



NOTE: Being used in lieu of exemption application until one is available

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

Name: Letitia Close
Title: Executive Director of Governmental Affairs
Company Name: Cook County Health and Hospitals System
Address: 1900 W. Polk Street, Chicago, IL 60618
Telephone Number: (312) 864-0908
E-mail Address: lclose@cookcountyhhs.org
Fax Number:

**Site Ownership**

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: County of Cook
Address of Site Owner: 1900 W. Polk Street, Chicago, IL 60618
Street Address or Legal Description of Site: Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statement, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease or a lease.
APPEND DOCUMENTATION AS <u>ATTACHMENT-2</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

**Operating Identity/Licensee**

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

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

**Organizational Relationships**

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

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

NOTE: Being used in lieu of exemption application until one is available

**Flood Plain Requirements      Not Applicable**

[Refer to application instructions.]

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

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

**Historic Resources Preservation Act Requirements      Not Applicable**

[Refer to application instructions.]

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

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

**DESCRIPTION OF PROJECT****1. Project Classification**

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

Part 1110 Classification:

 Substantive Non-substantive

**N/A – Exemption to  
Discontinue Category  
of Service**

NOTE: Being used in lieu of exemption application until one is available

## 2. Narrative Description

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

Provident Hospital temporarily discontinued its 23 bed obstetrics service over one year ago with appropriate notice to the HFSRB. It intends to permanently discontinue the service upon the Illinois Health Facilities and Planning Board's issuance of an exemption allowing it to do so.

This project is non-substantive under the Board's rules and is subject to an exemption under the current authorizing statute.

CCHHS will notify its state senator and representative within thirty (30) days of the issuance of an exemption to discontinue the obstetrics service.

NOTE: Being used in lieu of exemption application until one is available

**Project Costs and Sources of Funds**

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs			
Site Survey and Soil Investigation			
Site Preparation			
Off Site Work			
New Construction Contracts			
Modernization Contracts			
Contingencies			
Architectural/Engineering Fees			
Consulting and Other Fees			
Movable or Other Equipment (not in construction contracts)			
Bond Issuance Expense (project related)	N	/	A
Net Interest Expense During Construction (project related)			
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
<b>TOTAL USES OF FUNDS</b>			
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities			
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages			
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
<b>TOTAL SOURCES OF FUNDS</b>			
<b>NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</b>			

NOTE: Being used in lieu of exemption application until one is available

**Related Project Costs**

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

Land acquisition is related to project  Yes  No  
 Purchase Price: \$ \_\_\_\_\_  
 Fair Market Value: \$ \_\_\_\_\_

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

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

Estimated start-up costs and operating deficit cost is \$     N/A    .

**Project Status and Completion Schedules****For facilities in which prior permits have been issued please provide the permit numbers.**

Indicate the stage of the project's architectural drawings:

- None or not applicable  Preliminary  
 Schematics  Final Working

Anticipated project completion date (refer to Part 1130.140): Upon Exemption ApprovalIndicate the following with respect to project expenditures or to obligation (refer to Part 1130.140): **Not Applicable**

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

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

Are the following submittals up to date as applicable:

- Cancer Registry  
 APORS  
 All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted  
 All reports regarding outstanding permits

**Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.**

NOTE: Being used in lieu of exemption application until one is available

**Cost Space Requirements**

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

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

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

NOTE: Being used in lieu of exemption application until one is available

**Facility Bed Capacity and Utilization**

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

FACILITY NAME: Provident Hospital		CITY: Chicago			
REPORTING PERIOD DATES:		From: 11/01/2014 to 12/31/2014:			
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	79			0	79
Obstetrics	23			-23	0
Pediatrics					
Intensive Care	6*			0	6
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
<b>TOTALS:</b>	108				85

\*The hospital reduced its ICU beds from 11 to 6 in 2015 per notice to the Illinois Health Facilities and Services Review Board.

