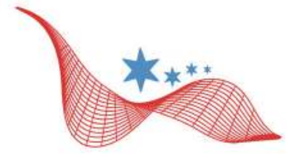

VOLUME 1

THE IMMINENT COLLAPSE OF CHICAGO'S HEALTH CARE SAFETY NET

May 2025

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EXECUTIVE SUMMARY

Chicago's health care safety net is on the verge of collapse. Conservatively, a cohort of nine of Chicago's 20 safety net hospitals are projected to produce a $2.46 billion operating loss, which is reduced to a $1.5 billion cumulative loss from 2025 through 2030 — after accounting for anticipated state and philanthropic subsidies. A steadily widening deficit from declining revenues and increasing expenditures creates a fundamentally untenable situation for hospitals. Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs) show a steadier picture, though significant environmental risks are compounding. The state's ability to continue subsidizing these losses is reaching its limits — and this before the anticipated historic cuts to long-standing federal programs like Medicaid. Simply put, the city's health care safety net has a serious math problem.

This paper showcases a slate of scenario-based outcomes for the city's safety net. The current financial projects closely align with earlier analysis that projected a $1.76 billion deficit from 2021 to 2025.[1] Those projections used pre-COVID-19 data from a similar subset of the 21 Chicago safety net hospitals to model the overall strain on the system over a subsequent five-year period. Federal funding through the Coronavirus Aid, Relief, and Economic Security (CARES) Act, American Rescue Plan Act (ARPA), and related government funding gave a reprieve for health care safety net entities grappling with mounting losses, allowing most of the city's health care safety net providers to break even and even make certain bespoke investments in the short run. Now, funding thresholds have been reached, and many of the city's health care safety net entities are again in crisis and vulnerable to insolvency.

Failure to act collectively would be a failure of leaders entrusted and empowered with taxpayer resources to ensure the existence of an economically viable health care safety net before hospitals are forced to close or halt operations, as seen with West Lake, MetroSouth, Mercy, and Ascension Saint Elizabeth. Hospital closures dramatically impact communities in need of high-quality, affordable care, and employment opportunities provided through these institutions. Such closures place tremendous pressure on community members, forcing them to seek care outside their neighborhoods at health care institutions unequipped to handle the increased patient load, further exacerbating health inequities.

The state alone cannot fix the health care safety net system. The way forward is highly complex, requiring a massive public-private partnership between government and industry to build an efficient and sustainable system of care. This system must include diverse funding streams, integrated care delivery, coordinated care, increased efficiency in the managed care-provider relationship, and capital to revitalize its crumbling infrastructure.

It is trite to say this paper is a "call to action." Such calls have been made for decades. This paper serves as an unequivocal five-alarm emergency to all market leaders, policymakers, philanthropists, businesses, Managed Care Organizations, and Illinois and Chicago health care systems. Failure to heed this alarm will force structural changes – reducing access to everything from emergency to primary care, eliminating jobs, and forfeiting real opportunities to improve health outcomes that are inextricably tied to stronger local economies and job growth in underserved communities.

Most importantly, ignoring this crisis will cost lives.

As of this paper's publication, there *are* strategic options to consider and pursue. If action is not taken imminently, the options narrow and become far less ideal.

This paper serves as an unequivocal five-alarm emergency to all market leaders, policymakers, philanthropists, businesses, Managed Care Organizations, and Illinois and Chicago health care systems.

A PRIMER TO CHICAGO'S HEALTH CARE SAFETY NET

The term "safety net services" spans the spectrum of housing support, food assistance, job placement, financial assistance, and health care. The "health care safety net" focuses on the assets and resources in a community focused on medical care for individuals, families, and communities that are economically underserved, vulnerable, or facing hardships. These safety net ecosystems are not mutually exclusive.

This paper is focused on the health care safety net in the city of Chicago. Even with that singular focus, the health care safety net (hereafter referred to as the "safety net") is a byzantine patchwork of fragmented public and private programs and facilities generally focused on providing health and health-related services to those unable to access similar health resources through non-government means (e.g., employer-sponsored insurance, cash pay services, etc.).

Medicaid and Medicare are government-funded insurance programs. The former is for individuals unable to afford or otherwise access traditional insurance marketplaces; the latter is generally available to seniors or individuals with a qualifying health status. Illinois' Medicaid program is managed by the Illinois Department of Healthcare and Family Services (HFS). HFS does not directly administer the day-to-day functions of the Medicaid program. Instead, the agency contracts with Managed Care Organizations (MCOs) to establish provider networks and reimburse providers who submit claims for clinical services provided to Medicaid beneficiaries.

To be economically viable, MCOs must pay out less than or equal to the amount they take in from HFS. There are five MCOs operating in the city of Chicago: Aetna Better Health of Illinois, Blue Cross Community Health Plan, CountyCare Health Plan, Meridian Health Plan, and Molina Healthcare of Illinois. Individuals enrolled in Medicaid through one of these MCOs can access providers throughout the city; however, not all providers accept Medicaid, and some impose limits on the total panel of Medicaid beneficiaries, reducing provider access for Medicaid beneficiaries.

To address funding issues, Medicaid's ability to provide health care to underserved communities is hindered due to being underfunded, paying much less than Medicare or employer-insurance, and creating a significant disincentive for many providers to accept a meaningful number of Medicaid beneficiaries. In Illinois, Medicaid reimbursement rates are around 60-70 percent of Medicare rates,[2] far below what most traditional providers require to cover the cost of the services they provide. Most providers can maintain some level of profitability through some minimum threshold of commercial insurance payment for their services, which are typically reimbursed at a rate of 190 percent (or more) of Medicaid.[3] Medicaid's ability to provide health care to underserved communities is hindered due to being underfunded, paying much less than Medicare or employer-insurance, and creating a significant disincentive for many providers to accept a meaningful number of Medicaid beneficiaries.

There are several different types of safety net providers. The four entity types that make up the majority of Chicago's safety net infrastructure are:

- **Safety Net Hospitals:** Publicly funded hospitals with a Medicaid inpatient utilization rate (MIUR) of at least 40 percent, a charity rate of at least 4 percent, or an MIUR of at least 50 percent.[4] These hospitals provide care to all patients, including uninsured and underinsured individuals; and provide emergency care, inpatient care, outpatient services, and specialized treatments--functioning as providers of last resort for individuals unable to access private care.
- **Federally Qualified Health Centers (FQHCs):** Community-based health centers are outpatient settings that provide comprehensive health care services for the medically underserved. FQHCs provide primary care, dental care, mental health services, and preventive care.
- **Community Mental Health Centers (CMHCs):** Community-based mental health centers that provide mental health support to the medically underserved. CMHCs offer mental health and substance use disorder services to low-income and vulnerable communities through counseling, psychiatric care, crisis intervention, and case management.
- **Free and Charitable Clinics:** Non-profit organizations that rely on volunteer providers and donations to offer free or low-cost health care, including basic primary care, dental care, prescription assistance, and sometimes specialty services.

To address this issue, specially designated providers are subsidized through government programs that create offsetting subsidies to support "health care safety net providers" so that more providers agree to accept Medicaid patients and so that providers who primarily serve Medicaid beneficiaries can remain viable.

Historically, Chicago has had a robust health care safety net. Today, chronic underfunding of the Medicaid program; stark inflationary pressures on health care salaries, supplies, and technology; and an ever-growing inability to access traditional debt markets have pushed this system to the point of existentialism.

The safety net providers facilitating these critical services can no longer survive under the current economic model, which may soon collapse the entire safety net system without a fundamental structural change. This collapse would have a devastating impact on the more than 3.4 million Medicaid patients[5] who currently rely on safety net providers for care. It would also put untenable pressure on traditional providers, who do not have the capacity to absorb the patients currently being served by Chicago's safety net.

SECTION 1:

HOW DID WE GET HERE? A BRIEF HISTORY OF CHICAGO'S HEALTH CARE SAFETY NET

Over the last 30 years, Chicago's safety net has undergone significant change driven by economic, political, and social factors. The city's network of safety net hospitals, clinics, behavioral health service providers, and community health organizations has worked to provide health care to underserved communities; particularly those on Medicaid and those without health insurance.

The number of FQHCs increased in the early 1990s. During this period, Chicago's safety net hospitals were predominantly publicly funded institutions or private non-profit hospitals in low-income areas. The Cook County Health System was anchored by the Cook County Hospital (now Stroger Hospital) serving as the "hospital of last resort" for the city's uninsured and low-income residents. Concurrently, financial pressures and unpredictability became the norm for providers, coinciding with the introduction of managed care in Medicaid and attendant cost-cutting measures that emerged in a health system beset by chronic inflationary pressures that outpaced the broader economy.

By the early 2000s, safety net hospitals faced aging infrastructure, limited funding, and rising patient volumes. In 2002, John H. Stroger Jr. Hospital of Cook County replaced the century-old Cook County Hospital, a modernization milestone for Chicago's safety net. Hospitals like Mount Sinai, St. Bernard, and Loretto Hospital continued to serve high-need areas, often providing care for little to no reimbursement, resulting in sustained operating losses, or – in best-case scenarios – years of "break-even" earnings. Safety net institutions adapted to the rising rates of uninsured patients, partially due to economic downturns and job loss. In 2008, Michael Reese Hospital closed its doors, marking the first significant medical facility casualty of the safety net's untenable economic structure. Additionally, Mercy Hospital, now Insight Hospital, faced near closure multiple times before being sold for one dollar in 2021, underscoring the continued economic strain on Chicago's safety net.

