

# COOK COUNTY HEALTH & HOSPITALS SYSTEM

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Cook County Board of Commissioners

**Warren L. Batts** • Chairman  
Cook County Health & Hospitals System

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Cook County Health & Hospitals System

**William T. Foley** • CEO  
Cook County Health & Hospitals System



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Andrea L. Zopp

June 28, 2010

The Honorable President and Members  
Cook County Board of Commissioners  
118 North Clark Street  
County Building, Room 567  
Chicago, Illinois 60602

Dear President and Members,

On Friday, June 25, 2010 the Cook County Health and Hospitals System Board of Directors approved the Five-Year Strategic and Financial Plan with a vote of ten yeas, no nays and one absent. Pursuant to Section 38-82 of the Ordinance Establishing the Cook County Health and Hospitals System, the Board of Directors of the Health System respectfully submits the Health System's Five-Year Strategic and Financial Plan to the Cook County Board of Commissioners for its approval.

The Health System began the planning process for its Five-Year Strategic and Financial Plan in May of 2009. This process entailed extensive community input and participation from a variety of stakeholders. At the outset of the process, as well as while the Plan evolved, the Health System conducted a series of Town Hall meetings for the public throughout the County. The Health System also held a series of employee, staff and physician Town Hall meetings at various System Affiliates. In addition, over 500 patients and other stakeholders were interviewed regarding their assessment of the County's healthcare needs and the Health System's current state.

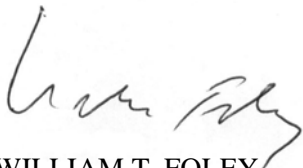
System leadership and staff have been closely involved in all phases of the planning process. Physicians and staff participated in four Service Line Working Groups established to make recommendations on the configuration of the delivery of healthcare services in critical areas.

The Five-Year Strategic and Financial Plan presented for the County Board's approval is the culmination of this collaborative process. The ultimate goal of the Plan is to provide more access and more care within available resources. The guiding principle of the planning process was to create a healthcare delivery framework to provide for more appropriate access to care for the vulnerable population in Cook County within available resources.

In support of the Health System's mission, the vision of the Five-Year Strategic and Financial Plan is that the Health System will be recognized locally, regionally, and nationally – and by patients and employees – as a progressively evolving model for an accessible, integrated, patient-centered, and fiscally responsible healthcare system focused on assuring high quality care and improving the health of residents of Cook County.

The Ordinance establishing the Health System provides that the County Board shall approve each Strategic and Financial Plan if, in its judgment, the Strategic and Financial Plan is complete, is reasonably capable of being achieved, and meets the requirements set forth in the Ordinance. After the System Board submits a Strategic and Financial Plan to the President and the County Board, the County Board shall approve or reject such Strategic and Financial Plan within 45 days or such Strategic and Financial Plan is deemed approved.

The Health System's Five-Year Strategic and Financial Plan has been submitted for the agenda of the July 13, 2010 County Board Meeting with the request that the plan be referred to the Health and Hospitals Committee for a meeting on Wednesday, July 14, 2010. We will be contacting your office to schedule a meeting prior to July 13<sup>th</sup> to discuss the plan. We look forward to working with you on this exciting endeavor that will bring more access and more care to our patients and your constituents.

A handwritten signature in black ink, appearing to read 'William T. Foley', is positioned above the typed name.

WILLIAM T. FOLEY  
Chief Executive Officer  
Cook County Health & Hospitals System

*Integrated Clinical  
Solutions, Inc.*



## ***Cook County Health and Hospitals System***

# **VISION 2015: Strategic Direction + Financial Plan**

July 2010

- **Background + Approach**
- **Summary of Key Issues**
- **Guiding Principles**
- **Strategic Direction: VISION 2015**
- **Action Priorities**
- **5-Year Financial Plan**
- **APPENDICES**

- **Background + Approach**
- Summary of Key Issues
- Guiding Principles
- Strategic Direction: VISION 2015
- Action Priorities
- 5-Year Financial Plan
- APPENDICES

### **BACKGROUND**

- The Cook County Health and Hospitals System (CCHHS, the System) is one of the largest public health systems in the country. Serving a population of over five million residents, the System encompasses the core facilities of John H. Stroger, Jr., Oak Forest, and Provident hospitals; as well as a geographically distributed Ambulatory and Community Health Network. The Cook County Department of Public Health is also a major component of CCHHS. In addition, CCHHS provides services for HIV patients and others with infectious disease at the Ruth M. Rothstein CORE Center; while Cermak Health Services provides healthcare to detainees at the Cook County Department of Corrections.
- The Cook County Health and Hospitals System essentially serves as a “safety net” system for the medically indigent population of Cook County. As is the case with many similar systems throughout the U.S., CCHHS faces some significant challenges, including:
  - A growing demand for health care services from an increasing number of uninsured and under-insured residents;

### **BACKGROUND**

- The lack of stability and predictability of revenues from the Illinois State Medicaid program; and
  - Ongoing significant operating deficits requiring County subsidization.
- National health reform initiatives, once implemented, will result in fewer uninsured and underinsured individuals in Cook County, and should provide more healthcare dollars overall for the care of the medically indigent. These impacts notwithstanding, there will likely remain substantial numbers of individuals in the County who remain without adequate health insurance coverage. This factor, combined with declining special payment and subsidy revenues, will pose ongoing challenges to the Cook County Health and Hospitals System. An additional impact will be the effects of Medicaid expansion and the ability of many patients currently utilizing the System to seek care options in the private sector.

### APPROACH

- In response to the above trends and challenges, the Cook County Health and Hospital System Board initiated a strategic planning process in May 2009. The national consulting firm of Integrated Clinical Solutions, Inc., was retained to provide technical and facilitation expertise throughout the process.
- The strategic planning process consisted of the following basic steps:
  - Discovery: Assessment of Health Care Needs and CCHHS Current State
  - Strategic Direction: Formulation of Vision, Core Goals, and overall Strategic Direction
  - Action Planning: Identification of Action Priorities
  - Financial Planning: Development of 5-Year Financial Plan
- The overall process, which extended over approximately a 14-month period, entailed extensive community and other stakeholder input. Interviews and group meetings were conducted with over 500 individuals. Town Hall meetings were conducted over a 4-month period. System leadership and staff were closely involved in all phases of the process.

- Background + Approach
- **Summary of Key Issues**
- Guiding Principles
- Strategic Direction: VISION 2015
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### **CURRENT STATE ASSESSMENT: KEY ISSUES**

The cumulative findings of the current state assessment of the Cook County Health and Hospital System are summarized as follows:

1. There are significant unmet healthcare needs in Cook County.
2. There are large disparities in health by region.
3. There are disparities in access.
4. As need has risen, CCHHS volumes have trended downward.
5. CCHHS access points are not aligned geographically.
6. System resources are disproportionately centered around the hospital environment.
7. The System is not deploying providers or utilizing facilities effectively.

### **CURRENT STATE ASSESSMENT: KEY ISSUES (cont'd.)—**

8. The current CCHHS delivery configuration is not sustainable.
9. The current cost structure is not sustainable.
10. A redirection of inefficient IP resources to OP modalities could substantially increase the volumes of services overall.

The background data and analyses that provide the foundation for this assessment are provided in APPENDIX A of this report.

- Background + Approach
- Summary of Key Issues
- **Guiding Principles**
- Strategic Direction: VISION 2015
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## GUIDING PRINCIPLES FOR SYSTEM DEVELOPMENT

In response to the critical issues and challenges identified, the CCHHS Board has set forth a set of guiding principles for the future development of the Cook County Health and Hospitals System. These guiding principles are as follows:

- ❖ Deliver the *best possible health care* for the vulnerable population of Cook County within the constraints of dollar resources available to the System.
- ❖ Provide healthcare that is *population-centered vs. hospital-centered*.
- ❖ Ensure that services are *accessible*.
- ❖ Provide health services that are focused on the needs of the vulnerable population, with a *major emphasis on the provision of specialty care and extension of primary care* through partnerships with other healthcare providers.

### GUIDING PRINCIPLES FOR SYSTEM DEVELOPMENT (cont'd)—

- ❖ Make CCHHS the *System of choice* for patient populations, with best practices and high patient/caregiver satisfaction on a System-wide basis.
- ❖ Provide *cost-effective* care.
- ❖ Strengthen role as *leading-edge institution* in clinical services, education, and research.
- ❖ Develop and support *caregiver training and leadership development* at all levels of the organization.

Based on these guiding principles, the Board adopted a Statement of Vision and set of Core Goals.

- Background + Approach
- Summary of Key Issues
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# Strategic Plan: VISION 2015

## Mission

To deliver integrated health services with dignity and respect regardless of a patient's ability to pay; foster partnerships with other health providers and communities to enhance the health of the public; and advocate for policies which promote and protect the physical, mental and social well being of the people of Cook County.

## Vision 2015

In support of its public health mission, CCHHS will be recognized locally, regionally, and nationally — and by patients and employees—as a progressively evolving model for an accessible, integrated, patient-centered, and fiscally-responsible healthcare system focused on assuring high-quality care and improving the health of the residents of Cook County.

## Core Goals

### I. Access to Healthcare Services

- Eliminate System access barriers at all delivery sites.
- Strengthen the ACHN network.
- Develop comprehensive outpatient centers at strategically-located sites.

### II. Quality, Service Excellence & Cultural Competence

- Develop an integrated, System-wide approach and supportive infrastructure for patient-centered care coordination.
- Implement a program of continuous process improvement: patient care quality, safety, and outcomes.
- Develop a comprehensive program to instill cultural competency.

### III. Service Line Strength

- Develop/strengthen clinical service lines in key disciplines based on patient population needs.
- Pursue mutually beneficial partnerships with community providers.
- Assure the provision of the Ten Essentials of Public Health.

