Area A-03 has a combined excess of 518 Medical-Surgical and Pediatric beds. However, the Medical-Surgical beds across the Planning Area are not interchangeable, and the raw bed numbers provide an incomplete picture of the need for inpatient capacity in Planning Area A-03. UCMC is the only academic medical center in A-03 and is a vital hospital in providing specialized services and care for patients with complex illnesses. The acuity mix of UCMC is more than 45% higher than that of any other hospital in the Planning Area, meaning that UCMC's Medical-Surgical and ICU beds are used for more acutely ill patients. UCMC also sees a higher volume of patients. In 2021, UCMC had close to 25,000 admissions while the next highest hospital in its Planning Area had only a fourth as many admissions. In 2022, UCMC had more than 25,000 admissions excluding pediatric and obstetric patients, and these admissions do not account for the hundreds of transfer requests from nearby safety net hospitals that UCMC must turn down because of its shortage of available beds.

1110.200(b)(4) - Planning Area Need - Service Demand - Expansion of Existing Category of Service

The proposed Project will include 80 total inpatient beds at the Medical Center, comprised of 64 Medical-Surgical beds and 16 ICU beds. The addition of these beds will be used to house cancer patients who would otherwise be placed in other Medical-Surgical units across the hospital.

These units will be included in a state-of-the-art comprehensive cancer facility that provides a premier patient experience, streamlines the delivery of cancer care, and continues the Medical Center's tradition of impeccable quality and safety.

The rate of cancer is increasing overall, with the incidence higher in the South Side communities than elsewhere in the city and state, but the demand for cancer treatment is not felt equally among providers. The increased demand for cancer care may soon outpace capacity of hospitals and inhibit their ability to provide timely treatment. Both the high acuity that UCMC treats and the incidence of cancer on the South Side, contribute to the pressing need for additional beds. A recently retrospective, hospital-level study using data from the National Cancer Database from January 1, 2007, to December 31, 2016, found that patient volume increased more rapidly at NCI-designated and academic centers than at community hospitals, with particularly high growth at referral centers at NCI-designated facilities. Specifically, in this study sample that included more than four million patients treated at 1351 hospitals, patient volume increased 40% at NCI centers, 25% at academic centers, and 8% at community hospitals. The mean annual patient volume growth rate was 45.2 patients at NCI hospitals and 13.9 patients at academic hospitals compared with 2.0 patients at community hospitals [1]

The study also found that, for most of the cancers studied, TTI increased regardless of hospital type. This trend may partially reflect the increasing complexity of treatment decisions and a desire to consider the results of molecular testing when making frontline treatment decisions. Because of the potential association of such delays with emotional distress and survival, continued efforts to ensure timely cancer treatment are warranted.

The health care needs of the population in Planning Area A-03 are also unique, with some of the highest rates of disease and mortality, which has only been compounded by the COVID-19 public health emergency. This incidence of disease isn't accounted for the bed utilization predicted for the future and only amplifies the critical need for additional resources.

It has been over two years since the COVID-19 pandemic created an unprecedented public health crisis throughout the world. Although the threat of COVID-19 has decreased due to vaccination efforts, its devastating effects will be felt for years to come. Especially concerning is the drop in cancer screening rates, with the most dramatic reduction in screening occurring in medically underserved communities. This has led to decreases in diagnosis and treatment and is expected to result in thousands of preventable deaths.

According to the Centers for Disease Control and Prevention, the screening rates for breast and cervical cancers fell by more than 80%, with the most severe declines occurring in populations of low-income women of color.

The threat of worsening cancer outcomes has been recognized by the international cancer research community as a leading priority. In a June 2020 editorial, the director of the National Cancer Institute, expressed concerns about the mortality related to breast and colorectal cancer in

[1] Frosch ZAK, Illenberger N, Mitra N, et al. Trends in Patient Volume by Hospital Type and the Association of These Trends With Time to Cancer Treatment Initiation. *JAMA Netw Open.* 2021;4(7):e2115675. doi:10.1001/jamanetworkopen.2021.15675

particular. Early projections showed that if these trends continue, mortality for these cancer types is expected to increase by nearly 10,000 in the next 10 years in the U.S. alone as a result of missed cancer screenings and treatment, assuming a disruption of 6 months. However, the pandemic has lasted far longer than anyone anticipated, so the effects could be greater. It is not surprising that the underserved communities comprising Black and Hispanic people are disproportionately affected.

As an NCI-designated Comprehensive Cancer Center, UCMC recognizes its ongoing responsibility to strive to overcome the existing barriers to high quality care and push the boundaries of what is possible for its community. Patients who are treated at comprehensive cancer centers experience superior survival rates compared to patients treated at facilities that have not received this designation.[2] While outcomes at NCI cancer centers are already strong, the rates of "textbook outcome" are even higher at dedicated cancer hospitals. The likelihood of a patient surviving their cancer after 5 years at a dedicated cancer center is 17 percent higher than at other hospitals. That is true across many types of cancer, including the most common – breast, colorectal, lung and prostate.[3]

The proposed dedicated cancer facility will strengthen the delivery of high-quality cancer care by improving access to critical services for its at-risk and vulnerable populations. It will bring the cancer care home to residents on the South Side, it will increase volume of available cancer care and clinical studies, and it will facilitate the interdisciplinary collaboration and care delivery necessary for targeted and precision therapies.

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[2] *See also Impact of care at comprehensive cancer centers on outcome: Results from a population-based study* Julie A. Wolfson MD, MSHS, Can-Lan Sun PhD, Laura P. Wyatt BA, Arti Hurria MD; 28 July 2015; **https://doi.org/10.1002/cncr.29576**; Among individuals aged 22 to 65 years residing in Los Angeles County with newly diagnosed adult-onset cancer, those who were treated at NCICCCs experienced superior survival compared with those treated at non-NCICCC facilities. Barriers to care at NCICCCs included race/ethnicity, insurance, socioeconomic status, and distance to an NCICCC) ***Cancer* 2015;121:3885–3893.** © *2015 American Cancer Society.* https://acsjournals.onlinelibrary.wiley.com/doi/10.1002/cncr.29576

See also Second Opinions from Comprehensive Cancer Centers Changed Treatment Plans for African American Patients, American Association for Cancer Research, https://www.aacr.org/about-the-aacr/newsroom/news-releases/second-opinions-from-comprehensive-cancer-centers-changed-treatment-plans-for-african-american-patients/, African American breast cancer patients who received second opinions from an NCI-designated Comprehensive Cancer Center (CCC) experienced changes to their treatment plans, according to results of a developmental study presented at the 12th AACR Conference on The Science of Cancer Health Disparities in Racial/Ethnic Minorities and the Medically Underserved, held here Sept. 20-23.

[3] Source: Medicare Data 2006-2011, CRG adjusted, Refined Provider Algorithm; available at http://www.adcc.org/sites/default/files/ADCC_Facts_On_Dedicated_Cancer_Centers.pdf

See also Dedicated Cancer Centers are More Likely to Achieve a Textbook Outcome Following Hepatopancreatic Surgery.; Mehta R, Tsilimigras DI, Paredes AZ, Sahara K, Dillhoff M, Cloyd JM, Ejaz A, White S, Pawlik TM. Ann Surg Oncol. 2020 Jun;27(6):1889-1897. doi: 10.1245/s10434-020-08279-y

See also "What Is the Value of Undergoing Surgery for Spinal Metastases at Dedicated Cancer Centers? Azeem Tariq Malik, Safdar N Khan, Ryan T Voskuil, John H Alexander, Joseph P Drain, Thomas J Scharschmidt. Clin Orthop Relat Res. 2021 Jun 1;479(6):1311-1319. DOI: 10.1097/CORR.0000000000001640.

Both the high acuity that UCMC treats and the incidence of disease, including cancer on the South Side, contribute to the pressing need for additional beds to ensure timely access to care.

The addition of beds will not cause any duplication of services because of the different roles served by UCMC as an academic medical center providing tertiary and quaternary care and the community hospitals with a primary and secondary care focus.

While these units will be physically designed to suit the unique requirements of cancer patients, there will also be significant care delivery benefits. Condition-specific units, like those in this Project, will ensure that the patient care team develops the specialized skillsets needed to address all of the components of Cancer care.

Medical-Surgical Beds

Utilization - Medical/Surgical only (FY2016-FY2029)					
	Dept/Service	Historical Utilization	Projected Utilization	State Standard	Meet Standard?
Year	Med/Surg Beds			90% Occupancy	
2016	506	118,273		64%	No
2017	506	130,516		71%	No
2018	506	130,347		71%	No
2019	506	136,794		74%	No
2020	506	130,516		71%	No
2021	506	146,524		79%	No
2022	481	153,459		87%	No
2023	481		156,835	89%	
2024	545		160,285	81%	
2025	545		163,812	82%	
2026	545		167,416	84%	
2027	545		171,099	86%	
2028	545		174,863	88%	
2029	545		178,710	90%	Yes

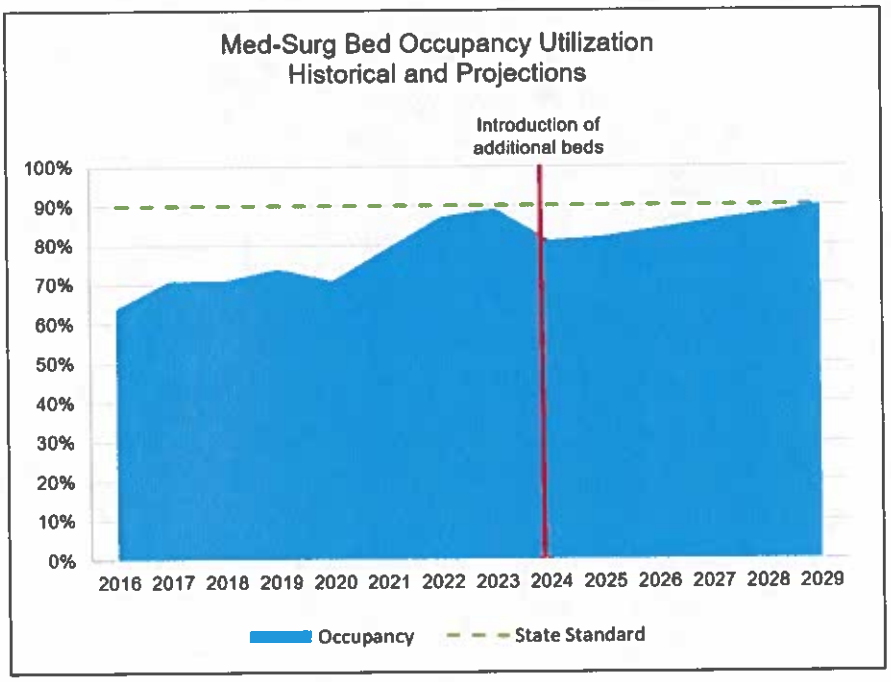
Source: EPIC ADT Patient Census Data

UCMC is currently renovating beds in the Mitchell Hospital as part of CON Project #16-008, which was altered in September 2021, and is now licensed for 481 Medical-Surgical beds. UCMC opened the Center for Care and Discovery in 2013, which was licensed for 300 Medical-Surgical beds at the time. Thirty-eight (38) additional Medical-Surgical beds were then added as part of CON Project #13-025 in October 2013, which reactivated beds in Mitchell Hospital. CON Project #16-008 was then approved in May 2016, and an alteration was approved in September 2021.

While *licensed Medical-Surgical* beds demonstrate an occupancy below the state standard of 90%, it is important to note that the Medical Center's Medical-Surgical beds available for

staffing (see: staffed Medical-Surgical beds), consistently have greater than 90% utilization. In the last twelve months, from January 2022 to January 2023, the average occupancy of staffed Medical-Surgical beds has been at 96% utilization at morning census. As staffing shortages are addressed and procedural cases are ramped up to pre-pandemic levels, it is anticipated that utilization figures will follow suit.

Medical-Surgical utilization has historically seen a compound annual growth rate of 4.4% between FY2015 and FY2022. Applying this growth rate would meet the states 90% utilization threshold in one year's time. However, the growth estimates shown in the table above are more conservative to account for any future volatility in inpatient volumes, largely to account for any pandemic-related disruptions. A projected growth rate of 2.2% was applied from FY2023 onward. Historical utilization is inclusive of standard inpatients and observation patients treated in licensed Medical-Surgical beds.



Historic Growth Even Amidst the COVID-19 Pandemic

Over the past four years, Medical-Surgical admissions have grown by nearly 10% and bed days have grown by nearly 20%. UCMC had observed an even stronger upward trajectory in the days before March 2020, but the COVID-19 pandemic had an outsized impact in dropping admissions and procedures for the following 12-24 months. At current, UCMC has been able to rebound from those volume declines and is returning to pre-pandemic volumes.

The key to this growth has been two-pronged, with steady growth in emergency admissions in the past two years as well as UCMC's intentional investments in key service lines (like Cancer, Digestive Diseases, Heart and Vascular, Musculoskeletal, Neurosciences, and Transplant).

Below is a graph that describes UCMC's anticipated growth across all service lines. Using annual growth rates from before the COVID pandemic (3.0%), during the height of the COVID

pandemic (-1.6%), and currently (2.2%), a model was created to estimate the expected number of patient admissions should patient volumes move along the trajectories of any of the three scenarios. At its current rate, the Medical Center is expected to see a total of 11.3% growth in admissions in the following four years.

The anticipated inpatient admission growth drives UCMC's need to expand its inpatient capacity. With the movement of cancer patients to a dedicated building with service-specific inpatient units, UCMC will use existing capacity for new backfill opportunities. Several key service lines have grown in both program size and patient demand over the past few years, with UCMC Neurosciences volumes expanding nearly 35% between 2018-2022 and Heart & Vascular growing nearly 15% in the same time period. UCMC fully expects to fill other inpatient capacity that is opened up as a result of this Project.

ICU Beds

UCMC is currently renovating beds in Mitchell Hospital as part of CON Project #16-008, which was altered in September 2022, and is now licensed for 142 ICU beds. UCMC opened the Center for Care and Discovery in 2013, which was licensed for 114 ICU beds at that time. Twelve ("12") additional ICU bed licenses were added as part of CON Project #14-013 in August 2014, which was a project to build out the shelled space on the 3rd and 4th floors of the Center for Care and Discovery, relocate beds to those floors, and add ICU beds. CON Project #16-008 was then approved in May 2016, and an alteration was approved in September 2021.

UCMC has exceeded 60% utilization for ICU beds each year since 2017, based on a license for 146 ICU beds, which has since been reduced to 142. The 37,663 patient days seen in FY21 would justify 172 ICU beds at 60% utilization.

UCMC is requesting an additional 16 ICU bed licenses, which would bring the total ICU bed licenses up to 158. The requested number is lower than the 172 justified above.

Utilization – ICU Only (FY2016-FY2029)					
	Dept/Service	Historical Utilization	Projected Utilization	State Standard	Meet Standard?
Year	ICU Beds			60% Occupancy	
2016	146	31,114		58%	
2017	146	32,629		61%	
2018	146	35,254		66%	
2019	146	36,348		68%	
2020	146	35,000		66%	
2021	146	37,663		71%	Yes
2022	142	40,902		79%	Yes
2023	142		41,516	80%	
2024	158		42,138	73%	
2025	158		42,770	74%	
2026	158		43,412	75%	
2027	158		44,063	76%	
2028	158		44,724	78%	
2029	158		45,395	79%	Yes

Source: EPIC ADT Patient Census Data

While ICU utilization has seen a historical compound annual growth rate of 4.7% between FY2016 and FY2022, the growth estimates shown are more conservative to account for any future volatility in ICU volumes. A projected growth rate of 1.5% was applied from FY2023 onward. Note that ICU utilization is inclusive of all ICU beds, agnostic of adult or pediatric designation. NICU beds are not included in this analysis.

Medical-Surgical Bed to ICU Bed Ratio Comparison

To better understand UCMC's current and future bed composition, an analysis was completed to compare bed counts and types across Chicago's academic medical centers. UCMC's ratio of Medical-Surgical beds to ICU beds is on par with other academic medical centers in the region, and the requested revisions to the bed licenses will not change the ratios drastically.

Hospital	Med/Surg Beds	ICU Beds	Ratio (M/S-ICU Beds)
Northwestern Memorial Hospital	506	139	4.0
Rush University Medical Center	506	132	2.7
University of Illinois Hospital and Clinics	506	65	3.7
UCMC Beds (Current + Requested)			
Hospital	**Med/Surg Beds**	**ICU Beds**	**Ratio (M/S-ICU Beds)**
University of Chicago Medical Center (Current Bed Count)	481	142	3.4
University of Chicago Medical Center (Current + Requested Bed Count)	545	158	3.7

Source: Illinois Annual Hospital Questionnaire 2020

1110.200(e) - Staffing Availability

After reviewing the staffing needs of the proposed Dedicated, comprehensive cancer facility, UCMC does not foresee any significant challenges to hire and recruit nurses to staff the anticipated service and program needs of the proposed project.

UCMC nurses have robust benefits packages. On top of earning among the highest salaries in the greater Chicago area, they are offered strong incentive programs, career growth and development opportunities, and are given the opportunity to provide world-class care in an environment where opinions are respected and teamwork rewarded. Our excellence has been recognized by organizations like LinkedIn who ranked us 24th in Chicago's Top Companies as recently as 2021.

While the COVID pandemic has certainly impacted the nursing workforce and contributed to nursing vacancies across Chicagoland, the state, and the country – UCMC has a strong team of Recruiters who work diligently to recruit and hire the best nursing talent. Successful nurse recruitment has been durable in the face of pandemic-related challenges and we anticipate being able to fill the positions required for the Center.

1110.200(f) - Performance Requirements

1. Medical-Surgical beds would total 545, which exceeds the required 100 beds within a Metropolitan Statistical Area ('MSA').
2. Medical-Surgical – The 64 Medical/Surgical bed addition and overall number of Medical/Surgical beds at UCMC would be 545, which meets the 100 bed minimum standard within a MSA.
3. Intensive Care – The addition of 12 ICU beds meets the minimum standard of 4 beds for an ICU

1110.200(g) - Assurances

A letter signed by Thomas Jackiewicz, UCMC's President, is included in this attachment attesting to meeting and sustaining occupancy standards for the requested additional Medical/Surgical and ICU beds by the second year of operation after Project completion.

AT THE FOREFRONT
UChicago Medicine

February 1, 2023

Ms. Debra Savage, Chair
Illinois Health Facilities and Services Review Board
525 West Jackson Street, 2nd Floor
Springfield, Illinois 62761

Re: The University of Chicago Medical Center – Cancer Center Hospital – Assurance of Utilization

Dear Ms. Savage,

This letter attests that The University of Chicago Medical Center ("UCMC") understands that it is expected to achieve and maintain the utilization standards specified in 77 Ill. Adm. Code §1110 Appendix B by the second year of operation after Project completion. UCMC reasonably expects to meet this utilization for medical/surgical beds, intensive care beds and all proposed other clinical services with no exception of ultrasound machines. Attachments 15 and 19 explain the utilization in detail and the reasons the addition of the ultrasound equipment is prudent for this Project.

Thomas Jackiewicz
President

Notarization:
Subscribed and sworn before me
this 1 day of February, 2023

Signature of Notary Public

"OFFICIAL SEAL"
CASSANDRA COLE
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 8/3/2026

Thomas Jackiewicz, President UChicago Medicine
5841 S. Maryland Avenue | MC 1000 | Chicago, IL 60637
41096039 1

M. Criterion 1110.270 - Clinical Service Areas Other than Categories of Service

Attachment 31

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):

	# of Existing Key Rooms	# of Proposed Key Rooms
☐ CT Scan	8	10
☐ MRI	9	11
☐ Ultrasound	8	10
☐ X-Ray/Radiography and Fluoroscopy	21	22
☐ Mammography	4	5

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

1APPEND DOCUMENTATION AS ATTACHMENT 31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The Project will consolidate the continuum of cancer care in one facility, fostering communicating, collaboration and strategic deployment of technology. Currently, a cancer patient has multiple points of entry to UCMC system with diffuse physical locations. The new building will be patient-centered to allow patients to have all appointments in one area and to improve multidisciplinary collaboration and cooperation, to timely address each patient's administrative and clinical needs.

This ongoing improvement of care, shaped by the fusion of clinical research and clinical practice, is at the core of UCMC's founding mission and for its future role and contribution to the health care system. At the center of cancer care is the patient, and the Project will allow UCMC to continue its tradition in transformational medicine.

Imaging

The proposed Project includes the following types of imaging equipment:

- 2 CT
- 2 MRI
- 2 Ultrasound
- 1 X-Ray unit
- 1 Mammography

All imaging rooms will be located on the first floor to accommodate both outpatient and inpatient cancer patients.

CT Scan

In FY21 and FY22, UCMC's CT Scan utilization justified 13 units, based on the state standard, and rounding up methodology. UCMC anticipates requesting two additional CT Scan units as part of the Project, differing slightly and adding one from the Master Design Permit CON. The additional CT Scan machine was seen as a broader system need that would support both volumes in the comprehensive cancer facility as well as other service line growth. The two additional machines will bring the total number of units from 9 to 11, which is still below the number justified by the state standard. CT utilization had a growth rate of 11.4% annually from 2016-2022. Applying a straight-line projection through FY29 would justify 25 CT scan units – well over the 10 total units that are requested for the system.

Utilization – CT Scan					
	Dept/Service	Historical Utilization	Projected Utilization	State Standard	Meet Standard?
Year	CT			7,000/unit	
2016	7	44,764		>42,000	
2017	8	50,567		>49,000	
2018	8	64,393		>49,000	
2019	8	70,063		>49,000	
2020	8	71,548		>49,000	
2021	8	84,053		>49,000	Yes
2022	8	85,415		>49,000	Yes
2023	8		95,127	>49,000	
2024	9		105,942	>56,000	
2025	9		117,988	>56,000	
2026	9		131,403	>56,000	
2027	9		146,343	>56,000	
2028	11		162,982	>70,000	Yes
2029	11		181,513	>70,000	Yes

Source: UCMC Internal Radiology Utilization Data

CT Scan justified at 7,000 visits per machine = 26 (181,513 visits / 7,000 visits per machine – rounded up)

MRI

In FY21 and FY22, UCMC's MRI utilization justified 11 units, based on the state standard and the rounding up methodology. UCMC anticipates requesting two additional MRI units as part of the dedicated, comprehensive cancer facility project, bringing the total from 10 units to 12 units, which is still below the number justified by the state standard. MRI utilization had a growth rate of 4.3% annually from 2016-2022. Applying a straight-line projection through FY29 would justify 15 MRI units – over the 12 total units.

Utilization – MRI					
	Dept/Service	Historical Utilization	Projected Utilization	State Standard	Meet Standard?
Year	MRI			2,500/unit	
2016	9	20,640		>20,000	
2017	9	22,549		>20,000	
2018	9	22,659		>20,000	
2019	9	24,259		>20,000	
2020	9	21,723		>20,000	
2021	9	26,557		>20,000	Yes
2022	9	26,526		>20,000	Yes
2023	9		27,659	>20,000	
2024	10		28,840	>22,500	
2025	10		30,071	>22,500	
2026	10		21,355	>22,500	
2027	10		32,694	>22,500	
2028	12		34,091	>27,500	Yes
2029	12		35,546	>27,500	Yes

Source: UCMC Internal Radiology Utilization Data

MRI Scan justified at 2,500 visits per machine = 15 (35,546 visits / 2,500 visits per machine – rounded up)

Ultrasound

In FY21 and FY22, UCMC's Ultrasound utilization justified 6 units, based on the state standard and the rounding up methodology. UCMC is requesting two additional Ultrasound units as part of the dedicated, comprehensive cancer facility project, bringing the total from 8 units to 10 units. Ultrasound utilization had a growth rate of 4.2% annually from 2016-2022. Applying a straight-line projection through FY29 would justify 8 Ultrasound units. While this number of units will not meet the state standard, we believe there is sufficient justification for these additional machines, outlined below.

- To ensure a smooth patient experience and efficient care delivery, it will be important to have all imaging performed in the same building. It is imperative to minimize patient movement, particularly for cancer patients who have such specialized needs and who are undergoing challenging treatments.
- Ultrasound units do not contribute significantly to high healthcare spend (relative to other costs), averaging about ~$250,000 per machine. We believe that this spend is justified to meet the level of patient experience we are looking to deliver.
- UCMC's existing ultrasound machines are commonly used for very specific purposes outlined in the list below. While utilization may appear lower in the aggregate, site-specific machines see utilization as high as 80% or more
    - Two units reserved for Comer Children's Hospital

- One unit is portable/hand-held and used for nephrology biopsies and another for transplant patients – volumes will grow as the Transplant service line grows (currently growing at nearly 7% year over year)
- One unit is used for inpatient exams and operating room procedures
- One unit is dedicated for biopsy procedures and is currently being utilized at 80%
- The remaining three are at Mitchell hospital and used for more generalized purposes

Utilization – Ultrasound					
	Dept/Service	**Historical Utilization**	**Projected Utilization**	**State Standard**	**Meet Standard?**
Year	**Ultrasound**			**3,100/unit**	
2016	7	12,843		>18,600	
2017	8	13,436		>21,700	
2018	8	13,868		>21,700	
2019	8	14,456		>21,700	
2020	8	13,400		>21,700	
2021	8	15,779		>21,700	
2022	8	16,421		>21,700	No
2023	8		17,108	>21,700	
2024	8		17,823	>21,700	
2025	8		18,568	>21,700	
2026	8		19,344	>21,700	
2027	8		20,153	>21,700	
2028	10		20,996	>24,800	No
2029	10		21,874	>24,800	No

Source. UCMC Internal Radiology Utilization Data

Ultrasound justified at 3,100 visits per machine = 8 (21,874 visits / 3,100 visits per machine – rounded up)

X-Ray / Radiography and Fluoroscopy

In FY21, UCMC's X-Ray utilization justified 28 units and in FY22, utilization justified 29 units, based on the state standard and the rounding up methodology. UCMC is requesting one additional x-ray unit as part of the dedicated, comprehensive cancer facility project, bringing the total from 21 units to 22 units, which is still below the number justified by the state standard. X-ray utilization had a higher growth rate of 5.7% annually from 2016-2022. Applying a straight-line projection through FY29 would justify 42 X-ray units – over the 22 total units being requested.

Utilization – X-Ray					
	Dept/Service	Historical Utilization	Projected Utilization	State Standard	Meet Standard?
Year	X-Ray			6,500/unit	
2016	20	132,862		>123,500	
2017	20	135,139		130,000	
2018	20	133,243		130,000	
2019	21	169,155		>130,000	
2020	21	171,515		>130,000	
2021	21	175,815		>130,000	Yes
2022	21	184,899		>130,000	Yes
2023	21		195,370	>130,000	
2024	21		206,433	>130,000	
2025	21		218,123	>130,000	
2026	21		230,475	>130,000	
2027	21		243,526	>130,000	
2028	22		257,317	>136,500	Yes
2029	22		271,888	>136,500	Yes

Source: UCMC Internal Radiology Utilization Data

X-Ray justified at 6,500 visits per machine = 42 (271,888 visits / 6,500 visits per machine – rounded up)

Mammography

UCMC currently provides mammography services in DCAM and will be relocated to the new comprehensive cancer facility once complete. The breast imaging services will be housed within the new Breast Center, which will be located on the first floor for ease of access, along with the aforementioned Breast Cancer & Prevention clinic.

In FY21, UCMC's mammography volume justified 4 units, based on the state standard and the rounding up methodology. We have seen a growth rate of 1.7% annually from 2016-2022. Applying a straight-line projection through FY29 would justify 4 units.

Utilization – Mammography based on historical annual growth rate					
	Dept/Service	Historical Utilization	Projected Utilization	State Standard	Meet Standard?
Year	Mammography			5,000/unit	
2016	5	14,925		>20,000	
2017	5	14,134		>20,000	
2018	4	14,057		>15,000	
2019	4	14,425		>15,000	
2020	4	12,341		>15,000	
2021	4	15,849		>15,000	Yes
2022	4	16,525		>15,000	Yes
2023	4		16,806	>15,000	
2024	4		17,092	>15,000	
2025	4		17,382	>15,000	
2026	4		17,678	>15,000	
2027	4		17,978	>15,000	
2028	5		18,284	>20,000	No
2029	5		18,595	>20,000	No

Source UCMC Internal Radiology Utilization Data

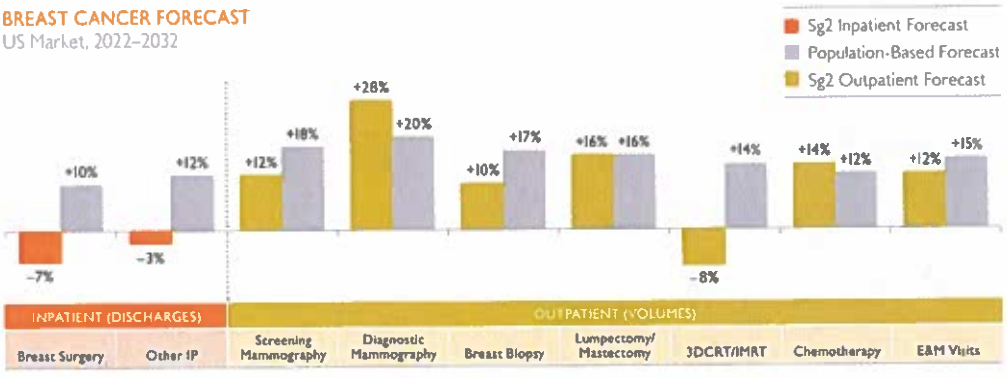
Mammography justified at 5,000 visits per machine = 4 (18,595 visits / 5,000 visits per machine – rounded up)

However, higher than historical growth is projected for mammograms and consequently UCMC is requesting to add one (1) additional mammography unit. While volume projection based on historical growth will not justify the additional mammography unit based the state standard, UCMC anticipates higher demand for mammograms in the future as it continues to grow its breast cancer screening and diagnostics program, as evidenced by the annual growth rate of 4.6% in the most recent 4 years.

Utilization – Mammography based on expected annual growth rate (3.5%)					
	Dept/Service	Historical Utilization	Projected Utilization	State Standard	Meet Standard?
Year	Mammography			5,000/unit	
2016	5	14,925		>20,000	
2017	5	14,134		>20,000	
2018	4	14,057		>15,000	
2019	4	14,425		>15,000	
2020	4	12,341		>15,000	
2021	4	15,849		>15,000	Yes
2022	4	16,525		>15,000	Yes
2023	4		17,103	>15,000	
2024	4		17,702	>15,000	
2025	4		18,322	>15,000	
2026	4		18,963	>15,000	
2027	4		19,627	>15,000	
2028	5		20,313	>20,000	Yes
2029	5		21,024	>20,000	Yes

Source: UCMC Internal Radiology Utilization Data

Sg2 report further supports UCMC's projection. Sg2 predicts that demand for breast cancer services, particularly in screening (12%) and diagnostics (28%) will steadily increase over the next 10 years.



Note: Analysis excludes 0-17 age group. Breast surgery includes mastectomy. Other IP includes other major and minor therapeutic procedures, diagnostics and no procedure. Screening and diagnostic mammography include both standard and 3D mammography (ie, tomosynthesis) for all service lines. Breast biopsy includes open, percutaneous and percutaneous breast biopsies. 3DCRT = 3D conformal radiation therapy; E&M = evaluation and management; IMRT = intensity-modulated radiation therapy; USPSTF = US Preventive Services Task Force. **Sources:** Impact of Change®, 2022; HCUP National Inpatient Sample (NIS), Healthcare Cost and Utilization Project (HCUP) 2019. Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2 All-Payer Claims Data Set, 2019. The following 2019 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility. Claritas Pop-Facts®, 2022. Sg2 Analysis, 2022.

UCMC is continuing to engage underserved communities, including Black and Latinx communities, to educate them on breast cancer risks and preventions. Early detection is critical and increasing the number of mammography units will reduce the wait times to schedule and will increase access for patients.

ATTACHMENT 31

M. Criterion 1110.270 - 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):

	# of Existing Key Rooms	# of Proposed Key Rooms
☐ Outpatient Oncology Clinic Exam Rooms	57	90
☐ Breast Center Cancer & Prevention Clinic Exam Rooms	8	18
☐ Outpatient Infusion	54	67
☐ Outpatient Cellular Therapy	5	12
☐ Cancer Urgent Care – Oncology Rapid Assessment	3	8

☐ Phlebotomy	
☐ Wellness Center	
☐ Pharmacy	
☐ Human Tissue Resource Center/Biofluids Lab	

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

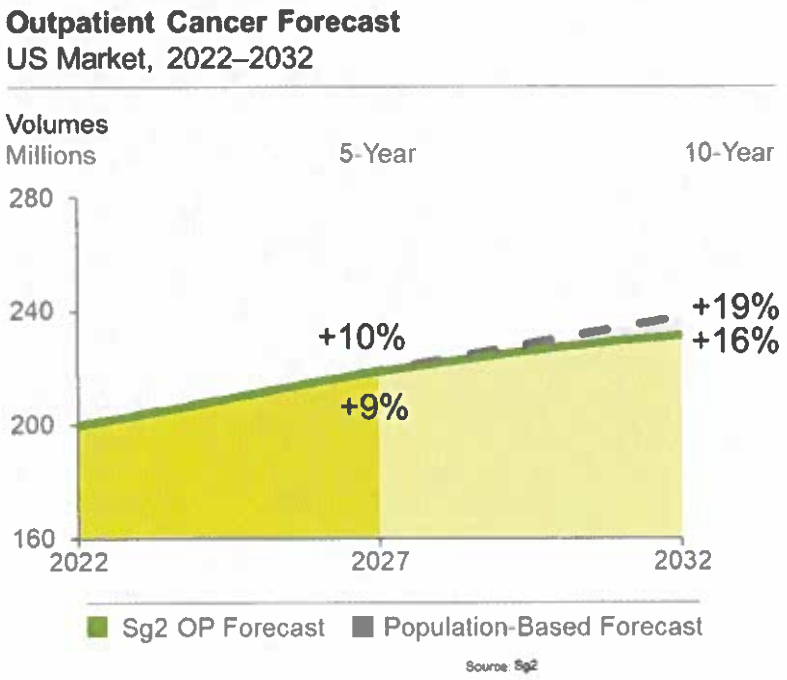
Project Type	Required Review Criteria
New Services or Facility or Equipment	(b) – Need Determination – Establishment
Service Modernization	(c)(1) – Deteriorated Facilities
	AND/OR
	(c)(2) – Necessary Expansion
	PLUS
	(c)(3)(A) – Utilization – Major Medical Equipment
	OR
	(c)(3)(B) – Utilization – Service or Facility
1APPEND DOCUMENTATION AS ATTACHMENT 31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

ATTACHMENT 31

Outpatient Clinic Exam Rooms

UCMC currently has 47 dedicated exam rooms in medical oncology and additional rooms spread throughout the Duchossois Center for Advanced Medicine ("DCAM") for surgical oncology patients, which is not optimal. A key objective of the comprehensive cancer facility is to reduce fragmentation and improve coordination of care and services across different disciplines. The Project will allow all providers to work under "one roof" and provide patients with a single destination to receive cancer care. The proposed project includes physician office space for an array of Biological Sciences Division (BSD) Faculty who provide specialized services for cancer patients. The physician offices will include medical oncology, surgical oncology, and palliative and supportive oncology specialists.

Cancer care is increasingly occurring in the outpatient environment. The trend towards outpatient care is forecasted to continue well into the next decade as outlined by Sg2. Outpatient cancer care is forecasted to increase over the next 10 years (16%) and that has been the case at UCMC where the growth has been more substantial in the outpatient environment compared to the inpatient environment.



At UCMC, current growth projections anticipate an outpatient growth rate of 4.7% annually. Using the existing room utilization trends, 90 rooms would be insufficient to meet this demand. However, with additional space and efficiency gains from an optimized layout UCMC anticipates that the room turns per day will increase from ~4.5 to ~7.0 room turns per room per day. This enhanced efficiency will allow us to see all of our oncology patients within the requested 90 exam rooms.

Outpatient Breast Center Clinic Exam Rooms

UCMC currently has 8 exam rooms in focused on treating breast cancer patients but they are spread throughout DCAM. The pandemic significantly impacted screenings as many patients either delayed or deferred, increasing the likelihood of higher-acuity breast cancer cases in the future. The proposed Breast Cancer Center will be well positioned to meet the anticipated demands for care, bringing together multidisciplinary care for Breast Cancer patients including medical oncology, surgical oncology, plastic surgery, and breast imaging all in the same suite. The clinic portion of the suite will include (18) exam/consult rooms and appropriate support spaces. The Prevention Center including a small clinic and resource library space. Community forums hosted by UCM and our dedicated patient panels indicated that there is a significant demand to provide resources for community education, cancer screening, and cancer prevention clinics to include both genetics clinics and lifestyle clinics.

The Breast Center will co-locate specialists from medical and surgical oncology as well as Plastic & Reconstructive Surgery ("PRS"). Given the nature of breast cancer, many of these providers see patients on the same day—especially the Breast Surgeons and PRS team. These surgeons typically see more than seven patients per room per day and consequently will need more than 10 rooms between them. While the room turns per day are smaller for medical oncology providers, advanced practice providers, survivorship providers and other providers that will practice in this space, an additional ten (10) rooms are needed to accommodate these services throughout the course of the week.

Outpatient Infusion Therapy

In addition to expansion of exam rooms, this project will expand the infusion services. In its current state, UCMC has 54 infusion bays for oncology patients on the Hyde Park campus and the plan is to add 13 infusion bays to improve access and meet the anticipated demands. In FY22, there were 23,944 infusion visits, which equated to utilization rate of 67%. Academic medical centers typically treat patients with higher acuity and as result have lower utilization rate, around 60%. With the expected 4.7% annual growth rate in the outpatient patient environment, the demand for infusion therapy will grow to about 34,000 infusion visits. With current operating parameters, UCMC will quickly surpass the need for 67 infusion locations. However, with the optimal distribution of infusion bays, UCMC will gain efficiencies compared to the current state and be able to serve the patients appropriately.

	FY22	FY29
# of Infusion Visits	**23,944**	**33,691**
Average Hours per Infusion	3	3
Total Hours of Infusion	71,832	101,073
Infusion Bays	54	67
Annual Hours of Operation	108,000	134,000
Utilization Rate	67%	75%

There is no State standard for utilization for outpatient infusion services.

Outpatient Cellular Therapy

UCMC provides access to state-of-the-art therapies. UCMC was the first hospital in Illinois and one of the first few in the country to offer CAR-T Therapy. UCMC started to offer CAR-T in 2016 in clinical trials. Since then, UCMC has done over 250 adult cell therapy infusions of commercial products and clinical trials. UCMC was the first center in the country to offer Novartis's Kymriah® for all three of its indications and the second center to offer Kite's Yescarta®. UCMC also has one of the largest cell therapy clinical trial portfolios in the US with trials in leukemia, lymphoma, multiple myeloma, and several solid tumors (breast, cervical, melanoma, NSCLC, GI malignancies, and H&N cancers).

As the leader in Cellular Therapy in Illinois, UCMC has seen its Cellular Therapy (Bone marrow transplants, Car-T, etc.) treatment volume grow. From FY16 to FY22, cell therapy volume at UCMC increased from 147 to 204, a 39% increase. UCMC's existing outpatient cellular therapy footprint consists of five (5) private bays. Over the next decade, it is anticipated that cellular therapy volume will nearly double. Historically, cellular therapy offerings have been limited to treating blood cancers. While that will continue to be the case, it is also anticipated that solid tumor cancer diagnoses will also increasingly have cellular therapy options as the standard of care in the future.

As a result of this expected demand for novel treatments, plus the anticipated shift of apheresis services and bone marrow biopsies to this area, UCMC expects that 12 rooms will be needed to meet this patient demand. These private rooms, which will be co-located next to the general infusion bays for Heme malignancies, are designed for Hematopoietic Stem Cell Transplantation (HSCT) and Apheresis services. This space is also the location that bone marrow biopsies will be performed.

Utilization – Cellular Therapy			
	Dept/Service	**Historical Utilization**	**Projected Utilization**
Year	**Cell Therapy**		
2016		147	
2017		172	
2018		197	
2019		197	
2020		147	
2021		215	
2022	5	204	
2023	5		216
2024	5		227
2025	5		240
2026	5		254
2027	5		268
2028	12		283
2029	12		298

There is no State standard for utilization for outpatient cellular therapy services.

Cancer Urgent Care – Oncology Rapid Assessment Clinic (ORAC)

Currently, UCMC's Oncology Rapid Assessment Clinic (ORAC) offer patients an alternative to the emergency room when cancer or treatment related side effects surface. Cancer patients, who are immunocompromised, are at enhanced risk of infection in an emergency room environment. Currently, with limited hours, UCMC uses roughly 3 ORAC bays per day. However, in its current form there are a variety of limitations on the services that are offered within this space.

In the new comprehensive cancer facility, UCMC will expand ORAC to an eight-bay service and operate it as a 24-hour service. These extended hours will enable to UCMC to increase the number of services that are offered within this space and thus will need the requested space to meet the needs of its patient population. With more treatments shifting to the outpatient setting, providing a controlled environment of ORAC is a safer environment for patients and consequently UCMC will take measured steps to increase the number of services that can be offered within this space.

Other Clinical Areas

The new facility will put the broader care continuum under one roof, unlike any other center in the Chicagoland area, creating synergies that will improve patient's outcomes and experience. To that end, the comprehensive cancer facility will house various clinical services to support the cutting-edge research and the state-of-the-art clinical services but will also be positioned to support the anticipated care innovation in the future.

Phlebotomy

While phlebotomists will be deployed throughout the facility to collect specimens, the comprehensive cancer facility will include a dedicated space for blood draw and processing to support the efficient care delivery for patients. For example, patients may have their blood draws completed in the outpatient departments or they can stop by the dedicated phlebotomy chairs on their way in or out of the facility. Inpatient blood draws will be done at the bedside by phlebotomists. When clinically viable, the inpatient and outpatient blood draws transport the specimen through the pneumatic tube system to the existing central Lab located in the Mitchell Hospital building.

Wellness Center

The Oncology Patient Support Center in the cancer facility includes supportive and integrative therapies. This space will include consultation rooms and rehabilitation gym equipment for the delivery of supportive outpatient services to support the cancer patient and family members during cancer treatment. Services include palliative care, cancer nutrition, physical and occupational therapy, social work services, psychology/psychiatry services, patient education, support groups, acupuncture, and massage.

Pharmacy

The cancer facility will include pharmacy space that will support the highly specialized tertiary and quaternary services that will be delivered. In order to maximize efficiency, inpatient and ambulatory pharmacy have been combined in the cancer facility.

The pharmacy will be responsible for providing first dose medications, stat medications, routine doses, IV preparation, and compounding for the adult Cancer Patient population. The pharmacy will have chemotherapy, immunotherapy, and oncology supportive care (IV nutrition, narcotics, etc) production located in the cancer building to minimize the time between testing and treatment for the patient.

The pharmacy department plans to utilize pharmacy technicians, pneumatic tube system, and potentially autonomous delivery robots to efficiently prepare and distribute medications. The pharmacy will be fitted with the latest technologies including medication carousels to increase capacity and ensure compliance with all regulatory agencies including USP 797/800 clean room standards. The pharmacy is planned for maximum flexibility and adaptability given the rapid changes in cancer drug approvals and pharmacology, and future growth.

Additionally, the pharmacy will include investigational drug pharmacy to support research activities. This pharmacy will include a gene therapy clean room, and USP 797 and 800 clean rooms. In accordance with best practice, research medications will be stored and prepared separately from standard of care treatments.

The pharmacy is customized to service the patient population and research conducted at The University of Chicago Medicine. The pharmacy has been thoughtfully designed based on federal clean room regulations, published pharmacy best practices, interviews with other large academic cancer centers, clinical research, and the need for future adaptability.

Human Tissue Resource Center (HTRC)/Biofluids Lab:

The comprehensive cancer facility includes a biobanking specimen lab space dedicated for the processing of specimens, bringing together HTRC and Biolfluids Lab, for clinical research trials. The space will be co-located near the infusion space to allow for enhanced collaboration and reduced waits between the collection of specimen and the processing of specimen.

The new lab accounts for the anticipated growth in innovative and personalized treatment options. UCMC anticipates a significant increase in the number of trials that are needed for its patients and furthermore, UCMC anticipates that the complexity of the trials it offers will continue to increase as well. The dedicated biobanking specimen lab space will enable these needed services to occur in an area that is proximate to where patients are being seen and will reduce the number of wasted steps that the care team has to take in order to deliver specimens to their existing processing labs.

Section VI, Availability of Funds

Attachment 34

Because UCMC has a bond rating of A- or better from Fitch's and/or Standard and Poor's rating agencies, or A3 or better from Moody's, this Section is not applicable. A copy of UCMC's bond ratings letters are included in Attachment 35.

Attachment 35

Financial Viability Waiver

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

S&P Global
Ratings

130 East Randolph Street
Suite 2900
Chicago, IL 60601
tel 312-233-7000
reference no.: 1738402

November 23, 2022

The University of Chicago Medical Center
150 Harvester Drive, Suite 300
Burr Ridge, IL 60527
Attention: Ann M. McColgan, Treasurer

Re: ***US$175,000,000 Illinois Finance Authority, Illinois, Revenue Bonds, (University of Chicago Medical Center), (Long-Term Fixed Rate), Series 2022A, dated: Date of Delivery, due: June 30, 2053***

Dear Ann M. McColgan:

Pursuant to your request for an S&P Global Ratings rating on the above-referenced obligations, S&P Global Ratings has assigned a rating of "AA-". S&P Global Ratings views the outlook for this rating as stable. A copy of the rationale supporting the rating is enclosed.

This letter constitutes S&P Global Ratings' permission for you to disseminate the above-assigned ratings 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 or to allow the Issuer to comply with its regulatory obligations) will become effective only after we have released the ratings 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. Any such dissemination shall not be done in a manner that would serve as a substitute for any products and services containing S&P Global Ratings' intellectual property for which a fee is charged.

To maintain the rating, S&P Global Ratings 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 S&P Global Ratings 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@spglobal.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:
S&P Global Ratings
Public Finance Department
55 Water Street
New York, NY 10041-0003

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.

S&P Global Ratings 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 S&P Global Ratings.

Sincerely yours,

S&P Global Ratings
a division of Standard & Poor's Financial Services LLC

jv
enclosures

cc: ***Brent Phillips***
Sara Perugini

S&P Global
Ratings

S&P Global Ratings
Terms and Conditions Applicable To Public Finance Credit Ratings

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No Third Party Beneficiaries. Nothing in any credit rating engagement, or a credit rating when issued, is intended or should be construed as creating any rights on behalf of any third parties, including, without limitation, any recipient of a credit rating. No person is intended as a third party beneficiary of any credit rating engagement or of a credit rating when issued.

FitchRatings

33 Whitehall Street
New York, NY 10004

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

November 17, 2022

Mr. Ivan Samstein
Chief Financial Officer
University of Chicago Medical Center
5841 S. Maryland Avenue
Chicago, IL 60637

Dear Mr. Samstein:

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 in any offering document in any instance in which US, UK or any other relevant securities laws requires such consent. Fitch does not consent to the inclusion of any written letter communicating its rating action in any offering document. You understand that Fitch has not consented to, and will not consent to, being named as an "expert" in connection with any registration statement or other filings under US, UK or any other relevant securities laws, including but not limited to Section 7 of the U.S. Securities Act of 1933. Fitch is not an "underwriter" or "seller" as those terms are defined under applicable securities laws or other regulatory guidance, rules or recommendations, including without limitation Sections 11 and 12(a)(2) of the U.S. Securities Act of 1933, nor has Fitch performed the roles or tasks associated with an "underwriter" or "seller" under this engagement.

Fitch will continue to monitor the credit quality of and maintain ratings on the Issuer/Securities. 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 Ratings, Inc. and any successor in interest.

Public ratings will be valid and effective only upon publication of the ratings on Fitch's website.

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.

Laura Porter
Managing Director - Global Group Head
Public Finance

LP/em

Enc: Notice of Rating Action
(Doc ID:253360 Rev 0)

ATTACHMENT 35

Notice of Rating Action

Bond Description	Rating Type	Rating Action	Rating	Outlook/ Watch	Eff Date	Notes
Illinois Finance Authority (IL) (UChicago Medicine) rev bonds ser 2022A	Long Term Rating	New Rating	AA-	RO:Sta	2022-11-17 09:16:35.0	
Illinois Finance Authority (IL) (UChicago Medicine) rev bonds ser 2022A	Unenhanced Long Term Rating	New Rating	AA-	RO:Sta	2022-11-17 09:16:35.0	
Illinois Finance Authority (IL) (UChicago Medicine) rev bonds ser 2022B	Long Term Rating	New Rating	AA-	RO:Sta	2022-11-17 09:16:35.0	
Illinois Finance Authority (IL) (UChicago Medicine) rev bonds ser 2022B	Unenhanced Long Term Rating	New Rating	AA-	RO:Sta	2022-11-17 09:16:35.0	

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

Attachment 36

Audited Financial Statements

UCMC's financial statements for the years June 2020 and 2021 were included in the application for permit for Project No. 22-004. That application was filed January 31, 2022 and approved March 15. 2022. Those financial statements are incorporated by reference. Financial Statements for fiscal year 2021 and 2022 are attached.

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidated Financial Statements June 30, 2022 and 2021

(With Independent Auditors Report Thereon)

4. THE UNIVERSITY OF CHICAGO MEDICAL CENTER

5. Table of Contents

KPMG LLP
Aon Center Suite 5500
200 E. Randolph Street Chicago, IL 60601-6436

7. Independent Auditors' Report

The Board of Trustees
The University of Chicago Medical Center:

Opinion

We have audited the consolidated financial statements of The University of Chicago Medical Center (the System), which comprise the consolidated balance sheets as of June 30, 2022 and 2021, and the related consolidated statements of operations and changes in net assets without donor restrictions, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of the System as of June 30, 2022 and 2021, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors Responsibilities for the Audit of the Consolidated Financial Statements section of our report. We are required to be independent of the System and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Consolidated Financial Statements

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

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the System's ability to continue as a going concern for one year after the date that the consolidated financial statements are issued.

Auditors' Responsibilities for the Audit of the Consolidated Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than

for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

KPMG

In performing an audit in accordance with GAAS, we:

Exercise professional judgment and maintain professional skepticism throughout the audit.

Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.

Obtain an understanding of internal control relevant to the audit 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 System's internal control. Accordingly, no such opinion is expressed.

Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.

Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the System's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The 2022 supplementary information included in schedules 1 through 3 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

Chicago, Illinois November
1, 2022

Consolidated Balance Sheets June 30, 2022 and 2021

(In thousands)

Assets

	2022	2021
Current assets:		
Cash and cash equivalents	$ 60,997	184,639
Patient accounts receivable	471,321	437,141
Current portion of investments limited to use	67,796	247,395
Current portion of malpractice self-insurance receivable	21,904	16,809
Current portion of pledges receivable	3,543	2,289
Prepaids, inventory, and other current assets	203,353	195,394
Total current assets	828,914	1,083,667
Investments limited to use, less current portion	1,604,017	1,722,327
Property, plant, and equipment, net	1,531,898	1,509,150
Pledges receivable, less current portion	4,604	5,708
Malpractice self-insurance receivable, less current portion	96,919	90,598
Other assets, net	113,005	122,867
Total assets	$ 4,179,357	4,534,317

Liabilities and Net Assets

Current liabilities:		
Accounts payable and accrued expenses	$ 289,214	282,219
Current portion of long-term debt	22,313	22,875
Current portion of other long-term liabilities	10,664	4,775
Estimated third-party payor settlements and Medicare Advance	275,805	454,530
Current portion of malpractice self-insurance liability	21,904	16,809
Due to University of Chicago	33,645	29,809
Total current liabilities	653,545	811,017
Other liabilities:		
Workers' compensation self-insurance liabilities, less current portion	8,124	8,604
Malpractice self-insurance liability, less current portion	178,013	168,640
Long-term debt, less current portion	903,182	937,757
Interest rate swap liability	83,440	147,362
Other long-term liabilities, less current portion	128,393	145,633
Total liabilities	1,954,697	2,219,013
Net assets:		
Without donor restrictions	2,088,996	2,169,780
With donor restrictions	135,664	145,524

ATTACHMENT 36

Total net assets	2,224,660	2,315,304
Total liabilities and net assets	$ 4,179,357	4,534,317

See accompanying notes to consolidated financial statements.

Consolidated Statements of Operations and Changes in Net Assets Without Donor Restrictions Years ended June 30, 2022 and 2021

(In thousands)

		2022		2021
Operating revenues:				
Patient service revenue	$	2,548,487		2,331,509
Other operating revenues and net assets released from restrictions used for operating purposes		436,961		457,645
Total operating revenues		2,985,448		2,789,154
Operating expenses:				
Salaries, wages, and benefits		1,294,763		1,134,205
Supplies and other		1,030,114		944,587
Physician services		316,946		303,435
Insurance		21,413		39,603
Interest		36,904		39,743
Medicaid provider tax		69,756		75,683
Depreciation and amortization		133,271		132,707
Total operating expenses		2,903,167		2,669,963
Operating revenue in excess of expenses		82,281		119,191
Nonoperating gains and losses:				
Investment return, net	(154,282)		387,316	
Change in fair value of nonhedged derivative instruments	4,229		2,637	
Derivative ineffectiveness on hedged derivative instruments	(1,427)			695
Other, net		(2,760)		(251)
Revenue and gains in excess (deficient) of expenses and losses		(71,959)		509,588
Other changes in net assets without donor restrictions:				
Net asset transfers to University of Chicago	(71,750)			(71,750)
Change in accrued pension benefits other than net periodic benefit costs		4	2,781	
Effective portion of change in valuation of derivatives	62,885		44,967	
Net assets released from restriction for capital purposes		36		125
Distributions and other, net		—		(24)

ATTACHMENT 36

Increase (decrease) in net assets without donor restrictions	$ (80,784)	485,687

See accompanying notes to consolidated financial statements.

Consolidated Statements of Changes in Net Assets Years ended June 30, 2022 and 2021
(In thousands)

		2022	2021
Net assets without donor restrictions:			
Revenue and gains in excess (deficient) of expenses and losses	$	(71,959)	509,588
Net asset transfers to University of Chicago, net		(71,750)	(71,750)
Change in accrued pension benefits other than net periodic benefit cost		4	2,781
Effective portion of change in valuation of derivatives	62,885		44,967
Net assets released from restrictions for capital purposes		36	125
Distributions and other, net		—	(24)
Increase (decrease) in net assets without donor restrictions		(80,784)	485,687
Net assets with donor restrictions:			
Contributions		10,944	12,513
Net assets released from restrictions used for operating purposes		(9,456)	(8,358)
Investment return, net		(11,312)	29,809
Net assets released from restrictions for capital purposes		(36)	(125)
Increase (decrease) in temporarily restricted net assets		(9,860)	33,839
Change in net assets		(90,644)	519,526
Net assets at beginning of year		2,315,304	1,795,778
Net assets at end of year	$	2,224,660	2,315,304

See accompanying notes to consolidated financial statements.

ATTACHMENT 36

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidated Statements of Cash Flows Years ended June 30, 2022 and 2021 (In thousands)

	2022	2021
Cash flows from operating activities:		
Change in net assets	$ (90,644)	519,526
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Net change in unrealized gains and losses on investments	232,738	(312,323)
Net asset transfers to University of Chicago	71,750	71,750
Restricted contributions and investment return	368	(42,322)
Realized gains on investments	(61,140)	(63,889)
Net change in valuation of derivatives	(63,922)	(46,545)
Change in accrued pension benefits other than net period benefit cost and other	(4)	(2,781)
Loss on refinancing of long-term debt	(7,764)	(832)
Loss on disposal of assets	393	235
Net assets released from restrictions for operations	9,456	8,358
Payment of lease obligations	(4,795)	(10,814)
Depreciation and amortization Changes in	133,271	132,707
assets and liabilities:		
Patient accounts receivable	(34,180)	(103,465)
Other assets, net	(4,868)	(38,892)
Accounts payable and accrued expenses	12,553	21,828
Due to University of Chicago	3,836	(7,840)
Estimated settlements with third-party payors and Medicare Advance	(178,725)	(82,317)
Self-insurance liabilities	13,988	25,142
Other liabilities	(3,735)	36,767
Net cash provided by operating activities	28,576	104,293
Cash flows from investing activities:		
Purchases of property, plant, and equipment	(156,412)	(83,744)
Change in construction payables	(5,558)	4,022
Purchases of investments	(274,809)	(944,485)
Sales of investments	389,808	637,099
Net cash used in investing activities	(46,971)	(387,108)
Cash flows from financing activities:		
Proceeds from issuance of long-term debt, including bond premium	—	47,270
Additional repayment of long-term debt	(27,373)	(72,642)
Payments of finance/long-term lease obligation	(7,612)	(8,113)
Net asset transfers to University of Chicago, net	(71,750)	(71,750)
Net assets released from restriction for operations	(9,456)	(8,358)
Proceeds from restricted contributions	10,944	42,322
Net cash used in financing activities	(105,247)	(71,271)
Net (decrease) increase in cash and cash equivalents	(123,642)	(354,086)
Cash and cash equivalents:		
Beginning of year	184,639	538,725
End of year	$ 60,997	184,639

ATTACHMENT 36

Noncash transactions:			
Other assets included for right-of-use assets – operating leases as a result of adopting ASU No. 842, Leases	$	60,050	60,148

See accompanying notes to consolidated financial statements.