The passage of the Affordable Care Act (ACA) in 2010 marked a significant turning point for Chicago's safety net. Medicaid expansion in Illinois brought health coverage to thousands of previously uninsured residents, relieving some of the financial pressure on safety net hospitals. During this time, Chicago's FQHCs and community clinics expanded to provide preventative care and reduce hospital dependency. Telehealth services and community-based care initiatives emerged as vital tools for increasing access in underserved neighborhoods.

Despite Medicaid expansion under the ACA, challenges persisted as reimbursement rates remained low (i.e., Illinois is 49th in the nation in Medicaid reimbursement rates) and undocumented immigrants did not have coverage for needed services. Though the state's Health Benefits for Immigrant Adults (HBIA) program supports undocumented immigrants, it will end on July 1, 2025, except for those aged 65 and older; leaving more than

35,000 people without coverage and facilities without an income mechanism for when the uninsured require emergency services.

The COVID-19 pandemic placed unprecedented stress on the safety net. Hospitals like Stroger, Mount Sinai, and Roseland were on the front lines of the pandemic, caring for the city's most vulnerable patients. COVID-19 exposed deep health disparities, with communities of color experiencing disproportionate rates of infection and mortality. Federal and state funding during the pandemic provided temporary relief, but many safety net hospitals faced workforce shortages and financial deficits. Increasing cost pressures, industry conditions, and stagnant revenues and subsidies continued to threaten the long-term viability of the city's safety net infrastructure.

In 2021, HFS launched the Healthcare Transformation Collaborative program with the agenda of distributing $150 million per fiscal year[6] to support collaboratives with a proposed approach to transforming health care in vulnerable communities across the state. Despite some incredible and innovative work from collaboratives like the South Side Healthy Community Organization (SSHCO), most of these funded efforts either lacked system-wide design strategies or tenable, long-term sustainability plans.

In 2023, Illinois introduced safety net hospital stabilization programs to address funding shortfalls and modernize infrastructure. These payments have been a critical lifeline to the city's safety net and are critical to its survival but are currently at risk given the budgetary volatility taking place in the United States Congress and White House.

For over 30 years, Chicago's safety net has evolved to address the needs of a growing and diversifying underserved population. Despite all efforts heretofore enumerated, safety net hospitals remain financially strained due to low Medicaid reimbursement rates, increased demand, and inflationary pressures on health care costs.

For their part, Chicago's FQHCs also face significant challenges due to their Prospective Payment System (PPS) rates not being adjusted or recalculated on a cost basis for over 20 years[7] and a heightened level of uncertainty in programs designed to subsidize care for the underserved.

The resources supporting the safety net must be radically re-configured for this system to be sustained. This re-envisioning of Chicago's safety net requires policy support, funding stability, and investments in preventative care and community health programs.

More than that, however, it requires a sense of urgency.

SECTION 2:

WHY EVERY CHICAGOAN SHOULD CARE ABOUT THE HEALTH CARE SAFETY NET

This paper is not an appeal to humanity. It is an appeal to common sense.

Without access to proper health care, individuals suffering from physical or mental ailments face significant barriers to education, employment, caregiving, and other essential societal functions. This lack of access creates a vicious cycle where poor health diminishes productivity and economic stability, further compounding the challenges faced by low-income communities and trapping individuals and families in a downward spiral of intergenerational financial and social instability.

It is prudent to assume that further erosion of access to a viable safety net will exacerbate poor community health. This intuitively decreases life expectancy and will impair economic productivity and mobility. Both outcomes would have dire implications for every Chicago neighborhood, business, and non-safety net health care provider.

Economic Impact on Non-Safety Net Hospitals from Safety Net Hospital Closures

Any safety net hospital closure in Chicago will result in patients seeking care at other institutions. It is difficult to predict the effects of any single hospital closure on the finances of adjacent hospitals. Still, the generally accepted theory is that, owing to Medicaid's low reimbursement rates, most services rendered would be at a loss to the replacement hospital and strain their baseline capacity and operating model.

To create a conservative, abstract picture for the financial impact of safety net hospital closures to adjacent facilities, we examined emergency department (ED) utilization data for a subset of Chicago safety net hospitals (see Exhibit 1).[8]

Exhibit 1: ED Utilization Volumes for Sample Safety Net Hospitals in Chicago (2022)

Hospital	ED (Not Admitted)	ED (Admitted)	Total ED Encounters
Mt. Sinai	25,129	6,099	31,228
Holy Cross	26,335	3,615	29,950
Saint Bernard	17,575	2,937	20,512
Loretto	7,656	3,207	10,772
Humboldt Park	20,623	2,052	22,675
Roseland	12,800	4,639	17,439
South Shore	3,248	742	3,990
Jackson Park	8,228	1,572	9,800

To model the cost impacts, we collected various cost and reimbursement benchmarks.

In a study published by the Journal of Hospital Medicine, average ED visits increased in adjacent hospitals by 3.59 percent prior to a neighboring hospital's closure and increased by 10.22 percent after.[9]

We analyzed ED admissions against reimbursement and cost rates to estimate prospective losses. Note that this analysis does not include other post-ED medical services that are similarly reimbursed at lower rates.

HFS sets the reimbursement rates for ED procedures. A sample of five CPT codes (99281, 99282, 99283, 99284, and 99285) shows reimbursement amounts ranging from $14.35 to $69.25.[10] Note that these reimbursement rates are for professional services only and do not represent facility fees associated with an ED visit.

The average cost (inclusive of facility fees) for a Medicaid reimbursed academic medical center's (AMC) ED care is $770.[11] The average cost for the same care in a non-academic medical center (non-AMC) range from $420 to $600.[12] Using these estimates across ED utilization for a sample of Chicago's safety net hospitals, we can estimate the EBIDA impact to adjacent non-safety net hospitals based on ED encounter costs and reimbursements.

The math shows what amounts to a considerable cost burden to non-safety net entities that, while diffuse, will largely be absorbed by the institutions closest to a closed hospital (see Exhibit 2).

These estimates *only* represent a conservative base cost allocation that would be absorbed by non-safety net hospitals. While certain offsets may be possible (e.g., DSH payments, 340b, DPP payments, etc.), they too would be costly to pursue and administer and would likely not have a material impact on stemming the losses.

Exhibit 2: Cost Impact to Non-AMC and AMC Hospitals for Absorbed ED Encounters (in millions)

Hospital Closure	Cost to Non-AMC (Low)	Cost to Non-AMC (High)	Cost to AMC (Low)	Cost to AMC (High)
Mt. Sinai	$10.9	$18.3	$21.9	$23.6
Holy Cross	$10.5	$17.5	$21.0	$22.6
Saint Bernard	$7.2	$12.0	$14.4	$15.5
Loretto	$3.8	$6.3	$7.5	$8.1
Humboldt Park	$8.0	$13.3	$15.9	$17.1
Roseland	$6.1	$10.2	$12.2	$13.2
South Shore	$1.4	$2.3	$2.8	$3.0
Jackson Park	$3.4	$5.7	$6.9	$7.4

Adjacent and downstream losses would create a multiple of the projections in Exhibit 2. Other loss drivers would include:

- Post-discharge services for Medicaid beneficiaries rendered by the non-safety net hospital where reimbursements will not meet cost thresholds across most clinical service lines.
- The opportunity cost or "crowd out" effect of shifting a non-safety hospitals payer mix away from stronger reimbursement business lines (e.g., employer sponsored insurance and Medicare) in favor of Medicaid.
- Higher cost and capital structures that expand the loss of a Medicaid encounter.

Based on feedback from non-safety net hospitals, the threat of major safety net hospital closures poses a significant risk to the ongoing financial viability of these institutions.

The challenge is similarly vexing for FQHCs that aspire to create access for patients where unnecessary or avoidable ER use is possible. FQHC closures pose the risk of turning a hospital ED into an elevated urgent care where patients seek clinical services under pressing scenarios in the absence of a contiguous, reliable relationship with a primary care physician. As one FQHC CEO commented to us, "FQHCs are the only thing standing in the breech and keeping unnecessary ER utilization lower than it would otherwise be."

The compounded losses to non-safety net hospitals for any material fractures in the safety net would have profoundly negative financial effects that would compound over time.

More importantly, these factors would also have profound implications for the community. There have been dozens[13] of instances where safety net hospitals have closed in different parts of the country, resulting in:

- reduced access to emergency services[14]
- decreased service duration per patient[15]
- increased mortality for certain conditions[16]
- increased travel time to access care[17]
- loss of essential services[18]

Economic Impact on Chicago of Safety Net Hospital Closures

Safety net hospitals are often the largest employers in their communities and do the important work of providing health care access to underserved communities. Job loss and health erosion represent a toxic mix that would undoubtedly result in catalyzing (or accelerating) a community's economic decline, which threatens to place further weight on already scarce safety net dollars and resources and reduce the tax base.

The inverse also is true: improved health begets productivity and creates GDP growth and community wealth.

More directly, an analysis of a one percent decrease in diabetes prevalence could result in a per capita income increase of $6,210.00.[I]

[I] Based on Third Horizon regression modeling across city of Chicago zip codes.