### IV. Staff Development

- Implement a full range of initiatives to improve caregiver/employee satisfaction.
- Focus on effective recruiting and retention processes.
- Develop a robust program for in-service education and professional skill building.

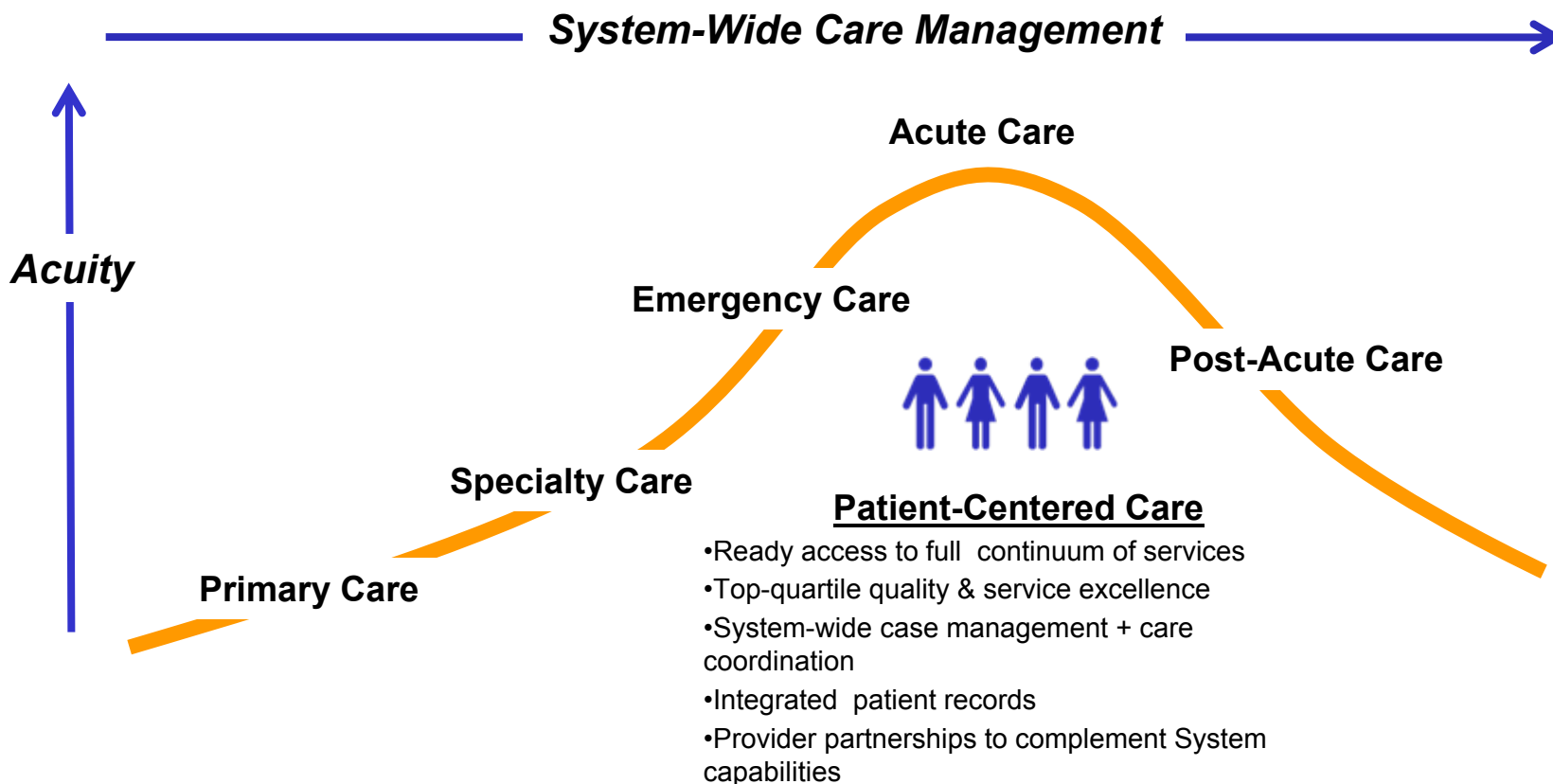
### V. Leadership & Stewardship

- Foster leadership development and succession planning.
- Develop long-term financial plans and sustaining funding.
- Hold Board and management leadership accountable to agreed-upon performance targets.

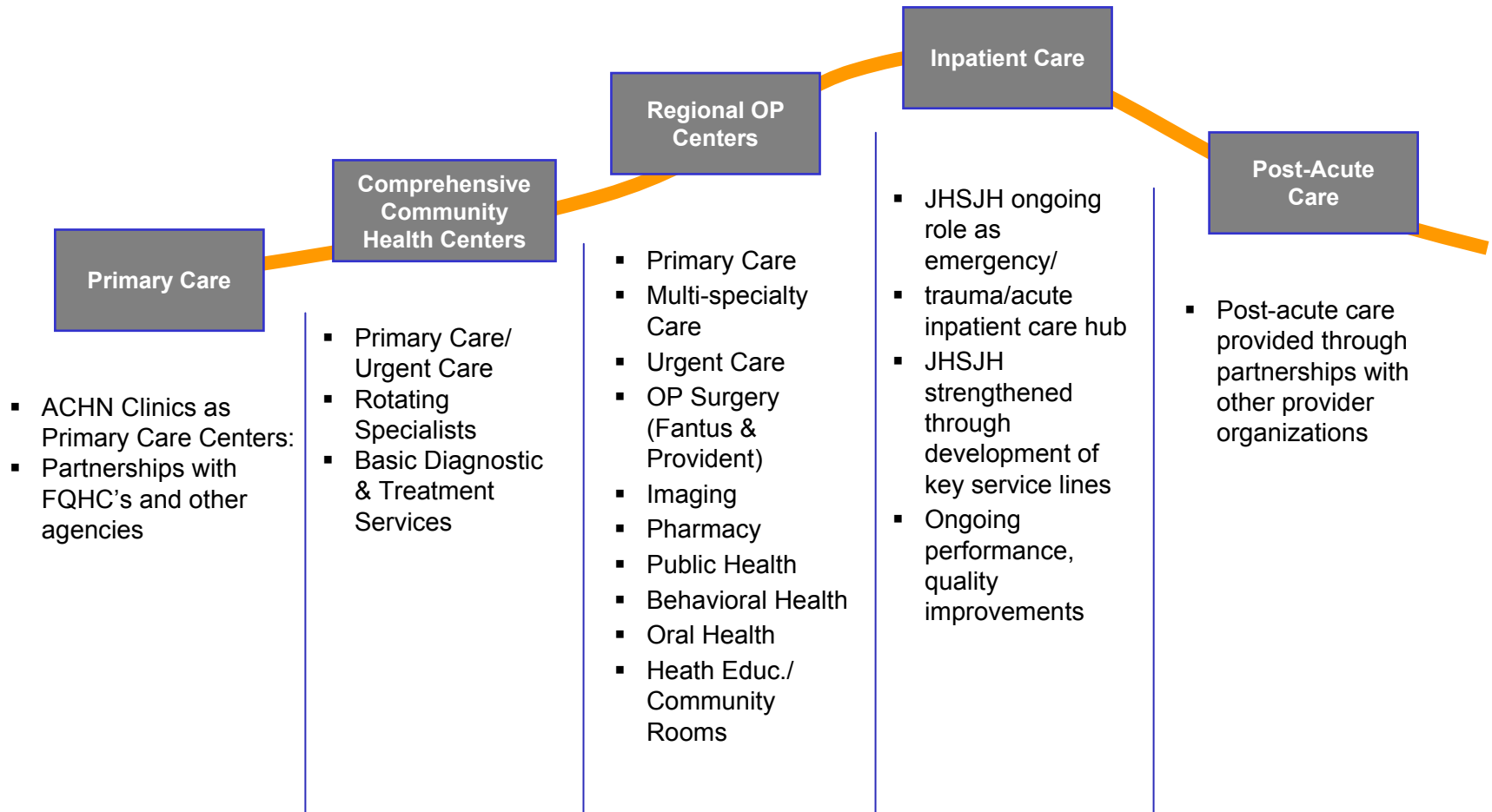
## Strategic Initiatives

# Vision 2015: Patient-Centered Accountability Across the Continuum of Care

The future-state Vision of Cook County Health and Hospitals System will place the patient at the center of a coordinated continuum of care...