(1) Organization and Basis of Presentation

The accompanying consolidated financial statements represent the accounts of The University of Chicago Medical Center and its affiliates (the System). The University of Chicago Medical Center (UCMC) is the parent of an integrated nonprofit healthcare organization, collaborating with the University of Chicago Biological Sciences Division, the University of Chicago Pritzker School of Medicine, and the University of Chicago Physicians Group to provide world-class medical care in an academic setting. Included within UCMC are the following entities; 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, the University of Chicago Medicine Care Network, the UCM Community Health and Hospital Division, Inc. (CHHD), and various other outpatient clinics and treatment areas.

UCMC s Obligated Group includes the following entities: UCMC (excluding the University of Chicago Medicine Care Network, UCMC Title Holding Corporation, and UCMC Title Holding Corporation II NFP), Ingalls Health System, Ingalls Memorial Hospital, Ingalls Development Foundation, and Ingalls Home Care as presented in the supplemental consolidating schedules. Entities of UCMC that are included in the Non-Obligated Group are the University of Chicago Medicine Care Network, University of Chicago Medicine Medical Group, UCMC Title Holding Corporation, and UCMC Title Holding Corporation II NFP. Entities of CHHD that are included in the Non-Obligated Group are Ingalls Provider Group, Ingalls Care Network, Medcentrix, Ingalls Health Ventures, Ingalls Casualty Insurance, Trulen Insurance SPC Limited, and Ingalls Same Day Surgery. These are presented in the supplemental schedules as Other Non-Obligated Group Entities for purposes of consolidation.

The University of Chicago (the University), as the sole corporate member of UCMC, elects UCMC s'Board of Trustees (the Board) and approves its bylaws. 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 bylaws, an affiliation agreement, an operating agreement, and several leases. See note 4 for agreements and transactions with the University.

(2) Summary of Significant Accounting Policies

(a) Principles of Consolidation

The consolidated financial statements of the System have been prepared on the accrual basis of accounting in accordance with U.S. generally accepted accounting principles. All significant intercompany accounts and transactions have been eliminated in consolidation.

(b) COVID-19 Pandemic

On March 11, 2020, the World Health Organization designated COVID-19 as a global pandemic. Patient volumes and the related revenues for most of our services were significantly impacted. Various policies were implemented by federal, state, and local governments in response to the COVID-19 pandemic.

During fiscal year 2022 and 2021, the System received approximately $4,740 and $11,136, respectively, in general and targeted Provider Relief Fund (PRF) distributions, as provided for under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Generally, these distributions from the PRF are not subject to repayment, provided the recipient is able to attest to and comply with the terms and conditions of the funding, including demonstrating that the distributions received have been used for healthcare-related expenses or lost revenue attributable to COVID-19. Such payments are accounted for as government grants and are recognized on a systematic and rational basis as other income once there is reasonable assurance that the applicable terms and conditions required to retain the funds will be met. Based on an analysis of the compliance and reporting requirements of the PRF and the impact of the pandemic on operating results through June 30, 2022, the System recognized through June 30, 2022 and 2021, $5,386 and $61,802, respectively. The unrecognized amount of general distributions and targeted distributions are recorded as estimated third-party payor settlements and Medicare Advance in the consolidated balance sheets as of June 30, 2022 and 2021 of $311 and $949, respectively. The System will continue to monitor compliance with the PRF and the impact of the pandemic on our revenues and expenses. If the System is unable to attest to or comply with current or future terms and conditions, the ability to retain some or all of the distributions received may be impacted.

In addition, during the fourth quarter of fiscal year 2020, the System received $214,500 of accelerated Medicare payments under the Medicare Advanced Payment Program (APP). After 120 days of receipt, claims for services provided to Medicare beneficiaries will be applied against the advance payment balance. Any unapplied advance payment amounts must be paid for the advance payments for acute care hospitals. As of June 30, 2022 and 2021, the System has recorded the APP payments as estimated third-party payor settlements and Medicare advance on the consolidated balance sheets of $36,248 and $183,259. On September 30, 2020, federal legislation extended the terms of APP payments such that any claims for services provided to Medicare beneficiaries will be applied against the advance payment balance beginning April 2021.

The CARES Act also provides for a deferral of payments of the employer portion of social security payroll tax incurred during the pandemic, allowing half of such payroll taxes to be deferred until December 2021 and the remaining half until December 2022. The System has deferred payroll taxes and recorded the deferral under the caption of accrued expenses on the consolidated balance sheets at June 30, 2022 and 2021 for $18,645 and $36,800, respectively.

(c) Use of Estimates

The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

(d) Community Benefits

The System 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. UCMC also accepts patients through the Perinatal and Pediatric Trauma Networks without regard to their ability to pay for services.

The System 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 the System does not pursue collection of these amounts, they are not reported as patient service revenue. The estimated 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, 2022 and 2021, are reported in note 6.

(e) Fair Value of Financial Instruments

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

The System 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 System. 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.

(f) Cash and Cash Equivalents

Cash equivalents include U.S. Treasury notes, commercial paper, and corporate notes with original maturities of three months or less, excluding investments whose use is limited. Cash equivalents held by investment managers are treated as investing activity in the consolidated statements of cash flows.

(g) Inventory and Supplies

The System values inventories and supplies at the lower of cost or market using the first-in, first-out method.

(h) Investments

Investments are classified as trading securities. As such, investment return (including realized or changes in unrealized gains and losses on investments, interest, and dividends) is included in excess of revenue and gains over expenses and losses unless the income is restricted by donor or law.

Investments are recorded in the consolidated financial statements at estimated fair value. If an investment is held directly by an entity 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 System 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, 2022 and 2021, the System had no plans to sell investments at amounts different from NAV.

A significant portion of the System s investments are part of the University s Total Return Investment Pool (TRIP). The System accounts for its investments in TRIP on the fair value method based on its share of the underlying securities and, accordingly, records the investment activity as if the System owned the investments directly using the fair value option election. The University does not engage directly in unhedged speculative investments; however, the Board of the University has authorized the use of derivative investments to adjust market exposure within asset class ranges.
A summary of the inputs used in valuing the System s investments as of June 30, 2022 and 2021 is included in note 7.

(i) 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 for future capital improvements and other specific purposes, over which the Board retains control and may at its discretion subsequently use for other purposes. Investments limited as to use also include investments held under swap collateral posting requirements, investments under the workers compensation self-insurance trust funds, and investments whose use is restricted by donors. Investments limited as to use are reported as net assets without donor restrictions. Investments whose use is restricted by donors are reported as net assets with donor restrictions.

(j) Derivative Instruments

The System accounts for derivatives and hedging activities in accordance with Accounting Standards Codification (ASC) Topic 815, *Derivatives and Hedging*, which requires that all derivative instruments be recorded as either assets or liabilities in the consolidated balance sheets at their respective fair values.

For hedging relationships, the System formally documents the hedging relationship and its risk management objective and strategy for understanding the hedge, the hedging instrument, the nature of the risk being hedged, how the hedging investment s effectiveness in offsetting the hedged risk will be

assessed, and a description of the method for measuring ineffectiveness. This process includes linking all derivatives that are presented as cash flow hedges to specific assets and liabilities in the consolidated balance sheets.

(k) Property, Plant and Equipment

Property, plant, and equipment are reported on the basis of cost, less accumulated depreciation and amortization. Depreciation is calculated using the straight-line method over their estimated useful lives, which generally range from three to eighty years. Interest costs incurred during the period of construction of capital assets are capitalized as a component of the cost of acquiring those assets.

Gifts of long-lived assets with explicit restrictions by donors that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted contributions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The System periodically assesses the recoverability of long-lived assets (including property, plant, and equipment) when indications of potential impairment based on estimated, undiscounted future cash flows exist. Management considers factors, such as current results, trends, and future prospects, in addition to other economic factors, in determining whether there is an impairment of the asset. There were no impairments of long-lived assets during 2022 or 2021.

(l) Leases

ROU assets for operating leases are recorded in other assets, net and the corresponding liability is recorded between current portion of other long-term liabilities and other long-term liabilities, less current portion. ROU assets for financing leases are presented as property, plant, and equipment (net) on the consolidated balance sheets and the corresponding liability is presented between current portion of other long-term liabilities and other long-term liabilities, net of current portion.

The System determines if an arrangement is or contains a lease at contract inception.

For operating leases, the lease liability is initially measured at the present value of the unpaid lease payments at the lease commencement date; it is subsequently measured at the present value of the unpaid lease payments. For finance leases, the lease liability is initially measured in the same manner and date as for operating leases and is subsequently measured at amortized cost using the effective-interest method.

Key estimates and judgments include how the System determines (1) the discount rate it uses to discount the unpaid lease payments to present value, (2) lease term, and (3) lease payments.

ASC Topic 842 requires a lessee to discount its unpaid lease payments using the interest rate implicit in the lease or, if that rate cannot be readily determined, its incremental borrowing rate. The System has elected to use the risk-free rate, which is the rate of a U.S. Treasury security for a period comparable to the lease term.

The ROU asset is initially measured at cost, which primarily comprises the initial amount of the lease liability. Lease expense for lease payments is recognized on a straight-line basis over the lease term.

For finance leases, the ROU asset is amortized using the straight-line method from the lease commencement date to the earlier of the end of its useful life or the end of the lease term unless the lease transfers ownership of the underlying asset to the System or the System is reasonably certain to exercise an option to purchase the underlying asset. In those cases, the ROU asset is amortized over the useful life of the underlying asset. Amortization of the ROU asset is recognized and presented separately from interest expense on the lease liability.

The System monitors for events or changes in circumstances that require a reassessment of one of its leases. Leases having an initial term of 1 year or less are expensed as incurred.

(m) Net Assets

Net assets are classified into two classes of net assets: without donor restrictions and with donor restrictions. Descriptions of the two net asset categories and the types of transactions affecting each category follows:

Without Donor Restrictions – Net assets that are not subject to donor-imposed restrictions. Items that affect this net asset category principally consist of fees for service and related expenses associated with the core activities of the System: patient care and provision of healthcare services. In addition to these exchange transactions, changes in this category of net assets include investment returns on funds functioning as endowment funds, actuarial adjustments to self-insurance liabilities, changes in postretirement benefit obligations, and other types of philanthropic support. The philanthropic support includes gifts without restriction, board-designated funds functioning as endowment, and restricted gifts whose donor-imposed restrictions were met during the fiscal year, as well as previously restricted gifts and grants for buildings and equipment that have been placed in service.

With Donor Restrictions – Net assets subject to donor-imposed restrictions that will be met either by actions of the System or the passage of time. Items that affect this net asset category are gifts for which donor-imposed restrictions have not been met in the year of receipt, including gifts and grants for buildings and equipment not yet placed in service; endowment, annuity, and life income gifts; pledges and investment returns on true endowment funds, and endowments where the principal may be expended upon the passage of a stated period of time (term endowments). Expirations of restrictions on net assets with donor restrictions, including reclassification of restricted gifts and grants for buildings and equipment when the associated long-lived asset is placed in service, are reported as net assets released from restrictions.

Also included in net assets with donor restrictions are net assets subject to donor-imposed restrictions to be maintained permanently by the System, including gifts and pledges wherein donors stipulate that the principal/corpus of the gift be held in perpetuity and that only the income be made available for program operations. Other permanently restricted items in this net asset category include annuity and life income gifts for which the ultimate purpose of the proceeds is permanently restricted.

The description of amounts classified as donor restricted net assets (endowments only) as of June 30, 2022 and 2021 is as follows:

		Perpetual	Time restricted by law	2022 Total
Restricted for pediatric healthcare	$	3,506	18,719	22,225
Restricted for adult healthcare		3,482	60,036	63,518
Restricted for educational and scientific programs		13,311	3,373	16,684
	$	20,299	82,128	102,427

		Perpetual	Time restricted by law	2021 Total
Restricted for pediatric healthcare	$	4,440	21,770	26,210
Restricted for adult healthcare		4,438	69,466	73,904
Restricted for educational and scientific programs		10,052	4,524	14,576
	$	18,930	95,760	114,690

The endowment component of net assets without donor restrictions comprises of amounts designated by the Board to function as endowment, which amounted to $1,242,517 and $1,339,160 included within investments limited to use as of June 30, 2022 and 2021, respectively.

In addition to endowments, the System has $33,237 and $30,834, respectively, of other restricted net assets at June 30, 2022 and 2021.

(n) Consolidated Statements of Operations and Changes in Net Assets Without Donor Restrictions

All activities of the System deemed by management to be ongoing, major, and central to the provision of healthcare services are reported as operating revenue and expenses.

The consolidated statements of operations and changes in net assets without donor restrictions includes revenue and gains in excess (deficient) of expenses and losses. Changes in net assets without donor restrictions that are excluded from revenue and gains in excess (deficient) of expenses and losses include net asset 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 System assets), net assets released from restriction for capital purchases, the effective portion of changes in the valuation of derivatives, change in accrued pension benefits other than net periodic benefit costs, and other, net.

(o) Patient Service Revenue, Accounts Receivable, Charity Care, and Third-Party Settlements

(i) Patient Service Revenues

Gross charges are retail charges and generally do not reflect what the System is ultimately paid and, therefore, are not displayed in the consolidated statements of operations and changes in net assets without donor restrictions. The System is typically paid amounts that are negotiated with insurance companies or are set by the government. Gross charges are used to calculate Medicare outlier payments and to determine certain elements of payment under managed care contracts (such as stop-loss payments). Because Medicare requires that gross charges be the same for all patients (regardless of payor category), gross charges are what is charged to all patients prior to the application of discounts and allowances.

The System recognizes revenue in the period in which it satisfies the performance obligations under contracts by transferring the services to its customers. The performance obligations for patient contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period. In accordance with ASC Topic 606, *Revenue from Contracts with Customers*, the System does not adjust the promised amount of consideration from patients and third-party payors for the effects of a significant financing component due to the expectation that the period between the time the service is provided to a patient and the time that the patient or a third-party payor pays for that service will be one year or less. Revenues are recognized in the amounts to which it expects to be entitled, which are the transaction prices allocated to the distinct services.

The System has agreements with governmental and other third-party payors that provide for payments to the System at amounts different from established charges. Payment arrangements for major third-party payors may be based on prospectively determined rates, reimbursed cost, discounted charges, per diem payments, or other methods. The transaction price is determined based on gross charges for services provided, reduced by explicit price concessions provided to third-party payors, discounts provided to uninsured patients in accordance with the Financial Assistance Program, and implicit price concessions provided primarily to uninsured patients. The estimates of explicit price concessions and discounts are based on contractual agreements, discount policies, and historical experience. The estimates of implicit price concessions are based on historical collection experience with these classes of patients using the portfolio approach.

(ii) Charity Care

The System provides charity care to patients who meet the criteria for charity care as published in their Financial Assistance Policy. Patients who qualify are provided care without charge or at amounts less than established rates. System policy is not to pursue collection of amounts determined to qualify as charity care; therefore, they do not report these amounts in patient service revenues. Patient advocates from the System screen patients in the hospital to determine whether those patients meet eligibility requirements for financial assistance programs. They also expedite the process of applying for government programs.

(iii) Third-Party Settlements

Revenues under the traditional fee-for-service Medicare and Medicaid programs are based primarily on prospective payment systems. Retrospectively determined cost-based revenues under these programs are estimated using historical trends and current factors. Cost report settlements under these programs are subject to audit by Medicare and Medicaid auditors and administrative and judicial review, and it can take several years until final settlement of such matters is determined and completely resolved. Because the laws, regulations, instructions, and rule interpretations governing Medicare and Medicaid reimbursement are complex and change frequently, the estimates recorded could change by material amounts.

The System has an estimation process for recording Medicare patient service revenue and estimated cost report settlements. As a result, the System records accruals to reflect the expected final settlements on our cost reports.

Settlements with third-party payors for retroactive revenue adjustments due to audits, reviews, or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care using the most likely outcome method. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Adjustments from the finalization of prior years cost reports and other third-party settlement estimates resulted in an increase in patient service revenues of
$16,997 and $4,035, for the years ended June 30, 2022 and 2021, respectively.

(p) Hospital Assessment Program/Medicaid Provider Tax

The Illinois Hospital Assessment Program and the Enhanced Illinois Hospital (collectively referred to herein as HAP) have been approved by CMS through December 31, 2022. Under HAP, the state receives additional federal Medicaid funds for the state s healthcare system administered by the Illinois Department of Healthcare and Family Services. In 2022, reimbursement under the HAP resulted in a net increase of $123,000 in operating income, which includes $192,755 in Medicaid payments included in patient service revenue offset by $69,755 in Medicaid provider tax expense. In 2021, reimbursement under the HAP resulted in a net increase of $83,757 in operating income, which includes $159,439 in Medicaid payments included in patient service revenue offset by $75,682 in Medicaid provider tax expense.

(q) Other Revenue

Other operating revenue includes revenue from nonpatient care services, clinical space rental revenue, contributions both unrestricted in nature and those released from restriction to support operating activities, related grant income, premium and capitation revenues, and other miscellaneous income.

Premium and capitation revenues are received and recognized as revenue ratably over the period for which the enrolled member is entitled to healthcare services. The timing of the System s performance may differ from the timing of the payment received, which may result in the recognition of a contract asset or a contract liability. The System has no material contract assets or liabilities at June 30, 2022 relating to premium and capitation revenue.

Revenue from grants is recognized in accordance with ASC Subtopic 958-605, *Not-for-profit entities Revenue recognition*, as other operating revenue, when the conditions of the contributions are substantially met.

Revenue from nongrant sources is generally recognized at point of service for these transactions in accordance with ASC Topic 606, *Revenue from Contracts with Customers*.

(r) Income Taxes

The System applies ASC Topic 740, *Income Taxes*, which clarifies the accounting for uncertainty in income taxes recognized in a company s financial statements., ASC Topic 740 prescribes a more likely than not recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken. Under ASC Topic 740, tax positions are evaluated for recognition, derecognition, and measurement using consistent criteria and provide more information about the uncertainty in income tax assets and liabilities. As of June 30, 2022 and 2021, the System does not have an asset or liability recorded for unrecognized tax positions.

UCMC and CHHD Obligated Groups comprise subsidiaries that are not-for-profit corporations as described in Section 501(c)(3) of the Internal Revenue Code (the Code) and therefore exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. UCMC and CHHD Non-Obligated Groups consist of several not-for-profit and taxable entities. The taxable entities include University of Chicago Medicine Care Network, LLC; Trulen Insurance SPC Limited; Medcentrix, Inc.; Ingalls Same Day Surgery; and Ingalls Provider Group (IPG), which are taxable entities under applicable sections of the Code.

Deferred income taxes on the taxable entities of the Non-Obligated Groups are recognized for the tax consequences of temporary differences by applying enacted statutory tax rates applicable to future years to differences between the consolidated financial statement carrying amounts and the tax bases of existing assets and liabilities. As of June 30, 2022 and 2021, the UCMC and CHHD Non-Obligated groups have deferred tax assets primarily relating to net operating losses (NOL) of $19,234 and
$17,763, respectively; however, it has a full valuation allowance as management believes that it was not more likely than not that the results of future operations would generate sufficient taxable income to realize the NOL.

(s) Subsequent Events

On September 13, 2022, UCMC and AdventHealth entered into a definitive agreement to enter into an affiliation under which UCMC will acquire a controlling interest in AdventHealth s Greta Lakes Region which includes its four Illinois hospitals in Bolingbrook, Glendale Heights, Hinsdale and LaGrange, Illinois along with ambulatory and related assets and an associated medical group (Advent Midwest Health) with AdventHealth retaining the remaining interest and continuing to manage daily operations

of the facilities with shared governance and certain reserve powers for UCMC. UCMC and AdventHealth will each retain their current system-level governance and administrative structures, and UCMC anticipates consolidating the financials of Advent Midwest Health into UCMC financial reporting. The affiliation is expected to close in early 2023, subject to regulatory approvals.

In connection with the preparation of the consolidated financial statements and in accordance with ASC Topic 855, *Subsequent Events*, the System evaluated events and transactions through November 1, 2022, the date the consolidated financial statements were issued.

(3) Financial Assets and Liquidity Resources

As of June 30, financial assets and liquidity resources available within one year for general expenditure, such as operating expenses, scheduled principal payments on debt, and capital construction costs not financed with debt, were as follows:

		2022	2021
Financial assets:			
Cash and cash equivalents and investments Limited to Use	$	128,793	425,799
Patient accounts receivable		471,321	437,141
Total financial assets available within one year		600,114	862,940
Liquidity resources:			
Bank lines of credit		100,000	100,000
Total financial assets and liquidity resources available within one year	$	700,114	962,940

Included in cash and cash equivalents as presented above, as of June 30, 2022, the System has $67,677 of cash held in current portion of investment, limited to use. In addition, $1,242,517 is held in funds functioning as endowment and $212,761 of CHHD investments, all available for general expenditure upon Board approval, of which $752,482 is liquid within 12 months. As of June 30, 2021, the System had $241,160 of cash held in current portion of investment, limited to use. In addition, $1,339,160 in funds functioning as endowment and $248,687 of CHHD investments, all available for general expenditure upon Board approval, of which $880,953 is liquid within 12 months.

(4) 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 operating agreement, as amended, provides, among other things, that the University provides 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 healthcare 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, 2022 and 2021, the University charged UCMC $38,661 and $34,857, respectively, for utilities, security, telecommunications, insurance, and overhead.

The University s Division of Biological Sciences provides physician services to UCMC. In 2022 and 2021, UCMC recorded $283,001 and $271,561, respectively, in expense related to these services.

UCMC s Board 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 and do not represent legally binding commitments until that approval. Unpaid portions of commitments approved by the UCMC Board are reflected as current liabilities. UCMC recorded net asset transfers of $71,750 in both 2022 and 2021 for this support.

(5) Patient Service Revenue and Patient Receivables

The System has agreements with third-party payors that provide for reimbursement at amounts different from their established rates. A summary of the reimbursement methodologies with major third-party payors is as follows:

(a) Medicare

The System is paid for various services rendered to Medicare program beneficiaries under prospectively determined rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. The prospectively determined rates are not subject to retroactive adjustment. The System s classification of patients under the prospective payment systems and the appropriateness of the patients admissions are subject to validation reviews.

Other services rendered to Medicare beneficiaries are reimbursed based on a combination of prospectively determined rates and cost reimbursement methodologies. For the cost reimbursement, the System is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the System and audits by the Medicare fiscal intermediary. UCMC s Medicare reimbursement reports through June 30, 2017 have been audited by the Medicare fiscal intermediary. CHHD s Medicare reimbursement reports through June 30, 2018 have been audited by the Medicare fiscal intermediary.

(b) Medicaid

The System is paid for inpatient acute care services rendered to Medicaid program beneficiaries under prospectively determined rates per discharge. For inpatient acute care services, payment rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors.
Medicaid outpatient services are reimbursed based on fee schedules. Medicaid reimbursement methodologies may be subject to periodic adjustment, as well as to changes in existing payment levels and rates, based on the amount of funding available to the State of Illinois Medicaid program and any such changes could have a significant effect on the System s revenue.

(c) Blue Cross

The System also participates as a provider of healthcare services under reimbursement agreements with Blue Cross under its indemnity program. The provisions of the agreements stipulate that services will be reimbursed at a tentative reimbursement rate and that final reimbursement for these services is determined after the submission of an annual cost report by the System and a review by Blue Cross. UCMC s and CHHD s Blue Cross reimbursement reports for 2021 and prior years have been reviewed by Blue Cross.

(d) Other

The System has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment under these agreements is negotiated by the System and includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined per diem rates.

Patient service revenue recognized in the period from these major payor sources are as follows:

		2022	2021
Medicare	$	723,757	675,959
Medicaid		650,874	580,336
Managed care		1,164,292	1,066,617
Patients and other		9,564	8,597
Patient service revenue	$	2,548,487	2,331,509

Patient service revenue recognized in the period by type of service is as follows:

		2022	2021
Inpatient	$	1,387,427	1,248,492
Outpatient/Ambulatory care		1,043,374	984,841
Physician services		117,686	98,176
	$	2,548,487	2,331,509

The mix of receivables from patients and third-party payors as of June 30, 2022 and 2021 is as follows:

	2022	2021
Medicare	20.7 %	22.5 %
Medicaid	28.8	31.7
Managed care	49.2	44.4
Patients and other	1.3	1.4
	100.0 %	100.0 %

(6) Community Benefits

The following is a summary of the System s unreimbursed cost of providing care, as defined under its 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, 2022 and 2021:

		2022	2021
Uncompensated care:			
Medicaid sponsored indigent healthcare	$	67,218	110,336
Medicare sponsored indigent healthcare – cost report		131,939	139,660
Medicare sponsored indigent healthcare – physician services		138,746	87,584
Total uncompensated care		337,903	337,580
Charity care		34,500	31,282
		372,403	368,862
Unreimbursed education and research:			
Education (unaudited)		71,880	66,774
Research (unaudited)		48,000	48,000
Total unreimbursed education and research		119,880	114,774
Total community benefits	$	492,283	483,636

The System 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, to determine a cost-to-charge ratio. The cost to charge ratio is applied to the charity care gross charges to calculate the charity care amount reported above. The System has not amended its financial assistance policies in 2022.

(7) Investments Limited as to Use

The composition of investments limited as to use is as follows at June 30, 2022 and 2021:

	2022				
	Separately Invested	TRIP	Other	Total	2021
Investments carried at fair value:					
Cash equivalents	$ 204	20,406	68,469	89,079	268,927
Global public equities	41,528	354,837	—	396,365	538,244
Private debt	—	55,200	—	55,200	61,525
Private equity:					
U.S. venture capital					
U.S. corporate finance	112		—	112	115
International	128	131,004	—	131,132	151,685
Real assets:	6,424	69,441	39,103 —	45,527	70,791
Real estate	—	162,929	—	162,929	168,427
Natural resources					
Absolute return:					
Equity oriented	—	73,054	—	73,054	72,146
Multistrategy	—	76,451	—	76,451	70,406
Credit oriented					
Protection oriented	—	127,911	—	127,911	155,678
Fixed income:	—	78,880	—	78,880	86,199
U.S. Treasuries, including TIPS	—	74,439	—	74,439	74,324
Other fixed income	165,056	37,129	—	165,056	169,848
Other:					
Beneficial interests in trust	—	—	9,074	9,074	10,715
Funds in trust	—	—	45,639	45,639	24,891
Total investments	$ 206,918	1,341,713	123,182	1,671,813	1,969,722

Investments classified as other consist of construction and debt proceeds to pay interest, donor restricted investments in beneficial interests in trusts, workers compensation, self-insurance, and trustee-held funds. Investments limited as to use are classified as current assets to the extent that they are available to meet current liabilities. Investments are presented in the consolidated financial statements as follows:

	2022	2021
Current portion of investments limited to use	$ 67,796	247,395
Investments limited to use, less current portion	1,604,017	1,722,327
Total investments limited to use	$ 1,671,813	1,969,722

A summary of investments limited as to use for the years ended June 30 is as follows:

	2022			
	UCMC	CHHD	Total	2021
Investments limited as to use:				
By the Board for capital improvements/restrictions by donors	$ 193,022	23,762	216,784	164,458
Funds held by custodian/trustee under indenture agreements				
Funds held by trustee for self-insurance				18,656
Collateral for interest rate swap	—	—	—	6,120
Working capital account – not limited as to use	67,677	—	67,677	241,160
TRIP investments	1,143,640	198,073	1,341,713	1,539,213
Total investments limited to use	$ 1,410,875	260,938	1,671,813	1,969,722

The composition of unrestricted investment return, net is as follows for the years ended June 30:

	2022			
	UCMC	CHHD	Total	2021
Interest and dividend income, net	$ 14,864	2,453	17,317	11,104
Realized gains on sales of securities, net	50,699	10,441	61,140	63,889
Change in unrealized gains and losses on securities, net	(198,579)	(34,160)	(232,739)	312,323
	$ (133,016)	(21,266)	(154,282)	387,316

Outside of TRIP, UCMC also invests in private equity limited partnerships. As of June 30, 2022, UCMC has commitments of $1,681 remaining to fund private equity limited partnerships.

Fair Value of Financial Instruments

The overall investment objective of the System 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 System diversifies its investments among various asset classes incorporating multiple strategies and external investment managers, including the University 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.

The carrying amount reported in the consolidated balance sheets for the following approximates fair value because of the short maturities of these instruments: cash and cash equivalents, patient accounts receivable, accounts payable and accrued expenses, and estimated payables under third-party reimbursement programs. Cash equivalent investments include cash equivalents and fixed-income investments, with original maturities of three months or less, 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, 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 is 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 monitors the valuation methodologies and practices of managers on behalf of the System.

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

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

Beneficial interests in trusts represent restricted investments that are assets held by third-party trustees for beneficial interests in perpetual trusts, comprising equities, fixed-income securities, and money market funds.

Funds in trust investments consist primarily of project construction funds and workers compensation trust funds. Funds in trust comprise 1% cash and cash equivalents and 99% fixed income investments at June 30, 2022 and comprise 1% cash and cash equivalents and 99% fixed income investments at June 30, 2021.

The System believes that the reported amount of its investments is a reasonable estimate of fair value as of June 30, 2022 and 2021. 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. Assets and liabilities recorded at fair value as of June 30, 2022 and 2021 were as follows:

Assets	Quoted prices in active markets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)	2022 Total fair value
Cash and cash equivalents	$ 60,997	—	—	60,997
Investments:				
Cash equivalents	89,079	—	—	
Global public equities	86,130			
Real assets:				
Real estate	11,625	—	—	11,625
Fixed income:				
U.S. Treasuries, including TIPS	83,041	—	—	
Other fixed income	165,058			
				89,079
		—	—	86,130
Investments measured at net asset value[1]				1,182,167
Total investments at fair value	502,466	39,103	9,074	1,782,849
Other assets	10,913	—	—	165,058
Restricted investments		—	9,074	9,074
Funds in trust	6,536	39,103	—	45,639
Total assets at fair value	$ 513,379	39,103	9,074	1,743,723
Liabilities				
Total liabilities at				10,913
Interest rate swap payable	$ —	83,440	—	83,440
fair value	$ —	83,440	—	83,440

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markets inputs inputs Total

Assets		(Level 1)	(Level 2)	(Level 3)	fair value
Cash and cash equivalents	$	184,639	—	—	184,639
Investments:					
Cash equivalents		268,927	—	—	
Global public equities		138,138			
Real assets:		Quoted	Significant		14,440
Real estate		14,440 prices in	other —	Significant	
Fixed income:		active	observable	unobservable	2021
U.S. Treasuries, including TIPS		76,315	—	—	
Other fixed income		105,846			
Investments measured at net asset value[1]			—	—	268,927 138,138 1,330,451
Total investments at fair value		800,524	12,671	10,715	2,154,361
Other assets		10,177	—	—	76,315
			—	—	105,846
Total assets at fair value	$	810,701	12,671	10,715	2,168,538
Restricted investments Funds in trust		12,219	12,671	—	24,890
Liabilities					
Interest rate swap payable	$	—	147,362	—	147,362
Total liabilities at fair value	$	—	147,362	—	147,362 10,177

[1] Certain investments that are measured at fair value using the NAV per share (or its equivalent) practical expedient have not been categorized in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated balance sheets.

During 2022, there were no transfers between investment between Levels 2 and 3. The interest rate swap arrangement has inputs, which can generally be corroborated by market data and is, therefore classified within Level 2.

The following table presents activity for the year ended June 30, 2022 for assets measured at fair value using unobservable inputs classified in Level 3:

Partnerships	N/A	Monthly to triennial with notice
Separate accounts	N/A	periods of 7 to 90 days Daily with notice periods of 1 to 90 days

	Level 3 rollforward
Beginning fair value	$ 10,715
Change in unrealized gains and losses, net	(1,641)
Ending fair value	$ 9,074

In addition, investment securities are exposed to various risks, such as interest rate, credit, and overall market volatility. Due to the level of risk associated with certain investment securities, it is reasonably possible that changes in the values of the System s investments could occur in the next term and that such changes could materially affect the amounts reported in the consolidated financial statements. 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 the System 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 the System s long-lived partnership investments include a combination of cost, discounted cash flow analysis, industry comparables, and outside appraisals. Significant changes in any inputs used by investment managers in determining NAVs in isolation would result in a significant change in fair value measurement.

The System 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
Global public equities:			
Commingled funds	N/A	Daily to triennial with notice periods of 2 to 180 days	Lock up provisions for up to 2 years; some investments have a portion of capital held in side pockets with no redemptions permitted
			Lock up provisions for up to 3 years; some investments have a portion of capital held in side pockets with no redemptions permitted
			None

Private debt:

Remaining life	Redemption terms	Redemption restrictions and terms	
Drawdown partnerships	1 to 11 years	Redemptions not permitted	N/A
Partnerships redemptions permitted	N/A	Redemptions not permitted	Capital held in side pockets with no
Mutual bond and equity funds	N/A	Daily to monthly with notice periods of 1 to 30 days	None
Real estate funds	N/A	Quarterly with notice periods of 45 to 90 days	None
Funds of funds	N/A	Monthly to quarterly with notice periods of 15 to 185 days	None
Private equity:			
Drawdown partnerships	1 to 21 years	Redemptions not permitted	N/A
Separate accounts	N/A	Daily with notice period of 1 day	None
Partnerships	N/A	Semiannual with notice period of 90 days	A portion of capital is held in side pockets with no redemptions permitted
Real estate:			
Drawdown partnerships	1 to 16 years	Redemptions not permitted	N/A
Separate accounts	N/A	Daily with notice period of 5 days	None
Natural resources:			
Drawdown partnerships	1 to 17 years	Redemptions not permitted	N/A
Commingled funds	N/A	Daily with notice period of 1 day	None
Absolute return:			
Commingled funds	N/A	Daily to triennial with notice periods of 1 to 122 days	Lock p provisions for up to three years some investments have a portion of capital held in side pockets with no redemptions permitted
Drawdown partnerships	1 to 4 years	Redemptions not permitted	N/A
Partnerships	N/A	Quarterly to triennial with notice periods of 45 to 180 days	Lock up provisions for up to five years some investments have a portion of capital held in side pockets with no redemptions permitted

	Remaining life	Redemption terms	Redemption restrictions and terms
Fixed income:			
Commingled funds	N/A	Weekly to monthly with notice periods of 5 to 10 days	None
Separate accounts	N/A	Daily to monthly with notice periods of 1 to 30 days	None
Funds in trust	N/A	Daily	None

(8) Endowments

The System 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 to function as endowments.
The net assets associated with endowment funds, including funds designated by the Board 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 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, the System classifies as net assets with donor restrictions (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 System has beneficial interests in trusts. The System has recorded its share of the principal of the trusts as net assets with donor restrictions. Distributions from the trusts are recorded within net assets without restrictions if unrestricted; otherwise, they are classified as net assets with donor restrictions until appropriated for expenditure. In some instances, the historical costs basis of the funds is not available as the System received the shares in 1929. The fair value of assets associated with individual donor-restricted endowment funds may fall below the amount of the original donation as a result of unfavorable market conditions. There were no such deficiencies at June 30, 2022 and 2021, respectively.

The System has the following donor-restricted endowment activities during the years ended June 30, 2022 and 2021 delineated by net asset class:

Changes in the fair value of endowment investments: Investment return:

2022	Without Donor Restrictions	With Donor Restrictions	Total
Endowment yield (interest and dividends)	$ 14,863	955	15,818
Net appreciation (realized and unrealized) on investments	(147,879)	(12,270)	(160,149)
Investment return, net of payout	(133,016)	(11,315)	(144,331)
Endowment payout	(57,852)	(3,961)	(61,813)
Net investment return	(190,868)	(15,276)	(206,144)
Other changes in endowment investments:			
Gifts and pledge payments received in cash	88,719	3,013	91,732
Other changes	5,506		5,506
Total other changes in endowment investments	94,225	3,013	97,238
Net change in endowment investments	(96,643)	(12,263)	(108,906)
Endowment investments at:			
Beginning of year	1,339,160	114,690	1,453,850
End of year	$ 1,242,517	102,427	1,344,944
Investments by type of fund:			
Donor-restricted "true" endowment:			
Historical gift value	$ —	20,299	20,299
Appreciation	—	82,128	82,128
Board-designated "funds functioning as endowment"	1,242,517	—	1,242,517
$ **Total – as above**	1,242,517	102,427	1,344,944

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Changes in the fair value of endowment investments: Investment return:

2021	Without Donor Restrictions	With Donor Restrictions	Total
Endowment yield (interest and dividends)	$ 9,246	679	9,925
Net appreciation (realized and unrealized) on investments	309,193	29,110	338,303
Investment return, net of payout	318,439	29,789	348,228
Endowment payout	(53,673)	(8,416)	(62,089)
Net investment return	264,766	21,373	286,139
Other changes in endowment investments:			
Gifts and pledge payments received in cash	157,589	18	157,607
Other changes	5,163	—	5,163
Total other changes in endowment investments	162,752	18	162,770
Net change in endowment investments	427,518	21,391	448,909
Endowment investments at:			
Beginning of year	911,642	93,299	1,004,941
End of year	$ 1,339,160	114,690	1,453,850
Investments by type of fund:			
Donor-restricted "true" endowment:			
Historical gift value	$ —	18,930	18,930
Appreciation	—	95,760	95,760
Board-designated "funds functioning as endowment"	1,339,160	—	1,339,160
$ **Total – as above**	1,339,160	114,690	1,453,850

Investment and Spending Policies

The System 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. The System expects its endowment funds to provide an average rate of return of approximately 7-8% annually. To achieve its long-term rate of return objectives, the System 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 the System 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 with the objective of a 5% average payout over time, was 5.5% for the fiscal years ended June 30, 2022 and 2021. 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, the System 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.

(9) Property, Plant, and Equipment

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

		2022	2021
Land and land rights	$	60,748	55,610
Buildings and improvements		1,964,500	1,941,958
Equipment		810,242	779,917
Construction in progress		125,350	35,712
		2,960,840	2,813,197
Less accumulated depreciation		(1,428,943)	(1,304,047)
Total property, plant, and equipment, net	$	1,531,897	1,509,150

The cost of buildings that are jointly used by the University and the System is allocated based on the lease provisions. In addition, land and land rights include $13,600 and $15,400 for 2022 and 2021, respectively, which represents the unamortized portion of initial lease payments made to the University.

Capitalized interest costs in 2022 and 2021 were approximately $658 and $751, respectively. Construction in progress consists of various routine capital improvements and renovation projects. As of June 30, 2022, the System had total contractual commitments associated with ongoing capital projects of approximately $5,306.

(10) Long-Term Debt

The long-term debt of both UCMC and CHHD is issued pursuant to the second Amended and Restated Master Trust Indenture (MTI) dated as of June 1, 2019, as subsequently amended and supplemented. The Obligated Group Members are UCMC, CHHD, Ingalls Memorial Hospital, Ingalls Home Care, and Ingalls

Development Foundation. Each series of bonds is collateralized by the unrestricted receivables of the obligated Group Members and subject to certain restrictions under the MTI.

Long-term debt at June 30, 2022 and 2021 consists of the following:

	Fiscal year maturity	Interest rate	2022	2021
University of Chicago Medical Center: Fixed rate:				
Illinois Finance Authority:				
Series 2009A (2009B bonds paid off 08-15-20)	2022	5.0 %	$	12,795
Series 2009D1 and 2009D2 (Synthetically fixed rate)	2044	3.9	70,000	70,000
Series 2009E1 and 2009E2 (Synthetically fixed rate)	2044	3.9	70,000	70,000
Series 2010A and 2010B (Synthetically fixed rate)	2045	3.9	92,500	92,500
Series 2011A and 2011B (Synthetically fixed rate)	2045	3.9	92,500	92,500
Series 2015A	2030	5.0	21,895	21,895
Series 2016A	2027	5.0	22,830	22,830
Series 2016B	2042	5.0	164,490	164,490
Series 2020A	2027	2.5	47,270	47,270
Teachers Insurance and Annuity Association of America (TIAA):				
Series 2017A	2047	4.4	30,000	30,000
New York Life:				
Series 2019E fixed rate taxable	2042	2.7	57,565	60,645
Unamortized premium			13,935	15,276
Total fixed rate			682,985	700,201
Variable rate:				
Series 2013A	2050	1.9/2.5	65,480	66,963
Illinois Educational Facilities Authority (IEFA)	2038	1.1/1.1	55,341	59,028
Total variable rate			120,821	125,991
Unamortized debt issuance costs			(4,302)	(4,607)
Less current portion of long-term debt			(18,543)	(17,358)
Total UCMC long-term portion of debt, less current portion			780,961	804,227
UCMC Title Holding Corporation: Fixed rate:				
Brownfield Revitalization 40 – Promissory note A			1.5	4,850
Urban Development Fund XLVI – Promissory note A	2024		—	
Urban Development Fund LI – Promissory note A	2024		1.5	— 4,576
Citi NMTC – QLICI	2024		1.8	6,500 6,500
Citi NMTC – QLICI	2032		1.2	3,476 3,476

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	Fiscal year maturity	Interest rate	2022	2021
URP QLICI – Loan A	2047	1.0 %	$ 7,334	7,334
URP QLICI – Loan B	2047	1.0	2,666	2,666
SCORE QLICI – Loan A	2047	1.0	4,176	4,176
SCORE QLICI – Loan B	2047	1.0	1,704	1,704
CNI QLICI – Loan A	2047	1.0	3,455	3,455
Total UCMC Title Holding Corporation debt			32,476	41,982
CNI QLICI – Loan B	2047	1.0	1,545	1,545
Title holding company LT portion			32,476	40,040
Less current portion			—	(1,862)
Total UCMC debt, excludig current portion			$ 813,437	844,257
CHHD:				
Fixed Rate: Series 2017	2034	2.5	$	
Fixed rate: Series 2019				
Unamortized debt issuance costs			32,390	34,325
	2042	2.7	61,445	63,165
Total debt and unamortized premiums (discount)			93,835	97,490
Less current portion of long-term debt			(3,770)	(3,655)
Total CHHD debt, excluding current portion			$ 89,745	93,490
Total notes and bonds payable			$ 925,495	960,632
Less current portion			(22,313)	(22,875)
Long-term debt, excluding current portion			$ 903,182	937,757

Scheduled annual repayments, excluding costs, premiums, or discounts, for the next five years and thereafter are as follows at June 30:

Year ending June 30:	
2023	$ 22,313
2024	23,293
2025	25,349
2026	26,103
2027	27,248
Thereafter	791,876
	$ 916,182

(a) Letters of Credit

Under its various credit agreements, UCMC 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 UCMC property; and certain other nonfinancial covenants.

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 2009E bonds expire in June 2023 and June 2026, respectively. The letters of credit that support the Series 2010A and 2010B bonds expire in May 2025 and July 2024, respectively. The letters of credit that support the Series 2011A and Series 2011B bonds expire in May 2025 and May of 2026, respectively. Payment of each of the IEFA bonds is collateralized by a letter of credit maturing May 2022. The letters of credit are subject to certain restrictions, which include financial ratio requirements. The most restrictive financial ratio is to maintain a debt service coverage ratio of 1:35:1.

Included in UCMC s debt is $55,341 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 one and three years, beginning after a grace period of at least one year from the event, 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.
Scheduled principal repayments on long-term debt based on the variable rate demand debt being put back to the System and a corresponding draw being made on the underlying credit facility, if available, excluding costs, premiums, or discounts, are as follows:

Year ending June 30:	
2023	$ 22,313
2024	171,726
2025	127,532
2026	155,827
2027	27,248
Thereafter	411,536
	$ 916,182

(b) Lines of Credit

At June 30, 2021, UCMC had a $100,000 line of credit from a commercial bank. As of June 30, 2022, UCMC has a $100,000 line of credit from a commercial bank that expires March 2, 2023.

As of June 30, 2022 and 2021, no amount was outstanding under the lines.

(c) Interest Payments

The System paid interest, net of capitalized interest, of approximately $31,200 and $31,300 in 2022 and 2021, respectively.

(d) UCMC Title Holding Corporation

During fiscal years 2017 and 2018, UCMC entered into New Markets Tax Credit (NMTC) financing agreements for the purposes of financing various projects at UCMC, including the financing of equipment and the construction of a new emergency department and adult trauma center. UCMC s NMTC consists of NMTC investors (Investors) who provide qualified equity investments to community development entities (CDE s) who in turn provide debt financing to separate not for profit, tax-exempt entities, which are qualified active low income community businesses (QALICB). UCMC Title Holding Corporation and UCMC Title Holding Corporation II NFP, the QALICB s, have been consolidated into the financial statements.

In May 2022, the tax compliance period ended for one of the NMTC financing agreements made for UCMC Title Holding Corporation. The Investor of USBCDC Investment Fund 147, LLC exercised their Put Option and UCMC purchased the investment fund for $1. At this time, UCMC recognized a gain of $1,079 related to the investment fund, and the loans in the amount of $7,977 from UCMC to the investment fund, as well as the outstanding principal from the investment fund to UCMC Title Holding Corporation in the amount of $7,763, were extinguished. As of June 30, 2022 UCMC Title Holding Corporation and UCMC Title Holding Corporation II NFP have remaining active financing agreements in the amount of $6,500 and $25,976, respectively.

(11) Derivative Instruments

The System has interest rate related derivative instruments to manage its exposure on debt instruments. By using derivative financial instruments to manage the risk of changes in interest rates, the System exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contracts. When the fair value of a derivative contract is positive, the counterparty owes the System, which creates credit risk for the System. When the fair value of a derivative contract is negative, the System owes the counterparty, and therefore, it does not possess credit risk; however, the System is required to post collateral to the counterparty when certain thresholds as defined in the derivative agreements are met. Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates. The market risk associated with interest rate changes is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. System management also mitigates risk through periodic reviews of their derivative positions in the context of their total blended cost of capital.

The System is required to post collateral under the specific terms and conditions for the various interest rate swap agreements as described below. At June 30, 2022 and 2021, $0 and $6,120 was held as collateral, respectively, and was recorded in current portion of investments limited to use and included in Note 7 as funds in trust for disclosure. Collateral postings are primarily driven by the value of the swap as measured at the reset date. Collateral requirements increase if credit ratings were to be downgraded.

The fair value of each swap is the estimated amount UCMC would receive or pay to terminate the swap agreement at the reporting date, taking into account current interest rates and the current creditworthiness of the swap counterparties. The fair value is included in interest rate swap liability on the consolidated balance sheets, while the change in fair value is recorded in other changes in net assets without donor restrictions for the effective portion of the change and in nonoperating gains and losses for the ineffective portion of the change.

UCMC Interest Rate Swap Agreement

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 UCMC 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 LIBOR. The inputs to the fair value estimate are considered Level 2 in the fair value hierarchy.

Management has determined that the interest rate swaps are effective and have qualified for hedge accounting. The fair value of the UCMC swap agreement liabilities was $78,870 and $138,563 at June 30, 2022 and 2021, respectively, and has been included in other long-term liabilities in the accompanying consolidated balance sheets. The net effective portion of the change in fair value on the UCMC swap agreements of $62,885 and $44,967 in 2022 and 2021, respectively, has been included in the change in net assets without donor restrictions in the accompanying 2022 and 2021 consolidated statements of operations and changes in net assets without donor restriction. Management has recognized ineffectiveness of approximately $1,427 in 2022 and an ineffectiveness of $695 in 2021 in nonoperating gains and losses. 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 net assets without donor restrictions. The interest rate swaps terminate on February 1, 2044. Cash settlement payments related to the swaps are recorded in interest expense.

On July 1, 2020 UCMC entered into a novation of the interest rate swap agreements for a five-year term. The novation to the new parties is under like-kind terms and arrangements that do not require designation of the heading relationship and related accounting.

The following summarizes the general terms of each of UCMC s swap agreements:

Effective date	Associated debt series	Original term	Current notional amount	UCMC pays	UCMC receives
August 9, 2011	2009 D/E, 2010 A/B, 2011 A/B	32.5 Years	$ 162,500,000	3.89%	68% of LIBOR
August 9, 2011	2009 D/E, 2010 A/B, 2011 A/B	32.5 Years	162,500,000	3.97%	68% of LIBOR

CHHD Swap Agreement

CHHD entered into an interest rate swap agreement on June 28, 2004 to lock in long-term fixed rates on the Series 2004 variable-rate debt issuance, with a maturity date of May 15, 2034. This agreement was amended on March 1, 2013. Under the amended agreement, the notional amount and maturity did not change, and CHHD receives, on a monthly basis, 67% of one-month LIBOR plus 47.5 basis points and makes payments on a monthly basis, an annualized fixed rate of 4.61%. The swap is not designated as a hedging instrument, and therefore, the change in fair value of the 2004 interest rate swap agreement of $4,229 and $2,637 in 2022 and 2021, respectively, was recognized as a component of nonoperating gains in the accompanying consolidated statements of operations and changes in net assets without donor restriction. The fair value of the Series 2004 interest rate swap agreement liability of $4,570 and $8,799 at June 30, 2022 and 2021, respectively, is included as a component of other long-term liabilities in the accompanying consolidated balance sheets. The differential to be paid or received under the Series 2004 interest rate swap agreement is recognized monthly and has been included as a component of interest expense in the accompanying consolidated statements of operations and changes in net assets without donor restriction.

A summary of outstanding positions under the interest rate swap agreements for CHHD at June 30, 2022 is as follows:

Series	Notional amount	Maturity date	Rate received	Rate paid
			54,219	
2004 Interest rate swap Agreement:	$ 34,450	May 15, 2034	% of LIBOR	Fixed 4.61%

leases	$ 49,270

(12) Leases

The components of lease cost for the years ended June 30, 2022 and 2021 reported as part of other expenses in the consolidated statements of operations and changes in net assets without donor restrictions, were as follows:

	2022	2021
Operating lease expense	$ 14,477	10,814
Finance lease expense:		
Amortization of right-of-use assets	6,138	5,802
Interest on lease liabilities		
Total finance lease expense	7,253	6,948
Total lease expense	$ 21,730	17,762

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Amounts reported in the consolidated balance sheets as of June 30, 2022 and 2021 were as follows:

		2022	2021
Operating Leases:			
Right-of-use assets – operating leases	$	66,269	64,323
Accumulated amortization		6,219	4,175
Other assets, net	$	60,050	60,148
Current portion of other long-term liabilities	$	5,831	4,626
Other long-term liabilities, less current portion			55,522
Total operating lease liabilities	$	60,050	60,148
Finance Leases:			
Right-of-use assets – finance			37,818
Accumulated amortization		12,107	7,643
Other assets, net	$	37,163	30,175
Current portion of other long-term liabilities	$	5,859	3,329
Other long-term liabilities, less current portion		32,553	28,055
Total finance lease liabilities	$	38,412	31,384

Other information related to leases as of June 30, 2022 and 2021 was as follows: Supplemental cash flow information:

		2022	2021
Cash paid for amounts included in the measurement of lease liabilities:			
Operating cash flow from operating leases	$	4,795	10,814
Financing cash flow from finance leases		7,812	8,113
ROU assets obtained in exchange for lease obligations:			
Operating leases		4,384	14,318
Finance leases		12,151	2,202
Reductions to ROU assets resulting from reductions to lease obligations:			
Operating leases			
Finance leases			

	2022	2021
Weighted average remaining lease term:		
Operating leases	13.3 years	12.7 years
Finance leases	10.1 years	13.4 years
Weighted-average discount rate:		
Operating leases	2.2 %	2.2 %
Finance leases	5.6	3.5

Amounts disclosed for ROU assets obtained in exchange for lease obligations include amounts added to the carrying amount of ROU assets resulting from lease modifications and reassessments.

Maturities of lease liabilities under non-cancelable leases as of June 30, 2022 are as follows:

		Operating	Finance
2023	$	7,080	6,813
2024		5,706	6,801
2025		5,356	5,411
2026		5,287	5,241
2027 and thereafter		45,559	23,614
		68,988	47,880
Less amount representing interest		8,938	9,468
Present value of net minimum lease payments	$	60,050	38,412

(13) Insurance

Professional and General Liability

The System maintains separate self-insurance programs for UCMC and CHHD. 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, 2022 and 2021 were $10,000 and $5,000, respectively, per claim and unlimited in the aggregate. Claims in excess of $10,000 are subject to an additional self-insurance retention limited to $7,500 per claim and $15,000 in aggregate. There are no assurances that the University will be able to renew existing policies or procure coverage on similar terms in the future.

CHHD maintains a self-insurance program for professional and general liability. Coverage from commercial insurance carriers is maintained for claims in excess of self-insured retentions at various levels by policy year. CHHD established a trust fund with an independent trustee for the administration of assets funded under the malpractice and general liability self-insurance program.

The System has engaged professional consultants for calculating an estimated liability for medical malpractice self-insurance and 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 rate commensurate with the duration of anticipated payments.

A comparison of the estimated liability for incurred malpractice claims (filed and not filed) and assets available for claims for the combined University and UCMC self-insurance program as of June 30, 2022 and 2021 is presented below:

		2022	2021
Actuarial present value of self-insurance liability for medical malpractice	$	239,308	202,419
Total assets available for claims		305,422	344,879

If the present-value method were not used, the ultimate liability for medical malpractice self-insurance claims would be approximately $39,047 higher at June 30, 2022. The interest rate assumed in determining the present value was 4.50% and 2.75% for 2022 and 2021, respectively. UCMC has recorded its pro rata share of the malpractice self-insurance liability in the amount of $107,689 and $96,204 at June 30, 2022 and 2021, respectively, 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 2022, UCMC s expense is estimated to be approximately $11,000 related to malpractice insurance.

On April 30, 2019, CHHD entered into a loss portfolio transfer for the Ingalls Memorial Hospital medical malpractice program by obtaining an occurrence-based policy for claims through June 30, 2018. At June 30, 2022, there was no additional liability calculated by the programs actuaries that would require additional reserves by CHHD or the Captive. Accruals for CHHD professional and general liabilities are recorded on a discounted basis consistent with the University s insurance program.

On October 1, 2020 a new tax-exempt Cayman domiciled captive, Trulen Insurance SPC Limited (Trulen), was incorporated to operate as the new medical malpractice framework for CHHD. Trulen was organized as a Segregated Portfolio Company, which consists of a core company and 3 segregated portfolios, or cells, which allow segregation of risk and assets between the Hospital and General Liability, employed community physicians, and non-employed contracted provider liabilities. The insurance business of Ingalls Casualty Insurance Limited (ICIL), the previous insurer of professional liability insurance for CHHD, was transferred and novated to the three separate portfolios by issuing three separate Deeds of Novation and Business Transfer between Trulen and ICIL. After the completion of the business transfer, ICIL ceased underwriting operations. As of June 30, 2022 the total assets of Trulen were $93,404 and total liabilities were $88,334. Total claim expense as of June 30, 2022 was $13,618.

(14) Pension Plans

Active Plans

A majority of UCMC s personnel participate in the University s, defined-benefit and contribution pension plans, which are considered multiemployer pension plans. 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 based on the guidelines set forth by the Employee Retirement Income Security Act of 1974, on an actuarially determined basis.

UCMC recognizes its share of net periodic pension cost as expense and any difference in the contribution amount as a transfer of net assets without donor restrictions. The adjustment to net assets without donor restrictions was $4 and $2,781 for the years ended June 30, 2022 and 2021. UCMC expects to make contributions not to exceed $3,200 for the fiscal year ending June 30, 2022.

