Touchette
REGIONAL HOSPITAL

Transformation Application

April 9, 2021

Application for Transformation

Funding Cover Sheet

EAST ST. LOUIS METRO AREA TRANSFORMATION PARTNERSHIP

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EAST ST. LOUIS METRO AREA TRANSFORMATION

EXECUTIVE SUMMARY

The East St. Louis Metro Area is the most distressed community in the State of Illinois as measured by the CDC Social Vulnerability Index (a measure of 15 census elements that demonstrate a community's economic and social vulnerability). The mostly African-American residents of this community contend with health disparities in virtually every measure, including Infant Mortality, Diabetes, Hypertension, Cancer Screenings, Mental Illness, Substance Use Disorder and Asthma. Residents also face considerable barriers to access, demonstrated by a large backlog of unmet specialist referrals, and excess ER usage. The service area for this community includes East St. Louis, Cahokia Heights, Washington Park, Sauget, Brooklyn, Venice, Madison, Granite City, and Alton.

Touchette Regional Hospital (TRH), a safety-net hospital serving this community since 1958, has developed the East St. Louis Health Transformation Partnership in order to affect large scale realignment of the health delivery system as well as improvements in the life circumstances of those living in the East St. Louis Metro Area. This collaborative partnership brings together: TRH (the only safety-net hospital in the community), SIHF Healthcare (the largest provider of primary care services in the area), Southern Illinois University School of Medicine, SLUCare Physician Group, Memorial Medical Group, and Washington University (to provide enhanced Specialist care), ConferMed (to provide peer-to-peer consultation with primary care physicians), Centene (to provide training for Community Health Workers), Healthier Together (a collective impact organization with over 70 service organizations dedicated to working together to improve community health), Comprehensive Behavioral Health Center (the provider of outpatient Substance Use Disorder and Mental Health Service in downtown East St. Louis), the St. Clair County Sherriff's Office and EMS services (to develop a new diversion center to treat minor offenders impacted by behavioral health), Southwestern Illinois Community College (to develop a new workforce development and training campus), the St. Clair County Housing Authority (to partnership on new community housing), Zade, LLC, and the Metropolitan Housing Development Corporation (to develop and own the community and supportive housing in partnership with SIHF).

Extensive community needs will require capital investment for a new Health Care Campus for ambulatory and hospital complexes, renovation funds for the development of an Urgent Care Center in midtown East St. Louis, a new Workforce Development and Training Center in Venice, the repurposing of the former TRH Hospital facility for a Diversion Center, Supportive Housing and Services, and an extensive community housing project to improve living conditions of individuals in the community.

Critical investment with the deployment of a new team of Community Health Workers in conjunction with a new Community Health Hub will link community residents with extensive health and social needs to a wide variety of collaborating service providers.

Equity in access and the elimination of disparities drive the overall goals of this collaboration. This is necessary to improve health outcomes in the health conditions that impact our community. The specific goals of this collaboration are based on measurable health outcomes data as follow:

PROJECT GOALS

Category	Currently in the Community	Target Goal
Infant Mortality Rate per 1,000	12.9	10.0
Uncontrolled Diabetes Rate (lower is better)	37%	30%
Controlled Hypertension Rate (higher is better)	56%	65%
Breast Cancer Screening Rate	51%	60%
Cervical Cancer Screening Rate	61%	70%
Percent of Mental Illness hospitalizations with a follow-up visit within 7 days	15%	35%
Percent of Substance Use Disorder hospitalizations with a follow-up visit within 7 days	29%	50%
Unmet Specialty Referrals	50% (currently 35,561)	10%
Excess ER usage	35% of visits (9,370 of 27,832)	20% of visits
Rate of ER visits for Asthma in the community per 10,000	155	75
Percent Live Births with Prenatal Care started in first trimester	49%	80%

The necessity for a community transformation in our distressed communities is clear. Unmet health needs, social barriers, lack of connectivity between organizations, years of disinvestment, limited jobs, and inequities in workforce opportunities require significant transformation in resources and collaboration to develop key elements over the next five years to create the necessary reinvestment that can truly alter the systems supporting ongoing sustainability for our distressed region. Taken together, these activities will commence the necessary transformations over the next five years that will advance the health and well-being of residents of the East St. Louis Metro Area well into the future.

MAJOR PROJECTS THAT SHAPE THIS TRANSFORMATION

Activity	Description	Purpose
New Health Care Campus near major highways and transportation hubs	Development of a new Health Care Campus with an ambulatory care center for expanded access to specialty care, general acute care hospital including emergency medicine, expanded behavioral health unit, acute medical unit along with diagnostic and social services to address social determinants.	TRH is a 60 year old facility, located in a neighborhood with poor access and facility challenges as an acute hospital. A modern health care campus more central and accessible to specialty and social services will improve ***Health Equity***.
Development of an Urgent Care Center in midtown East St. Louis	This Urgent Care Center will feature Walk-In acute care services integrated with primary care, ancillary diagnostics for radiology, lab, pharmacy, and care management.	Opening this center in East St. Louis will address the acute care needs of this community and improve linkage to primary care services. Bringing this increasingly common service delivery site into the community will improve ***Health Equity***.
Development of a Community Health Hub to improve resources	The Community Health Hub will improve the integration, efficiency, and coordination of care across provider types and levels of care while also providing increased access to supportive life services in order to help improve the SDOH.	Development of the Health Hub will improve access to care and help improve health literacy and healthcare outcomes driven by the current lack of ***Health Equity***.
Deployment of Community Health Workers	Local Community Health Workers will work closely with partners and families to connect to social and medical services to remove barriers to health.	Deploying Community Health Workers throughout the community will ensure individuals have resources to connect them to a wide assortment of health and supportive services. These services will address both ***Health Equity*** and the ***Social Determinants of Health***.
New Workforce Development and Job Training Center in Venice	The Workforce Development Center will include a combined new campus in Venice, Illinois to be supported by Southwestern Illinois Community College, SIU-e, SIHF Healthcare, and local business leaders to increase job training and educational opportunities with an emphasis on trades.	A Workforce Development project will improve the educational, training and job options of the community. This is a direct response to negative ***Social Determinants of Health*** *and* ***Economic Equity***.
Repurposing of current TRH facility to provide a Diversion program, supportive housing and transitional housing	The repurposing of the former hospital will include: 1) a diversion program in partnership with the St. Clair County Sheriff, 2) the implementation of a crisis living room center that provides an alternative delivery model for those with an acute mental health situation versus emergency room utilization; 3) supportive housing that creates a continuum of care for those being discharged from the diversion program, the hospital's inpatient behavioral health unit, and others, and 4) the transition of additional hospital space to provide workforce development, life skills training, behavior health counseling, high school equivalency programming, and guidance towards steps in acquiring permanent external housing.	This partnership will start to address the over incarceration that affects this community and address the negative ***Social Determinants of Health*** that affect those caught in the legal system and the families often left behind.
Public Housing Replacement Project	Our housing transformation initiative will focus on affordable and safe neighborhoods that seek to lower associated health problems with chronic diseases, injuries, childhood development, violence control, psoriasis, asthma, respiratory conditions, and mental distress.	Housing is a key element of the built environment that can affect health outcomes. Housing improvements will directly impact the ***Social Determinants of Health.***

COMMUNITY INPUT

The service area for this project is the East St. Louis Metro Area that inhabits both St. Clair and Madison Counties located just across the Mississippi River from St. Louis, Mo. The focus of much of our transformations will be in the hardest impacted communities of East St. Louis, Cahokia Heights (inclusive of Centreville, Cahokia, and Alorton), Washington Park, Venice, Brooklyn, Fairmont City, Alton, Granite City, and Madison, Illinois. Voters in Cahokia, Alorton and Centreville recently approved a proposal to merge their towns to create a new city called "Cahokia Heights," This merger took effect on April 7, 2021. The focus communities share the highest proportion and concentration of African-American residents that have been impacted the most by very low incomes and social conditions. In 2019, Centreville (now part of the new Cahokia Heights) was ranked the poorest town in Illinois in a 24/7 Wall St. analysis examining small communities with high poverty rates and financial hardships.

Community input has been gathered for our transformation through several means. Over the last year our respective team has participated in weekly calls lead by the United Church Groups in both St. Clair and Madison Counties. These weekly calls have leaders from churches, agencies, government, and others seeking a platform for transformation and interventions. The focus since April 2020 has been the disparities and needs for services in our hardest hit communities from COVID-19. The St. Clair group has been adamant that if East St. Louis cannot support a new hospital then an Urgent Care Center must be started. This group's sense of health needs in the community allowed us to hear voices directly from the community in order to learn how to best address their health and social needs.

Dr. Robert Farmer, the Co-Chair of Healthier Together, has played a key role in the development of this proposal through extensive in-person meetings. Healthier Together is a 100% volunteer driven organization governed by an independent Council of Partners whose members include leaders in the healthcare, business, faith, education and local government sectors. Healthier Together supports the efforts of community work groups targeting Chronic Disease Prevention, Community Safety, Education, Maternal and Child Health, Mental Health, and Substance Use Disorder. Healthier Together brings over 70 organizations, currently dedicated to working together to improve community health and overall quality of life to this project. Healthier Together seeks to transform St. Clair County and the Metro East area into the top 25% of healthiest counties in Illinois by 2025, by creating opportunities so all residents can experience a safer, healthier quality of life. A listing of all of the organizations participating in the Healthier Together Collaborative is included as an attachment to this application.

In preparation for our transformation we also engaged HMA Consultants to conduct one-on-one interviews with our elected officials, local leaders, church leaders, community agencies, Sheriff, Mental Health Board, Memorial Hospital, and the Board of Directors for TRH and SIHF. The existing services, needs of the communities, care gaps, and considerations for our transformation plans were presented to 28 individuals during this input process.

Throughout the above processes, TRH leadership has been holding meetings with local, state, county, and federal elected officials on the components of our transformation. Officials consulted for this project

include: Mayor Jackson of Centreville, Lamar Gentry of Alorton, Township Supervisor Curtis McCall, and future Mayor of Cahokia Heights, Representative Latoya Jackson, Senator Chris Belt, Congressman Bost U.S. Representative for Illinois's 12th congressional district, Sen. Duckworth, Sen. Durbin, and Mayor Robert Eastern of East St. Louis.

These elected officials provided invaluable feedback on needs, locations, and services. Their involvement has been integral to the development of transformation activities. In fact some of our previous efforts have resulted in continued participation in our efforts to improve the health of our community. Our most recent engagement with some of the same officials led to extensive feedback on COVID testing and vaccine clinics. This plan with state, local and federal officials was last reviewed on March 29, 2021.

The plan to repurpose TRH was developed through a collaborative effort with the St. Clair County Sherriff's office, St. Clair County Government, EMS systems, and local behavioral health providers. Input on housing plans have been collected from meetings held with the SCCHA, and the residents of the current complexes that will be impacted by the changes. Upcoming partnership with the Illinois Housing Development Authority will extend the input from our residents, business owners, elected officials and others as we will be commencing a Community Revitalization Planning effort with their consultation starting in August 2021.

Community stakeholders including Southern Illinois University, Edwardsville (SIUe), Southwestern Illinois College (SWIC), Madison County Community Development, and SIHF Healthcare have worked together on an extensive project plan for the workforce development and training facility, including soliciting input from local elected officials in these communities.

SIHF Healthcare also provided extensive community input through data reports detailing local demographics and health outcomes and through extensive meetings with staff directly responsible for patient care as well as senior leadership. As a Federally Qualified Health Center, SIHF is governed by an active community-based Board of Directors with a majority of the board members being current SIHF patients and 8 of the current 14 board members are African-American and one is Latina. This enables SIHF to provide continual input from patients throughout the community in order to guide program activities and adjust to patient needs as they evolve.

Data sources for community information include the Transformation Data & Community Needs Report: East St. Louis Metro Area, published by the University of Illinois Chicago, US census data, health data from the CDC, data from local health departments, and internal data collected from TRH and SIHF medical records systems. SIHF's Electronic Health record system already includes an individual health record for nearly 120,000 residents of this community based on a three year analysis of unique patients in these zip codes.

Every three years, Touchette Regional Hospital hosts a Community Partners Roundtable to obtain input for a Community Need Assessment and surveys stakeholders in the community to determine health priorities. This process includes an open meeting (advertised in local newspapers) to solicit community

input for anyone who would like to be included but who was missed in the initial planning process. The community agencies participating in the 2019 Community Health Needs Assessment process included:

- Hoyleton Youth and Family Services/ Puentes de Esperanza - Initially a provider of residential services, Hoyleton's proactive approach has enabled their expansion into several service lines including: child welfare services, behavioral health, and preventive care services focused on teen pregnancy, substance abuse, and more. These services are also offered for Spanish-speaking clients through the Puentes de Esperanza program.
- St. Clair County Mental Health Board - Working to improve the development and delivery of mental health services for persons in St. Clair County.
- SIHF Healthcare Healthy Start Initiative - Providing comprehensive case management and support to mothers, their children, and their families before, during, and after pregnancy.
- Windsor Health Center - One of SIHF Healthcare's 30+ health centers providing healthcare services to the greater Southern Illinois area. Services offered include family health, women's health, behavioral health, and primary care.
- Catholic Urban Programs - One of the best-known providers of food, rent subsidies, clothing, and financial support for individuals that fall between the cracks of service providers.
- Lessie Bates Davis Neighborhood House - Providing early childhood development and comprehensive youth services in addition to individual and family support services, all which help move individuals and families out of poverty.

TRH has also recently launched a community dialogue and workgroup program, supported by Healing Illinois, hosting community-wide discussions through ZOOM to discuss Racial Inequity and Racial Healing with various leaders in the community. TRH has hosted 6 monthly discussion groups attended by over 20 local faith and community leaders, led by Cora Hughes, Chaplain and Community Services Manager with TRH. This program has finished its first six months of operations and participants have already contacted Cora to request the program continue. SIHF has also recently initiated a dialogue with Daryl Rice, pastor of Greater Love Family Church in an effort to provide health outreach and COVID-19 vaccinations through local church councils.

Beyond all of the community input solicited in the development of this project, TRH will continue to seek and respond to community inputs as an active process throughout the operational phase of the Transformation. Outreach efforts will continually seek input from Black and Hispanic local and national community organizations, local homeless shelters, public housing providers and residents, mayors, Boards of Alderman, local health departments, elected officials and other local and regional healthcare and social service entities.

DATA

The design of this Transformation was based on a data-driven analysis of community need in conjunction with extensive community input. Specific data points used in this design included: Infant Mortality Rates, Diabetes Rates, Hypertension Rates, Asthma Rates, Cancer Screening Rates, rates of follow-up care to hospitalizations for Mental Illness and Substance Use Disorder, the number of unmet Specialty referrals from SIHF Healthcare, the number of non-emergency ER visits, and entry into Prenatal Care.

These measures were selected as they mirror several independent needs analysis provided by local stakeholders, Healthier Together reports, and TRH's own Community Needs Assessment. These Needs Assessments along with feedback from patients and staff at TRH and SIHF also align with the University of Illinois Chicago report, "Transformation Data & Community Needs Report: East St. Louis Metro Area." In each of these assessments, services for Mental Health and Substance Abuse as well as "ambulatory care sensitive conditions" or Chronic Disease care for heart disease, diabetes and asthma were all identified as community concerns. Improved access and coordination of care for these chronic health conditions can reduce hospitalizations through early intervention that can prevent complications and progression to more severe disease. The same can be said for mental health and Substance Use Disorder services.

This process of examining needs in the community led to the following data elements identified as the Goals of the East St. Louis Metro Area Health Transformation Partnership. These measures align with the Department's Quality Strategy and many of the same data points are measured.

PROJECT GOALS

Item	Measure Description	Current	Goal
Infant Mortality Rate per 1,000	The number of infant deaths for every 1,000 live births.	12.9	10.0
Uncontrolled Diabetes Rate *lower is better	Patients 18 - 75 years of age with diabetes with A1c value is > 9.0% or not tested	37%	30%
Controlled Hypertension Rate *higher is better	Patients 18 - 85 years of age who had a diagnosis of hypertension/most recent blood pressure was adequately controlled (< 140/90 mmHg)	56%	65%
Breast Cancer Screening Rate	Women 50 - 74 years of age with a mammogram within the past 24 months	51%	60%
Cervical Cancer Screening Rate	Women ages 21 - 64 who were screened for cervical cancer	61%	70%
Percent of Mental Illness hospitalizations with a follow-up visit within 7 days	Patients with mental health issues receiving outpatient care within 7 days following a hospitalization/ER visit	15%	35%
Percent of Substance Use Disorder hospitalizations with a follow-up visit within 7 days	Patients with substance use disorder issues receiving outpatient care within 7 days following a hospitalization/ER visit	29%	50%
Unmet Specialty Referrals	Number of referrals to specialty care that were not able to be completed within 90 days	50% (currently 35,561)	10%
Excess ER usage	Hospital visits over a 2-year period with acuity levels 4 or 5 (less urgent)	35% of visits (9,370 of 27,832)	20% of visits
Rate of ER visits for Asthma in the community per 10,000	The number of ER visits for Asthma in the community per 10,000	155	75
Timeliness of Prenatal Care	Percent Live Births with Prenatal Care started in first trimester	49%	80%

These goals will guide our collective efforts with our partners through ongoing monitoring throughout the program and the Transformation actions that will seek to meet these preliminary goals within five years.

HEALTH EQUITY AND OUTCOMES

A severe lack of Health Equity in the East St. Louis Metro Area has led to a series of poor health outcomes. This lack of health resources and services has been driven by white flight and medical services following this population. With the loss of the region's major employers and over two thirds of the residents in East St. Louis fleeing for the suburbs, the community began to fall into state and federal debt as crime and corruption began to rise. This resulted in the loss of significant medical services

culminating in the closure of two of the community's hospitals (Christian Welfare in the 1980's and Kenneth Hall Regional Hospital in 2016) leaving East St. Louis, one of the most dangerous cities in America, without an Emergency Room. Concurrently, neighboring health systems have limited access or have denied access completely to those on Medicaid and those without health insurance. Services like specialist care and acute emergency care are very limited in the community.