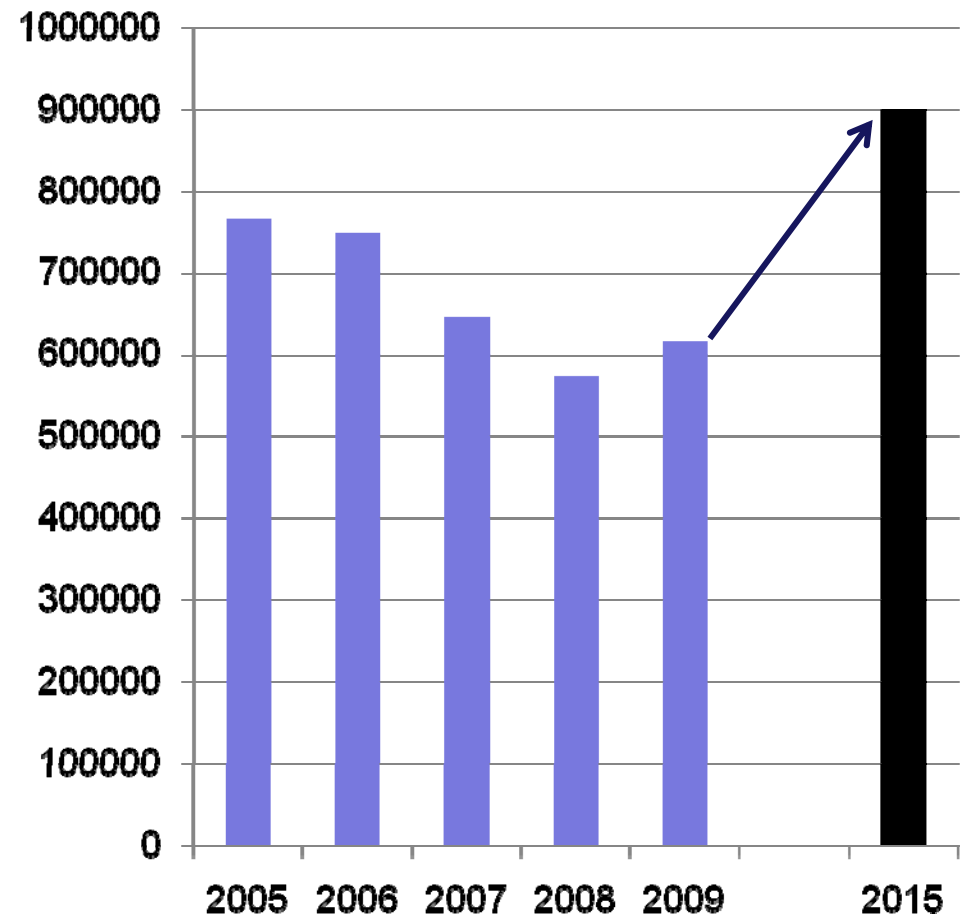
# VISION 2015: "What CCHHS will Look Like"



# A Reallocation of Resources to Meet the Needs of the County's Vulnerable Population...

- There is a significant opportunity to increase the overall service impact of the System by reallocating dollars currently being spent on inefficient hospital operations.
- Through reallocation, primary care and specialty care outpatient volume can be increased by 50+% over current levels.
- Patients can receive more timely care in a geographically accessible setting.

## Trended and Forecasted Primary Care and Specialty Visits, CCHHS



Source: CCHHS, ICS Analysis

# Agenda

- Background + Approach
- Summary of Key Issues
- Guiding Principles
- Strategic Direction: VISION 2015
- **Action Priorities**
- 5-Year Financial Plan
- APPENDICES

## ACTION PRIORITIES BY GOAL

### ■ GOAL I: ACCESS TO HEALTHCARE SERVICES

- I. 1: Eliminate System access barriers at all delivery sites.
- I. 2: Strengthen the ACHN network; develop Comprehensive Community Health Centers at selected sites.
- I. 3: Redevelop Oak Forest Hospital as a Regional Outpatient Center.
- I. 4: Restructure Provident Hospital as a Regional Outpatient Center + focused inpatient facility and emergency department.
- I. 5: Rebuild Fantus Clinic; redevelop as a Regional Outpatient Center.

### ■ GOAL II: QUALITY, SERVICE EXCELLENCE, AND CULTURAL COMPETENCE

- II. 1: Execute System-wide performance improvement initiatives.
- II. 2: Implement System-wide service excellence and cultural competency initiatives.

## **ACTION PRIORITIES BY GOAL (cont'd.)—**

### ■ **GOAL III: SERVICE LINE STRENGTH**

III. 1: Continue to develop/strengthen key clinical services.

III. 2: Develop the infrastructure to support clinical services.

### ■ **GOAL IV: STAFF DEVELOPMENT**

IV. 1: Dramatically improve staff recruitment , training, and development processes.

IV. 2: Implement a full range of initiatives to improve staff satisfaction levels.

### ■ **GOAL V: LEADERSHIP & STEWARDSHIP**

V. 1: Develop CCHHS leadership for today and for the future.

V. 2: Continue to strengthen the stewardship responsibilities of System Board and management.

## GOAL I: ACCESS TO HEALTHCARE SERVICES

### ■ I. 1: Eliminate System access barriers at all delivery sites.

- Conduct a comprehensive review of access and service issues at CCHHS facilities; develop specific plans and timetables to remedy major access barriers:
  - Fantus operations
  - ACHN and Specialty Clinics scheduling
  - Stroger inpatient bed availability
  - Surgical services infrastructure and scheduling
  - Etc.
  
- Pursue related improvements in service, staff, and technology (refer to Goals II, IV, and V).

### ■ Timetable:

<b>I. 1 Eliminate access barriers--all sites.</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015+</b>
Comprehensive review/action plan development						
Ongoing implementation		Continuous & Ongoing Implementation				

## GOAL I: ACCESS TO HEALTHCARE SERVICES

### ■ I. 2: Strengthen the ACHN network; develop Comprehensive Community Health Centers at selected sites.

- Increase efficiency and volumes through increases in staffing/support:
  - Expanded primary care + specialty care physician FTEs
  - Staff-to-provider ratios increased from 2.8 to targeted 4.0
- Define partnerships with FQHC's and other Community Health Center's.
- Develop targeted CCHC sites: Northwest, West, and South.
- Evaluate consolidation of ACHN clinics if volume thresholds are not met (after in-depth analysis/recommendations).

### ■ Timetable:

<b>I. 2 ACHN + CCHC Development</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015+</b>
ACHN staffing plan developed	■					
Physician + support staff increases		Continuous & Ongoing Implementation				
CCHC site selections finalized	■	■				
Planning/design: new + build-outs		■				
Facility expansion/construction (if required)			■			
Evaluation of ACHN clinics re: consolidation	■	■				
Possible consolidation--selected clinics		■				

# Action Priorities

## GOAL I: ACCESS TO HEALTHCARE SERVICES (cont'd.)—

- **I. 3: Redevelop Oak Forest Hospital as a Regional Outpatient Center.**
  - Evaluate site options and develop plan for long-term ROC development.
  - Short-term, consolidate/expand OP services in “E” Building:
    - Primary/specialty care, urgent care, advanced imaging, pharmacy, health education/community space
  - Discontinue all inpatient services; develop service and transfer agreements for inpatients.

### ■ Timetable:

<b>I. 3 Redevelop OFH as ROC</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015+</b>
Inpatient transition planning	■	■				
Patient transfer agreements in place		■				
Suspension--IP operations			■			
Detailed ROC planning/design			■			
Construction build-out--existing facilities			■	■		
Staffing: planning & expansion			■	Continuous & Ongoing Implementation		

**Note: Timetable incorporates necessary regulatory (CON) review and approvals.**

# Action Priorities

## GOAL I: ACCESS TO HEALTHCARE SERVICES (cont'd.)—

- **I. 4: Restructure Provident Hospital as a Regional Outpatient Center + focused inpatient facility with Emergency Department.**
  - Continue to explore collaborative options with UCMC.
  - Expand outpatient services and staffing:
    - Primary/specialty care, OP surgery, advanced imaging, pharmacy, health education/community rooms
  - Retain ED + low acuity observation unit (<30 beds)
    - JHSJH utilized for OB inpatient services + acute care transfers

### ■ Timetable:

<b>I. 4 Restructure Provident Hospital as ROC +</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015+</b>
<b><u>Focused IP Facility with ED</u></b>						
Ongoing UCMC discussions	■					
Suspension OB/ICU; reduction M/S; overflow 18 beds		■	■			
Detailed ROC planning/design		■	■			
ROC space build-out			■	■		
Staffing: planning & expansion			■	Continuous & Ongoing Implementation		

**Note: Timetable incorporates necessary regulatory (CON) review and approvals.**

## GOAL I: ACCESS TO HEALTHCARE SERVICES (cont'd.)—

### ■ I. 5: Rebuild Fantus Clinic; redevelop as a Regional Outpatient Center.

- Replace existing facilities: new construction + expanded parking.
- Expand outpatient surgical capacity (+4 rooms, +2 procedure rooms).
- Relocate OB/Peds to distributed clinics.

### ■ Timetable:

<u>I. 5 Rebuild Fantus as ROC</u>			<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015+</u>
Program design + sizing			■					
Site evaluation/selection				■				
Detailed planning & design					■			
Construction--new facility						■		

**Note: Timetable incorporates necessary regulatory (CON) review and approvals.**

## GOAL II: QUALITY, SERVICE EXCELLENCE, AND CULTURAL COMPETENCE

- **II. 1: Execute System-wide performance improvement initiatives.**
  - Fully implement System-wide program of continuous process improvement:
    - Evidence-based methodologies
    - Key patient safety & quality indicators monitored on continuous basis
  - Implement System-wide patient care management processes:
    - Coordinated care & transitions
    - Robust HIT: EMR, Individual Health Record
    - Rule-based referral and service coordination with provider partners
    - Accountability for episode of care
  
- **Timetable:**

<b>II. 1 Implement process improvement initiatives</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015+</b>
Process improvement focus + direction		Continuous & Ongoing Implementation				
System-wide care management processes		Continuous & Ongoing Implementation				

# Action Priorities

## GOAL II: QUALITY, SERVICE EXCELLENCE, AND CULTURAL COMPETENCE (cont'd.)—

### ■ II. 2: Implement System-wide service excellence and cultural competency initiatives.

- Systematically identify/remedy key patient dissatisfiers.
  - Access, way-finding, wait times
  - Environmental safety and ambiance
- Develop a comprehensive plan for instilling cultural competency at all locations:
  - On-site interpreters, staff diversity
  - Health information/signage geared to language and cultural norms

### ■ Timetable:

<u>II. 2 Implement Process Improvement</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015+</u>
Service excellence plan developed & implemented			Continuous & Ongoing Implementation			
Cultural focus plan developed & implemented			Continuous & Ongoing Implementation			

## GOAL III: SERVICE LINE STRENGTH

### III. 1: Continue to develop/strengthen key clinical services.

- Develop/strengthen key needs-based areas:
  - Strengthen OB/Peds, Emergency/Trauma, Surgical Services (ongoing planning and development), Geriatrics Services
  - Develop/further strengthen other key services; e.g., asthma/COPD, cancer, cardiac, stroke, diabetes, communicable disease/HIV, geriatric care, palliative care.
  - Pursue partnerships for rehab, post-acute care, behavioral health, and oral health
- Pursue national leadership in key areas of medical education , research, and innovations in health delivery. Toward this end, pursue collaborations and partnerships:
  - Academic medical centers
  - Community health systems
  - FQHC 's, health centers, and public health agencies

### ■ Timetable:

<b>III.1 Develop/Strengthen Clinical Services</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015+</b>
Completion of service line planning in process						
Completion of planning for add'l. key service lines						
Partnership discussions/collaborations	Continuous & Ongoing Implementation					

## GOAL III: SERVICE LINE STRENGTH (cont'd.)—

### ■ III. 2: Develop the infrastructure to support clinical services.

- Develop a comprehensive plan for capital equipment investment and replacement.
- Implement Health Information Technology to support System clinical processes:
  - Implementation of EMR, migration to Individual Health Record
  - Ongoing participation in IRIS and other community health referral networks
- Develop a comprehensive marketing and branding program to enhance public awareness of CCHHS services, strengths, and ongoing performance.
- Implement steps to review ALOS and otherwise optimize capacity utilization at JHSJH.
- Develop a dashboard reporting system to monitor quality, safety, and satisfaction outcomes.