Extrapolating the annualized impact of this change in diabetes prevalence for these three vulnerable communities creates a potential absolute income increase of $9.4 billion. This is a conservative estimate when applied to the range of health-related challenges that, if mitigated, have the potential to create a significant increase in economic productivity, raising the tide of all stakeholders in Chicago:

- More individuals contributing to the tax base decreases the overall tax burden for Illinoisans, allowing for more strategic funding of public health infrastructure. For example, the above example of decreasing diabetes prevalence by one percent in vulnerable Chicago communities can potentially add $468 million to the Illinois state budget for a single year.
- Stronger economic growth and increased mobility foster a thriving business ecosystem, creating new jobs and opportunities across the city.
- A vibrant and capable workforce, ready to meet the demands of cutting-edge industries—from the newly envisioned quantum computing park to the countless jobs essential for an AI-driven economy.
- Safer communities flourish, enabling residents to express their unique identities in every neighborhood across the city.

There is a version of our city's future where communities ravaged by decades of divestiture do not need to be left on their own. A future where we can facilitate access to a working system of health and care that makes it possible for other communities to participate in our economy. A future where the American Dream and the promise of this incredible city is not perpetually out of reach due to lack of access to health care.

SECTION 3:

CHICAGO'S PERSISTENT AND PERVASIVE HEALTH DISPARITIES

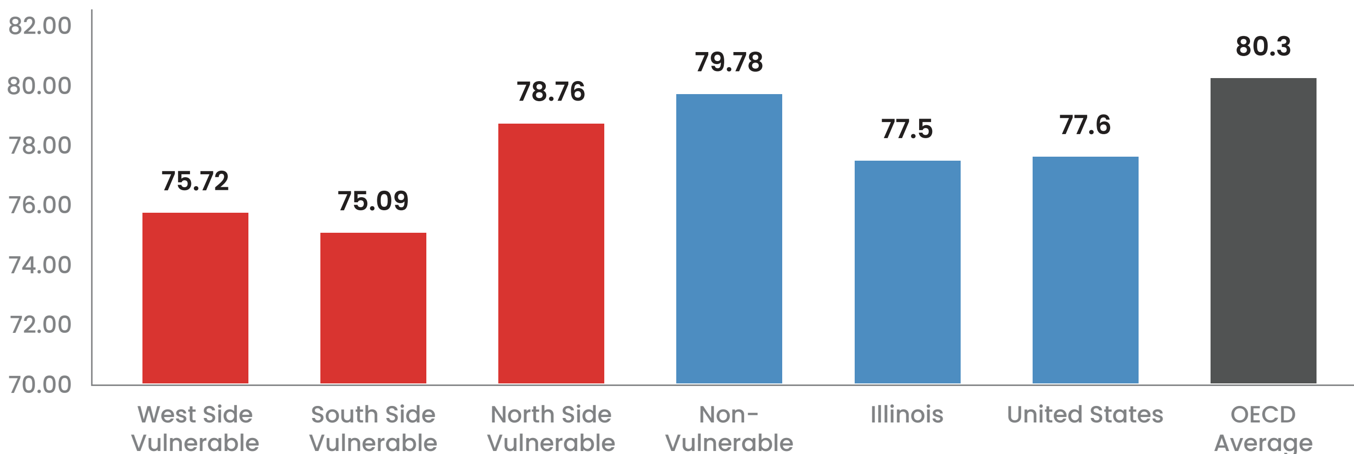
Chicago is a tale of two cities, where access to essential social and health-related services is widely accessible to some and largely inaccessible to others. The biopsychosocial disparities that exist in Chicago are ultimately reflected in life expectancy across the city, which ranges from 68 to 83 years old,[19] depending on one's zip code. Lower life expectancies are concentrated on the city's South and West Side, where safety net providers operate with limited resources and provide urgent, complex care to underserved communities of color.

For the exhibits in this section, we used and weighted public health data based on population densities by zip code.[ll]

No one's zip code should be a predictor of their lifespan. Yet, as Exhibit 3 illustrates, residents of the city's most disinvested areas face lower life expectancy than the averages for the rest of the city, the state of Illinois, the United States, and the Organisation for Economic Co-Operation and Development (OECD). Addressing these disparities requires a unified commitment to provide the same access to health services in underserved neighborhoods as other Chicagoans enjoy in better-endowed ones.

Three important data points drive the case for strengthening Chicago's challenged safety net. The first is social vulnerability — a predicate for cognitive, physical, and social

Exhibit 3: Life Expectancy[20] Range in Chicago



Defined as: Life expectancy at birth, or the start of the specified age bracket. This is equal to the average age at death of all people born in this place, or all people who have lived to the start of the specified age bracket.

[ll] West Side Vulnerable zip codes are 60608, 60612, 60624, 60638, 60639, 60644, 60651, and 60652. South Side Vulnerable zip codes are 60456, 60609, 60615, 60616, 60617, 60619, 60620, 60621, 60623, 60628, 60629, 60632, 60633, 60636, 60637, 60649, 60653, and 60827. North Side Vulnerable zip codes are 60626, 60645, and 60659. Non-Vulnerable zip codes represent the geographies of Chicago that are more affluent or in line with statewide averages for income and include 60601, 60602, 60603, 60604, 60605, 60606, 60607, 60610, 60611, 60613, 60614, 60618, 60622, 60625, 60630, 60631, 60634, 60640, 60641, 60642, 60643, 60646, 60647, 60654, 60655, 60656, 60657, 60660, 60661, 60707, and 60804.

development. Exhibit 4 represents the vast distinction between Chicago neighborhoods, where Chicago's less vulnerable communities have a more than 50 percent lower level of community distress.

Research consistently shows that social influencers of health (SIOH) — the conditions within which people are born, grow, live, work, and age — are stronger predictors of health outcomes than medical care alone. SIOH includes transportation, affordable childcare, income, education, employment, housing, and access to nutritious food. Strengthening the safety net allows providers and individuals to focus on preventive and routine care, rather than relying on emergency care and its high cost. Additionally, healthy individuals miss fewer work and school days and maintain a more stable income, making childcare, housing, and transportation more manageable.

The second acute vulnerability for these communities is in the pervasiveness of mental health disorders. Exhibit 5 shows that depression, anxiety, isolation, and substance use disorders are prevalent in these communities, significantly exacerbating downstream chronic disease challenges. Poverty begets trauma, trauma begets mental health disorders, and such disorders become chronic disease. The massive failure to provide mental health resources to communities that have been witness to decades of divestiture and economic depression has created an intergenerational challenge with no sign of abatement.

Exhibit 4: Chicago Community Distress Score[21]

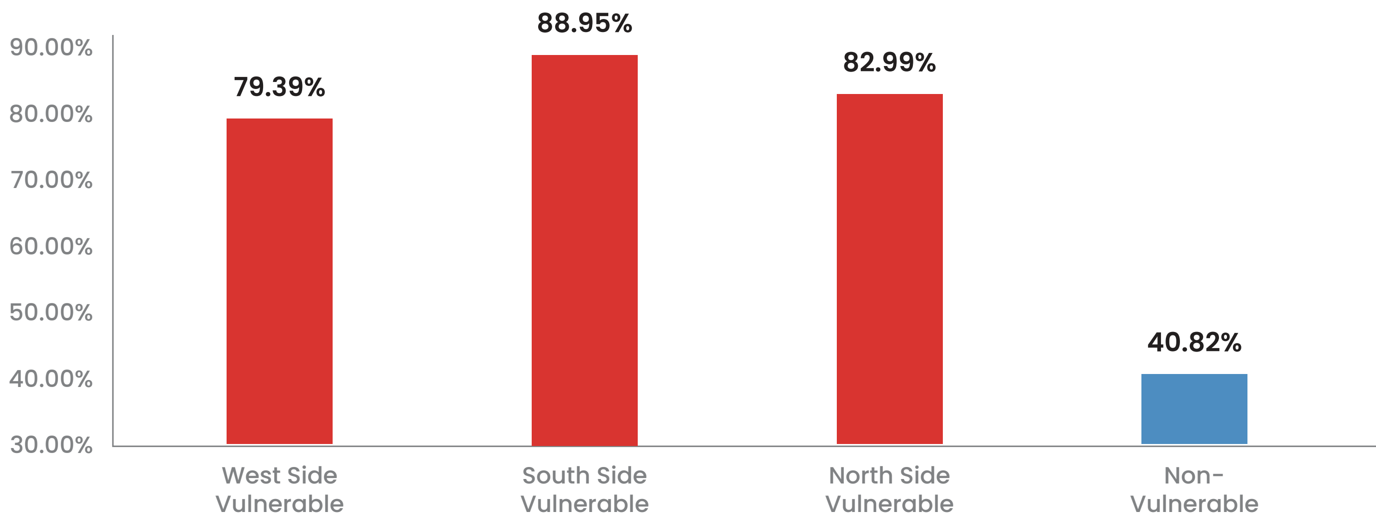
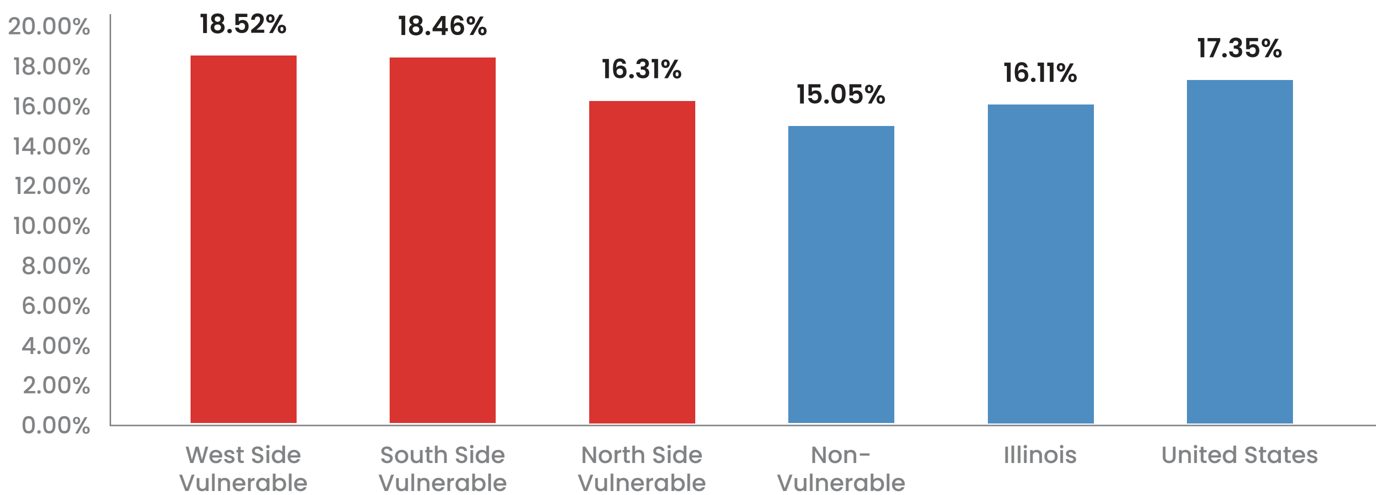