The East St. Louis Metro Area Health Transformation Partnership directly seeks to improve health equity in these distressed communities with improved health conditions and outcomes through enhanced patient support and a revised delivery services. Chronic under-investment across social and health care in the community has created an environment that leads to multiple health risks and social challenges. Local organizations struggle to address the full breadth of health related needs due to the overwhelming social issues impacting our community. Service providers in our community struggle to maintain wages, job resources, and comparable benefits that other larger providers and those in more affluent areas enjoy. Recruitment and retention of clinicians and staff in our distressed area and organization is complicated by the fact our funding is based upon 76% uninsured and Medicaid patients. This very condition results in a lack of equity when compared to other communities employment offerings. Specific equity issues directly affecting the healthcare delivery system in the community include:

- Inadequate health care campus/hospital with an aging facility that lacks modern operational capabilities. The current campus and infrastructure of Touchette Regional Hospital is over 60 years old, well beyond the useful life of a community regional hospital;
- Lack of specialist services due to challenges in recruitment for patient payment categories and the denials from other providers;
- Lack of an acute care/urgent care facility in the East St. Louis community to address immediate acute needs for the many community residents who seek use of emergency rooms for their non-emergency care;
- Lack of care management services in order to overcome a lack of health literacy and health education in the community; and
- Lack of connection to the health related resources available in the community

All of these listed inequities have been demonstrated to affect communities of color much more than majority white communities. Coupled with a lack of safe housing, parks are often in disrepair and dangerous, poor air quality, rampant crime, low capacity for revenue for city governments, and abundant brown fields plague our communities and make it difficult to bring forth resources to improve health equity.

The current trend in the area has been to see resources funneled away from these communities. One hospital in neighboring Belleville underwent a relocation that moved them further away from the Metro East St. Louis Area and another Belleville Hospital opened a new more modern facility on the east side of their community further from East St. Louis. Both facilities are conveniently located near more

economically viable populations, leaving the East St. Louis Metro Area with facilities decades behind those of their neighbors with health results to match.

A brief look at health disparity conditions negatively affecting the community can be seen below in comparison with state and national figures, clearly showing extensive disparities in health outcomes:

Disparity	East St Louis	Illinois	Unites States
Infant mortality rate per 1,000 births	12.9	6.5	5.7
Diabetes (adults 18+)	17.6%	14.4%	8.5%
Hypertension	46.7%	37.0%	32.2%
Breast Cancer Screening	51.0%	78.7%	78.3%
Obesity (county health rankings)	37%	30%	30%

Achieving a community with greater health equity requires a comprehensive reimagining of the health and healthcare services provided in both cultural approaches and delivery methods. Housing, care management, outreach, more convenient access, cultural sensitivity, workforce improvement, educational support, and community engagement are all necessary steps that a collective partnership for transformation must pursue. The specific activities in this Transformation that relate directly to Health Equity include:

A new convenient and comprehensive Health Campus that addresses our community needs in the East St. Louis Metro Area

The new Health Campus will feature an ambulatory care center that embeds partnerships with multi-specialty groups to address regional unmet needs for Medicaid and uninsured patients through face-to-face visits, telemedicine, peer-to-peer consultations, expanded dental access, and outpatient surgery. The Health Campus will provide an expanded solution to the unmet need for inpatient behavioral health services for adults, adolescents, and geriatrics through a new behavioral health services model supported by medical detox services. An outpatient area adjacent to the ED for a “living room” Crisis Stabilization Unit will provide a welcoming and culturally competent way to ensure those who come to the ED with Behavioral Health issues do not face social stigma while seeking care and are more comfortable to share their concerns and amenable to further treatment. Community rooms and food resources will be developed through partnerships with local food and nutrition outreach efforts like the current collaborative program to deliver fresh, healthy food in the community in partnership with the Sweet Potato Patch food service.

The new health care campus will also serve as the primary community location for improved specialty care service through collaboration with SIU School of Medicine, Washington University, Memorial Medical Group, ConferMed and others to develop multi-specialty programming to address regional unmet needs for Medicaid and uninsured patients through face-to-face visits, telemedicine, and peer-to-peer consultations. Peer-to-peer consultation programming, supported by ConferMed will allow SIHF’s primary care physicians to consult with a multitude of specialists in order to support providing care for those whose conditions are easily controlled through their primary care physician, lessening the need for

additional visits with external specialists. Consultations above the comfort of the primary care provider can be referred directly to a specialist for a face-to-face or telehealth encounter. This program will be supported in all SIHF primary care sites in the service area. Our ability to provide hospital-based specialty care, either independently or via partnerships, will allow us to realize substantial savings by avoiding the astronomical cost of sustaining imperative service lines through locums services. Locum costs currently create a tremendous strain to our limited resources which would be better deployed to satisfy basic patient needs.

Specialty partnerships will work through the necessary collaborative structure to allow for assessment and diagnostics to be provided in the immediate community and for higher-level diagnostics and procedures to be performed by specialists at Memorial Hospital. It is our intention to proceed in this manner to help provide for greater continuum of care without actions that would duplicate necessary resources and cost. Furthermore, our partnership has a collective desire to create a sustainable and effective service line for women's health care and services to ensure prenatal, postpartum, and other key related women's health needs are addressed in a similar manner. This respective partnership will look at how we can deliver effective quality care at the most cost-efficient manner that shall advance the health outcomes of the women and subsequently their newborns. This partnership will require greater access to subspecialty prenatal services, a more effective utilization of shared medical data between the clinicians, linkages to community health workers and care coordination, and wraparound services to address any social determinants of health.

Establishing these services will require the implementation of an appropriate EHR system. The installation of a Meditech system to link all partnering organizations will resolve inadequacies in current EHR interoperability and functionality and reduce deficiencies caused by multiple independent systems that lack integration with each other and external entities. Inadequate referral and scheduling tools in the current systems create barriers to access for patients in our region. Antiquated system functionality stands as a barrier to efficient care and decision support for providers. A modern, integrated full-service system is attractive to specialist and sub-specialist providers, improving our ability to recruit specialists, thus reducing the current care access crisis.

Development of an Urgent Care Center in midtown East St. Louis

Urgent Care Centers are fast becoming a fundamental part of the healthcare landscape for acute care needs. Presently, there are no urgent care centers in the East St. Louis Metro area that the population could easily access. A new Urgent Care Center could greatly benefit accessibility for residents by providing a greater range of services than traditional physician offices. Our integrated Urgent Care Model will be developed through existing space with extensive renovation to meet the needs of patients. Primary care services will be imbedded in the Center to provide increased accessibility while also providing more affordable care versus having residents continue using emergency rooms. This Urgent Care Center will feature:

- Comprehensive Primary Care with no waits for those needing immediate attention or unable to access care during normal business hours;

- Ancillary Services to support and enhance the provision of Urgent Care, including Diagnostic Radiology, and Lab Services (Lab Draw Station, General POC and limited onsite testing);
- Pharmacy Services; and
- Enhanced Care Management through the deployment of Community Health Workers within the facility.

This Urgent Care Center improves access to acute services and features walk-in primary care services as a direct response to community input. Members of the community have repeatedly stated they want a walk-in urgent care center. This is unsurprising as a 2017 report by the Commonwealth Fund, *Listening to Low-Income Patients: Obstacles to the Care We Need, When We Need It*, noted that "Along with the cost of care, the patients we spoke to reported that taking time off work, juggling child care, handling family matters, and finding transportation are problems for them in a traditional appointment only model." This new structure will keep working, low-income people, who often do not get paid sick leave, from losing precious income when they take time off to go to the doctor.

Additionally, an Urgent Care Center alleviates excess hospital visits. By locating this center in the midtown area of East St. Louis, the location will be convenient to many individuals and easier to access in a more modern facility. According to the SSM Health network, any community with 25,000 or more people without an urgent care center is an area with sufficient need to support one. Estimates of urgent care services are calculated at 560 visits per 1,000 persons per year would anticipate approx.14,560 encounters per year for the City of East St. Louis alone.

Connecting People to Health through Community Health Workers & Health Hub

Currently, even when services are available in the community, they are not always easy to access for everyone. When you combine the labyrinthine features of many health systems today that baffle those with greater resources, this can present insurmountable barriers to those who lack health literacy. Community Health Workers will serve as a liaison, link, and intermediary between health and social services and the community to improve the quality and cultural competence of service delivery that includes all transition of care needs. Integration of CHW into the local health delivery system will build individual and community capacity by increasing health knowledge and self-sufficiency through a variety of activities that include outreach, community education, informal counseling, social support, and advocacy. Thus, we will create a new workforce of Community Health Workers to serve as a conduit to our partners to bring services to those most vulnerable.

TRH will be partnering with Centene to providing initial and ongoing training for the Community Health Workers. These CHWs will be organized into teams targeting specific health outcomes to enable workers to fully immerse themselves in the most effective ways to support those suffering from specific diseases. CHWs will actively participate in local health-related functions for community engagement and maintain a working knowledge of services available in the area and how they are best accessed. The Community Health Workers serving this community will work closely with staff from the new Community Health Hub, the center of this Transformation project's health education, outreach and

social services support space. Community Health Workers will also be embedded into the operations across our partnerships to assist in integration with care teams at these agencies and into the community where they can provide health education and outreach. CHWs will work to remove the social barriers to care faced by many low-income African-American patients, affect behavioral changes, and prevent unnecessary Emergency Department and hospitals visits. CHWs will also assist in our healthy food initiatives in the community.

QUALITY METRICS

The HFS Quality Strategy framework prioritizes equity across all program goals for transformation efforts. The framework includes 5 pillars of improvement: Maternal and Child Health, Adult Behavioral Health, Child Behavioral Health, Equity, and Improving Community Placement. The Department identified 12 goals that fall within 3 categories: Better Care, Healthy People/Healthy Communities, and Affordable Care as particularly relevant to the health of distressed communities. Each of these goals is addressed through our Transformation as described below:

Better Care

1. Improve population health. The Community Health Worker deployment will drive improvements in health outcomes through increased Care Coordination with greater patient engagement that supports linkages to services and guidance for patient activities beyond direct health services.
2. Improve access to care. The partnerships and service locations in this Transformation will improve access to previously unmet care needs for specialty services and transform access with expanded hours and walk-in services for primary and urgent care needs. Additionally, the new Health Care Campus will bring improved ambulatory, inpatient and social services to our underserved community to provide more accessible and cost effective services.
3. Increase effectiveness of care coordination. The Community Health Worker program will increase coordination of care with patients being individually tracked and supported throughout the continuum of care. The Community Health Workers deployment in coordination with community partners will become a collaborative effort to guide individuals to more effective utilization of services.

Healthy People/Healthy Communities

4. Improve participation in preventive care and screenings. Community Health Workers will improve patient engagement, new outpatient access, remote monitoring, and direct outreach. This will advance our screening outcomes for breast and cervical cancer that will be tracked and monitored with specific goals for performance improvement.
5. Promote integration of behavioral and physical healthcare. Our outpatient partner, SIHF, has been integrating behavioral health into primary care locations for the last 12 years with 30 individual site locations now integrated. Advancing this integration of behavioral health services

with local partners in law enforcement, corrections, and judicial is a gap we will address through a new diversion program on the former Touchette Campus. This transformation will provide a new entry source for individuals to receive care for both mental and physical health. Partnerships with Comprehensive Behavioral Health Center, SIHF, Life Links, and local hospital partners will guide patients into necessary behavioral health and substance use disorder services within our collaborative. These services will be tracked through a shared data approach among participating partners.

6. Create consumer-centric healthcare delivery system. Each unique transformation action is a direct response to consumer needs and demand for improved health status. Housing, specialty care, supportive housing, judicial reform, urgent access, food services, transportation, and community health workers are services that make our community and residents the center of health.
7. Identify and prioritize to reduce health disparities. Specific data measures will be linked and tracked to align with community-based needs assessments. These priorities shall guide program implementation, growth and success.
8. Implement evidence-based interventions to reduce disparities. The affordable and supportive housing, community health worker program, improved access to specialists, and workforce development all have evidence based research linked to improved health outcomes. The collaborative is dedicated to providing evidence based care and implementing best practices throughout service delivery.
9. Invest in the development and use of health equity performance measures. All measures shall be tracked in terms of patient demographics and health status to allow for an equity-based analysis of program impact on outcome results.
10. Incentivize the reeducation of health disparities and achievement of health equity. The entire Transformation is based around ensuring patients can receive the social and health care services that are needed through entities working together to improve health outcomes. This includes the sharing of program funds and resources to increase the ability of program partners to deliver needed services.

Affordable Care

11. Transition to value and outcome based payment. As part of the program's sustainability plan, TRH and SIHF will continue efforts with our MCO partners to migrate to value-based payments as a shared program to advance patient outcomes. This target for the Collaborative shall advance the purpose of health care providers, social service agencies, and community leaders to promote healthier outcomes of our community as the basis to determine effectiveness within this community through APM models.
12. Deploy technology initiatives and provide incentives to increase adoption of electronic health records (EHRs) and streamline and enhance performance reporting, eligibility and enrollment procedures, pharmacy management, and data integration. Presently all medical and behavioral providers utilize EHR for tracking patient progress. The collaboration will seek ways to share

this data effectively to ensure a cohesive system of care where patient records are available to multiple providers as necessary for the provision of quality care without duplication of services.

Data collected for our transformation matches several identified "pillars" of the Department's Quality Strategy. Our actions fit into the Department's desire to collect and monitor this data on a continual basis for measures that include the following:

Pillar	Specific Measure
Adult Behavioral Health	7-Day Follow-Up After Hospitalization for Mental Illness
Child Behavioral Health	7-Day Follow-Up After Hospitalization for Mental Illness
Equity	Breast Cancer Screening Rates
Equity	Cervical Cancer Screening Rates
Equity	Controlled Hypertension Rate
Improving Community Placement	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Maternal and Child Health	Time of Entry to Prenatal Care

As shown in the chart above, all five of the department's "pillars" are measured to ensure continuous improvement in community health. Each data point evaluated will be measured every three years and new baselines and goals will be set. Each of these pillars is central to the provision of health services in the community.

CARE INTEGRATION AND COORDINATION

Care Integration and Coordination is a significant focus of this Transformation's development of a Community Health Hub. Within the community there are healthcare service providers, community resource providers, housing agencies, food banks, etc. However, there is no successful process to ensure that available resources get to individuals who need them. This Transformation will establish a Community Health Hub to provide linkage between partners and resources that exist to the individuals who need them. This operation would establish a fully integrated, collaborative network of providers throughout the East St. Louis Metro Area to help coordinate access to services. Leadership and staff from the Community Health Hub will develop relationships with service providers throughout the area, contract with social service organizations and establish care plans to meet specific service needs. When a Community Health Worker identifies the needs of an individual, they will then engage the Community Health Hub to coordinate services and engage partner organizations.

A team of Community Health Workers will be hired to launch the program with this first cohort of workers embedded in SIHF, TRH, and targeted community partners as a means to integrate care teams for better access to needed services. Additionally, these staff members will perform outreach in the community by attending local health fairs and community gatherings in order to identify those who could benefit from their services. Participating community partners are expected to grow as the program develops the model of integration with key partners over the initial year of the project.

Community Health Hub models are financially accountable and based on confirmed risk mitigation. The Community Health Hub model is built on the Social Determinants of Health/Systems Theory and Social Support Theory. The model relies on understanding the pathways that address steps to help overcome issues that prevent individuals from accessing health care, housing, food, employment, education, and other critical support directly impacts health outcomes. The Hub model recognizes that modifiable risk factors within medical care, social services, and behavioral health are interlinking and interdependent in their impact and a more holistic approach to addressing risk is needed to improve outcomes (U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2019).

For example, an expectant mother who is homeless, depressed, and lacks prenatal care may have significantly better outcomes, including reduced stress, if all three of these critical risks are identified and addressed compared to approaches that may only address one or two of these factors. CHWs establish the community engagement necessary to build trusting relationships with community members served. High risk individuals benefit from the evidence based approach to identifying and addressing their risks in a holistic community and person centered approach.

The members of Healthier Together bring a wealth of social support services that will be integrated with existing health care providers through this new Hub. Healthier Together's significant health and supportive resources are already engaged in supporting a community-based movement to transform the East St. Louis Metro Area into the top 25% of healthiest counties in Illinois by 2025. This partnership will create opportunities so all residents can experience a safer, healthier quality of life. Currently, pathways will be focused on six specific areas: Chronic Disease Prevention, Community Safety, Education, Maternal and Child Health, Mental Health and Substance Use Disorder. Each of these areas requires advanced interventions to address overall community transformation and so they each align with the overall goals of this project. Further, the vast number of organizations brought together in an effort to unite and bring about change encompasses a broad range of services from healthcare to education to job support, financial support for the economically vulnerable, legal services for low-income individuals, and many more. In addition to direct service providers, significant representation from local business leaders have all pledged their support to the Healthier Together mission to create a healthier metro east region and to create opportunities for all citizens of the metro east area to achieve their best possible health. A full list of Healthier Together members is included as an Attachment to this application.

ACCESS TO CARE

Over 50% of primary care referrals from SIHF Healthcare providers for specialty consults are unmet due to the current lack of providers, denials due to payor source, and providers no longer accepting Medicaid MCO's. These conditions lead to a severe lack of access to care in our community that directly impacts all health measures and outcomes. Our very own clinicians express their concern for our patients' acute needs in distressed communities and for the legal threat to their license due to the risk for law suits. The

delayed appointments, procedures used, repeated rescheduling, and termination of coverage conflicts with the very principle of value based care. Challenges in acquiring referrals create greater strains on our clinicians and staff that diligently pursue the right path of care for our patients. Access, equity, and value are issues that our Transformation plans to overcome in order to ensure that members of the East S. Louis Metro Area receive the level of services they need and deserve.