Effective January 1, 2017, the 401(a) defined-benefit pension plan was frozen for UCMC employees participating in the plan and was replaced with an enhanced defined-contribution plan. 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 $28,400 and $11,700 for the years ended June 30, 2022 and 2021, respectively.

UCMC s expense related the multiemployer University s defined-benefit plans included in the University s consolidated financial statements for the years ended June 30, 2022 and 2021 was $0, respectively.

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The benefit obligation, fair value of plan assets, and funded status for the University s defihed-benefit plan included in the University s consolidated financial statements as of June 30 are shown below.

		2022	2021
Projected benefit obligation	$	767,140	1,006,857
Fair value of plan assets		673,813	871,372
Deficit of plan assets over benefit obligation	$	(93,327)	(135,485)

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

	2022	2021
Discount rate	5.0 %	3.2 %
Expected return on plan assets	5.8	6.0
Rate of compensation increase	3.5	3.5

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

	2022	2021
Domestic equities	29 %	26 %
International equity	20	21
Fixed income	51	53
	100 %	100 %

Domestic and international equities are presented as Level 1 investments and fixed income securities are presented as Level 2 investments within the fair value hierarchy.

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.

Expected future benefit payments excluding plan expenses are as follows:

Fiscal year:		
2023	$	75,297
2024		50,528
2025		50,608
2026		49,817
2027		50,486
2028-2032		254,148

UCMC and CHHD also maintain additional defined-contribution retirement plans for employees. The System s pension expense under these distinct defined-contribution retirement plans for UCMC was $9,900 and $700 for the years ended June 30, 2022 and 2021, respectively.

CHHD expense under these distinct defined-contribution retirement plans was $2,900 and $800 for the years ended June 30, 2022 and 2021, respectively.

		—
Interest	1,831	—
Medicaid provider tax	—	—
Depreciation and amortization	1,321	—

(15) Functional Expenses

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

	2022			
	Healthcare services	Admin	Fundraising	Total
Salaries, wages, and benefits	$ 1,165,697	127,257	1,809	1,294,763
Supplies and other	916,851	112,140	1,124	1,030,115
Physician services	312,825	4,121	—	316,946
Insurance	21,191	222		21,413
	35,075			36,906
	69,756			69,756
	131,949			133,270
Total	$ 2,653,344	246,892	2,933	2,903,169

				1,134,205
	1,017,375			944,587
Salaries, wages, and benefits	846,656	115,028		303,435
Supplies and other	297,190	97,190		To[illegible]603
Physician services	39,458	6,245	—	39,743
Insurance	36,242	145	—	75,683
Interest	75,683	3,501	—	132,707
Medicaid provider tax	131,844	—	—	
Depreciation and amortization		883	—	
Total	$ 2,444,448	222,972	2,543	2,669,963

In accordance with ASU 2016-14, Topic 958, Not-for-profit entities are required to report expenses both by their natural classification and their functional classification. Functional classifications have been determined based on their relationship to major program services and supporting activities. For support functions directly related to major program services, an allocation has been applied based on the percentage of time and effort devoted to the program service. For overhead expenses such as utilities and interest expense, an allocation based on square footage has been applied. The costs related to support functions not directly related to program activities have been fully classified as supporting activities.

(16) Contingencies

(a) Litigation

The System is subject to various legal proceedings and claims that are incidental to its normal business activities. In the opinion of the System, the amount of ultimate liability with respect to these actions will not materially affect the consolidated operations or net assets of the System.

(b) Regulatory Investigation and Other

The U.S. Department of Justice and other federal agencies routinely conduct regulatory investigations and compliance audits of healthcare providers. The System is subject to these regulatory efforts.
Additionally, the laws and regulations governing the Medicare, Medicaid, and other government healthcare programs are extremely complex and subject to interpretation, making compliance an ongoing challenge for the System and other healthcare organizations. Recently, the federal government has increased its enforcement activity, including audits and investigations related to billing practices, clinical documentation, and related matters. The System maintains a system-wide compliance program and conducts audits and other activities to identify potential compliance issues, including overpayments by governmental payors. Compliance reviews may result in liabilities to government healthcare program, which could have an adverse impact on the System s net patient service revenue.

(c) Tax Exemption for Sales Tax and Property Tax

Effective June 14, 2012, the governor of Illinois signed into law, Public Act 97-0688, which created new standards for state sales tax and property tax exemptions in Illinois. The law establishes new standards for the issuance of charitable exemptions, including requirements for a nonprofit hospital to certify annually that in the prior year, it provided an amount of qualified services and activities to low-income and underserved individuals with a value at least equal to the hospital s estimated property tax liability. The System certified in 2022 and 2021 and has not recorded a liability for related property taxes based upon management s current determination of qualified services provided.

Consolidating Balance Sheet Information June 30, 2022

(Dollars in thousands)

	Medical Center	The University of Chicago Heath System	Memorial Hospital	Ingalls Development Foundation	Ingalls Home	Ingalls Group Care	Ingalls UCMC	Eliminations	CHHD Consolidation	Obligated Group Consolidated Entities	Other Non-Obligated Group Assets Entities	Other Non-Obligated Group Eliminations	total		
Current assets			$	43,473	4,971	29	1,439	—	—		49,912	7,079	4,006	—	60,997
Cash and cash equivalents			425,693		—	39,280	—	2,398		—	467,371	2,289	1,661	—	471,321
Patient accounts receivable			67,774		22	—	—		—	—	67,796	—	—	—	67,796
Current portion of investments limited to use			21,904		—	—	—		—	—	21,904	—	—	—	21,904
Current portion of malpractice self-insurance receivable			3,543		—	—	—		—	—	3,543	—	—	—	3,543
Current portion of pledges receivable			128,980		2,393	100,500	295	11,152		(49,511)	193,809	2,981	14,076	(210,866)	—
Due from affiliates				148,666	1,055	11,208	248		127	—	161,304	2,178	41,161	(1,290)	203,353
Prepaids, inventory, and other current assets			840,033		8,441	151,017	1,982	13,677		(49,511)	965,639	14,527	60,904	(212,156)	828,914
Total current assets			1,343,101		8,221	132,560	66,111		19,073	(3,215)	1,565,851	—	38,166	—	1,604,917
Investments, limited as to use, less current portion			1,304,718		6,025	196,156	—		—	—	1,506,899	18,393	6,607	(1)	1,531,898
Property, plant, and equipment, net			4,604		—	—	—		—	—	4,604	—	—	—	4,604
Pledges receivable, less current portion			96,919		—	—	—		—	—	96,919	—	—	—	96,919
Malpractice self-insurance receivable, less current portion				411,715	(5,803)	(2)	—		—	(325,220)	80,690	57,542	1,547	(26,774)	113,005
Other assets, net			$	4,001,090	16,884	479,731	68,093		32,750	(377,946)	4,220,602	90,462	107,224	(238,931)	4,179,357
Total assets															
Liabilities and Net Assets															
Current liabilities:															
Accounts payable and accrued expenses			$	232,137	(37,148)	96,109	1,128	3,119		—	295,345	5,862	36,696	(48,689)	289,214
Current portion of long-term debt			18,543		—	3,770	—		—	—	22,313	—	—	—	22,313
Current portion of other long-term liabilities			10,462		—	—	—		—	—	10,462	1,496	—	(1,294)	10,664
Estimated third-party payor settlements and Medicare Advance			236,882		—	36,882	—	400		—	274,164	—	1,640	1	275,805
Current portion of malpractice self-insurance liability			21,904		—	—	—		—	—	21,904	—	—	—	21,904
Due to affiliates				—	50,622	15,713	58		88	(49,511)	16,970	83,260	61,946	(162,176)	—
Due to the University of Chicago				33,645	—	—	—		—	—	33,645	—	—	—	33,645
Total current liabilities			553,573		13,474	152,474	1,186	3,607		(49,511)	674,803	90,618	100,282	(212,158)	653,545
Workers compensation self-insurance liability, less current portion			8,124		—	—	—		—	—	8,124	—	—	—	8,124
Malpractice self insurance liability, less current portion			96,919		—	—	—		—	—	96,919	—	81,094	—	178,013
Long-term debt, excluding current installments			780,961		—	89,745	—		—	—	870,706	32,476	—	—	903,182

Interest rate swap liability	78,870	—	4,570	—	—	—	83,440	—	—	—	83,440
Other long-term liabilities, less current portion	129,521	4,509	10,738	—	164	(2,358)	142,574	22,283	52	(36,516)	128,393
Total liabilities	1,647,968	17,983	257,527	1,186	3,771	(51,869)	1,876,566	145,377	181,428	(248,674)	1,954,697
Net assets (deficit):											
Without donor restrictions	2,216,641	(1,099)	218,994	54,624	28,974	(309,740)	2,208,394	(54,915)	(74,226)	9,743	2,088,996
With donor restrictions	136,481	—	3,210	12,283	5	(16,337)	135,642	—	22	—	135,664
Total net assets (deficit)	2,353,122	(1,099)	222,204	66,907	28,979	(326,077)	2,344,036	(54,915)	(74,204)	9,743	2,224,660
Total liabilities and net assets	$ 4,001,090	16,884	479,731	68,093	32,750	(377,946)	4,220,602	90,462	107,224	(238,931)	4,179,357

See accompanying independent auditors' report.

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Consolidating Statement of Operations and Changes in Net Assets Without Donor Restrictions Information Year ended June 30, 2022

(Dollars in thousands)

	The University of Chicago	Ingalls	Ingalls Medical Center	Ingalls Heath System	Ingalls Memorial Hospital	Development Foundation	Obligated Home Care	Other Non-Obligated Group Eliminations	Other Non-Obligated Group Group Consolidation	UCMC Entities	CHHD Entities	Eliminations	Consolidated total
Revenue:													

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Patient service revenue	$ 2,164,565	—	325,487	—	9,667	—	2,499,719	24,290		26,302	(1,824)		2,548,487		
Other operating revenue and net assets released from restrictions	407,166	6,763	10,302	1,743	443	(6,208)	420,209	3,156		37,285	(23,689)		436,961		
Total operating revenues	2,571,731	6,763	335,789	1,743	10,110	(6,208)	2,919,928	27,446		63,587	(25,513)		2,985,448		
Operating expenses:															
Salaries, wages, and benefits	1,070,188	2,189	161,902	369	8,282	—	1,242,930	18,083		35,059	(1,309)		1,294,763		
Supplies and other	883,190	2,047	120,287	1,168	1,845	(900)	1,007,637	11,373		15,582	(4,478)		1,030,114		
Physician services	275,449	1,400	23,278	21	241	(4,251)	296,138	6,339		16,660	(2,191)		316,946		
Insurance	4,360	1,127	16,208	—	221	(1,057)	20,859	1,550		14,876	(15,872)		21,413		
Interest	33,483	—	4,131	—	—	—	37,614	943		3	(1,656)		35,904		
Medicaid provider tax	51,832	—	17,924	—	—	—	69,756	—		—	—		69,756		
Depreciation and amortization	113,917	534	15,370	—	9	—	129,830	2,416		1,025	—		133,271		
Total operating expenses	2,432,419	7,297	359,100	1,558	10,598	(6,208)	2,804,764	40,704		83,205	(25,506)		2,903,167		
Operating revenue in excess (deficit) of expenses	139,312	(534)	(23,311)	185	(488)	—	115,164	(13,258)		(19,618)	(7)		82,281		
Nonoperating gains (losses), net:															
Investment income, net	(133,016)	(500)	(13,461)	(5,850)	(1,455)	—	(154,282)	—		—	—		(154,282)		
Change in fair value of nonhedged derivative instruments	—	—	4,229	—	—	—	4,229	—		—	—		4,229		
Derivative ineffectiveness on hedged derivative instruments	(1,427)	—	—	—	—	—	(1,427)	—		—	—		(1,427)		
Other, net	(9,570)	(466)	(574)	(259)	(86)	—	(10,955)	7,763		(498)	930		(2,760)		
Net nonoperating gains (losses)	(144,013)	(966)	(9,806)	(6,109)	(1,541)	—	(162,435)	7,763		(498)	930		(154,240)		
Revenue and gains in excess (deficient) of expenses and losses	(4,701)	(1,500)	(33,117)	(5,924)	(2,029)	—	(47,271)	(5,495)		(20,116)	923		(71,959)		
Other changes in net assets without donor restriction:															
Net asset transfers to University of Chicago, net	(71,750)	—	—	—	—	—	(71,750)	—		—	—		(71,750)		
Change in accrued pension benefits other than net periodic benefit costs	4	—	—	—	—	—	4	—		—	—		4		
Effective portion of change in valuation of derivatives	62,885	—	—	—	—	—	62,885	—		—	—		62,885		
Net assets released from restriction for capital purposes	36	—	—	—	—	—	36	—		—	—		36		
Distributions and other, net	(5,000)	(2)	13,914	(7,512)	—	—	1,400	—		(1,405)	5		—		
Increase (decrease) in net assets without donor restrictions	$ (18,526)	(1,502)	(19,203)	(13,436)	(2,029)	—	(54,696)	(5,495)		(21,521)	928		(80,784)		

See accompanying independent auditors' report.

#23-011

ATTACHMENT 36

Schedule 3

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Consolidating Statement of Changes in Net Assets Information

Year ended June 30, 2022

(Dollars in thousands)

	The University of Chicago Medical Center	Ingalls Health System	Ingalls Memorial Hospital	Ingalls Development Foundation	Ingalls Home Care	Eliminations	Obligated Group Consolidation	Other Non-Obligated Group UCMC Entities	Other Non-Obligated Group CHHD Entities	Eliminations	Consolidated total
Net assets without donor restrictions:											
Revenue and gains in excess (deficient) of expenses and losses	$ (4,701)	(1,500)	(33,117)	(5,924)	(2,029)	—	(47,271)	(5,496)	(20,116)	923	(71,959)
Net asset transfers to University of Chicago, net	(71,750)	—	—	—	—	—	(71,750)	—	—	—	(71,750)
Change in accrued pension benefits other than net periodic benefit cost	4	—	—	—	—	—	4	—	—	—	4
Effective portion of change in valuation of derivatives	62,885	—	—	—	—	—	62,885	—	—	—	62,885
Net assets released from restriction for capital purposes	36	—	—	—	—	—	36	—	—	—	36
Distributions and other, net	(5,000)	(1)	13,913	(7,512)		—	1,400	—	(1,405)	5	—
Increase (decrease) in net assets without donor restrictions	(18,526)	(1,501)	(19,204)	(13,436)	(2,029)	—	(54,696)	(5,496)	(21,521)	928	(80,784)
Net assets with donor restrictions:											
Contributions	10,846	—	—	396			10,944	—	(3)	3	10,944
Change in net interest in Foundation	—	—	50	—	—	(50)	—		—	—	—
Net assets released from restrictions used for operating purposes	(9,108)	—	—	(348)	—		(9,456)	—	—		(9,456)
Net assets released from restrictions used for capital purposes	(36)	—	—		—	—	(36)	—	—		(36)
Investment return, net	(9,871)	—		(1,641)	—	—	(11,312)	—	—	—	(11,312)
Increase (decrease) in net assets with donor restrictions	(8,269)	—	50	(1,591)	—	(50)	(9,860)	—	(3)	3	(9,860)
Change in net assets	(26,795)	(1,501)	(19,154)	(15,027)	(2,029)	(50)	(64,556)	(5,496)	(21,524)	931	(90,644)
Net assets (deficit) at beginning of year	2,379,917	402	241,358	81,934	31,008	(326,027)	2,408,592	(49,420)	(52,680)	8,812	2,315,304
Net assets (deficit) at end of year	$ 2,353,122	(1,099)	222,204	66,907	28,979	(326,077)	2,344,036	(54,915)	(74,204)	9,743	2,224,660

See accompanying independent auditors' report.

#23-011

ATTACHMENT 36

Economic Feasibility

Attachment 37

Economic Feasibility

A. Reasonableness of Financing Arrangements.

The Project will be financed through a bond issuance cash on hand and securities and is a land lease. Letters attesting to the reasonableness of the financing arrangements are attached.

B. Conditions of Debt Financing.

The Project is being paid for through cash and securities. A letter attesting to the Conditions of Debt Financing is attached.

C. Reasonableness of Project and Related Costs.

There are no state standards for Master Design Permits and those standards will be addressed in the Construction CON application. The Project appears to comply with all State standards for Project Costs with the exception of the "New Construction" line item. For this Project UCMC engaged the firm of Cumming to act as a third-party cost estimator. A letter from Cumming describing cost premiums is included in this Attachment 37.

Section IV - Size of Project

Reviewable	Cost/SF A New	Cost/SF B Modernized	Gross SF (BGSF) C New	Gross SF (BGSF) D Circulation	Gross SF (BGSF) E Modernization	Gross SF (BGSF) F Circulation	Construct. Cost $ G (A x C)	Modern. Cost $ H (B x E)	Total Costs (G+H)
Medical / Surgical	$630	$0	38,085	25%	0	0	$37,754,931	$0	$37,754,931
ICU	$750	$0	14,864	24%	0	0	$11,148,011	$0	$11,148,011
General Radiology	$950	$0	14,722	20%	0	0	$13,986,267	$0	$13,986,267
Breast Center	$630	$0	7,923	23%	0	0	$5,149,976	$0	$5,149,976
Outpatient Clinics	$672	$0	38,316	27%	0	0	$25,748,169	$0	$25,748,169
Infusion Therapy	$700	$0	28,994	27%	0	0	$20,295,569	$0	$20,295,569
Outpatient Cell Therapy (OCT)	$950	$0	4,850	20%	0	0	$4,607,408	$0	$4,607,408
ORAC	$985	$0	8,318	19%	0	0	$8,193,395	$0	$8,193,395
Phlebotomy	$595	$0	1,777	23%	0	0	$1,056,767	$0	$1,056,767
Wellness	$599	$0	4,074	15%	0	0	$2,439,314	$0	$2,439,314
Cancer Ancillaries	$850	$0	12,898	4%	0	0	$10,963,240	$0	$10,963,240
Total Reviewable			194,820	23%	0	0%	$141,343,067	$0	$141,343,067
Contingencies									
Grand Total Reviewable									

Non-Reviewable

Building Support	$1,250	$0	103,960	0%			$129,950,009	$0	$129,950,009
Staff Support	$675	$0	33,566	9%			$22,656,835	$0	$22,656,835
Public	$950	$700	83,749	77%	4,091	100%	$84,311,584	$2,863,539	$87,175,123
Administrative Offices	$600	$0	3,215	20%			$1,928,778	$0	$1,928,778
Shell	$600	$0	135,739	0%			$81,443,619	$0	$81,443,619
Bridges	$3,230	$0	2,204	100%			$7,118,920	$0	$7,118,920
Tunnel	$1,700	$0	1,258	100%			$2,138,600	$0	$2,138,600
Make Ready Work	$0								
Site Preparation	$0								
Total Non-Reviewable			368,691	21%	4,091	100%	$329,548,365	$2,863,539	$332,411,904
Contingencies									
Grand Total Non-Reviewable									

Notes:
HTRC/Biofluids & Pharmacy are included under "Cancer Ancillaries"
Public "Modernization" includes renovated areas in Garage B (L1 & L2) and CCD L5
Modernization SF is 3,733 DGSF x 1.09 grossing factor to achieve BGSF
All Modernization is 100% circulation currently
Admin Offices includes UCM offices only

#23-011

ATTACHMENT 37

D. Project Operating Costs

Direct Operating Expenses	$50,959,468
Total Patient Days	273,714
Expense / Patient Day	$186

E. Total Effect of Project on Capital Costs

Total Patient Days	$273,714
Total Project Cost	815,112,669
Useful Life (years)	30
Total Annual Depreciation	$27,170,422
Depreciation Cost per Volume Stats	$99

CUMMING
Building Value Through Expertise

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Chicago, IL 60602
Phone: 708-967-3571
Fax: 708-967-3572
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February 1, 2023

Patrick Knightly
University of Chicago Medicine
5841 S. Maryland Ave
Chicago, IL 60637

Re: University of Chicago Medicine – Cancer Center
CON Premiums

Dear Patrick,

The University of Chicago Medicine appointed Cumming Management Group Ltd. as 3rd Party Estimators on the above-mentioned project. As part of the appointment, we have undertaken numerous estimates to verify as an independent 3rd Party, the value of the design at Concept and Schematic Design stages from August 2022 to January 2023.

We have worked closely with Turner Construction to reconcile our estimate with Turner's at each estimate issuance and can verify that certain premiums associated with the new Cancer Center are evident in the study of the design documentation.

To that end, the attached "Appendix A" captures a sample of the cost premiums discussed between Turner, the University of Chicago Medicine and Cumming Group during the concept and schematic design stages, with indicative values associated with those premiums. The list is not exhaustive; however, we can verify that it represents and captures premium components present in the current design.

I trust the above is in order, but should you have any queries or questions, please feel free to contact me anytime.

Very truly yours

Etienne Nel
Managing Director Cumming

APPENDIX A			
Description of Premiums for Cancer Center Project			
2/1/2023			
	Description	Value	Notes
1	Deep foundation system (Premium for phase 2 loads) / High Water table w/ Earth Retention and Caissons	$ 4,000,000	Structural and foundation premiums for a caisson system
2	Basement Construction	$ 4,500,000	Costs for basement including excavation, concrete and underground work such as plumbing
3	Contaminated Soils (Chicago Fill/Class D)	$ 2,500,000	Contaminated soil has a high disposal cost
4	New seismic codes adopted thru Chicago Building Code 2019, require additional supports for MEP systems and additional steel support for curtain wall system	$ 2,000,000	Additional supports and miscellaneous steel for MEP systems and steel framing for curtain wall system
5	Exterior wall construction, to satisfy the architectural integrity of the University campus	$ 12,000,000	Higher aesthetic façade to align with University of Chicago Campus
6	Tall floor to floor heights at lower levels in order for connecting bridge to align with 5th floor of existing Center for Care & Discovery Building	$ 3,000,000	Building is 12 feet taller in order to have a proper alignment with 5th floor of the Center for Design & Discovery (CCD). Some of the aspects are additional structure, curtain wall, MEP risers and walls
7	Enhanced Campus landscaping to align with Cancer Center	$ 900,000	Landscaping beyond building in order to coordinate appearance with Cancer Center
8	Uninterrupted Power System (UPS) in a redundant set-up (2N) for Technology Systems	$ 1,200,000	Technology rooms are on emergency power and have a redundant UPS system
9	Premiums costs for staging and safety due to urban campus environment and proximity of UCM Emergency Department across street from site	$ 750,000	To ensure safe and minimize traffic impacts, flaggers are required for all entry/exiting of the site. An offsite staging area has been leased also to minimize traffic impacts around the site
10	Premium for Phase 2 structural system	$ 1,000,000	Structural steel premiums in phase 1 structure for phase 2 building
11	Premium for Phase 2 mechanical/electrical/plumbing systems	$ 900,000	Add 'l capacity for MEP systems in phase 1 in order to support phase 2
12	Additional Structural capacity built into shelled floors for future shelled floor program flexibility	$ 1,100,000	Higher floor structural loadings in order to provide flexible uses in the future
13	Technology connections to existing campus infrastructure	$ 1,050,000	Premium due to distances and working in an existing facility and redundant paths
14	MEP connections to campus utilities for redundancy	$ 500,000	Additional steam & chilled water lines for greater campus reliability and maintenance
15	Steam tunnel for personnel and utilities to connect to existing University tunnel system	$ 450,000	Concrete tunnel including earth retention for steam tunnel
16	Pneumatic tube connection and system enhancement to existing hospital system	$ 1,400,000	Premium due to distance to existing services and working in an existing facility
17	Bridges for connection to Parking Garage B and CCD	$ 7,100,000	Bridges are for Patient, staff and family to connect to existing facilities
18	Sustainability and LEED Gold	$ 3,250,000	Enhanced mechanical, electrical and plumbing systems and additional landscaping including terraces
19	Total	$ 47,600,000	
20	Note: All values are before 10% contingency		

AT THE FOREFRONT
UChicago Medicine

Ivan Samstein
Executive Vice President and Chief Financial Officer

January 31, 2023

Mr. John Kniery
Administrator
ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: The University of Chicago Medical Center ("UCMC") Cancer Hospital
Reasonableness of Financing Arrangements 1120.140(a)(1)

Dear Mr. Kniery:

UCMC anticipates that the total estimated project costs and related costs will be funded 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.

UCMC further attests that the conditions of debt financing are reasonable in that the selected form of debt financing for the Project will be at the lowest net cost available

THE UNIVERSITY OF CHICAGO MEDICAL CENTER

Ivan Samstein
Executive Vice President and Chief Financial Officer

Notarization:

Subscribed and sworn before me
this 31st day of ~~February~~ January, 2023

"OFFICIAL SEAL"
CASSANDRA COLE
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 6/3/2025

Signature of Notary Public

ATTACHMENT 37

5841 South Maryland Avenue · MC 1000 · Chicago, Illinois 60637
Telephone: 773-702-4114 · Fax: 773-702-1897 · E-mail: ivan.samstein@uchospitals.edu

Section XI, Safety Net Impact Statement

Attachment 38

XI. Safety Net Impact Statement

1. <u>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.</u>

<u>UCMC IS A KEY PROVIDER OF SAFETY NET SERVICES</u>

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.[1] At a time when many neighboring hospitals have reduced the scope of their medical services or closed entirely, UCMC has invested in its facilities, creating additional inpatient and emergency room capacity and establishing an Adult Level I Trauma Center. With the construction of a dedicated, comprehensive cancer facility, UCMC proposes one of the largest investments on the South Side of Chicago, which is a demonstration of its enduring commitment to low-income and other vulnerable populations and 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 a patient's zip code or its own strained capacity as potential obstacles to their timely receipt of quality health care in the community. UCMC further recognizes the existing maldistribution of healthcare resources within the City of Chicago, including access to high quality cancer care, and through this Project champions the fight against cancer injustice for its community.

The proposed dedicated cancer facility will increase capacity and make more accessible the specialty 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 high-quality, specialty healthcare. The population of the South Side is approximately 73.7 percent African American, 6.9 percent White and 14.6 percent Hispanic. The South Side is relatively poor compared to the City of Chicago as a whole with 26.7 percent of community residents reporting family incomes below the poverty level compared with 18.4 percent for the city as a whole. In addition, 32.2 percent of households are considered "severely rent-burdened" which means a household spends more than 50% of its income on housing.

While the Chicagoland Area has other prestigious medical centers, none of them has a freestanding cancer hospital. UCMC's dedicated cancer facility would be on the South Side of

[1] UCMC is also 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.

Chicago, in the heart of the most underserved part of Chicago, and would reduce median travel time for South Side patients who otherwise would leave the area. The South Side community is one of the unhealthiest in Cook County, with high rates of cancer, 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, with the life expectancy for residents in Englewood estimated to be 30 years less than residents in Streeterville, a community only slightly north in the City.

Six-hundred thousand individuals die of cancer each year, but twenty-two percent could have lived with access to quality health care. While cancer, overall, is a second leading cause of death in 2020 in the City of Chicago, cancer has an outsized impact on minority communities. Lung, prostate and other cancers occur at higher rates in UCMC's services area that the City of Chicago's average, with a pronounced disparity in the 60621, 60636, and 60653 zip codes and are frequently diagnosed at later stages because of delays in screening and diagnosis among these vulnerable populations. In fact, patients on the South Side of Chicago are twice as likely to die from cancer than those who live just about anywhere else in America. Cancer injustice is not a science problem, a technology problem or a genetics problem, but a toxic combination of disinvestment and neglect that have contributed to the erosion of critical social, economic and health-promoting infrastructure necessary to address priority health needs. UCMC views this Project as a unique opportunity to address these inequities and to create a model for eliminating cancer disparities.

UCMC's Community Health Needs Assessment ("CHNA") for FY 2021-2022 identified the importance of the prevention and maintenance of chronic diseases, and cancer stood out as one of the priority issues for the community. These domains are the principle health concerns faced by the communities that UCMC serves. These needs are identified as a result of rigorous data collection and analysis in partnership with the community and represent a coordinated strategy to create long-term health and prosperity on the South Side. UCMC is pooling resources from across its university system to address inequities in health care and to create a model for eliminating cancer disparities. Cancer screening, prevention and timely treatment, along with screening for the social determinants of health, can help catapult a disenfranchised community from a health injustice to health equity.

UCMC routinely screens its patients for social determinants of health and, when needed, connects patients to resources they need – whether it's food from UCMC's food pantry; domestic violence support for victims, housing or something else. In fact, this work first started at the Medical Center by oncologists on the UCMC cancer team and has since grown across the system today to become a regular part of its patient screening. Addressing widespread chronic disease among adults is among the greatest opportunities UCMC has to dramatically strengthen cancer outcomes for patients on the South Side is to increase access to prevention and screenings. However, there are many impediments to living a healthy lifestyle in this service area. UCMC's approach to helping its residents to establish healthy behaviors and to dramatically scale access to prevention and screenings includes multiple initiatives, some of which are summarized below and elsewhere in this application.

Community Engagement	Prostate Cancer Outreach and Screening Grant	Cervical Cancer and HPV Vaccination Efforts	South Side Health Healthy Communities Project
Partnering with respected community organizations to fund outreach and education programs with partners including the Cancer Support Center, Equal Hope, Blue Hat Foundation, EGFR Resisters and Screen to Save	Statewide partnerships with select partner CBO and FQHCs in hot spot counties	Equal Hope Chicago (formerly Metropolitan Breast Cancer Task Force) **ITM Grant:** UCCCC OCECHE/Rush/Equal Hope. CHW training and evaluation IL HPV Cancer Task Force (IL Comprehensive Cancer Plan) **UCM Community Benefit Grant** to Equal Hope for community specific navigation in breast and cervical cancer.	5 yr $146M grant to address disparities in health care on the South Side. Part of the investment goes to care coordination for cancer patients and increased cancer screenings

ADVANCES IN CANCER TREATMENT NOT SHARED EQUALLY

Fifty years ago, President Nixon signed The National Cancer Act of 1971, which established the National Cancer Institute and signified what he first described as the nation's "war on cancer." After five decades of progress, cancer researchers are at an inflection point about how they think about cancer. They now know that cancer is not monolithic. Previously, when women were diagnosed with ovarian cancer, everybody got the same treatment, with the treatment working better for some than others. Then researchers began finding genetic differences in people and their cancers. These differences explained a great deal about why cancers responded differently to the same treatment. Cancer researchers have been able to see that, at a molecular level, tumors are different in different tissues even in the same body, that even cancers from the same original site, like breast cancer, can be radically different because of their molecular profiles, and that the tumors change over time. Cancer researchers also know that cancer evolves and reoccurs, so a patient's treatment over time will likely change as his or her response to the treatment changes.

Despite recent advances in the treatment of cancer, the disease remains a leading cause of death by disease worldwide and even more so in UCMC's own backyard. The CDC anticipates that one in two people will be diagnosed with cancer in their lifetime, which means there is a pressing need to ease the burden of disease, especially on those hit hardest.

Traditional therapies for cancer, or "one size fits all" approach, such as surgery, chemotherapy and radiation, underestimate the aggressiveness and heterogeneity of cancer. Precision and personalized medicine ("PPM") is the future of cancer therapy, which means the development of specialized treatments for each type of cancer that can be tailored to specific tissues based on an understanding of a patient's genetic data. More and more, it is possible to identify the cancer treatments that are likely to be most effective, minimizing damage to healthy tissues as well as harsh side effects, which may include targeted antibodies, cancer vaccines, and T-cell therapies, for which UCMC has been a national leader.

This ability to understand the genetic makeup of tumors can make a dramatic difference in cancer care and can maximize the benefit of treatment based upon a person's genes. In a retrospective medical record review of non-small cell lung cancer patients treated at community hospitals patients for patients who did not undergo molecular testing and did not receive a targeted cancer therapy and instead received chemotherapy, of the 482 patients who received chemotherapy, the median overall survival was 12.7 months and for the 131 patients who received a targeted therapy at some time during their treatment, the median overall survival was 31.8 months.[2]

Precancer care can now also mean mitigating genetic risk factors and reducing the chances of developing an actual cancer. This can be especially important with women found to have the BRCA1 and BRCA2 genes making them more susceptible to ovarian and breast cancers. It also means more aggressive cancer screening. Evidence is growing that wellness and lifestyle changes, including changes in exercise, nutrition, and overall well-being, and other key social determinants of health, support survival and recovery, and also reduce recurrences.

UCMC believes it is imperative to try to reduce the cancer burden for all people, reduce disparities in access to care and in clinical trials, and close the gap between researchers and community.

PROJECT WILL INCREASE ACCESS TO SAFETY NET SERVICES

In relevant part, the Project will increase access by reducing the travel burden of South Side residents. Currently 67% of residents on the South Side leave Planning Area A-03 for cancer treatment, which means significant travel times for medical care. The burden of travel from a patient's residence to health care providers is an important issue that can affect the diagnosis and treatment of cancer. Although several studies have highlighted that the travel burden can result in delays in diagnosis and treatment of many common cancers, its role still appears to be underestimated in the treatment of patients in clinical practice. In addition, the burden of travel from a patient's residence to his or her health care provider can be an important issue that can delay and influence access to diagnosis and treatment services for cancer needs. The necessity for repeated visits for cancer diagnosis and treatment on an outpatient or an inpatient basis makes distance an important issue for the cancer patient to consider during the course of the disease. One recent review suggests that the travel burden is an important factor affecting access to appropriate and current cancer diagnosis and treatment and that it can worsen

[2] Genomic Profiling of Advanced Non-Small Cell Lung Cancer in Community Settings: Gaps and Opportunities, Journal of Clinical Lung Cancer,Vol. 18, Issue 6 (Nov. 1, 2017), Gutierrez, Choi, Lanman, Pecora, Schultz, Goldberg.https://doi.org/10.1016/j.cllc.2017.04.004

the achievement of universal high-quality care for cancer patients.[3] It suggests that even a small increase in distance can result in a substantial barrier for this subset of the population.

Specifically, it was noted that distance from the hospital had a negative impact on patients affected by cancer in four primary ways: the stage at diagnosis, treatment received, prognosis, and quality of life. In almost all the studies analyzed, patients who lived far from hospitals and had to travel more than 50 miles had a more advanced stage at diagnosis, lower adherence to recommended treatments, a worse prognosis, and a diminished quality of life. These four aspects are all very important for patients and for health care policies and costs.

The National Institutes of Health also recently released a comprehensive study of the patient economic burdens of cancer, which analyzed both patient out-of-pocket costs and time costs associated with cancer treatment as part of its annual report to the nation on the status of cancer. It found that, nationally, time costs represent approximately 23% ($4.9 billion/$21.1 billion) of a patient's economic burden.

For all cancers combined, patient out-of-pocket costs were estimated to be $16.22 billion, with the highest costs for breast ($3.14 billion), prostate ($2.26 billion), colorectal ($1.46 billion), and lung ($1.35 billion) cancers, consistent with the higher incidence of these cancers. Annual time costs in 2019 were estimated to be $4.87 billion for all cancers combined, with breast ($1.11 billion) and prostate ($1.04 billion) cancers accounting for almost one-half of time costs.[4] The estimates of patient time were associated with round-trip travel to care, waiting for care, and receiving care and were calculated separately for each service category using national data sources from previously published studies and separately for metropolitan and nonmetropolitan statistical areas.

A key aim of any cancer treatment is quality of life for cancer patients and to give patients and their families the possibility to live their lives to the greatest extent possible. In this context, UCMC must account for the travel burden of cancer patients, especially when so many patients are already leaving the area, and seeks to bring more accessible cancer care to its community.

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.

Since the founding of the Medical Center, history has been there made time and time again. Cancer research has also grown for immeasurably inside UCMC's walls; hormone treatments, chemotherapy, genetic links to cancers, the foundation of modern cancer immunotherapies and

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[3] Distance as a Barrier to Cancer Diagnosis and Treatment: Review of the Literature Massimo Ambrogi,[a] Claudia Biasini,[a] Cinzia Del Giovane,[c] Fabio Fornari,[b] and Luigi Cavanna [a]: Published online 2015 Oct 28. doi: 10.1634/theoncologist.2015-0110

[4] Annual Report to the Nation on the Status of Cancer, Part 2: Patient Economic Burden Associated with Cancer Care K Robin Yabroff, PhD, Angela Mariotto, PhD, Florence Tangka, PhD, Jingxuan Zhao, MPH, Farhad Islami, MD, PhD, Hyuna Sung, PhD, Recinda L Sherman, PhD, S Jane Henley, MSPH, Ahmedin Jemal, DVM, PhD, Elizabeth M Ward, Phonics: *Journal of the National Cancer Institute*, Volume 113, Issue 12, December 2021, Pages 1670-1682, https://doi.org/10.1093/jnci/djab192; https://seer.cancer.gov/report_to_nation/?cid=pr_cgov_en_sharedlink_arn_lp

benefits of targeted therapy have all been discovered or advanced by groundbreaking research there.

As an enhancement of UCMC's existing facilities and mission to treat tertiary and quaternary care patients, the proposed Project should not have an adverse impact on the provision of care within UCMC's planning area. Additionally, UCMC's proposed construction of a dedicated, comprehensive cancer facility will not impact the ability of other providers or health care systems to cross-subsidize safety net services. Rather, this Project will foster more timely and efficient delivery of specialty care at UCMC and can better integrate the resources of both UCMC and community hospitals into the local health care delivery system, each of which plays a role that is important and distinct. UCMC, as an academic medical center, helps to bind together a highly fragmented health care market, to harness clinical strengths in clusters of otherwise lower occupancy hospitals, and to strengthen the collective health care safety net that they comprise. Through this Project and other vital initiatives, including the South Side Healthy Community Organization described in more detail below, UCMC proposes not just to build a new building or expand the number of inpatient beds at UCMC but also its working relationships with other hospitals and health care resources in its planning area. Through this Project, UCMC, in tandem with the other local community hospitals, also seeks to bring medical care closer to home for the many patients who currently leave the planning area services.

The Project should 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 specialty cancer care in the community and to consolidate the interdisciplinary cancer services that a patient will need once at UCMC. Nothing about a cancer diagnosis is simple, but UCMC aims to make accessible, patient-centric care as simple as possible for its patients.

With respect to alternatives, there is no other institution with equivalent breadth and depth of expertise in the area or with comparable commitments to cancer research, emerging treatments, community service and training the next generation of providers. Currently, UCMC is pioneering treatment for colorectal, ovarian, stomach and neuroendocrine cancers, offering state-of-the art therapies that include:

- **HIPEC Therapy**. Hyperthermic Intraperitoneal Chemotherapy ("HIPEC") is a targeted therapy that treats cancers existing in the abdominal cavity (*e.g.* colorectal, ovarian, stomach). HIPEC is done when a patient is in surgery and after the cancer has been removed; chemotherapy is then heated to 108 degrees and infused into the abdominal cavity to provide targeted and concentrated treatment. This therapy provides a one-two punch by having the tumor/cancer removed and immediately having the chemotherapy infused. It also minimizes the side effects of chemotherapy by allowing a patient to return to their normal lives faster. ***UCMC is one of three centers in the U.S. that offers this innovative therapy.*** Every patient who undergoes HIPEC is assigned to a multi-disciplinary team to ensure all his or her needs are met.

- **Neuroendocrine tumor (NETS) program**. UCMC has the only program in the market leader for NE tumors in the Midwest. UCMC treats neuroendocrine tumors of the GI tract, pancreas, lung and thymus and medullary thyroid cancer with a fully dedicated

team consisting of Surgery, Oncology, Nuclear Medicine, Nursing, Pathology, Radiology and IR. Additionally, ***UCMC is the only center in the Midwest to use 3D-guided microwave ablation*** and the only center to that hosts a patient conference for those living and surviving with NE cancers.

2. 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.

OVERVIEW

UCMC believes in the overall health of a community, not just the individual. Under the umbrella of community health and in alignment with UCMC's mission to serve the health needs of the community, UCMC is committed to enhancing health and wellness of residents on Chicago's South Side. Through its 2021-2022 Community Health Needs Assessment, UCMC identified community health priorities, which guide where UCMC will commit resources that it believes can most effectively improve community members' health and wellness. The priorities for the communities served for fiscal years 2023-2025 are to prevent and manage chronic diseases (specifically heart disease, diabetes, and cancer), to build trauma resiliency with a focus on violence prevention, trauma recovery, mental health and maternal services, and to reduce health inequities (especially access to care, food insecurity, and workforce development). Participants also voiced a desire for more community-based screenings for chronic disease and cancer care.

UCMC provides a substantial amount of care for which it does not receive payment. For fiscal year 2021, UCMC provided $20,500,000 in charity care and incurred losses on government programs of $346,400,000, and incurred uncompensated charges—or bad debt—of $99,700,000. UCMC also incurred $1,000,000 in unreimbursed education expenses during FY 2021, provided research support of $48,000,000, $545,000 cash/in kind and incurred $4,300,000 for other community programs for a total expenditure of $520.4 million.

However, the community benefit provided by UCMC goes well beyond the number of charity care and Medicaid patients treated at the Medical Center. For example, in 2020 and 2021, during the COVID-19 crisis, UCMC made vaccine distribution, education, and outreach a priority. In July 2022, UCMC expanded its ongoing work in violence prevention and trauma resiliency with Southland RISE, through which $150,000 was awarded to 18 grassroots organizations for their programs designed to keep young people safe over the summer.

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. UCMC also accepts patients through the Perinatal and Pediatric Trauma Networks without regard to their ability to

pay for services. UCMC's Financial Assistance Policy (the "Policy") offers patients 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 patient service revenue.

SAFETY NET SERVICES AT UCMC

ADULT PATIENT CARE IN THE CENTER FOR CARE AND DISCOVERY ("CCD") AND BERNARD A. MITCHELL HOSPITAL

CCD. CCD is UCMC's flagship hospital in Hyde Park. The 10-story facility first opened in 2013 and is home to world-class medical and surgical care. The CCD includes 436 beds (all private rooms, which are spacious enough to accommodate family for overnight stays), 52 intensive care beds, 9 suites for advanced imaging and interventional procedures, and 23 operating rooms designed to accommodate hybrid and robotic procedures. The CCD provides a home for complex specialty care with a focus on cancer, gastrointestinal disease, neuroscience, advanced surgery, and high-technology medical imaging. The facility is designed for family-centered care and improved communication among all members of the patients care team.

Mitchell Hospital. Mitchell Hospital opened in 1983 as UCMC's main adult patient care facility, replacing the original hospital known as Billings Hospital, and continues to operate approximately 159 medical surgical beds.

*Adult Emergency Department ("**ED**").* The new and expanded emergency department, which opened in December 2017 is located adjacent to the CCD and is connected above and below ground to provide enhanced access to the operating and procedural rooms in the CCD. The emergency department includes 41 treatment stations, including four trauma resuscitation bays, two radiographic imaging rooms, and one CT room as well as an on-site bio containment unit for highly infectious disease. UCMC also provides Level I adult trauma services in the ED, which supplements its Level 1 pediatric trauma services and the trauma services provided in the Burn and Complex Wound Center, one of only two burn units in Chicago providing care to critically-injured adult and pediatric patients. UCMC's Emergency Department is open 24 hours a day, 7 days a week and provides over 75,000 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.

UCMC admitted more than 32,708 adult patients with almost 500,000 adult and pediatric visits to the outpatient ambulatory care facility. UCMC 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 200 bone marrow or stem cell transplant procedures for the treatment of various cancers for both adult and pediatric patients in FY2021.

CHICAGO COMER CHILDREN'S HOSPITAL

Comer, a six-story, 242,000 square-foot children's hospital, was designed to provide the most advanced care for children in a family-centered environment. Comer is a major referral center and currently has 165 beds in operation, including a neonatal intensive care unit with 47 level-III beds. In addition to inpatient units, Comer has six pediatric operating rooms (including one for interventional cardiac procedures), radiology, a palliative care unit, child life, and family support areas (such as playrooms, resource center, and family kitchen and laundry), conference rooms, and house staff education space.

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 facility. 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. Comer Children's Hospital annually admits about 5,000 patients from the Chicago area, the Midwest and around the world. UCMC's outpatient clinics accommodate 37,000 general pediatric and specialty visits in its ambulatory care facility and over 30,000 visits were made to the Comer pediatric emergency room.

Comer is the only pediatric Level 1 Trauma Center on the south side of Chicago and provides highly specialized pediatric emergency services on the first floor of the Comer Center for Children and Specialty Care, which is adjacent to the main Comer building. The other floors of this building house pediatric specialty clinics and the Family Birth Center. Comer has been treating children with traumatic injuries for over 35 years.

Comer Children's Hospital is staffed by more than 170 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.

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 12 area hospitals with consultation as well as transport services for approximately. 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.

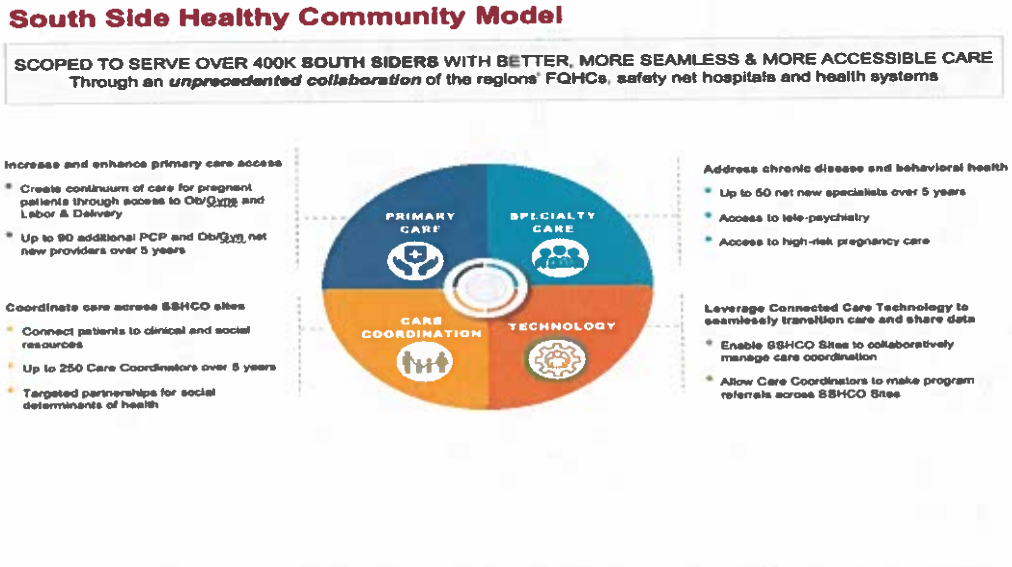
INNOVATIVE CARE DELIVERY INITIATIVES

SOUTH SIDE HEALTHY COMMUNITY ORGANIZATION

UCMC's South Side community lacks needed health care services. Chicago's South Side has lost seven hospitals since 1985 and thousands of inpatient beds in the past decade alone. 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.

In July 2021, the Illinois Department of Healthcare and Family Services granted nearly $150 million in funding over five years to a collaborative of 13 health care organizations – including the University of Chicago Medical Center and other area hospitals, health systems and Federally Qualified Health Centers ("FQHC"s) united with hundreds of community members and leaders representing healthcare interests, grassroots organizations and their faith community. The group – known as the South Side Health Community Organization ("SSHCO") hopes to transform the landscape of health and healthcare on the South side of Chicago. The model is designed to serve more than 400,000 South Siders with better, more seamless and more accessible care. In the first year, $26 million in funding will support the hiring of community health workers, providers, provide access to specialty care and develop connected care

technology. Overall, the SSHCO seeks to boldly increase and enhance primary care and improve material health with 90 additional primary and obstetric providers; address unmet chronic disease and behavioral needs with dedicated access to 50 priority specialties including cancers, address care coordination and social determinant needs with about 250 community health works; and seamless transition of care with a connected care technology platform.



THE URBAN HEALTH INITIATIVE

The Urban Health Initiative ("UHI") is UCMC's community health division. The UHI oversees population health management and community benefit programs, working with community health centers, community hospitals, community-based organizations, local schools, churches and other groups to develop innovative strategies to improve the quality of and access to services on the South Side. UHI serves as a two-way bridge to the community and ensures that UCMC is an active part of improving the lives of resident's in the medical center's service area. UHI builds goodwill, social capital and the relationships needed to create new services and programs addressing population health. Community health challenges are approached with a collaborative, community-based and participating focus that promotes health equity. UHI develops high-quality educational programs and communications that reflect and address the needs of community residents

VIOLENCE RECOVERY PROGRAM

Launched in May 2018, the Violence Recovery Program is designed to reduce violence through holistic interventions that lead to sustainable, long-term recovery from violent traumatic injury for adult patients, pediatric patients and their families. VRP services begin when a patient arrives in the Emergency Department and the patient and/or family meets a Violence Recovery Specialist VRS. Services provided include crisis intervention, help to patients and families to navigate the health care system, evaluating the need for social services and mental health support and providing intensive case management support. From July 1, 2019 – January 31, 2022 almost 5000 trauma engaged with and were supported by the VRP.

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OFFICE OF COMMUNITY ENGAGEMENT AND CANCER DISPARITIES

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. The Comprehensive Cancer Center established the Office of Community Engagement and Cancer Health Equity (OCECHE) in 2010 as part of a renewed and expanded commitment to serve local communities through research, education and outreach programs. The mission of the OCECHE is to serve as a bridge between the University of Chicago Medicine Comprehensive Cancer Center and academic and community stakeholders to promote equitable collaboration and eliminate cancer disparities through community capacity building, participatory research, advocacy and innovative education and training.

COMMUNITY EDUCATION AND OUTREACH

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 participates in, and holds community events, to build partnerships with local communities and engage directly in providing information and solutions that enhance healthcare in the neighborhoods surrounding UCMC. 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, and invites community residents to participate in events on specific diseases and diagnoses.

The South Side Pediatric Asthma Center ("SSPAC") is a multi-institution partnership in collaboration with UCMC's Comer Children's Hospital, La Rabida Children's Hospital, Friend Family Health Center, and the St. Bernard Hospital The SSPAC focuses on improving health outcomes among children with asthma by facilitating access to care and providing standardized treatment and education through communication, engagement and outreach. The education arm of the SSPAC develops and distributes standardized and easy to understand asthma education materials, hosts and annual Asthma Summit, and provides ongoing asthma training to school staff, daycare center staff, parents and clinical providers. They also participate in community events to promote asthma awareness and education to caregivers.

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. The Center is exploring health disparities based upon certain social and environmental factors that put some groups at extraordinary risk for adverse health outcomes. The University researchers have focused on a downward causal model, originating at the population two. They have used this approach to identify now specific social environments cause disease, illustrated by the disparity in mortality from aggressive pre-menopausal breast cancer suffered by black women.

UCMC also invests in research conducted under a Clinical and Translational Science Award (CTSA) – funded by federal grants to the University with additional investment by UCMC – to provide more effective community health care by helping to translate basic science research into programs that benefit the community. The CTSA initiative is led by the National Center for Research Resources at the National Institutes of Health and is aimed at improving the way biomedical research is conducted across the country, reducing the time it takes for laboratory discoveries to become treatments for patients, engaging communities in clinical research efforts, and training the next generation of clinical and translational researchers. In an effort to marshal available intellectual resources, this research includes the involvement of University social scientists and social workers to help researchers and practitioners better understand how to overcome social and/or cultural hurdles and improve community health.

UCMC is deeply committed to providing health care solutions and services for patients, the community and the region. With a continued focus on its three critical missions – patient care, research and education – UCMC strives be a leader in complex care and to have a lasting impact on the health and vitality of Chicago's South Side.

The community benefit services are described in greater detail in the FY2021 Community Benefit Report, the FY 2020-2022 Community Benefit Evaluation Report, and the FY 2023-2025 Strategic Implementation Plan attached hereto.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	**FY20**	**FY21**	**FY22**
Inpatient	940	340	460
Outpatient	21,192	14,870	10,012
Total	**22,132**	**15,210**	**10,472**
Charity (cost in dollars)			
Inpatient	$17,320,551	$3,505,779	$13,413,005
Outpatient	$24,157,208	$16,982,180	$13,541,260
Total	**$41,477,759**	**$20,487,959**	**$26,954,265**
MEDICAID			
Medicaid (# of patients)	**FY20**	**FY21**	**FY22**
Inpatient	11,635	12,335	12,617
Outpatient	147,940	138,695	159,040

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Total	**159,576**	**151,030**	**171,657**
Medicaid (revenue)			
Inpatient	$334,038,769	$409,276,752	$447,645,408
Outpatient	$88,188,976	$143,646,625	$167,306,485
Total	**$422,227,745**	**$552,923,377**	**$614,951,893**

At the Forefront of Health Equity

2021 Community Benefit Report

AT THE FOREFRONT
UChicagoMedicine

To you, our community.

The University of Chicago Medicine works with community partners to make high-quality healthcare more accessible and equitable for residents on Chicago's South Side and in the Southland.

In fiscal 2021, UChicago Medicine health system programs resulted in nearly $607 million in benefit to the community, including $520.4 million through the University of Chicago Medical Center and $86.5 million through UChicago Medicine Ingalls Memorial.

In response to the continued COVID-19 crisis, in 2021, UChicago Medicine prioritized vaccine distribution, education and outreach to address the challenges of access, misinformation and distrust that were leading to low vaccination rates in Black and Brown communities. We also invested in community-based programs and increased hospital resources to treat trauma resulting from community violence.

The Urban Health Initiative is the hospital department that leads much of this important work, greatly supported by members of our Community Advisory Council.

This Community Benefit Report highlights these efforts; you will find additional detail, expanded resources and interactive features in the online version of the report: community.uchicagomedicine.org/2021.

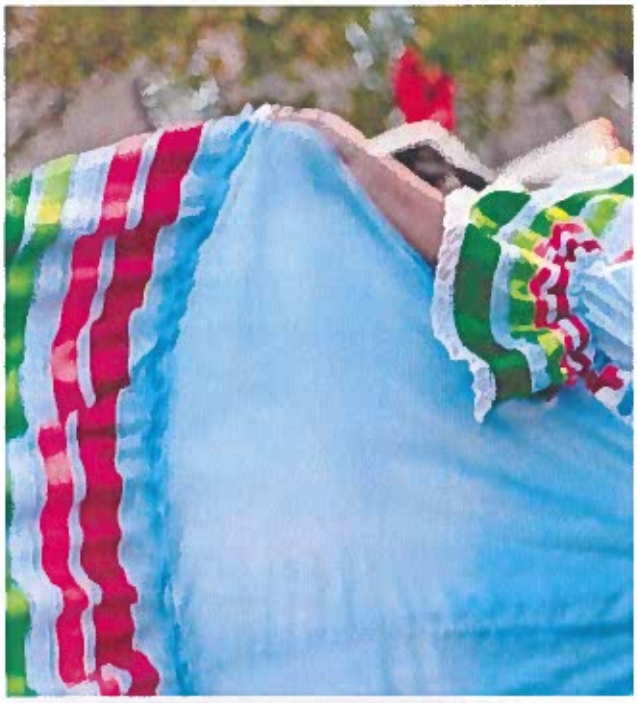
If you have questions or feedback, please contact: communitybenefit@uchospitals.edu.

Kenneth S. Polonsky, MD

Dean and Executive Vice President for Medical Affairs, University of Chicago

Brenda Battle, RN, BSN, MBA

Senior Vice President for Community Health Transformation and Chief Diversity, Equity and Inclusion Officer, UChicago Medicine



"Whether we are addressing pediatric asthma, diabetes, or emergency care, the University of Chicago Medical Center and its partners will continue to collaborate on community-based solutions to the health challenges facing the South Side."

Tom Jacklewicz

President, the University of Chicago Medical Center

"To help foster a healthier Southland, UChicago Medicine Ingalls Memorial is focused on developing and investing in community partnerships and programs to meet our communities' unique health needs."

Randy Nelswonger

President, Ingalls Memorial

$606.9 million Total investment

University of Chicago Medical Center

Total uncompensated care
$466.6 million

- Medicaid and Medicare program losses **$346.4 million**
- Unrecoverable patient debt **$99.7 million**
- Charity care **$20.5 million**

Medical research
$48 million

Uncategorized community benefit
$4.3 million

Cash/in kind
$545,000

Medical education
$1 million

Total
$520.4 million

UChicago Medicine Ingalls Memorial

Total uncompensated care
$85 million

- Medicaid and Medicare program losses **$44.2 million**
- Unrecoverable patient debt **$33.9 million**
- Charity care **$6.9 million**

Uncategorized community benefit
$200,597

Cash/in kind
$91,326

Medical education
$1.2 million

Total
$86.5 million

Read the online report COMMUNITY.UCHICAGOMEDICINE.ORG/2021 • 3

Health Equity

UChicago Medicine is working to end disparities and help all community members live their healthiest lives.