Exhibit 5 represents the self-reported mental health rates between Chicago neighborhoods, where Chicago's most vulnerable communities report poorer mental health rates.

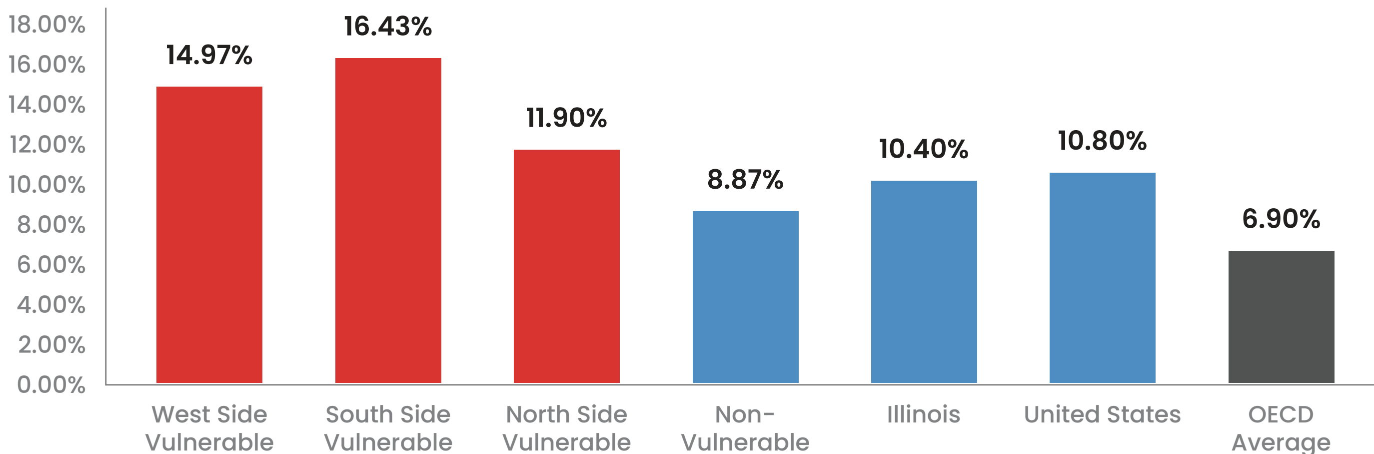
This segues to the third and most pernicious of the health challenges in Chicago's safety net: chronic disease prevalence. Conditions such as type-2 diabetes, chronic kidney disease, and coronary heart disease represent significant impediments to physical functionality and are material cost drivers for the underlying system. As shown in Exhibits 6, 7, and 8, Chicago's West Side, South Side, and North Side communities experience higher rates of these conditions compared to the state, national, and the OECD average.

Exhibit 5: Self-Reported Poor Mental Health[22]



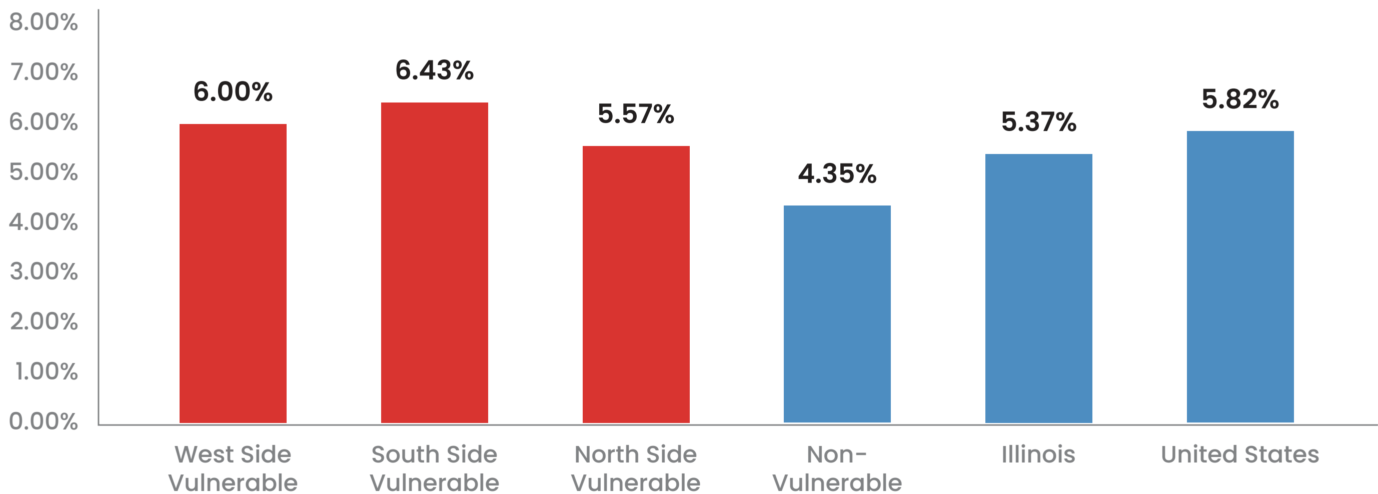
Definition: Percent of resident adults aged 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.

Exhibit 6: Prevalence of Diabetes Diagnoses[23] in Chicago



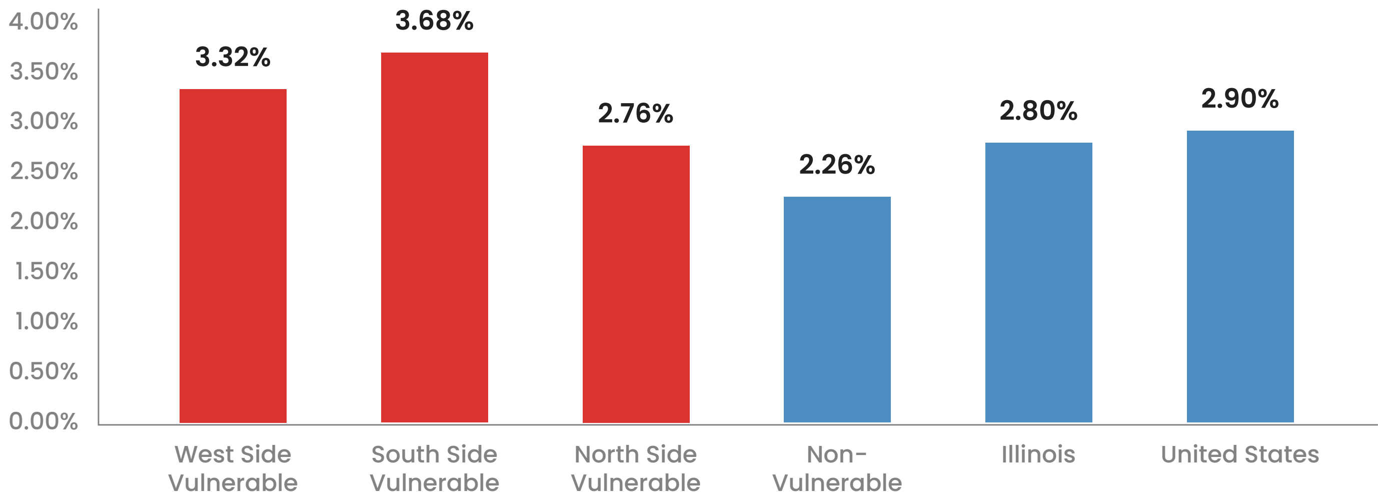
Definition: Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have diabetes, other than diabetes during pregnancy. Data for counties and states are age-adjusted. Data for zips, tracts and smaller layers are raw.