The long standing environment in the East St. Louis Metro Area for those on Medicaid and uninsured is one of grave concern in the trust and respect of the health care providers. This lack of trust further interferes with the population's commitment to their health and belief in health care being there for everyone. Currently, there are limited specialty services offered in the immediate service area for Medicaid and uninsured patients, including a small number of specialty services offered through Touchette Regional Hospital. TRH offerings are limited due to physical space limitations and a lack of interest from regional specialists to care for this population due to payment levels, MCO challenges, and medical malpractice concerns. TRH has been partially successful in providing specialty care for Pulmonology, ENT, Orthopedics, Cardiology, and Nephrology. Other specialty services are extremely difficult or not available for access to our community for reasons previously stated. Currently, TRH has identified nearly 36,000 unmet referrals throughout this community due to a lack of specialty care in the community with the largest categories of unmet need being in Cardiology, Neurology, Orthopedics, Urology, Gastroenterology, Dermatology, Otolaryngology, and Pulmonology.

In order to remedy this situation, TRH and SIHF have planned partnerships with Memorial Medical Group, ConferMed, Centene, Washington University, Southern Illinois University School of Medicine, and SLUCare to provide specialty care in the community in a more accessible ambulatory care center through our transformation plan. The new Ambulatory Care Center would embed partnerships with multi-specialty groups to address regional unmet needs for Medicaid and uninsured patients through face-to-face visits, telemedicine, peer-to-peer consultations, expanded dental access, and outpatient surgery. The integration of these services within TRH and SIHF will have truly dramatic changes to access and health status and outcomes for our community by removing physical and financial barriers for individuals on Medicaid and those that are uninsured.

For those who qualify for Medicaid or health insurance subsidies through the federal health exchange, SIHF will assign patients to one of their current Healthcare Navigators specializing in health insurance signup and how to operate the healthcare marketplace website. This team has signed up 21,737 individuals for Medicaid or Health Insurances since it was established through the Affordable Care Act in 2010 with implementation of the Federal Exchange Healthcare in 2013.

Specialty care will be further enhanced through collaboration with ConferMed to provide peer-to-peer e-consults for SIHF providers in the service area. While many patients require a visit to a specialist for a formal diagnosis or for more advanced conditions that are beyond the comfort level of primary care physicians, many conditions are able to be maintained through regular primary care visits with the additional peer support provided through e-consults. Through the e-consultation program, specialist physicians are able to consult directly with primary care physicians to provide guidance and details of

treating specific conditions to increase the comfort of primary care providers providing this care and lessening the difficulty for patients navigating the health system and trying to schedule regular appointments with multiple providers. According to an article published in the Journal of Telemedicine and Telecare vol. 21, "E-consults are feasible in a variety of settings, flexible in their application, and facilitate timely specialty advice."

The establishment of an Urgent Care Center in midtown East St. Louis will feature walk-in access for primary care and acute services, something local residents time and again have stated is their preferred method of service delivery. The difficulties low-income individuals have scheduling services in advance and getting time off during regular business hours has long been a barrier to care for this community. Establishing a walk in center with expanded service hours will allow patients to access services when they are able, rather than hoping patients can navigate barriers on their own and make and complete all medical appointments they need.

In addition to the Urgent Care Center, the deployment of Community Health Workers will directly address access to care barriers to preventive and primary care. Community Health Workers will serve as a liaison, link, and intermediary between health and social services and the community to improve the quality and cultural competence of service delivery. CHWs will link patients to transportation services supported by the TRH transportation department that already offers over 10,000 rides per year to local residents seeking medical care, helping to address transportation barriers to care. They will also link patients to a host of supportive services to remove barriers to care through partnership with Healthier Together. Linking services in this manner takes the often long and difficult process of identifying and contacting multiple service providers out of the patient's hands and into the hands of a qualified individual with a wide breadth of knowledge of what services are available and how to access these services.

SOCIAL DETERMINANTS OF HEALTH

It is estimated that up to 50% of an individual's health outcomes are the result not of the quality of the direct medical care they receive but by their living conditions, often referred to as the Social Determinants of Health (SDOH). The CDC indicates that the SDOH can be allocated into five general categories: Economic Stability, Education Access and Quality, Healthcare Access and Quality, Neighborhood and Built Environment, and Social and Community Context. For the people of East St. Louis, negative social situations strongly affect each of these categories.

Economic Stability

In the East St. Louis Metro Area, economic stability is hard to find. Centreville, where TRH currently sits, has been named the poorest town in America with a median household income of $17,441. Recent sales of single-family homes throughout the Metro East St. Louis Area have been limited, though none have exceeded $50,000. Sale prices ranging from $10,000 to $20,000 are much more common and vacant or abandoned homes are visible throughout the community. This area is located on a Mississippi

River floodplain known as American Bottoms that experiences chronic flooding and raw sewage disposal problems due to the area's inadequate system of drainage ditches, levees and emergency pumps.

Education Access and Quality

Educational outcomes in the targeted area are far below both state and national averages. There are more individuals in the area who have not completed high school (18%) than have completed a college degree (12%). Truancy rates in the area are beyond 40% in some districts.

Healthcare Access and Quality

Healthcare access in the community has limitations due to a lack of some services, delivery methods that are often a poor fit for the specific needs of this patient population, and actions that deny access due to payor sources. Specialty care in particular is difficult and almost impossible to access in the community, especially for patients on Medicaid or who are uninsured. There is currently a backup of nearly 36,000 unmet specialty care referrals in the local community. There is also no integrated Urgent Care center that can create alternative acute access in the greater East St. Louis area, resulting in frequent and over utilization of emergency rooms.

Neighborhood and Built Environment

According to a study published in the Environmental Health News by Crystal Gammon, “Housing in the city ranges from, at best, small homes that often house multiple families to crowded, low-income apartment complexes. Some people live in burned-out buildings and tents. There are few grocery stores, so residents buy most of their food at convenience marts. A quart of milk costs around $6 and a bottle of children’s Tylenol is $15 at one such store, according to nurses at a local clinic run by Community Nursing Services of Southern Illinois University-Edwardsville. Raw sewage backs up into homes, businesses and schools whenever the volume overwhelms the city’s decaying 150-year-old pipes. Garbage collection, which halted completely from 1987 to 1992, now is only available to households that pay out-of-pocket for the service. Most trash is burned in back yards, adding to the polluted air, or dumped in vacant lots.”

These poor housing conditions combined with awful road conditions, sewer lines that regularly back up, packs of stray dogs roaming the streets, and high crime rates making the living environment a severe detriment to the health and wellbeing of residents

Social and Community Context

People’s relationships and interactions with family, friends, co-workers, and community members can have a major impact on their health and well-being. Overall community safety negatively affects relationships between individuals in the community. Those who interact with the legal system are often removed from family situations, leaving children and families without important social connections. As Senator Belt stated in a press conference in 2020, our families are exposed to “persistent traumatic stress”. Using recent FBI data and crime reports, East St. Louis was ranked as the most dangerous city in the United States of America.

The following chart details current data points demonstrating the area's negative SDOH that continue to affect health outcomes:

Social Determinant of Health	Characteristic	Finding	Geographic Area	Data Source
Economic Stability	Population classified as low-income or living in poverty	33.9% in poverty 60.7% low-income	East St. Louis and surrounding communities (62201-62207, 62060, 62090)	ACS 2019
Economic Stability	Food insecurity	12.2% of total population experienced food insecurity 67% of total population eligible for SNAP benefits (<165% poverty)	St. Clair County, Illinois	Feeding America
Education Access and Quality	Level of educational attainment	Did not complete High School - 18% Completed a college degree - 12%	East St. Louis and surrounding communities (62201-62207, 62060, 62090)	ACS 2019
Healthcare Access and Quality	Percentage of population who experienced access issues due to financial problems	• 15.19% Delayed/did not seek treatment due to cost • 18.89% Adults with no usual source of medical care • 7% uninsured	East St. Louis and surrounding communities (62201-62207, 62060, 62090)	UDS Mapper
Neighborhood and Built Environment	Percentage of population that pays more than 30% of monthly income for housing costs	41.2%	East St. Louis and surrounding communities (62201-62207, 62060, 62090)	ACS 2019
Social and Community Context	Percentage of 8th and 10th grade students who: • Feel safe at school • Do not have an adult they feel they can talk to/confide in	• 39% • 23%	St. Clair County, Illinois	Illinois Youth Survey 2020

Transformation partners will continually monitor all of these data elements throughout the life of the Transformation. Many of these goals are long term issues that developed over a number of decades to reach critical levels. New baselines will be attained and monitored as the project progresses and community improvement becomes apparent.

Specific inequities that are directly addressed by projects within this proposal include:

- Lack of jobs and training opportunities, including geographically accessible, affordable education and job training;
- Extreme disparities in the number of individuals who are involved in the criminal justice system, including high rates of incarceration for those with behavioral health problems;

- Lack of supportive housing for those with health issues and transitional housing for those transitioning from homelessness or incarcerations trying to re-enter the community;
- Lack of connection to supportive social services in the community and overall lack of coordination in these services;
- Lack of safe and affordable homes that provide opportunities for fitness and safe social engagements; and
- Lack of services accessible to those who are best served in a language other than English. Within the service area, this represents approx. 4% of the population and the vast majority of these individuals speak Spanish.

These issues are addressed through the following projects:

New Workforce Development Center

The Leadership Council of Madison County in partnership with Southern Illinois University, Edwardsville (SIUe), Southwestern Illinois College (SWIC), Madison County Community Development, and SIHF Healthcare will initiate a community revitalization plan featuring a Workforce Development Center to increase job training and educational opportunities. The program will be primarily focused on Workforce Development for trades, but will also feature extensive health and supportive services for students and their families. This includes a comprehensive health care facility located within the campus where students and their families can receive primary care services directly and access to specialty through direct care and telemedicine. This health facility will address disparities of health that extend direct services by incorporating advanced care coordination and management that improves health and reduce the negative impacts of social determinants.

Additional activities enhancing the community will involve extensive business and housing development supported through private ownership. Private ownership will build a full services grocery store consisting of high quality discount groceries, emphasizing cut-in-store meat, fresh produce, assortment of high-quality food and household needs as well as 65 affordable homes with two/three bedrooms and garage. Infrastructure upgrades to sewer and streets will be needed to support construction. In order to support the revitalization development along Broadway where proposed development is planned, repairs are necessary to the adjacent roads and sewer to provide access to the new development and parking, providing safer infrastructure for proposed housing in the neighborhood to the south of the development.

Venice will serve as the anchor of this project. It was selected because of its location in an Enterprise Zone, Opportunity Zone, and within a TIF district that serves as the main thoroughfare leading into Madison, Brooklyn, Granite City and downtown St Louis, Missouri. It is less than one minute from Route 3, and six minutes from downtown St Louis with approximately 15,000 motorists traveling this route daily. This comprehensive stimulus is aimed at scaling services and benefits to the 6,400 citizens of Venice, Brooklyn and Madison.

Repurposing of Current TRH Facility

The current campus of TRH will be repurposed to address individuals impacted by serious mental illness, homelessness, and substance abuse that may result in behaviors that traditionally directed interventions to be addressed through law enforcement.

The repurposing of the former hospital will include: 1) a partnership with the St. Clair County Sheriff and local police departments for a diversion program to care for individuals with homelessness, mental health illness, and substance abuse that avoids direct incarceration of these individuals for minor offenses; 2) the implementation of a "living room" Crisis Stabilization Unit that provides an alternative delivery model for those with an acute mental health situation versus emergency room utilization; 3) the transition of former hospital space into supportive housing that creates a continuum of care for those being discharged from the diversion program, the hospitals inpatient behavioral health unit, and others that can be redirected prior to a mental health or legal event occurring; and 4) the transition of additional hospital space to provide workforce development, life skills training, behavior health counseling, high school equivalency programming, and guidance towards steps in acquiring permanent external housing.

This collective effort shall assist in reversing the use of correctional facilities for holding those with mental illness in prisons and lower crime through an improved continuum of care to ensure these individuals receive the care they need to turn their lives around. The Department of Justice most recently reported that 51 percent of people in prison and 71 percent of people in jail have or have had a mental health problem (Bronson and Berzofsky 2017). Moreover, 58 percent of people serving state prison sentences and 63 percent of people serving jail sentences met the criteria for drug dependence or abuse (Bronson et al. 2017). This correlates with the St. Clair County Jail that estimates housing 680 inmates results in 482 with mental illness and 428 impacted by substance abuse.

Spanish Language Service Outreach

Language barriers are a serious impediment to Health Equity. If you cannot communicate with the health system, access services can be difficult and often impossible. This Transformation project will emphasize the importance of hiring and utilizing Spanish-speaking staff and will translate all program materials into Spanish. SIHF already operates a fully Spanish-speaking health center in Fairmont City, the home of the largest Spanish-speaking population in the area, and both TRH and SIHF have bilingual staff at multiple site locations. This project will work to ensure these services are expanded and that it becomes a priority in the local care system to search for and hire bilingual staff.

A new convenient and comprehensive Health Campus that addresses our community needs in the East St. Louis Metro Area

Not only will the opening of a new Health Campus improve Health Equity and Access, but the Campus will feature additional programming to address the Social Determinants of Health. The Crisis Stabilization Unit will link directly to the Diversion Program, a jointly operated program to ensure individuals receive mental health care instead of a jail cell as appropriate. This program seeks to prevent the negative outcomes for families when individuals are incarcerated.

Community rooms and food resources will be developed through partnerships with local food and nutrition outreach efforts. Touchette Regional Hospital will partner with Sweet Potato Patch to address racial disparities in maternal child health and chronic disease by reducing food insecurity and increasing healthy eating. Community health workers and Sweet Potato Patch staff will provide meal kits and prepared meals to low income pregnant women and individuals with chronic disease who are food insecure and need nutritional support. Sweet Potato Patch is a Chicago-based food business whose mission is to increase healthy food access and provide farm-to-table healthy meals to residents in food deserts. TRH and SIHF both already partner with Sweet Potato Patch to provide healthy meals to African American pregnant women in St. Clair and Madison Counties through funding from Centene Corporation. This program currently serves approximately 50 pregnant women each month.

BUDGET

The following budget presentation details costs for all project activities over five years. For more detailed budgets, first year budgets for each individual project activity are included as an attachment to this proposal.

TOTAL BUDGET REQUEST

Heatlhcare Transformation Proposal Budgets					**LINE ITEM BUDGET FORM**		
			Master Budget				
Collaboration name: SIHF & SCCHA Housing Transformation					**Project Period:**	**3/1/2021 - 6/1/2031**	
Primary Contact	**Larry McCulley**						
Preparer Name/Title:	**Dave Weil**						
Phone:	**Email: dweil@sihf.org**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Temporary Staff related to implementation or initial cost of permanent employees							
		4,004,029	28,843,131	8,525,326	8,927,331	8,565,686	58,865,502
B. Other Direct Costs							
		40,792,071	70,434,219	239,695,853	141,194,626	255,092,963	747,209,732
C. Consultants							
		703,200	887,400	1,013,400	1,053,400	2,900,400	6,557,800
E. Subcontract(s)							
		390,000	440,000	570,000	1,005,000	1,220,000	3,625,000
	TOTAL BUDGET REQUEST	45,889,300	100,604,750	249,804,579	152,180,357	267,779,049	816,258,034
F. Revenue							
Source	**Activity Funded**	**Amount**	**Amount**	**Amount**	**Amount**	**Amount**	**Amount**
Transformation Funds		22,000,000	22,014,502	21,834,761	20,041,816	14,845,801	100,736,879
Collaborators' Funds		2,512,500	4,150,200	24,208,770	11,611,893	6,138,600	48,621,963
State Capital Funds		-	6,250,000	113,000,000	10,000,000	-	129,250,000
Philanthropy		-	-	-	-	-	-
Other		21,376,800	68,190,048	90,761,048	110,526,648	246,794,648	537,649,192
	Total Revenue	45,889,300	100,604,750	249,804,579	152,180,357	267,779,049	816,258,034

MONTHLY EXPENSES REQUIRED IN YEAR 1

Year 1 Monthly Expenses	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	total
Total Salary and Benefits	333,669	333,669	333,669	333,669	333,669	333,669	333,669	333,669	333,669	333,669	333,669	333,669	4,004,029
Total Other Direct Costs	3,399,339	3,399,339	3,399,339	3,399,339	3,399,339	3,399,339	3,399,339	3,399,339	3,399,339	3,399,339	3,399,339	3,399,339	40,792,071
Total Consultants	58,600	58,600	58,600	58,600	58,600	58,600	58,600	58,600	58,600	58,600	58,600	58,600	703,200
Total Subcontract(s)	32,500	32,500	32,500	32,500	32,500	32,500	32,500	32,500	32,500	32,500	32,500	32,500	390,000
												Total	45,889,300

DETAILED BUDGETS FOR EACH YEAR FOR EACH SPECIFIC PROJECT ACTIVITY ARE INCLUDED IN ATTACHMENT 2 OF THIS APPLICATION.