NOTE: Being used in lieu of exemption application until one is available

CERTIFICATION

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

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

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

Doug Elwell  
SIGNATURE

Karen Duncan  
SIGNATURE

Doug Elwell  
PRINTED NAME

Karen Duncan, MD  
PRINTED NAME

Deputy CEO for Finance & Strategy  
PRINTED TITLE

Chief Operating Officer – Hospital Based Services  
PRINTED TITLE

Notarization:  
Subscribed and sworn to before me this 29<sup>th</sup> day  
of December

Notarization:  
Subscribed and sworn to before me this 29<sup>th</sup> day  
of December

Trumell Shells  
Signature of Notary

Trumell Shells  
Signature of Notary

Seal  
OFFICIAL SEAL  
TRUMELL SHELLS  
NOTARY PUBLIC - STATE OF ILLINOIS  
MY COMMISSION EXPIRES: 08/18/16  
\*Insert EXACT legal name of the applicant

Seal  
OFFICIAL SEAL  
TRUMELL SHELLS  
NOTARY PUBLIC - STATE OF ILLINOIS  
MY COMMISSION EXPIRES: 08/18/16

NOTE: Being used in lieu of exemption application until one is available

## SECTION II. DISCONTINUATION

This Section is applicable to any project that involves discontinuation of a health care facility or a category of service. **NOTE:** If the project is solely for discontinuation and if there is no project cost, the remaining Sections of the application are not applicable.

### Criterion 1110.130 - Discontinuation

READ THE REVIEW CRITERION and provide the following information:

#### GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.
2. Identify all of the other clinical services that are to be discontinued.
3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.
4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.
5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.
6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 60 days following the date of discontinuation.

#### REASONS FOR DISCONTINUATION

The applicant shall state the reasons for discontinuation and provide data that verifies the need for the proposed action. See criterion 1110.130(b) for examples.

#### IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.
2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.
3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

APPEND DOCUMENTATION AS ATTACHMENT-10, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOTE: Being used in lieu of exemption application until one is available

**XI. Safety Net Impact Statement**

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

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

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

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

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

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

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

NOTE: Being used in lieu of exemption application until one is available

**XII. Charity Care Information**

Charity Care information **MUST** be furnished for **ALL** projects.

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

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

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

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

APPEND DOCUMENTATION AS **ATTACHMENT-41**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

NOTE: Being used in lieu of exemption application until one is available

After paginating the entire, completed application, indicate in the chart below, the page numbers for the attachments included as part of the project's application for permit:

<b>INDEX OF ATTACHMENTS</b>		
<b>ATTACHMENT NO.</b>		<b>PAGES</b>
1	Applicant/Coapplicant Identification including Certificate of Good Standing	14
2	Site Ownership	15
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	17
5	Flood Plain Requirements	
6	Historic Preservation Act Requirements	
7	Project and Sources of Funds Itemization	
8	Obligation Document if required	
9	Cost Space Requirements	
10	Discontinuation	18
11	Background of the Applicant	
12	Purpose of the Project	
13	Alternatives to the Project	
14	Size of the Project	
15	Project Service Utilization	
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
19	Mergers, Consolidations and Acquisitions	
	<b>Service Specific:</b>	
20	Medical Surgical Pediatrics, Obstetrics, ICU	
21	Comprehensive Physical Rehabilitation	
22	Acute Mental Illness	
23	Neonatal Intensive Care	
24	Open Heart Surgery	
25	Cardiac Catheterization	
26	In-Center Hemodialysis	
27	Non-Hospital Based Ambulatory Surgery	
28	Selected Organ Transplantation	
29	Kidney Transplantation	
30	Subacute Care Hospital Model	
31	Children's Community-Based Health Care Center	
32	Community-Based Residential Rehabilitation Center	
33	Long Term Acute Care Hospital	
34	Clinical Service Areas Other than Categories of Service	
35	Freestanding Emergency Center Medical Services	
	<b>Financial and Economic Feasibility:</b>	
36	Availability of Funds	
37	Financial Waiver	
38	Financial Viability	
39	Economic Feasibility	
40	Safety Net Impact Statement	20
41	Charity Care Information	22

### **Ownership of Applicant**

Provident Hospital is owned by the County of Cook, Illinois. Provident Hospital and other Cook County health facilities are operated by the Cook County Health & Hospitals System, an agency of the County of Cook that is governed by the Cook County Health & Hospitals Systems Board of Directors.

**Ownership of Site**

Provident Hospital and its grounds and facilities are owned by the County of Cook, Illinois.

### **Operating Identity/Licensee**

By Cook County ordinance, the Cook County Health & Hospitals System (CCHHS), an agency of Cook County government, is responsible for management and operations of Cook County's health facilities, including Provident Hospital. Other Cook County licensed health facilities include John H. Stroger, Jr. Hospital. CCHHS is governed by the Cook County Health & Hospitals System Board of Directors.