Transforming Healthcare on the South Side: In July 2021, the Illinois Department of Healthcare and Family Services (HFS) granted nearly $150 million in funding over five years to a collaborative of 13 healthcare organizations — including UChicago Medicine and other area hospitals, health systems and Federally Qualified Health Centers (FQHCs), united with hundreds of community members and leaders representing healthcare interests, grassroots organizations, and the faith community. The group — now known as the South Side Healthy Community Organization — hopes to transform the landscape of health and healthcare on the South Side of Chicago, where life expectancy can be 30 years shorter than in neighborhoods just 10 miles to the north.

In the first year, $26 million in funding will support:

- Hiring providers
- New access to specialty care
- Care coordinators
- Community health workers
- Development of a connected care technology

The South Side Healthy Community Model

This model is designed to serve more than 400,000 South Siders with better, more seamless and more accessible care. It involves an unprecedented collaboration of the region's FQHCs, safety net hospitals and health systems.

We will:

- **Boldly increase and enhance primary care and dramatically improve maternal/infant health** with 90 additional primary care providers and obstetric hires.
- **Address unmet chronic disease and behavioral needs** with dedicated access to nearly 50 priority specialists.
- **Address care coordination needs, social determinant needs and preventative care** with about 250 Community Health Workers and care coordinators, along with targeted social determinants of health programming.
- **Seamlessly transition care and share data** with a connected care technology platform.

To achieve:

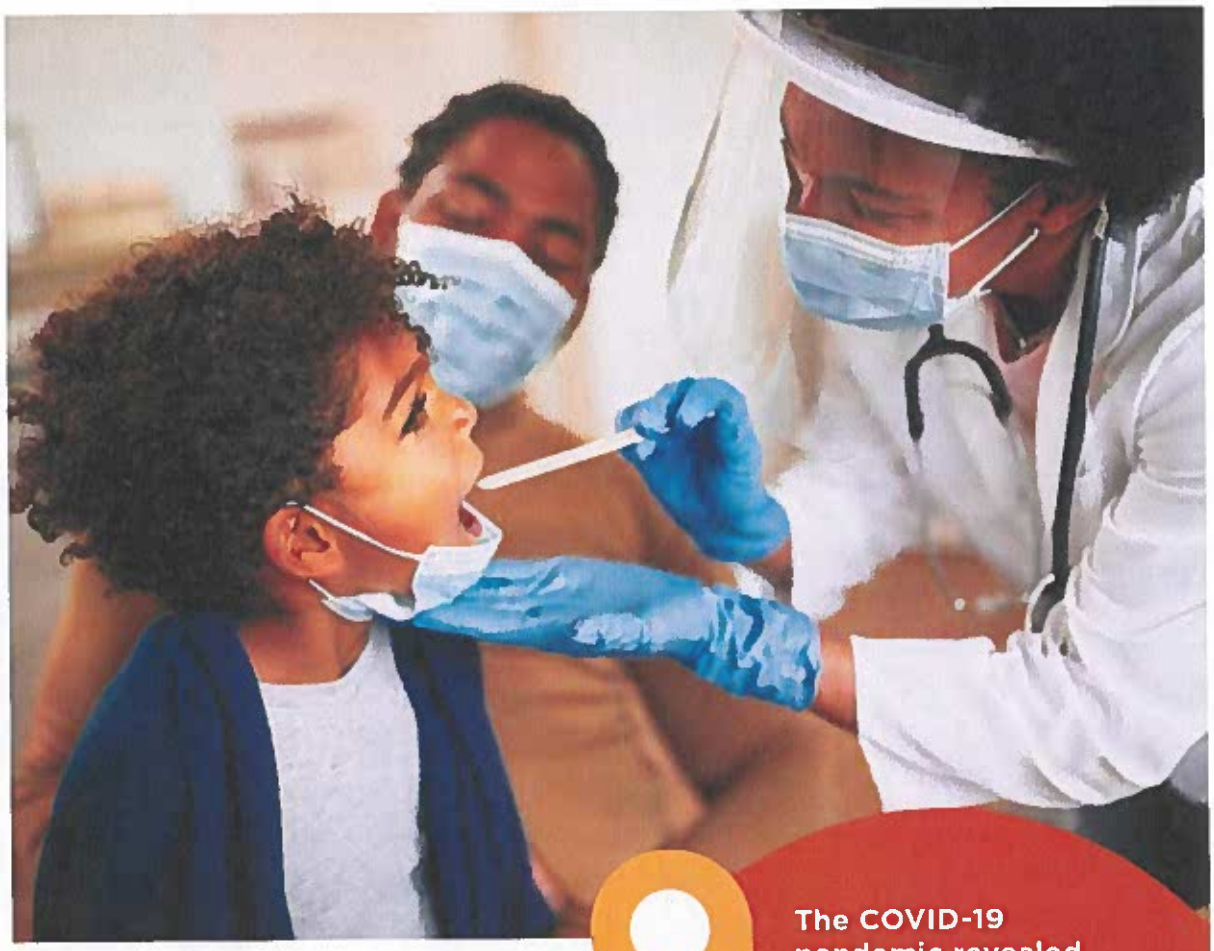
REVERSAL OF LONGSTANDING HEALTH DISPARITIES

- **Reduced infant mortality**
- **Reduced chronic disease morbidity**
- **Enhanced life expectancy**

REDUCED COSTS AND IMPROVED ECONOMIC SUSTAINABILITY

- **Improved value and outcomes per dollar**
- **More care delivered locally**
- **Over 400 new jobs created**

Read the online report COMMUNITY.UCHICAGOMEDICINE.ORG/2021



Advancing Equity: UChicago Medicine's comprehensive system-wide Equity Plan continues to identify and address inequities in the workforce, work climate, healthcare delivery/services and the community, resulting in:

- 37% increase in promotion rates for Black, Indigenous and People of Color (BIPOCs)
- Improvement in search and hiring processes to identify more diverse candidates
- Compassion fatigue training to more than 900 employees to address burnout
- More than 969 hours of virtual Cultural Competence training provided to staff
- 13% increase in percentage of surveyed employees who agreed UChicago Medicine has "an inclusive culture"

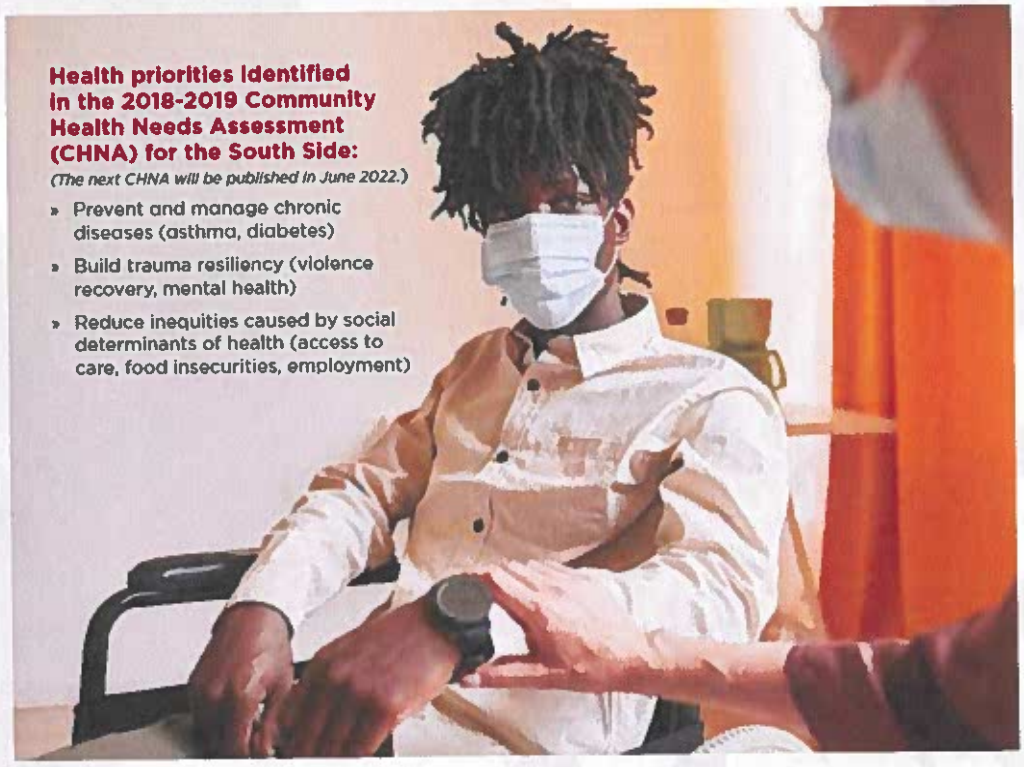
The COVID-19 pandemic revealed the disparities that exist in health and healthcare access, including in vaccination rates across the city.

93% of residents in the 60604 (Loop) ZIP code are fully vaccinated, compared with **40%** of residents in 60621 (Englewood).

Source: Chicago Data Portal, 11/21/2021

See page 10 to learn about our COVID-19 response.

Health Priorities



Health priorities identified in the 2018-2019 Community Health Needs Assessment (CHNA) for the South Side:

(The next CHNA will be published in June 2022.)

- Prevent and manage chronic diseases (asthma, diabetes)
- Build trauma resiliency (violence recovery, mental health)
- Reduce inequities caused by social determinants of health (access to care, food insecurities, employment)

COMMUNITY HEALTH WORKERS (CHWs) are community members trained to work with patients and their families to provide healthcare support at home and help lessen barriers to care, while improving patients' overall health and wellness. The Liaisons in Care (LinC) program's CHWs support patients with heart failure, adolescent sickle cell disease, stroke, pediatric asthma, hypertension and diabetes.

- UChicago Medicine awarded $400,000 in grant funding to four community-based organizations to help increase the number of CHWs serving the South Side. The grant funding was made possible by AbbVie, which donated $8 million to UChicago Medicine in 2020.
- Total number of patient encounters completed by CHWs since the program's launch in 2021: 1,140

***Geri Pettis, MA-CMHC,** is a violence recovery specialist who works with pediatric patients through UChicago Medicine's Violence Recovery Program (VRP). Since May 2020, Geri has seen hundreds of patients, most of whom are child and teenage victims of violence.*

Read the online report COMMUNITY.UCHICAGOMEDICINE.ORG/2021

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ASTHMA — SOUTH SIDE PEDIATRIC ASTHMA CENTER (SSPAC)

775 community members engaged at asthma education events by Community Health Workers and a respiratory therapist

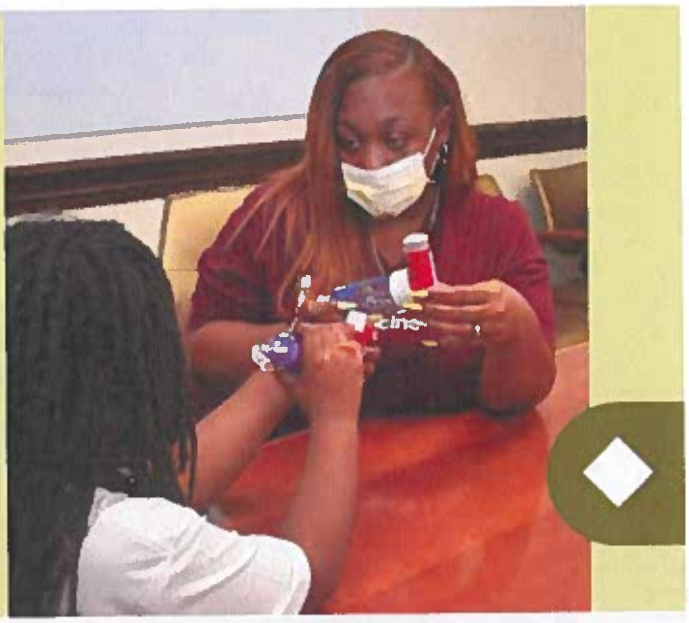
162 community members attended asthma trainings

79 attendees for SSPAC's virtual asthma education summit

DIABETES

256 fitness sessions for South Side Fit program

12 workshops for Diabetes Education & Empowerment Program (DEEP™)



TRAUMA RESILIENCY

Violence Recovery Program: UChicago Medicine's Violence Recovery Program (VRP) is the only hospital-based violence intervention program in Chicago. The Urban Health Initiative launched the VRP in May 2018, when UChicago Medicine opened its Level 1 Adult Trauma Center. The VRP provides intensive wraparound services to victims of intentional violence during admission and post-discharge to promote comprehensive recovery and reduce risks of reinjury.

- Since its launch, the VRP has engaged 5,574 patients, 2,389 families and more than 627 children.
- The violence recidivism rate is less than 1% (return rate to UChicago Medicine's trauma center).

Summer Grant Awards: In 2021, Southland RISE (Resilience Initiative to Strengthen and Empower) awarded $150,000 to 15 grassroots organizations for their summer trauma resiliency and violence prevention programs — a 50% increase over the previous year. Southland RISE is a collaboration between UChicago Medicine and Advocate Health Care inspired by U.S. Senator Dick Durbin's Chicago HEAL (Hospital Engagement, Action and Leadership) program. Through Southland RISE, 30 community-based organizations on the South Side have received $350,000 for their summer youth programs since 2019.

BHC Collaborative: The VRP is part of the Block Hassenfeld Casdin (BHC) Collaborative for Family Resilience, which takes an innovative, community-driven and holistic approach to treat trauma in children and families. With the BHC Collaborative's support, 2,117 patients and/or families (39% of total seen) received one or more interventions (through October 2021):

263 received housing interventions, including housing referrals (41)

300 received employment interventions, including employment referrals (114)

71 received food interventions, including food referrals (37)

111 received education interventions

1,035 received victim's compensation support

781 received mental health interventions, including mental health referrals to community partners (179)

Health Priorities

UChicago Medicine Ingalls Memorial

UChicago Medicine Ingalls Memorial identified these health priorities for the Southland in its 2018-2019 Community Health Needs Assessment (CHNA):

(The next CHNA will be published in June 2022.)

Prevent and manage chronic diseases

- Asthma
- Diabetes
- Heart disease

Increase access to maternal health services

- Prenatal care

Promote cancer awareness

- Breast cancer
- Prostate cancer

MATERNAL HEATH, VIA INGALLS' HEALTHY BABY NETWORK (HBN):

- Enrolled 115 women in its program to provide community-based prenatal care — including medical, nutritional and financial assistance; there were 73 full-term deliveries
- Hosted Drive-Thru Baby Shower, which provided prenatal resources to 100 women
- Distributed nine car seats to families in the community

CANCER

- The Ingalls Development Foundation provided $786,000 in funding for a community-based cancer research trial that screened 300 patients, increasing minority enrollment in clinical trials.
- Community Impact Grants
  - $30,000 to the Cancer Support Center for prevention, screening and educational resources
  - $25,000 to Family Christian Health Center to increase mammography utilization in the Southland

CHRONIC DISEASE

- Hosted 17 education sessions on nutrition, fitness, diabetes, heart health, cancer and mental health in 2021; 200 people attended the events

- Read the online report COMMUNITY.UCHICAGOMEDICINE.ORG/2021

ATTACHMENT 38

Workforce & Community Development

WORKFORCE AND COMMUNITY INVESTMENT

Hiring from South Side Communities (2021)

24% of total workforce live in the University of Chicago Medicine service area (UCMSA)

25% of total 2021 hires live in the UCMSA

$31.36/hr
Average hourly wage for employees in the UCMSA

LOCAL AND DIVERSE PURCHASING

For the past 15 years, UChicago Medicine has worked with local firms for our purchasing and construction needs. Ten local* firms worked on UChicago Medicine construction projects from 2019-2021.

$13.7 million
in contracts awarded and paid to certified minority- and woman-owned firms

$1.05 million
in wages earned by 169 Chicago residents working on UChicago Medicine construction projects

$1.5 million
in wages went to minority and female construction workers

$485.6 million
in economic benefit for certified minority- and woman-owned firms via UChicago Medicine's capital and renovation projects (2001-2021)

Source: Construction Compliance Initiative 2020-21 Year-End Report

**From ZIP codes 60609, 60615, 60616, 60619, 60621, 60637, 60649, 60653*

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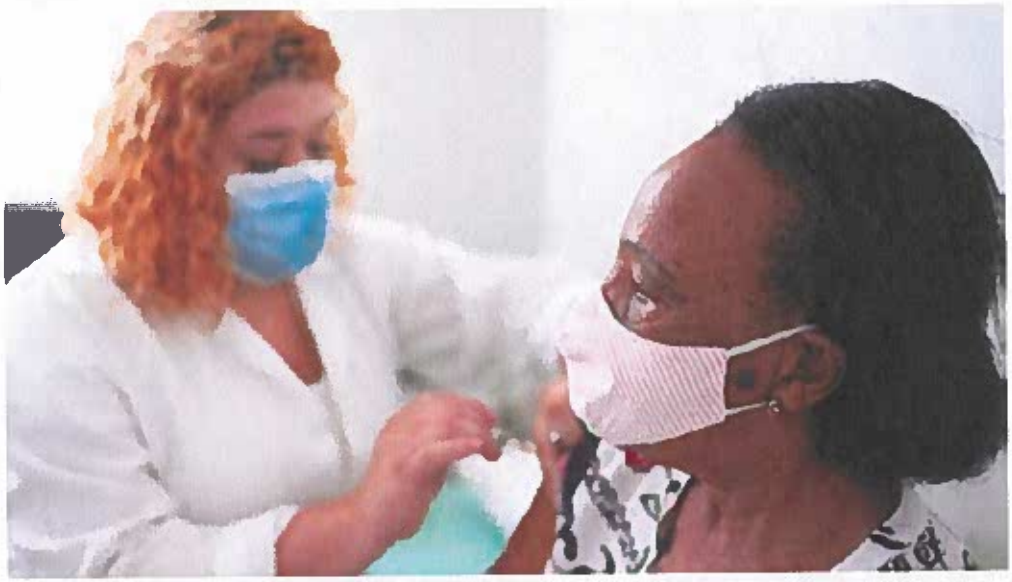
Community Outreach



Recognizing the wide disparities in vaccination rates in the communities we serve, UChicago Medicine mobilized its partners in response, with an emphasis on vaccine outreach and distribution, but also through providing supplies, grants, testing, and educational resources.

COVID-19 Response (2021):

More than **2,000** COVID-19 patients treated

More than **295,000** tests performed

134,000 COVID-19 vaccine doses administered to nearly 69,000 people

427 COVID-19-related publications authored by University of Chicago-affiliated researchers, a 36% increase over 2020

Community Champions Program: In 2021, UChicago Medicine's Graduate Medical Education (GME) department launched the Community Champions program, giving resident physicians the chance to work with and learn from local underserved communities. Participants supported COVID-19 vaccine outreach efforts organized by the Urban Health Initiative through 51 in-person and virtual events, including a pop-up clinic serving the Roseland and Washington Heights communities, where vaccination rates had been lagging.

WNBA Chicago Sky: In the lead-up to the WNBA Chicago Sky's October 2021 league championship, finals MVP Kahleah Copper helped to raise awareness for breast health. Copper has a history of breast cancer in her family. In October, she was a guest on WVON 1690-AM's Community Health Focus Hour with experts from UChicago Medicine. She also recorded videos that were played on social media and on the JumboTron during a Sky game that focused on breast cancer. UChicago Medicine is a major sponsor of the Chicago Sky and partners with the team on community programs, serving as an official Sky Cares Legacy Partner.

Kahleah Copper

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Connecting with the community to promote better health

Bud Billiken Parade: Physicians and staff marched in the 92nd annual parade in August 2021, promoting the importance of checkups and vaccinations for children.

Black Women's Expo: For the August 2021 event, physicians provided health screenings and answered questions about women's health issues.

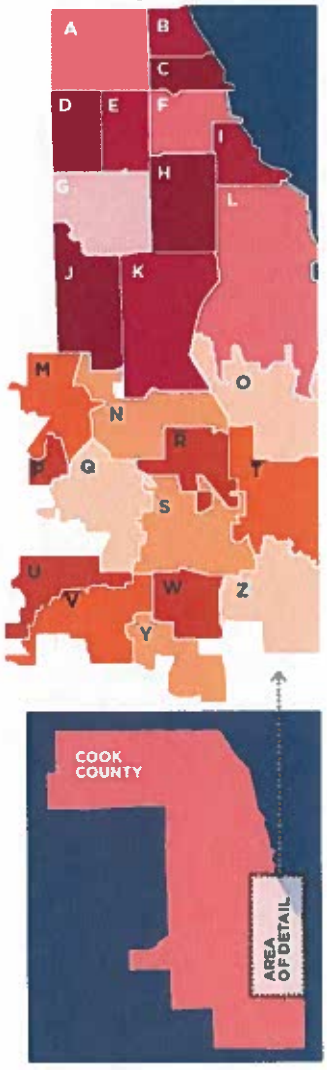
DOSAR: For its Day of Service and Reflection (DOSAR), the Urban Health Initiative provided 15 community partners with supplies, gift cards and virtual health-related workshops.

Community Health Survey: The Urban Health Initiative surveyed close to 1,000 community members through 22 events for its 2021-22 Community Health Needs Assessment.

Healthcare Career Events: UChicago Medicine hosted two virtual high school healthcare career events that drew 100 participants.

The University of Chicago Medicine works with community partners to make high-quality healthcare more accessible and equitable for residents on Chicago's South Side and in the Southland. The Urban Health Initiative is the hospital department that leads much of this important work, greatly supported by members of our Community Advisory Council. In fiscal 2021, UChicago Medicine health system programs provided nearly $607 million in benefit to the community, including $520.4 million through the University of Chicago Medical Center and $86.5 million through UChicago Medicine Ingalls Memorial.

ZIP code regions



OUR SERVICE AREA

University of Chicago Medical Center

12 South Side ZIP codes

35 neighborhoods

A

60609
Armour Square
Bridgeport
Douglas
Fuller Park
Gage Park
Grand Boulevard
McKinley Park
New City
Washington Park

B

60653
Douglas
Grand Boulevard
Kenwood
Oakland

C

60615
Grand Boulevard
Hyde Park
Kenwood
Washington Park

D

60636
Chicago Lawn
Gage Park
West Englewood

E

60621
Englewood
Greater Grand Crossing
Washington Park

F

60637
Greater Grand Crossing
Hyde Park
Washington Park
Woodlawn

G

60620
Ashburn
Auburn Gresham
Englewood
Greater Grand Crossing
Roseland
Washington Heights

H

60619
Avalon Park
Burnside
Calumet Heights
Chatham
Greater Grand Crossing
Roseland
South Shore

I

60649
South Shore
Woodlawn

J

60643
Beverly
Morgan Park
Washington Heights
West Pullman

K

60628
Pullman
Riverdale
Roseland
Washington Heights
West Pullman

L

60617
Avalon Park
Calumet Heights
East Side
Hegewisch
South Chicago
South Deering

UChicago Medicine Ingalls Memorial

13 ZIP codes

19 suburbs

M

60406
Blue Island
Dixmoor
Posen
Riverdale

N

60827
Blue Island
Calumet Park
Chicago
Dolton
Riverdale

O

60633
Burnham
Calumet City
Chicago

P

60469
Posen

Q

60426
Dixmoor
Harvey
Markham
Phoenix

R

60419
Dolton

S

60473
Dolton
South Holland
Thornton

T

60409
Burnham
Calumet City
Lansing

U

60429
East Hazel Crest
Harvey
Hazel Crest
Markham

V

60430
Hazel Crest
Homewood
Thornton

W

60476
Thornton

Y

60425
Glenwood

Z

60438
Lansing

AT THE FOREFRONT
UChicagoMedicine

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AT THE FOREFRONT
UChicago Medicine

Strategic Implementation Plan

Fiscal Years
2023-2025

ATTACHMENT 38

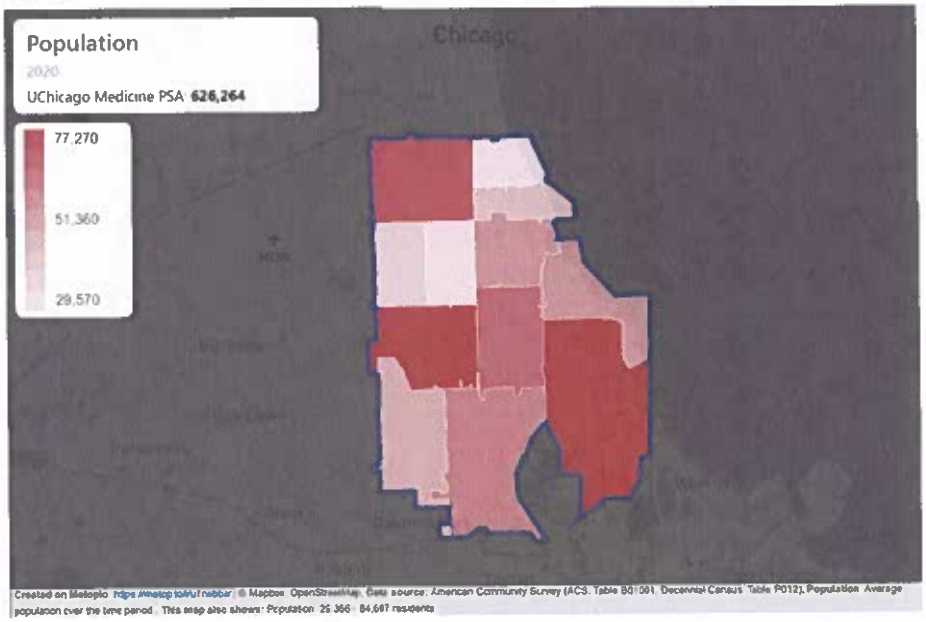
Introduction

University of Chicago Medicine, one of the nation's leading academic medical institutions, has been at the forefront of medical care since 1927. Collectively, it is comprised of the University of Chicago Pritzker School of Medicine, the University of Chicago Biological Sciences Division, and the University of Chicago Medical Center (UCMC).

UCMC's mission is to provide superior healthcare in a compassionate manner, ever mindful of each patient's dignity and individuality. UCMC strives to improve the health of Chicago's South Side by working in collaboration with community members, community and faith-based organizations, public agencies, faculty and staff, and others to implement interventions that address the priority healthcare needs and social determinants of health that impact members of our community. The following pages in this strategic implementation plan provide an overview of UCMC's approach to assessing, prioritizing, and addressing specific health needs.

Target Area and Priority Population

Figure 1. The UCMC Service Area Spans 28 Chicago Community Areas



UCMC is located in the Hyde Park neighborhood on Chicago's South Side. Chicago's South Side is a unique collection of vibrant, resilient, culturally rich, and diverse communities. Steeped in African-American heritage and history, the South Side is marked by deep social bonds and anchored by vital community and faith-based organizations. UCMC defines its service area (UCMCSA) as 12 contiguous zip codes surrounding UCMC (see Figure 1).[1] The UCMCSA spans 28 Chicago Community Areas and has a population of approximately 626,264 residents. Currently, six out of the eleven poorest communities in Chicago are in the UCMCSA.[2] Residents in these communities face many social and economic challenges that contribute to healthcare inequities when compared to other areas of Chicago. Moreover, health disparities across the UCMCSA are vast, as demonstrated by strikingly high rates of asthma, diabetes, obesity, cancer, and other chronic diseases.[3] These health conditions are exacerbated by social determinants of health like poverty, food insecurity, and a lack of employment opportunities.

American Community Survey (ACS) data show changes in the UCMCSA population since the previous CHNA cycle. The UCMCSA population declined by 3.1%, while the population of Chicago increased by 1.9%. The UCMCSA remains predominantly African American (74%) but did see a roughly 6% decrease in the African American population, while the Hispanic or Latino population increased by nearly 20%. The median age in the UCMCSA is 37.5 years old—over 2.7 years older than Chicago's median age of 34.8. The majority of the UCMCSA population (77%) is 18 or older. Despite these shifts, residents in these communities still contend with the effects of institutional and structural racism, disinvestment, and neglect that have contributed to the erosion of the critical social, economic, and health-promoting infrastructure necessary to address priority health needs. As a result, communities in the UCMCSA continue to experience among the worst economic, social, and health outcomes across Chicago.

At the Forefront of Health Equity

UCMC believes all members of our community should have the opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social position or other socially determined circumstances. UCMC's Urban Health Initiative (UHI) ensures that UCMC is doing its fair share for the community, working to create better health, investing in trusted community partners, and leveraging the assets of UCMC and the University to address the health disparities that persist throughout the South Side of Chicago. The UHI connects UCMC's world-class clinicians, researchers, staff, and care to the lives and health of our neighbors in the 12 zip codes on the historic South Side. As a division of the UHI, UCMC's Diversity, Inclusion, and Equity Department works in concert with our community efforts to promote health equity within UCMC through staff training in cultural competence and plain-language patient education materials.

Community Health Needs Assessment

UCMC and Metopio, a software and services company, partnered to carry out a collaborative CHNA process between April 2021 and February 2022. The CHNA process is adapted from the Mobilizing for Action through Planning and Partnerships (MAPP) framework, a community-engaged strategic planning framework that was developed by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). The MAPP framework promotes a system focus, emphasizing the importance of community engagement, partnership development, and data-driven decision-making. Primary data for the CHNA was collected through the following methods:

- Community resident surveys
- Community resident focus groups
- Healthcare and social service provider focus groups
- Key informant interviews

Community resident surveys were designed to ask about health issues that were most important to the following age groups: youth (0-17), adult (18-64), and seniors (65+). While the questions in the Community Health Needs Assessment Survey were bracketed by age group, the identified health priorities account for all age categories.

Secondary data for the CHNA were aggregated on Metopio's data platform and included:

- Hospital utilization data
- Secondary sources including, but not limited to, the American Community Survey, the Decennial Census, the Centers for Disease Control, the Environmental Protection Agency, Housing and Urban Development, and the Chicago Department of Public Health

Health Issue Prioritization Process

Building on UCMC's past two CHNAs, the Community Benefit and Evaluation Team worked with the Community Benefit Management and Steering Committees, as well as the Community Advisory Council, to prioritize health issues for UCMC's next three years of community benefit programming for FY 2023-2025. Representatives from the UCMC Urban Health Initiative, select UCMC faculty, and community stakeholders were among the three major constituencies involved in the health priority selection process. These constituencies were strategically selected for their respective understanding of community perspectives, community-based health engagement, and community health programming. The MAPP framework promotes a system focus, emphasizing the importance of community engagement, partnership development, and data-driven decision-making. Figure 2 outlines the criteria used to review CHNA data and make decisions to select the final priority health areas.

Figure 2. Criteria for Selecting Health Priority Areas

Criteria Examples (CHA)
Magnitude: the number of people impacted
Severity: the risk of morbidity
Historical trends
Alignment with organizational strength and priorities
Impact of problem on vulnerable populations
Importance of problem to the community
Existing resources addressing problem
Relationship of problem to other community issues
Feasibility of change
Value of immediate intervention versus delay, especially for long-term or complex threats

Data Needs and Limitations

UCMC and Metopio made substantial efforts to comprehensively collect, review, and analyze primary and secondary data. However, there are limitations to consider when reviewing CHNA findings.

- Population health and demographic data are often delayed in their release, so data are presented for the most recent years available for any given data source.
- Variability in the geographic level at which data sets are available (ranging from census tract to statewide or national geographies) presents an issue, particularly when comparing similar indicators collected at disparate geographic levels. Whenever possible, the most relevant localized data are reported.
- Due to variations in geographic boundaries, population sizes, and data collection techniques for suburban and city communities, some datasets are not available for the same periods or at the same level of localization throughout the county.
- Gaps and limitations persist in data systems for certain community health issues such as mental health and substance use disorders for youth and adults, crime reporting, environmental health, and education outcomes. Additionally, these data are often collected and reported from a deficit-based framework that focuses on needs and problems in a community, rather than assets and strengths. A deficit-based framework contributes to systemic bias that presents a limited view of a community's potential.

With this in mind, UCMC, Metopio, and all stakeholders were deliberate in discussing these limitations throughout the development of the CHNA and selection of the FY 2023-2025 health priority areas.

Significant Health Issues That Will Not Be Addressed

In acknowledging the wide range of priority health issues that emerged from the CHNA process, UCMC determined that it could only effectively focus on those which a) emerged as a top priority from the data collected, and b) fit within the current resources available. For example, UCMC has invested in asthma prevention/management for many years, but this did not emerge as a top priority for the population surveyed in this cycle (compared to other health issues that were perceived as more pressing). However, according to IHA COMPdata from 2020, asthma hospitalization rates in UCMC's service area were nearly three times that of the state of Illinois (106.14 per 100,000 residents versus 29.31). Therefore, UCMC will sustain its historical investment in asthma prevention/management to continue building community trust in these programs and further promote prevention on a population level. These efforts will take a similar form to those employed for chronic disease prevention (detailed on the following page), with a focus on addressing social determinants of health.

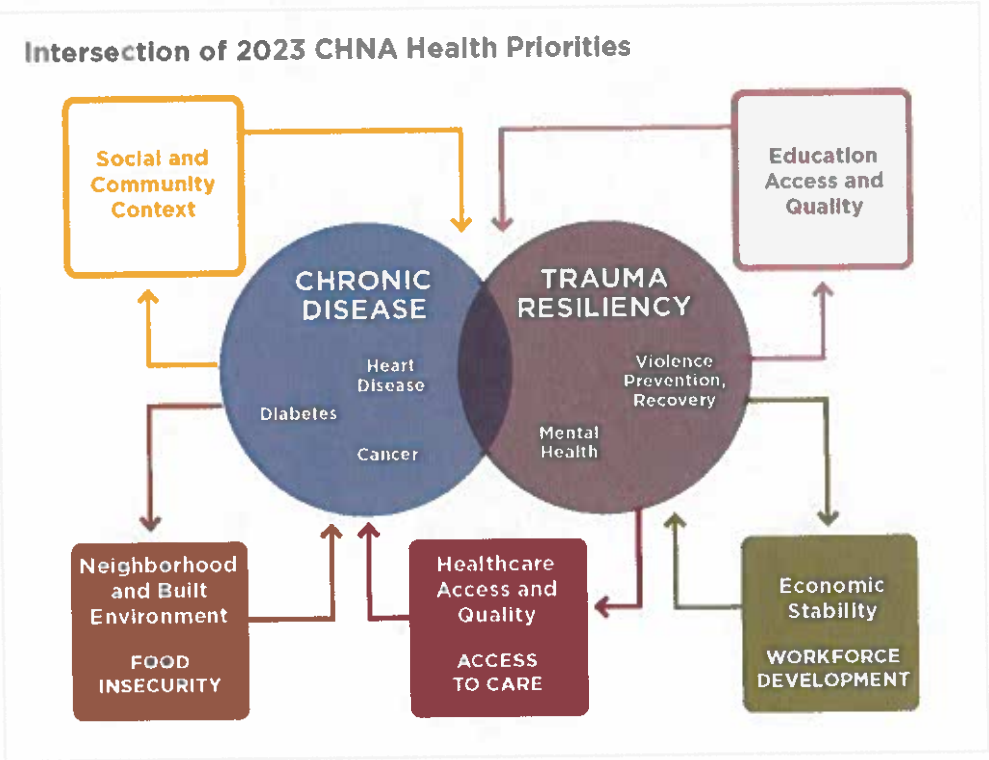
Health Priority Areas

UCMC retained the following primary health priority issues from the 2018-2019 CHNA: diabetes, violence prevention, mental health, access to food, employment (i.e. workforce development), and access to care. In response to the needs assessment, heart disease and cancer were added to the list.

The priority health areas are grouped by three themes that emerged from the CHNA data collection process: **chronic disease, trauma resiliency, and social determinants of health**.

Social determinants of health (SDOH) are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect health outcomes and risks, functioning, and quality of life.[4] These social, economic, and environmental conditions, in addition to health behaviors, relate to an estimated 80% of health outcomes in the United States.[5] See Figure 3 for a conceptual model demonstrating the intersection of social determinants of health with chronic disease and trauma resiliency.

Figure 3. Framework for Community Benefit Health Priorities



1 UCMCSA zip codes: 60609, 60615, 60617, 60619, 60620, 60621, 60628, 60636, 60637, 60643, 60649, 60653

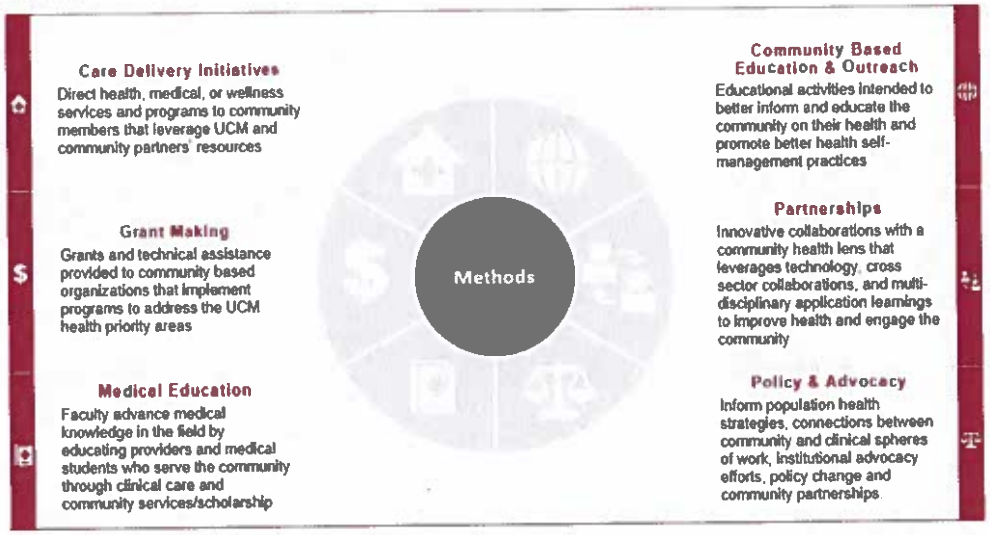
2 2018-2019 Community Health Needs Assessment

3 2018-2019 Community Health Needs Assessment

UCMC's Strategic Implementation Approach

All UCMC community benefit investments and programs are built on a framework that promotes health equity and is framed by the community benefit overarching goal to enhance community health and wellness around the CHNA priority health needs in the UCMC Service Area. To achieve this goal, UCMC executes its interventions, services, and/or programs through the following methods:

Figure 4. Implementation Approach



Examples of specific strategies and initiatives corresponding to each of the selected health priority areas are outlined on the following pages. See Appendix 1 for the fully detailed evaluation framework relating to these strategies. UCMC will continue to identify opportunities to implement interventions to address these priority needs.

4 Office of Health Promotion and Disease Prevention. Healthy People 2020. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

5 County Health Rankings & Roadmap. Available at: http://www.countyhealthrankings.org/our-approach

I. HEALTH PRIORITY AREA 1:
Chronic Disease

Addressing widespread chronic disease among adults is important to residents of all ages in the service area, as living with comorbidities is associated with a poorer quality of life and a lower life expectancy. It also contributes to financial instability and poor mental health. The first step to preventing chronic disease is to establish healthy behaviors. However, there are many impediments to living a healthy lifestyle in the UCMCSA. Regardless of age, residents struggle to access healthy food, safe places to exercise, healthy environments, screenings, and other preventive services.

Health Priority 1 Objective: Reduce the Impact of Chronic Disease			
STRATEGIES			
Provide screening and education opportunities for heart disease, diabetes, and cancer	**Empower community members to manage their heart disease, diabetes, and/or cancer**	**Increase access to care**	**Reduce inequities caused by social determinants of health (SDOH)**
» Expand free/subsidized screenings that include education » Continue community education initiatives focused on chronic disease prevention	» Increase access to healthy food » Manage comorbidities including hypertension and obesity	» Assist patients with healthcare navigation » Encourage patients to establish care with a primary care physician » Increase the capacity of the health system for primary and specialty care, internal and external to UCMC » Expand and streamline care coordination across the UCMC hospital system » Train healthcare staff in cultural competency, shared decision-making, and plain language	» Expand screening for social determinants of health across the health system » Connect patients and community members with resources such as housing, employment, food, and transportation, etc.

UCMC continues to **invest in care delivery initiatives** and **expand partnerships** that address primary, secondary, and tertiary prevention for heart disease, diabetes, and cancer. Key programs that support these initiatives are the Liaisons in Care Community Health Worker program, Patient Advocates program, Feed First, and the South Side Healthy Community Organization.

II. HEALTH PRIORITY AREA 2: Trauma Resiliency

The South Side, including the UCMCSA, has a history of trauma that is founded on structural and systemic disinvestment in these communities. Several causes of traumatic health outcomes co-exist on the South Side, adding daily pressure to residents seeking a healthy life. During focus groups, participants noted situations that contribute to trauma, including abuse, crime, and stigma around mental health, among others. As we consider building trauma resiliency, much of the work will be focused on violence prevention and mental health.

Health Priority 2 Objective: Improve Trauma Resiliency			
STRATEGIES			
Cultivate and maintain partnerships to improve community health and safety	**Embed trauma-informed care across the hospital system**	**Increase access to mental healthcare and services**	**Reduce inequities caused by social determinants of health (SDOH)**
» Continue building a violence prevention ecosystem that addresses mental health and social determinants of health » Build and strengthen partnerships with street outreach organizations across the South Side	» Promote hospital and community-based programs that serve unmet needs related to social determinants of health » Train healthcare staff in trauma-informed care, cultural competency, shared decision-making, and plain language » Expand the scope and capacity of the Violence Recovery Program to more holistically address patient and family needs	» Collaborate with internal and external efforts focused on providing mental health services » Increase the capacity of mental health services within UCMC and in the community » Execute interventions to address employee wellness » Implement behavioral health services within the primary care setting	» Expand screening for social determinants of health across the health system » Connect patients and community members with resources such as housing, employment, food, and transportation, etc.

UCMC continues to develop **partnerships**, create trauma-informed **medical education**, and engage in **community-based education and outreach** programs that prevent and treat trauma on the South Side. Key programs that support this health priority include the UCMC Violence Recovery Program, Healing Hurt People – Chicago, Southland RISE, and the South Side Healthy Community Organization. Programs targeted toward career development and employee wellness include the Workforce Resilience Enhancement Project and BRIDGE Initiative.

Community Benefit Report Communication

UCMC made its CHNA and Strategic Implementation Plan publicly available online via the UChicago Medicine website, after it was approved and adopted by the Board of Directors in May 2022. Additionally, UCMC will share the Strategic Implementation Plan with its Community Advisory Council and various external stakeholders (e.g., community members, local political representatives, faith leaders, healthcare providers, and community-based organizations), and make copies available upon request.

Appendix 1:

Priority Area #1: Chronic Disease

Goal: Prevent and manage risk factors known to worsen morbidity and mortality due to chronic disease

OBJECTIVE	STRATEGY	PROGRAMS, SERVICES, PARTNERSHIPS	ANTICIPATED IMPACT	METRICS
Objective 1: Provide screening and education opportunities about heart disease, diabetes, and cancer	Expand free/ subsidized screenings that include education components	» Mammogram screenings (SCORE) » Asthma screenings	Community members will have increased access to chronic disease screenings and educational tools, with access to clinical care when necessary	» Increased rates of chronic disease screenings » Number of events held » Number of event participants
	Continue community education initiatives focused on chronic disease prevention	» Community Affairs Grand Rounds » NCI Education Modules » Asthma Summit » Heart Walk » DEEP » Southside Fit » CHW programs	Community members will have increased access to chronic disease screening and educational tools, with access to clinical care when necessary	» Number of events held » Number of encounters where CHW-related roles provided health education
Objective 2: Empower community members to manage their heart disease, diabetes, and/or cancer	Increase access to healthy food	» FeedFirst » GB8 Garden » Home Veggie Rx » NowPow » Community Rx Hunger Clinical Trial/HealtheRx	Patients, employees, and the community will be aware of internal and external food programming and have increased food access	» Continue food pantries internal to UCMC » Number of programs that incorporate food referral services » Pounds of food distributed » Number of programs that screen for food insecurity
	Manage comorbidities like hypertension and obesity	» Population Health Nurse Team (diabetes/ hypertension outreach) » CHW programs » Patient Advocates » South Side Healthy Community Organization	Patients will understand their condition, know how to manage medication, and be aware of/ avoid lifestyle factors that could prompt readmission (high-salt diet, for example)	» Number of community members provided education on hypertension » Number of community members provided education on obesity » Number of patients engaged in Hypertension service line of LinC program » Number of supplies given to community members that assist in managing chronic conditions (glucometers, blood pressure cuffs, smoking cessation kits, etc.)

(CONTINUED)	STRATEGY	PROGRAMS, SERVICES, PARTNERSHIPS	ANTICIPATED IMPACT	METRICS
Objective 3: Increase access to care	Assist patients with healthcare system navigation	» Patient Advocates » CHW programs	Patients will have increased access to healthcare navigator resources and improved understanding of how to independently navigate their healthcare	» Improvement in patient satisfaction/experience » Reduction in out-of-network visits » Number of patients with documented medical homes
	Encourage patients to establish care with a primary care physician	» LinC CHW program » Patient Advocates » Population Health nurse team	Patients will seek preventive care from their PCP instead of relying on the ED for primary care	» Reduction in ED utilization
	Increase capacity of the health system for primary and specialty care internal and external to UCMC	» South Side Healthy Community Organization » Chicago Children's Health Alliance	Community members in the UCMCSA will have more options to meet their healthcare needs	» Reduction in ED utilization » Number of patient referrals to a medical home
	Expand and streamline care coordination across the UCMC hospital system	» LinC Community Health Worker program » Care coordination » South Side Healthy Community Organization » Patient Advocates » Population Health nurses	A patient's medical history and needs will be known by whichever provider they see in the UCMC service area	» Reduction in readmissions » Reduction in hospitalizations
	Train healthcare staff in cultural competency, shared decision-making, and plain language	» Office of Diversity, Equity, & Inclusion training series	Patients will be better informed about how to manage their health and will know how to (and feel comfortable to) seek support when needed	» Improvement in health knowledge » Improvement in patient satisfaction surveys
Objective 4: Reduce inequities caused by social determinants of health	Expand screening for social determinants of health across the health system	» CHW programs » Patient Advocates » Violence Recovery Program » Population Health » Social workers	More patients are screened for SDOH needs across the UCMC system	» Continue utilization of the SDOH screening tool in Epic » Expand the utilization of the SDOH screening tool in Epic to new service lines
	Connect patients and community members with resources like housing, employment opportunities, food, and transportation	» CHW programs » Patient Advocates » Violence Recovery Program » Population Health » Social workers	More patients receive referrals to organizations and/or services that address and mitigate social determinants of health	» Number of referrals related to social determinants of health » Number of community-wide events held to promote health » Number of engagements with virtual communications promoting health

Priority Area #2: Trauma Resiliency

Goal: Prevent, manage and promote recovery from trauma

OBJECTIVE	STRATEGY	PROGRAMS, SERVICES, PARTNERSHIPS	ANTICIPATED IMPACT	METRICS
Objective 1: Cultivate and maintain partnerships to improve community health and safety	Continue building a violence prevention ecosystem that addresses mental health and social determinants of health	» Community benefit grantmaking » Community- and faith-based partnerships » Southland RISE » Partnership with Mayor's Office » Chicago HEAL Initiative	Deepen community partnerships by maintaining and expanding community investment, supporting community-based programs, and highlighting community initiatives across the South Side	» Number of partners and programs working to build a violence prevention ecosystem » Number of external coalition-building events held or participated in » Number of grantees supported » Number of summits held
	Build and strengthen partnerships with street outreach organizations across the South Side	» Street Outreach Partnerships » Metro Peace Initiative	Community members will receive more support immediately following community incidents of violence	» Number of citywide street outreach meetings attended » Number of UCMC referrals to street outreach organizations » Number of incidents responded to/intervened by street outreach workers
Objective 2: Embed trauma-informed care across the hospital system	Promote hospital and community-based programs that serve unmet needs related to social determinants of health	» Grantmaking » Office of Diversity, Equity & Inclusion training series » Violence Recovery Program	Patients and community members will have increased access to screenings, interventions, and resources	» Number of SDOH screenings conducted by UCMC Violence Recovery Specialists » Number of referrals initiated by UCMC Violence Recovery Specialists » Number of grant programs supported that incorporate referrals related to social determinants of health
	Train healthcare staff in trauma-informed care, cultural competency, shared decision-making, and plain language	» Office of Diversity, Equity & Inclusion training series	» Staff will have sufficient resources and training to perform culturally competent, trauma-informed care across the organization » Patient resources and education materials will be easy to understand	» Number of staff trained in resiliency-based care » Improvement in patient satisfaction surveys » Improvement in staff satisfaction surveys
	Expand the capacity and scope of the Violence Recovery Program to more holistically address patient and family needs	» Violence Recovery Program » Healing Hurt People-Chicago » Med-Legal Partnerships	Patients and their families receive ongoing support after a traumatic event	» Number of patients receiving case management services » Number of patients receiving Med-Legal services » Number of patients

(CONTINUED)	STRATEGY	PROGRAMS, SERVICES, PARTNERSHIPS	ANTICIPATED IMPACT	METRICS
Objective 3: Increase access to mental healthcare and services	Collaborate with internal and external workgroups working on mental health	» Community- and faith-based partnerships » Youth-oriented programs » Grantmaking	Community members will have more access to community-based mental health services and resources	» Number of workgroups » Number of external partnerships » Amount of grant funding
	Increase capacity of mental health services	» South Side Healthy Community Organization » REACT and USTAR » Healing Hurt People-Chicago » TURN Center	» More patients and community members will have access to mental health services » Patient wait times for appointments will decrease	» Number of behavioral health and/or mental health providers added to the UCMCSA » Number of referrals to behavioral health services
	Execute interventions to address employee wellness	» Workforce Resilience Enhancement Project	Staff receive ongoing support to: » Reduce compassion fatigue » Increase resilience » Emphasize employee wellbeing	» Number of employees participated in ECHO-Chicago Workplace Resilience series » Improvement in staff satisfaction surveys
	Implement behavioral health services within the primary care setting	» Behavioral Health Integration Program	» Mental health screenings and care will be embedded in the primary care processes	» Number of mental health screenings conducted during PCP visits » Number of mental health referrals via PCP visits
Objective 4: Reduce inequities caused by social determinants of health	Expand screening for social determinants of health across health system	» CHW programs » Patient Advocates » Violence Recovery Program » Population Health » Social workers	» More patients are screened for SDOH needs across the UCMC system	» Number of patients screened for SDOH needs
	Connect patients and community members with resources like housing, employment opportunities, food, and transportation	» CHW programs » Patient Advocates » Violence Recovery Program » Population Health » Social workers » Community Affairs Programs	More patients receive referrals to organizations and/or services that address and mitigate the social determinants of health	» Number of referrals related to social determinants of health » Number of community-wide events held to promote health » Number of engagements with virtual communications promoting health
	Increase the local workforce's commitment to address economic hardship	» Inclusive Pathways program (HR) » BRIDGE Initiative Chicago (HR) » NSA Pathway Program » MAPP (HR with West Side United)	Community members will have more pathways to career opportunities that will lead to better economic agency	» Number of community health workers hired from the UCMC service area » Number of individuals placed in career development programs » Number of resulting hires from career development programs » Workforce diversity

Contact for Feedback

Any questions or concerns regarding the CHNA, Strategic Implementation Plan, or Community Benefit Evaluation Report can be sent to uch-communitybenefit@uchicagomedicine.org.

AT THE FOREFRONT
UChicago Medicine

AT THE FOREFRONT
UChicago Medicine

Community Health Needs Assessment 2021-2022

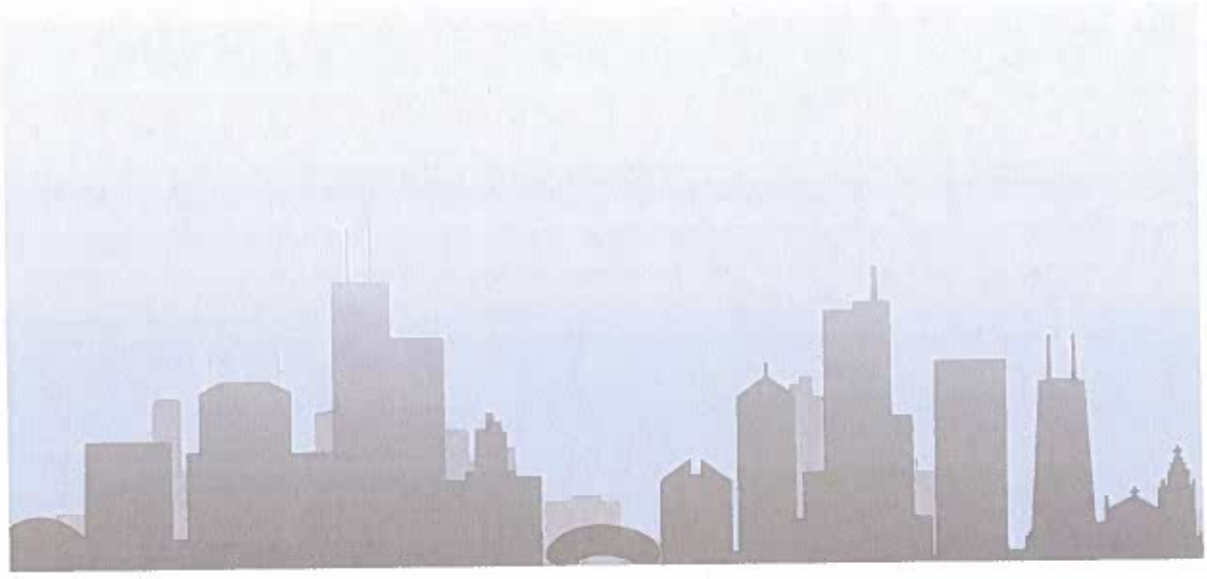


Table of Contents

University of Chicago Medical Center (UCMC) Community Health Needs Assessment (CHNA) identifies community health priorities, which guide the hospital on where to commit resources that can most effectively improve community members' health and wellness.

Based on community input and analysis of a myriad of data, the priorities for the communities served by UChicago Medical Center for Fiscal Years 2023-2025 are:

IRS Form 990, Schedule H Compliance

For nonprofit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Form 990, Schedule H, the following table cross-references related sections.

Section	Description	Pages
Part V Section B Line 3a	*A definition of the community served by the hospital facility*	7
Part V Section B Line 3b	*Demographics of the community*	10
Part V Section B Line 3c	*Existing healthcare facilities and resources within the community that are available to respond to the community's health needs*	68
Part V Section B Line 3d	*How data was obtained*	8-13
Part V Section B Line 3e	*The significant health needs of the community addressed by the hospital facility*	Throughout
Part V Section B Line 3f	*Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups*	Throughout
Part V Section B Line 3g	*The process for identifying and prioritizing community health needs and services to meet community health needs*	64-65
Part V Section B Line 3h	*The process for consulting with persons representing the community's interests*	8-9
Part V Section B Line 3i	*The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)*	Appendix 2

Introduction

A goal of the University of Chicago Medical Center (UCMC) is to improve the health of the communities we serve. UCMC seeks to understand community needs through a Community Health Needs Assessment (CHNA) process that is systematic and data-driven. UCMC directly engages with community members and stakeholders to identify the issues of greatest need and determine the largest impediments to health. This information helps UCMC allocate resources toward improving overall health and reducing inequities.

The important work of CHNA was codified in the Patient Protection and Affordable Care Act through the addition of Section 501(r) to the Internal Revenue Service Code, which requires nonprofit hospitals, including UCMC, to conduct a CHNA every three years. UCMC completed similar needs assessments in 2012, 2015, and 2018.

The process UCMC used was designed to meet federal requirements and guidelines in Section 501(r), including

- Clearly defining the community served by the hospital and ensuring that the defined community does not exclude low-income, medically underserved, or minority populations in proximity to the hospital
- Providing a clear description of the CHNA process and methods, community health needs, partners and collaborators, including public health experts, and existing facilities and resources in the community
- Receiving input from persons representing the broad needs of the community
- Documenting community comments on the CHNA and the identified health needs in the community
- Documenting the CHNA in a written report and making it widely available to the public

The following report provides an overview of the process used for this cycle's CHNA, including data collection methods and sources, UCMC's service area, historical inequities faced by the residents in the service area, and considerations of how COVID-19 has impacted community needs.

Included in Appendix 2 is an evaluation report summarizing our past efforts to address the community needs identified in the 2018–19 CHNA.