MILESTONES

All projects have developed timelines with milestones designated to ensure steady progress and that all activities will be completed in a timely manner. Timelines with milestones for all project activities are shown below:

TOUCHETTE REGIONAL HOSPITAL

- **NEW CAMPUS CONSTRUCTION PROJECT**
- **SPECIALTY PHYSICIANS**
- **INFORMATION TECHNOLOGY – MEDITECH IMPLEMENTATION**

Touchette Regional Hospital - New Campus Construction Project					
MILESTONES	2021 Target Date	2022 Target Date	2023 Target Date	2024 Target Date	2025 Target Date
Design Phase					
Start design services	Month 1				
Programming validation complete	Month 3				
Schematic design package complete		Month 7			
Design development package complete		Month 11			
Construction documents package complete		December			
State Approvals					
CON approval		Month 9			
Design development IDPH submission approvals		Month 13			
Permitting			Month 19		
Construction documents IDPH submission approvals		Month 6			
Bidding					
Program cost opinion complete schematic	Month 4				
Schematic design cost opinion complete		Month 8			
Design development cost opinion complete		Month 12			
GMP bidding and awards			Month 19		
Construction					
Mobilization/ Site work activation			Month 22		
Building construction activities – 22 months total					Month 44
Substantial completion					Month 44

Closeout					
IDPH certification review					Month 48
IDPH site review					Month 48
Furniture, fixtures & equipment					Month 48
Activation / operations preparation					Month 48
First patient day					Month 48

Touchette Regional Hospital - Specialty Physicians

MILESTONES	2021 Target Date	2022 Target Date	2023 Target Date	2024 Target Date	2025 Target Date
Hold in-person initial organizational meeting the three organizations. 1. Memorial Medical Group. 2. SIU School of Medicine. 3. Washington School of Medicine • Coverage for Community Hospital level of coverage. • Cardiology, Gastroenterology, Pulmonology, Orthopedics, Urology, General Surgery, Telemedicine for Infectious Disease, Neurology	Month 1				
Physician onboarding process. Medical staff credentialing.	Month 3				
Finalization of organizational contracting processing.	Month 4				
Marketing campaign	Month 5				
Formal physician onboarding, orientation, and IT access with electronic medical records training. Open patient scheduling modules.		Month 6			
First patient day –all specialties		Month 7			

Touchette Regional Hospital
Information Technology – Meditech Implementation

MILESTONES	2021 Target Date	2022 Target Date	2023 Target Date	2024 Target Date	2025 Target Date
Preparation: Workflow and site assessments per hospital service line and departments.	Month 2				
Planning and design per department and service line	Month 5				
Building and testing per department and service line		Month 8			
Live preparation and go live		Month 10			
Optimization phase and ongoing Meditech operational support		Month 11			
Ongoing monthly fee for subscription	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing

East St. Louis Urgent Care Transformation Project

East St. Louis Urgent Care Transformation Project					
MILESTONES	2021 Target Date	2022 Target Date	2023 Target Date	2024 Target Date	2025 Target Date
Facilitate first stakeholder meeting, to include community members/leaders	Month 1				
Initiate initial project meeting	Month 2				
Design facility	Month 5				
Commence renovation construction		Month 6			
Construction completion		Month 10			
Commence operations		Month 11			

Regional Community Health Hub Transformation Project

Regional Community Health Hub Transformation Project					
MILESTONES	2021 Target Date	2022 Target Date	2023 Target Date	2024 Target Date	2025 Target Date
Facilitate first stakeholder meeting, to include community members/leaders and potential community resource partners	Month 4				
Hire and select program leader	Months 5-6				
Design and create community resource pathways		Months 7-12			
Purchase/create and implement integrated software platform		Months 10-15			
Reimbursement contract negotiations with MCO partners		Months 13-15			
Contract with community resource providers		Months 16-18			
Contract with community health worker organizations		Months 16-18			
Hire and train staff		Months 16-18			
Commence operations			Month 19		

COMMUNITY HEALTH WORKER PROGRAM

Community Health Worker Program					
MILESTONES	2021 Target Date	2022 Target Date	2023 Target Date	2024 Target Date	2025 Target Date
Recruit and hire CHW Program Manager and CHW Trainers/ Supervisors (2)	Month 3				
Implement Software/ Platform and assessment/ evaluation tool	Month 3				
MOUs/ agreements and integration plans with Partners	Month 4				
Complete Centene CHW Training and Certification Program for Manager and Trainers	Month 5				
Recruit, hire and train 15 CHW Staff (200 hr training module)		Month 6 (15); Month 11 (15)			
Recruit, hire and train additional 10 CHW Staff			Month 18	Month 30	
Recruit and hire (2) Dieticians		Month 6			
Start CHW Service		Month 8			
Centene Annual Training Refresher		Month 5	Month 17	Month 29	Month 41

WORKFORCE TRANSFORMATION PROJECT IN VENICE

Workforce/Venice Transformation Project					
MILESTONES	2021 Target Date	2022 Target Date	2023 Target Date	2024 Target Date	2025 Target Date
Obtain options for targeted properties	Month 1				
Complete property assessments and environmental reports	Month 3				
Acquire all properties		Month 7			
Proceed with architectural designs for submittal to City		Month 9			
Complete all demolition and property preparation for construction		Month 14			
Coordinate construction to start on each part of development to include grocery store & barber shop, workforce development center, and community health center			Month 20		
Finish construction			Month 25		
Open health center				Month 30	
Open grocery store				Month 32	
Open workforce development center				Month 36	

DIVERSION & SUPPORTIVE TRANSFORMATION PROJECT

Diversion & Supportive Transformation Project					
MILESTONES	2021 Target Date	2022 Target Date	2023 Target Date	2024 Target Date	2025 Target Date
Complete contracts and policies for Diversion program with SCC			Month 25		
Start design work for Diversion inpatient & outpatient area			Month 27		
Complete design work for Diversion inpatient & outpatient area				Month 28	
Start design work on supportive housing				Month 28	
Complete design on supportive housing				Month 36	
Redesign Diversion footprint Diversion OP and IP area.				Month 37	
Open IP and OP Diversion programming areas				Month 41	
Start modeling of staffing and finances for supportive housing				Month 35	
Complete modeling of staffing and finances for supportive housing				Month 38	
Submit Preliminary full application to IHDA for first 24 units					Month 44
Start construction					Month 47
Acquire programming and commitments for wrap services					Month 48
Open first 24 units					Month 55
Submit Preliminary full application to IHDA for second 24 units					Month 56
Start construction					Month 59
Open second set of 24 units					Month 67
Submit Preliminary full application to IHDA final 12 units					Month 68
Start construction					Month 70
Open final 12 units					Month 79

HEALTH & HOUSING TRANSFORMATION PROJECT

Health & Housing Transformation Project					
MILESTONES	2021 Target Date	2022 Target Date	2023 Target Date	2024 Target Date	2025 Target Date
PHASE 1 Cahokia Heights Community Revitalization Planning					
Hold in-person initial project meeting	Month 1				
Participate in project check-ins via phone call or in-person meetings**	-				
Designate a project lead	Month 1				
Provide existing community planning materials from as well as a list of available community funding sources within 10 years	Month 1				
Compile a list of local stakeholders and organizations to provide to IHDA	Month 1				
Provide assistance and/or volunteers for disseminating the Community Needs Assessment Survey	Month 4				
Provide assistance and/or volunteers for conducting the Housing Stock Survey		Month 7			
Assist with scheduling and logistics of community meeting(s), including securing location and community outreach		-			
Contribute to any relevant and goal-oriented sections of the Housing Needs Assessment		Month 9			
Participate in community and/or stakeholder meetings in-person**	-				
Conduct market analyses comprised of demographic, economic, and housing data	Month 2				
Facilitate the first stakeholder meeting	Month 1				
Conduct a Community Needs Assessment Survey	Month 4				
Facilitate the first community meeting	Month 5				
Conduct a Housing Stock Survey		Month 7			
Produce a final written Housing Needs Assessment		Month 13			
Submit Preliminary Project Assessment to IHDA		Month 15			
Submit full Application to IHDA			Month 29		
Commence construction on first phase (est. 200 units)			Month 36		
PHASE 2 Northern St. Clair County Revitalization Planning					
Hold in-person initial project meeting	Month 1	Month 17			
Participate in project check-ins via phone call or in-person meetings**	-	-	-	-	-
Provide existing community planning materials from as well as a list of available community funding sources within 10 years	Month 1	Month 17			
Compile a list of local stakeholders and organizations to provide to IHDA	Month 1	Month 17			
Provide assistance and/or volunteers for disseminating the Community Needs Assessment Survey	Month 4		Month 20		
Provide assistance and/or volunteers for conducting the Housing Stock Survey			Month 26		
Assist with scheduling and logistics of community meeting(s), including securing location and community outreach		-	-	-	-
Contribute to any relevant and goal-oriented sections of the Housing Needs Assessment		Month 9	Month 24		

Participate in community and/or stakeholder meetings in-person**	-	-	-	-	-
Conduct market analyses comprised of demographic, economic, and housing data	Month 2		Month 21		
Conduct a Community Needs Assessment Survey	Month 2		Month 19		
Facilitate the first community meeting	Month 5		Month 21		
Conduct a Housing Stock Survey		Month 7	Month 22		
Produce a final written Housing Needs Assessment		Month 7	Month 22		
Submit Preliminary Project Assessment to IHDA		Month 14	Month 28		
Submit full Application to IHDA			Month 15	Month 30	
Commence construction on first phase (est. 160 units)			Month 15	Month 33	
PHASE 3 Central/South Community Revitalization Planning					
Milestones for phase three will repeat so actions from phase 2				Month 36 – Month 44	
PHASE 4 - 9 Final Stages for Housing Developments					
These steps will be repeated over five final phases to complete the 1,100 units targeted					Month 54 – Month 114
Submit Preliminary Project Assessment to IHDA					
Submit full Application to IHDA					
Commence construction on first phase (est. 160 units)					

RACIAL EQUITY

The East St. Louis Metro Area has long suffered through severe inequities driven by race. From the race riots in 1917 to the systematic disinvestment as many industrial facilities in the area split off from the East St. Louis region in the 50s to white flight in the 60s, East St. Louis has suffered from a series of racially motivated incidents of disinvestment and neglect, creating a racially inequitable situation where neighboring majority white communities thrive as East St. Louis continues to suffer. The City of East St. Louis is made up of 94.2% African-American residents with only 1.9% of the community white. Thus, the disparities that plague East St. Louis cannot be separated from the disparities that affect African-Americans in the area.

The University of Illinois Chicago report provided by HFS identified the East St. Louis Metro Area as the area with the highest score on the CDC Social Vulnerability Index (SVI) of the 5 distressed areas in the State they studied. The Social Vulnerability Index (SVI) uses 15 census variables to measure community need. The East St. Louis Metro Area has an SVI score of 93.6. It should come as no surprise that a community of over 90% African-Americans has attained this dubious distinction.

Every activity within this Transformation project will directly impact racial equity by leading a large scale re-investment in the community, locating significant resources and services within the East St. Louis Metro Area, ensuring the cultural competency of all services, and hiring staff directly from the targeted communities in order to raise the economic hopes of our community. Details on how each component will address racial equity follows:

New Health Care Campus

Many surrounding majority white communities have multiple state-of-the-art hospital facilities available, all targeting more affluent neighborhoods with two of these new facilities opening in the last 5 years. Meanwhile, African-American residents of the East St. Louis Metro Area continue to visit a 60 year old, regional community safety-net hospital. Construction of a new facility to allow the African-American population in this community access to the same level of care as in surrounding communities would improve racial equity significantly by bringing the same quality health care to our community. This project will ensure that once operational the health campus will focus specifically on hiring staff from the local community in order to ensure the cultural competence of day-to-day activities. This will not only improve the cultural competence of services, but will also provide additional jobs and economic growth in our community.

Urgent Care Center

Urgent Care Centers have emerged as a major part of the healthcare landscape in many communities, allowing more convenient access to services and ensuring the availability of acute care services. While many urgent care clinics are located in urban settings, they tend to sit in more well-off areas and gentrified neighborhoods. As such, patients of lower socioeconomic status (many of whom are underrepresented minorities) may have significantly more difficulty accessing urgent care centers than more wealthy residents. “Additionally, many urgent care clinics have insurance and/or upfront payment

requirements that must be met before patients can be seen by a provider. Many would-be patients of lower socioeconomic status do not meet these requirements and are therefore unable to receive care." (The Challenge of Inequity in Urgent Care Medicine: A Call to Action, from the Journal of Urgent Care Medicine by Lindsey E. Fish, MD.) Additionally, patients who preferentially seek care in urban urgent care settings tend to be at relatively high risk for having unmet preventive medical needs. Underrepresented minority patients experience greater difficulties in accessing primary care for a multitude of reasons, which increases the need for care in sites such as Emergency departments of Urgent Care units. For this reason, the Urgent Care Center for East St. Louis will include an integrated walk-in primary care clinic and access to Community Health Workers to address health issues beyond acute needs that bring patients to the Urgent Care Center. This is a service delivery method specifically sought by our community leaders.

Workforce Development and Training Center

The economic devastation in the East St. Louis Metro Area is obvious and a significant investment is needed for education and job training to start to uplift local residents. African-Americans in Illinois face significant disparities in employment. The most recent unemployment rates available from the Bureau of Labor Statistic by race (2020Q3) showed that the unemployment rate for African-Americans in Illinois is 15.7% as opposed to 9.2% for whites.

This education and job training center will ensure access for the African-American community and those who struggle to attend by featuring a host of supportive services on-site to remove barriers to participation faced by many in our communities. The program will be primarily focused on Workforce Development, but will also feature extensive health and supportive services for students and their families, including a comprehensive health care facility located within the campus where students, their families, and community members can receive primary care services directly and access to specialty through direct care and telemedicine. This health facility will address disparities of health by directly extending services through care coordination and management with Community Health Workers that improve connectivity with needed health and social support services that can reduce the negative impacts of social determinants.

Diversion Center and Supportive Housing

African-Americans make up 49% of the jailed population in Illinois while comprising only 15% of the overall population. The need for a behavioral health diversion center was specifically designed to address racial inequities in the legal system where African-Americans, especially African-American males, are more likely to be arrested than whites for similar offenses. In a 2018 *"Report to the United Nations on Racial Disparities in the U.S. Criminal Justice System,* The Sentencing Project found that "African-American adults are 5.9 times as likely to be incarcerated than whites." Further, as of 2001, one of every three black boys born in that year could expect to go to prison in his lifetime." According to the National Alliance on Mental Illness (NAMI), the most recent data available from the Bureau of Justice Statistics shows that more than one quarter of people in jail met the threshold for serious psychological distress and nearly half had been told by a mental health professional that they have a mental illness. What's troubling is that even though people of color are more likely to be involved in the

criminal justice system, there is evidence that they are less likely to be identified as having a mental health problem. Also, they are less likely to receive access to treatment once incarcerated. A Diversion Center to keep those with Mental Illness out of prison and into appropriate treatment is a critical transformation requirement.

According to an AMA Journal article, a 2010 review of diversion programs found that those who were diverted from formal court processing "had lower rates of recidivism (return to the justice system) than youth who were formally processed. The same study also found that diverting youth to treatment further reduced offending (including offenses that do not reach the justice system)." This new Diversion structure will be a vital partnership with the local health systems, law enforcement, and judicial systems to lessen incarceration for those impacted by mental health and substance abuse.

Community Housing Project

As is the case in many areas with higher proportions of African-American residents, housing stock in the community remains poor and many individuals live in housing that is substandard in every respect. This project seeks to undue the decades of warehousing low-income African-Americans in large housing complexes that inevitably succumb to neglect over time and become eye sores with significant deficiencies in basic safety. The partnership between SIHF and the St. Clair County Housing Authority to improve public housing by decentralizing and constructing a series of new homes to relocate up to 1,100 families will directly seek to refocus public housing from warehousing of people to constructing safe and inviting family homes. Steps to engage the Illinois Housing Development Authority has already commenced with technical assistance to design regional Community Revitalization Plans scheduled to get underway August 2021 with key stakeholders. SIHF has previously completed multiple collaborative housing developments, including senior housing facilities in both Centreville and in Chicago. The most recent housing development spearheaded by SIHF is the Cottages at Cathedral Square, a newly constructed complex that provides affordable rental housing with supportive services for seniors in the Belleville, Illinois area. The development consists of 32 affordable apartments, half of which are one-bedroom garden-style and the remaining are two-bedroom units. This development has been so successful there is a current waiting list of over 100 individuals for this housing.

Amenities at most current properties in the community are limited, and do not accurately reflect the demands for the current market, particularly for targeted housing. Key amenities for the new housing under development include many amenities people in other communities take for granted as well as additional supportive services tailored to improve the health and well-being of residents. These amnesties include the following: Utilities (at minimum, water, sewer, and trash services) will be included with rent; Appliances, kitchens will be outfitted with an electric oven/range and refrigerator; Community Room and Outdoor Common Areas, a common area for residents to congregate with ample seating and tables will be provided; a Fitness Room will be provided; Media/Computer Room will be provided; On-Site Laundry will be provided along with linkages to community park improvements, when available. Community Health Workers will maintain a presence in the newly built complexes to ensure healthcare access, health screening, vaccinations and other regular care needs for the residents as necessary.

Community Health Hub

A regional Community Health Hub will be designed with partners across the transformation area to address racial equity problems and connect residents to services available directly in the community. This new Health HUB will create connections for residents seeking health and social services taken for granted in many communities, but in this service area would be a big step toward providing increased racial equity. This Health HUB seeks to fully integrate a collaborative network of providers throughout St. Clair County to provide the 'Clinical-Community Linkage" needed to improve health outcomes. The Community Health Hub will be focused on the coordination and linkages to health and community resources through Community Health Workers to provide assistance and care coordination services in a hub and spoke model. In this model, the CHW's will assess client needs, source community linkages, coordinating clinical care and ultimately ensure the needed service was actualized for the client. The Community Health Hub partnership will encourage further collaboration with providers to improve the overall health of the county.

Community Health Workers

According to the NIH Community Engagement Alliance, Community Health Workers (CHWs) are ideally positioned to identify issues and barriers to health care access that diverse racial and ethnic groups face. They are critical frontline public health workers who are trusted members of the community served. A CHW serves as a liaison between health and social services and the community to facilitate access to services and to improve the quality and cultural competence of service delivery. Hiring Community Health workers from the communities can address racial equity by improving health access for African-Americans. We also uplift our community by providing direct employment opportunities in these positions. These additional jobs can provide economic advancement for families that previously struggled to acquire employment.

MINORITY PARTICIPATION

TRH, the lead agency for this application, is majority controlled and managed by minorities through five African-American members on the nine-person Board of Directors. TRH Hospital is a legally controlled entity by SIHF Healthcare that is also governed by a minority controlled community board who also are a majority of SIHF patients. This enables SIHF to provide continual input from patients throughout the community in order to guide program activities and adjust to patient needs as they evolve.