### ■ Timetable:

<b>III. 2 Develop Infrastructure--Clinical Services</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015+</b>
Capital equipment assess./plng.						
Capacity optimization--JHSJH						
IT planning/system implementation						
Marketing program development						

# Action Priorities

## GOAL IV: STAFF DEVELOPMENT

- **IV. 1: Dramatically improve staff recruitment , training, and development systems and processes.**
  - Streamline current recruitment processes; eliminate System barriers.
  - Develop a comprehensive 3-year staff development plan for all System sites:
    - Reviews of position descriptions vs. actual job requirements
    - Comprehensive plan for staff in-service training, leadership skill development, and job-specific education (incorporating innovation with safety and quality focus)
  - Recruit/train staff to meet defined needs:
    - Physicians, by specialty, by site
    - RN's
    - Physician assistants and other physician extenders
    - Other allied health professionals and caregivers

### ■ Timetable:

<b>IV.1 Staff Recruitment + Training</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015+</b>
Streamlined recruiting processes in place						
System-wide training program developed						
Staff recruitment + development	Continuous & Ongoing Implementation					


# Action Priorities

## GOAL IV: STAFF DEVELOPMENT (cont'd.)—

### ■ IV. 2: Implement a full range of initiatives to improve staff satisfaction levels.

- Systematically identify and target key staff satisfiers.
- Foster open communication, collaboration, and teamwork at all sites/levels of the System:
  - Clear communication of System Vision and overall direction
  - Open communications and collaboration in decision-making
  - Support of risk-taking and flexibility to make needed decisions
- Target and achieve employee satisfaction at benchmarks (nationally or at highest level possible).

### ■ Timetable:

<u>IV.2 Staff Satisfaction Improvement</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015+</u>
Assessment and focused plan development						
Attainment 3rd quartile satisfaction levels				Ongoing Implementation 		

# Action Priorities

## GOAL V: LEADERSHIP AND STEWARDSHIP

- **V. 1: Develop CCHHS leadership for today and for the future.**
  - Develop and implement a comprehensive program for leadership development:
    - Defined leadership goals
    - Formalized leadership evaluations and feedback
    - Succession planning
    - Structured leadership training and development
  - Educate for management functions with annual competencies verifications.
  - Conduct formalized leadership 360 degree evaluations.

### ■ Timetable:

<b>V.1 Staff leadership development</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015+</b>
Program definition/implementation						
Ongoing leadership development			Continuous & Ongoing Implementation			

## GOAL V: LEADERSHIP AND STEWARDSHIP (cont'd.)—

- **V. 2: Continue to strengthen the stewardship responsibilities of System Board and management.**
  - Set measureable System objectives and milestones.
  - Hold the Board and senior management accountable for results:
    - Organizational performance vis a vis the strategic Plan and other defined objectives
    - 5-Year Financial Plan

### ■ Timetable:

<u>V.2 Stewardship</u>				<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015+</u>
Targets + measures									
Results monitoring + feedback					Continuous & Ongoing Implementation				

- Background + Approach
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## 5-Year Financial Plan: Intended Use and Limitations

***Guiding Principle: The strategic plan creates a framework to provide for more appropriate services to serve the vulnerable population of Cook County. The Strategic Plan does not seek to reduce operating funds or levels of required investments.***

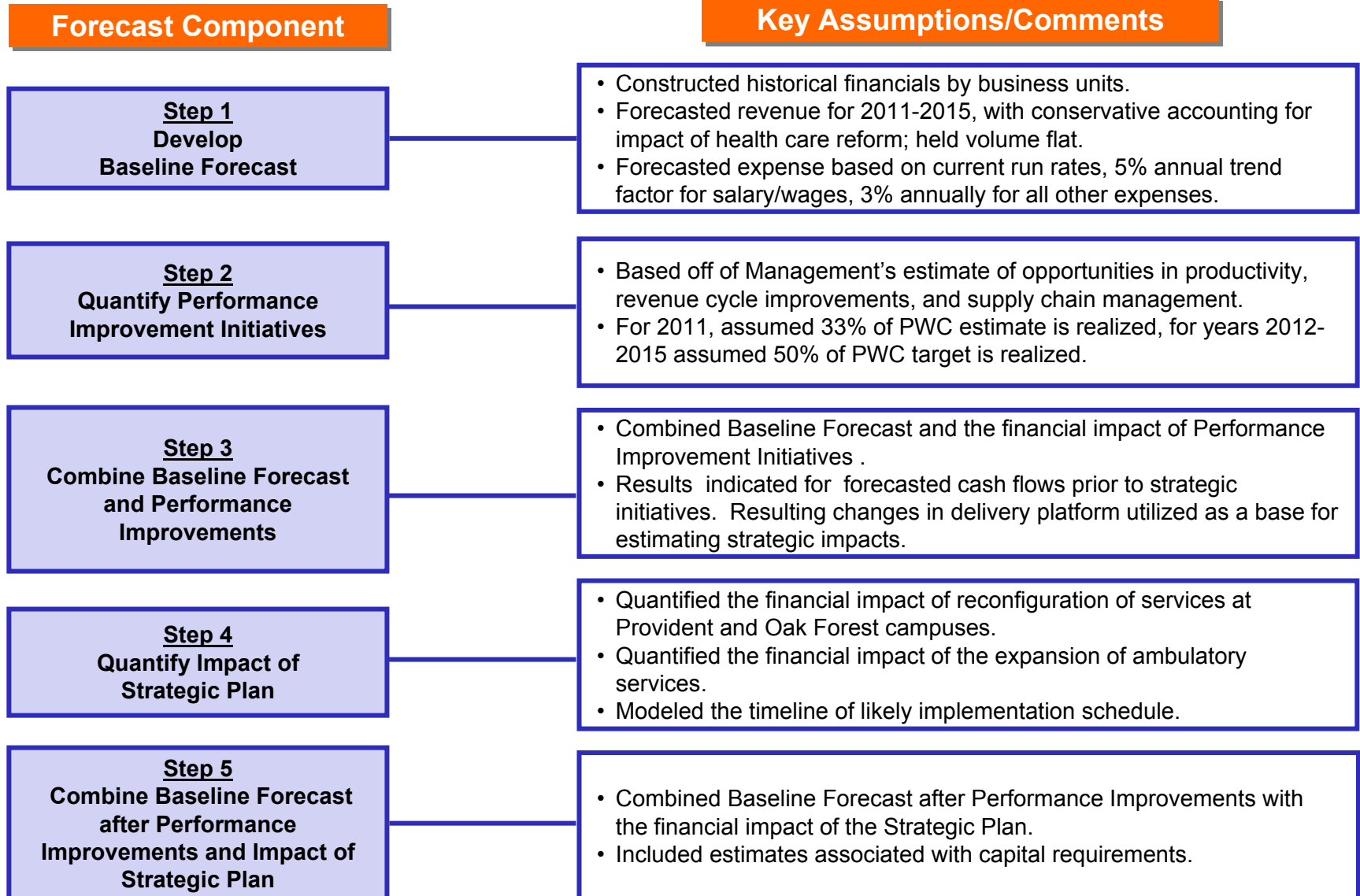
### **Intended Use**

■ The five-year financial plan reflects management's best efforts to quantify the likely operating and financial impacts of (a) management's performance improvement initiatives, and (b) the 2010 – 2015 Vision and Strategic Plan. It provides a working model of the underlying dynamics and relative impacts of the proposed initiatives. As such, it is a helpful resource to guide decision making. It is not intended as a long-term operating budget, particularly in the later years as the difficulty in forecasting increases.

### **Limitations**

■ The financial plan cannot fully anticipate and quantify inherent uncertainties in the health care environment. Further, there are limitations owing to the quality of available data, as well as unknowns regarding the specifics and timing of actual plan implementation.