UCMC OVERVIEW

The University of Chicago Medical Center (UCMC), one of the nation's leading academic medical institutions, has been at the forefront of medical care since 1927. Renowned for treating some of the most complex medical issues, UCMC brings the very latest medical treatments to patients in the City of Chicago, across Illinois, and around the world. In this way, UCMC furthers its commitment to patient care, clinical practice, and community health.

UCMC partners with University of Chicago physicians and University of Chicago's Pritzker School of Medicine to educate the next generation of physicians and other healthcare professionals. UCMC is a leading provider of complex care in the state of Illinois, the largest provider of Medicaid services (by admissions and patient days) on the South Side of Chicago, and the largest provider of inpatient and outpatient care by volume in the state of Illinois.

UCMC's mission is to provide superior healthcare in a compassionate manner, ever mindful of each patient's dignity and individuality. To accomplish our mission, we call upon the skills and expertise of all who work together to advance medical innovation, serve the health needs of the community, and further the knowledge of those dedicated to caring. Our aim to "serve the health needs of our community" anchors our mission statement and shapes the ethos and work of University of Chicago Medicine. Our community advises us on strategy, informs our research, and partners with us for collective impact toward improving the health and wellness of our community.

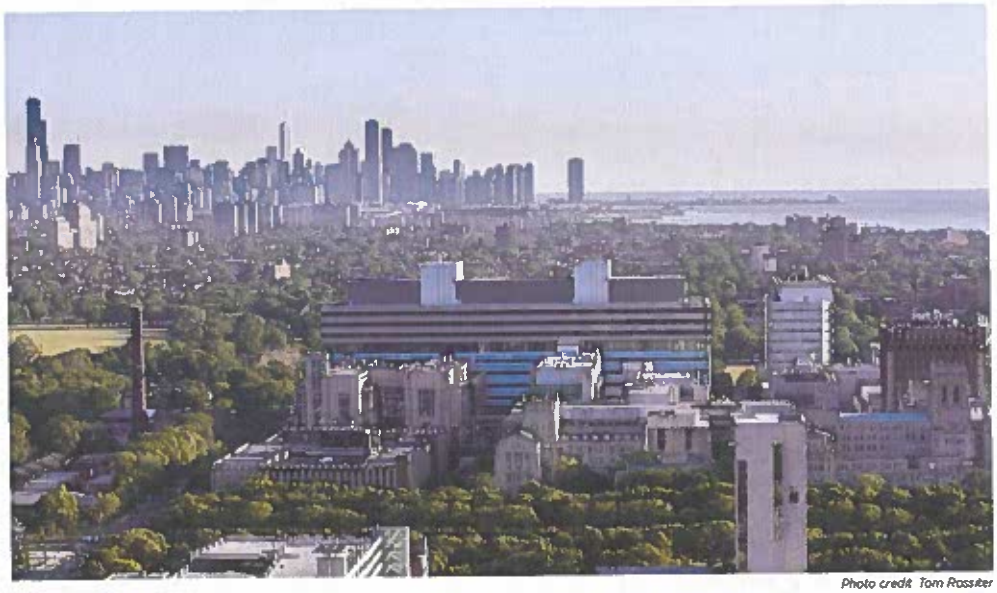


Photo credit: Tom Rossiter

URBAN HEALTH INITIATIVE

The Urban Health Initiative (UHI) is UCMC's community health division. The UHI oversees population health management and community benefit programs, working with community health centers, community hospitals, community-based organizations, local schools, churches, and other groups to develop innovative strategies to improve the quality of and access to services on the South Side.

UHI serves as a two-way bridge to the community and ensures UCMC is an active part of improving the lives of residents in the medical center's service area. UHI builds goodwill, social capital, and the relationships needed to create new services and programs addressing population health. Community health challenges are approached with a collaborative, community-based, and participatory focus that promotes health equity. UHI develops high-quality educational programs and communications that reflect and address the needs of community residents.

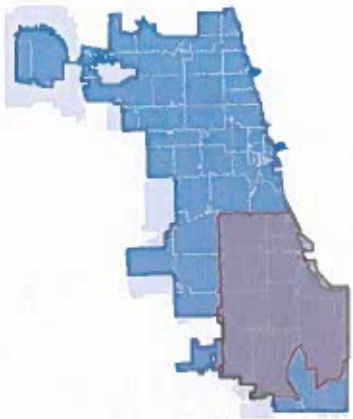
UHI's asset-based community development approach is delivered by the following departments, which make up the UHI:

- Community Benefit & Evaluation: Tracks community benefit activities and oversees UCMC's compliance with 501(r) regulations
- Office of Community Affairs: Organizes and supports activities and events in the community
- Office of Diversity, Equity, and Inclusion: Advances health equity by building cultural competency and health literacy
- Strategic Affiliations and Evaluation: Supports UCMC's efforts to reduce health disparities and promote health equity by partnering with hospitals and clinics on the South Side of Chicago to measure outcomes and evaluate the impact of UHI programs
- Volunteer Services: Manages volunteer services at the hospital

UCMC SERVICE AREA

The UCMC community benefit service area (UCMCSA) is represented by 12 zip codes that surround the medical center campus on the South Side of Chicago. The service area is also comprised of 28 Chicago Community Areas, with partial coverage of additional communities.

In the results section, we describe the demographic and socioeconomic characteristics of our 12 zip-code service area population and present the health indicators that are available by zip code or census tract. The remainder of this document incorporates community area-level data for communities included in the 12 zip codes and 28 community areas. The decision to use community area-level data was based on 1) presenting accessible data in a format that Chicago residents easily identify (neighborhood versus zip codes), 2) aligning with public health departments and other hospital systems that are collecting and analyzing Chicago data by community area, and 3) using available data for disease prevalence, incidence, and mortality, which are not available at the zip code level.



Zip Codes					
60609	60615	60617	60619	60620	60621
60628	60636	60637	60643	60649	60653

UCHICAGO MEDICINE SERVICE AREA

Zip Codes and Community Areas*

60609
Armour Square
Bridgeport
Douglas
Fuller Park
Gage Park
Grand Boulevard
McKinley Park
New City
Washington Park

60615
Grand Boulevard
Hyde Park
Kenwood
Washington Park

60617
Avalon Park
Calumet Heights
East Side
Hegewisch
South Chicago
South Deering

60619
Avalon Park
Burnside
Calumet Heights
Chatham
Greater Grand Crossing
Roseland
South Shore

60620
Ashburn
Auburn Gresham
Beverly
Chatham
Englewood
Greater Grand Crossing
Roseland
Washington Heights

60621
Englewood
Greater Grand Crossing
Washington Park

60628
Pullman
Riverdale
Roseland
Washington Heights
West Pullman

60636
Chicago Lawn
Gage Park
West Englewood

60637
Greater Grand Crossing
Hyde Park
South Shore
Washington Park
Woodlawn

60643
Beverly
Morgan Park
Washington Heights
West Pullman

60649
South Shore
Woodlawn

60653
Douglas
Grand Boulevard
Kenwood
Oakland

* Some community areas stretch across multiple zip codes. Our community benefit service area extends only to those parts of a community area within the 12 zip codes identified.

ATTACHMENT 38

CHNA Process and Methods

Stakeholder Engagement

The CHNA process engaged several internal and external stakeholders to collect, curate, and interpret data, and then use that data to prioritize the health needs of the community. Partners and stakeholder groups also provided insight and expertise around the indicators to be assessed, types of focus group questions to be asked, interpretation of results, and prioritization of areas of highest need.

Metopio is a software and services company grounded in the philosophy that communities are connected through places and people. Metopio's visualization tools use data to reveal valuable, interconnected factors that influence outcomes in different locations. Leaders from the UHI worked with Metopio to guide the strategic direction of the CHNA and engage the CHNA Steering Committee, other various internal committees, and workgroups to ensure broad engagement of diverse perspectives across UCMC.

The Community Benefit Steering Committee is comprised of staff and faculty who provide advice and oversight of UCMC's community benefit programs, reporting, and CHNA development and execution. The committee is responsible for providing input on the planning and implementation of policies, processes, and programs that support the community benefit function. The committee meets quarterly and oversees the development and implementation of the Community Health Needs Assessment and Community Benefit/Implementation Strategy Reports.

The Community Advisory Council (CAC) was established by the UHI in 2016 and is comprised of a representative group of 20 volunteer members who live and/or work in the UCMCSA. The CAC members serve as advisors to UCMC on issues of interest to the community. The CAC is an essential partner in achieving UCMC's goals related to broader community interests, community benefit, access to care, and effective community engagement.

The CAC has advised UCMC leadership on pivotal projects including, but not limited to, designing community communication and engagement plans that inform our CHNA, as well as programming connected to the Strategic Implementation Plan. Specifically, the CAC played a key role in identifying community organizations for our focus groups, disseminating the survey, and ensuring diverse community voices were heard throughout the CHNA process.

In alignment with UCMC's mission, vision, and values and UHI's purpose, engagement of both internal and external stakeholders is a critical component of assessing and addressing community health needs.

The CHNA Steering Committee developed parameters for the 2021–2022 CHNA process that help drive UHI and UCMC's work:

- The CHNA builds on prior CHNAs from 2018–2019, as well as other local assessments, regional assessments, and plans.
- The CHNA provides greater insight into community health needs and strategies for ongoing community health priorities, including the UCMC Strategic Implementation Plan.
- The CHNA leverages the expertise of community residents, community partners, and key stakeholders, with careful consideration and inclusion of a broad range of sectors and voices that are disproportionately affected by health inequities.

- The CHNA provides an overview of the community health status of a designated area and highlights data related to health inequities
- The CHNA informs strategies related to population health, connections between community and clinical sectors, anchor institution efforts, policy change, and community partnerships
- The CHNA highlights and discusses health inequities and their underlying root causes throughout the assessment

Data Collection

UCMC conducted its CHNA between April 2021 and February 2022 using a process that was adapted from the Mobilizing for Action through Planning and Partnerships (MAPP) framework.[1] This planning framework is one of the most widely used for CHNAs. It focuses on community engagement, partnership development, and inclusion of those who have historically been excluded from decision-making processes. The MAPP framework was developed in 2001 by the National Association for County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC).

Primary data for the CHNA was collected through four channels:

- Community resident surveys
- Community resident focus groups
- Healthcare and social service provider focus groups
- Key informant interviews

Secondary data for the CHNA were aggregated by Metopio on their data platform and included:

- Hospital utilization data
- Secondary sources including, but not limited to, the American Community Survey, the Decennial Census, the Centers for Disease Control and Prevention, the Environmental Protection Agency, Housing, and Urban Development, and the Chicago Department of Public Health

Primary and secondary data from a diverse range of sources were utilized for robust data analysis and to identify community health needs in the UCMCSA.

Community Resident Surveys

Between July 2021 and November 2021, 975 residents in the UCMCSA contributed to the CHNA process by completing a community resident survey. The survey was available online and in paper form, and it was offered in both English and Spanish. UCMC and its community partners distributed the survey through multiple channels. The survey sought input from priority populations in the UCMCSA that are typically underrepresented in assessment processes, including communities of color, immigrants, persons with disabilities, members of the LGBTQ+ community, and low-income residents. The survey was designed to collect information regarding:

- Demographics of respondents
- Perception of health needs for different age groups in the community
- Perception of community strengths
- Utilization and perception of local health services

The survey was based on a design used extensively for CHNAs by public health agencies across Illinois. UCMC hosted 12 survey development feedback sessions with internal and external stakeholders to develop the final tool. Based on their input and final consensus, the survey deviated from previous versions as UCMC sought more specific input from respondents on community health needs for different age groups. Respondents were asked to identify the health needs of Youth (0-17 years), Adults (18-64 years), and Seniors (65+ years). The final survey included 29 questions. The full community resident survey and summary of results can be found in Appendix 1. Table 1 summarizes the demographics of survey respondents in the UCMCSA.

Table 1. Demographics of Community Input Survey Respondents in UCMC Communities

Age (n=975)	
18-24	3.0%
25-44	25.9%
45-64	39.9%
65 and older	31.2%
Gender Identity (n=974)	
Male	16.3%
Female	82.0%
Transgender man, FTM	0.0%
Transgender woman, MTF	0.0%
Genderqueer/gender-nonconforming	0.4%
Other	0.22%
Decline to answer	1.0%
Orientation (n=964)	
Straight or heterosexual	87.6%
Lesbian or gay	2.3%
Bisexual	4.4%
Queer, pansexual, and/or questioning	0.9%
Other	0.5%
Don't know	0.5%
Decline to answer	3.8%
Race (n=972 with multiple answers allowed)	
American Indian or Alaska Native	1.5%
Asian or Mideast Asian	1.5%
Black or African-American	70.7%
Choose to not disclose	3.1%
Hispanic/Latino(a)	5.3%
More than one race	5.2%
Unknown	0.7%
White	15.2%

Education (n=963)	
Less than high school	0.7%
Some high school	1.9%
High school graduate or GED	6.7%
Vocational or technical school	1.5%
Some college	20.5%
College graduate	30.1%
Advanced degree	38.6%
Current Living Arrangements (n=963)	
Own my home	58.9%
Rent my home	33.7%
Living in emergency or transitional shelter	0.3%
Living outside	0.2%
Living with a friend or family	5.3%
Other	1.6%
Average Number of Children in Home	0.54
Disability in Household	151
Income (n=885)	
Less than $10,000	7.7%
$10,000 to $19,999	5.6%
$20,000 to $39,999	12.3%
$40,000 to $59,999	16.8%
$60,000 to $79,999	16.9%
$80,000 to $99,999	11.3%
Over $100,000	29.3%

Community Focus Groups and Key Informant Interviews

A critical part of robust, primary data collection for the CHNA involved speaking directly to community members, partners, and leaders that live and/or work in the UCMCSA. This was done through focus groups and key informant interviews.

UCMC held six focus groups between September and November 2021, each covering a specific health area. All focus groups were coordinated by UCMC and facilitated by Metopio. As in the community resident surveys, UCMC sought to ensure groups included a broad range of individuals from priority populations in the UCMCSA that are typically underrepresented in assessment processes, including communities of color, immigrants, persons with disabilities, members of the LGBTQ+ community, and low-income residents. Focus group health topic areas included:

- Adult Health
- Maternal and Child Health
- Youth Health
- Community Safety and Violence
- Mental Health
- Healthcare and Social Service Providers

Due to the COVID-19 pandemic, UCMC conducted most of its focus groups virtually over Zoom. Each focus group lasted 90 minutes with up to 12 community members participating in each one.

In addition to the six focus groups, the CHNA Steering Committee identified 10 key informants for 1:1 interviews. Each informant represented a vulnerable or medically underrepresented population and was selected to further explore themes that emerged from the community resident surveys and community focus groups. Key informant interviews were conducted virtually by Metopio and lasted 30 minutes each.

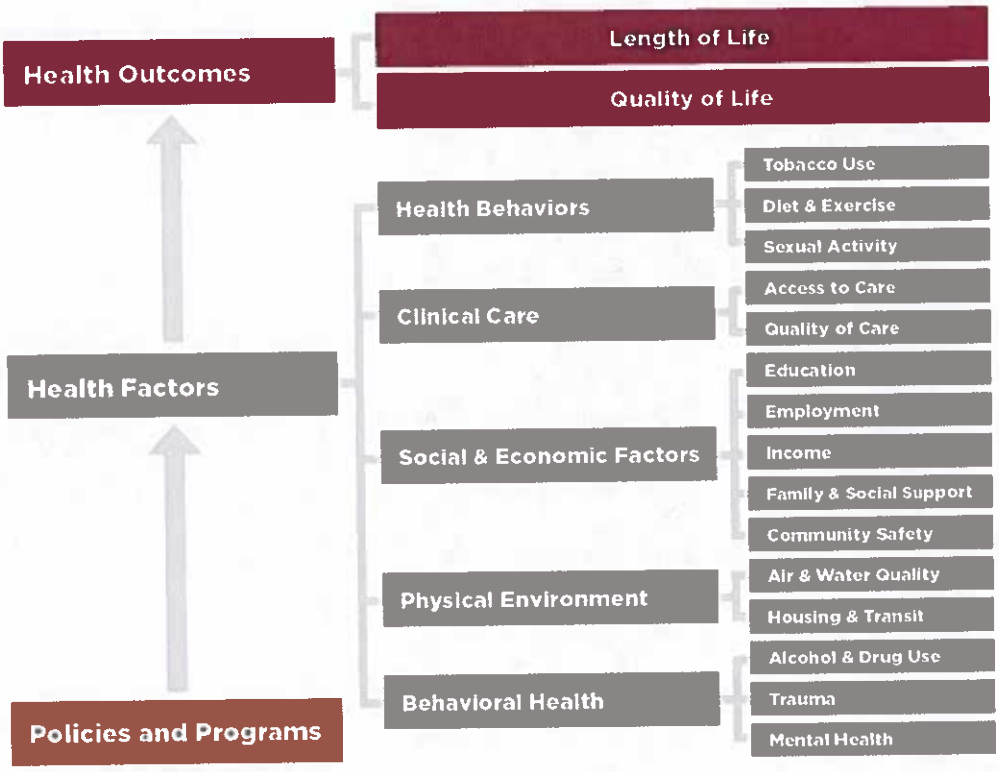
Secondary Data

UCMC used a common set of health indicators to understand the prevalence of morbidity and mortality in the UCMCSA, then compared these metrics to benchmark regions at the county, state, and federal levels. Building on previous CHNA work, these measures were adapted from the County Health Rankings Model[1] (see Figure 1 on the next page).

Given community input on economic conditions and community safety, UCMC sought more granular datasets to illustrate hardship. Data with stratifications were used when available to better explore and better articulate health inequities in detail.

Secondary data included population health and demographic data from myriad sources, including Illinois Hospital Association (IHA) COMPdata. All data were uploaded and analyzed using the Metopio data platform. A full list of data sources is included in Appendix 3.

Figure 1. Adapted County Health Rankings and Roadmaps Model



Modified from County Health Rankings and Roadmaps Model, 2014, http://www.countyhealthrankings.org/

Data Needs and Limitations

UCMC and Metopio made substantial efforts to comprehensively collect, review, and analyze primary and secondary data. However, there are limitations to consider when reviewing CHNA findings:

- Population health and demographic data are often delayed in their release, so data is presented for the most recent years available for any given data source.
- Variability in the geographic level at which data sets are available (ranging from census tract to statewide or national geographies) presents an issue, particularly when comparing similar indicators collected at disparate geographic levels. Whenever possible, we have reported the most relevant localized data.
- Due to variations in geographic boundaries, population sizes, and data collection techniques for suburban and city communities, some datasets are not available for the same periods or at the same level of localization throughout the county.
- Gaps and limitations persist in data systems for certain community health issues, such as mental health and substance use disorders for both youth and adults, crime reporting, environmental health statistics, and education outcomes. Additionally, these data are often collected and reported from a deficit-based framework that contributes to systemic bias.

With this in mind, UCMC, Metopio, and all stakeholders were deliberate in discussing these limitations throughout the development of the CHNA and the selection of the Fiscal 2023-2025 health priority areas.

Historical Inequities and Structural Barriers To Health

Chicago has a long, well-documented history of unfair policies that disproportionately burden communities of color. The South Side is a storied and unique collection of vibrant, resilient, culturally rich, and diverse communities. Steeped in African-American heritage and history, the South Side is marked by deep social bonds anchored in neighborhoods and faith-based organizations. However, generations of structural inequities and neglect have contributed to the erosion of the critical social, economic, and health ecosystem necessary to adequately meet the needs of this community.

For decades, institutions and systems of power at the national and city level, including those located on the South Side, have perpetrated racial discrimination through housing, employment, education, healthcare, and criminal justice policies. The literature demonstrates that residentially segregated neighborhoods have an unequal distribution of resources and worse health outcomes, including substandard housing, limited opportunities for high-quality education and employment, lack of access to quality healthcare, increased risk of chronic diseases, more exposure to air pollutants, lower life expectancy, and higher crime rates.

Structural racism in the form of residential segregation continues to persist in the City of Chicago, and the result of this is visible in the limited economic opportunities and adverse health outcomes experienced by residents in the UCMCSA. The disparities in life expectancy for South Side residents are evident; the life expectancy for residents in Englewood is estimated to be 30 years less than residents in Streeterville, a community area on the North Side of the city.[3]

The last CHNA cycle noted that the unemployment rate of those living in the UCMCSA was three times the national rate. That ratio still held true through the most recent data available from the American Community Survey (16% compared to 5%). When residents struggle to find affordable

housing, good jobs, or quality education, it becomes harder and harder to make healthy lifestyle choices, and nearly half of residents in the UCMCSA are at risk of food insecurity. UCMCSA residents also have significantly higher rates of chronic disease, including diabetes, heart disease, and certain cancers.

Every community has a right to be healthy, and UCMC remains committed to working with our partners to address the structural and systemic barriers our community faces.

Consideration of COVID-19

A question faced during this CHNA was, "Is the pandemic its own health issue, or is it a contributing factor to existing community health needs?"

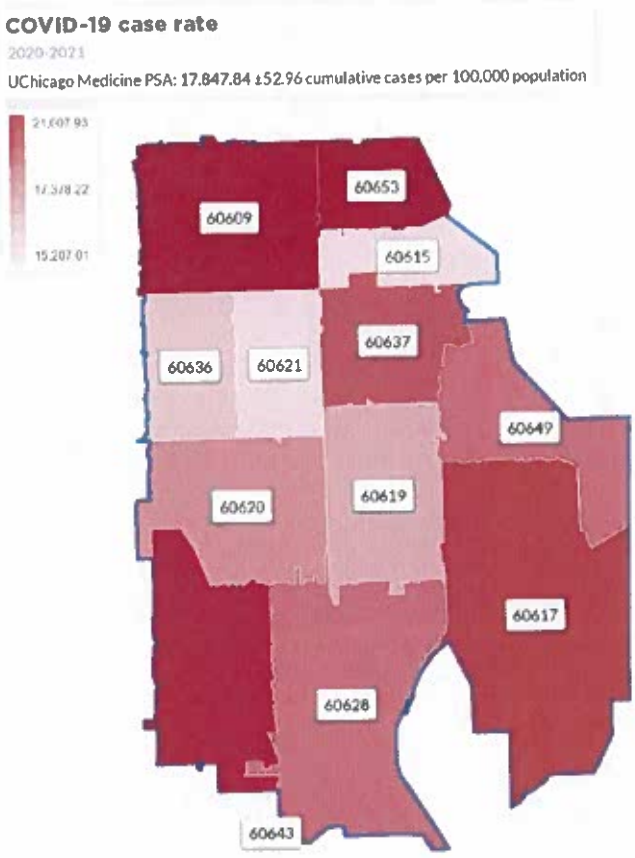
The COVID-19 pandemic has laid bare the longstanding structural drivers of health inequities on the South Side of Chicago. Early in the pandemic, the UCMCSA experienced high case rates and case fatality rates compared to Illinois and the United States. In 2020, COVID-19 became the third leading cause of death in the UCMCSA. While causal factors are hard to pinpoint, several important determinants of health are more pronounced in the UCMCSA, including a lack of access to care, higher rates of chronic disease, being an essential worker who might experience adverse working conditions, and a reliance on public transit, to name a few. These vulnerabilities certainly exacerbated the spread and impact of COVID-19.

The challenges of COVID-19 in the UCMCSA shined a light on longstanding inequities in the community. This was repeatedly demonstrated throughout the needs assessment process. But COVID-19 was not an issue that rose to the top of community concern, as demonstrated in the survey results in Table 2, most community members were not directly impacted by a COVID-19 diagnosis or hospitalization, but they did experience challenges in delayed medical care, loss of income, and feelings of depression. In focus groups and key informant interviews, residents emphasized the need to address the compounding barriers to health equity, like access to jobs, housing, food, safety, and care—resources that are necessary for long-term community resilience and weathering public health crises, both now and in the future.

Table 2. Community Input Survey Responses to COVID-19 Questions (n=939)

Were you or anyone in your household diagnosed with COVID-19 since March 2020?	**% of Respondents**
Yes	15.4%
No	84.6%
Were you, or was anyone in your household, hospitalized since March 2020 due to COVID-19?	
Yes	2.7%
No	97.3%
Because of the pandemic, did you delay or avoid medical care?	
Yes	42.8%
No	57.1%
Have you, or has anyone in your household, had a loss of employment income during the pandemic (since March 2020)?	
Not at all	45.9%
Several days every month	40.3%
More than half the days every month	10.0%
Nearly every day	5.0%

Note. Survey responses were collected between July 2021 and November 2021, prior to the omicron coronavirus variant surge.



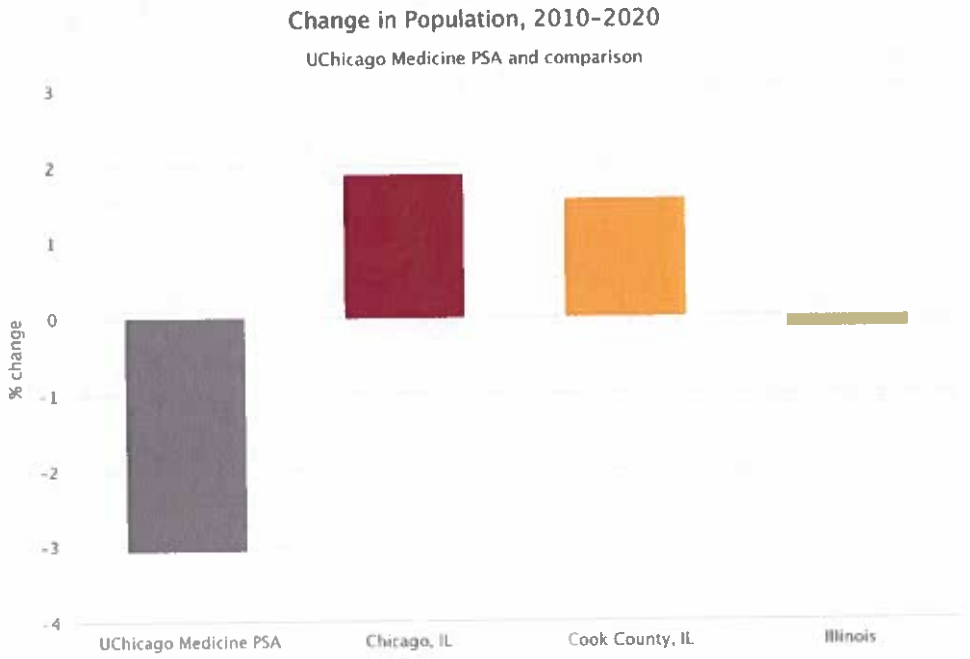
Data sources: The New York Times (based on reports from state and local health agencies), Various state health departments (COVID dashboards)

ATTACHMENT 38

CHNA Results

DEMOGRAPHIC CHARACTERISTICS

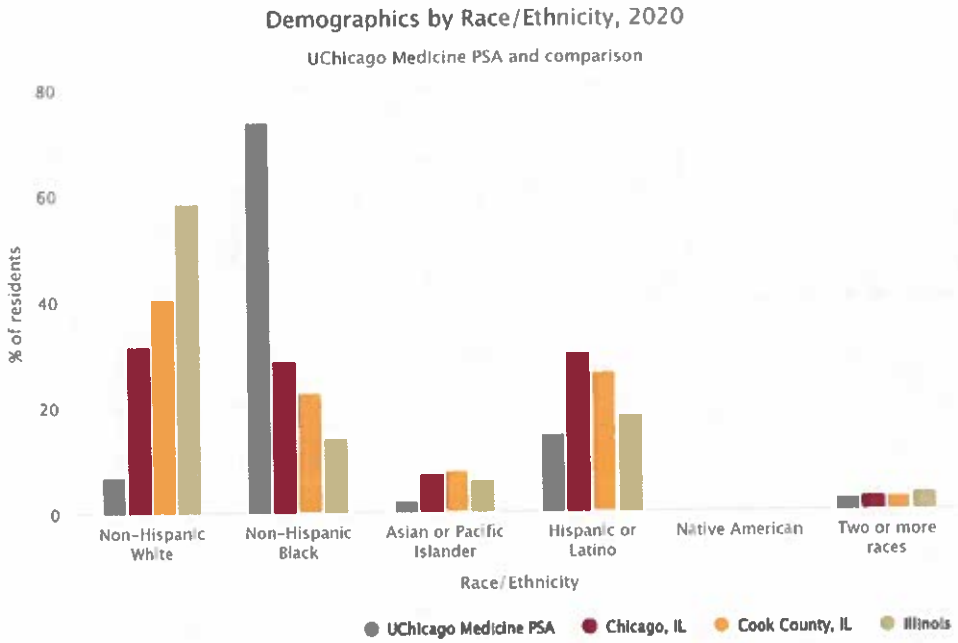
The population of the UCMCSA has changed significantly over the last decade. The 2020 Census revealed that the UCMCSA's population declined by 3.1%, while the total population of Chicago increased by 1.9%. Currently, 626,264 people live in the UCMCSA. In particular, the Black population saw a roughly 6% decrease since the previous CHNA, while the Hispanic or Latinx population increased by nearly 20%.



Created on Metopio | https://metop.io | Data source: Decennial Census (Derived from 2010 and 2020 Census data)
Change in Population: Percent change of population between the 2010 and 2020 decennial census

ATTACHMENT 38

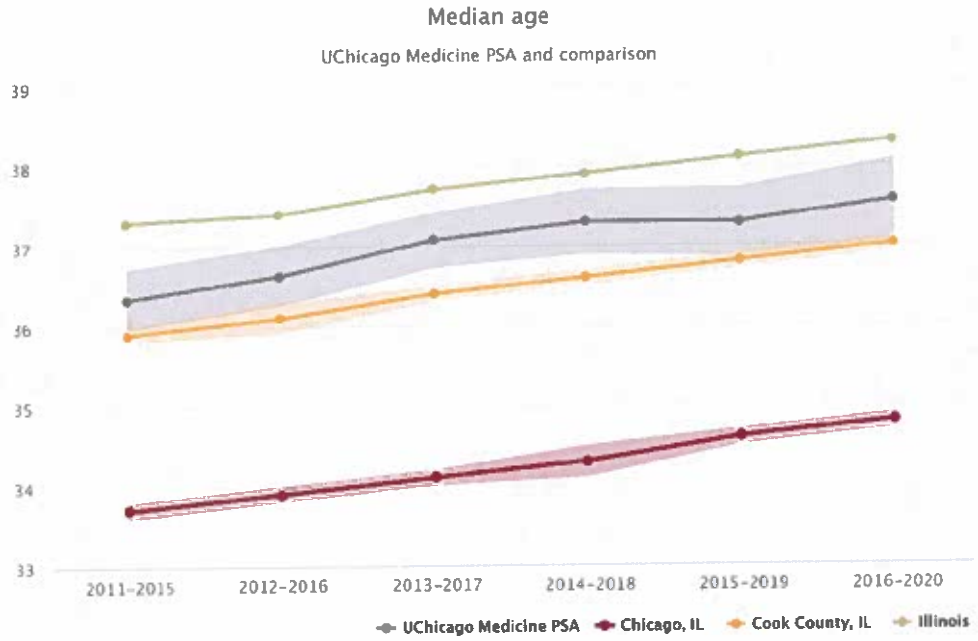
The overwhelming majority of the UCMCSA is Black, making up 73.7% of the population, compared to 28.7% in all of Chicago. Hispanic or Latinx people account for 14.6% of the UCMCSA population (29.8% citywide), non-Hispanic Whites represent 6.9% of the UCMCSA population (31.5% citywide), and Asians account for 2.0% (6.9% citywide).



Created on Metopio | https://metopio.io/q/t3ph-eg | Data source: American Community Survey (Table B01001)
Demographics: Percent of residents within each major demographic group. Use this topic to explore age, gender, and racial/ethnic breakdowns. This topic is expressed as a percent; to see a breakdown of all residents (pie or area chart), use Population (POP).

ATTACHMENT 38

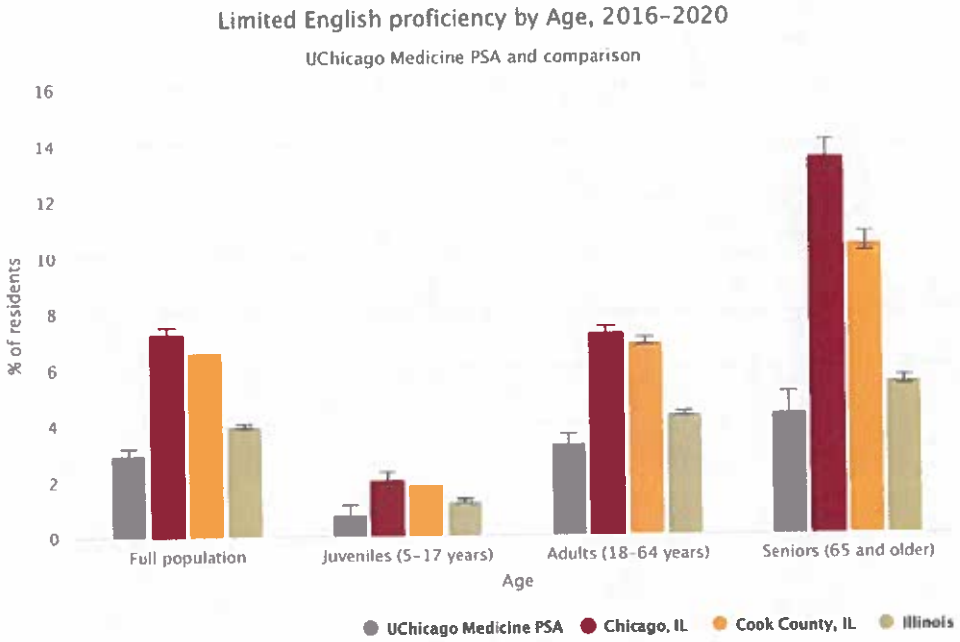
Females make up 54.5% of the UCMCSA population and males represent 45.5%, which is a slightly larger difference than in Chicago, where 51.2% of the population is female and 48.6% is male. The median age in the UCMCSA is 37.5 years old, which is over 2.5 years older than Chicago's median age of 34.8.



Created on Metopio | https://metop.io | Data source: American Community Survey (Table E01002)
Median age: The median age represents the age of the "middle" resident. If they were all lined up from youngest to oldest. (Half of all residents are older than this, and half are younger.)

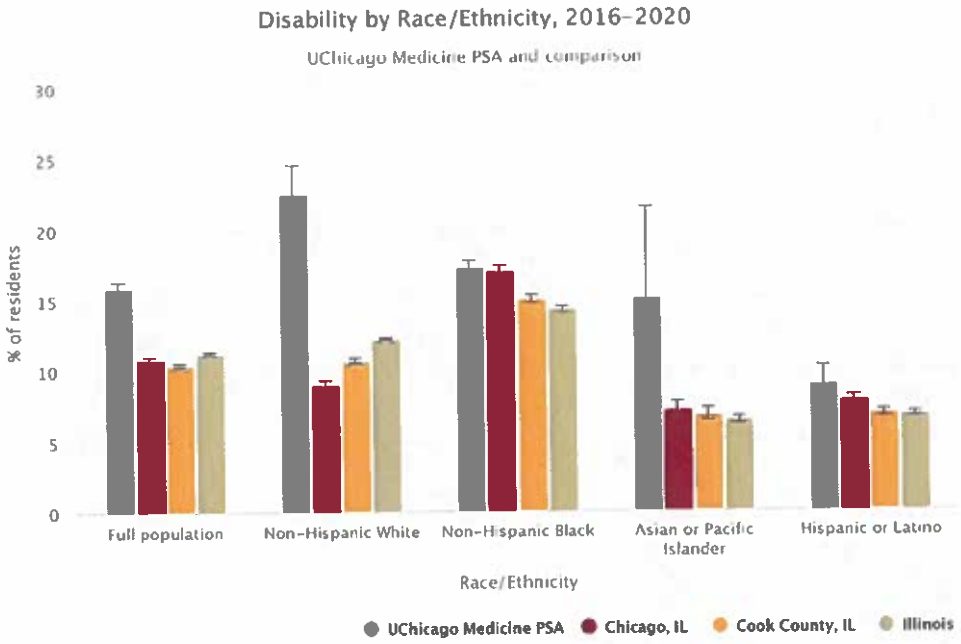
ATTACHMENT 38

In the UCMCSA, 2.8% of households include someone who speaks limited English. This is substantially lower than the 7.6% of households in Chicago that speak limited English. Limited-English households are primarily concentrated in two zip codes in the UCMCSA—60609 (13.8%) and 60617 (6.4%).



ATTACHMENT 38

The UCMCSA has higher rates of residents with a disability (15.9%) than Chicago (10.8%) or the state (11.2%). Disability here is defined as one or more sensory disabilities or difficulties with everyday tasks.



Created on Metopio | https://metopio | Data source: American Community Survey (Table S1810)
Disability: Percent of residents with a disability, defined as one or more sensory disabilities or difficulties with everyday tasks (topics DIF, DIU, DIV, DIW, DIX, and DIY)

ATTACHMENT 38

GENERAL COMMUNITY INPUT

Community residents who participated in focus groups and the survey provided in-depth input about how specific health conditions impact community and individual health. Key insights from this community input are highlighted below.

Community Survey Priorities

In the community survey, residents were asked to rank the top health needs of three different age groups: Youth (0-17 years old), Adults (18-64 years old), and Seniors (65+ years old). Stratifying priority health needs and opportunities for improvement by age provides a more granular understanding of community needs. The following question was asked about each of the three age bands, and the top five responses across all respondents are shown below. Mental health is the only health issue that appeared across all three age groups, while violent crime, obesity, diabetes, and access to healthy food items were selected by respondents as top needs for two of the three age groups.

Figure 3. Tell us what you think are the 5 most important health problems in the area where you live for Youth (0-17 years old).

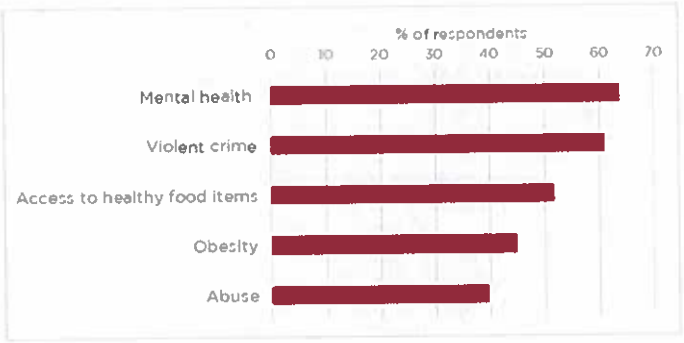


Figure 4. Tell us what you think are the 5 most important health problems in the area where you live for Adults (18-64 years old).

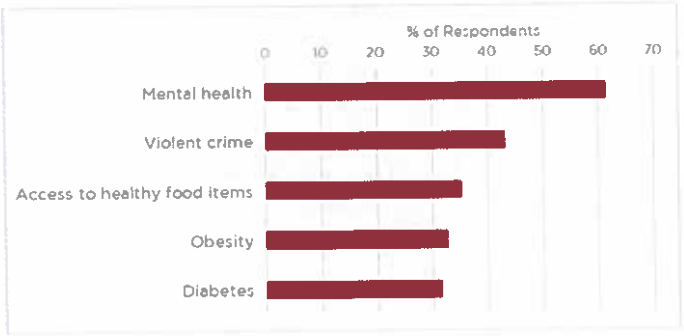
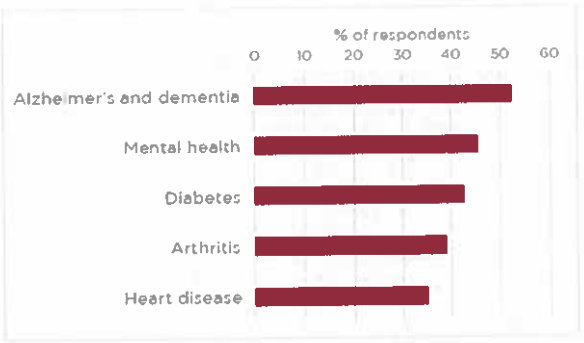


Figure 5. Tell us what you think are the 5 most important health problems in the area where you live for Seniors (65 years and up).



Respondents were also asked to select the characteristics they think are most important for a healthy community.

Figure 6. What do you think are the most important things for a healthy community?

ATTACHMENT 38

Community Focus Group Highlights

Six different focus groups were conducted to get an understanding of the strengths and challenges in the UCMCSA. Several themes emerged across multiple focus groups, including:

» **Community-wide trauma** caused, in part, by crime, especially shootings, crimes of opportunity, and violent crimes.

> One participant said, "These weigh on everyone's psyche, regardless of age, education, and income."

» **Mental health**, the most common health challenge touching all age groups, and ranging from isolation and loneliness to severe mental illness. Exacerbating factors include a lack of services, specifically providers that take Medicaid, as well as cultural stigma against seeking treatment.

> A community member noted, "Mental health problems are everywhere, but nobody talks about it because they don't know how to talk about it."

» **Chronic diseases** such as heart disease and diabetes are seen as major issues, in part because the choices for a healthy lifestyle—including food access, local preventive care, and affordable medications—are hard to find in the UCMCSA.

> A participant from Calumet Heights said, "Most people leave the community to see a doctor because of limitations with Medicare and Medicaid."

» **The lack of economic opportunities** in the community is acute and causes a sense of despair among many residents.

> A participant in the Community Safety focus group said, "Can't get a step ahead because every door is closed. Can't pay a bill because you can't get a job."

SOCIAL AND STRUCTURAL DETERMINANTS OF HEALTH

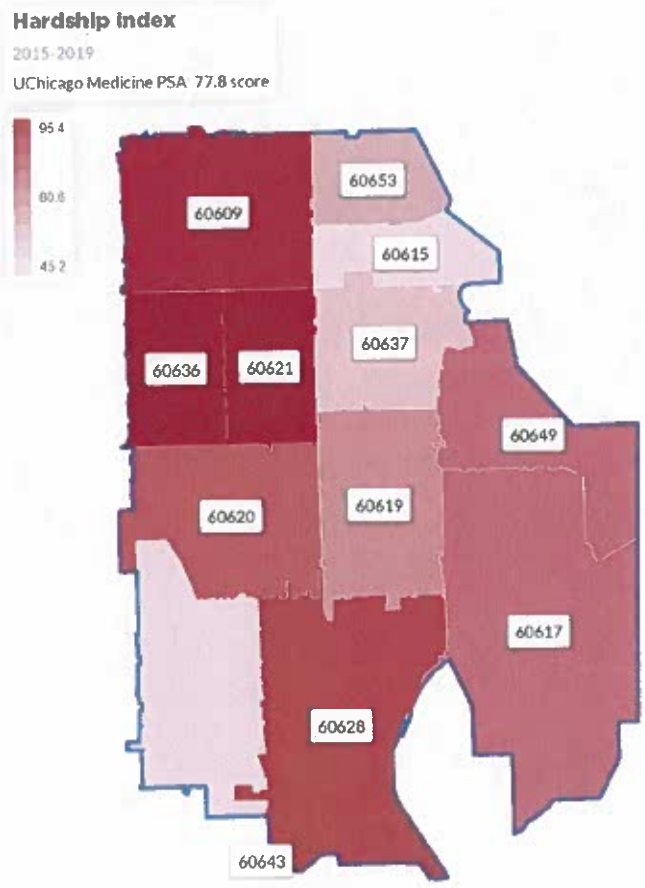
Residents who participated in focus groups and the community resident survey provided in-depth input about how social and structural determinants of health such as education, economic inequities, housing, food access, access to community services and resources, and community safety and violence impact community and individual health. Key insights from this community input are highlighted in each of the sections below.

Survey respondents provided input about the strengths of their communities.

Figure 7. A word cloud of community strengths, showing the 75 most common words used by survey respondents

Hardship

One way to measure overall economic distress in a place is with the Hardship Index[4]—a composite score from the American Community Survey reflecting hardship in the community (higher values indicate greater hardship). It incorporates unemployment, age dependency, education, per capita income, crowded housing, and poverty into a single score. The Hardship Index score for the UCMCSA is 77.8, one of the highest in the city, and over 15 points higher than the score for Chicago (62.2). The following section explores the hardship index, as well as some of its components, in more detail.



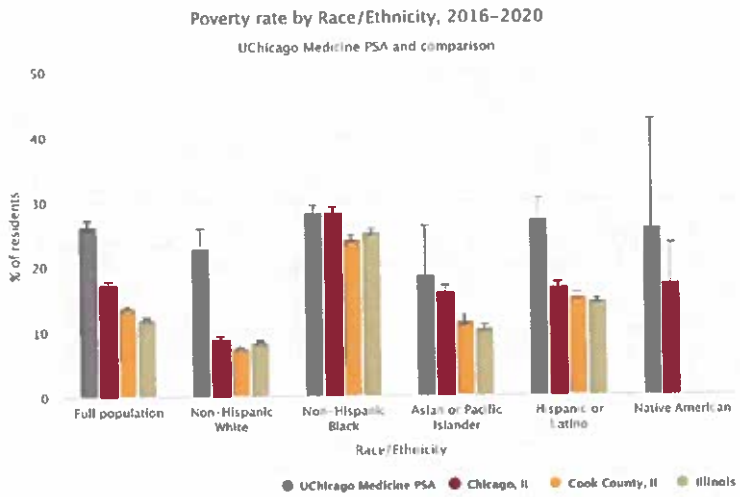
Data source American Community Survey (Calculated by Metopio)

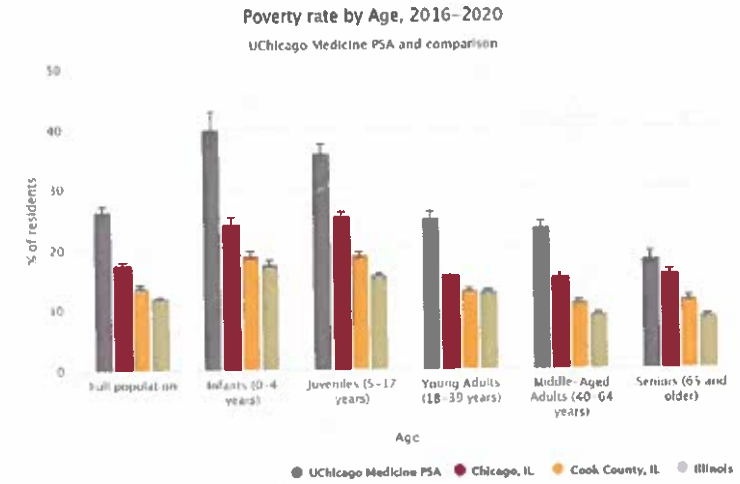
COMMUNITY INPUT

During the Youth focus group, several participants described their neighborhoods as "risky, divided, dangerous, toxic, wild and unpredictable." They talked about how it is "impossible to exercise or spend time outside because of the violence and crime." When they want to socialize, they are often forced to go to the suburbs or spend time at malls in places like Oak Brook.

Poverty

Poverty and its corollary effects are present throughout the UCMCSA. The median household income is $40,502 and the poverty rate is 26.7%. In comparison, Chicago's median household income is $61,784 and 18.4% of households live in poverty. The poverty rate is even more pronounced for children, with 39.9% of those ages 0-4 and 36.5% of those ages 5-17 living in poverty. In addition, 32.2% of households in the UCMCSA are considered "severely rent-burdened," meaning a household spends more than 50% of its income on housing. For Chicago as a whole, the percentage is 23.9%.

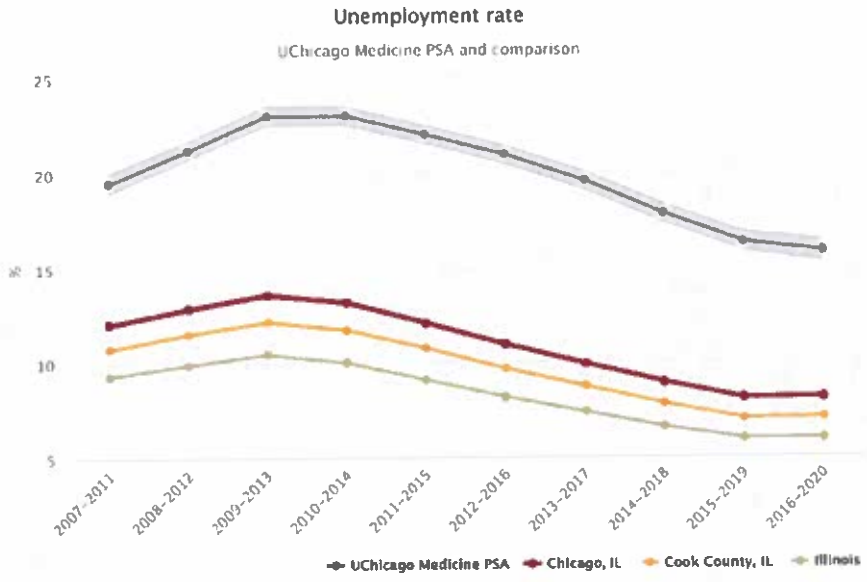




ATTACHMENT 38

Unemployment

The unemployment rate in the UCMCSA (15 8%) is nearly double the rate in Chicago (8 1%) and nearly triple that of the United States (5 4%). These differences remained during the height of the COVID-19 pandemic in 2020.

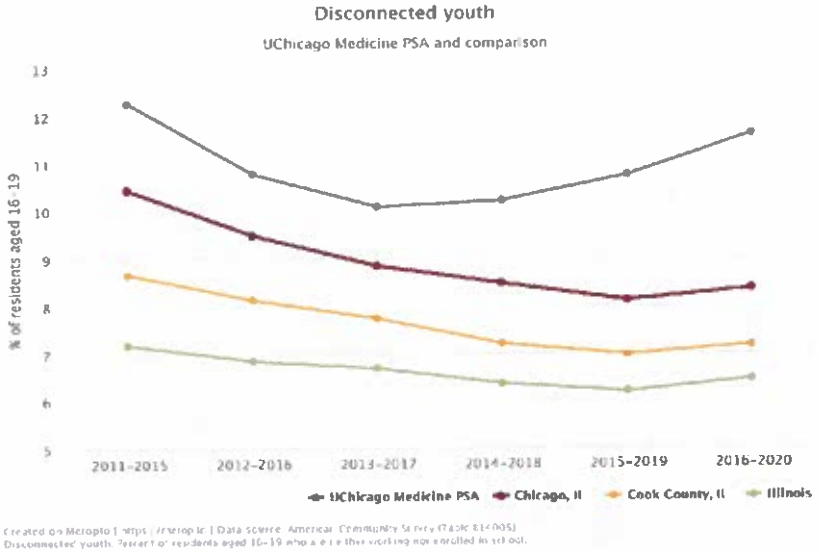


Created on Metopio (https://metopio.) Data source: American Community Survey (Tables B23025, B23001 and C23002)
Unemployment rate: Percent of residents 16 and older in the civilian labor force who are actively seeking employment.

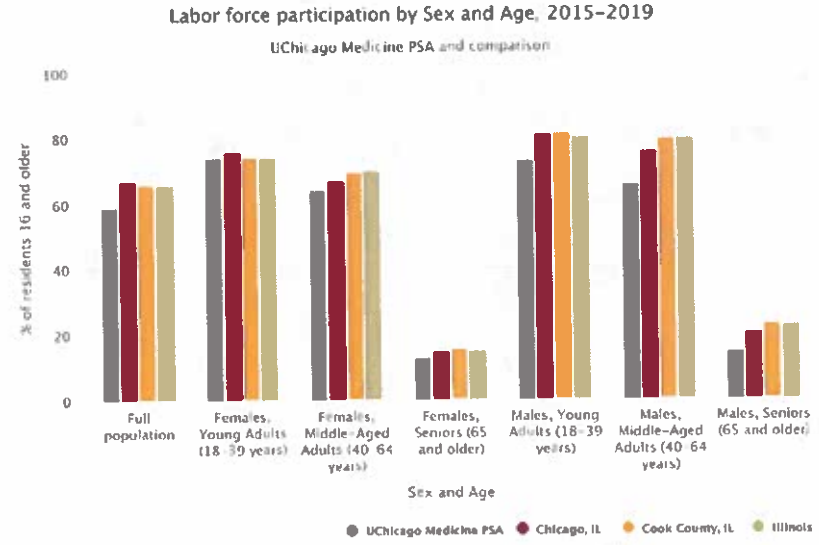
COMMUNITY INPUT

"We're told the government is going to put resources here but we never see it. If you want to solve all these health problems, you have to solve poverty. We need universal basic income." -Focus Group Participant

Another measure of potential economic stress is Disconnected Youth, defined as the percent of residents aged 16-19 who are neither working nor enrolled in school. For the UCMCSA, the figure is 11.6%, compared to 8.3% in Chicago and 6.4% in Illinois.



Created on Metopio | https://metopio.io | Data source: American Community Survey (Table B14005)
Disconnected youth: Percent of residents aged 16-19 who are neither working nor enrolled in school.



Created on Metopio | https://metopio.io | Data source: American Community Survey (Tables B23025, B23001, and C23001)
Labor force participation: Percent of residents 16 and older who are currently employed, enlisted in the armed forces, or actively seeking employment

Education

The high school graduation rate in the UCMCSA is 85%, which is in line with city and national averages (85.1% and 88.0% respectively). Educational inequities start to become apparent when looking at post-secondary education. The percentage of residents ages 25 years or older with any post-secondary education, including less than 1 year of higher education, is 56.8% in the UCMCSA and 62.6% in Chicago. But the rate of those completing a higher education degree, such as an associate or bachelor's degree or higher, is only 31.7% in the UCMCSA, compared to 45.3% in Chicago and 40.6% in the US.

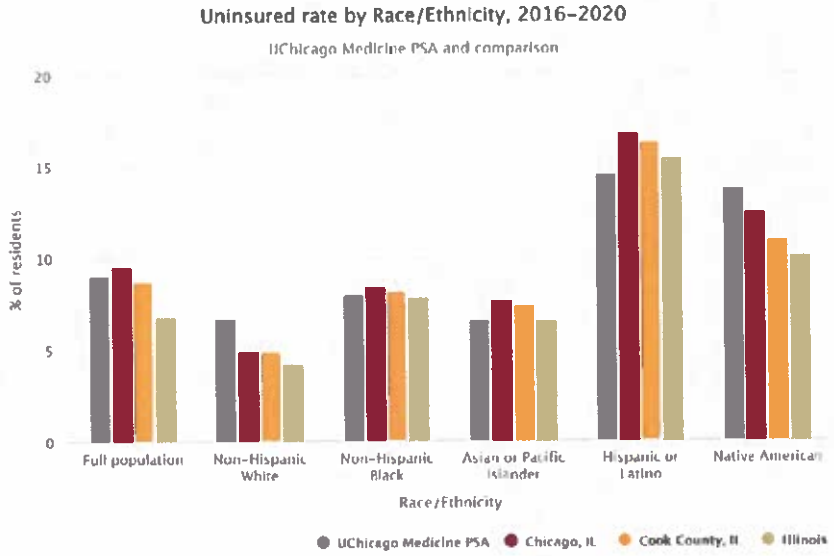
COMMUNITY INPUT

"People in our community can choose from four career paths—1. Follow an established career like being a teacher 2. Be a caregiver for family members, which doesn't pay 3. Be an entrepreneur, but it's hard to be entrepreneurs because banks won't give us loans. 4. Criminal activity." -Focus Group Participant

Access to Care

UCMCSA's uninsured rate is lower than Chicago's (8.6% compared to 9.7%). Many residents rely on government health insurance for coverage, especially Medicaid. The percentage of residents covered by Medicaid is 45% higher in the UCMCSA than in Chicago (38.1% to 26.3%). Access to care is especially important for disabled people and seniors, particularly those who live alone. The percentage of individuals living with disabilities is nearly 50% greater in the UCMCSA than in Chicago (15.1% to 10.2%), and about 4 in 10 seniors live alone.