Additional minority participation is gathered through the many service agencies that are collaborating on the various transformation initiatives. Many of these organizations, including many members of Healthier Together, are owned and operated by minorities or provide services to minority members of this community. These and other local providers and business leaders will play key roles in this Transformation and will link services with Community Health Workers to ensure access to their services in the community. These organizations include:

Owned/Operated by Minorities:

- Comprehensive Behavioral Health Center- A local community health center that will be a critical partner in our diversion and supportive housing programming within the transformation. CBHC is overseen by a majority controlled African-American board of directors.
- No Father Left Behind - This is a new minority owned entity focused on assisting African-American fathers transition from corrections back into family and social life. Mr. Shaquille Armstrong is the founder of this new Corporation. SIHF leadership is assisting to mentor him through the legal paperwork for his 501c3, bylaws, and policies. This organization will be embedded into our diversion program and partnership with the St. Clair County Sheriff. We plan to provide a mentoring and developing road to assist him in stabilizing and moving forth his corporation as a key participant in our collaborative using community health workers and therapists.
- Make Health Happen - A community partnership working to promote healthy eating while increasing access to healthy food options in East St. Louis.
- Racial Harmony - a not–for–profit 501(C) (3) community organization dedicated to making a difference through mediation, teaching, training, and cooperative learning.
- The House of Prayer Christian Academy (HOPCA) Family & Community Center (FaCCs) - An incubator of family support; community services; business development; career enhancements; and job creation. This partnership will be supportive of our community health workers and job training.
- The Mount Calvary Church - a registered member of the internationally recognized Church of God In Christ, Inc. – A Lutheran Church that serves Washington Park and surrounding communities will help support with community outreach to committee health workers.
- Sav-A-Lot IRE - one of the few black grocery store owners in the country; health/ fresh food; education; cooking classes. They will be partnering with the project to support food access and nutrition classes.
- The Sweet Potato Patch – Owned by Stacey Minor, the sweet potato patch has been working with SIHF to provide Healthy Meals, Fresh Fruits and Vegetables, Cooking Classes to African-American pregnant women. We plan to extend this service to help us assist with individuals with diabetes and hypertension.
- The Grind Fitness and Performance - Over 10 years of experience training student and adults. They specialize in toning, weight loss, nutrition, muscle mass, speed, agility, conditioning, and academics. The Grind will become a referral source to assist our participants/patients to have access to a health and fitness center.
- Zade, LLC. is a local construction and housing developer that would be embedded into our community and supportive housing programming as a developer and owner.
- Metropolitan Housing Development Corporation (MHDC) is a primary partner in our housing development and is operated by Richard Gonzales.
- Clayborne and Associates will be utilized for necessary legal services related to our tax credits, contracting, housing options, and other relevant legal activities.

Serve primarily minority participants in the East St. Louis Metro Area:

- Puentes de Esperanza (Bridges of Hope) is a trusted resource for Southern Illinois' Spanish-speaking residents living in Madison and St. Clair Counties. They provide services that address the physical, emotional, social, and spiritual needs of the local Hispanic community. This organization will be embedded into our community health and worker programming.

In addition to extensive participation for racial minority businesses, **female owned businesses** are also extensively involved in this Transformation, including:

- Hesed Comprehensive Psychological and Assessment Services provides neuropsychological assessment services for learning difficulties, attention problems, memory concerns, autism spectrum disorders, and dementia/Alzheimer's disease, and will be embedded inside of our community health hub and as a referral source.
- Barbo Design is an independent marketing and communications firm that will be used for local community promotions relates to the new transformation and services.
- The Blue Wall Institute offers consulting, needs assessment services, and training to law enforcement. We have approached this organization about being a participant with our diversion program and supportive housing efforts.
- Fister, Inc. is a Graphic design agency that will be partnered with to assist in new designs to support the new campus.
- Moonlight Computing LLC offers website design, development and hosting services in addition to providing technology solutions for small businesses. Partnership efforts will include participation and vocational training at the new supportive housing locations.

Construction activities will focus on utilizing contractors from the Illinois Business Enterprise Program listing of certified minority owned businesses. Unfortunately, in the entirety of St. Clair and Madison counties, there are only 16 BEP certified minority owned businesses with many focused on the same lines of business. Contractors for all capital projects will focus efforts on procuring BEP certified minority businesses when possible and focus on firms that employ minorities extensively where it is not possible to directly contract with an MBE.

JOBS

Most of the transformational area in the East St. Louis Metro region presents a picture of a community with few jobs or resources and a population struggling to survive. Reflective of the African-American segment of the overall population, over 33% of East St. Louis lives in poverty and 76% of the population meets the federal standard for low-income (200% of poverty and below). Of those under 18, 45% of children in East St. Louis live in poverty and 84% of families led by single mothers live in poverty. The unemployment rate currently sits at 10% and the median household income is only

$19,520. Educational attainment is low with only 12% of the population having a college degree, fewer than the 17% who have not finished high school. (US Census ACS 2019) Unemployment in St. Clair County as a whole is 7.6% in line with 7.8% throughout Illinois but higher than the national rate of 6.3%. In East St. Louis itself, this rate is dramatically higher at 11.9%. Thus, creating jobs and opportunity is a focus of this Transformation.

Within this region, Touchette Regional Hospital and SIHF Healthcare represents two of the largest employers in St. Clair County and are the top two employers in Centreville. In fact, Centreville is currently home to the census tract with one of the highest job growths in the County according to the Opportunity Atlas (https://opportunityatlas.org/). Jobs in the 1716350250 Census Tract have grown at a rate of 24% over the most recently measured 5 year period. This job growth has been largely due to continual expansion of services at TRH and the SIHF Healthcare Centreville Health center that sits next door. TRH currently employs 457 individuals, including 288 African-Americans making up over 63% of the TRH workforce. SIHF employs 556 individuals with 185 African-American employees. This represents 33% of staff. However, SIHF's overall service area includes many rural areas where most residents are white. The proportion of African-American employees correlates with the 33% percent of patients they serve that are African-American. SIHF also employees 11 Hispanic workers, most of whom are bilingual with many working at the Fairmont City Health Center where all services are offered in Spanish for a community with the largest Spanish-speaking population in the area.

The focus on employment of local staff will be a pillar of the contractual intent for all collaborating partners. Comprehensive Behavioral Health Center has already committed through this proposal to add on an **additional 11 staff** here in the local community. Furthermore, the work to deploy community health workers across the region will allow us a pillar of job growth from the community to be used to ultimately employ **50 new Community Health Workers** by the end of year 5 that can help us elevate the economic and social health of our residents. Each of the transformational areas bring forth substantial opportunities for regional job growth. The housing developments alone in our local community should bring hundreds of new well-paying positions that if coordinated to the local training programs could assist in helping those that have lived in poverty to migrate to a sustainable career in the trades. Couple the housing with our diversion program and supportive training and development will also be an asset to help facilitate those individuals impacted by social determinants with prior life experiences to place individuals on a pathway for job opportunities here in the local community. This opportunity coupled with supportive housing is a blended initiative that will allow individuals to structure their finances and lifestyle with the intent of transitioning into the community through a sustainable supportive system.

Our workforce development and job training facility to be developed in neighboring Venice is part of our strategy of community revitalization aiming to spur economic growth and jobs in the area. With the focus on trades, this training facility shall become a critical employment feeder into the housing transformation and other local employers that presently struggle to find competent and reliable employees in the trades. Each of our transformational efforts for housing, increased healthcare services, the new health care campus, the community health hub, and the community health workers are all

critical cornerstones to advancing employment opportunities and addressing social determinants of care. Secondarily, an array of partnerships will also see new commercial developments such as the grocery, barbershop and beauty salons that are now embedded into the plan for the new Venice redevelopment. This job development is coupled with the new construction activity that will create new construction, healthcare, commercial, and social service jobs throughout the region.

1. Southwestern Illinois College (SWIC) implementation of the Venice Regional Workforce Training Facility will be a critical pipeline for training and preparing minorities and other citizens to enter the workforce resulting in needed skilled workforce to bolster the regional economy.
2. TRH and SIHF Healthcare will have the capacity to build a more comprehensive health care workforce in this local region as a result of our transformation initiatives. The community health care workers, medical assistants, nursing, and other necessary medical support staff continue to grow beyond the present levels that we have demonstrated over the last five years.
3. Private ownership will build 65 affordable homes with two/three bedrooms and garage.
4. A projected result of this transformation is the recent focus for the improvement in the local infrastructure upgrade to the sewer, water, and streets. The capacity to link our transformation in coordination with the respective communities for upgrades to the infrastructure shall also produce opportunities for job growth.

This complete project will consist of both public and private engagement, including a grocery store and other retail, recreation center, affordable homes, comprehensive health care, and regional trades workforce training. It is estimated that this revitalization initiative will yield approximately $40 million in new construction; 250 construction jobs; 70 full time jobs and 50 part-time jobs.

Additional job creation will be triggered by the New Health Campus construction project where it is anticipated the 2 year construction period would create 360 direct full time jobs over 2 years.

Jobs directly created to provide services and complete activities proposed through this Transformation include:

For the Community Health Worker Deployment:

- 1 program manager
- 50 Community Health Workers
- 2 CHW/Trainers
- 2 dieticians

New Hospital Campus and Specialty Services:

- Construction jobs will be created as shown above

- Specialty services will also require approx. 17.0 FTE specialists to cover all planned activities. These positions will likely be contracted positions or filled through partnership agreements rather than directly staff.

For the Urgent Care Center:

- 3 Providers
- 3 RNs
- 5 MAs
- 3 PRCs
- 3 Technicians

Public Housing Development, Diversion & Supportive Housing within TRH and the Workforce Development project will utilize staff from multiple program partners lead by a new 1.0 FTE Director of Business Development to lead these project activities

Venice Workforce Development will also include the following staff for continued operations:

- 1 Provider
- 1 counselor
- 1 CHW
- 3 support staff

In total, this project will create 430 full-time construction jobs for at least 2 years along with another 50 part time construction jobs. Continued staffing will require the hiring of an additional 79 FTE permanent staff.

SUSTAINABILITY

The decades of underinvestment into our community and others is the very reason this transformation programming is being pursued by the department, elected officials, and our collective partnerships. The transformation investment is a great start to helping change the pathway of our distressed communities and residents who have suffered from this lack of investment. The practicality of having complete success where no further investment is required in such a short timeframe for a community is unwise. We collectively understand that is a significant first step for the Department and our collective partnership to achieve significant progress in changing the health equity and outcomes this region deserves. We request that our long term sustainability be part of the ongoing discussions with the department so we can formulate a mutual solution that is sustainable for the desired outcomes and that is being sought through this transformation. Our transformation efforts and our partners will also seek local and regional opportunities for investment and funding to supplement those initiatives that are successful to improving health outcomes and equity. We would also propose that the department create a structure where each of the transformational projects can collectively share and discuss next steps of sustainability as a means to foster ideas for success.

Specialist Care

The proposed transformation effort to address the unmet specialty care needs will seek to collaborate with the Department of Health and Family Services to create alternative payment opportunities that will sustain the services directly and with our respective partners. The considerations for these partnerships and sustainability will need to address recruitment, retention, and method of service delivery. Options for consideration under this transformation shall take in consideration the partnership with our academic institutions, managed care partners, and private partners are possibly different type of payment platforms for sustainability. It is our belief the only viable sustainable solution is one that can be mutually concurred with by the department. Thus, during the course of our programming, we anticipate providing the department options for consideration for our sustainability of the unmet need that ultimately will allow us to achieve access and equity in our region. It is hoped that HFS will work with us and local providers to ensure payments for specialist care at the level required to create ongoing sustainability.

Community Health Workers

CHWs' proven effectiveness within alternative payment structures and association with the proposed integrated health homes may have the opportunity to create long-term sustainability to support inclusion of CHWs in the health care system for the long-term. Part of our proposal for sustainability continues to work with HFS on these alternative payment methods and structures that could not only be sustainable but have targeted focus for community based needs and outcomes where community health workers can be of great asset in the improvement of health outcomes in the reduction in overall healthcare expenses. One example of a coordinated effort between HFS and our transformation should materialize from our community health hub and supportive housing which may have alternative funding sources to assist our sustainability.

The State of Illinois has also in the past considered the funding of more intensive care management through the deployment of case management services paid for through enhanced State funding. We would anticipate this consideration to be part of our conversations with the department.

GOVERNANCE STRUCTURE

The Transformation project governance will be structured for each individual transformation activity. The variation of the transformation components do not equate to having a simple governance structure. Instead we are proposing to partner with Healthier Together as the regional advisory body that can help facilitate connections, community communications, data sharing, and goal setting which can assist us in achieving higher healthcare ranking for our transformation area. This input would allow us to help guide the content in common factors to include in data sharing agreements and reports.

All payment of transformation funds will be tracked centrally and reports will be required of participating entities in order to ensure funds continue to be spent as appropriate for the purposes of this Transformation. TRH and SIHF have extensive fiscal departments that have managed external relationships and reporting from the host of healthcare and social service entities. This collective

experience will assist in the structure needed to ensure specific oversight to these funds and these projects.

New Health Care Campus & Specialist Access

Each of the multiple partners to participate in the access for equity within the new health care campus will be required to execute a partnership and contractual agreement that describes the terms of participating in our transformation. The conditions will require data sharing, coordination with community health workers, monthly/quarterly reports, a biannual analysis of the strengths and weaknesses of partnership along with recommendations for improvement, optional shared records, and necessary business associate agreements.

Urgent Care Center

This transformation component will be governed by a data sharing agreement between SHF Healthcare and Touchette Regional Hospital. This agreement will require necessary participation in data sharing on SDOH key operational conditions that are related to targeted outcomes set forth in the agreement and link back to our transformation.

Workforce Development and Training Center

This transformation component will be governed by a contractual agreement between SIHF Healthcare and Touchette Regional Hospital. This contractual agreement will require necessary participation in data sharing agreements and incorporate contractual terms that shall require monthly and quarterly reporting related to targeted outcomes that shall be set forth in the contractual agreement.

Diversion Center and Supportive Housing

A joint partnership agreement between the St. Clair County Sheriff's Department, participating please departments, and emergency management systems (EMS) will be created to guide the operations of the diversion program by the partners in coordination with local law enforcement and judicial system.

The supportive housing initiative will initially commence governance through an existing Community Revitalization Contract between the Illinois Housing Development Authority (IHDA), SIHF Healthcare, and the St. Clair County Housing Authority (SCCHA). Concurrently, SIHF Healthcare and Metropolitan Housing Development Corporation (MHDC) who formed St. Clair County HDP, LLC, a Illinois limited liability company in 2017 will serve as a joint-venture with the St. Clair County Housing Authority (SCCHA) for housing consulting and as their master development/housing development partner. A new development and ownership Corporation will be created upon the initial approval of the first supportive housing development that will include joint development and ownership by SIHF, SCCHA, MHDC, and Zade, LLC. Zade, LLC. is a regional minority owned construction business originating of East St. Louis. The local experience, insight, and an interest will provide great value in helping to embed equity considerations into our developments. This new corporation will be guided by the requirements for the Supportive Housing Program (LIHTC) for the initial development. New corporations that achieve the same framework will be required to be completed for each and all subsequent developments as well.

Community Housing Project

The affordable housing initiative will initially commence governance through an existing Community Revitalization Contract between the Illinois Housing Development Authority (IHDA), SIHF Healthcare, and the St. Clair County Housing Authority (SCCHA). Concurrently, SIHF Healthcare and Metropolitan Housing Development Corporation (MHDC) who formed St. Clair County HDP, LLC, a Illinois limited liability company in 2017 will serve as a joint-venture with the St. Clair County Housing Authority (SCCHA) for housing consulting and as their master development/housing development partner. A new development and ownership Corporation will be created upon the initial approval of the first housing development that will include joint development and ownership by SIHF, SCCHA, MHDC, and Zade, LLC. Zade, LLC. is a regional minority owned construction business originating of East St. Louis. The local experience, insight, and an interest will provide great value in helping to embed equity considerations into our developments. This new corporation will be guided by the requirements for the Low Income Housing Tax Credit program (LIHTC) for the initial development. New corporations that achieve the same framework will be required to be completed for each and all subsequent developments as well.

Community Health Hub

The Health Hub will be a collaborative effort among health and social service agencies to formulate the integration, referrals, and assistance to patients and residents in our communities. Each of these partners will be required to execute a contract stipulating the participation rights and responsibilities for being a participant in our community health HUB. These requirements will guide the responsibilities for adhering to patient care metrics, reporting, and pathways that are coordinated through the community health worker Advisory Board.

Community Health Worker Expansion

To govern the Community Health Worker program, an Advisory Board consisting of patients and stakeholders will be formed. The advisory board will have input for the training, staffing structure, targeted populations, targeted health and service agencies, and community outreach activities. All participating agencies in the program will be required to execute data sharing and partnership agreements that require monthly and quarterly reporting to their agreed to metrics that are linked back to our transformation.

REQUIRED RACIAL EQUITY IMPACT ASSESSMENT GUIDE

1. IDENTIFYING STAKEHOLDERS

Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal/policy?

The communities at the center of the TRH healthcare transformation project have a predominantly African American population. There is also a small but notable Hispanic population in the area with many limited-English speaking residents.

2. ENGAGING STAKEHOLDERS

Have stakeholders from different racial/ethnic groups especially those most adversely affected—been informed, meaningfully involved and authentically represented in the development of this proposal? Who's missing and how can they be engaged?

From the outset, stakeholders from the affected racial and ethnic groups have played an essential role in the development of the proposal with input gathered through several means, including weekly calls lead by the United Church Groups in both St. Clair and Madison County. These weekly calls have leaders from churches, agencies, government, and others seeking a platform for transformation and interventions. Additionally Transformation leadership has met extensively with local, county, state, and federal elected officials who represent the districts affected by this proposal. Social service agencies in the community regularly participate in TRH's Community Needs Assessment conducted every three years (most recently conducted in 2019). Healthier Together, a 100% volunteer-driven group of over 70 local organizations currently dedicated to working together to improve community health and overall quality of life, contributed significantly to this project via extensive in-person meetings.

3. IDENTIFYING AND DOCUMENTING RACIAL INEQUITIES

Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?

Currently the East St. Louis Metro Area and its largely African-American residents are the most disadvantaged by the current available healthcare in their communities. A severe lack of Health Equity in the region has led to a series of poor health outcomes for the residents. Chronic under investment across social and health care in the community has created an environment that leads to multiple health risks and social challenges. Local organizations struggle to address the full breadth of health related needs due to the overwhelming social issues impacting our community.

4. EXAMINING THE CAUSES

What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?