Exhibit 7: Prevalence of Coronary Heart Disease[24] in Chicago



Definition: Coronary heart disease (% of adults), 2022.

Exhibit 8: Prevalence of Chronic Kidney Disease[25] in Chicago



Definition: Percent of resident adults aged 18 and older who report ever having been told by a doctor, nurse, or other health professional that they have kidney disease. Data for counties and states are age-adjusted. Data for zip codes, tracts and smaller layers are raw.

The currently constituted system is built to address chronic disease costs and support related acute events, as that is where the greatest demand lies. Chicago is a hospital-centric city that invests little in upstream interventions that can prevent life-altering illnesses that are bankrupting the safety net system.

SECTION 4:
A DEEPLY TROUBLING FINANCIAL OUTLOOK

A fundamental maxim of any for-profit or non-profit business to be viable is that revenues must exceed or match expenditures. This is sometimes untenable for earlier-stage or at-risk companies, resulting in some form of capital infusion.

Many of Chicago's safety net institutions cannot access traditional capital markets due to their non-profit nature or their current lack of creditworthiness. The economic fundamentals do not warrant the alternative sources of capital needed to revitalize the system for increased efficiency and patient volumes.

A financial review of the performance and viability of the safety net shows that expenditures have protractedly exceeded revenues due to years of stagnant reimbursement rates, inflation, declining patient volumes, and, in some cases, debt. These financial deficits paint a deeply troubling picture.

The state has pursued initiatives, such as the Hospital Assessment Program, transformation funding, and other subsidies, to improve system efficiency and sustainability. Further, the philanthropic community continues to gift massive amounts of money to safety net providers throughout the city year after year. However, the sum of these government subsidies and philanthropic contributions are insufficient to overcome the steadily growing deficits threatening to collapse Chicago's safety net. Thus, the fundamental misalignment between revenues and costs remains. In the next six to 24 months, certain safety net institutions will require an unprecedented, likely untenable, level of subsidization that will force difficult decisions.

Health Care Safety Net Hospital Financial Analysis

This study analyzed nine of the city's 20 designated safety net hospitals.[III]

These nine hospitals, referred to as the "cohort" going forward, represent all corners of the city where emergency, trauma, and specific clinical services are provided. The total net patient revenue[IV] (NPR) for this cohort increased by 9.87 percent from 2013 to 2023. There were three distinct periods over the preceding decade.

- **Period 1 (2013 – 2016):** An increase in overall utilization driven by the effectuation of the ACA facilitating improved and expanded coverage for the Medicaid program *and* individuals or families with income under 400 percent of the Federal Poverty Level (FPL) and without access to employer-sponsored health insurance. The overall growth of NPR for this period was 8.25 percent.
- **Period 2 (2017 – 2019):** Increases in utilization flatlined, marking a general slowing of *new* dollars and patients entering the system. For this period, NPR was essentially even.
- **Phase 3 (2020 – 2023):** The COVID-19 pandemic ushered in a sudden and rapid suspension of certain non-emergency services in hospitals for an extended period. During this and subsequent periods,

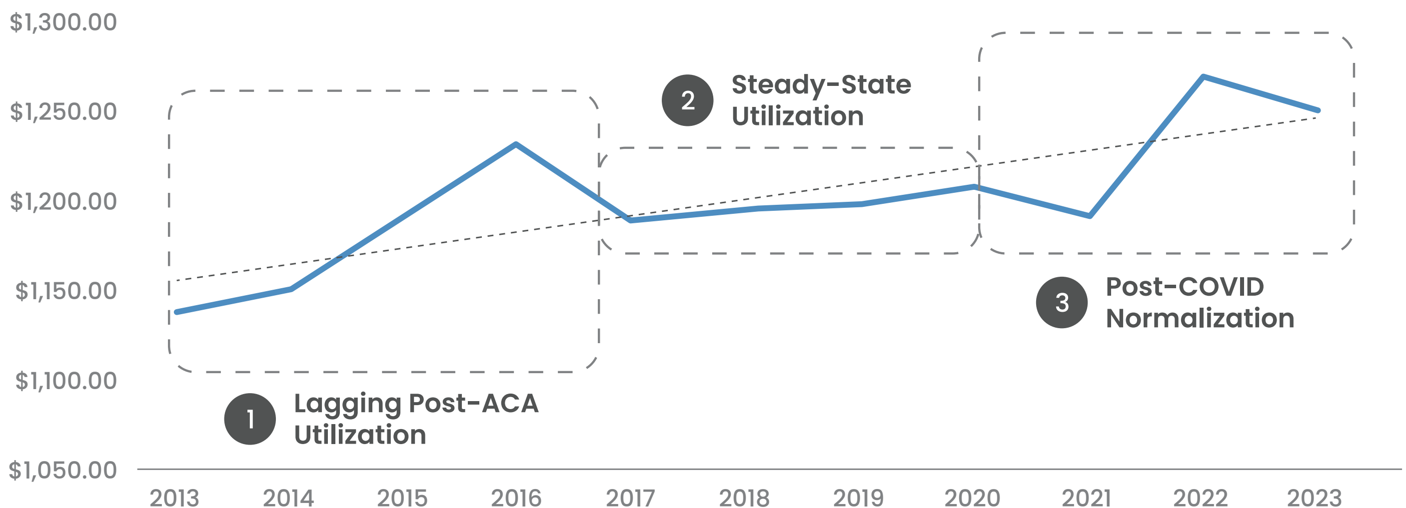
[III] Included in the cohort are: Holy Cross, La Rabida Children's Hospital, Loretto, Humboldt Park Health, Insight Hospital and Medical Center, Mount Sinai Hospital, Roseland Community Hospital, St. Bernard Hospital, South Shore Hospital. Safety net hospitals not included were either government-owned and operated, had inconsistent financial reporting, or were generally not applicable to the analysis.

residents of communities across the city curtailed seeking care for routine or other non-emergent needs. It is unlikely that utilization patterns will completely normalize until 2025, but thus far, aggregate multi-year NPR grew just slightly at 3.5 percent.

Exhibit 9 depicts NPR's growth pattern through these three periods. Note the decline in NPR heading into 2023. Overall, NPR's growth from 2013 through 2023 is positive, with an average annual expansion of 0.88 percent. However, the *rate of growth* declined by 0.11 percent annually. Thus, it is likely only a matter of years until NPR begins to contract, while core unit service costs maintain their steady increase.

Community feedback and research indicate that residents increasingly avoid utilizing safety net institutions in their communities to pursue care at places like the University of Chicago Medicine, Rush, Northwestern, or other medical facilities outside their immediate vicinity. This is due to perceptions that the safety and quality of the city's safety net hospitals are not on par with the city's non-safety net hospitals.[26] Residents seeking care outside of their communities includes insured individuals, which further complicates the reimbursement calculus by reducing the payer-mix in their respective communities, which directly correlates with NPR as seen in Exhibit 10.

Exhibit 9: Overall Cohort NPR for 2013 – 2020 (in millions)



[IV]Net Patient Revenue represents the actual revenue a hospital realizes and is paid through the claims adjudication process as opposed to what a hospital facility might bill or what the underlying services are worth or cost.

Exhibit 10: Year over Year (YoY) Change in NPR from 2013 – 2023

8.00%
6.00%
4.00%
2.00%
0.00%
-2.00%
-4.00%
2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023

Government subsidies, philanthropy, investment income, and "other" revenue have generally kept the safety net cohort at break-even throughout these three periods ranging from 2013 to 2023. These subsidies and contributions even helped the cohort experience slight profit margins in five of the past 10 years. However, most additional, non-operating funds were immediately absorbed to cover the operating expenditures or deficits, leaving no room to strengthen balance sheets. There are insufficient margins to re-invest in capital improvements that could enhance the efficiency, aesthetics, and safety of the facilities in the cohort. As a result, the capacity of Chicago's safety net system remains stubbornly static *and* underutilized.

Operating expenditures, which have climbed markedly since 2013, have exacerbated the situation of flat revenues. Overall spending increased by 31.87 percent from 2013 through 2024. Driven by an unusual surge in inflation during and after the COVID-19 pandemic—combined with an already high industry-wide increase in medical cost inflation—this expansion of expenditures dwarfs NPR as seen in Exhibit 11.