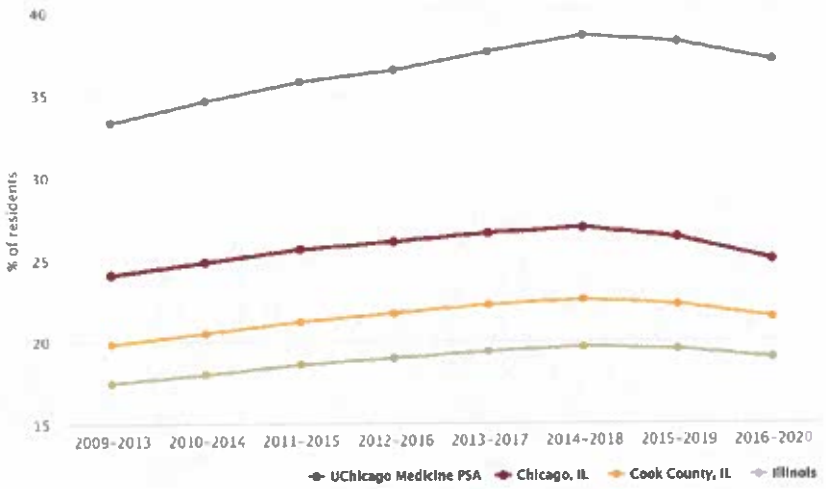
Some survey respondents and focus group participants noted the high cost of medicine as another impediment to healthy living. "If I have to decide between food and medicine, I'm going to pick food," one participant said.



Created on Metopio | https://metopio.io | Data source: American Community Survey (tables B27001, C27001)
Uninsured rate: Percent of residents without health insurance (at the time of the survey)

Medicaid coverage

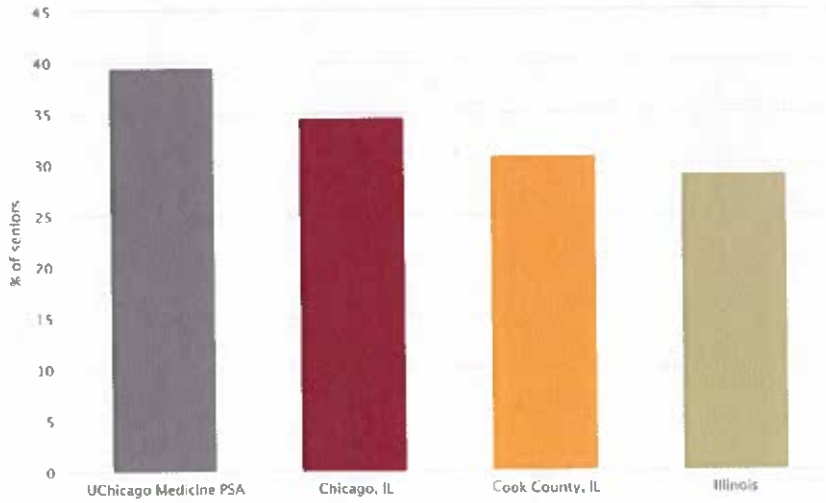
UChicago Medicine PSA and comparison



Created on Metopio | https://metop.io | Data source: American Community Survey (Tables S2704, S2701, and B27010)
Medicaid coverage: Percent of residents covered by Medicaid, a state administered health insurance program for residents meeting certain income limits and other eligibility standards that vary by state.

Seniors living alone, 2016-2020

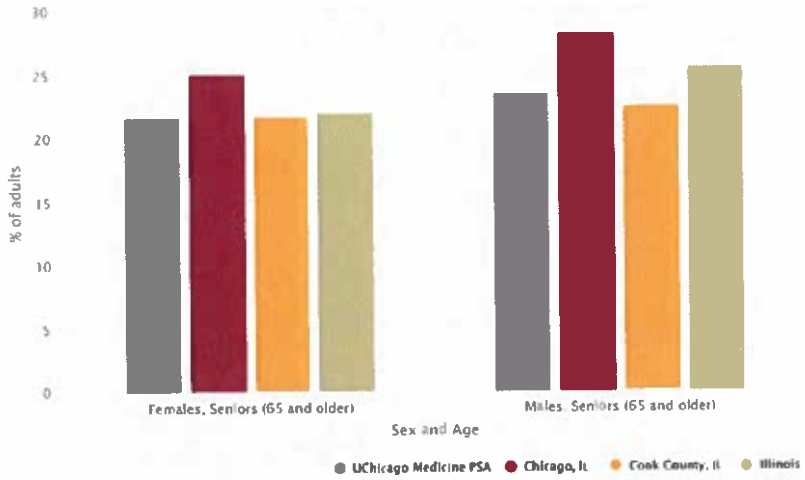
UChicago Medicine PSA and comparison



Created on Metopio | https://metop.io | Data source: American Community Survey (Table B09020)
Seniors living alone: Percent of residents age 65 and older who live alone. Does not include those living in group homes such as nursing homes

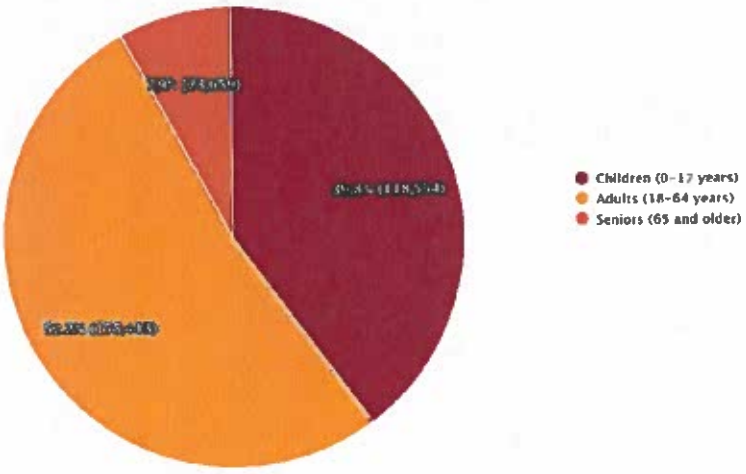
Seniors up to date on core preventive services by Sex and Age, 2018

UChicago Medicine PSA and comparison



Medicaid Enrollment by Age, UChicago Medicine PSA

2020



There are about 297,600 residents on Medicaid in the UCMCSA, which is 5.5% fewer than in 2018-19. The drop was led by fewer children and adults, while the number of seniors receiving Medicaid increased by 14.0% over the same period.

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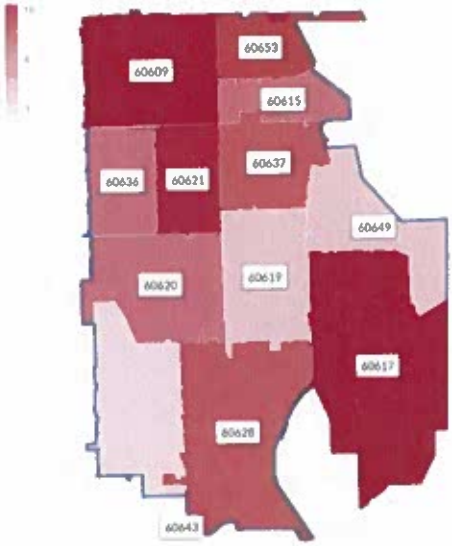
There are currently 53 Federally Qualified Health Centers (FQHCs) operating in the UCMCSA. About half of them are located in either the 60609, 60617, or 60621 zip codes. According to data from the Health Resources and Services Administration, the majority of the UCMCSA is considered a Health Professional Shortage Area for primary care, dental care, and mental health

Federally qualified health centers

2021

UChicago Medicine PSA: 53 FQHCs



Data source: Provider of Services Files

COMMUNITY INPUT

All of the participants in the Youth focus group are connected to primary care physicians (PCP) because of the Children's Health Insurance Program (CHIP). However, most doctor's offices are in the Illinois Medical District, a long trip from the South Side. Adult focus group participants noted a lack of wraparound services and discharge planning to prevent readmissions. They also talked about the need for satellite clinics, especially in South Shore and Calumet Heights but "only if they accept a patient's insurance, because a lot of providers do not accept a patient's insurance."

Topic	UChicago Medicine PSA	Cook County, IL	Illinois
Psychiatry physicians per capita *physicians per 100,000 residents, 2021*	19 ± 0	16 ± 0	11 ± 0
Clinical social workers per capita *physicians per 100,000 residents, 2021*	63.07 ± 0.00	113.22 ± 0.00	85.51 ± 0.00
Medicaid psychologists per capita *providers per 100,000 residents, 2021*	2.00 ± 0.00	9.72 ± 0.00	5.61 ± 0.00
Medicaid behavioral health professionals per capita *providers per 100,000 residents, 2021*	11.60 ± 0.00	22.30 ± 0.00	26.65 ± 0.00
Medicaid social workers per capita *providers per 100,000 residents, 2021*	0.33 ± 0.00	1.98 ± 0.00	1.67 ± 0.00

Food Access

Nearly half of Chicago's residents who live in areas with structural inequities for food access are in the UCMCSA.

Food insecurity is the household-level economic and social condition of limited or uncertain access to adequate food. A food desert is defined as an area in which there is not a supermarket for at least one mile in any direction. Low food access is defined as an individual living in a low-income household that also is in a food desert

Topic	UChicago Service Area	Chicago, IL
Food insecurity *% of residents, 2020*	17.5 ± 0.0	21.3 ± 0.0
Living in food deserts *% of residents, 2019*	1.33 ± 0.00	0.66 ± 0.00
Individuals living in a food desert *residents, 2019*	8,531 ± 0	17,119 ± 0
Low food access *% of residents, 2019*	39.98 ± 0.00	21.93 ± 0.00
Very low food access *% of residents, 2019*	2.69 ± 0.00	1.20 ± 0.00
Food stamps (SNAP) *% of households, 2015-2019*	32.28 ± 0.66	16.63 ± 0.62

COMMUNITY INPUT

Adult and Youth focus group participants said they know what to eat but that "it's very hard to get any healthy food."

During the Youth focus group, participants spoke about obesity and noted that it's an issue they all see with their parents' generation. Other community members spoke about metabolic disease as one of the most common health challenges for adults in the UCMCSA. In addition to food deserts and provider deserts, the community noted that transportation is a challenge, especially for people living with a disability.

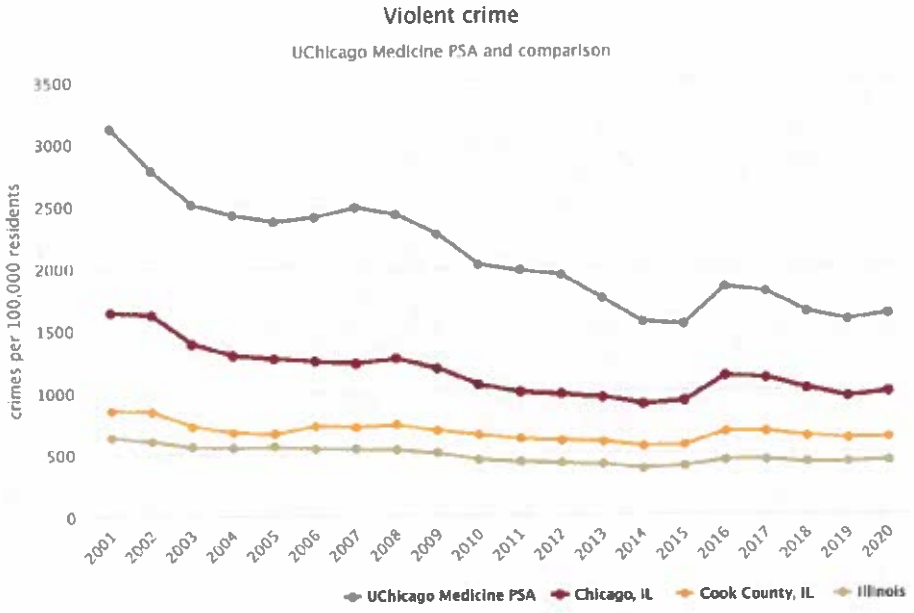
Violence and Community Safety

VIOLENT CRIME

Residents expressed that violent crime was the most prioritized health need for both children and adults. This was supported by survey results, focus group responses, and secondary data. Within the UCMCSA, the crime rate per 100,000 residents is higher than the citywide average across the board, but the rate of aggravated assault/battery, in particular, is notably higher than the average rate in Chicago, and it is almost 4x the rate for the state of Illinois.

In the chart below, violent crime represents the combined rates of homicide, criminal sexual assault, robbery, aggravated assault, and aggravated battery. Each crime is also included individually for comparison. Overall, violent crime had been following a downward trend since the early 2000s. However, rates have increased since 2019. The data represented here does not include 2021, but initial data indicates another year-over-year increase of violent crime in Chicago.

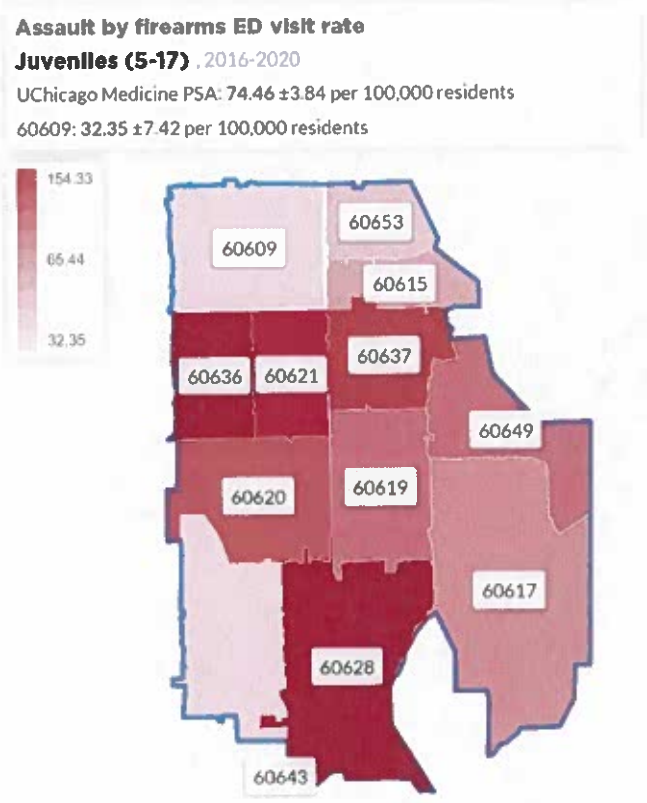
Topic	UChicago Service Area	Chicago, IL	Illinois
Violent crime *crimes per 100,000 residents, 2020*	1,616.8 ± 0.0	1,125.6 ± 0.0	425.9 ± 0.0
Aggravated assault/battery *crimes per 100,000 residents, 2020*	1,054.1 ± 0.0	695.2 ± 0.0	278.9 ± 0.0
Burglary *crimes per 100,000 residents, 2020*	527.7 ± 0.0	351.0 ± 0.0	246.4 ± 0.0
Homicide *crimes per 100,000 residents, 2020*	55.7 ± 0.0	36.6 ± 0.0	9.1 ± 0.0
Larceny (theft) *crimes per 100,000 residents, 2020*	1,786.6 ± 0.0	1,686.3 ± 0.0	1,143.5 ± 0.0
Arson *crimes per 100,000 residents, 2020*	35.0 ± 0.0	24.9 ± 0.0	12.2 ± 0.0
Property crime *crimes per 100,000 residents, 2020*	2,919.4 ± 0.0	2,510.0 ± 0.0	1,559.4 ± 0.0
Robbery *crimes per 100,000 residents, 2020*	432.5 ± 0.0	339.0 ± 0.0	97.4 ± 0.0
Criminal sexual assault *crimes per 100,000 residents, 2020*	74.5 ± 0.0	49.7 ± 0.0	40.4 ± 0.0
Motor vehicle theft *crimes per 100,000 residents, 2020*	570.1 ± 0.0	447.8 ± 0.0	169.5 ± 0.0



Created on Metopio | https://metop.io | Data sources: FBI Crime Data Explorer, New York City Police Department (NYPD), Chicago Police Department
Violent crime: Crimes related to violence (yearly rate). Includes homicide, criminal sexual assault, robbery, aggravated assault, and aggravated battery.

YOUTH

The UCMCSA has one of the highest hospitalization rates in the state for assault by firearms, ranking in the 95th percentile. The map below displays a breakdown of emergency department visit rates for assault by firearms by zip code for juveniles (5-17). Zip codes that are shaded white do not have enough data to display.



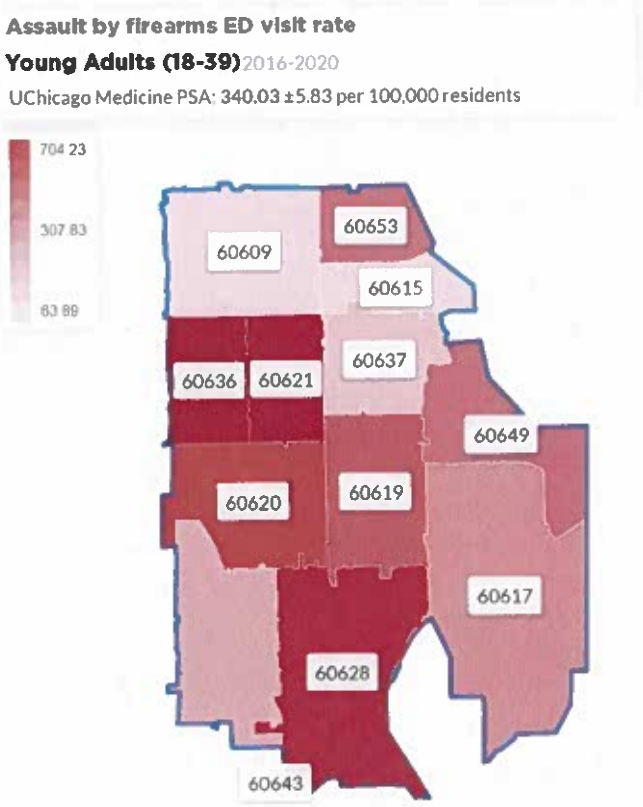
Data source: IHA COMPdata informatics (Calculated by Metopio)

Violent crime rates have a huge impact on juveniles in the community. Survey and focus group participants reported violence both in schools, particularly after returning to the classroom after remote learning, and in the streets. Youth reported that violence in their neighborhoods made them hesitant to spend time exercising or playing outside.

One participant explained, "As a young black male, I have to always watch where I'm going—could be gangs after me or the police." Another further explained their thoughts on community safety by stating, "We want more police, but only ones we can trust."

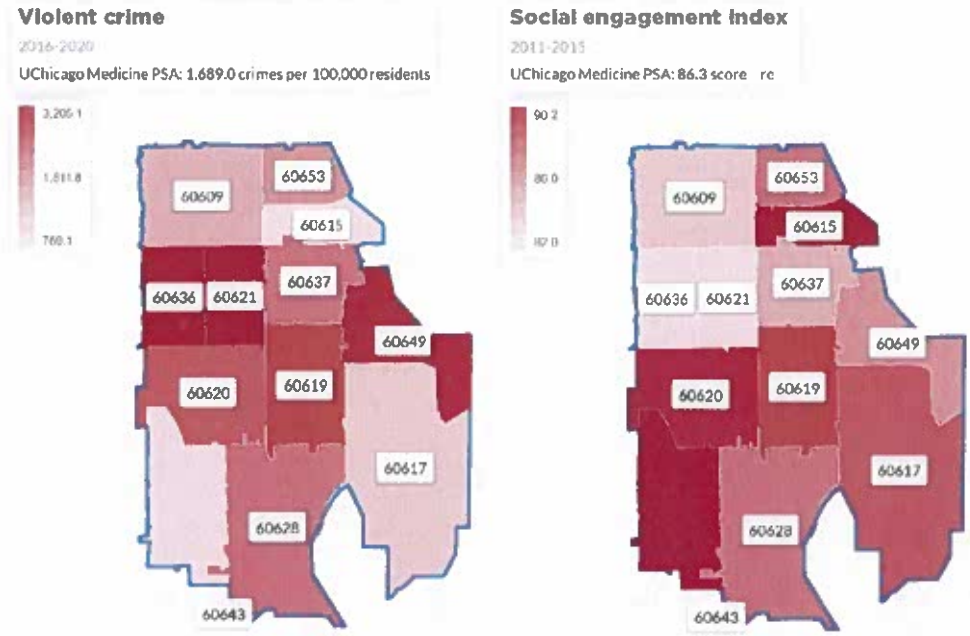
ADULT

Emergency department visits and hospitalization rates for young adults within the UCMCSA related to assaults by firearms are also within the 95th percentile for Illinois. These rates are particularly high in the 60636 and 60621 zip codes.



Data source: IHA COHPdata informatics (Calculated by Metopia)

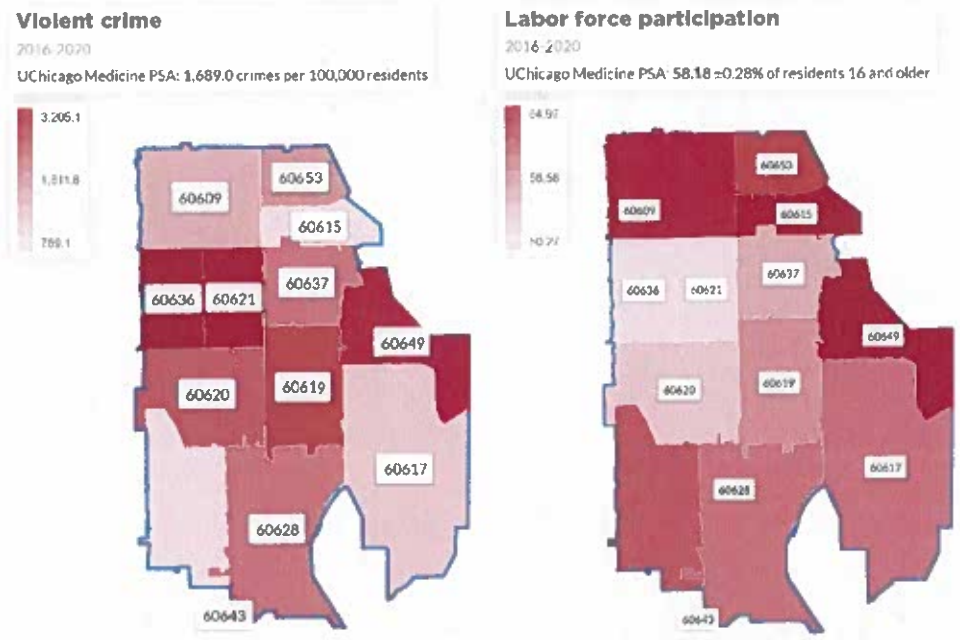
The community safety focus group provided some potential causes for high rates of violence within the service area. **Participants reported that there is more tension in the streets than there has been in the past.** They partially attribute this to a growing disconnect between neighbors, explaining that neighborhoods are missing a collective feeling of responsibility and the need to care for their community. In the past, block clubs helped neighbors keep an eye on each other, but since those have gone away, community members report feeling more isolated. Secondary data supports these claims, as violent crime rates appear to be negatively correlated with social engagement.



Data source: FBI Crime Data Explorer, Crime data portal and Metopio

Adult focus group participants expressed **conflicting thoughts on policing, similar to those shared by Youth participants.** They reported that negative experiences with the police, including specific issues with witness protection programs, make them wary of relying on the police for help. One participant described, "We need protection, but over-policing can make people feel disconnected from safety. It's a balance we have to find."

Finally, secondary data revealed that high rates of violent crime correlate with a lack of economic opportunities. These two maps show violent crime and labor force participation at the zip code level. Looking closely at 60636 and 60621, we see both high rates of crime and the lowest labor force participation in the service area.



Data source: FBI Crime Data Explorer, Crime data portal and American Community Survey (Tables B23025, B23001, and C23002)

ATTACHMENT 38

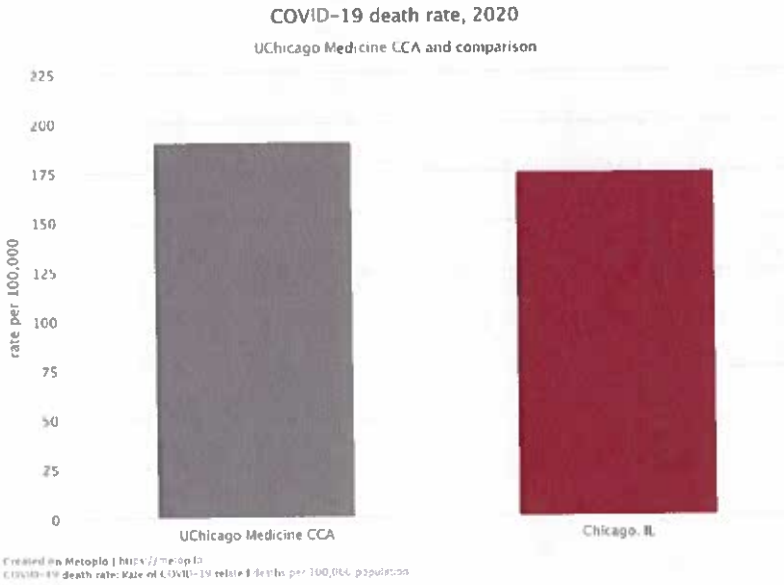
HEALTH OUTCOMES, MORBIDITY, AND MORTALITY

Leading Causes of Death

While the leading causes of death in the UCMCSA mirror those in the City of Chicago, almost all of the causes disproportionately impact the UCMCSA's non-Hispanic Black population. According to data from the Illinois Department of Public Health, the top 10 causes of death in 2020 in the City of Chicago were:

1. Heart disease
2. Cancer
3. COVID-19
4. Accidents*
5. Stroke
6. Chronic Lower Respiratory Disease
7. Alzheimer's Disease
8. Diabetes
9. Kidney Disease
10. Influenza and Pneumonia

During its first year in circulation, COVID-19 quickly became the third leading cause of death in the service area, the city, and the state. Additional stratifications are not yet available, but we know that the pandemic had an outsized impact on minority communities, especially ones also experiencing economic hardship.

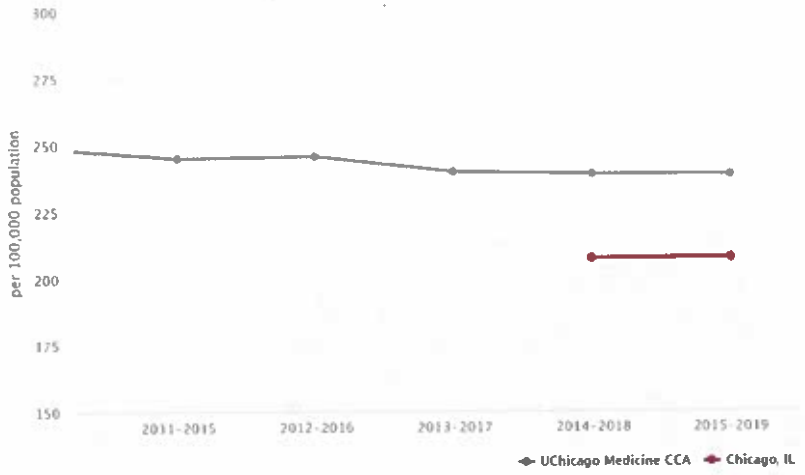


Accidents include motor vehicle deaths, workplace deaths, and assault (homicides), among others. When causes of death are stratified by age, the second leading cause of death for those ages 1-44 is homicide.

ATTACHMENT 38

Heart disease mortality rate

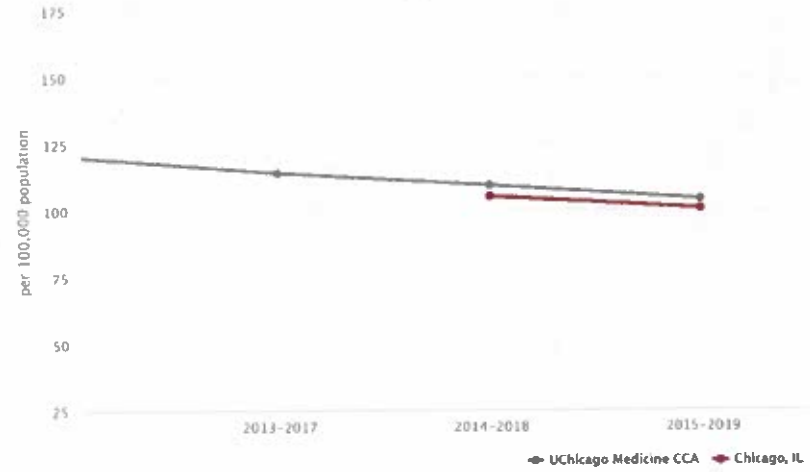
UChicago Medicine CCA and comparison



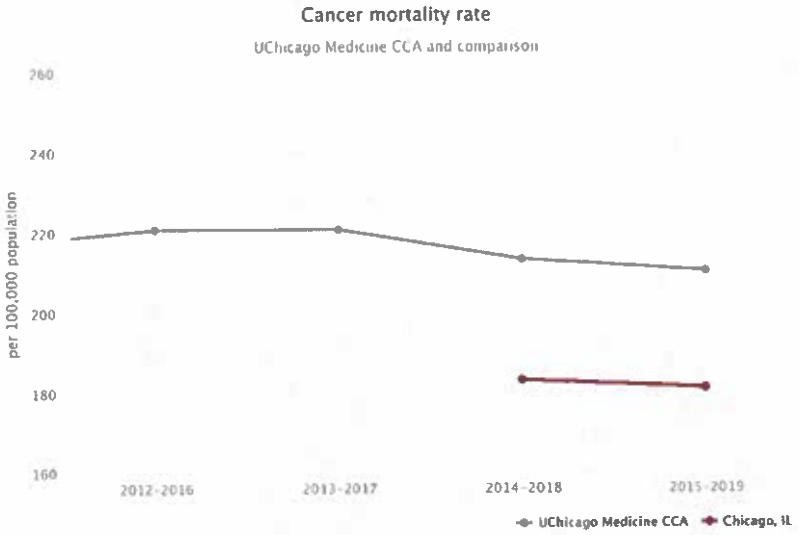
Created on Metopio | https://metopio.io
Heart disease mortality rate: Age-adjusted rate of people who died due to heart disease

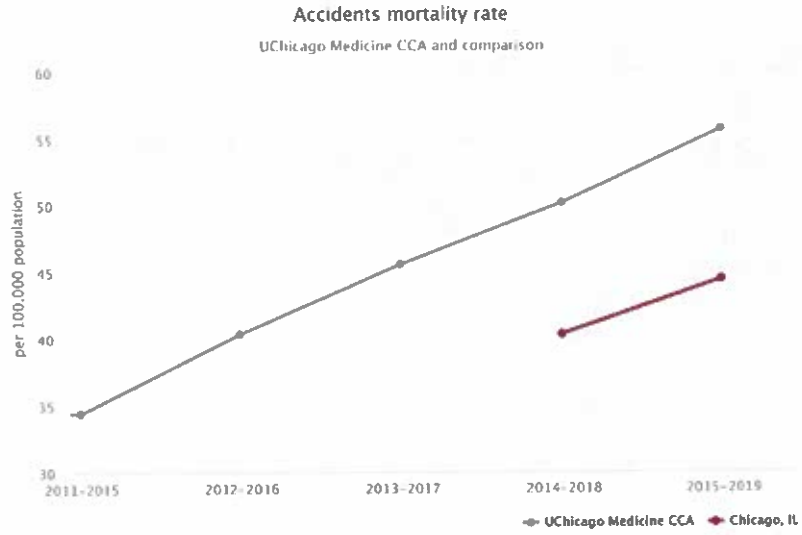
Coronary heart disease mortality rate

UChicago Medicine CCA and comparison

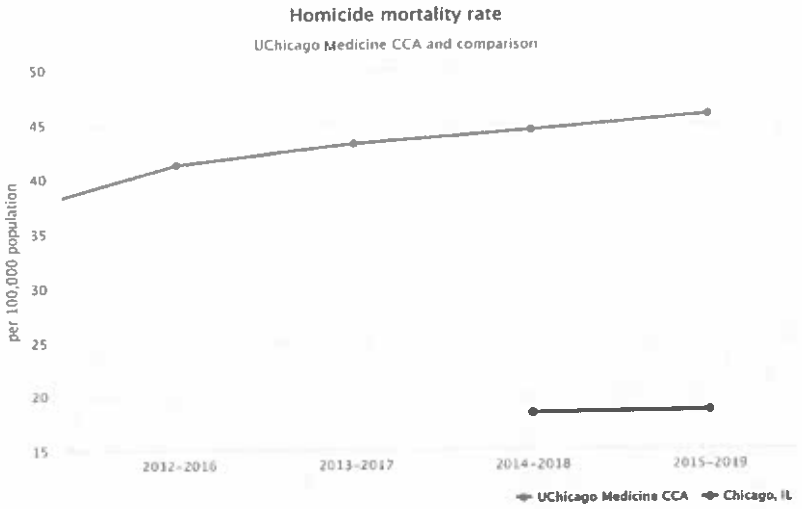


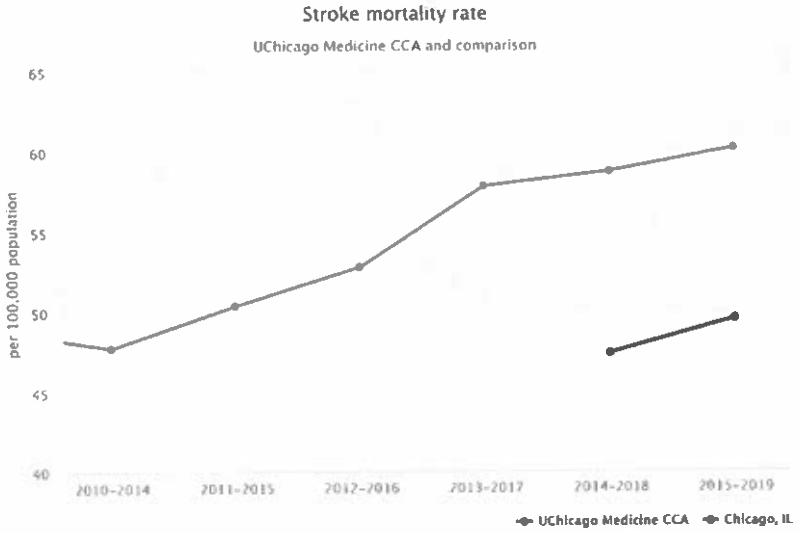
Created on Metopio | https://metopio.io
Coronary heart disease mortality rate: Age-adjusted rate of people who died due to coronary heart disease.





ATTACHMENT 38

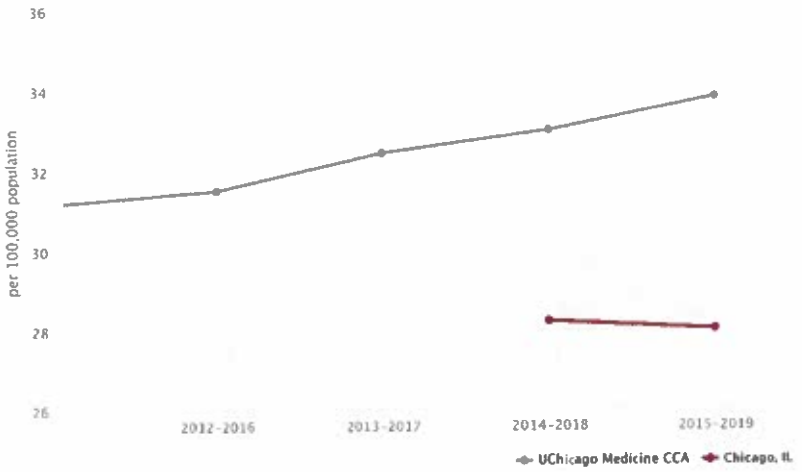




ATTACHMENT 38

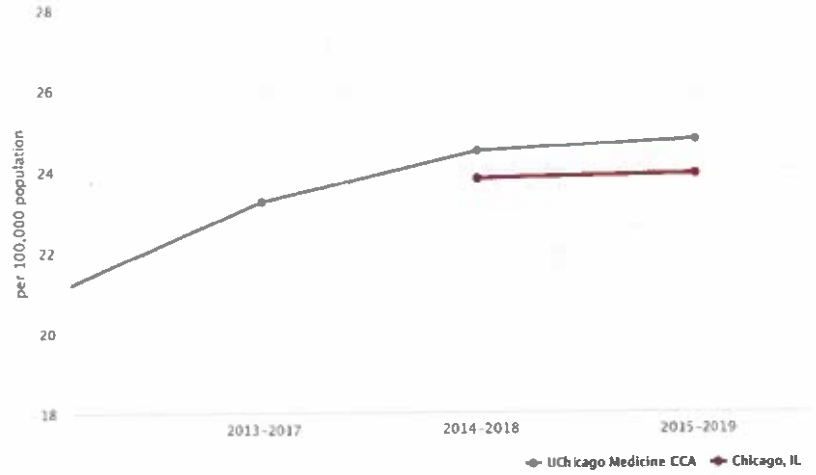
Chronic lower respiratory disease mortality rate

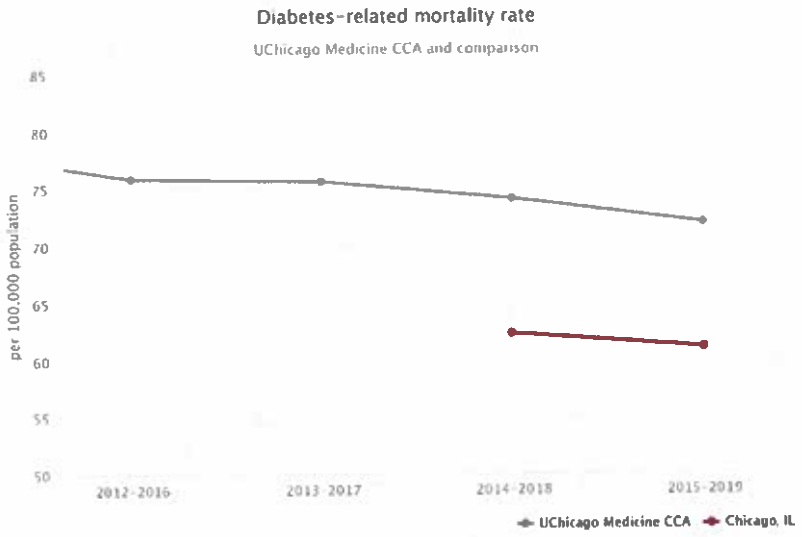
UChicago Medicine CCA and comparison



Alzheimer's disease mortality rate

UChicago Medicine CCA and comparison





Hospital and Emergency Department Utilization

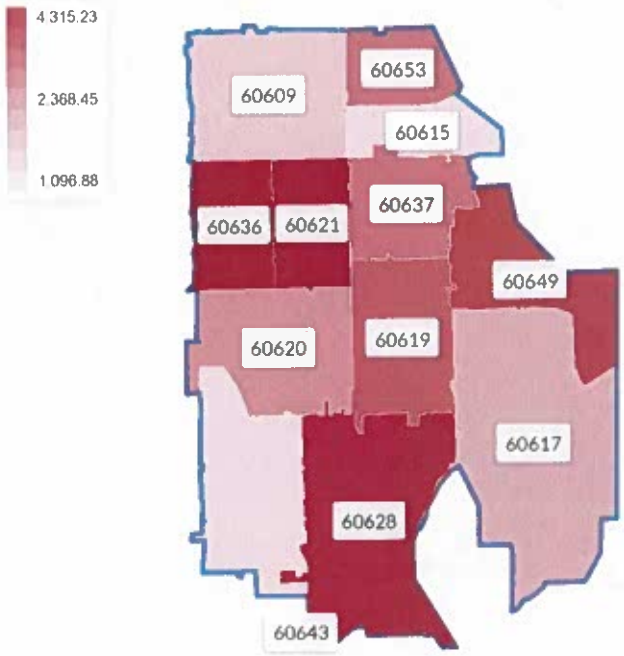
One community member noted, "Healthcare on the South Side is really hard to get, so the emergency department (ED) becomes the front door."

This sentiment is reflected in hospital utilization data, where the preventable chronic conditions hospitalization rate in the UCMCSA is among the highest 5% in Illinois, according to IHA COMPdata Informatics. Preventable chronic condition hospitalizations are caused by Ambulatory Care-Sensitive Conditions—those conditions, such as heart disease, diabetes, or asthma, that are best treated in an outpatient setting. High rates of preventable visits indicate that community members struggle to manage chronic diseases for a variety of reasons, including, but not limited to, a lack of access to care, prescription costs, and lifestyle choices.

Preventable chronic emergency department (ER) visit rate

2016-2020

UChicago Medicine PSA: 2,346.98 ±8.98 per 100,000 residents



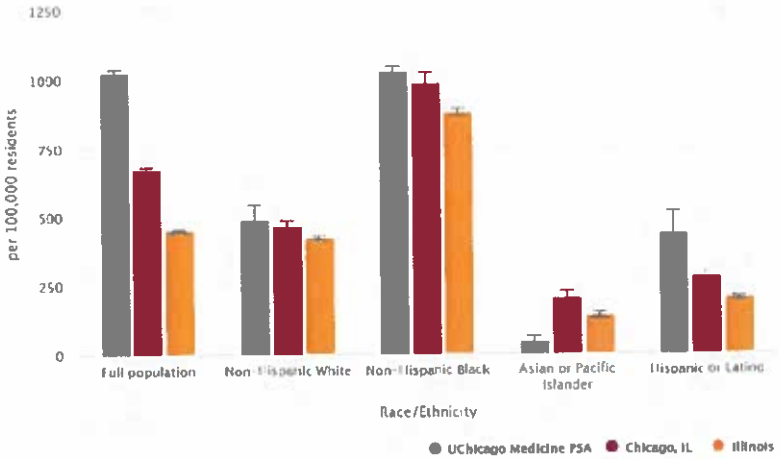
Data source IHA COMPdata Informatics (Calculated by Metopio)

While the reported rates of preventable chronic condition hospitalizations include many different diseases, the rates are equally notable for specific chronic conditions.

Heart failure and hypertension hospitalization rates are all among the highest 5% in the state, as is the rate of uncontrolled diabetes hospitalizations. Type 2 diabetes hospitalizations are in the 95th percentile, and stroke, COPD, and asthma hospitalizations are in the 90th percentile. All of this is calculated from IHA COMPdata Informatics.

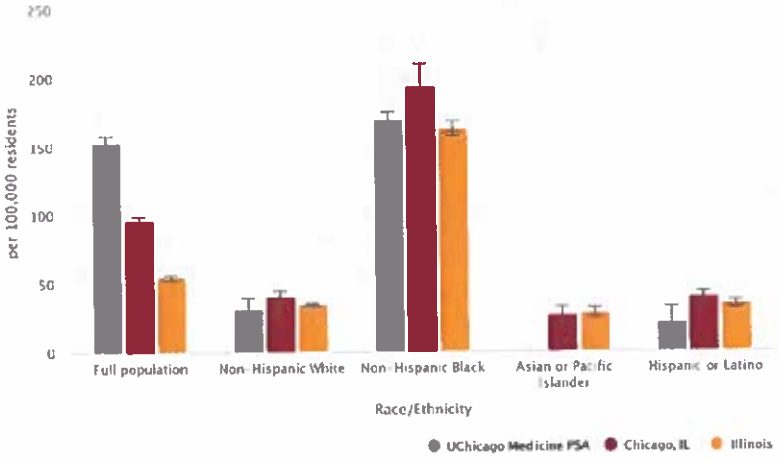
Heart failure hospitalization rate by Race/Ethnicity, 2016-2020

UChicago Medicine PSA and comparison



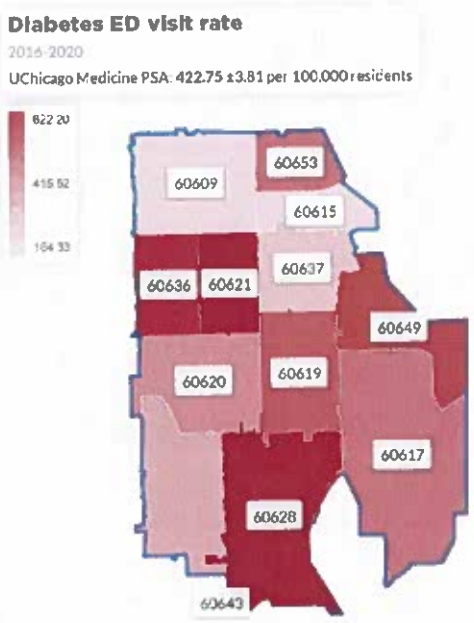
Hypertension hospitalization rate by Race/Ethnicity, 2016-2020

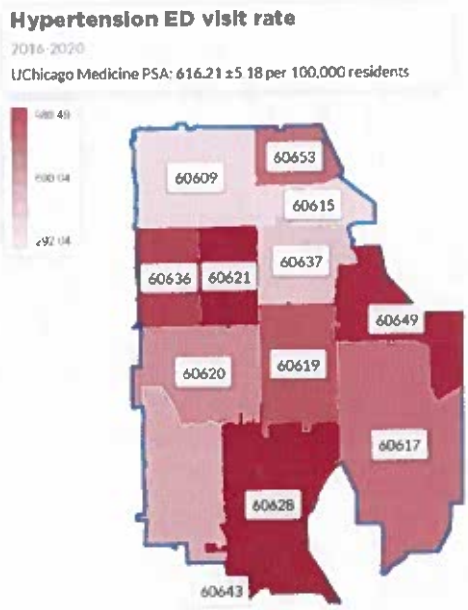
UChicago Medicine PSA and comparison



ATTACHMENT 38

When mapped across zip codes, the distribution of preventable chronic visits follows a similar trend to the social determinants of health and rates of violence. For example, ED visits for diabetes and hypertension occur at higher rates in 60636, 60621, 60628, and 60649.





Data source: IHA COMPdata Informatics (Calculated by Metopio)

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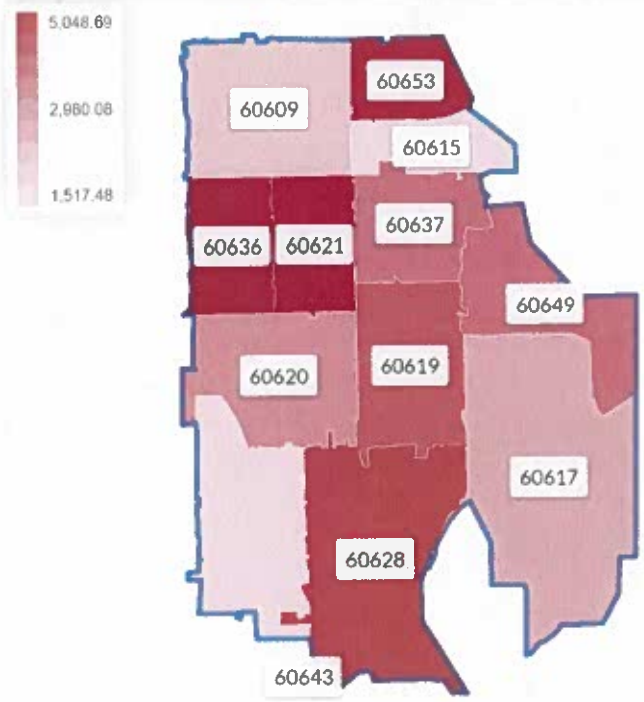
In addition to chronic conditions, the UCMCSA is in the 95th percentile for behavioral health hospital admissions. Rates of ED visits are also in the top 5% statewide for substance and alcohol use.

Behavioral health ED visit rate

2016-2020

UChicago Medicine PSA: 2,754.42 ±9.90 per 100,000 residents



Data source: IHA CORPdata Informatics (Calculated by Metopio)

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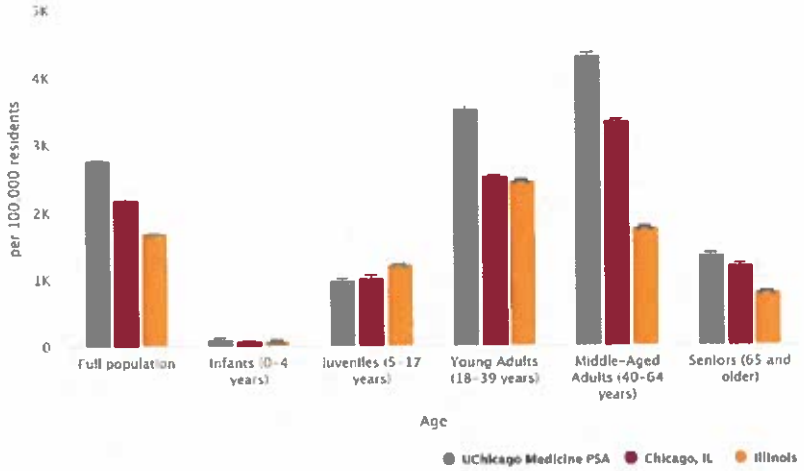
Behavioral health emergency department visit rate by Age, 2016-2020

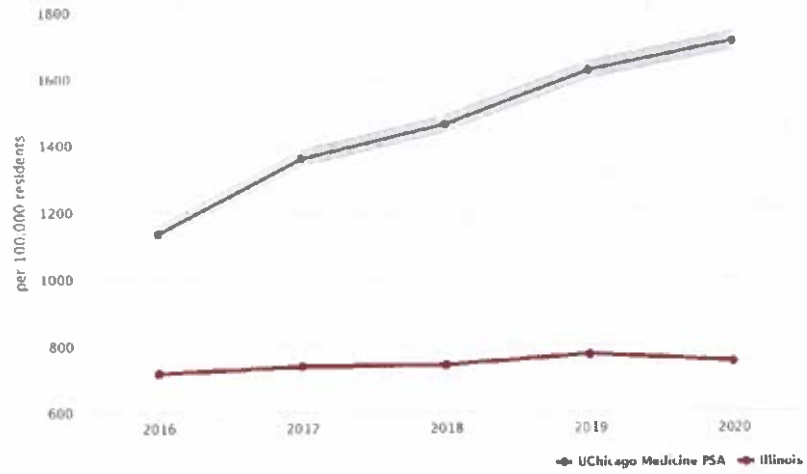
UChicago Medicine PSA and comparison



Created on Metopio | https://metopio.io | Data source: [illegible]
Behavioral health emergency department visit rate: Annual emergency department visits for behavioral health per 100,000 residents. Includes mental health and substance abuse. Risk-adjusted by age and sex. All hospital providers, all payers, base, on patient residence

Substance use emergency department visit rate

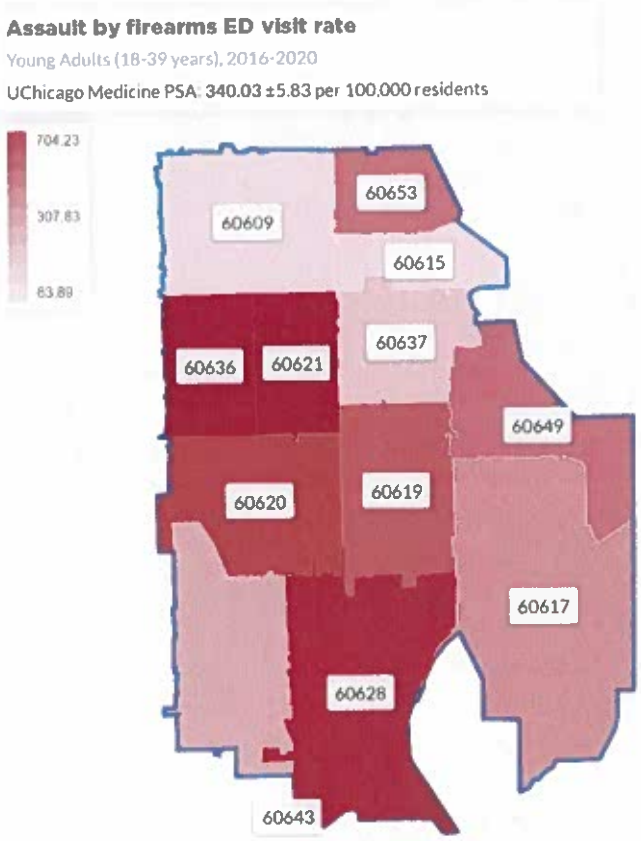
UChicago Medicine PSA and comparison



Created on Metopio | https://metopio.io | Data source: [illegible] CDC/Vizient Information Calculated by Metopio
Substance use emergency department visit rate: Annual emergency department visits for substance use per 100,000 residents. Substance use includes the use of controlled substances such as opioids, heroin, methadone, cocaine, hallucinogens, and other substances. Risk-adjusted by age and sex. All hospital providers, all payers. Based on patient residence

ATTACHMENT 38

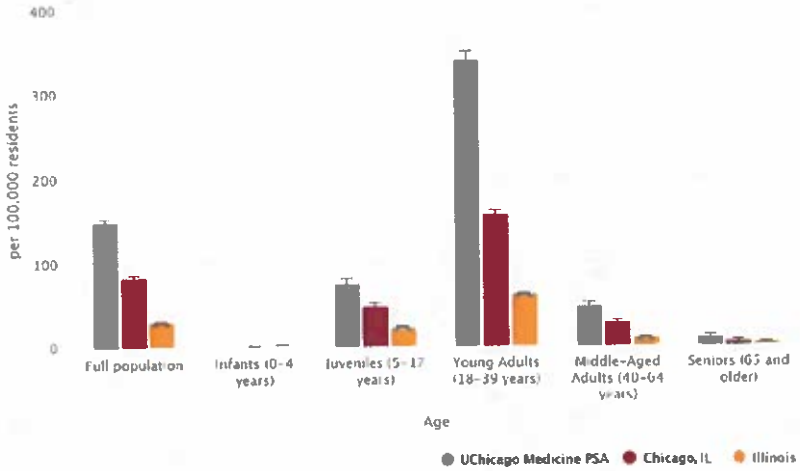
Lastly, surveys, focus groups, key informants, utilization data, and secondary data identified violent crime as a major issue in the UCMCSA. The ED visit rate for assault by firearms for young adults (18-39) is in the 95th percentile in Illinois and over double the rate for the City of Chicago. Many of the patients seeking treatment for gunshots live in 60636, 60621, and 60620 zip codes.



Data source: IHA COMPdata Informatics (Calculated by Metopio)

Assault by firearms emergency department visit rate by Age, 2016–2020

UChicago Medicine PSA and comparison



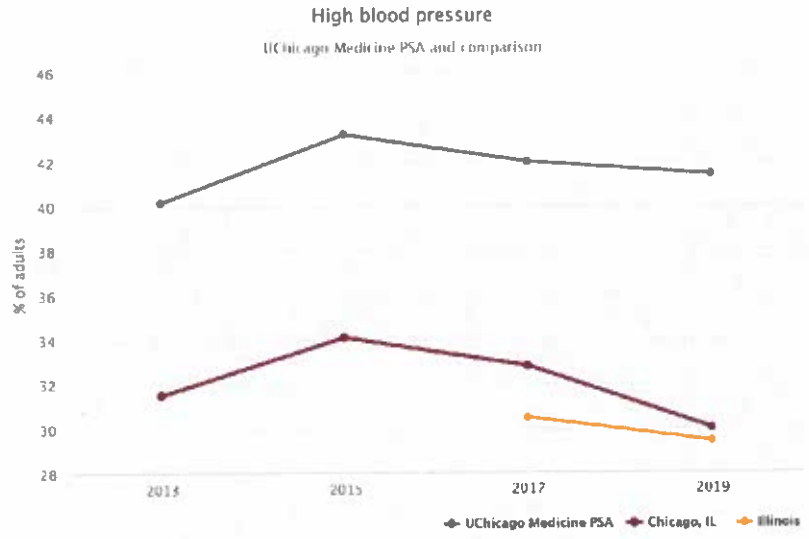
Created on Metopio | https://metopio.ai | Data source: [illegible]

Assault by firearms emergency department visit rate: Annual emergency department visits for assaults with firearms per 100,000 residents, risk-adjusted by age and sex. All hospital providers, all payers. Based on patient residence.

ATTACHMENT 38

HEART DISEASE

The highest rates of heart disease mortality in the city occur in several specific community areas in the UCMCSA: Englewood, Greater Grand Crossing, and Washington Park. As noted earlier, the hospitalization rates for hypertension and heart failure in these neighborhoods are also among the highest in the state.