# 5 Year Financial Plan: Process Overview



## 5-Year Financial Plan: Baseline Forecast

### Baseline Forecast: System Rollup

Annual, in 000's

	FY09	FY10	FY11	FY12	FY13	FY14	FY15
	Actual (Unaudited)	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
<b>Operating revenue</b>							
Patient Service Revenue (includes IG \$	371,262	\$ 341,996	\$ 350,085	\$ 350,085	\$ 354,462	\$ 354,462	\$ 358,926
ARRA/Stimulus Funds	36,000	38,582	3,215	-	-	-	-
Net DSH	225,000	150,000	138,000	138,000	138,000	128,000	126,000
Total Patient Service Revenue	632,262	530,578	491,300	488,085	492,462	482,462	484,926
Other revenue	3,768	5,467	5,631	5,800	5,974	6,153	6,338
Total operating revenue	636,030	536,045	496,931	493,885	498,436	488,615	491,264
<b>Operating expenses</b>							
Salaries and wages	526,330	546,911	503,014	528,165	554,573	582,302	611,417
Supplies	125,772	129,119	118,947	122,516	126,191	129,977	133,876
Purchased services, rental and other	145,293	169,342	156,981	161,690	166,541	171,537	176,684
Utilities	18,235	18,633	17,165	17,680	18,211	18,757	19,320
Total operating expenses	815,630	864,005	796,108	830,051	865,516	902,573	941,296
<b>Operating Loss</b>	<b>\$ (179,601)</b>	<b>\$ (327,960)</b>	<b>\$ (299,177)</b>	<b>\$ (336,166)</b>	<b>\$ (367,080)</b>	<b>\$ (413,958)</b>	<b>\$ (450,033)</b>
Capital requirement - Routine	-	-	(25,000)	(25,000)	(25,000)	(25,000)	(25,000)
Capital requirement - Strategic	-	-	-	-	-	-	-

*Note: The forecast is based on high level assumptions and as such is intended as a tool to aid in strategic and financial planning, not an operating budget.*

## 5-Year Financial Plan: Performance Improvement Initiatives

### Incremental Performance Improvement: System Rollup

*Annual, in 000's*

	FY09	FY10	FY11	FY12	FY13	FY14	FY15
	Actual/ Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
<b><u>Operating revenue</u></b>							
Patient Service Revenue (includes IG \$	-	-	\$ 55,000	\$ 40,238	\$ 41,445	\$ 42,688	\$ 43,969
ARRA/Stimulus Funds	-	-	-	-	-	-	-
NetDSH	-	-	-	-	-	-	-
Total Patient Service Revenue	-	-	55,000	40,238	41,445	42,688	43,969
Other revenue	-	-	-	-	-	-	-
Total operating revenue	-	-	55,000	40,238	41,445	42,688	43,969
<b><u>Operating expenses</u></b>							
Salaries and wages	-	-	(9,833)	(15,306)	(15,765)	(16,238)	(16,725)
Supplies	-	-	(12,101)	(18,836)	(19,401)	(19,983)	(20,583)
Purchased services, rental and other	-	-	11,284	(26,796)	(29,574)	(30,461)	(31,375)
Utilities	-	-	-	-	-	-	-
Total operating expenses	-	-	(10,650)	(60,938)	(64,740)	(66,682)	(68,683)
<b>Operating Loss</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 65,650</b>	<b>\$ 101,175</b>	<b>\$ 106,185</b>	<b>\$ 109,370</b>	<b>\$ 112,651</b>
Capital requirement - Routine							
Capital requirement - Strategic	-	-	-	-	-	-	-

*Note: The forecast is based on high level assumptions and as such is intended as a tool to aid in strategic and financial planning, not an operating budget.*

## 5 Year Financial Plan: Forecast After Performance Improvement

<b>Forecast after Performance Improvement Initiatives: System Rollup</b>							
<i>Annual, in 000's</i>							
	FY09	FY10	FY11	FY12	FY13	FY14	FY15
	Actual/ Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
<b><u>Operating revenue</u></b>							
Patient Service Revenue (includes IG ARR/ARRA/Stimulus Funds)	\$ 371,262	\$ 341,996	\$ 405,085	\$ 390,323	\$ 395,906	\$ 397,150	\$ 402,895
NetDSH	225,000	150,000	138,000	138,000	138,000	128,000	126,000
Total Patient Service Revenue	632,262	530,578	546,300	528,323	533,906	525,150	528,895
Other revenue	3,768	5,467	5,631	5,800	5,974	6,153	6,338
Total operating revenue	636,030	536,045	551,931	534,123	539,880	531,303	535,232
<b><u>Operating expenses</u></b>							
Salaries and wages	526,330	546,911	493,181	512,859	538,808	566,064	594,692
Supplies	125,772	129,119	106,847	103,680	106,790	109,994	113,294
Purchased services, rental and other	145,293	169,342	168,265	134,895	136,967	141,076	145,308
Utilities	18,235	18,633	17,165	17,680	18,211	18,757	19,320
Total operating expenses	815,630	864,005	785,458	769,114	800,776	835,891	872,614
<b>Operating Loss</b>	<b>\$ (179,601)</b>	<b>\$ (327,960)</b>	<b>\$ (233,527)</b>	<b>\$ (234,991)</b>	<b>\$ (260,896)</b>	<b>\$ (304,588)</b>	<b>\$ (337,381)</b>
Capital requirement - Routine	-	-	(25,000)	(25,000)	(25,000)	(25,000)	(25,000)
Capital requirement - Strategic	-	-	-	-	-	-	-

*Note: The forecast is based on high level assumptions and as such is intended as a tool to aid in strategic and financial planning, not an operating budget.*

## 5-Year Financial Plan: Incremental Impact of Strategic Plan

<b>Incremental Strategic Plan: System Rollup</b>							
<i>Annual, in 000's</i>							
	FY09	FY10	FY11	FY12	FY13	FY14	FY15
	Actual (Unaudited)	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
<b><u>Operating revenue</u></b>							
Patient Service Revenue (includes IG \$	-	-	\$ (15,469)	\$ (11,783)	\$ (5,592)	\$ (3,070)	\$ (2,932)
ARRA/Stimulus Funds	-	-	-	-	-	-	-
NetDSH	-	-	-	-	-	-	-
Total Patient Service Revenue	-	-	(15,469)	(11,783)	(5,592)	(3,070)	(2,932)
Other revenue	-	-	(233)	(240)	(247)	(255)	(262)
Total operating revenue	-	-	(15,702)	(12,023)	(5,839)	(3,325)	(3,194)
<b><u>Operating expenses</u></b>							
Salaries and wages	-	-	(25,874)	(22,936)	(9,159)	(3,824)	(5,200)
Supplies	-	-	1,578	2,253	3,188	3,554	3,661
Purchased services, rental and other	-	-	36	(1,719)	(4,377)	(4,375)	(4,506)
Utilities	-	-	(1,763)	(1,816)	(1,824)	(1,598)	(1,646)
Total operating expenses	-	-	(26,023)	(24,219)	(12,172)	(6,242)	(7,690)
<b>Operating Loss</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 10,322</b>	<b>\$ 12,196</b>	<b>\$ 6,333</b>	<b>\$ 2,917</b>	<b>\$ 4,496</b>
Capital requirement - Routine							
Capital requirement - Strategic	-	-	(41,000)	(27,500)	(21,500)	(8,500)	(103,900)

*Note: The forecast is based on high level assumptions and as such is intended as a tool to aid in strategic and financial planning, not an operating budget.*

## 5-Year Financial Plan: Impact of Strategic Plan by Initiative

Strategic Capital Reallocation – Forecast 2010 - 2015 (in millions)						Comments
Impact on Operations	Forecasted					
	2011	2012	2013	2014	2015	
<b>Oak Forest</b>						
Discontinue all patient services	\$ 42.2	\$ 42.6	\$ 45.0	\$ 48.1	\$ 51.0	2011 includes partial year and transition costs.
Transfer agreements/transition costs	(7.0)	(3.0)	-	-	-	Transition costs associated with displaced pts.
Build/grow ambulatory clinic services	(1.7)	(4.9)	(7.5)	(8.3)	(8.5)	Grows to 105K patient visits.
Relocate Rehab Unit	(4.2)	(4.6)	(4.9)	(5.3)	(5.6)	Contract with community hospital.
<b>Provident</b>						
Discontinue inpatient OB and ICU, resize IP unit.	2.5	10.9	11.6	12.4	13.1	Result is 36 bed IP unit plus overflow, ER remains.
Expand ambulatory services	(2.7)	(6.1)	(11.0)	(13.5)	(13.9)	Grows to 140K patient visits.
<b>ACHN</b>						
PC expansion	(2.2)	(3.5)	(4.9)	(5.2)	(5.4)	Using 4.3 ratio, adds 70 support ftes.
Expand Cicero and Cottage Grove	(1.6)	(3.8)	(5.4)	(5.7)	(5.9)	Combined increase of 40K patient visits.
New Northwest Clinic	-	-	(0.6)	(3.3)	(3.4)	34K patient visits.
<b>Stroger</b>						
Strategic Investment, Stroger Hospital	(15.0)	(15.5)	(15.9)	(16.4)	(16.9)	Invest in service line development, OR staffing.
<b>Forecasted Change in Operating Cash</b>	<b>10.3</b>	<b>12.2</b>	<b>6.3</b>	<b>2.9</b>	<b>4.5</b>	
<b>Capital Costs</b>						
IT Infrastructure	(16.0)	(9.5)	(11.5)	(8.5)	(11.9)	Invest in IT infrastructure.
Fantus rebuild					(92.0)	Based on \$500 per foot, 180K feet.
PC clinic expansion/update	(3.0)	(3.0)	(3.0)	-	-	6 clinics at \$1.5M per clinic
CCHC clinic expansion/update	(3.0)	(3.0)	(7.0)	-	-	2 CCHC's at \$3M each, \$7M for new clinic.
Provident reconfigure	-	(12.0)	-	-	-	Retro fit space for clinic expansion.
Oak Forest reconfigure	(19.0)	-	-	-	-	Reconfigure building E, new equipment.
<b>Forecasted Strategic Capital Requirements</b>	<b>\$ (41.0)</b>	<b>\$ (27.5)</b>	<b>\$ (21.5)</b>	<b>\$ (8.5)</b>	<b>\$ (103.9)</b>	