Exhibit 11: Cohort Profit Margins from 2013 – 2023 (in millions)

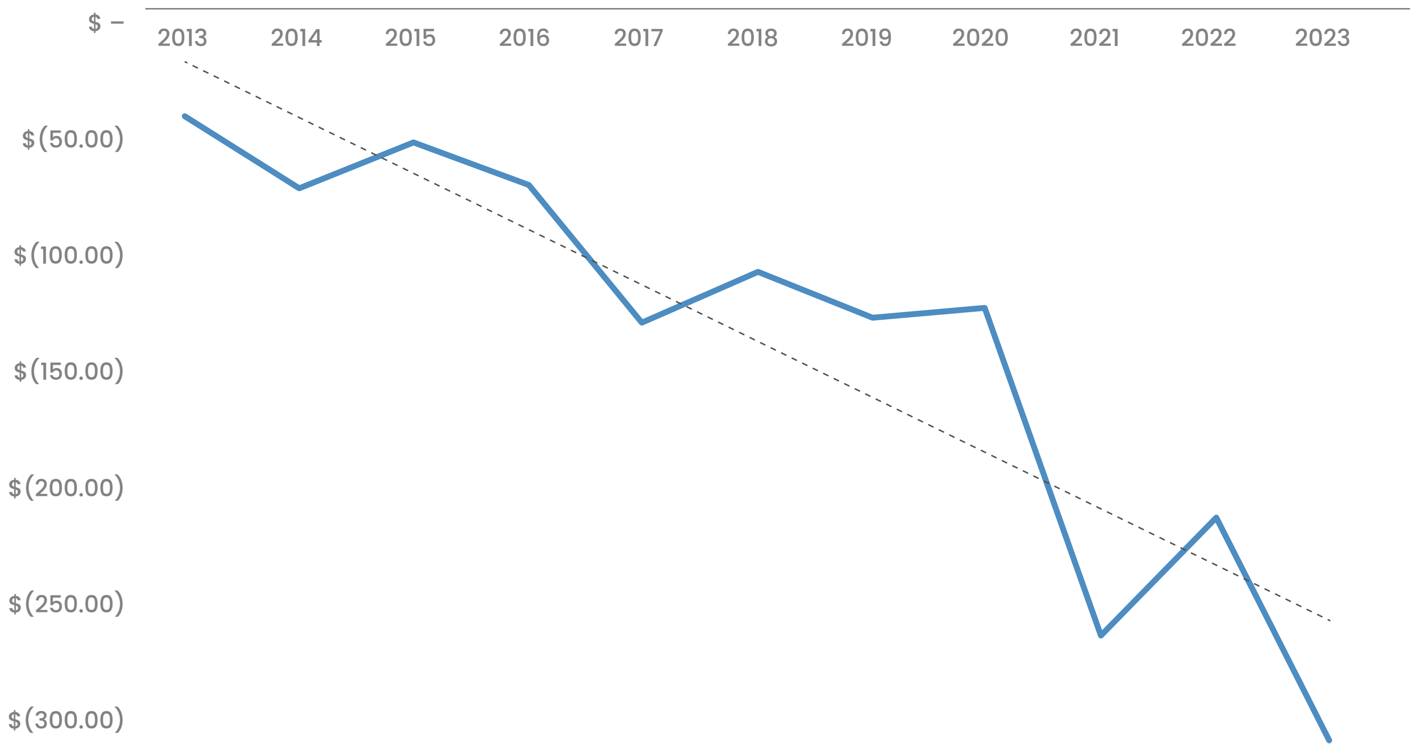
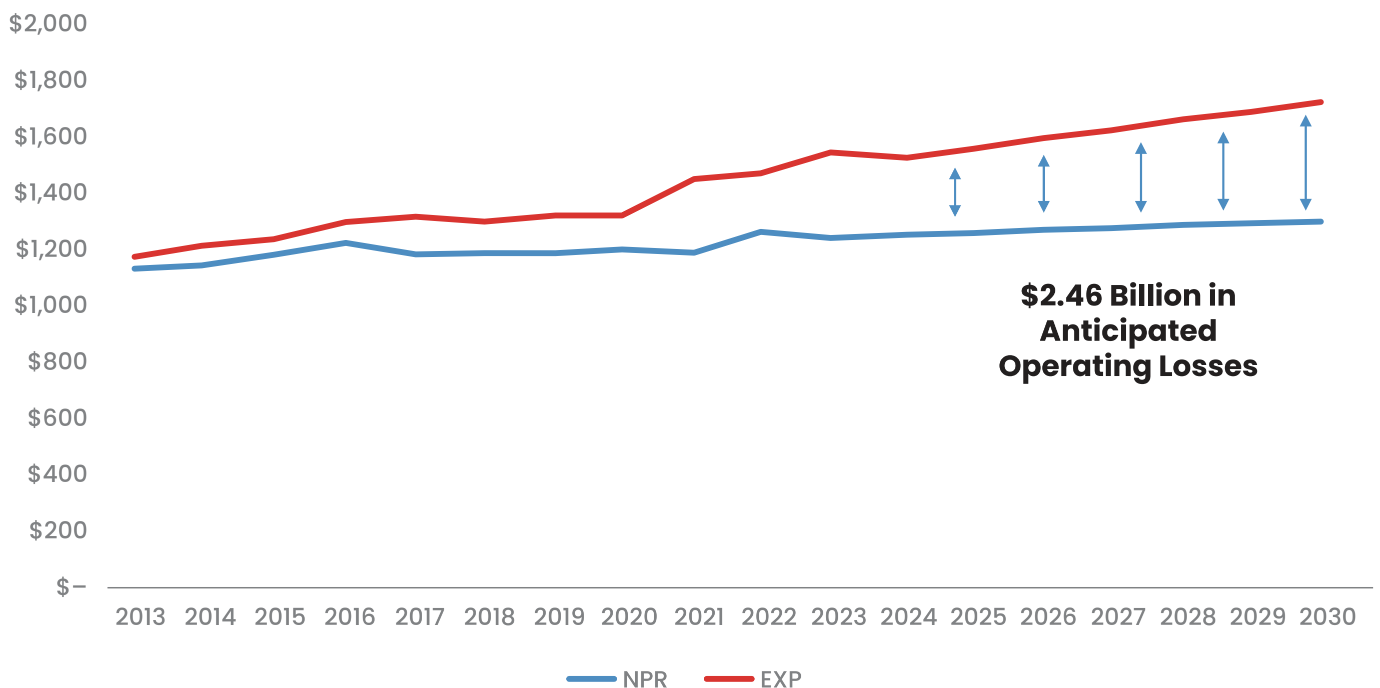


Exhibit 12: Forecasted NPR and Expenditures for Hospital Cohort (in millions)



Using the current trend analysis and applying longitudinal regression logic, Exhibit 12 provides a conservative forecast for how these losses will take shape from 2023 through 2030. The cohort is expected to experience a $2.46 billion operating loss during this period, absent any other subsidization or non-clinical revenue.

However, this analysis also modeled the historical non-operating revenue lines to identify what the actual loss is anticipated to be. The team assessed three other revenue categories found in the publicly available IRS records:

- **Grants and contributions:** Revenues from state or federal government subsidies and philanthropy represent 4.51 percent of NPR on average.
- **Investment Income:** Revenues related to the sale of securities or property that create a marginal income stream or an unusual increase in revenue during a liquidity event represent 0.37 percent of NPR on average.
- **Other Revenue:** Operating revenues derived from non-clinical activities such as a parking garage, cafeteria, other business-to-business services, etc., represent an average of 3.64 percent.

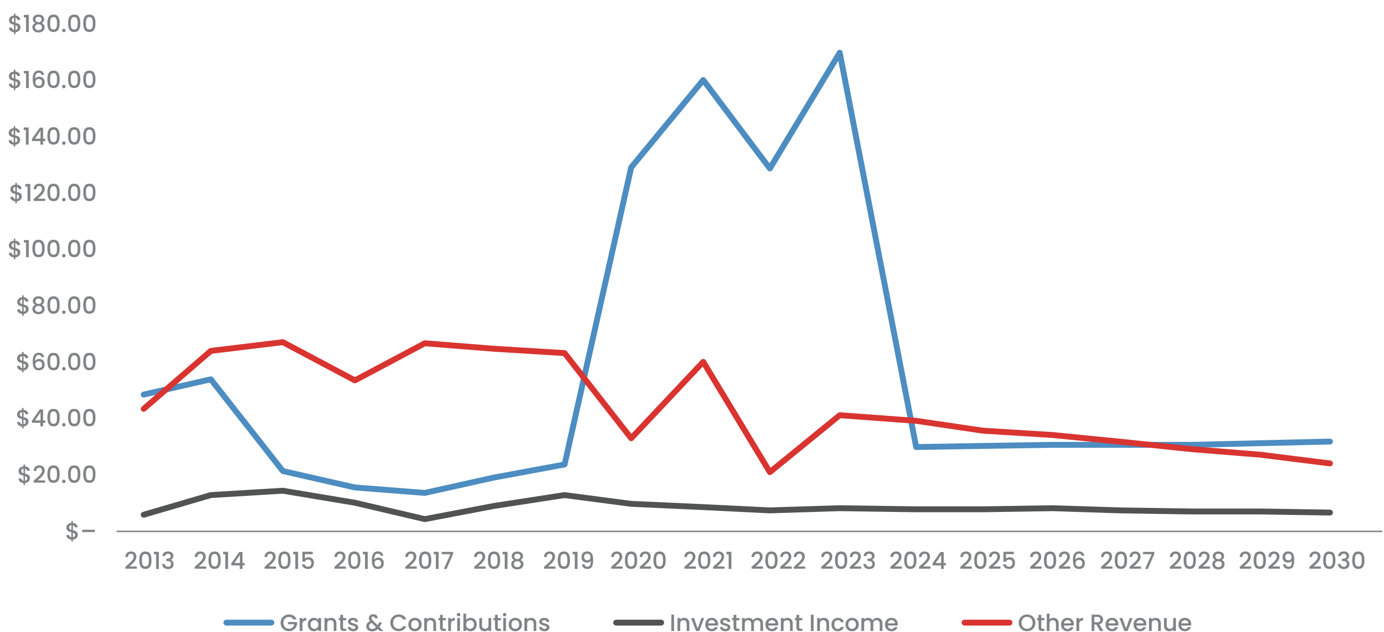
The revenue for these three non-clinical categories is shown in Exhibit 13.