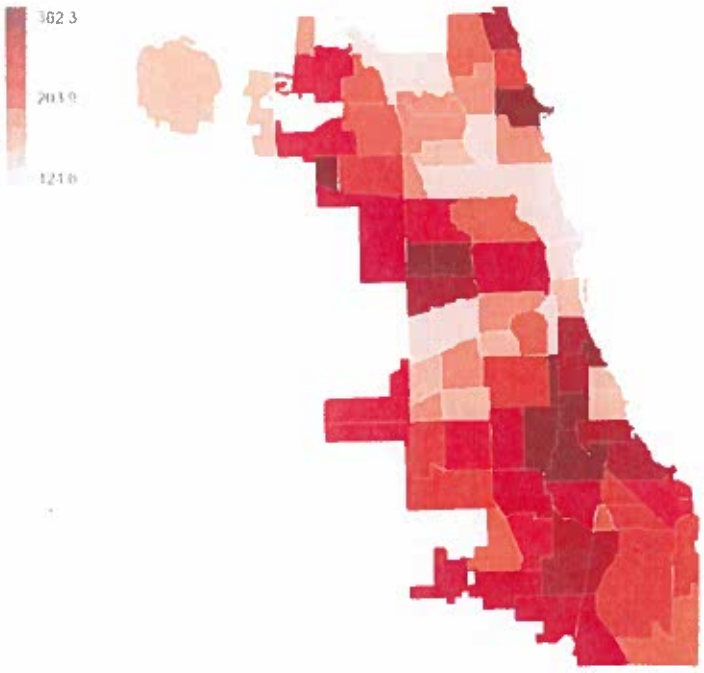


ATTACHMENT 38

Heart disease mortality rate

2015-2019

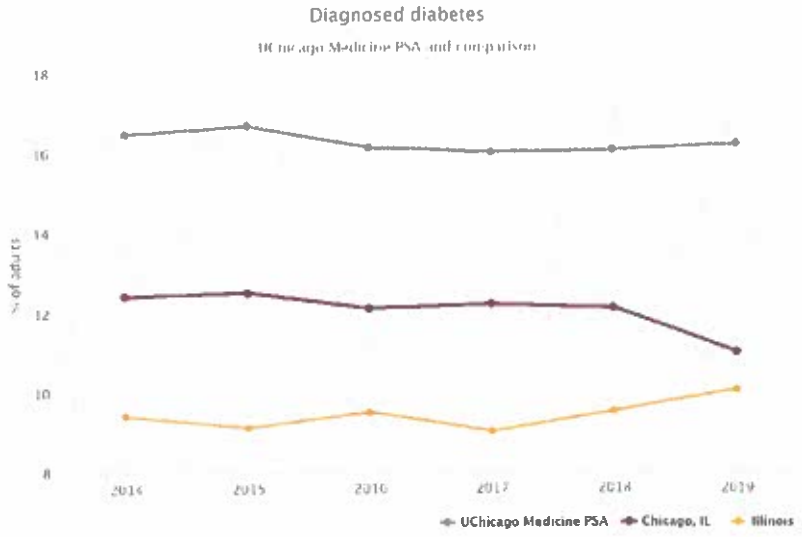
per 100,000 population



Data source Illinois Department of Public Health, Death Certificate files

DIABETES

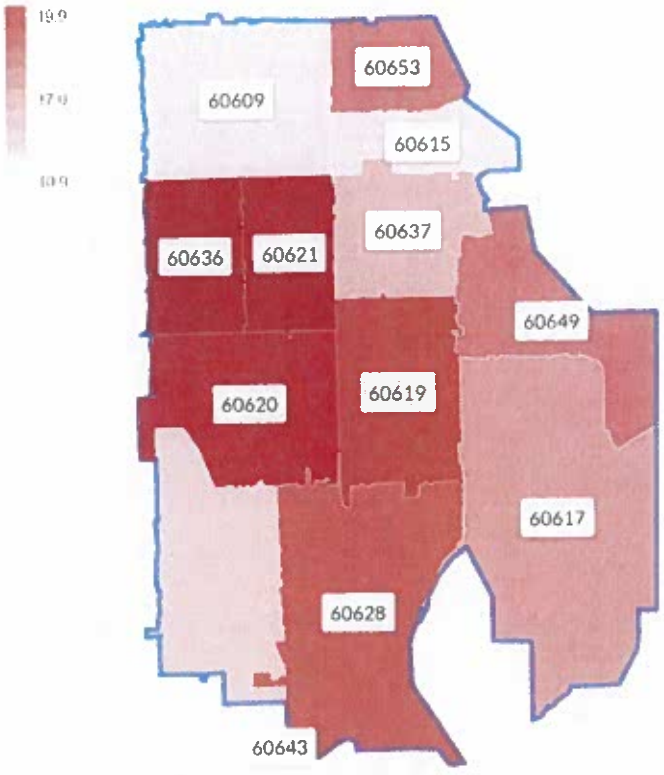
The rate of diabetes is 30% higher in the UCMCSA than in Chicago. Additionally, the rate has remained unchanged for several years. Some of the highest rates of diabetes mortality occur in community areas that fall within the UCMCSA.



Diagnosed diabetes

2019

UChicago Medicine PSA: 16.2% of adults



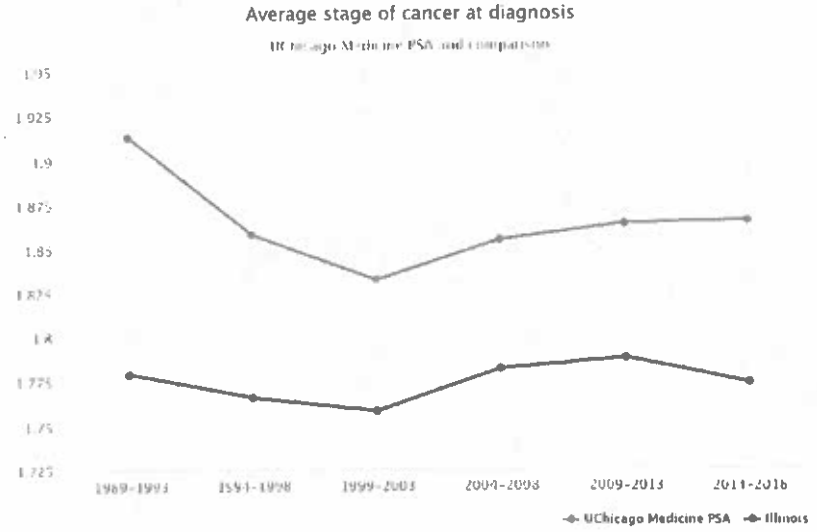
Data sources. PLACES, Diabetes Atlas (County and state-level data)

ATTACHMENT 38

CANCER

Lung, prostate, and other cancers occur at particularly high rates in the UCMCSA when compared to the city average. In addition, the distant/systemic cancer diagnosis rate, which refers to receiving an initial diagnosis of Stage 4 or metastatic cancer, is significantly higher than the city's rate, on average. This disparity is especially pronounced in the 60621, 60636, and 60653 zip codes. This is especially significant for patient outcomes because the more advanced a cancer is at diagnosis, the worse the prognosis—and such disparities in screening and diagnosis tend to be more pronounced among more vulnerable communities

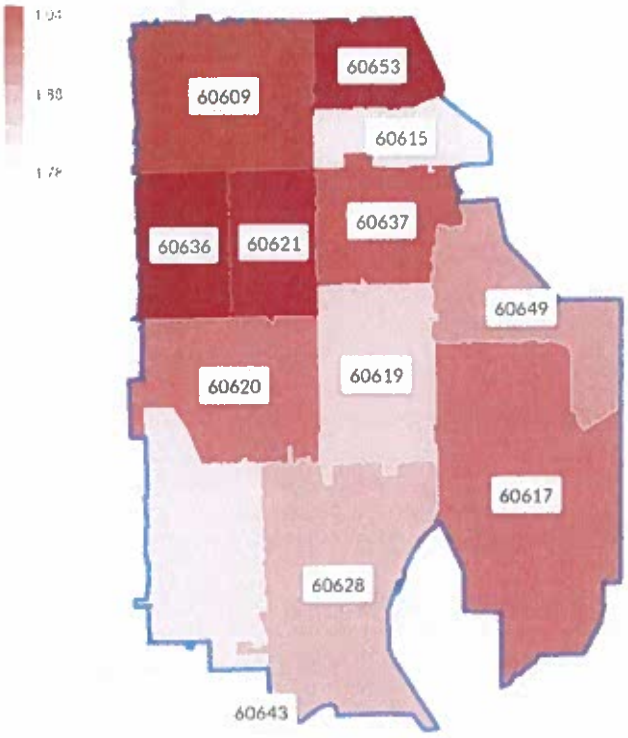
Within the UCMCSA, cancer mortality is lowest in Hyde Park and Kenwood and highest in Englewood, Washington Park, and Oakland



Average stages of cancer at diagnosis

2014-2018

UChicago Medicine PSA: 1.87



Data source: Illinois Department of Public Health, Illinois State Cancer Registry (Calculated by Metopio)

COMMUNITY INPUT

All Youth participants have an awareness of chronic disease in adults – especially diabetes and hypertension. Chronic disease was identified as one of the most common health challenges for adults in the UCMCSA, largely because of a lack of preventative care. Adult participants noted that accessing care, especially with specialists, is a huge challenge. "You have to wait months for appointments," one community member noted. Participants also want more community-based screenings for chronic disease and cancer.

Mental Health

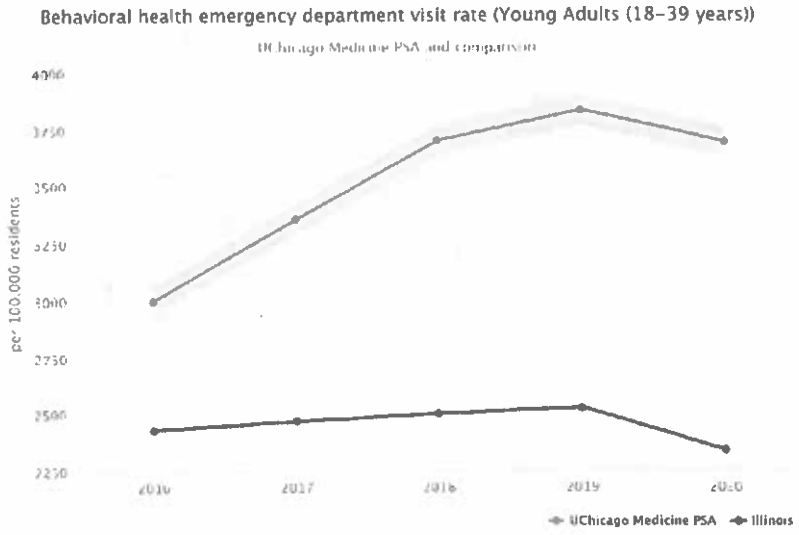
Mental health was listed as a top priority for all age groups, ranking as the second most important health concern for Youth and Adults and the third most important health concern for Seniors.

YOUTH

Youth focus group participants shared that mental health problems are everywhere in their lives, but they are not sure how to address them. Specific mental health concerns were not discussed, but high levels of poverty and violent crime indicate that juveniles in the service area face corresponding high numbers of adverse childhood experiences and traumatic events that impact their mental health.

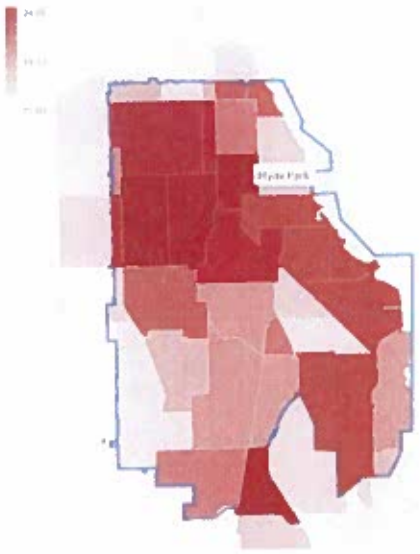
ADULTS

Adults in the UCMCSA experience some of the highest behavioral health hospitalization and emergency department visit rates. The communities within the UCMCSA rank within the 95th percentile for each of these measures.

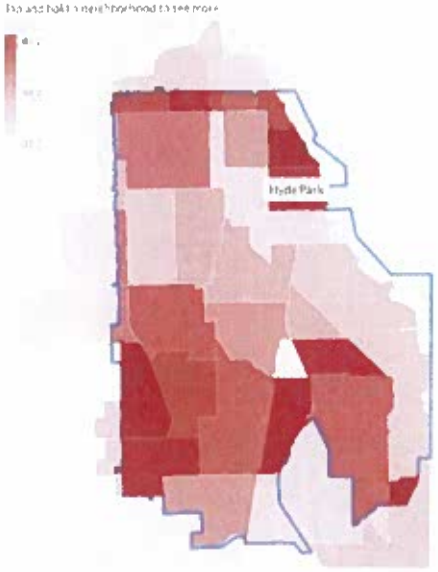


Adult focus group participants reported that loneliness, isolation, and crime contribute to poor mental health in the community. One focus group participant proposed that "loneliness has a higher rate of illness and death than smoking." Secondary data aligns with this perspective, showing that the percentage of adults who report poor mental health is inversely related to the percentage of adults who feel that they are part of their neighborhood. Poor mental health is defined as reporting "not good" mental health during 14 or more days in the past 30 days.

Poor self-reported mental health



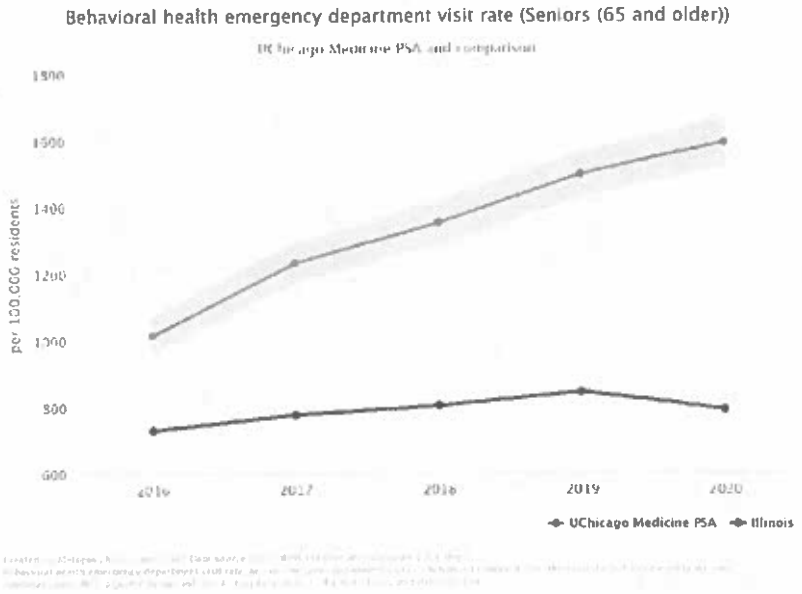
Community belonging rate



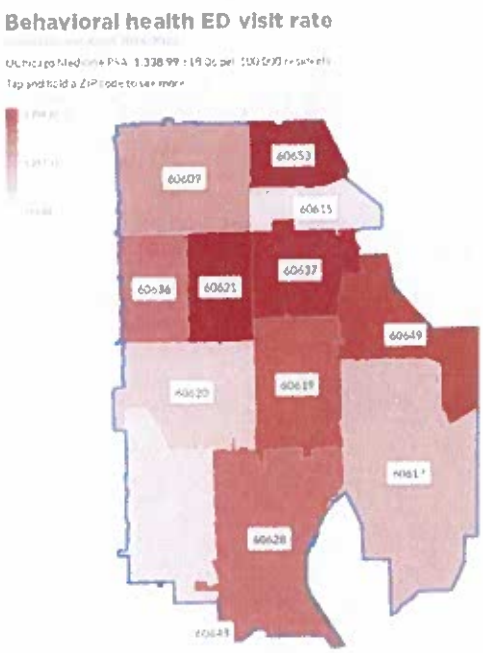
Data sources: CDC PLACES and CDPH Healthy Chicago Survey

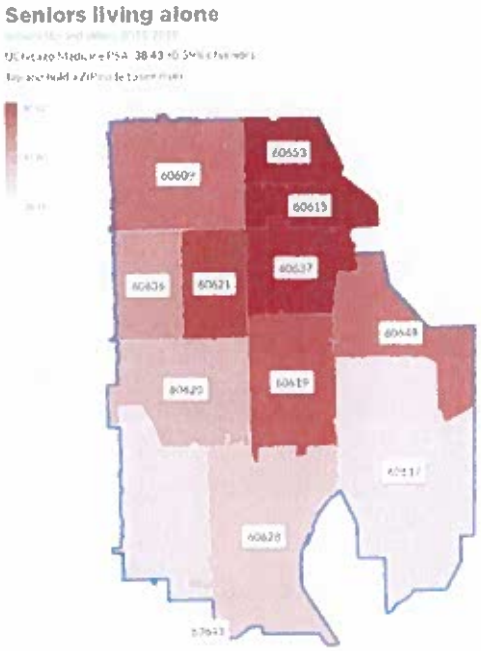
SENIORS

The UCMCSA has one of the highest behavioral health hospitalization rates for seniors (age 65+) in the state, ranking in the 95th percentile. It should be noted that the zip codes that display high rates of behavioral health hospitalization for seniors are different from those with high rates for youth and adults.



Loneliness may also play a role in the mental health status of seniors. Within the UCMCSA, the number of seniors living alone has increased by 10% over the last decade, according to data from the American Community Survey. Secondary data demonstrates a correlation between zip codes where there are a high number of seniors living alone and zip codes that have high behavioral health hospitalization rates for seniors





Data sources: CDC PLACES and CDPH Healthy Chicago Survey

Conclusion

PROCESS FOR DETERMINATION OF HEALTH PRIORITIES

The Community Benefit and Evaluation Team worked with the Community Benefit Steering Committee and the Community Advisory Council to prioritize the health issues of community benefit programming for Fiscal Years 2023-2025. These groups of internal and external stakeholders were selected for their knowledge and expertise of UCMC's community efforts, community conditions, and community health education best practices. Using a prioritization framework guided by the MAPP framework outlined in Figure 8, the process included a multi-pronged approach to determine health issue prioritization.

1. The Community Benefit Steering Committee reviewed health issue data selected by at least 30% (n=293) of survey respondents. The Community Benefit Steering Committee ranked the most severe indicators by considering existing programs and resources.

2. The Community Advisory Council discussed the rankings and community conditions that led to the health issues.

3. The CHNA Steering Committee reviewed the scores assigned to the various criteria for each health issue in the Prioritization Framework to see which issue had the highest score. These highest-scoring health issues were reconciled with previous cycles' selected priorities for a final determination of priority health issues.

Figure 8. Prioritization Framework		
Size	*How many people are affected?*	Secondary Data
Seriousness	*Deaths, hospitalizations, disability*	Secondary Data
Equity	*Are some groups affected more?*	Secondary Data
Trends	*Is it getting better or worse?*	Secondary Data
Intervention	*Is there a proven strategy?*	Community Benefit Steering Committee
Influence	*How much can UChicago affect change?*	Community Benefit Steering Committee
Values	*Does the community care about it?*	**Survey, Focus Groups, Key Informant Interviews**
Root Causes	*What are the community conditions?*	**Community Advisory Council**

UCMC Selected FY 2023–2025 Health Priority Areas

UCMC retained five of its primary health priority issues from the 2018-2019 CHNA: diabetes, mental health, violence prevention, access to care, and food insecurities. UCMC added three new issues in response to the needs assessment results: heart disease, cancer, and workforce development.

Although asthma was removed as a primary health priority issue from this CHNA cycle, UCMC will continue to maintain its current work on this issue, which was a priority in 2018-19.

The framework for this cycle's priority health areas is organized under three primary domains. These domains were retained from the 2018-2019 CHNA (Figure 9).

Figure 9. UCMC FY 2023-2025 Community Benefit Priority Areas

- Prevent and manage chronic diseases, specifically heart disease, diabetes, and cancer
- Build trauma resiliency with a focus on violence prevention and recovery and mental health
- Reduce health inequities caused by the social determinants of health, especially access to care, food insecurity, and workforce development

These domains and corresponding issues are the principal health concerns that UCMC community efforts will target, and they will serve as the designated issue areas for official reporting. They are the result of rigorous data collection and analysis in partnership with the community. These domains represent a coordinated strategy to create long-term health and prosperity on the South Side.

Adoption by the Board

University of Chicago Medical Center's Board of Directors Government and Community Relations Committee received the 2021-2022 CHNA, FY 2020-2022 Evaluation Report, and FY 2023-2025 Strategic Implementation Plan for review and formally approved all three documents in May 2022.

Contact for Feedback

Any questions or concerns regarding the CHNA, Strategic Implementation Plan, and the Evaluation Report can be sent to uch.communitybenefit@uchicagomedicine.org.

Endnotes

1 National Association of County and City Health Officials. *Mobilizing for Action through Planning and Partnerships (MAPP).* https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

2 County Health Rankings and Roadmaps. *Measures and Data Sources.* https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources

3 Department of Population Health, NYU Langone Health. *City Health Dashboard.* https://www.cityhealthdashboard.com/

4 Chicago Data Portal. (2014, September 12). *Hardship Index.* https://data.cityofchicago.org/Health-Human-Services/hardship-index/792q-4jtu

5 Morère, J.F., Eisinger, F., Touboul, C., Lhomel, C., Couraud, S., Viguier, J. 2018. Decline in Cancer Screening in Vulnerable Populations? Results of the EDIFICE Surveys. *Curr Oncol Rep, 20*(1):17. doi: 10.1007/s11912-017-0649-7. PMID: 29508084.

Community Resources Serving the UChicago Medical Center Service Area

Access Community Health Network

Ada S. McKinley Social Services

Advocate Aurora Health

Alliance of the SouthEast (ASE)

American Cancer Society

Aunt Martha's

Beloved Community Family Wellness Center

Boys and Girls Club

Cancer Support Centers

Catholic Charities

Centers for New Horizons

Centro de Salud Esperanza (Esperanza Health Centers)

Chicago Coalition for the Homeless

Chicago Department of Public Health-CDPH

Chicago Family Health Center

Chicago Park District

Chicago Survivors

Christian Community Health Center

Community Counseling Centers of Chicago

Cook County Health Department

Englewood Health Center- Cook County Health

Fearless Leading by the Youth (F.L.Y)

Friend Health

Gilda's Club

Girls Like Me Project

Grand Boulevard Prevention Services

Grand Prairie Services

Guitars Over Guns

iGrow Chicago

Illinois Coalition of Free and Charitable Clinics

Illinois Department of Public Health

Institute for Nonviolence Chicago

Jackson Park Hospital

John H. Stoger, Jr. Hospital of Cook County

Kenneth Young Center

Kids Off The Block

La Rabida Children's Hospital

Ladies of Virtue

Lawndale Christian Health Center

Lost Boyz Inc

Mental Health Association of Greater Chicago

Metropolitan Chicago Breast Cancer Task Force

Metropolitan Family Health

Miles Square Health Clinic

Near North Health

PADS Homeless Shelter

PCC Wellness

Public Equity

Roseland Community Hospital

Sinai Chicago Holy Cross Hospital

South Shore Hospital

St. Bernard Hospital and Health Care Center

St. Titus One Youth Anti-Violence & Mentoring Program

TCA Health

Thresholds

UChicago Medicine Ingalls Memorial Hospital

University of Illinois Cancer Center

What About the Children Here (W.A.T.C.H.)

Woodlawn Community Reentry Project Chicago (West Suburban Neighborhood Development Corporation)

Appendix 1:

Primary Data Tools – Community Response Survey, Focus Group Guides, Key Informant Interview Guides

Primary data was collected through the main channels:

- community surveys
- focus groups
- key informant interviews

The instruments used for each are included in this appendix

Figure 1. Community Health Needs Assessment Survey

Community Health Needs Assessment Survey

Welcome to UChicago Medicine's
Community Health Needs Assessment Survey.

This survey will only take about 10 minutes. We will ask you questions about the health needs of your community. The information we get from the survey will help us:

- Find health problems that affect the people in your community
- Better understand the needs for your community
- Work together to find a solution

The survey is voluntary and you do not have to take part. You can also skip any questions you do not want to answer or stop the survey at any time.

The answers you give are very important to us. Your answers will be private (we will not know who gave the answers) and we will protect the information you are giving. We will not share your personal information and how you answered the survey to anyone outside of UChicago Medicine.

We thank you for your help.

Your information	
Your home zip code:	How many years you lived here:
What town or neighborhood do you live in?	
What do you like best about where you live? (List up to 3 things)	
1.	
2.	
3.	

AT THE FOREFRONT UChicagoMedicine

Health Literacy and Plain Language Translation by Diversity Inclusion and Equity Department 5-12-2021 Page 1 of 9

Community Health Needs Assessment Survey	
Community Health Questions	
Tell us what you think are the 5 most important health problems in the area where you live for **children (0- 17 years old).**	**Children (0 – 17 years old)**
Abuse (child, emotional, or physical abuse, neglect, sexual assault, domestic violence)	
Access to healthy food items	
ADHD	
Autism Spectrum Disease	
Cancers	
Cerebral Palsy	
Chronic pain	
Dental disease	
Diabetes (high blood sugar)	
Epilepsy (seizures)	
Family planning (birth control)	
Heart disease (hypertension)	
Lung disease (asthma, chronic obstructive pulmonary disease or COPD)	
Mental health (depression, anxiety, post-traumatic stress disorder PTSD)	
Obesity	
Sexually Transmitted Infections (STIs and STDs), including Human Immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS)	
Substance-use (alcohol, tobacco, prescription misuse, and other drugs)	
Suicide	
Violent crime (homicide, aggravated assault, shootings)	
Other (please specify) :	

Community Health Needs Assessment Survey

Community Health Questions

Tell us what you think are the 5 most important health problems in the area where you live for **adults (18- 64 years old)**.	**Adults (18 – 64 years old)**
Abuse (child, emotional, or physical abuse, neglect, sexual assault, domestic violence)	
Access to healthy food items	
Access to prenatal care (including insurance, medical providers, transportation)	
Alzheimer's and dementia	
Arthritis	
Cancers	
Chronic pain	
Dental disease	
Diabetes (high blood sugar)	
Eating healthy (including preparing meals and cooking)	
Family planning	
Hearing and vision loss	
Heart disease (hypertension)	
Infectious diseases (hepatitis, tuberculosis or TB, flu, COVID-19)	
Lung disease (asthma, chronic obstructive pulmonary disease or COPD)	
Maternal and child health (preterm birth, gestational diabetes, maternal hypertension, preeclampsia, maternal death, infant mortality)	
Mental health (depression, anxiety, post-traumatic stress disorder or PTSD)	
Motor vehicle crash injuries	
Obesity	
Property crime (theft, burglary and robbery, motor vehicle theft)	
Sexually Transmitted Infections (STIs and STDs), including Human Immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS)	
Substance-use (alcohol, tobacco, prescription misuse, and other drugs)	
Suicide	
Violent crime (homicide, aggravated assault, shootings)	
Other (please specify) :	

Community Health Needs Assessment Survey

Community Health Questions

Tell us what you think are the 5 most important health problems in the area where you live for seniors (65 years and up).	Seniors (65 years and up)
Abuse (child, emotional, or physical abuse, neglect, sexual assault, domestic violence)	
Access to healthy food items	
Alzheimer's and dementia	
Arthritis	
Cancers	
Chronic pain	
Dental disease	
Diabetes (high blood sugar)	
Eating healthy (including preparing meals and cooking)	
Hearing and vision loss	
Heart disease (hypertension)	
Infectious diseases (hepatitis, tuberculosis or TB, flu, COVID-19)	
Lung disease (asthma, chronic obstructive pulmonary disease or COPD)	
Mental health (depression, anxiety, post-traumatic stress disorder or PTSD)	
Motor vehicle crash injuries	
Obesity	
Property crime (theft, burglary and robbery, motor vehicle theft)	
Sexually Transmitted Infections (STIs and STDs), including Human Immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS)	
Substance-use (alcohol, tobacco, prescription misuse, and other drugs)	
Suicide	
Violent crime (homicide, aggravated assault, shootings)	
Other (please specify) :	

Community Health Needs Assessment Survey

Questions About Your Community

What do you think are the most important things for a healthy community? *Circle up to 5.*

- Access to affordable and healthy food (fresh fruits and vegetables)
- Access to community services, such as resources for housing
- Access to health care
- Access to health support services (diabetes, cancer, diet, nutrition, weight management, quit smoking, end of life care)
- Access to mental health services
- Access to technology
- Access to transportation
- Affordable childcare
- Affordable housing
- Arts and cultural events
- Cancer risk reduction (mammograms, colon cancer screenings, HPV vaccine/Pap smear)
- Clean environment
- Fitness (gyms place to work out)
- Getting quality services whatever my race, gender or where I live
- Good schools
- Inclusive and equal care for all people whatever race, gender identity or sexual orientation (LGBTQ)
- Life skill trainings (cooking, how to budget)
- Parks and recreation
- Preventive ways to improve health
- Workforce development and quality job opportunities
- Racial equity
- Religion or spirituality
- Safety and low crime
- Strong community cohesion and social network opportunities
- Strong family life
- Other:

What changes would you like to see where you live?

Community Health Needs Assessment Survey

Questions About You

What is your age?

- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65-74
- ☐ 75-84
- ☐ 85 and older

How do you identify yourself?

- ☐ Male
- ☐ Female
- ☐ Transgender man/trans man/female-to-male (FTM)
- ☐ Transgender woman/trans woman/male-to-female (MTF)
- ☐ Genderqueer/gender nonconforming neither exclusively male nor female
- ☐ Additional gender category (or other): please specify: _____
- ☐ Decline to answer

Which of the following best represents how you think of yourself?

- ☐ Straight or heterosexual
- ☐ Lesbian or gay
- ☐ Bisexual
- ☐ Queer, pansexual, and/or questioning
- ☐ Something else; please specify: _____
- ☐ Don't know
- ☐ Decline to answer

Which racial and ethnic groups do you identify with? (check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian or Mideast Asian
- ☐ Black or African-American
- ☐ Choose to not disclose
- ☐ Hispanic/Latino(a)
- ☐ More than one Race
- ☐ Unknown
- ☐ White

Is a language other than English spoken in your home?

☐ Yes ☐ No

If Yes: What language or languages other than English are spoken in your home?

_____

What is the highest level of education you have completed?

- ☐ Less than high school
- ☐ Some high school
- ☐ High school graduate or graduate equivalency degree (GED)
- ☐ Vocational or technical school
- ☐ Some college
- ☐ College graduate
- ☐ Advanced degree (such as MS, MEd, MSW, MD, PhD, JD, etc.)

Community Health Needs Assessment Survey

Questions About Your Household

What are your current living arrangements?

- ☐ Own my home
- ☐ Rent my home
- ☐ Living in emergency or transitional shelter
- ☐ Living outside (e.g., unsheltered, car, tent, abandoned building)
- ☐ Living with a friend or family
- ☐ Other: _____

How many people live in your household? _____

How many children (less than 18 years old) live with you in your home? _____

If you have children in your home under the age of 18, please give the number of children in each age group.

- ☐ ____Children aged 0-4 in my household
- ☐ ____Children aged 5-12 in my household
- ☐ ____Children aged 13-17 in my household

Are you or is anyone in your household a veteran?

☐ Yes ☐ No

Do you or anyone in your household have a disability? (such as cerebral palsy, schizophrenia or sickle cell disease)

☐ Yes ☐ No

What is the yearly household income? (The total income before taxes are deducted, of every person in the home who financially helps)

- ☐ Less than $10,000
- ☐ $10,000 - $19,999
- ☐ $20,000 to $39,999
- ☐ $40,000 to $59,999
- ☐ $60,000 to $79,999
- ☐ $80,000 to $99,999
- ☐ Over $100,000

Community Health Needs Assessment Survey

Questions about Your Health

Do you have a medical or healthcare professional that you see regularly (primary care provider)?

☐ Yes ☐ No

Have you ever had any cancer screenings?

☐ Yes ☐ No

If yes, check all that apply:

- ☐ Mammogram (breast) (within past 1-2 years)
- ☐ Cervical (pap smear) or HPV test (within past 3-5 years)
- ☐ HPV vaccine for yourself, child or grandchild
- ☐ Colonoscopy (colon/intestinal screening for cancer) (within 10 years)
- ☐ Home stool (poop) test (within past 1 year)
- ☐ Prostate cancer screening
- ☐ Lung cancer screening (if history of tobacco use)
- ☐ Other (please specify): _____

If no, please explain why not:

- ☐ not aware of when I should have the screenings (age)
- ☐ lack of time
- ☐ lack of transportation
- ☐ conflicts with work schedule/can't get time off work
- ☐ lack of insurance
- ☐ fear of pain
- ☐ fear of bad results
- ☐ fear of side effects
- ☐ have no opinion but would be interested in learning more

Community Health Needs Assessment Survey

Questions About COVID-19

Were you or anyone in your household diagnosed with COVID-19 since March 2020?

☐ Yes ☐ No

Were you or was anyone in your household hospitalized since March 2020 due to COVID-19?

☐ Yes ☐ No

Because of the pandemic did you delay or avoid medical care?

☐ Yes ☐ No

Have you, or has anyone in your household had a loss of employment income during the pandemic (since March 2020)?

☐ Yes ☐ No

During the pandemic (since March 2020), how often have you been bothered by feeling down, depressed, or hopeless? *Check only one answer.*

☐ Not at all
☐ Several days every month
☐ More than half the days every month
☐ Nearly every day

How often do you have access to a computer or other digital device with internet?

☐ Always ☐ Often ☐ Sometimes ☐ Very Rare ☐ Never

Figure 2. Focus Group Moderator Guides

CHNA Focus Group Guide

Population: Broad Adult Health

Date and Time: Saturday, October 2nd, 10:00-11:30am

Location: Zoom

FACILITATION PROTOCOLS

1. Establishing ground rules

- Establish purpose of the focus group
  - We are meeting today to learn about your community. Specifically, we want to understand what you like about where you live and what you would like to see changed. We also want to understand the biggest health challenges your family and friends face
  - You were selected to participate in this focus group because of the valuable insight you can provide
  - We would like to understand how the hospital can partner to make improvements in your neighborhood
- Establish confidentiality of the participants' responses.
  - Our team will be taking notes about what is discussed, but individual names or identifying information will not be used
- Establish guidelines for the conversation
  - Keep personal stories "in the room"
  - Everyone's ideas will be respected
  - One person talks at a time
  - It's okay to take a break if needed or to help yourself to food or drink (if provided)
  - Everyone has the right to talk
  - Everybody has the right to pass on a question
  - There are no right or wrong answers
- Explain to participants how their input will be used
  - Your input is part of the Community Health Needs Assessment process
- Give participants an estimated timeline of when results will be shared
  - We expect to make the report available in the spring of 2022
- Establish realistic expectations for what the hospitals and partners can do to address community needs

2. Introductions

- When we speak about community it can have different meanings. For example, it can mean your family, the people you live or go to school with, the neighborhood you live in, a group of people you belong to. We are interested in hearing about your community, no matter how you define it
- The facilitator will go around the room and ask each participant
  - Name
  - How long have you lived in the community?
  - What one word would you use to describe your community?

3. Survey-alignment questions

- Can you describe your community?
  - What are things you like?
  - What are the challenges?
    - How can those challenges be overcome?

4. Health questions

- What do you think are the biggest health challenges in your community?
  - Follow up on specifics—diabetes, heart disease, asthma/COPD, cancer, sickle cell, substance abuse
  - With chronic disease answers probe on what are the specific challenges (i.e. managing diabetes, accessing medicine, getting screened, etc.)
  - For cancer ask about specifics
  - For substance abuse follow up on types—alcohol, marijuana, opioids, other?
- What do you think could prevent these issues from being so challenging?
  - Follow up on specific ideas--Access to preventive care? Education?
- How has COVID-19 impacted you and your community?
  - Follow up on specifics—job loss, homeschooling, severe illness, mental health, ability to access the internet and health information at home

5. Access and Education questions

- How easy is it for adults in your community to access health services?
  - Do they have a primary care provider?
  - Can they access Behavioral Health services?
  - Are they able to get cancer screenings and vaccinations?
  - Is Telehealth an option? Why/why not?
  - Is transportation a barrier?
- How easy is it for adults in your community to maintain a healthy lifestyle?
  - Is there access to healthy food?
  - Where do people shop/eat?
  - Are there places to exercise? Do they or their family/friends exercise regularly?
- What resources are available in your community to maintain health?
  - Follow up on medical care options as well as social cohesion

6. Solutions and strategies questions

- What do you think a community needs to be healthy?
  - Depending on responses, follow up on specifics
- What would make it easier for people to exercise?
- What would make it easier to eat healthy?
- What else would like to see changed in your community?
- What do you think UChicago could do to help your community?

7. Final Questions

- Where do you get your health information now?
- What is the best way to communicate with you about health information?

8. Closing and Next Steps

- Explain how the notes will be synthesized and shared
- Ask whether participants would like to be involved in future stages of the CHNA and set the process for continued engagement
- Thank everyone for their participation

CHNA Focus Group Guide

Hospital UChicago Medicine

Population Broad Youth Health

Location Gary Comer Youth Center

FACILITATION PROTOCOLS

1. Establishing ground rules

- Establish purpose of the focus group
  - We are meeting today to learn about your community. Specifically, we want to understand what you like about where you live and what you would like to see changed. We also want to understand the biggest health challenges your family and friends face
  - You were selected to participate in this focus group because of the valuable insight you can provide
  - We would like to understand how the hospital can partner to make improvements in their neighborhoods
- Establish confidentiality of the participants' responses
  - Our team will be taking notes about what is discussed, but individual names or identifying information will not be used
- Establish guidelines for the conversation
  - Keep personal stories "in the room"
  - Everyone's ideas will be respected
  - One person talks at a time
  - It's okay to take a break if needed or to help yourself to food or drink (if provided)
  - Everyone has the right to talk
  - Everybody has the right to pass on a question
  - There are no right or wrong answers
- Explain to participants how their input will be used
  - Your input is part of the Community Health Needs Assessment process
- Give participants an estimated timeline of when results will be shared
  - We expect to make the report available in the spring of 2022
- Establish realistic expectations for what the hospitals and partners can do to address community needs.

2. Introductions

- When we speak about community it can have different meanings. For example, it can mean your family, the people you live or go to school with, the neighborhood you live in, a group of people you belong to. We are interested in hearing about your community, no matter how you define it
- The facilitator will go around the room and ask each participant:
  - Name and age
  - How long have you lived in the community?
  - What one word would you use to describe your community? (Probe: Tell me a little bit more what you mean by that?)

3. Survey-alignment questions

- Can you describe your community?
  - What are things you like?
  - What are the challenges?
    - What do you think are ways those challenges could be overcome?
- What does being "healthy" mean to you?
  - What makes it easy to be healthy?
  - What makes it hard to maintain health?
- What do you think are the biggest health challenges your community has?
  - Follow up on specifics—Chronic disease, mental health, social determinants?
- Can you tell us about a normal day?
  - What do you do before school? After school?
- Based on your experience, do people in your community leave the community to see a doctor or get other health services?
  - Why/why not?
- How has COVID-19 impacted you and your family?
  - Follow-up on specifics—school, internet access at home, job loss, sick family members

4. Solutions and strategies questions

- What do you think a community needs to be healthy?
  - Depending on responses, follow up on specifics—what kinds of jobs or schools or parks, etc.?
- What would like to see changed?
- What do you think UChicago could do to help your community?

5. Closing and next steps

- What is the one thing you think should be done right now to help kids in your community?
- Do you have any questions for me at this point?
- Explain how the notes will be synthesized and shared
- Ask whether participants would like to be involved in future stages of the CHNA and set the process for continued engagement
- Thank everyone for their participation

CHNA Focus Group Guide

Population: Maternal and Child Health

Date and Time: Thursday, October 7th, 5:30-7:00pm

Location: Zoom

FACILITATION PROTOCOLS

1. Establishing ground rules

- Establish purpose of the focus group
  - We are meeting today to learn about your community. Specifically, we want to understand what strengths exist for mothers and children and what you would like to see changed. We also want to understand the biggest health challenges expecting mothers and young children face
  - You were selected to participate in this focus group because of the valuable insight you can provide
  - We would like to understand how the hospital can partner to make improvements in your neighborhood
- Establish confidentiality of the participants' responses
  - Our team will be taking notes about what is discussed, but individual names or identifying information will not be used
- Establish guidelines for the conversation
  - Keep personal stories "in the room"
  - Everyone's ideas will be respected
  - One person talks at a time
  - It's okay to take a break if needed or to help yourself to food or drink (if provided).
  - Everyone has the right to talk
  - Everybody has the right to pass on a question
  - There are no right or wrong answers
- Explain to participants how their input will be used
  - Your input is part of the Community Health Needs Assessment process
- Give participants an estimated timeline of when results will be shared
  - We expect to make the report available in the spring of 2022
- Establish realistic expectations for what the hospitals and partners can do to address community needs

2. Introductions

- When we speak about community it can have different meanings. For example, it can mean your family, the people you live or go to school with, the neighborhood you live in, a group of people you belong to. We are interested in hearing about your community, no matter how you define it
- The facilitator will go around the room and ask each participant
  - Name
  - How long have you lived in the community?
  - What one word would you use to describe your community?

3. Survey-alignment questions

- Can you describe your community?
  - What are things you like?
  - What are the challenges?
    - How can those challenges be overcome?

4. Expecting Mothers

- What do you think are the biggest challenges expecting mothers face in your community?
  - Follow up on specifics—access to prenatal doctor's visits, nutrition, counseling, support groups?
  - What services are available and how are they accessed?
  - What services are missing?
  - Do you feel like expecting mothers in your community know what services are available?
- In a women's family, who helps a mother to remain healthy during her pregnancy?
  - Follow-up with who specifically—spouse, partner, immediate family?
  - How are they helpful—advice, taking them to appointments, taking care of other kids?
- In your community, who helps expecting mother's during their pregnancy?
  - Follow-up asking on specific roles and organizations—social workers, nurses, midwives? Church, social services, etc.?
- How has COVID-19 impacted you and your children? How about other expecting mothers and newborns in your community?
  - Follow up on specifics—job loss, homeschooling, severe illness, mental health, ability to access the internet and health information at home

5. Mothers and Infants

- How easy is it for newborns and infants in your community to access health services?
  - Do they have a pediatrician?
  - Are they able to get vaccinations?
  - Is Telehealth an option? Why/why not?
  - Is transportation a barrier?
- What do you think mothers should/can do to keep their newborns healthy?
  - Follow-up on specifics—what, in their opinion, do new mothers feed their babies? (i.e. breastfeeding, powder milk, etc.)
  - Are there any resources to help mothers with infant nutrition?
- What other resources are available in your community to help you with your newborn?
  - Follow up on medical care options as well as social cohesion
  - When mothers have to go back to work, who takes care of the infant?
- When you think about the future health of your baby, what do you need to do to for it to remain healthy?
  - Follow-up on specifics—family support, healthy food, community cohesion, education, team sports, babysitters?
- What do new mothers need to keep themselves healthy?

6. Solutions and strategies questions

- What do you think makes a community a good place to raise a child?
- What would make it easier for mothers to access prenatal services?
  - Depending on responses, follow up on specifics
- What would make it easier for children to be healthy?
- What, if anything, would you like to see changed in your community?
- What do you think UChicago could do to help your community?

7. Final Questions

- Where do you get your health information now?
- What is the best way to communicate with you about health information?

8. Closing and Next Steps

- Explain how the notes will be synthesized and shared
- Ask whether participants would like to be involved in future stages of the CHNA and set the process for continued engagement
- Thank everyone for their participation

CHNA Focus Group Guide

Population: Mental Health

Date and Time: Tuesday, October 5th, 5:30-7:00pm

Location: Zoom

FACILITATION PROTOCOLS

1. Establishing ground rules

- Establish purpose of the focus group
  - We are meeting today to learn about your community. Specifically, we want to understand what mental health resources are available and where there are barriers to accessing services
  - We want to understand the strengths and challenges in your community with mental health and mental health services
  - You were selected to participate in this focus group because of the valuable insight you can provide
  - We would like to understand how the hospital can partner to make improvements in your neighborhood
- Establish confidentiality of the participants' responses
  - Our team will be taking notes about what is discussed, but individual names or identifying information will not be used
- Establish guidelines for the conversation
  - Keep personal stories "in the room"
  - Everyone's ideas will be respected
  - One person talks at a time
  - It's okay to take a break if needed or to help yourself to food or drink (if provided)
  - Everyone has the right to talk
  - Everybody has the right to pass on a question
  - There are no right or wrong answers
- Explain to participants how their input will be used
  - Your input is part of the Community Health Needs Assessment process
- Give participants an estimated timeline of when results will be shared
  - We expect to make the report available in the spring of 2022
- Establish realistic expectations for what the hospitals and partners can do to address community needs

2. Introductions

- When we speak about community it can have different meanings. For example, it can mean your family, the people you live or go to school with, the neighborhood you live in, a group of people you belong to. We are interested in hearing about your community, no matter how you define it
- The facilitator will go around the room and ask each participant
  - Name
  - How long have you lived in the community?
  - What one word would you use to describe your community?

3. Survey-alignment questions

- Can you describe your community?
  - What are things you like?
  - What are the challenges?
    - How can those challenges be overcome?

4. Health questions

- What does "mental health" mean to you?
- How do you think people in your community would define "mental health?"
- What do you believe are the biggest mental health challenges in your community?
  - Follow up on specifics—stress, depression, schizophrenia, anxiety, trauma, substance abuse
  - Why do you think people in your community experience these mental health challenges?

  Probe if substance abuse is raised--What do you think is most challenging—alcohol, marijuana, heroin, opioids, other?
- What do you think are the biggest challenges/barriers for seeking mental health treatment in your community?
  - Follow up on specifics—stigma, lack of understanding, no options for care, family support
- What do you think could prevent these issues from being so challenging?
  - Follow up on specific ideas--Access to care? Education? Support groups?
- How has COVID-19 impacted mental health in your community?
  - Follow up on specifics triggers—job loss, restlessness, housing instability, sick family members

5. Access questions

- How do people in your community access mental health services (if at all)?
  - Do they have a way to see a provider (social worker, psychologist or psychiatrist)?
  - Is insurance and/or cost a barrier?
  - Is Telehealth an option? Why/why not?
  - Is transportation a barrier?
- How do people in your community access substance abuse services?
  - Follow-up on specifics—do people seek treatment? How and where?
- What resources are available in your community to maintain mental health?
  - Follow up on medical care options as well as social cohesion

6. Solutions and strategies questions

- What do you think a community needs to have in order to help people with their mental health?

Figure 3. Key Informant Interview Guide

CHNA Key Informant Interview Guide

FACILITATION PROTOCOLS

1. Establishing ground rules

- Establish purpose of the interview
  - UChicago Medicine is conducting a Community Health Needs Assessment and your input is an important part of the work
  - We have collected thousands of surveys and held over two dozen focus groups. Now we are interviewing key informants like yourself
  - You were selected to participate in this interview because of the valuable insight you can provide
  - We would like to understand how the hospital can partner to improve the health of the community
- Establish confidentiality of the conversation
  - I will be taking notes about what is discussed, but your name and identifying information will not be used
- Give participants an estimated timeline of when results will be shared
  - We expect to make the report available later this year

2. Introductions

- During our time together, I'm interested in learning about your work and the needs of the people you serve
- What is your
  - Name?
  - Organization?
  - Work you do for that organization and/or the community?

3. Survey-alignment questions

- What are strengths you see with your patients/community members right now?
- What are the challenges they face?
  - How do you think those challenges can be addressed?
- What programs or partnerships have worked well? Why?

4. Health questions

- What do you think are the biggest health challenges your patients/constituents/community members face?
  - Follow up on specifics—diabetes, heart disease, asthma/COPD, cancer, sickle cell, substance abuse, mental health
  - With chronic disease answers probe on what are the specific challenges (i.e. managing diabetes, accessing medicine, getting screened, etc.)
  - For cancer ask about specifics
  - For substance abuse follow up on types—alcohol, marijuana, opioids, other?
- How has COVID-19 impacted you and your work?

5. Social Determinant questions

- What elements in the community make it hard for people to be healthy?
  - Follow up on food access, affordable housing, childcare, crime, access to care, etc
- How can UChicago Medicine help address these issues?

6. Next Steps

- Explain how the notes will be synthesized and shared
- Thank them for their participation

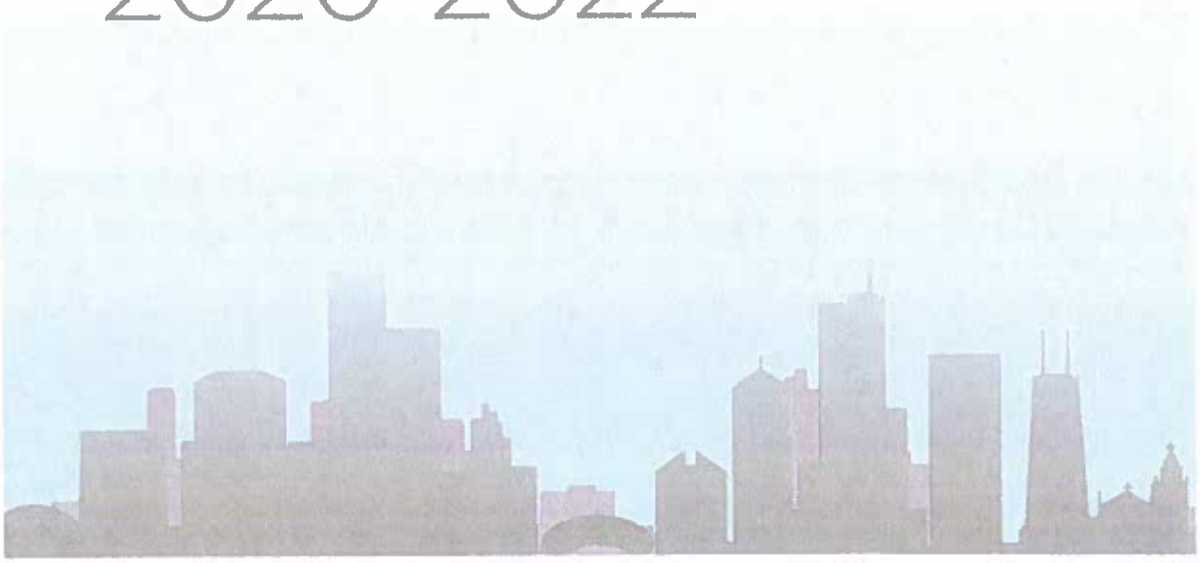
Appendix 2:

Evaluation Report FY 2020-2022

AT THE FOREFRONT
UChicago Medicine

Community Benefit Evaluation Report

Fiscal Years
2020-2022



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Background

The University of Chicago Medical Center (UCMC) has a long history of community-based programming designed to improve the health and vitality of residents living on the South Side of Chicago. These initiatives span a myriad of health issues and are implemented using a variety of methods. The results of these endeavors often serve to inform further programming, with the ultimate goal of improving health among residents on the South Side.

In recent years, as an imperative of the Internal Revenue Service (IRS), UCMC has diligently focused its efforts around specific health priority areas informed by a **Community Health Needs Assessment (CHNA)** and its resultant **Strategic Implementation Plan (SIP)**. These components inform our **community benefit strategic framework** by providing a roadmap to maximize community benefit dollars to address unmet community needs. This roadmap also provides an important snapshot, allowing us to look back on collective efforts while evaluating our impact on goals tied to each priority health area.

WHAT IS COMMUNITY BENEFIT?

In line with the Internal Revenue Service (IRS) and the Catholic Health Association (CHA), UCMC defines community benefit as programs and services undertaken by nonprofit hospitals designed to improve health in the communities they serve and increase access to healthcare.

Purpose

This evaluation report provides a comprehensive summary of UCMC and its community partners' efforts to address the 2018-2019 CHNA priority health areas, as outlined in the FY 2020-2022 SIP. This report summarizes the collective efforts and impact achieved through community benefit programs and services. UCMC recognizes that achieving community-level impact can only occur through collaborative, iterative processes that center around patient and community voices. Furthermore, we work to pilot and scale these programs to ensure that the most effective systems are in place to implement the most impactful programs.

One of the key goals of community benefit is to demonstrate UCMC's reach and impact across its service area, learning from the experience and strategies implemented over the past three years. Although there are limitations in quantifying impact (e.g., program turnover, inconsistent program reporting, adaptations of programs), we have identified key core processes and outcome-level metrics to establish a snapshot of the broad-scale impact on the community and its issues.

Looking Back: UCMC's Service Area, 2018-2019

UCMC is located in the Hyde Park neighborhood on Chicago's South Side—a storied and unique collection of vibrant, resilient, culturally rich, and diverse communities. Steeped in African-American heritage and history, the South Side is marked by deep social bonds and anchored by vital community and faith-based organizations. As part of the community benefit requirements, UCMC defines its service area as 12 contiguous zip codes[1] surrounding UCMC (see Figure 1). In 2018–2019, the UCMC Service Area (UCMCSA) included 28 locally defined community areas and had a population of approximately 625,707 people.[2]

Institutional and structural racism, disinvestment, and neglect have contributed to the erosion of critical social, economic, and health-promoting infrastructure necessary to address priority health needs. As a result, communities in the UCMCSA continue to experience some of the worst economic, social, and health outcomes across Chicago

Figure 1. UCMC Service Area

1 UCMCSA's 12 zip codes are as follows: 60609, 60615, 60617, 60619, 60620, 60621, 60628, 60636, 60637, 60643, 60649, 60653

2 2018-2019 Community Health Needs Assessment

Looking Back: Priority Health Areas of Focus for 2020-2022

Using the 2018–2019 CHNA as foundational data, a CHNA multidisciplinary workgroup selected **seven priority health areas** for the FY 2020-2022 community benefit cycle. Asthma, Diabetes, Violence Prevention and Recovery, Mental Health, Access to Care, Food Insecurities, and Employment. These were further organized[3] under three priority health domains: (I) Prevent and manage chronic diseases, (II) Build trauma resiliency; and (III) Reduce inequities caused by social determinants of health.

Figure 2. Community Benefit Priority Health Areas (2020-2021)

Figure 3. Community Benefit Priority Health Area Goals (2020-2022)

3 2016 UCMC Selected Health Priority Areas were organized under domains Pediatric, Adult, Adult and Pediatric, rather than by broad health topics as demonstrated in the 2020-2022 SIP

Evaluation Report Methods

This evaluation report shares the programmatic efforts undertaken across the UCMCSA to meet priority health area goals and produce intended outcomes as outlined in the FY 2020-2022 Strategic Implementation Plan. This report compiles rich qualitative and quantitative data collected from a wide array of stakeholders, including data from community benefit grantees, program operations and evaluation data, and community event logs—with results organized under each priority health area of the 2018-2019 CHNA.

As a large academic medical institution in an urban setting, UCMC runs many community-based initiatives that target various health issue areas. To gain a full understanding of the programs at UCMC, the Community Benefit Team conducted a comprehensive inventory via two approaches utilized in its last cycle

1. **UCMC website scan and CBISA review:** Initial review of the UCMC website revealed UHI community-based programs, departmental descriptions of community-based initiatives, and faculty research or program descriptions. The Community Benefit Team cross-checked these programs against its list of existing programs cataloged in the Community Benefit Inventory for Social Accountability (CBISA) platform.
2. **Departmental interviews and meetings:** Ongoing updates and reviews with UCMC staff and faculty occurred throughout the CHNA process. The Community Benefit Team was able to discover additional programs and/or program details to include in this report.

Once a list of programs and partners was established, the Community Benefit Team requested data from identified contacts regularly, via REDcap surveys and emails, to enter into CBISA to facilitate annual IRS reporting requirements.

Additional data were requested as part of the 2021-2022 CHNA cycle in preparation for this report's development. These requests were sent individually to contacts, and all requests asked for process and outcome data aligned with the FY 2020-2022 SIP intended outcomes to streamline reporting efforts.

Evaluation Report Data

Identified programs and services were asked to share specific process and outcome metrics that demonstrated impact on the priority health area goals (outlined on page 4, Figure 3). Programs addressing priority health areas internally, as well as those implemented by partner organizations, were required to incorporate one or more measures listed in the FY 2020-2022 SIP, which allowed the aggregation of specific results across all programs.

Because of the varied program structures and approaches under UCMC's portfolio of community benefit efforts, the Community Benefits Team defined three overarching areas to organize data sources and reporting mechanisms to further clarify the comprehensive picture of community benefit in the UCMCSA.

Figure 4. Evaluation Report Data Sources

Community-Based Partners

Community-based programs provide UCMC with data based on program goals and objectives These data include process and outcome level measures, often captured through activity logs, standard or customized designed reporting templates, surveys, Electronic Medical Records, and qualitative reports.

UCMC Departments

Multiple UCMC department staff and faculty work collaboratively with community partners and internal stakeholders to track and log program activities and services to capture process-level data on UCMC-designed tracking tools.