This lack of health resources and services has been driven by white flight and medical services following this population. This has resulted in the loss of significant medical services culminating in the closure of two of the community's hospitals (Christian Welfare in the 1980's and Kenneth Hall Regional Hospital in 2016) leaving East St. Louis, one of the most dangerous cities in America, without an Emergency Room. Specific equity issues directly affecting the healthcare delivery system in the community include: inadequate health care campus/hospital with an aging facility that lacks modern operational capabilities; lack of specialist services; lack of an acute care/urgent care facility in the East St. Louis community; lack of care management services in order to overcome a lack of health literacy and health education; and a lack of connection to the health-related resources available in the community. These factors continue to this day and without a significant Transformation in this community, these inequalities will only grow.

This proposal addresses these inequities by implementing projects that will transform the delivery of healthcare in the East St. Louis Metro Region by addressing not only the specific health equity issues discussed but by also working as a larger collaboration to improve the Social Determinants of Health for the region by addressing workforce development, safe and affordable housing, and food insecurity.

5. CLARIFYING THE PURPOSE

What does the proposal seek to accomplish? Will it reduce disparities or discrimination?

The proposal seeks to transform the healthcare delivery system in order to reduce health disparities in the predominantly African American population in the East St. Louis Metro Region. The collaboration will accomplish this goal through several capital and programmatic projects which not only focus on health disparities but also inequities in the Social Determinants of Health.

6. CONSIDERING ADVERSE IMPACTS

What adverse impacts or unintended consequences could result from this policy? Which racial/ethnic groups could be negatively affected? How could adverse impacts be prevented or minimized?

Unexpected adverse impacts or unintended consequences may result from any proposal that seeks to make a large, transformational impact on racial inequities that have deepened over time. The team behind this proposal has prioritized continuous assessment on the progress of overall implementation and specific data points and benchmarks throughout. The quality review team will work with proposal partners and community stakeholders to address any possible adverse impacts or unintended consequences that may arise.

7. ADVANCING EQUITABLE IMPACTS

What positive impacts on equity and inclusion, if any, could result from this proposal? Which racial/ethnic groups could benefit? Are there further ways to maximize equitable opportunities and impacts?

In addition to reducing the healthcare inequities addressed by the proposal, additional racial inequities that are directly affected by projects within this proposal include: lack of jobs and training opportunities, including geographically accessible, affordable education and job training; disparities in the number of individuals who are involved in the criminal justice system, including high rates of incarceration for those with behavioral health problems; lack of supportive housing for those with health issues and transitional housing for those transitioning from homelessness or incarcerations trying to re-enter the community; lack of connection to supportive social

services in the community and overall lack of coordination in these services; lack of safe and affordable homes that provide opportunities for fitness and safe social engagements; and lack of services accessible to those who are best served in a language other than English.

8. EXAMINING ALTERNATIVES OR IMPROVEMENTS

Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

The proposal incorporates the most effective methods of reducing racial disparities and advancing racial equity as determined through extensive communication with community stakeholders and project partners. As continuous quality assessment is an essential part of the project implementation in addition to ongoing community input, any alternative suggestions that arise that may better advance racial equity will be given due consideration.

9. ENSURING VIABILITY AND SUSTAINABILITY

Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement? Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

The proposal is data-driven and focused with specific mechanisms for assessing project implementation on an ongoing basis. Specific data points used in this design included: Infant Mortality Rates, Diabetes Rates, Hypertension Rates, Asthma Rates, Cancer Screening Rates, rates of follow-up care to hospitalizations for Mental Illness and Substance Use Disorder, the number of unmet Specialty referrals from SIHF Healthcare, the number of non-emergency ER visits, and entry into Prenatal Care. Regular assessment of these data points will be shared with all proposal partners.

10. IDENTIFYING SUCCESS INDICATORS

What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?

The proposal identifies 11 specific health measures as benchmarks for overall success in reducing health disparities, each of which includes a specific target or outcome to indicate goal achievement. These goals will guide our collective efforts with our partners through ongoing monitoring throughout the program and the Transformation actions that will seek to meet these preliminary goals within five years.

ATTACHMENT 1 – HEALTHIER TOGETHER PARTNERS

NAME	DESCRIPTION	LOCATION
HEALTHCARE		
Chestnut Health Systems	Chestnut Health Systems provides whole-person, integrated primary care, behavioral health services, and supportive services, including housing and financial, to improve the health and well-being of communities.	Illinois
SIHF Healthcare	SIHF Healthcare is a Federally Qualified Health Center offering medical services including internal medicine, family medicine, obstetrics and gynecology, pediatrics, dental, and behavioral health, to all people regardless of health insurance status or income.	Sauget
VA St. Louis Healthcare System	The VA St. Louis Healthcare System provides inpatient and ambulatory care to veterans in medicine, surgery, psychiatry, neurology, and rehabilitation, and many other subspecialty areas.	St. Louis Metro Region (Shiloh location)
BEHAVIORAL HEALTH		
Karla Smith Behavioral Health	Karla Smith's mission is to empower individuals and their families to overcome mental and behavioral health challenges through an integrated therapeutic model that supports the clinical, emotional, educational and spiritual journey into life-long recovery and independent living.	O'Fallon
Gateway Foundation	Addiction treatment agency using evidence-based practices and leading experts to develop customized treatment plans for every patient.	Illinois
Hesed Comprehensive Psychological and Assessment Services	Hesed Comprehensive Psychological and Assessment Services provides neuropsychological assessment services for learning difficulties, attention problems, memory concerns, autism spectrum disorders, and dementia/Alzheimer's disease.	Swansea
Provident	Provident works to build brighter futures through exceptional behavioral health services, especially for those with the greatest need.	St. Louis metro area
HOSPITALS		
HSHS St. Elizabeth's Hospital	St. Elizabeth's Hospital is a member of Hospital Sisters Health System (HSHS), a multi-institutional health care system that sponsors 15 hospitals in 14 communities across Illinois and Wisconsin, and an integrated physician network.	O'Fallon
Memorial BJC Hospital	Two hospitals providing medical services in the Metro-East region.	Belleville, Shiloh
Touchette Regional Hospital	Hospital providing medical services to the residents of Centreville and surrounding communities for over 60 years.	Centreville

SUPPORTIVE SERVICES		
Age Smart Community Resources	AgeSmart Community Resources works to help older adults remain independent in their homes and communities through planning, funding, responding to community needs and providing answers on aging.	O'Fallon
American Foundation for Suicide Prevention	American Foundation for Suicide Prevention is a voluntary health organization that gives those affected by suicide a nationwide community empowered by research, education and advocacy to take action against this leading cause of death.	St. Louis Metro Region
American Heart Association	The American Heart Association is the nation's oldest and largest voluntary organization dedicated to fighting heart disease and stroke.	St. Louis Metro Region
Asthma & Allergy Foundation of America	AAFA is dedicated to saving lives and reducing the burden of disease for people with asthma and allergies through support, advocacy, education and research.	St. Louis Region
Belleville Main Street	Belleville Main Street is a not-for-profit organization committed to the renovation, economic growth, and business recruitment and retention of the downtown.	Belleville
BJC School Outreach and Youth Development	The BJC School of Outreach and Youth Development provides health prevention education and career exploration opportunities for K-12th grade youth.	St. Louis
Call For Help, Inc.	Call for Help works to equip individuals to overcome crisis, trauma, and homelessness through stabilization, transitional, and support programs to help them achieve their maximum potential.	East St. Louis
Children First Foundation, Inc.	The mission of the Children First Foundation is to help children and caregivers effectively adapt to divorce, separation, parental responsibilities, and parenting time exchange issues by creating services and products that address these issues.	Belleville
Climb for PTSD	Climb for PTSD's mission is promoting wellbeing and purpose through education, confidence building and peer bonding.	Fairview Heights
East Side Aligned	East Side Aligned is not an organization or program; rather, it is a collective impact process happening within the greater East St. Louis area to improve outcomes for young people. The process works to align policy, practice and investment across sectors to ensure all children and youth are supported and ready for life.	Metro-East
Family Hospice Heartlinks	Heartlinks offers professional counseling, support groups and community programs, and information on managing change, loss and grief.	Belleville
Gateway Region YMCA	The Gateway Region YMCA is dedicated to nurturing the potential of every child and teen,	St. Louis Metro Area

	improving health and well-being, and supporting and serving our neighbors.	
Hoyleton Youth and Family Services	Hoyleton is a CARE and trauma-informed organization empowering children and families to reach their full potential.	Fairview Heights
Make Health Happen	Make Health Happen is a community partnership working to promote healthy eating while increasing access to healthy food options in East St. Louis.	East St. Louis
Nat'l Alliance for the Mentally Ill-Homefront Veterans	NAMI Southwestern Illinois is dedicated to providing support, education and advocacy for persons with mental illnesses, their families and others whose lives are affected by these diseases.	St. Clair/ Madison counties
R3 – East St. Louis	R3 Development is a non-profit community development organization whose mission is to empower the youth of East St. Louis with job opportunities that equip them with the resources and skills necessary for success.	East St. Louis
Racial Harmony	Racial Harmony is a not–for–profit 501(C) (3) community organization dedicated to making a difference through mediation, teaching, training, and cooperative learning.	Belleville
St. Clair County Health Department	The mission of the St. Clair County Health Department is to prevent disease, promote healthy lifestyles and protect the health of the people we serve.	St. Clair County
St. Clair County Mental Health Board	The St. Clair County Mental Health Board promotes the availability of and access to a range of behavioral health, intellectual/ developmental disability and substance use disorder services which address the needs of individuals and families in our communities.	St. Clair County
St. Clair County Regional Office of Education	The St. Clair County Regional Office of Education provides educational support service, programs, and resources to the K-12 schools in St. Clair County.	St. Clair County
SWIC – Programs and Services for Older Persons	Programs and Services for Older Persons staff provide a wide variety of direct and referral services to older adults, as well as their families and caregivers.	Belleville
United Way of Greater St. Louis	United Way uses local partnerships with nonprofits, as well as programs and services such as United Way 2-1-1, STLVolunteer, and others, we are able to create a stronger, healthier and more equitable region.	St. Louis Metro Region
PUBLIC EDUCATION		
School District 118 – Belleville	Public school district covering 9 elementary schools and 2 junior high schools in Belleville.	Belleville
School District 119 – Belle Valley	Public school district covering 1 elementary school and 1 junior high school in Belleville.	Belleville
School District 175 – Harmony Emge	Public school district covering 2 elementary schools and 1 junior high school in Belleville.	Belleville

School District 189 – East St. Louis	Public school district covering 1 early childhood center, 5 elementary schools, 2 middle schools, 1 high school, and 1 alternative school.	East St. Louis
School District 203 – O'Fallon Township High School	Public school district covering 1 high school.	O'Fallon
HIGHER EDUCATION		
SIUE – School of Nursing	The SIUE School of Nursing faculty and staff educate, empower, and support diverse learners to achieve excellence in nursing.	Edwardsville
University of Illinois Cooperative Extension	Through our interdisciplinary teams and an extensive network of trained volunteers, University of Illinois Extension in Madison-Monroe-St Clair is committed to reaching a broad and diverse audience to address growing, accessing and preparing food.	St. Clair/ Madison/ Monroe counties
Washington University	Washington University in St. Louis' mission is to discover and disseminate knowledge, and protect the freedom of inquiry through research, teaching and learning.	St. Louis
Lindenwood University	Lindenwood University delivers comprehensive student-centric learning and community engagement through innovative, relevant, and forward-thinking academic and experiential programs.	St. Charles, MO (Belleville location)
McKendree University	The mission of McKendree University is to provide a high quality educational experience to outstanding students by guiding them in the pursuit of academic excellence, which will prepare them for leadership roles in our society.	Lebanon
LAW ENFORCEMENT/MILITARY		
Armed Forces Reserve Center	The mission of the Armed Forces Reserve Center is to provide combat-ready units and soldiers to the Army and the Joint Force.	Belleville location
Belleville Police Department	Law enforcement agency serving the city of Belleville.	Belleville
Scott Air Force Base	Scott Air Force Base is a global mobility and transportation hub for the Department of Defense. The base is home to several command and control elements that represent logistics for the United States military in air, over land and across the sea in a true joint environment that brings together the Army, Navy, Air Force, Marines and Coast Guard.	St. Clair County
St. Clair County Probation	The mission of the 20th Judicial Circuit Court Services and Probation Department is to serve the court and provide balanced and restorative justice in the judicial system by supervising adults and juvenile probationers as well as to hold in custody any juvenile offenders between the ages 10 to 16 years old at the St. Clair County Detention Center.	St. Clair County
St. Clair County Sheriff's	Law enforcement agency serving St. Clair County.	St. Clair County

Department		
Swansea Police	Law enforcement agency serving Swansea.	Swansea
PRIVATE SECTOR/BUSINESS		
Barbo Design	Independent marketing and communications firm.	Belleville
Blue Wall Institute	The Blue Wall Institute offers consulting, needs assessment services, and training to law enforcement.	Belleville
Holland Construction	Holland Construction Services is a full-service construction management, general contracting, and design/build firm.	Swansea
Fister, Inc.	Graphic design agency.	St. Louis
Wolfsberger Funeral Home	Family-owned and operated funeral home.	O'Fallon
Jack Schmitt Automotive	Full service car dealership.	O'Fallon
Moonlight Computing LLC	Business offering website design, development and hosting services in addition to providing technology solutions for small businesses.	Metro-East
Pessin, Baird, and Wells	Small law firm serving St. Clair County.	Belleville
Vertical Performance	Vertical Performance is in the business of transforming people and workplace cultures by employing a strength-based, participant-centered approach, resulting in high levels of engagement with exceptional results.	Belleville
FAITH-BASED ORGANIZATIONS/CHURCHES		
Esquiline	The Esquiline is a faith-based Life Plan Community dedicated to the pursuit of active living and wellness in body, mind and spirit, offering independent living, assisted living, and skilled nursing care for seniors.	Belleville
Faith Family Church	Faith Family Church is a contemporary, nondenominational church whose vision is a thriving culture of belonging.	Shiloh
First United Presbyterian Church – Belleville	First United Presbyterian Church is a Christian church offering meaningful worship, active discipleship, faithful service, and nurturing fellowship.	Belleville
HOPCA Family & Community Center	The House of Prayer Christian Academy (HOPCA) Family & Community Center (FaCCs) is an incubator of family support; community services; business development; career enhancements; and job creation.	Washington Park
Mount Calvary Church of God in Christ	The Mount Calvary Church is a registered member of the internationally recognized Church of God In Christ, Inc.	Washington Park
Trinity Lutheran Church – Washington Park	Lutheran Church that serves Washington Park and surrounding communities.	Washington Park

ATTACHMENT 2 – INDIVIDUAL PROJECT BUDGETS

Heatlhcare Transformation Proposal Budgets — **LINE ITEM BUDGET FORM**

Diversion and Supportive Housing - Larry McCulley

Collaboration name: Diversion & Supportive Housing Transformation — **Project Period: 3/1/2021 - 6/1/2028**

Primary Contact: Larry McCulley

Preparer Name/Title: Dave Weil

Phone: **Email:** dweil@sihf.org

						Year 1	Year 2	Year 3	Year 4	Year 5	Total
Temporary Staff related to implementation or initial cost of permanent employees											
Name if known	**Title**	**Annual Salary**	**Benefits**	**FTE%**	**Length of employment**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**
TBD	Director of Business Dev.	120,000	27,600	50%		73,800	73,800	73,800	73,800	-	295,200
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
			Total Salary and Benefits			73,800	73,800	73,800	73,800	-	295,200
							-	-	-	-	-
B. Other Direct Costs							-	-	-	-	-
Item	**Description/Justification**					**Total**	**Total**	**Total**	**Total**	**Total**	**Total**
Property Acquisition									2,500,000	-	2,500,000
Land & Title Searches							-	-	11,000	-	11,000
Construction Cost							-	-	17,500,000	2,100,000	19,600,000
Soft cost of developments							-	-	325,000	65,000	390,000
Developer fees							-	-	750,000	600,000	1,350,000
Taxes & Reserves							-	-	135,000	230,000	365,000
MyCare Service	Ipads for first responders					42,000	65,000	85,000	85,000	125,000	402,000
							-	-	-	-	-
			Total Other Direct Costs			42,000	65,000	85,000	21,306,000	3,120,000	24,618,000
							-	-	-	-	-
C. Consultants							-	-	-	-	-
Name	**Organization**	**Activity**		**Fees/Travel Expenses**		**Total**	**Total**	**Total**	**Total**	**Total**	**Total**
Amy Bashiti	IHDA	Technical Assistance				-	-	-	-	-	-
Jerry Burka/Kurt Schulte	Old Orchards	Application Support					-	25,000	15,000	95,000	135,000
Brad Beggs	Development Strategies	Market Studies					-	16,000	45,000	23,000	84,000
TBD	Novogradac & Compact	Accounting					-	15,000	22,000	45,000	82,000
TBD	IMPACT Strategies	Construction Consultant					-	9,000	45,000	400,000	454,000
TBD	Design Alliance	Architects					-	85,000	45,000	32,000	162,000
Scott Moore	Lewis & Rice	Tax Credits				12,000	28,000	16,000	16,000	16,000	88,000
Matt Drinnen	Green Street	Tax Credits				16,000	12,000	12,000	36,000	95,000	171,000
James Clayborne	Clayborne & Associates	Legal				8,500	-	6,000	-	-	14,500
			Total Consultants			36,500	40,000	184,000	224,000	706,000	1,190,500
							-	-	-	-	-
E. Subcontract(s)							-	-	-	-	-
Organization	**Contact Person**		**Activity**			**Total**	**Total**	**Total**	**Total**	**Total**	**Total**
Zoie, Inc	Dana Howard		Construction/Co-Developer				-	-	25,000	65,000	90,000
CMHC						-	230,000	360,000	680,000	720,000	1,990,000
						-	-	-	-	-	-
						-	-	-	-	-	-
			Total Subcontract(s)			-	230,000	360,000	705,000	785,000	2,080,000
							-	-	-	-	-
			TOTAL BUDGET REQUEST			152,300	408,800	702,800	22,308,800	4,611,000	28,183,700
							-	-	-	-	-
							-	-	-	-	-
F. Revenue											
Source	**Activity Funded**					**Amount**	**Amount**	**Amount**	**Amount**	**Amount**	**Amount**
Transformation Funds						121,800	367,400	300,800	661,200	407,400	1,858,600
Collaborators' Funds						30,500	6,400	256,000	2,116,000	696,000	3,104,900
State Capital Funds							-	-	-	-	-
Philanthropy						-	-	-	-	-	-
Other							35,000	146,000	19,531,600	3,507,600	23,220,200
	Total Revenue					152,300	408,800	702,800	22,308,800	4,611,000	28,183,700