The COVID-19 period between 2020 and 2024 prompted an unusual increase in grants and contributions, primarily driven by state and federal subsidies intended to subsidize hospitals (in Illinois and across the United States) for forgone revenues from collapsed utilization.

Using these uncommitted funds to offset the burgeoning gap between expenditures and revenues for the cohort has become too broad to subsidize sustainably.

Inclusive of these additional revenue lines, the cohort is forecast to experience a loss of $1.54 billion from 2025 through 2030,

Exhibit 13: Non-Clinical Revenues from 2013 – 2030 (in millions)



net of *all* incomes across services, state subsidies, philanthropy, investments, and non-clinical services.

Offsetting Assets

In 2023, the cohort's convertible assets, or assets that can be converted to cash, were running low, at $256 million between cash, savings, pledge contributions, and accounts receivable. For comparison, the total convertible asset base for the cohort in 2013 stood at $425 million. By 2030, convertible assets can only cover 16.67 percent of the total subsidized operating loss (see Exhibit 14).

In short, Chicago's safety net is categorically insolvent and unsustainable, with compounding losses forecast.

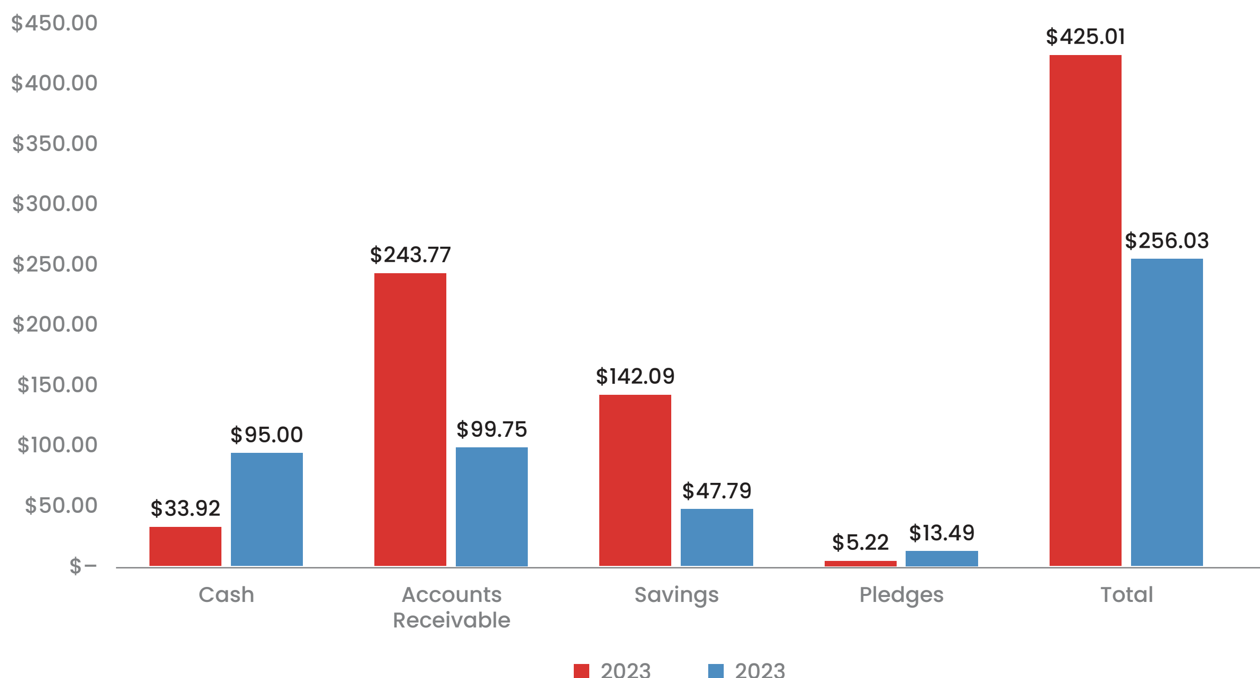
Certain hospitals have already entered the "zone of insolvency," and closures are imminent.

Federally Qualified Health Center Financial Analysis

Analyzing FQHC's financial health in Chicago is a far different exercise than analyzing hospitals' financial health. There are 22 FQHC organizations in Chicago, representing over 150 other care sites. These providers are essential to the safety net, providing primary care and related services to community members regardless of insurance type, with a particular emphasis on those with Medicaid, Medicare, or the uninsured.

We analyzed the financial filings of 19 of the 22 FQHC entities in the city from 2016 through 2023. FQHCs in Chicago have seen gross revenues increase from $562.0 million in 2016 to $1 billion in 2023, an increase of 78

Exhibit 14: Convertible Asset Comparison, 2013 and 2023 (in millions)



percent.[27] Approximately two thirds of this revenue growth occurred during COVID-19, when government programs and subsidies offset dynamic utilization patterns and inflationary pressures. However, as federal relief funding becomes completely exhausted, it's reasonable to anticipate a decline in these total revenues, which are likely to fall between $850 and $900 million.

The net income for these facilities is showing signs of strain. The absolute EBIDA dollars declined by approximately 10 percent, with the total share of EBIDA against revenue falling from an average of 7.17 percent (2016 – 2022) to 3.66 percent, a decline of 55 percent overall.

To be sure, margins remain healthier for FQHCs than their safety net peers. There is a reasonable degree of solvency across these entities, with $944.0 million in assets against $323.4 million in liabilities. However, FQHCs operate in a highly pressurized political and economic environment, with four areas that could immediately destabilize these institutions' financial integrity and medium-term solvency. The various revenue streams and underlying programs that comprise FQHC's income are complex and manifold. These programs allow FQHCs to generate a marginal amount of net income. However, a threat to any of these programs could rapidly and significantly shift the economic architecture of the FQHC community. This analysis examined four key areas of vulnerability.

- **Health Benefits for Immigrant Adults:** Program eligibility for the HBIA in Illinois began in July 2022, providing access to immigrant adults aged 42 to 64 who are ineligible for traditional Medicaid due to their immigration status. HFS recently suspended new enrollees[28] given higher-than-expected program costs. Growing

legislative opposition to its long-term maintenance given the state's budget challenges[29] resulted in the closure of this program on July 1, 2025. FQHCs in Chicago report that approximately 4 percent of their program revenues were derived from the HBIA program. FQHCs pride themselves on seeing every possible patient, regardless of ability to pay or immigration status. Hence, the revenues provided by the HBIA program are designed to offset these losses and create sustainability.

- **Medicaid Expansion Trigger Law:** If the federal government were to materially cut the Medicaid program affecting the ACA adult expansion program for Medicaid, enhanced FMAP rates will fall under 90 percent. Senate Bill 741 (passed in 2013) "triggers" the automatic termination of coverage for all adults in the expanded population definition,[30] representing a potential loss of insurance coverage for 931,169 Illinois residents. Chicago FQHCs report that this would disrupt approximately 15 percent of revenue with self-pay rates generally operating between 10-25 percent of what the Medicaid reimbursement rate is.
- **340b Program:** FQHCs participate in a government program that allows certain drugs to be purchased at a significant discount directly from manufacturers and filled for patients through a reimbursement mechanism that pays substantially more than the drug's cost. The program has come under scrutiny in recent years because of abuses from non-safety net health care institutions who leverage 340b as a mechanism for enhancing profits. The vulnerabilities are from all sides. Pharmaceutical companies are limiting contract pharmacies and imposing other restrictions to their ongoing participation in the program, MCOs and PBMs are beginning to impose discriminatory reimbursement practices, and the United States Congress has been churning through proposals that would impose stricter eligibility criteria, transparency requirements, and program reductions.
- **Inflation:** It is difficult to statistically isolate the precise impact inflation had on FQHCs during the COVID-19 and post-COVID-19 recovery periods. However, revenue growth outpaced expenditure growth for these periods, indicating that federal and state relief funds helped to blunt what could have otherwise been a catastrophic outcome for FQHCs. If the United States enters a new inflationary period, and such subsidies are not afforded to FQHCs, several organizations will be in financial straits.

We estimated the potential annualized EBIDA losses to this 19-FQHC cohort should funding or programmatic support go away (see Exhibit 15).

Exhibit 15: Scenario Analysis for EBIDA Impacts to FQHCs

Elimination of HBIA	-$41,094,000
Medicaid Trigger Law	-$154,105,000
Significant Change to 340b	-$102,737,000
Inflationary Pressures	-$47,933,000
Total	**-$345,870,000**

These estimates represent the worst-case outcome for FQHCs, where several bad things happen simultaneously. The reality is that any one of these changes will likely have offsets, wind downs, or other mitigating forces that would contain the worst-case scenario and allow FQHCs to make certain strategic pivots.

However, given the low operating margins of FQHCs today, less conservative estimates show scenarios that could represent a death blow to FQHCs. Given the incredible importance of these organizations to the safety net, it is critical to find additional ways to solidify the economics of these institutions and help them achieve a level of greater predictability and certainty so their focus can be on their highest and best use – serving vulnerable communities.