# 5-Year Financial Plan: Forecast after Performance Improvement and Strategic Plan Initiatives

## Forecast after Performance Improvement/Strategic Plan: System Rollup

Annual, in 000's

	FY09	FY10	FY11	FY12	FY13	FY14	FY15
	Actual (Unaudited)	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
<b>Operating revenue</b>							
Patient Service Revenue (includes IGT)	\$ 371,262	\$ 341,996	\$ 389,617	\$ 378,540	\$ 390,314	\$ 394,080	\$ 399,963
ARRA/Stimulus Funds	36,000	38,582	3,215	-	-	-	-
NetDSH	225,000	150,000	138,000	138,000	138,000	128,000	126,000
Total Patient Service Revenue	632,262	530,578	530,832	516,540	528,314	522,080	525,963
Other revenue	3,768	5,467	5,398	5,560	5,727	5,899	6,075
Total operating revenue	636,030	536,045	536,230	522,100	534,041	527,978	532,038
<b>Operating expenses</b>							
Salaries and wages	526,330	546,911	467,308	489,923	529,649	562,240	589,492
Supplies	125,772	129,119	108,425	105,932	109,978	113,548	116,955
Purchased services, rental and other	145,293	169,342	168,300	133,175	132,591	136,701	140,802
Utilities	18,235	18,633	15,402	15,864	16,387	17,159	17,674
Total operating expenses	815,630	864,005	759,435	744,894	788,604	829,649	864,923
<b>Operating Loss</b>	<b>\$ (179,601)</b>	<b>\$ (327,960)</b>	<b>\$ (223,205)</b>	<b>\$ (222,795)</b>	<b>\$ (254,563)</b>	<b>\$ (301,671)</b>	<b>\$ (332,885)</b>
Capital requirement - Routine	-	-	(25,000)	(25,000)	(25,000)	(25,000)	(25,000)
Capital requirement - Strategic	-	-	(41,000)	(27,500)	(21,500)	(8,500)	(103,900)

*Note: The forecast is based on high level assumptions and as such is intended as a tool to aid in strategic and financial planning, not an operating budget.*

- Background + Approach
- Summary of Key Issues
- Guiding Principles
- Strategic Direction: VISION 2015
- Action Priorities
- 5-Year Financial Plan
- **APPENDICES**

- Appendix A – The Case for Change
- Appendix B – Five-Year Financial Forecast Narrative
- Appendix C – Five-Year Financial Forecast Detail

*Integrated Clinical  
Solutions, Inc.*



***Cook County Health  
and Hospitals System***

***Phase II Strategic Planning:***  
***APPENDIX A— THE CASE FOR CHANGE***

June 25, 2010

## *APPENDIX C—A Compelling case for Change*

1. There are significant unmet healthcare needs in Cook County.
2. There are large disparities in health by region.
3. In addition, there are disparities in access.
4. As need has risen, CCHHS volumes have trended downward.
5. CCHHS access points are not aligned geographically.
6. System resources are disproportionately centered around the hospital environment.
7. The System is not deploying providers and facilities effectively.
8. The current CCHHS delivery configuration is not sustainable.
9. The current cost structure is not sustainable.
10. A redirection of inefficient IP resources to OP modalities could substantially increase the volumes of services overall.

# 1. Significant unmet healthcare needs in Cook County...

Cook County ranked in the bottom tier for health outcomes in Illinois (81 out of 101)

	Cook County	Target Value*
<b>Health Outcomes</b>		
<b>Mortality</b>		
Premature death	7,701	5,694
<b>Morbidity</b>		
Poor or fair health	18%	9%
Poor physical health days	3.3	2.4
Poor mental health days	3.2	2.0
Low birthweight	9%	6%

\* Reflects 90<sup>th</sup> percentile  
 Source: www.countyhealthrankings.org

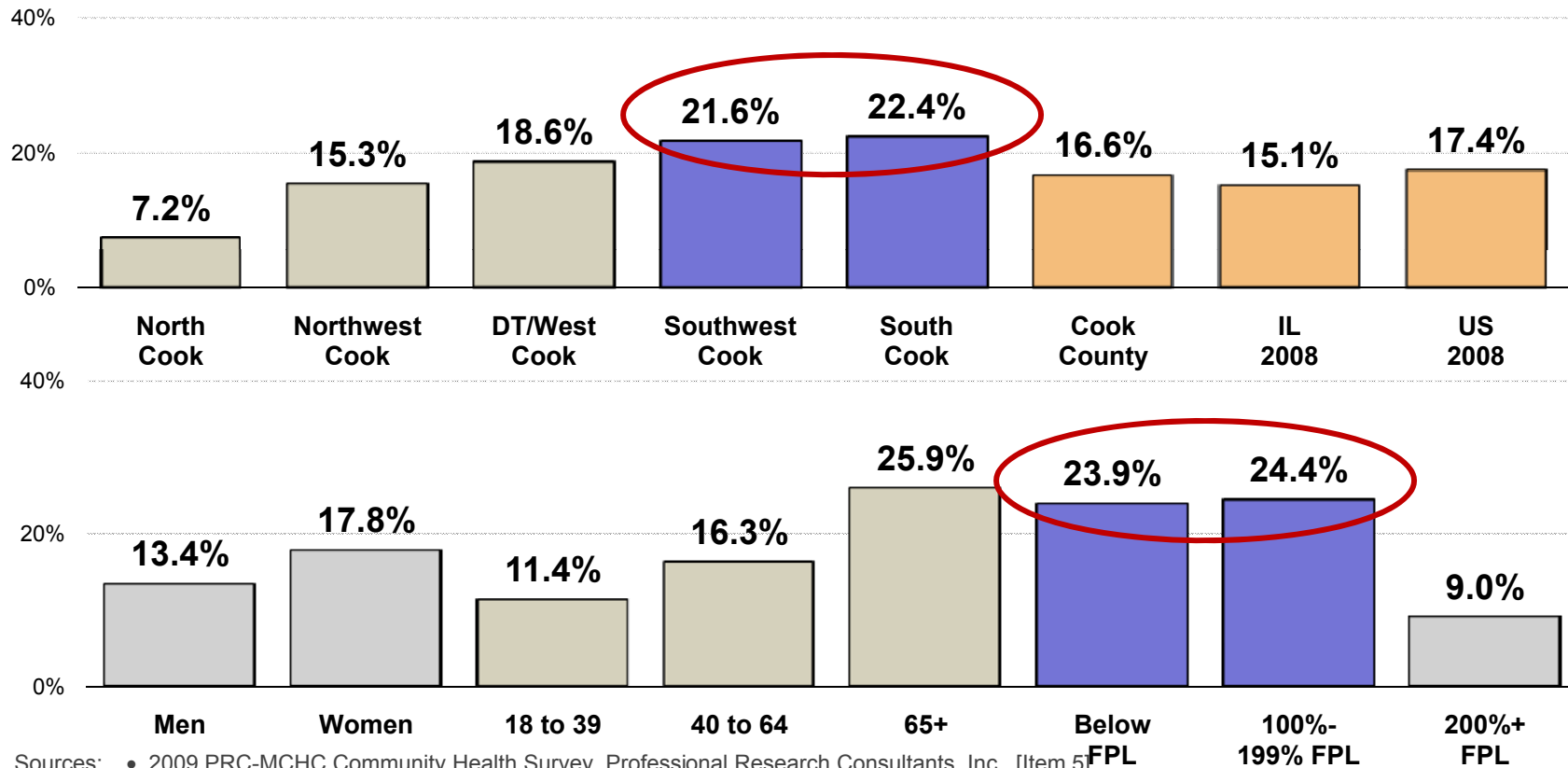
The DT/West and South Cook regions face greater health challenges

North Cook	Northwest Cook	Downtown/West Cook	Southwest Cook	South Cook
Difficulty Accessing Healthcare (Adults & Children)	Children's Routine Medical Care	Childhood ADD/ADHD	Arthritis & Osteoporosis	Arthritis
Mold in the Home	Eye Exams	Childhood Asthma	Environmental Tobacco Smoke	Chronic Lung Disease
Routine Medical Care	HIV Testing	Children's Bicycle Helmet Usage	High Blood Cholesterol	Dental Care
	Smoking Cessation	Diabetes Management	Lack of Health Insurance Coverage	Emergency Room Utilization
		Lack of Health Insurance Coverage		Environmental Tobacco Smoke
		Prostate Screenings		Family Violence
		Seat Belt Usage		Fruit/Vegetable Consumption
				Hypertension
				Mental Health Status
				Obesity
				Perceptions of Local Healthcare
				Senior Flu Shots
				Tobacco Use
				Violent Crime

Source: 2009 PRC-MCHC Community Health Report

**The highest percent of reporting “Fair or Poor” health are those in Southland communities and in low-income cohorts**

**Respondents That Experience “Fair” or “Poor” Overall Health By Cook County Region**



Sources: • 2009 PRC-MCHC Community Health Survey, Professional Research Consultants, Inc. [Item 5]  
 • 2008 PRC National Health Survey, Professional Research Consultants, Inc.  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2008 Illinois data.

Notes: • Asked of all respondents.