Heatlhcare Transformation Proposal Budgets — **LINE ITEM BUDGET FORM**

Health Campus - Jay Willsher

Collaboration name: SIHF & SCCHA Housing Transformation — **Project Period:** **3/1/2021 - 6/1/2031**

Primary Contact **Larry McCulley**

Preparer Name/Title: **Dave Weil**

Phone: **Email:** dweil@sihf.org

Temporary Staff related to implementation or initial cost of permanent employees

Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total	Total
N/A						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
			Total Salary and Benefits			-	-	-	-	-	-
							-	-	-	-	-

B. Other Direct Costs

Item	Description/Justification	Total	Total	Total	Total	Total	Total
Soft Costs (FF&E / Design)		12,000,000	9,250,000	9,250,000	6,924,210	6,924,210	44,348,420
Sitework		5,498,970	5,251,030	4,450,000	1,200,760	-	16,400,760
Building Construction		-	6,250,000	136,000,000	43,073,403	-	185,323,403
Title Work		26,000	-	-	-	-	26,000
Land Acquisition		625,000	-	-	-	-	625,000
		-	-	-	-	-	-
			-	-	-	-	-
			-	-	-	-	-
	Total Other Direct Costs	18,149,970	20,751,030	149,700,000	51,198,373	6,924,210	246,723,583
			-	-	-	-	-

C. Consultants

Name	Organization	Activity	Fees/Travel Expenses	Total	Total	Total	Total	Total	Total
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
		Total Consultants		-	-	-	-	-	-
					-	-	-	-	-

E. Subcontract(s)

Organization	Contact Person	Activity	Total	Total	Total	Total	Total	Total
			-	-	-	-	-	-
			-	-	-	-	-	-
			-	-	-	-	-	-
			-	-	-	-	-	-
		Total Subcontract(s)	-	-	-	-	-	-
				-	-	-	-	-
		TOTAL BUDGET REQUEST	18,149,970	20,751,030	149,700,000	51,198,373	6,924,210	246,723,583
				-	-	-	-	-
				-	-	-	-	-

F. Revenue

Source	Activity Funded	Amount	Amount	Amount	Amount	Amount	Amount
Transformation Funds		16,149,970	14,501,030	14,001,030	11,924,210	6,924,210	63,500,450
Collaborators' Funds		2,000,000	-	2,698,970	5,274,163	-	9,973,133
State Capital Funds		-	6,250,000	113,000,000	10,000,000	-	129,250,000
Philanthropy		-	-	-	-	-	-
Other		-	-	20,000,000	24,000,000	-	44,000,000
	Total Revenue	18,149,970	20,751,030	149,700,000	51,198,373	6,924,210	246,723,583

Heatlhcare Transformation Proposal Budgets — **LINE ITEM BUDGET FORM**

Urgent Care

Collaboration name: East St. Louis Urgent Care Transformation — **Project Period:** **6/1/2021 - 7/1/2022**

Primary Contact **Larry McCulley**

Preparer Name/Title: **Dave Weil**

Phone: **Email:** dweil@sihf.org

Temporary Staff related to implementation or initial cost of permanent employees

Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total	Total
	Physician	225,000	51,750	140%			387,450	387,450	387,450	387,450	1,549,800
	APP	115,000	26,450	140%			198,030	198,030	198,030	198,030	792,120
	RN	55,931	12,864	280%			192,627	192,627	192,627	192,627	770,508
	MA	28,163	6,478	560%			193,988	193,988	193,988	193,988	775,952
	PRC	31,658	7,281	280%			109,029	109,029	109,029	109,029	436,115
	Tech	44,000	10,120	280%			151,536	151,536	151,536	151,536	606,144
							-	-	-	-	-
			Total Salary and Benefits			-	1,232,660	1,232,660	1,232,660	1,232,660	4,930,640
							-	-	-	-	-

B. Other Direct Costs

Item	Description/Justification				Total	Total	Total	Total	Total	Total
Construction Cost	Renovation of existing health center space to add Urgent Care practice				650,000	-	-	-	-	650,000
Equipment Acquistion	Digital X-Ray System				180,000	-	-	-	-	180,000
Design Services					40,000	-	-	-	-	40,000
IT Equipment	Additional IT needs for Urgent Care				20,000	-	-	-	-	20,000
						-	-	-	-	-
Supplies	Clinical Supplies for Patient Care					578,888	578,888	578,888	578,888	2,315,552
						-	-	-	-	-
						-	-	-	-	-
			Total Other Direct Costs		890,000	578,888	578,888	578,888	578,888	3,205,552
						-	-	-	-	-

C. Consultants

Name	Organization	Activity	Fees/Travel Expenses		Total	Total	Total	Total	Total	Total
					-	-	-	-	-	-
					-	-	-	-	-	-
					-	-	-	-	-	-
					-	-	-	-	-	-
					-	-	-	-	-	-
					-	-	-	-	-	-
					-	-	-	-	-	-
					-	-	-	-	-	-
			Total Consultants		-	-	-	-	-	-
						-	-	-	-	-

E. Subcontract(s)

Organization	Contact Person	Activity		Total	Total	Total	Total	Total	Total
				-	-	-	-	-	-
				-	-	-	-	-	-
				-	-	-	-	-	-
				-	-	-	-	-	-
		Total Subcontract(s)		-	-	-	-	-	-
					-	-	-	-	-
		TOTAL BUDGET REQUEST		890,000	1,811,548	1,811,548	1,811,548	1,811,548	8,136,192

F. Revenue

Source	Activity Funded	Amount	Amount	Amount	Amount	Amount	Amount
Transformation Funds		890,000	-	-	-	-	890,000
Collaborators' Funds		-	-	-	-	-	-
State Capital Funds		-	-	-	-	-	-
Philanthropy		-	-	-	-	-	-
Other			1,811,548	1,811,548	1,811,548	1,811,548	7,246,192
	Total Revenue	890,000	1,811,548	1,811,548	1,811,548	1,811,548	8,136,192

Heatlhcare Transformation Proposal Budgets — **LINE ITEM BUDGET FORM**

Specialty Care - Jay Willsher

Collaboration name: SIHF & SCCHA Housing Transformation — **Project Period:** **3/1/2021 - 6/1/2031**

Primary Contact **Larry McCulley**

Preparer Name/Title: **Dave Weil**

Phone: **Email:** dweil@sihf.org

Temporary Staff related to implementation or initial cost of permanent employees

Total FTEs	Title	Annual Salary	Benefits	FTE%	Length of employment	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total	Total
2.50	Cardiology	693,048		100%		693,048	693,048	693,048	693,048	693,048	3,465,239
1.13	Endocrinology/Metabolism	183,859		100%		183,859	183,859	183,859	183,859	183,859	919,297
2.00	Gastroenterology	553,198		100%		553,198	553,198	553,198	553,198	553,198	2,765,991
0.51	Infectious Dis. (telemed)	92,820		100%		92,820	92,820	92,820	92,820	92,820	464,098
0.50	Neurology (telemed)	85,247		100%		85,247	85,247	85,247	85,247	85,247	426,233
1.00	Pulmonology	228,335		100%		228,335	228,335	228,335	228,335	228,335	1,141,673
2.20	General Surgery	515,448		100%		515,448	515,448	515,448	515,448	515,448	2,577,239
2.00	Orthopedics	582,136		100%		582,136	582,136	582,136	582,136	582,136	2,910,681
1.33	Urology	368,839		100%		368,839	368,839	368,839	368,839	368,839	1,844,195
1.26	Nephrology	453,579		100%			453,579	453,579	453,579	453,579	1,814,316
1.75	Ophthalmology	684,320		100%			684,320	684,320	684,320	684,320	2,737,280
1.50	ENT/Otolaryngology	449,229		100%			449,229	449,229	449,229	449,229	1,796,916
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
			Total Salary and Benefits			3,302,929	4,890,057	4,890,057	4,890,057	4,890,057	22,863,156
							-				-

B. Other Direct Costs

Item	Description/Justification	Total	Total	Total	Total	Total	Total
			-	-	-	-	-
Meditech		356,000	1,618,800	1,618,800	1,618,800	1,618,800	6,831,200
		-	-	-	-	-	-
		-	-	-	-	-	-
		-	-	-	-	-	-
		-	-	-	-	-	-
		-	-	-	-	-	-
			-	-	-	-	-
			-	-	-	-	-
	Total Other Direct Costs	356,000	1,618,800	1,618,800	1,618,800	1,618,800	6,831,200
			-	-	-	-	-
			-	-	-	-	-

C. Consultants

Name	Organization	Activity	Fees/Travel Expenses	Total	Total	Total	Total	Total	Total
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
		Total Consultants		-	-	-	-	-	-
					-	-	-	-	-

E. Subcontract(s)

Organization	Contact Person	Activity	Total	Total	Total	Total	Total	Total
			-	-	-	-	-	-
			-	-	-	-	-	-
			-	-	-	-	-	-
			-	-	-	-	-	-
		Total Subcontract(s)	-	-	-	-	-	-
				-	-	-	-	-
		TOTAL BUDGET REQUEST	3,658,929	6,508,857	6,508,857	6,508,857	6,508,857	29,694,356
				-	-	-	-	-
				-	-	-	-	-

F. Revenue

Source	Activity Funded	Amount	Amount	Amount	Amount	Amount	Amount
Transformation Funds		3,658,929	4,890,057	4,890,057	4,890,057	4,890,057	23,219,156
Collaborators' Funds		-	1,618,800	1,618,800	1,618,800	1,618,800	6,475,200
State Capital Funds		-	-	-	-	-	-
Philanthropy		-	-	-	-	-	-
Other		-	-	-	-	-	-
	Total Revenue	3,658,929	6,508,857	6,508,857	6,508,857	6,508,857	29,694,356

Heatlhcare Transformation Proposal Budgets — **LINE ITEM BUDGET FORM**

Housing - Larry McCulley

Collaboration name: Diversion & Supportive Housing Transformation — **Project Period:** **3/1/2021 - 6/1/2028**

Primary Contact **Larry McCulley**

Preparer Name/Title: **Dave Weil**

Phone: **Email:** dweil@sihf.org

Temporary Staff related to implementation or initial cost of permanent employees

Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total	Total
TBD	Director of Business Dev.	120,000	27,600	50%		73,800	73,800	73,800	73,800	73,800	369,000
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
			Total Salary and Benefits			73,800	73,800	73,800	73,800	73,800	369,000
							-	-	-	-	-

B. Other Direct Costs

Item	Description/Justification	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total	Total
			-	-	-	-	-
Property Acquisition		2,500,000	300,000	200,000	200,000	550,000	3,750,000
Land & Title Searches		11,000	35,000	25,000	20,000	60,000	151,000
Construction Cost		17,500,000	62,700,000	62,700,000	62,700,000	229,900,000	435,500,000
Soft cost of developments		325,000	627,000	627,000	627,000	2,299,000	4,505,000
Developer fees		750,000	1,380,000	1,380,000	1,380,000	5,060,000	9,950,000
Taxes & Reserves		135,000	1,312,500	1,312,500	1,312,500	4,812,500	8,885,000
			-	-	-	-	-
			-	-	-	-	-
	Total Other Direct Costs	21,221,000	66,354,500	66,244,500	66,239,500	242,681,500	462,741,000
			-	-	-	-	-

C. Consultants

Name	Organization	Activity	Fees/Travel Expenses	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total	Total
				-	-	-	-	-	-
Jerry Burka/Kurt Schulte	Old Orchards	Application Support		95,000	225,000	225,000	225,000	600,000	1,370,000
Brad Beggs	Development Strategies	Market Studies		32,000	72,000	72,000	72,000	192,000	440,000
TBD	Novogradac & Compact	Accounting		105,000	91,500	91,500	91,500	244,000	623,500
TBD	IMPACT Strategies	Construction Consultant		75,000	90,000	90,000	90,000	240,000	585,000
TBD	Design Alliance	Architects		152,000	225,000	225,000	225,000	600,000	1,427,000
Scott Moore	Lewis & Rice	Tax Credit		66,000	95,250	95,250	95,250	254,000	605,750
James Clayborne	Clayborne & Associates	Legal		15,800	20,250	20,250	20,250	54,000	130,550
		Total Consultants		540,800	819,000	819,000	819,000	2,184,000	5,181,800
					-	-	-	-	-

E. Subcontract(s)

Organization	Contact Person	Activity	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total	Total
				-	-	-	-	-
Zoie, Inc	Dana Howard	Construction/Co-Developer	65,000	135,000	135,000	225,000	360,000	920,000
			-	-	-	-	-	-
			-	-	-	-	-	-
			-	-	-	-	-	-
		Total Subcontract(s)	65,000	135,000	135,000	225,000	360,000	920,000
				-	-	-	-	-
		TOTAL BUDGET REQUEST	21,900,600	67,382,300	67,272,300	67,357,300	245,299,300	469,211,800

F. Revenue

Source	Activity Funded	Year 1 Amount	Year 2 Amount	Year 3 Amount	Year 4 Amount	Year 5 Amount	Amount
Transformation Funds		73,800	108,800	98,800	-	-	281,400
Collaborators' Funds		450,000	1,580,000	2,100,000	2,173,800	3,823,800	10,127,600
State Capital Funds			-	-	-	-	-
Philanthropy		-	-	-	-	-	-
Other		21,376,800	65,693,500	65,073,500	65,183,500	241,475,500	458,802,800
	Total Revenue	21,900,600	67,382,300	67,272,300	67,357,300	245,299,300	469,211,800

Heatlhcare Transformation Proposal Budgets — **LINE ITEM BUDGET FORM**

Venice Workforce - Larry McCulley

Collaboration name: Venice/Workforce Transformation — **Project Period:** **3/1/2021 - 6/1/2028**

Primary Contact **Larry McCulley**

Preparer Name/Title: **Dave Weil**

Phone: **Email:** dweil@sihf.org

Temporary Staff related to implementation or initial cost of permanent employees

Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total	Total
Clinician	FNP	110,000	25,300	100%	12 mo.		-	-	135,300	-	135,300
	Support staff	28,000	6,440	100%	12 mo.		-	-	34,440	-	34,440
	Support staff	28,000	6,440	100%	12 mo.		-	-	34,440	-	34,440
	Support staff	32,000	7,360	100%	12 mo.		-	-	39,360	-	39,360
	Counselor	48,000	11,040	100%	12 mo.		-	-	59,040	-	59,040
	Community Health Worker	35,000	8,050	100%	12 mo.		-	-	43,050	-	43,050
						-	-	-	-	-	-
			Total Salary and Benefits			-	-	-	345,630	-	345,630
							-	-	-	-	-

B. Other Direct Costs

Item	Description/Justification	Total	Total	Total	Total	Total	Total
Property Acquisition			145,000			-	145,000
Title Search and preparations		14,000				-	14,000
Legal		18,000	32,000			-	50,000
Site Preparations			1,400,000				1,400,000
Construction Cost			-	21,000,000		-	21,000,000
Soft cost of developments			-	230,000	-	-	230,000
Developer fees			-	35,000	-	-	35,000
Insurance					6,500		6,500
E HR					12,500		12,500
Supplies					35,000		35,000
Administrative					29,500		29,500
			-	-	-	-	-
			-	-	-	-	-
	Total Other Direct Costs	32,000	1,577,000	21,265,000	83,500	-	22,957,500

C. Consultants

Name	Organization	Activity	Fees/Travel Expenses	Total	Total	Total	Total	Total	Total
Matt Drinen	Green Street	Tax Credit			18,000	-	-	-	18,000
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
					-	-	-	-	-
		Total Consultants		-	18,000	-	-	-	18,000

E. Subcontract(s)

Organization	Contact Person	Activity	Total	Total	Total	Total	Total	Total
				-	-	-	-	-
			-	-	-	-	-	-
			-	-	-	-	-	-
			-	-	-	-	-	-
		Total Subcontract(s)	-	-	-	-	-	-
		TOTAL BUDGET REQUEST	32,000	1,595,000	21,265,000	429,130	-	23,321,130

F. Revenue

Source	Activity Funded	Amount	Amount	Amount	Amount	Amount	Amount
Transformation Funds			-	-	-	-	-
Collaborators' Funds		32,000	945,000	17,535,000	429,130	-	18,941,130
State Capital Funds			-	-	-	-	-
Philanthropy		-	-	-	-	-	-
Other			650,000	3,730,000	-	-	4,380,000
	Total Revenue	32,000	1,595,000	21,265,000	429,130	-	23,321,130

Heatlhcare Transformation Proposal Budgets — **LINE ITEM BUDGET FORM**

Community Health Workers - Dt Ross, Patrice, Paual

Collaboration name: SIHF & SCCHA Housing Transformation — **Project Period:** **3/1/2021 - 6/1/2031**

Primary Contact **Larry McCulley**

Preparer Name/Title: **Dave Weil**

Phone: **Email:** dweil@sihf.org

Temporary Staff related to implementation or initial cost of permanent employees

Name if known	Title	Annual Salary	Benefits	FTE%	Length of employment	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total	Total Total
	CHW Program Manager	50,000	11,500	100%		-	63,038	64,613	66,229	67,884	261,764
	CHW Trainer/Supervisors	37,500	8,625	200%		-	94,556	96,920	99,343	101,827	392,646
Year 1 (15), 2 (40), 3-5 (50)	Community Health Worker	30,000	6,900	5000%		553,500	1,512,900	1,938,403	1,986,863	2,036,535	8,028,201
	Dietitians	60,000	13,800	200%		-	151,290	155,072	158,949	162,923	628,234
						-	-	-	-	-	-
						-	-	-	-	-	-
						-	-	-	-	-	-
			Total Salary and Benefits			553,500	1,821,784	2,255,009	2,311,384	2,369,169	9,310,846
							-	-	-	-	-