Community Mental Health Center Financial Analysis

Non-profit CMHCs in Chicago also face significant financial and operational challenges that threaten their ability to serve vulnerable communities. We assessed four non-profit CMHCs in Chicago.[V] These centers have consistently and reliably expanded their reach, service, and fundamental economics, seeing a growth in topline revenue from $150.9 million in 2016 to $293.3 million in 2023, a 94 percent increase. Though subject to the same inflationary pressures experienced across the economy during the COVID-19 period, CMHCs have hovered around a weighted average of 3.62 percent EBIDA, driving a 50 percent increase in the core asset base and a 72.5 percent increase in net assets (as strengthening assets have eliminated certain liabilities). In short, CMHCs are comparatively stable. However, like other areas of the safety net, red lights are blinking.

A primary financial challenge is the stagnation of Medicaid fee-for-service (FFS) reimbursement rates, which consistently fail to keep pace with inflation and rising operational costs. This chronic underfunding forces these centers to continually seek private philanthropic support to fill financial gaps and sustain their essential services to underserved populations. While Illinois is increasingly focused on mental health "parity" (a policy requiring mental health services to be paid on relative par with medical and surgical services), these programs are persistently underfunded across commercial, Medicare, and Medicaid lines of business.

Moreover, value-based payment reforms intended to improve sustainability and quality have been slow to materialize,

[V] Included in this analysis are Thresholds, Center on Halsted, Metropolitan Family, and Pilsen Wellness Center.

leaving providers stuck in outdated payment systems that do not reward holistic, proactive, and preventative care.

Operationally, many CMHC providers face substantial workforce challenges. Recruiting and retaining qualified mental health professionals who can deliver care in challenging community settings remains a persistent difficulty. The demanding nature of serving vulnerable populations—often in their own environments (in vivo)—requires significant investment in staff training, retention strategies, and competitive compensation packages. However, constrained financial resources materially limit these necessary investments, exacerbating staff turnover and burnout.

Regulatory barriers and policy-related challenges further complicate service delivery. State-led initiatives such as the health care transformation grants authorized and distributed by HFS have often prioritized investments in internal hospital infrastructure rather than robust, sustained, community-based mental health partnerships. According to leaders in the community mental health sub-sector, hospitals in Chicago have generally not shown long-term commitment or investment in meaningful collaborations with CMHCs. Consequently, individuals experiencing Serious Mental Illness (SMI) crises continue cycling through EDs and inpatient care without the necessary ongoing, coordinated outpatient care that CHMC providers are best equipped to deliver.

Additionally, antiquated approaches to regulation and inadequate recognition of community mental health services within transformation initiatives have left providers as secondary considerations rather than primary partners in health care delivery. Hospitals typically utilize these transformation grants for internal infrastructure improvements, relegating community mental health services to an afterthought rather than an integral component of health care transformation.

Lastly, structural barriers such as inadequate housing and insufficient community resources, especially for individuals with SMI, seriously undermine patient care outcomes. Addressing SMI effectively demands integrating stable social solutions (e.g., housing, employment, food, etc.) alongside medical and psychiatric care. Without coordinated strategies that include sustained housing support, patients with SMI remain at high risk of rehospitalization and instability.

Mental health and addiction services are a critical pathway to improving health across the city of Chicago. Underinvestment, both

in capital and reimbursement, has left in its wake a system that (for the moment) meets urgent community needs, but is inadequately equipped to focus on behavioral health as a mission-critical predicate to physical health. There are incredible intergenerational social and economic benefits from a cohesive and coordinated community mental health system.

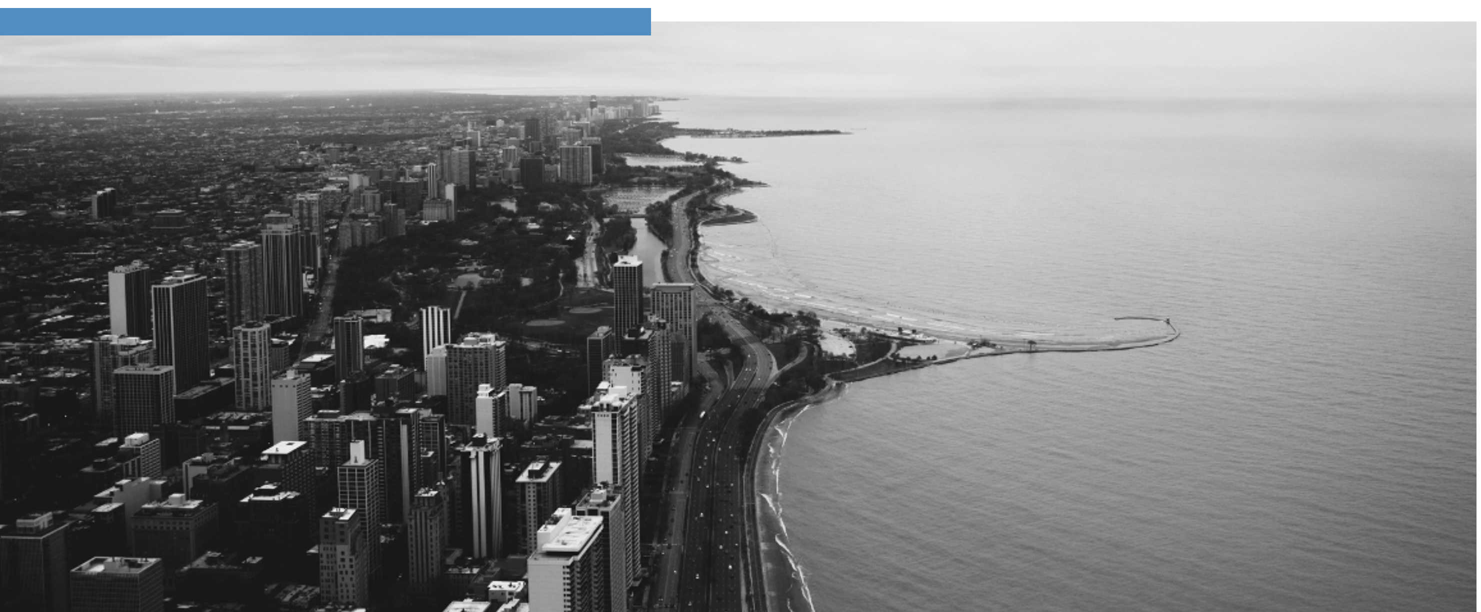
Environmental Headwinds

Chicago's safety net represents a three-legged stool comprised of mental health (consummate whole-person health and prevention), primary care (chronic disease prevention), and acute care (emergency care and chronic disease treatment). Chicago's safety net has this formula backwards, putting far too much emphasis on inpatient acute care beds, placing an untenable amount of weight on this "leg" of the stool.

There is a myriad of risk factors in the ecosystem that could escalate the urgency of an already existential situation:

- Federal Medicaid funding cuts would trigger the state's disenrollment of 931,169 beneficiaries and substantially increase the amount of uncompensated care rendered by medical providers across Chicago.
- The Trump administration does not approve the $2 billion increase to the Directed Payments Program, further cutting off the flow of needed subsidies to safety net providers.
- The economy enters a recession with a duality of increased unemployment and increased inflation, placing significant operating pressure on safety net entities across the city.
- The state has a budget deficit of $3.2 billion.
- There could be fundamental changes to the 340b or HBIA programs.

With or without the manifestation of these headwinds as real operational impediments, Chicago's safety net remains in a perilous position. If any one of these threats becomes a reality, the timeline to a systemic fracture will be shortened.



SECTION 5:

CONCLUSION

Chicago's safety net stands at a critical juncture. For decades it has played an essential role in providing health care to the city's most vulnerable residents, adapting to significant policy shifts, economic challenges, and public health crises. However, the financial instability facing safety net hospitals and clinics – driven by stagnant revenues, rising expenditures, and decreased public funding – threatens the infrastructure designed to serve underserved populations. Without intervention, these institutions will struggle to sustain operations, forcing entire communities to seek care from less accessible and convenient locations (e.g., University of Chicago, Northwestern, Advocate) and further exacerbating the already pervasive health disparities in Chicago's underserved neighborhoods.

Addressing this challenge requires a bold, systemic approach. The gaps in funding and utilization must be met with innovative solutions, including stronger public-private partnerships, increased investment in preventive care, and modernization of health care facilities. Policy initiatives, like the recent health care safety net hospital stabilization programs, offer a foundation, but a sustainable financial model is essential to reverse the current trajectory. By strengthening the financial outlook of safety net providers and investing in SIOH that drive poor health outcomes, Chicago can create a resilient health care safety net system capable of delivering accessible, high-quality care to all residents. The stakes are high; the time to act is now.

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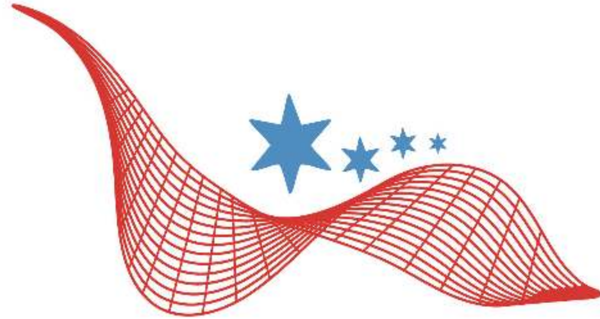

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