## 2. Large disparities in health...

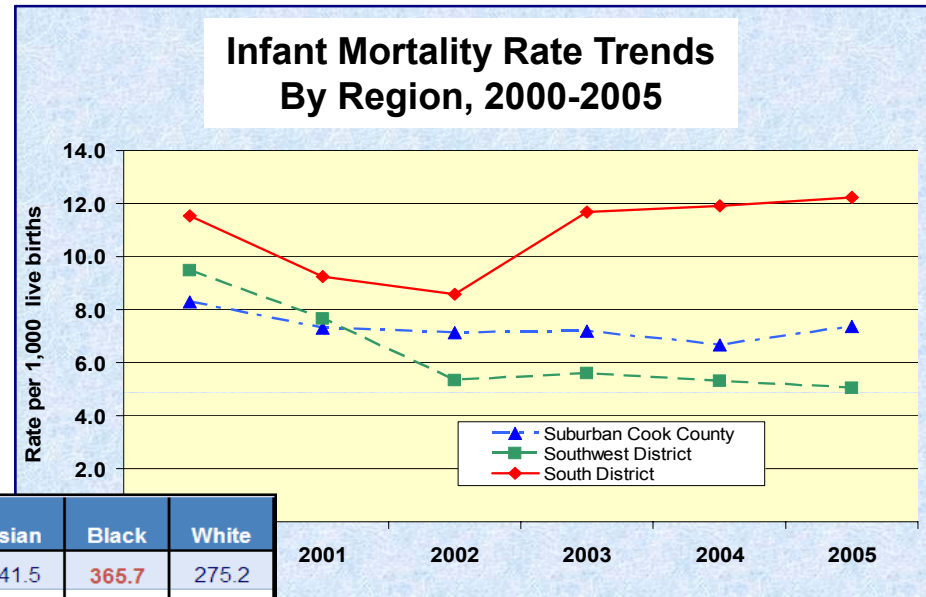
Health outcomes, such as IMR and leading causes of death, demonstrate the disparities by region and race

### 10 Leading Causes of Death by Race/ Ethnicity for 2005 in Chicago

Causes of Death	All Races	Hispanic	Mexican	Puerto Rican	Asian	Black	White
Heart Disease	265.4	132	152.7	202.5	141.5	365.7	275.2
Cancer	204.6	109.5	121.6	175.1	132.7	304.4	193.6
Stroke	49.5	22.7	32.8	RS	27.2	75.5	45.3
Chronic Lwr Resp Dis	33.2	RS	RS	RS	RS	40.9	38.9
Diabetes	29	31.6	36.3	60.6	25.6	41.9	22.9
Nephritis	22.5	RS	18.1	RS	RS	39.2	16.4
Alzheimer's Disease	RS	RS	RS	RS	RS	RS	17.6
Homicide	16.4	9.6	9.6	RS	RS	36.2	RS
Septicemia	25.5	20	21.4	50.1	RS	44.2	19.3
Influenza & Pneumonia	23	14.4	RS	RS	RS	29	24.6
Accidents	33.9	26.1	25.9	40.8	RS	49.6	30.6
Liver Disease	RS	16.9	15.6	36.5	RS	RS	RS
Infant Mortality	RS	4.3	3.7	RS	RS	RS	RS

SOURCE: CDPH

RS = Rate Suppressed because the number of deaths < 21



SOURCE: CCDPH

Note: interventions to address disparities goes beyond the health system and must target the intersections between biology, behavior, and social circumstances to reduce the unequal burden

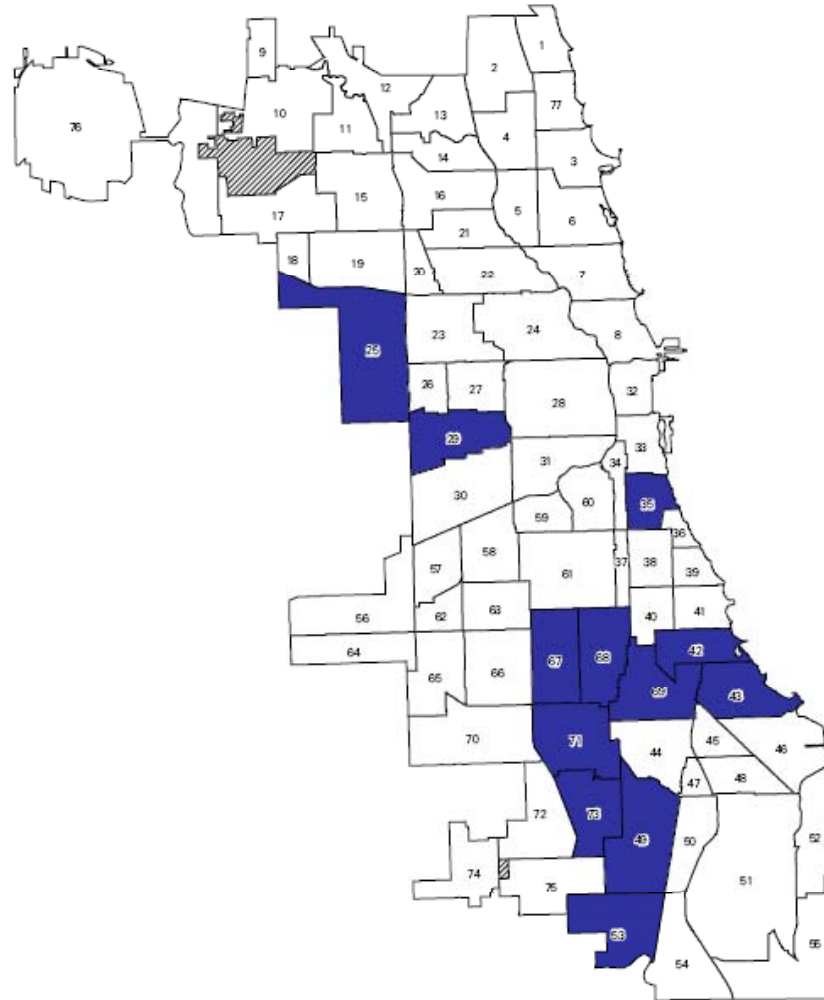
## The disease burden is greater in key communities

The areas with the lowest health rankings have the fewest health resources and also where CCHHS draws the majority of its patients.

### Chicago Community Areas with the Lowest Health Ranking Composite, 2004

- 1 – Englewood (68)
- 2 – West Englewood (67)
- 3 - Auburn Gresham (71)
- 4 - North Lawndale (29)
- 5 – West Pullman (53)
- 6 – Greater Grand Crossing (69)
- 7 – Woodlawn (42)
- 8 – Roseland (49)
- 9 – Washington Heights (73)
- 10 – South Shore (43)



Source: Chicago Department of Public Health








### 3. There are disparities in access

*CCHHS access points are not aligned with the poorer parts of the county, many of which have seen considerable population migration*

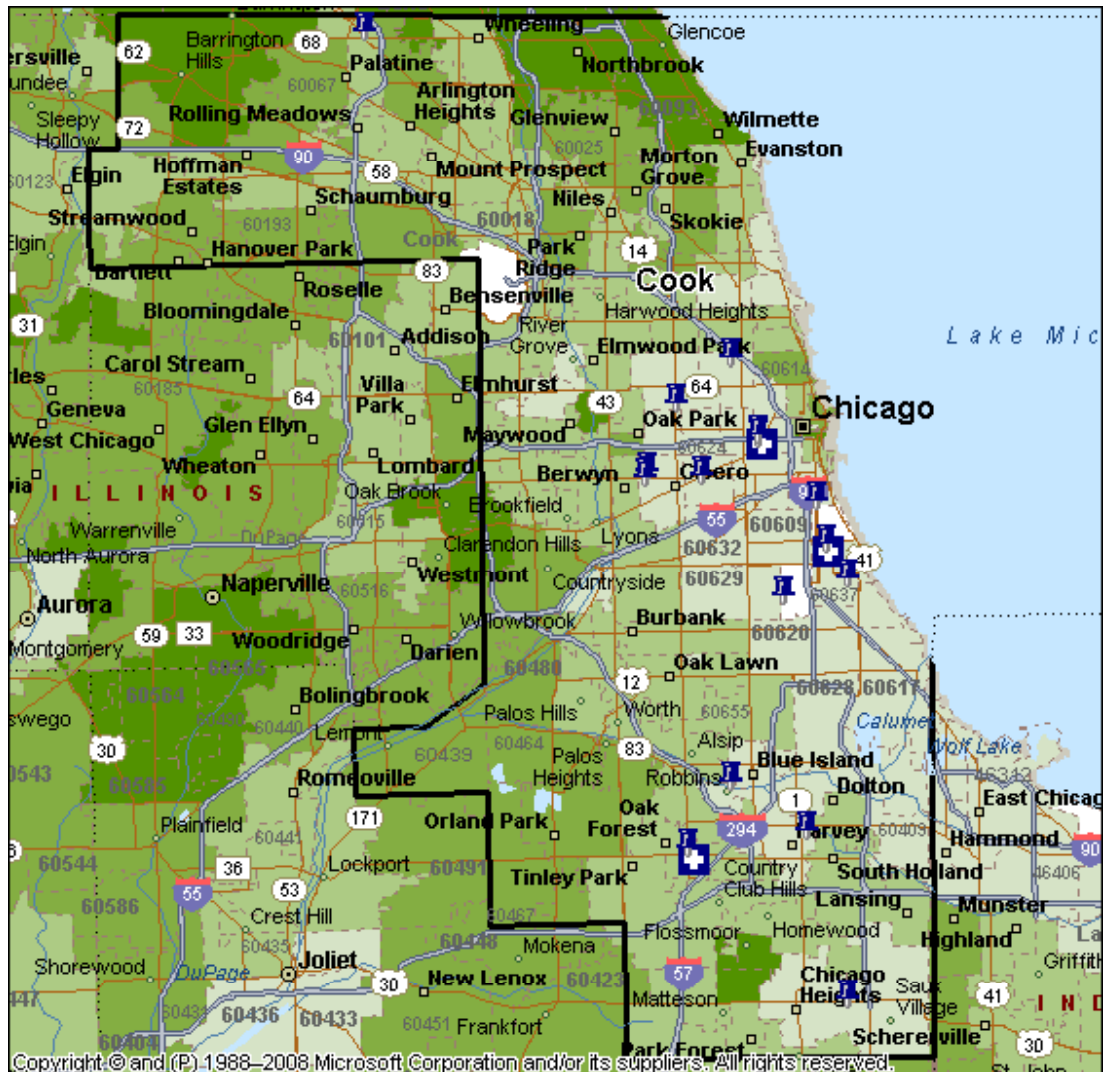
#### CCHHS Locations and Median Household Income by ZIP Code