## Organizational Relationships

Cook County Health and Hospitals System,  
an Agency of County of Cook



Provident Hospital

## Discontinuation

### GENERAL INFORMATION REQUIREMENTS

1. Identify the categories of service and the number of beds, if any that is to be discontinued.

**Obstetrics – 23 beds**

2. Identify all of the other clinical services that are to be discontinued.

**None**

3. Provide the anticipated date of discontinuation for each identified service or for the entire facility.

**Upon issuance of an exemption.**

4. Provide the anticipated use of the physical plant and equipment after the discontinuation occurs.

**The service has been discontinued for some time, and the space has been vacant in part and used in part for outpatient services.**

5. Provide the anticipated disposition and location of all medical records pertaining to the services being discontinued, and the length of time the records will be maintained.

**The medical records for the obstetrics service will be maintained by Provident Hospital and in compliance with state and federal law.**

6. For applications involving the discontinuation of an entire facility, certification by an authorized representative that all questionnaires and data required by HFSRB or DPH (e.g., annual questionnaires, capital expenditures surveys, etc.) will be provided through the date of discontinuation, and that the required information will be submitted no later than 60 days following the date of discontinuation.

**N/A**

### REASONS FOR DISCONTINUATION

The obstetrics service has had no volume in 2013 and 2014. The services are provided to area residents by John H. Stroger Hospital. The cost of staffing a unit at Provident is not justified when the service is readily accessible at Stroger.

### IMPACT ON ACCESS

1. Document that the discontinuation of each service or of the entire facility will not have an adverse effect upon access to care for residents of the facility's market area.

**For over a year the service has not been provided to area residents with no known impact on access to care. Prior to that time the service had little to no volume.**

2. Document that a written request for an impact statement was received by all existing or approved health care facilities (that provide the same services as those being discontinued) located within 45 minutes travel time of the applicant facility.

**N/A per technical assistance, since the discontinuation of a category of service is now subject to an exemption.**

3. Provide copies of impact statements received from other resources or health care facilities located within 45 minutes travel time, that indicate the extent to which the applicant's workload will be absorbed without conditions, limitations or discrimination.

**N/A per technical assistance.**

## Safety Net

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

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

CCHHS believes that the abundant supply of obstetric beds in the Planning Area and Health Service Area are sufficient to ensure that this project will not have a material impact on essential safety net services in the community.

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

Given that Provident has not provided in patient obstetric services for over a year, this project will not materially impact the ability of other providers or health care systems to subsidize safety net services.

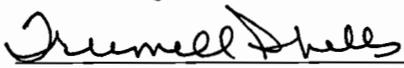
3. *How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by applicant.*

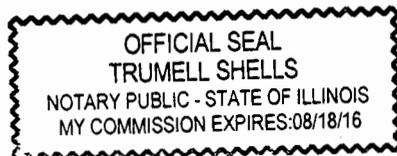
Given that Provident has not provided in patient obstetric services for over a year, this project will not materially impact the ability of other providers or health care systems to subsidize safety net services.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	FY2012	FY2013	FY2014
Inpatient	3,236	3,034	3,034
Outpatient	255,771	212,781	212,781
<b>Total</b>	<b>259,007</b>	<b>215,815</b>	<b>215,815</b>
Charity (cost in dollars)			
Inpatient	\$63,787,452	81,055,287	64,412,468
Outpatient	\$192,765,550	170,469,477	109,529,708
<b>Total</b>	<b>256,553,002</b>	<b>251,524,763</b>	<b>173,942,176</b>
MEDICAID			
Medicaid (# of patients)	FY2012	FY2013	FY2014
Inpatient	8,769	12,036	12,036
Outpatient	346,367	449,884	449,874
<b>Total</b>	<b>355,136</b>	<b>461,920</b>	<b>461,920</b>
Medicaid (revenue)			
Inpatient	\$179,016,898	\$277,432,838	\$308,216,047
Outpatient	\$109,479,851	\$215,372,084	\$265,967,280
<b>Total</b>	<b>\$288,496,749</b>	<b>\$493,804,922</b>	<b>\$574,183,327</b>

  
 Doug Elwell  
 Deputy CEO for Finance & Strategy  
 Cook County Health & Hospitals System

Subscribed and sworn to before me this  
 29<sup>th</sup> day of December, 2015

  
 Notary Public



**Charity Care  
Provident Hospital**

<b>CHARITY CARE</b>			
	<b>Year 2012</b>	<b>Year 2013</b>	<b>Year 2014</b>
<b>Net Patient Revenue</b>	\$39,263,108	\$25,225,839	\$14,929,443
Amount of Charity Care (charges)	\$23,527,005	\$18,468,718	\$9,442,662
Cost of Charity Care	\$19,692,431	\$14,917,609	\$6,889,281