B. Other Direct Costs

Item	Description/Justification	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total	Total Total
Office Supplies	Office supplies $200/FTE	3,000	9,000	11,000	11,000	11,000	45,000
Uniform/Safety Kit	(2 per staff) @ $75 for CHW Staff	2,250	6,450	7,950	7,950	7,950	32,550
Mileage	50 miles per weeks for CHW Staff for 48 week @ .56/mile	20,160	53,760	67,200	67,200	67,200	275,520
Technology	Initial Technolgy Package $3,100 (laptop, cellphone, printer, scanner)	46,500	93,000	31,000	-	-	170,500
Technology	Recurring technology expense $1,200 annually (cellphone/ hotspot)	18,000	54,000	66,000	66,000	66,000	270,000
Health Education Material	Material	1,500	1,500	1,500	1,500	1,500	7,500
Marketing/promotion		500	500	500	500	500	2,500
Admin Costs	10% de minimus	9,191	21,821	18,515	15,415	15,415	80,357
	Total Other Direct Costs	101,101	240,031	203,665	169,565	169,565	883,927

C. Consultants

Name	Organization	Activity	Fees/Travel Expenses	Total	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total	Total Total
	Centene	CHW training course		115,500	-	-	-	-	-	115,500
	Centene	Ongoing TA		10,400	10,400	10,400	10,400	10,400	10,400	52,000
					-	-	-	-	-	-
					-	-	-	-	-	-
					-	-	-	-	-	-
					-	-	-	-	-	-
					-	-	-	-	-	-
					-	-	-	-	-	-
			Total Consultants	125,900	10,400	10,400	10,400	10,400	10,400	167,500

E. Subcontract(s)

Organization	Contact Person	Activity	Total	Year 1 Total	Year 2 Total	Year 3 Total	Year 4 Total	Year 5 Total	Total Total
Healthier Together	Robert Farmer, MD	Pathways HUB Software host	325,000	75,000	75,000	75,000	75,000	75,000	625,000
			-	-	-	-	-	-	-
			-	-	-	-	-	-	-
			-	-	-	-	-	-	-
		Total Subcontract(s)	325,000	75,000	75,000	75,000	75,000	75,000	625,000
		TOTAL BUDGET REQUEST	1,105,501	2,147,215	2,544,074	2,566,349	2,624,134	2,624,134	10,987,273

F. Revenue

Source	Activity Funded	Amount	Year 1 Amount	Year 2 Amount	Year 3 Amount	Year 4 Amount	Year 5 Amount	Total Amount
Transformation Funds		1,105,501	2,147,215	2,544,074	2,566,349	2,624,134	2,624,134	10,987,273
Collaborators' Funds		-	-	-	-	-	-	-
State Capital Funds		-	-	-	-	-	-	-
Philanthropy		-	-	-	-	-	-	-
Other		-	-	-	-	-	-	-
	Total Revenue	1,105,501	2,147,215	2,544,074	2,566,349	2,624,134	2,624,134	10,987,273

ATTACHMENT 3 – 990S

Partner Organization 990s enclosed*:

1. Touchette Regional Hospital
2. SIHF Healthcare
3. Hoyleton Youth and Family Services
4. Washington University
5. Comprehensive Behavioral Health Center

Partner organizations that as private corporations do not file 990s:

6. Centene
7. Memorial Medical Group
8. ConferMed
9. Zade, Inc.

Partner organization that is a public entity and does not file a 990:

10. SIU School of Medicine

**Only the first page of each organization's 990 is submitted due to size. Full 990s for each partner organization that submits 990s annually are available upon request.*

efile Public Visual Render | ObjectId: 001 - Submission: 2015-01-16 | TIN: 20-5478191

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter social security numbers on this form as it may be made public.

▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 01-01-2019 , and ending 12-31-2019

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Final return/terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
TOUCHETTE REGIONAL HOSPITAL

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
5900 BOND AVENUE

City or town, state or province, country, and ZIP or foreign postal code
CENTREVILLE, IL 62207

D Employer identification number
37-1305510

E Telephone number
(618) 332-3060

G Gross receipts $ 56,731,187

F Name and address of principal officer:
LARRY MCCULLEY
5900 BOND AVENUE
CENTREVILLE,IL 62207

H(a) Is this a group return for subordinates? ☐ Yes ☑ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☑ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.TOUCHETTE.ORG

K Form of organization: ☑ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1992

M State of legal domicile: IL

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities:
SERVING THE INTEGRATED HEALTHCARE NEEDS FOR MEDICAL AND BEHAVIORAL HEALTH.

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	8
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	8
5	Total number of individuals employed in calendar year 2019 (Part V, line 2a)	5	607
6	Total number of volunteers (estimate if necessary)	6	15
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0
b	Net unrelated business taxable income from Form 990-T, line 39	7b	0

			Prior Year	Current Year
Revenue	8	Contributions and grants (Part VIII, line 1h)	328,524	1,051,201
	9	Program service revenue (Part VIII, line 2g)	58,493,968	55,273,428
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	8,515	-34,757
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	403,220	396,935
	12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	59,234,227	56,686,807
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	0	0
	14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	32,071,234	29,497,025
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
	17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	29,374,324	30,187,307
	18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	61,445,558	59,684,332
	19	Revenue less expenses. Subtract line 18 from line 12	-2,211,331	-2,997,525
			Beginning of Current Year	**End of Year**
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	31,623,242	28,539,949
	21	Total liabilities (Part X, line 26)	19,760,468	19,654,040
	22	Net assets or fund balances. Subtract line 21 from line 20	11,862,774	8,885,909

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

▶ Signature of officer — Date 2020-10-28

▶ THOMAS CHAUNDY CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
		2020-10-28		P00970069

Firm's name ▶ CLIFTONLARSONALLEN LLP — Firm's EIN ▶ 41-0746749

Firm's address ▶ 1 BRONZE POINTE
BELLEVILLE, IL 62226 — Phone no. (618) 233-1200

May the IRS discuss this return with the preparer shown above? (see instructions) ☑ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions. Cat. No. 11282Y Form **990** (2019)

efile Public Visual Render | ObjectId: 001 - Submission: 2015-01-16 | TIN: 20-5478191

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations) ▶ Do not enter social security numbers on this form as it may be made public.

▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 01-01-2019 , and ending 12-31-2019

B Check if applicable: ☐ Address change ☐ Name change ☐ Initial return ☐ Final return/terminated ☐ Amended return ☐ Application pending

C Name of organization: SOUTHERN ILLINOIS HEALTHCARE FOUNDATION

Doing business as

Number and street (or P.O. box if mail is not delivered to street address): 2041 GOOSE LAKE RD | Room/suite

City or town, state or province, country, and ZIP or foreign postal code: SAUGET, IL 62206

D Employer identification number: 37-1158318

E Telephone number: (618) 332-0953

G Gross receipts $ 67,016,135

F Name and address of principal officer:
LARRY MCCULLEY
2041 GOOSE LAKE RD
SAUGET,IL 62206

H(a) Is this a group return for subordinates? ☐ Yes ☑ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status: ☑ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.SIHF.ORG

K Form of organization: ☑ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1985

M State of legal domicile: IL

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities:
PROVIDING A COORDINATED NETWORK OF HEALTH AND SUPPORTIVE SERVICES.

2 Check this box ▶☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	12
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	12
5	Total number of individuals employed in calendar year 2019 (Part V, line 2a)	5	762
6	Total number of volunteers (estimate if necessary)	6	12
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0
b	Net unrelated business taxable income from Form 990-T, line 39	7b	0

			Prior Year	Current Year
Revenue	8	Contributions and grants (Part VIII, line 1h)	17,972,183	17,602,735
	9	Program service revenue (Part VIII, line 2g)	47,840,399	49,345,836
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	12,339	25,423
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	84,861	42,141
	12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	65,909,782	67,016,135
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	106,230	29,078
	14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	47,811,416	46,211,009
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
	17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	20,262,168	20,712,072
	18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	68,179,814	66,952,159
	19	Revenue less expenses. Subtract line 18 from line 12	-2,270,032	63,976
			Beginning of Current Year	**End of Year**
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	32,053,448	30,623,024
	21	Total liabilities (Part X, line 26)	12,913,389	11,418,989
	22	Net assets or fund balances. Subtract line 21 from line 20	19,140,059	19,204,035

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

▶ Signature of officer — Date 2020-07-28

▶ THOMAS CHAUNDY CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
		2020-07-28		P01251012

Firm's name ▶ CLIFTONLARSONALLEN LLP — Firm's EIN ▶ 41-0746749

Firm's address ▶ 600 WASHINGTON AVENUE SUITE 1800 ST LOUIS, MO 63101 — Phone no. (314) 925-4300

May the IRS discuss this return with the preparer shown above? (see instructions) ☑ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions. Cat. No. 11282Y Form **990** (2019)

efile Public Visual Render | ObjectId: 001 – Submission: 2015-01-16 | TIN: 20-5478191

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter social security numbers on this form as it may be made public.
▶ Information about Form 990 and its instructions is at www.IRS.gov/form990.

OMB No. 1545-0047

2018

Open to Public Inspection

A For the 2018 calendar year, or tax year beginning 07-01-2018 , and ending 06-30-2019

B Check if applicable:
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Final return/terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
HOYLETON YOUTH AND FAMILY SERVICES

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
8 EXECUTIVE DRIVE SUITE 200

City or town, state or province, country, and ZIP or foreign postal code
FAIRVIEW HEIGHTS, IL 62208

D Employer identification number
37-1222958

E Telephone number
(618) 688-4727

G Gross receipts $ 13,578,687

F Name and address of principal officer:
CHRISTOPHER COX
8 EXECUTIVE DRIVE SUITE 200
FAIRVIEW HEIGHTS,IL 62208

H(a) Is this a group return for subordinates? ☐ Yes ☑ No
H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)
H(c) Group exemption number ▶

I Tax-exempt status: ☑ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J **Website:** ▶ WWW.HOYLETON.ORG

K Form of organization: ☑ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1988

M State of legal domicile: IL

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities:
SEE SCHEDULE O

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets.

3	Number of voting members of the governing body (Part VI, line 1a)	3	13
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	13
5	Total number of individuals employed in calendar year 2018 (Part V, line 2a)	5	309
6	Total number of volunteers (estimate if necessary)	6	102
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0
b	Net unrelated business taxable income from Form 990-T, line 34	7b	

			Prior Year	Current Year
Revenue	8	Contributions and grants (Part VIII, line 1h)	12,090,001	13,274,017
	9	Program service revenue (Part VIII, line 2g)	46,714	0
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	347,815	197,987
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	76,210	81,577
	12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	12,560,740	13,553,581
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	1,336,934	1,405,978
	14	Benefits paid to or for members (Part IX, column (A), line 4)		0
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	8,138,605	9,130,598
	16a	Professional fundraising fees (Part IX, column (A), line 11e)		0
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶278,446		
	17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	2,876,941	3,666,637
	18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	12,352,480	14,203,213
	19	Revenue less expenses. Subtract line 18 from line 12	208,260	-649,632

			Beginning of Current Year	End of Year
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	7,774,059	8,697,187
	21	Total liabilities (Part X, line 26)	2,907,166	4,480,311
	22	Net assets or fund balances. Subtract line 21 from line 20	4,866,893	4,216,876

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

Sign Here

Signature of officer — Date 2019-03-20

CHRISTOPHER COX PRESIDENT & CEO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
KEVIN J TEPEN	KEVIN J TEPEN	2020-03-31		P00296127

Firm's name ▶ CJ SCHLOSSER & COMPANY LLC — Firm's EIN ▶ 37-1031116

Firm's address ▶ 233 E CENTER DR ALTON, IL 620025931 — Phone no. (618) 465-7717

May the IRS discuss this return with the preparer shown above? (see instructions) ☐ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate Instructions. Cat. No. 11282Y Form **990** (2018)

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493197070630

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter social security numbers on this form as it may be made public

▶ **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No 1545-0047

2018

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 07-01-2018 , and ending 06-30-2019

B Check if applicable
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Final return/terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
WASHINGTON UNIVERSITY

Doing business as

Number and street (or P O box if mail is not delivered to street address) | Room/suite
700 ROSEDALE AVENUE CB 1034

City or town, state or province, country, and ZIP or foreign postal code
SAINT LOUIS, MO 631121408

D Employer identification number
43-0653611

E Telephone number
(314) 935-8283

G Gross receipts $ 10,448,371,294

F Name and address of principal officer
ANDREW D MARTIN
ONE BROOKINGS DR
ST LOUIS, MO 63130

H(a) Is this a group return for subordinates? ☐ Yes ☑ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status ☑ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ www wustl edu

K Form of organization ☑ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation 1905

M State of legal domicile MO

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities
The Washington University is a co-educational, nondenominational university with a long and distinguished history of teaching, research and community service Its schools and colleges contd on Schedule O

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets

3	Number of voting members of the governing body (Part VI, line 1a)	3	60
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	55
5	Total number of individuals employed in calendar year 2018 (Part V, line 2a)	5	26,075
6	Total number of volunteers (estimate if necessary)	6	18,000
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	8,602,174
b	Net unrelated business taxable income from Form 990-T, line 34	7b	

			Prior Year	Current Year
Revenue	8	Contributions and grants (Part VIII, line 1h)	995,937,669	855,494,240
	9	Program service revenue (Part VIII, line 2g)	2,536,746,858	2,676,850,592
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,273,921,063	528,594,841
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	34,981,191	35,548,547
	12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	4,841,586,781	4,096,488,220
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	385,965,115	415,335,328
	14	Benefits paid to or for members (Part IX, column (A), line 4)		0
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	1,798,726,642	1,960,065,812
	16a	Professional fundraising fees (Part IX, column (A), line 11e)		0
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶42,342,166		
	17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	1,264,742,454	1,316,498,980
	18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	3,449,434,211	3,691,900,120
	19	Revenue less expenses Subtract line 18 from line 12	1,392,152,570	404,588,100
			Beginning of Current Year	**End of Year**
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	13,321,256,000	14,144,232,000
	21	Total liabilities (Part X, line 26)	2,827,288,000	3,095,300,375
	22	Net assets or fund balances Subtract line 21 from line 20	10,493,968,000	11,048,931,625

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge

Sign Here

****** 2020-07-15
Signature of officer Date

ANGIE LEAHY CONTROLLER
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date 2020-07-15	Check ☐ if self-employed	PTIN
Firm's name ▶ PRICEWATERHOUSECOOPERS LLP			Firm's EIN ▶	
Firm's address ▶ 600 13TH NW STE 1000 WASHINGTON, DC 20005			Phone no (202) 414-1000	

May the IRS discuss this return with the preparer shown above? (see instructions) ☐ Yes ☑ No

For Paperwork Reduction Act Notice, see the separate instructions. Cat No 11282Y Form **990** (2018)

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493091007220

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

▶ Do not enter social security numbers on this form as it may be made public

▶ Go to *www.irs.gov/Form990* for instructions and the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 07-01-2018 , and ending 06-30-2019

B Check if applicable
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Final return/terminated
- ☐ Amended return
- ☐ Application pending

C Name of organization
COMPREHENSIVE BEHAVIORAL HEALTH CENTER
OF ST CLAIR COUNTY INC

Doing business as

Number and street (or P O box if mail is not delivered to street address) | Room/suite
505 S EIGHTH STREET

City or town, state or province, country, and ZIP or foreign postal code
EAST ST LOUIS, IL 62201

D Employer identification number
37-0760015

E Telephone number
(618) 482-7330

G Gross receipts $ 4,772,643

F Name and address of principal officer
STACEY K JONES
505 S EIGHTH STREET
EAST ST LOUIS, IL 62201

H(a) Is this a group return for subordinates? ☐ Yes ☑ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list (see instructions)

H(c) Group exemption number ▶

I Tax-exempt status ☑ 501(c)(3) ☐ 501(c) ( ) ◀ (insert no) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW CBHC1 ORG

K Form of organization ☑ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation 1957

M State of legal domicile IL

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities
TO PROVIDE SERVICES TO QUALIFIED PERSONS IN NEED OF MENTAL CARE AND SUBSTANCE ABUSE COUNSELING, INCLUDING RESIDENTIAL ASSISTANCE FOR THE COMMUNITY

2 Check this box ▶ ☐ if the organization discontinued its operations or disposed of more than 25% of its net assets

3	Number of voting members of the governing body (Part VI, line 1a)	3	15
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	15
5	Total number of individuals employed in calendar year 2018 (Part V, line 2a)	5	75
6	Total number of volunteers (estimate if necessary)	6	0
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0
b	Net unrelated business taxable income from Form 990-T, line 34	7b	0

			Prior Year	Current Year
Revenue	8	Contributions and grants (Part VIII, line 1h)	1,368,714	1,498,481
	9	Program service revenue (Part VIII, line 2g)	4,103,692	3,250,049
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	7,062	24,113
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	0	0
	12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	5,479,468	4,772,643
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	48,683	45,695
	14	Benefits paid to or for members (Part IX, column (A), line 4)	0	0
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	2,569,063	2,408,805
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
	b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
	17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	2,968,138	2,836,369
	18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	5,585,884	5,290,869
	19	Revenue less expenses Subtract line 18 from line 12	-106,416	-518,226
			Beginning of Current Year	**End of Year**
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	12,415,769	11,763,832
	21	Total liabilities (Part X, line 26)	13,425,907	13,292,196
	22	Net assets or fund balances Subtract line 21 from line 20	-1,010,138	-1,528,364

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge

Sign Here

****** 2020-02-19
Signature of officer Date

STACEY K JONES BOARD PRESIDENT
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
		2020-02-19		P00560435

Firm's name ▶ UHY ADVISORS MO INC — Firm's EIN ▶ 43-1305800

Firm's address ▶ 15 SUNNEN DRIVE SUITE 100
ST LOUIS, MO 631433819 — Phone no (314) 615-1200

May the IRS discuss this return with the preparer shown above? (see instructions) ☑ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions. Cat No 11282Y Form **990** (2018)