Data Systems

UCMC faculty and/or staff utilize databases and/or internal tracking templates to document and report programs and services as requested or on a regular reporting basis. UCMC tracks all programs operated by UCMC using a standard database and program dashboards.

The UHI Community Benefits Team organized the collected programs and services data, aggregated it under the corresponding priority health area(s), and used the findings to illustrate impact of said programs and services to better understand the impact to share with community stakeholders. Figure 5 highlights some of the key tools put into place to monitor progress across programs and ultimately assess programmatic impact.

Figure 5. Pathway to Community Benefit Evaluation

Evaluation Report Development

Using the process outlined above, the UCMC Community Benefit Team was able to evaluate the breadth of community benefit initiatives, as well as their impact, by actively integrating sound evaluation methods for monitoring, assessment, and reporting. For completed programs, both process and outcome measures (if available) are presented, while only the process measures are presented for programs that are ongoing or in their infancy. Unless a statistical test is noted, outcome measures (change in knowledge or behavior) presented are pre/post percent changes for which statistical significance cannot be assessed. When possible, overall reach across focus areas is presented using process-level metrics. The following report sections highlight key programmatic results aligned with the UCMC-selected health priority areas identified through the FY 2020-2022 SIP.

Findings

The following pages profile evaluation results and impact across asthma, diabetes, violence prevention and recovery, mental health, access to care, food insecurities, and employment—the priority areas identified in the FY 2020-2022 Strategic Implementation Plan.

COVID-19 Impact on Findings

Throughout this report, findings include specific callouts to COVID-19 efforts and the pandemic's effects on programs and services. This report also includes an additional section summarizing specific COVID-19 efforts beyond our outlined priority health areas on page 39. ***The magnifying glass icon is used throughout this report to denote COVID-19's impact on services across focus areas and/or where efforts pivoted to continue operating during the pandemic to meet ongoing community needs.***

Unless otherwise noted, all data are for FY 2020–2022

Community Benefit Health Priority Areas:

I. PREVENT AND MANAGE CHRONIC DISEASE

Asthma

Building on the FY 2020-2022 Strategic Implementation Plan, UCMC continued to collaborate with community hospitals, community-based organizations, and community health centers to implement programs that addressed environmental factors and asthma management behaviors. UCMC focused its efforts on maintaining the South Side Pediatric Asthma Center (SSPAC) and deploying community health workers. Despite COVID-19 disruptions, both SSPAC and asthma community health workers were able to continue services using virtual methods of communication and engagement.

Goal	**Strengthen people's ability to appropriately manage asthma**
Objectives	◦ Reduce hospitalizations, emergency department visits, and missed school/work days for asthma ◦ Increase education and treatment plans for people with asthma ◦ Improve provider understanding and treatment of asthma ◦ Increase understanding of asthma triggers and environmental modification
Impact	Leveraging existing partnerships, the **South Side Pediatric Asthma Center** continued its efforts to address asthma in the community. Collectively, the implemented strategies led to an increased number of families and children being educated on asthma management, even with their Summit event being moved to a virtual format. The **Community Health Worker program** continued to offer individualized services and home visits (in-person and via Zoom) to assist patients and families with managing asthma, including asthma triggers.

The following programs are included to demonstrate the impact on asthma as a priority health area, in alignment with the above goal and objectives:

South Side Pediatric Asthma Center (SSPAC)

The SSPAC is a multi-institution partnership in collaboration with UCMC's Comer Children's Hospital, La Rabida Children's Hospital, Friend Family Health Center, and St. Bernard Hospital. The SSPAC focuses on improving health outcomes among children with asthma by facilitating access to care and promoting standardized treatment and education through community engagement and outreach. **The various components of SSPAC and their impact are highlighted below.**

Community Education

The education arm of the SSPAC develops and distributes standardized and easy-to-understand asthma education materials (reviewed for health literacy), hosts an annual **Asthma Summit**, and provides ongoing asthma training to school staff, daycare center staff, parents, and clinical providers. They also participate in community events to promote asthma awareness and education to caregivers. Despite COVID-19 disruptions to community events, the SSPAC outreach coordinator was able to work with community stakeholders to organize education sessions, attend virtual community events, and maintain an in-person presence at events that took place outdoors or indoors with new safety measures.

25
Community Events

4,918
Community Members Reached

69
Daycare Staff Educated on Asthma Management Basics

264
School Staff Educated on Asthma Management Basics

SSPAC Annual Asthma Education Summit

Due to the COVID-19 pandemic, the SSPAC leveraged virtual platforms in 2020 and 2021 to increase the number of annual summit attendees. Virtual platforms increased accessibility, thereby reaching a larger audience for **a combined 3-year attendance number of 312 participants**. Further breakdown is detailed below:

SSPAC Summit		"Compared to before the Asthma Education Summit, my overall knowledge of pediatric asthma":		
Year	Attendees	Stayed the same	Increased slightly	Increased greatly
2019	114	-	21.2%	78.8%
2020	119	5.1%	46.2%	48.7%
2021	79	11.8%	47.1%	48.7%

Asthma Community Health Worker Program (SSPAC/LinC)

UCMC's Asthma Community Health Worker (CHW) program is part of two larger UHI initiatives: SSPAC and the newly developed Liaisons in Care (LinC) CHW Program.[4] As part of these initiatives, asthma CHWs serve as liaisons between a family and the participant's clinical provider. CHWs provide home visits, asthma management education, and environmental assessments to identify and mitigate triggers and connect participants to community resources. Due to the COVID-19 pandemic, CHWs paused home visits from March-May 2020. During this time, CHWs developed new processes for providing virtual home visits via Zoom and/or FaceTime platforms and continued patient encounters via phone, text-based engagement, and video calls.

Asthma CHW Visits	
Patients who received *at least* one home visit	294 patients
Total home visits completed	606 home visits completed
Virtual visits** completed	1,529 virtual patient visits completed
Patients who received supplies to manage in-home asthma triggers	206 patients
Asthma CHW Interventions*	
Number of patients with asthma that reported receiving formal asthma education from CHW	498 patients
Proportion of persons with asthma who received written asthma management plans from their healthcare provider	76% (392 out of 519 CHW asthma patients)
Proportion of persons with asthma who have received an assessment of environmental triggers in the home	40% (207 out of 519 CHW asthma patients)

4 For a full description of the LinC program, see page 28

*Data Timeframe: July 1, 2019 – January 31, 2022. During this period, a total of 519 patients were engaged by and/or enrolled in the Asthma CHW program

** Virtual visits include both phone and video (Zoom) visits with an asthma CHW

ECHO-Chicago: Pediatric Asthma Series

Echo-Chicago is a "telementoring" service for community-based providers It expands access to care by leveraging existing assets to build primary care capacity Providers gain knowledge and skills for managing chronic conditions, including asthma

ECHO-Chicago trained 51 community providers through the Complex Pediatric Asthma series:

63% of providers were from FQHCs, safety net hospitals, and free and charitable clinics

85% of participants showed an increase in self-efficacy or confidence in their ability to manage complex asthma after completing the series, as compared to baseline

91% of participants reported having made at least one change to their practice by the end of the series

Diabetes

Our mechanism for scaling efforts to address diabetes included engaging in community-based education and outreach and launching our new CHW program service line for patients with hypertension and/or diabetes Programs such as physical fitness and wellness programs were continued during this timeframe, despite changes in format due to COVID-19.

Goal	**Improve the health and quality of life for those living with diabetes**
Objectives	» Improve glycemic control and diabetes-related care among persons with diabetes » Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education » Increase prevention behaviors in persons at high risk for diabetes and those with prediabetes » Increase consumption of nutritious food and physical activity among persons with diagnosed diabetes
Impact	UCMC's **community-based education and outreach initiatives** enabled UCMC staff to provide comprehensive diabetes education to community members to promote prevention behaviors. Collectively, diabetes programs increased access to diabetes self-management education and access to places for physical activity and nutrition education The launch of our **Liaisons in Care (LinC) CHW program** in January 2021 extended our CHW services beyond asthma. The hypertension and diabetes service line launched on December 8, 2021, to provide navigation support to patients with diabetes. CHWs provided individualized services, formal education, and home and virtual visits to improve health behaviors and quality of life for those living with diabetes.

The following programs are included to demonstrate the impact on diabetes as a priority health area, in alignment with the goal and objectives on the previous page:

Diabetes Education and Empowerment Program (DEEP)

The UHI Community Outreach team continued to coordinate the Diabetes Education and Empowerment Program™ (DEEP™) workshops at no cost to community members. DEEP™, a diabetes self-management program, is successful in helping participants take control of their disease and reduce the risk of complications. The purpose of DEEP™ is to reduce diabetes-related health disparities among minorities in the U.S. and prevent and/or reduce adverse health outcomes related to diabetes. Due to COVID-19, classes were moved to virtual platforms.

Number of DEEP Education Sessions	Total Community Members Registered to Attend Education Sessions	Total Community Members Educated
22	231	276

South Side Fit (SSF)

In 2017, UCMC partnered with the Timothy Community Corporation (TCC) to launch the SSF program to **increase community access and capacity to achieve healthy living lifestyles and manage chronic conditions**. With input from the community and faith-based organizations, a four-pronged model was developed: education, disease management, physical activity, and faith messaging. SSF aims to give participants assessments of their health, exercise, diet habits, weight, Body Mass Index (BMI), and blood pressure. To meet health goals, participants commit to regular exercise, health consultations, nutritional and lifestyle seminars, and exercise classes, including Zumba, yoga, cycling, low-impact workouts, and walking groups.

In 2019, SSF hired a health coach to provide one-on-one behavior change counseling to program participants to increase prevention behaviors and/or manage chronic conditions such as diabetes, high blood pressure, and high cholesterol. Due to the COVID-19 pandemic, class offerings and health coach meetings were moved to virtual platforms in March 2020. Biometric screenings/assessments were also stopped and have yet to restart. Despite these COVID-19 limitations, the workshop and fitness class components of SSF continued virtually, providing an ongoing means to increase physical activity for those with limited access to health classes and fitness resources.

Total SSF Classes Offered	Total SSF Class Attendees
647	1,783

Community Fitness Walkers

This program has been in existence for over 24 years at the Museum of Science and Industry and encourages adults in the community to integrate healthy fitness habits into their lifestyles. Three days a week, the museum is open for all adults to walk, and they offer a cardio class twice a week. Due to COVID-19, classes were moved to Facebook from March-May 2020. Despite the shift in class delivery, **the program conducted 321 total fitness sessions from FY 2020-2022 (an average of 107 classes per year). These fitness sessions reached 10,376 community members, with an average of 32 attendees per session.**

ECHO-Chicago: Diabetes Series

ECHO-Chicago is a "telementoring" service for community-based providers. It expands access to care by leveraging existing assets to build primary care capacity. Providers gain knowledge and skills for managing chronic conditions, including diabetes.

In 2020, ECHO-Chicago piloted a new series focused on complex diabetes. ECHO-Chicago trained 30 community providers to provide care to patients with complex diabetes diagnoses through this pilot program.

100% of participating providers were from Federally Qualified Health Centers and community health clinics

87% of participants showed an increase in self-efficacy or confidence in their ability to manage complex diabetes after completing the series when compared to the baseline

92% of participants reported having made at least one change to their practice by the end of the series

II. BUILD TRAUMA RESILIENCY

Violence Prevention & Recovery

Urban violence is a complex and systematic issue requiring multiple stakeholders to invest in a multitude of approaches and strategies. As noted in the FY 2020-2022 Strategic Implementation Plan, care delivery services such as violence prevention and recovery programs for patients coming to the trauma center served as a primary pillar in our work to address community violence. Additionally, UCMC continued to expand its reach by growing partnerships with community-based organizations that address violence prevention at the community level.

Goal	**Trauma Prevention and Recovery on the South Side**
Objectives	• Reduce violent re-injury • Provide wraparound resources to support the holistic needs of our patients and their families experiencing trauma and linking them to specialized, trauma-informed counseling services and other community-based social supports • Invest in community-based organizations that provide critical resources that help children and adults, as well as their families and the community, build long-term trauma resiliency
Impact	UCMC supported **49 community-based partners** to provide immediate and ongoing support to existing community-based violence prevention programs, which addressed career development, gang and violence prevention, education and training, and self-awareness. In addition, **hospital-based programs were expanded** to serve higher volumes of patients with wraparound services to reinforce the continuity of care. Through these **strategic partnerships** and this multi-pronged approach, UCMC **asserts a nontraditional approach** to violence prevention and recovery.

The following programs are included to demonstrate the impact of violence prevention initiatives as a priority health area, in alignment with the above goal and objectives:

Violence Recovery Program (VRP)

Launched in May 2018, the VRP is designed to reduce violence through holistic interventions that lead to sustainable, long-term recovery from violent traumatic injury for adult patients, pediatric patients, and their families. VRP services begin when a patient arrives at the Emergency Department (ED) and the patient and/or family meets a Violence Recovery Specialist (VRS). Services provided include crisis intervention, helping patients and families navigate the healthcare system (immediate and post-discharge), evaluating the need for social services and mental health support (immediate and post-discharge), and providing intensive case management support. Due to COVID-19, VRS engaged patients virtually from March-May 2020. Through virtual engagement, VRS was able to ensure the continuity of crisis intervention and case management services.

Summary of Violence Recovery Program Impact from July 1, 2019–January 31, 2022

4,670
trauma patients (adult and pediatric) engaged and supported by the VRP

1,975
families engaged and supported by the VRP

597
non-patient children (i.e. child family members) engaged and supported by the VRP

1,594
patients expressed one or more SDOH needs to a VRS

1,289
patients expressed one or more mental health needs to a VRS

1,251
patients received at least one SDOH intervention and/or referral

1,054
patients received at least one mental health intervention and/or referral

Healing Hurt People Chicago (HHP-C)

HHP-C is a nationally recognized, hospital-based violence intervention program operated by John H. Stroger, Jr. Hospital of Cook County and UCM's Comer Children's Hospital. Through assessment, trauma-focused emotional support and psycho-education, intensive case management, group therapy, and mentoring, HHP-C helps youth who have been violently injured heal physically and emotionally. **From January 1, 2019, to December 31, 2021, HHP-C reached 400 children through hospital outreach and support and trauma psychoeducation, and enrolled 174 children into intensive case management services at UCMC.**

Recovery and Empowerment after Community Trauma (REACT)

REACT serves children who have been exposed to violence but may not be direct survivors of violent injury. The program addresses the psychological, psychiatric, social, and behavioral effects of exposure to violence by offering psychiatric needs assessments, prescriptions for psychiatric medications, and referrals for ongoing counseling. The REACT clinic program is patient-centered and the depth of intervention depends on the needs of the child and family. **From January 1, 2019, to December 31, 2021, REACT served 323 new patients, offering assessment services from the REACT clinic/psychiatry department, therapy provider partners, and program staff.**

Wellness Recovery Arts Program (WRAP)

WRAP is a trauma-based program for teens that uses the arts to explore their experiences with violence. Art forms provided include theater, spoken word, African dance/percussion, and visual arts. WRAP includes four highly-skilled, trauma-informed teaching artists that conduct workshops over the summer. Due to COVID-19, session offerings were severely limited in the summers of 2020 and 2021. **Approximately 43 teens participated in the WRAP program sessions during FY 2020-2022.**

Trauma Resiliency | Grant Programs

Rapid Cycle Grants

In partnership with Advocate Christ through the Southland RISE initiative, **43 grantees received funds** to support community-level summer violence prevention efforts on the South Side. The awarded groups were able to expand programming to address juvenile reentry, career development, education, access to care, and more. Since 2019, UCMC and Advocate Christ have awarded over **$345,725 in grant funding to grassroots organizations. Three of the grantees are highlighted below.**

2019 Grantee: The Woodlawn Re-Entry Project

108 young people received support with their transitions from correctional education programs to schools and communities in Woodlawn and its surrounding neighborhoods. They also received support with re-enrollment and education enrichment services.

2020 Grantee: Ladies of Virtue

Five mental health sessions served 69 parents, topics included mindfulness, ways to cope with stress, and improving communication between mothers and daughters

2021 Grantee: Fearless Leading by the Young (FLY)

FLY's Heal the Hood Movement violence reduction program aims to confront the impact of violent street crime and trauma in the predominantly African American Woodlawn Community using a grassroots approach.

Heal the Hood Fest was held over the summer as a space to spark a revolution and confront the impact of violent street crime and trauma.

1 Community Garden was planted in a vacant Woodlawn lot, and 200 people participated in the Fest and/or the garden efforts. These spaces were used to educate the community on healing techniques and skills and refer people to SDOH resources.

Violence Prevention Grants (2019 Community Benefit Grantees)

UCMC's **community benefit grantmaking initiatives** supported community-based organizations in developing and implementing programs aimed to address violence prevention and trauma recovery in the UCMCSA. Grantees from this cycle include **Chicagoland Prison Outreach (CPO), Lost Boys Inc. (LBI), and Woodlawn Restorative Justice Hub (WRJH)**. These grant programs served as a primary means by which to address community violence on the South Side and build an ecosystem of healing and support. **Combined, these programs represent over $140,000 of funding and impacted over 70 individuals across the UCMCSA during FY20.**

Chicagoland Prison Outreach (CPO) | Carpentry Apprenticeship Program

The CPO grant supported a vocational training program for the formerly incarcerated in the Bronzeville, Woodlawn, Grand Crossing, and South Shore neighborhoods. This program provided support to returning citizens on the South Side of Chicago by providing carpentry training, one year of case management, and job placement assistance in collaboration with Teamwork Englewood's Reentry Resource Center. CPO provided 18 weeks of intensive training to two cohorts of students, in addition to providing mentors, life skills coaches, and one year of case management to participants.

The CPO grant endeavored to improve trauma prevention and recovery by increasing the engagement of at-risk youth and adults, as well as their families, in violence prevention and recovery programs; utilizing public health approaches to reduce intentional violence and build long-term trauma resiliency; and partnering with UChicago's Community Partner Accelerator (CPA) for capacity-building support. **In FY19, CPO was awarded $41,700 of funding and served a total of 43 participants.**

10
Community Recruitment Events

43
Program Participants

28
Students Successfully Graduated from the Program

4
Students Successfully Obtained Employment

Lost Boyz Inc. (LBI) Grant | Successful Youth Leaders (SYL) Program

LBI's SYL program focuses on enhancing the developmental assets of youth by providing a continuum of service, centered on baseball, for teens and young adults ages 16 to 24. The program is five years in duration, running from high school through college graduation, and it is implemented through collaborative partnerships. The program acts as a link to local and national youth resource providers based on a hybrid model of 1) character development, 2) job readiness, and 3) service learning. Program participants are exposed to four industry paths while earning a wage, developing job-life readiness skills, receiving academic support, and giving back through volunteerism. The overarching goal of the LBI SYL program is to expose youth to potential career fields and prepare them to fill niches in the local economy through education, training, partnerships, and mentors. **In FY19, LBI was awarded $50,000 of funding and served 11 participants.**

Woodlawn Restorative Justice Hub (WRJH) Grant | Young People for Peace Program

WRJH engaged the young people most impacted by violence (e.g. court-involved and street organization-involved youth) to promote healing, growth, and peace. The intensive, multidisciplinary program aimed to serve one cohort of 10 core youth, with an additional 10 youth for specific program pieces. Programming components included restorative justice, artistic expression, economic empowerment, and civic engagement. Services provided included mentoring, case management, attendance stipends, and transportation. This comprehensive violence prevention program aimed to 1) reduce violence; 2) develop community capacity to hold restorative justice peace circles; 3) create opportunities for artistic expression in a trauma-informed context; 4) connect disconnected young people to social services; 5) create a long-term mentorship support system for youth who are most at-risk; and 6) develop youth civic leadership. **In FY19, WRJH was awarded $50,000 of funding and served 20 individuals.**

Mental Health

Mental Health was added as a priority health area to the FY 2020-2022 Strategic Implementation Plan. UCMC addressed this broad and complex issue by engaging in community-based education and outreach (Community Health Focus Hours, Community Grand Rounds), supporting the mental health and behavioral health needs of violently injured patients and their families (VRP), piloting a new compassion fatigue training for UCMC staff, and grantmaking to support community programs that addressed the intersection of mental health and other issues areas such as violence, SDOH needs, and access to care.

Goal	**Support mental health initiatives on Chicago's South Side**
Objectives	• Provide mental health support and services to our violently injured patients and their families • Provide education on compassion fatigue and resiliency-based care to hospital care providers and staff • Increase mental health awareness and education in the community
Impact	**Community-based education and outreach** enabled UCMC staff to provide comprehensive mental health education to community-based providers and community members. Collectively, these efforts increased mental health awareness, education, and access to resources in the community.

Efforts to address mental health needs were embedded across many community benefit programs. For this reason, we acknowledge mental health components throughout this report, where mental health intersects with other issue areas, in addition to those highlighted below.

The following programs are included to demonstrate the impact on mental health as a priority health area, in alignment with the goal and objectives on the previous page:

Workforce Resilience Enhancement Project (WREP)

WREP was initiated in January 2020 as a collaboration between Chicago community-based workforce development organization, UHI, and University of Chicago. This project was made possible through grant funding by AT&T. Soon thereafter, COVID-19 began spreading across the globe and changed everything about how we live and work. The widespread traumatic effects of COVID-19 demonstrated that, more than ever before, workforce development and job readiness professionals needed preparation to attend to the psychological and emotional trauma that affects people's abilities to focus on education and training opportunities, self-motivate to search for and gain employment, and engage in the self-regulation needed to maintain employment. **The two main components of WREP and their impact are described below:**

ECHO-Chicago Trauma & the Workforce: Strategies to Enhance Resilience Series

The Trauma & the Workforce series was piloted with five community workforce development organizations. The training was modeled after the Extension for Community Health Outcomes (ECHO)-Chicago model. Two cohorts were offered and each cohort was 10 weeks. Participants met once per week for an hour-long session. Sessions were comprised of a short didactic lecture on best practices (20-25 minutes) followed by participant-led case presentations about trauma-related situations they have encountered at their organizations. Through case discussions, participants can contextualize the recommended practices within all the complexities of real-world situations. Using an "all teach, all learn, all support" model, participants learned from and supported each other, in addition to learning from the guidance provided by subject matter experts.

1,975
individuals participated across both cohorts

Session Topics

- Anger Management Techniques for Clients Who Have Experienced Trauma
- Assessing, Discussing, and Processing Clients' Traumatic Life Experiences*
- Building Trust Remotely*
- Destigmatizing Accessing Mental Health Services*
- Mindfulness and Self-Compassion*
- Motivational Interviewing Techniques
- Strategies to Support Clients Who Have Experienced Domestic Violence and Sexual Abuse
- Stress Management and Self-Care for Job Readiness/Workforce Development Processionals*
- Supporting Clients Who Have Been Impacted by Community Violence

**Most helpful session topics, as voted by participants*

Outcomes of the program were assessed through pre- and post-series survey administration. Surveys measured the self-efficacy of participants, an individual's confidence in their ability to address trauma and resilience with their clients, and behavior change, specifically changes participants have made to their work as a result of training series participation. **An increase in self-efficacy was observed among 80% of respondents from the second cohort.**

Workplace Resilience in the Aftermath of COVID-19: Facilitating Economic Recovery by Supporting Workplace Mental Health (Conference)

The WREP conference was held in June 2021 and was comprised of three panels focused on sharing policies and practices that promote employee resilience. Panel titles are below. WREP collaborators recognized the importance of learning from a diverse group of voices. Panelists included mental health providers, employee advocates, a corporate wellness consultant, an industrial psychologist, and a person with the lived experience of accessing mental health services.

29
average attendees per panel

Panel Topics

- Changing the Mental Health System, Eliminating Discrimination and Enacting Policy
- Creating Caring Workplaces: Workplace Wellness and Organizational Practices that Support Wellbeing and Build Resilience
- The Mental Health Effects of Hate Crimes, Employer Responsibilities, and the Workplace Culture that Can Facilitate Resilience

Compassion Fatigue Series for Employees

Compassion Fatigue sessions began in April 2020 as part of a larger resilience-based care initiative focused on supporting staff at the height of the COVID-19 pandemic. The program began offering brief Zoom sessions to teach clinical managers and leaders how to help the staff on COVID floors manage stress and anxiety. This series quickly expanded and was offered to all levels of employees across the hospital system. The training was based on work done by psychologist J. Eric Gentry, Ph.D., a pioneer in the field of traumatic stress and compassion fatigue. In collaboration with Gentry, UChicago Medicine's group adapted and condensed six hours of training content into 30-minute seminars. The session goal was to decrease burnout and compassion fatigue, as well as increase satisfaction and resilience among the healthcare teams. Training objectives were to define secondary traumatic stress, burnout, and compassion fatigue and identify strategies to enhance personal and professional resilience. **Over 1,370 total hospital staff took part in compassion fatigue training, along with an additional 329 external healthcare staff at partner sites.**

Intersection of Violence Prevention and Recovery + Mental Health

Violence Recovery Program (VRP)

As summarized under our violence prevention and recovery section, the VRP launched in May 2018 and is a program designed to reduce violence through the delivery of holistic interventions aimed at sustainable, long-term recovery from violent traumatic injury for adult patients, pediatric patients, and their families. The VRP uses trauma-informed principles throughout its intervention services and case management provisions. Services provided include crisis intervention, helping patients and families navigate the healthcare system (immediate and post-discharge), assessing for social services and mental health needs (immediate and post-discharge), and providing intensive case management support. Due to COVID-19, the VRP engaged patients virtually from March-May 2020. Through virtual engagement, they were able to ensure the continuity of crisis intervention and case management services.

Trauma patients (adult and pediatric) engaged and supported by the VRP
4,670

Families engaged and supported by the VRP
1,975

Non-patient children (i.e. child family members) engaged and supported by the VRP
597

1,289
patients expressed one or more mental health needs to a VRS

1,054
patients received at least one mental health intervention and/or referral

Healing Hurt People Chicago (HHP-C)

HHP-C is a nationally recognized, hospital-based violence intervention program operated by John H. Stroger, Jr. Hospital of Cook County and UCM's Comer Children's Hospital. Through assessment, trauma-focused emotional support and psychoeducation, intensive case management, group therapy, and mentoring, HHP-C helps youth who have been violently injured heal physically and emotionally. **From January 1, 2019, to December 31, 2021, HHP-C reached 400 children through hospital outreach and support and trauma psychoeducation, and enrolled 174 children into intensive case management services at UCMC.**

Recovery and Empowerment after Community Trauma (REACT)

REACT serves children who have been exposed to violence but may not be direct survivors of violent injury. The program addresses the psychological, psychiatric, social, and behavioral effects of exposure to violence by offering psychiatric needs assessments, prescriptions for psychiatric medications, and referrals for ongoing counseling. The REACT clinic program is patient-centered and the depth of intervention depends on the needs of the child and family. **From January 1, 2019, to December 31, 2021, REACT served 323 new patients, offering assessment services from the REACT clinic/psychiatry department, therapy provider partners, and program staff.**

Trauma Resiliency + Mental Health | Grant Programs

Block Hassenfeld Casdin Collaborative for Family Resilience Grants

In alignment with priority health areas to address trauma and mental health, the UHI received funds from the Block Hassenfeld Casdin Collaborative to support both the VRP program and the larger ecosystem of community violence prevention and recovery. Funds were awarded to community-based organizations that provide existing or new programs/services for children, families, and the broader community to support long-term, holistic recovery from complex trauma.

Three grantees each received $25,000–$50,000 per year for two years to provide programs and services supporting mental health and trauma recovery. All grantees were affected by COVID-19's impact on in-person services and engagement. Still, grantees worked hard to pivot their work to ensure ongoing service provision and outreach. Year 2 is still in progress, so details on each grantee's efforts and impacts from Year 1 are provided below.

Bright Start Community Outreach | Care and Resilient Environment (C.A.R.E) Program

Bright Start Community Outreach (BSCO) is a non-profit organization working to create an ecosystem that addresses violence by building resilience through the community, specifically within the Greater Bronzeville area.

BSCO used BHC funds for their C.A.R.E. Rooms Program: a program led by school-based Trauma Advocates that offers school-engaged youth solace and support. These Trauma Advocates provided at least 15 hours of weekly emotional and physical support to students, teachers, and parents. Through the enhancement of existing trauma-support and educational services related to C.A.R.E. rooms, BSCO aims to provide more trauma-awareness education, care coordination, direct one-on-one supportive counseling, trauma-support student groups, and wraparound resources to support the holistic needs of children and/or families. **BSCO was awarded $40,000 and has supported thousands of individuals.**

309 students participated in C.A.R.E. room programming, receiving support from Trauma Advocates

551 adults received training on trauma-informed care topics and/or case management services

Over **100** youth between the ages of 12–21 received support via BSCO's support helpline services

1,035 community members received a referral to at least one trauma service offered through BSCO

Centers for New Horizons (Centers) | Horizons Program

With a mission to develop the capacities of individuals and families to become self-reliant, improve the quality of their lives, and participate in rebuilding their community, Centers targets individuals at the highest risk of violence on Chicago's South Side. These funds helped Centers hire a crisis intervention specialist to expand its capacity for street outreach programming in key community areas. This program ensured first response, outreach, and interventions were available to community members in the street, in hospitals, and/or in police departments. **Centers was awarded $40,445 in Year 1 to engage families and youth in violence prevention services.**

51 youth and 24 family members were engaged by the Crisis Intervention Specialist

40 of 51 youth met with Centers' clinician in group sessions to discuss the effects of community violence on them and their families

17 youth were enrolled in individual counseling sessions

Staff hosted community events and virtual community awareness events to discuss violence and strategies to reduce it

Gary Comer Youth Center (GCYC) | Youth and Community Mental Health and Trauma Resiliency

GCYC is a community-based organization that invests in young people and families within their service area by providing a safe, supportive, and secure environment through trauma-informed responses, positive youth development principles, and restorative justice. Built with a holistic approach designed to address community needs and trauma resiliency, their comprehensive violence prevention and recovery program was funded to 1) increase access to trauma care (e.g. mental health, substance abuse, social service programs); 2) reduce violent re-injury among program participants through a restorative justice program; 3) increase care providers' capacity to care for individuals affected by trauma by increasing the number of referrals to on-campus partners; and 4) increase child and family engagement in violence prevention and/or recovery through the GCYC Peace Building & Restorative Justice Initiative. **GCYC was awarded $39,500 in Year 1 to engage families and youth in violence prevention services.**

Offered **33** engagement opportunities for youth and family related to violence prevention and recovery, including Women-talk Wednesdays, Male-talk Mondays, Youth Health Virtual Summit, and Selfies and Self-Care Events

25 youth participated in group or individual counseling sessions

37 youth participated in a social-emotional development program

10 trauma care capacity workshops were facilitated, with 164 total attendees across all workshop sessions

20 restorative justice/peace circles were held in Year 1

III. REDUCE INEQUITIES CAUSED BY SOCIAL DETERMINANTS OF HEALTH

Access to Care, Addressing Food Insecurity, Employment

The foundation of UCMC's approach to community benefit is building community partnerships that leverage UCMC's assets for the community. Recognizing the complexity of issues UCMCSA residents face concerning the Social Determinants of Health, UCMC formally added addressing SDOH to its FY 2020-2022 SIP, with specific focuses on access to care, addressing food insecurities, and employment opportunities. UCMC maintained programming related to care access and expanded its reach in the community through community benefits grants to support food access and employment initiatives.

Goal	**Reduce inequities caused by social determinants of health (SDOH)**
Objectives	• Increase access to food for patients with food insecurities • Increase access to care for patients without a usual source of care • Increase employment opportunities for community members in our service area
Impact	UCMC's **community benefit grantmaking initiatives** supported community-based organizations to develop and implement group and individualized programs to address SDOH needs in both community and clinical settings. **Community-based education and outreach** enabled UCMC staff to provide food insecurity resources through community-based providers and community members. The launch of our **Liaisons in Care (LInC) CHW program** in January 2021 extended our CHW services beyond asthma. The launch of several new service lines greatly increased our capacity to support patients with healthcare navigation and access to care. Finally, commitment to addressing employment inequities via UCMC HR initiatives has created new pathways to employment for South Side residents. Collectively, these efforts sustain efforts to address inequities caused by SDOH.

Access to Care

The following programs are included to demonstrate the impact on select SDOH as a priority health area, in alignment with the above goal and objectives:

Medical Home and Specialty Care Connection (MHSCC)

Since 2011, the MHSCC program has connected South Side residents to community health centers and doctors who can provide preventive care, regular treatment for non-emergency health conditions, long-term management of chronic disease, and referrals to specialists. Patient advocates assist patients on the emergency department and inpatient floors, provide patient education on medical homes and insurance, directly connect patients to primary care providers, and provide resource referrals to meet Social Determinants of Health needs. Due to COVID-19, patient advocates shifted services from in-person encounters to engagement via phone follow-up calls. Despite necessary shifts in engagement modes, patient advocates were able to maintain consistent outreach to and support for low-acuity patients arriving at the emergency department.

Patient advocates educated a total of 11,991 patients on the importance of maintaining a primary care provider and a medical home.* Of these, **72%** of encounters included scheduling a follow-up appointment with the assistance of a patient advocate.

*Patient numbers reported from July 1, 2019 – January 31, 2022

Liaisons in Care (LinC)

Launched in January 2021, the LinC program's primary aim is to increase the percentage of UCMC patients receiving navigational support from Community Health Workers (CHWs). By increasing patient support via CHWs in key chronic health areas, LinC promotes access to care and makes the necessary resources available to reduce health inequities and address Social Determinants of Health (SDOH). Over five years, the program's goal is to measurably reduce health disparities for 50,000-70,000 individuals by expanding the number of CHWs supporting patients as they access healthcare services, address their SDOH needs, and improve their healthcare knowledge and navigation. **The LinC Program also impacts employment by providing new career opportunities to UCM-based and community grantee-based CHWs—approximately 20 FTE positions in total.**

Launched during the COVID-19 pandemic, the UCMC LinC CHW program model was designed to be flexible in meeting the needs of patients and the broader community. Patient outreach, education, assessments, and case management services take place both in-person and virtually.

Throughout the first year*, UCMC LinC Program CHWs enrolled 143 new patients and provided a total of 1,104 patient encounters across all five service lines. In addition, the following milestones were achieved:

- Hired 16 new UCMC program staff
- Launched a 12 week CHW training program for new staff
- Developed CHW program models for four new service lines
- Launched four new services lines: Cardiology, Hypertension/Diabetes Mellitus, Sickle Cell Disease, and Stroke
- Granted four community and faith-based organizations funds to develop and launch community-based CHW programs
- Launched a LinC Program Support Learning Collaborative for grantees
- Developed data collection instruments and an evaluation framework to measure the program's impact over the next four years

*LinC outcomes reported here are from January 1, 2021–December 31, 2021. Year 1 consisted primarily of program design, development, planning, and launching. More details on processes and outcome measures demonstrating impact will be included in the next cycle's evaluation report.

Food Insecurity

FeedIst

FeedIst is a service and research program that aims to alleviate hunger and food insecurity among families and caregivers of patients and staff at UCMC. Pantries are located throughout the hospital, including at Comer Children's Hospital. Food is free and self-serve, and there are no limits on how much food families may take—making the food pantry welcoming and accessible to anyone in need. From July 2019 to January 31, 2022, FeedIst delivered the following:

56,745
Pounds of Food Distributed

8,368
Estimated Households Served

21,204
Estimated Individuals Served

C4P Community Garden Program

As part of the Comprehensive Care, Community, and Culture Program (C4P), the C4P Community Garden Program aims to address patients' needs for healthy eating, social engagement, physical activity, and increased access to fresh produce. Quarterly food insecurity screenings and physical activity screenings among garden participants showed:

14% reported having unmet food needs

24% reported having unmet food and physical activity needs

Through funding from the Robert Wood Johnson Foundation, **patients participated in planting and harvesting in the learning garden and took part in a series of healthy cooking demonstrations.**

In addition to several ongoing partnerships with neighboring community gardens, C4P collaborated with the Urban Growers Collective and Neighborspace to transform a vacant lot in Woodlawn into a functional community garden and a space for arts and wellness programming that kicked off in Spring 2022. **Patients continue to report an appreciation for the chance to be in nature with community members, and they enjoy learning new and exciting ways to cook in healthier and more affordable ways.**

Employment Initiatives

UCMC HR Initiatives

In 2021, UChicago Medicine launched multiple workforce development programs and partnerships to advance and develop opportunities for employees and South Side community members, particularly people of color. **In CY21, 31% of UCMC's new hires were from the UCMCSA.** Career pathway programs, such as the **Nursing Assistant Pathway Program**, provide educational assistance and employment access to help community members and incumbent workers pursue in-demand careers. Development programs, such as Rise Higher, provide specialized training that promotes the advancement of people of color into higher-wage roles and leadership positions and increases racial equity across careers and our workforce. Three of the new programs launched in 2021 were a result of **Bridge Initiative Chicago**, a JP Morgan Chase grant-funded partnership between UChicago Medicine, Advocate Aurora Health, and Sinai Health. These programs, **Evolve, Rise Higher, and Healthcare Forward**, address the inequities that contribute to skills gaps of disenfranchised community members and give our employees opportunities for economic mobility.

Inclusive Pathways Program (IPP)

The Inclusive Pathways Program (IPP) is a Kessler Foundation grant-funded partnership with the Anixter Center, designed to increase the hiring and retention of people with disabilities and improve inclusive employment practices across organizations. IPP connects individuals with disabilities to meaningful, competitive employment opportunities, while also building the systems and supports to facilitate job retention. **As of January 2022, UCMC had hired 18 individuals with disabilities through the program and provided on-site and virtual retention services.**

Healthcare Forward

Healthcare Forward is the community-based component of Bridge Initiative Chicago, focused on educating and recruiting individuals—particularly those on the West and South Sides of Chicago—who may have never considered a career in healthcare. The program offers community members a no-cost career-readiness course that provides education on healthcare careers and operations and provides guidance on how to improve their job application skills. After completion, individuals are guaranteed an interview at one of the three participating health systems, including UCMC. The training sessions are scheduled to run from January 2022 through May 2022. **Over 250 community members signed up to attend one of the multiple sessions offered.**

Medical Assistant Pathway Program (MAPP)

Through a partnership with the Chicago Healthcare Workforce Collaborative, UCMC supports the Medical Assistant Pathway Program (MAPP), which provides an opportunity for currently enrolled Medical Assistant students to receive educational assistance during their program and offers a guaranteed externship and a job at UCMC

Nursing Support Assistant (NSA) Pathway Program

In collaboration with Skills for Chicagoland's Future, UCMC launched the Nursing Support Assistant (NSA) Pathway Program in 2021 to create a path-to-hire for community members and build a pipeline of talent for an in-demand occupation. Participants complete Malcolm X Community College's accredited 8-week Basic Nursing Assistant training program while working in a paid, non-clinical position at UCMC. Upon program completion, participants earn their C.N.A. certifications and advance into Nursing Support Assistant roles at UCMC.

UHI Employment Initiatives through Grant Funding

The UHI is committed to addressing key health priorities on the South Side of Chicago. UHI has received over $21.4 million in grant funding to help continue this important work. UHI has used these funds to expand existing programs, launch new programs, and further distribute grant dollars to community-based organizations. Grant-funded UHI programs and UHI-funded grantees are highlighted throughout this report. **As of May 2022, there are 58 UCMC full-time equivalents (FTEs) funded through UHI-administered grants, and countless more programs and program staff supported across the community through our grantmaking initiatives.**

Access to Care, Food Insecurity, Employment | SDOH Grant Programs

Social Determinant of Health (SDOH) Grantees (Community Benefit FY 2020-2022 Grantees)

UCMC's **community benefit grantmaking initiatives** supported community-based organizations in developing programs aimed to influence and improve the social determinants of health (SDOH) in the UCMCSA. SDOH are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect health outcomes and risks, functioning, and quality of life.[5] Grantees included **Common Threads, Communities in Schools (CIS), and Ignite**. These grant programs support a variety of community needs, including food access, health education and resources, and career development. **Combined, these programs represent over $100,000 of funding and impacted over 10,000 individuals across the UCMCSA during FY21.**

Common Threads | Healthy, Hands-On Cooking and Nutrition Education for Oakwood Shores Residents

Common Threads provides children and families with cooking and nutrition education to encourage healthy habits that contribute to wellness. They equip under-resourced communities with information to make affordable, nutritious, and appealing food choices through cooking and nutrition classes, and participants also receive healthy food kits. Their program aims to improve access to healthy food, healthcare, and health education, provide multi-generational community-based education; build cooking skills, and increase social interaction. Programming was impacted by COVID-19 restrictions, but grantee staff members were able to pivot their work to meet community needs during this difficult time. **Common Threads was awarded $33,500 of funding and served a total of 364 individuals in FY21.**

360 Grocery Boxes and Supply Kits Delivered	**181** Participants in Cooking and Nutrition Programs	**19** Cooking and Nutrition Sessions
62 Youth Enrolled in Small Bites Program	**6** Small Bites Lessons	**6** Medical Students and Healthcare Volunteers Engaged

5. Office of Health Promotion and Disease Prevention. Healthy People 2020. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Communities in Schools (CIS) | Intensive Student Supports Program

The Intensive Student Supports Program works in **30 Chicago Public Schools, seven of which are covered by this grant and located within the UCMCSA**. Through a network of partners, the program connects students to essential health and mental health services, including sexual health education, nutrition education to help prevent chronic health conditions, asthma treatment, immunizations, vision screenings, and trauma-informed care. **Between October 2020 and October 2021, CIS identified 227 students as having the highest risk of falling off track. These students received direct and individualized case management support in a remote setting.** Case-managed students receive individualized and small group mental health support, grief counseling, and social-emotional skill development. The program also provides Youth Mental Health First Aid training to school staff, increasing the number of adults that can spot risky behavior. The goal of the program is to ensure students have access to services and support that help them build healthy, thriving lives.
CIS was awarded $33,500 of funding and served a total of 1,316 people in FY21.

1,206 Students Connected to Community Partners	**227** Socio-emotional Assessments Completed	**24** Quarterly Meetings with School Leadership
8 Trainings on Youth Mental Health First Aid	**87%** Students Met at Least One Behavior Goal	**93%** Students Graduated High School

Ignite | Employment and Financial Empowerment Program

Employment and Financial Empowerment Program (formerly Teen Living Programs) breaks the cycles of poverty and youth homelessness for those aged 14-26 through transformative programming and services that ignite opportunity, community, and resiliency. Ignite has developed a flexible model of workforce development by meeting clients on their self-determined terms. The program includes tailored, one-on-one services, including job leads, resume and cover letter development, referrals to job programs through community partners, technical support, transportation, uniforms, and employment-centered life skills groups, in addition to access to computers, phones, printers, and free Xerox copying for employment-related documents. Paid, professional internships and financial literacy education are part of the program as well. **Ignite was awarded $33,500 of funding and informed over 9,000 individuals of the program's services through team outreach in FY21.**

150
Participants from UCM Service Area

302
Unique Clients Engaged in Programs

32
Clients from Residential Programming Who Gained Employment

332
People Served By Program During Grant Period

Liaisons in Care (LinC) Program Grantees

In alignment with the secondary LinC Program goal, UCMC increased access to CHWs through community and faith-based organizations using capacity-building grants. These capacity-building grants aim to improve **access to care and employment** by investing approximately $1.25 million into community- and faith-based organizations over the next five years.

In July 2021, four community-based organizations were selected to receive $50,000 in LinC per year for two years, with opportunities to receive funding for an additional three years. These organizations were selected to develop and launch community-based CHW programs that complement the UCMC-based program. Outreach efforts served as the main indicator of progress for LinC grantees. **Combined, these programs represent $200,000 of funding invested in community-based CHW programs in Year 1 of LinC.**

At the start of the grant period, significant effort was put into laying the foundation and structure for the program, as well as onboarding CHW roles at non-traditional, community-based sites. All grantees cited COVID-19 as a challenge that impacted outreach efforts, the number of people that could be reached, and the way grantees engaged with residents and administered programs. Grantees utilized both virtual and in-person methods to promote services, including presence at community events, outreach to hospitals, and distribution of program materials on platforms like Nextdoor, RentCafe, and other social media networks. Organizations used virtual platforms and connected through social media to keep the work going despite COVID-19.

Liaisons in Care (LinC) Program impact details from July 2021-December 2021 are provided below for each grantee:

Equal Hope

Equal Hope's mission is to "save women's lives by eliminating health disparities in Illinois, originally through the lens of breast cancer and now expanded to cervical cancer and other women's cancers." Equal Hope used grant funds to build and pilot a South Side cervical cancer CHW program. The program aims to address cervical cancer disparities and higher mortality rates experienced in five South Side neighborhoods by building upon their existing cervical cancer and medical home outreach, education, and navigation programs. Funds allowed Equal Hope to hire a full-time CHW to educate uninsured women, help them access free cervical cancer screenings, and guide them to care based on their public insurance plan's network of providers. This project also provides care coordination for women by supporting regular care establishment upon the completion of cervical screenings. **Equal Hope was awarded $50,000 of funding and reached at least 7,052 people.**

People Educated via Outreach Events and Community Canvassing **7,052**	**Number of Clients Engaged and Offered Services** **5,690**	**Uninsured Women Navigated to Cervical Cancer Screenings** **4**
Women Provided SDOH Referrals and Services **38**	**Publically Insured Women Navigated to Primary Care Services** **5**	**Types of Support Service Connections** **Immigration Support** **Financial Assistance** **Healthcare Navigation**

The Community Builders

The Community Builders (TCB) is a nonprofit real estate developer that owns or manages more than 13,000 apartments in Chicago. TCB used grant funds to launch a Health Champions program. This program equipped five residents with the knowledge and skills needed to serve as community Health Champions. In their Health Champion roles, these leaders build up the skills and capacity of other residents in South Side TCB buildings in Oakwood Shores, Willard Square, Cornerstone, Shops & Lofts, and Merrill Courts. These Health Champions serve as peer health advocates to help residents with chronic health conditions lead more productive lives and reduce the number of 911 calls and emergency vehicles dispatched to Oakwood Shores, Willard Square, Cornerstone, Shops & Lofts, and Merrill Courts. **TCB was awarded $50,000 of funding and reached at least 4,475 people through various levels of engagement in FY22.**

The Renaissance Collaborative

The Renaissance Collaborative, Inc. (TRC) is a community-based social impact organization that provides affordable housing, workforce development, employment, and educational services to residents in Bronzeville and the surrounding areas. TRC used funds for an on-site CHW role at their Senior Village to focus primarily on community outreach for seniors, with an emphasis on reducing health disparities.

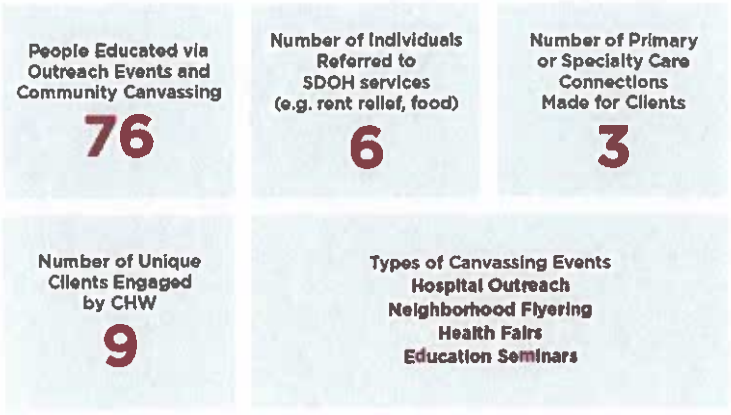
The CHW worked alongside the Service Coordinator of Senior Village and focused on outreach via flyering and canvassing, introductions to individuals and business owners in the community, and education on the mission and goals of a CHW. **TCB was awarded $50,000 of funding and reached at least 138 people.**

People Educated via Outreach Events and Community Canvassing: **138**	Number of Individuals Referred to SDOH Services (e.g. rent relief, food): **25**	Number of Individuals Provided Health Education and Resource Materials: **120**
Number of Unique Clients Engaged by CHW: **50**	Number of Primary and Specialty Care Appointments Made for Resident Clients: **18**	

YWCA Metropolitan Chicago

The YWCA's CHW Program is focused on addressing high blood pressure and diabetes. The goal of the program is to improve patient experiences and patient health outcomes, reduce health disparities, and provide strong linkages between health resources and social services. The YWCA used funds to hire a CHW to increase awareness of high blood pressure and diabetes and present people with good options for self-management. The funded project also aims to increase the use of primary and specialty care services and increase access to social services that address basic needs and social determinants of health.

In the first two quarters of funded work, the CHW was able to facilitate community events that connected potential clients to specialty clinic resources. **The YWCA was awarded $50,000 of funding and reached at least 76 individuals.**



Other Community Benefit Initiatives

The following programs are included to demonstrate impact across one or more of the select priority health areas on page 6. The programs and initiatives highlighted below also address other priority health needs and areas beyond the scope of Strategic Implementation Plan goals and objectives. UCMC recognizes there are myriad health inequities demonstrated in the CHNA, and it uplifts programs and services focused on these additional areas. These programs are aimed at addressing education, resource support, direct service needs, and more.

Office of Community Affairs (OCA)

OCA was established to promote and facilitate engagement and collaboration between the medical center and South Side communities. Under the framework of asset-based community development, UCMC's philosophy is to partner with and leverage the strengths and talents of existing community assets to improve local health and well-being. OCA strengthens relationships between UCMC and the community to foster and promote collaborative, community-based programs and initiatives for residents on the South Side. **Programs that fall under OCA include South Side Fit, Community Grand Rounds, Community Health Focus Hour, Community Fitness Program,** and more.

Community Health Focus Hour

Community Health Focus Hour is a weekly WVON radio broadcast series that is also shared over Facebook. It is led by faculty and involves community members as guests. The program focuses on specific health topics impacting the community and includes a social media component and live calls from guests. Topics of discussion have included: "COVID and mental health, anxiety, depression, domestic/interpersonal violence," "Taking Control of Asthma on the South Side," "Defeat Cervical Cancer; Get Screened, Get the HPV Vaccine," "Effects of Homelessness and the Pandemic on our LGBTQIA Community," "Men's Health: Keeping Black Fathers Alive Longer," and many more. **From FY 2020-2022*, the series hosted 66 shows with a total of 47,534 Facebook participants/viewers.**

*through February 2022

Community Grand Rounds (CGR)

Community Grand Rounds shares the University's knowledge and research with the community to improve health on the South Side. Each event is hosted in a community setting, outside of the University walls. During the COVID-19 pandemic, talks were moved to virtual platforms such as Facebook. Topics are chosen by a well-rounded group of community members in partnership with faculty. During FY 2020-2022, topics included: "Health Navigation and Advocacy," "Men's Health," "Empowering Older Adults During the Pandemic," "Breast Cancer Awareness and Survivorship," "Voter's Suppression and Voter's Rights Virtual CGR," and many more. **From FY 2020-2022*, CGR held 17 events with a total of 996 attendees.**

*through December 2021

COVID-19 Pandemic Response

In 2020, COVID-19 became the third leading cause of death in the UCMCSA, and the pandemic further exposed and exacerbated the longstanding structural drivers of health inequities. UCMC met the pandemic with a significant institutional response, working alongside the University of Chicago and community partners to deliver valuable resources and support to those struggling to stay healthy. **In addition to the efforts highlighted throughout this report, additional key contributions are noted below:**

UCMC provided outstanding patient care and a robust testing and vaccination program. In 2021:

- Treated more than 2,000 COVID-19 patients
- Performed more than 295,000 tests across the health system
- Administered about 134,000 doses of the COVID-19 vaccine to nearly 69,000 people

Pandemic-driven research resulted in:

- 427 publications containing the terms SARS-CoV-2 or COVID-19 authored by University of Chicago-affiliated researchers (a 36% increase over 2020)
- 12 invention disclosures—including PPE devices, therapeutics, and diagnostics
- 2 licenses for anti-SARS-Cov2 antibodies

UCMC's UHI created a COVID-19 patient case investigation and contact tracing (CICT) team[6] in partnership with the Chicago Department of Public Health (CDPH). This program increased citywide capacity and community-level support for individuals who tested positive for COVID-19 and their exposures. Since January 2021, the UHI team has:

- Conducted approximately 13,298 case investigations
- Successfully contacted and reached 3,488 people (cases and/or contacts of cases)
- Provided over 5,000 CBO connections to nearly 400 households via the NowPow platform and/or engagement with UHI's Patient Advocate team for more intensive service support

6 UHI's CICT team was awarded funds from CDPH to serve as a Delegate Agent responsible for investigating patients who test positive at UCMC and those exposed to these individuals. UHI works alongside the University of Chicago's testing and infection control programs to cover different populations across the hospital and University campus.

The United Health Group (UHG) Foundation granted UHI about $500,000 to distribute among South Side Healthcare Collaborative (SSHC) members—all of which are Federally Qualified Health Centers and Community Hospitals—to provide immediate COVID-19 Testing Program support. At a time when staffing was low, PPE and testing supplies were in critically short supply, and test result turnaround time was at an all-time high:

» 7 SSHC partners received funds to support their COVID-19 Testing Programs

» Across all funded SSHC sites, 17,801 individuals were tested for COVID-19

» All SSHC sites used funds to buy tens of thousands of critical PPE for testing staff and individuals getting tested (e.g. surgical masks, gowns, N95 masks, face shields, gloves)

» Several SSHC sites used funds to rent climate-controlled tents that were used to host high-volume testing sites in their communities

University of Chicago's COVID-19 Community Support initiative provided immediate aid to South Side community members[7]:

» In partnership with the Greater Chicago Food Depository, UChicago, and the UHI Office of Community Affairs, over 20 sites across the South Side provided 225,000 meals to community residents from March–June 2020

» Distributed $680,000 in emergency bridge grants from the University to 182 South Side small businesses

» The University gave $310,000 in rent relief and grants to the University's small business tenants

» The University provided $400,000 in grants and organizational help to 79 community-based nonprofits on the South Side

7 Source [illegible]

Data Limitations

- The CHNA does not measure all of the possible aspects of health in the community, nor does it adequately represent all possible populations. The majority of data represented here are self-reported and not based on clinical measurements.
- COVID-19 led to major programming disruptions across all priority health areas, affecting available resources, staff members' ability to engage the community, and community needs.
- Programs are implemented across a variety of settings and populations and present challenges in both the validity and reliability of aggregate data.
- Small, community-based programs lack evaluation capacity and human resources to provide valid and reliable data.

Conclusion

UCMC is continuously iterating and strengthening its processes, structures, and programs to ensure that Chicago's South Side residents receive the highest quality services. It is UCMC's imperative to tirelessly work to improve the health of South Side residents suffering from the health and chronic conditions outlined in this report and to prevent the spread of these conditions. UCMC will continue to evaluate each program regularly and adjust its programming accordingly.

Plans to address the following three years of UCMC community benefit focus are outlined in the UChicago Medicine FY 2023-2025 Strategic Implementation Plan. More information on UCMC's community efforts, and current programs, events, and initiatives supported by UChicago Medicine, can be found at https://www.uchicagomedicine.org/about-us/community.

Contact for Feedback

Any questions or concerns regarding the CHNA, Strategic Implementation Plan, or Community Benefit Evaluation Report can be sent to uch-communitybenefit@uchicagomedicine.org.

AT THE FOREFRONT
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Appendix 3:

Data Sources

Secondary data that was used throughout this report was compiled from Metopio's data platform. Beneath each graphic in this report, there is a label that cites the data source for that visual. Primary sources of this data include:

- American Community Survey
- Behavioral Risk Factor Surveillance System
- Centers for Disease Control PLACES data
- Centers for Medicare and Medicaid Services: Provider of Services Files
- Chicago Data Portal
- Chicago Police Department
- Decennial Census (2010 and 2020 census data)
- Diabetes Atlas
- FBI Crime Data Explorer
- Feeding America
- Illinois Department of and Family Services
- Illinois Department of Public Health
- Illinois Hospital Association COMPdata Informatics
- The New York Times
- State health department COVID-19 dashboards
- United States Department of Agriculture: Food Access Research Atlas

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Charity Care Information

Attachment 39

Shown below is the amount of charity care provided by UCMC

CHARITY CARE			
	FY20	**FY21**	**FY22**
Net Patient Revenue	**$1,746,725,000**	**$2,000,232,997**	**$2,188,854,056**
Amount of Charity Care (charges)	$181,577,629	$115,238,011	$116,107,626
Cost of Charity Care	$41,477,759	$20,487,959	$26,954,265
Ratio of Charity Care Cost to Net Patient Rev.	2.37%	1.02%	1.23%