-  ACHN Locations
-  Hospitals

#### Median HH Income (2007)

-  \$100,000 to \$500,000
-  \$75,000 to \$99,999
-  \$50,000 to \$74,999
-  \$25,000 to \$49,999
-  \$0 to \$24,999



Sources: CCHHS; Microsoft MapPoint data








*The south/southwest parts of the county clearly have gaps in primary care access points*

*Overlaying FQHC/CHC locations displays the relative lack of primary care facilities in the poorer Southern regions.*

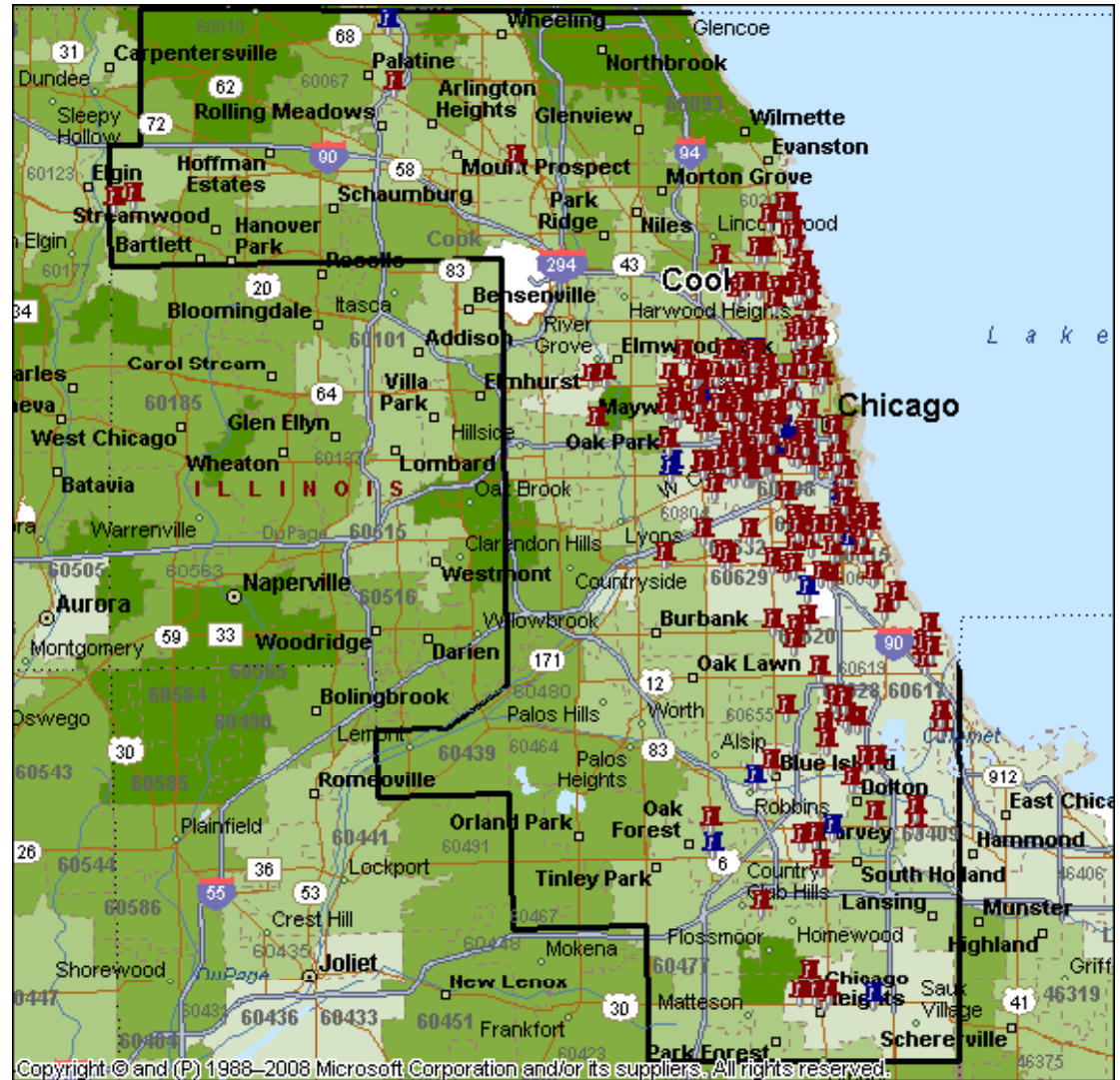
**FQHC/CHC Locations and Median Household Income by ZIP Code**

-  FQHC/CHC Locations
-  ACHN Locations

**Median HH Income (2007)**

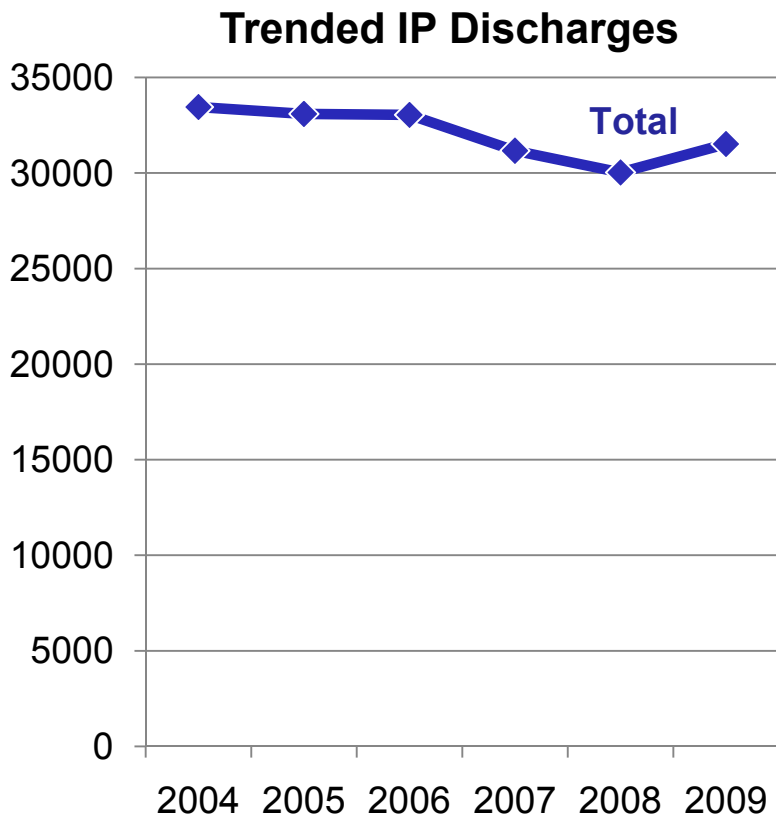
-  \$100,000 to \$500,000
-  \$75,000 to \$99,999
-  \$50,000 to \$74,999
-  \$25,000 to \$49,999
-  \$0 to \$24,999

Sources: CCHHS; Microsoft MapPoint data; Illinois Primary Healthcare Association

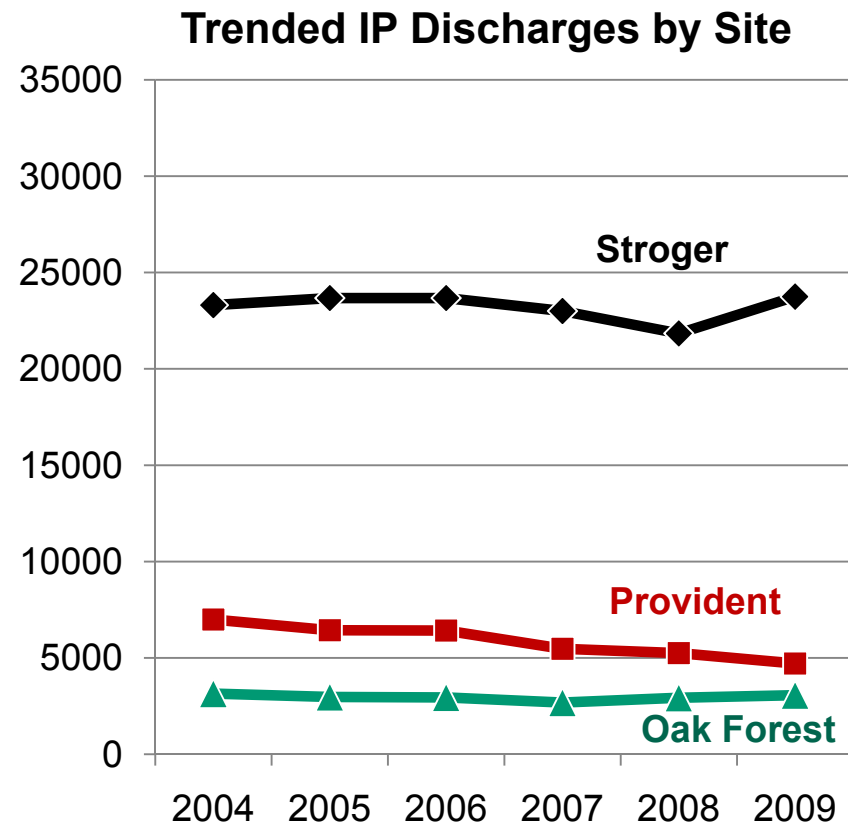


## 4. In a time of rising need, CCHHS volumes have trended downward, although 2009 has showed some sign of reversal

While healthcare needs in the County have grown, budget cuts have contributed to a decline in CCHHS inpatient and outpatient activity over the last five years.

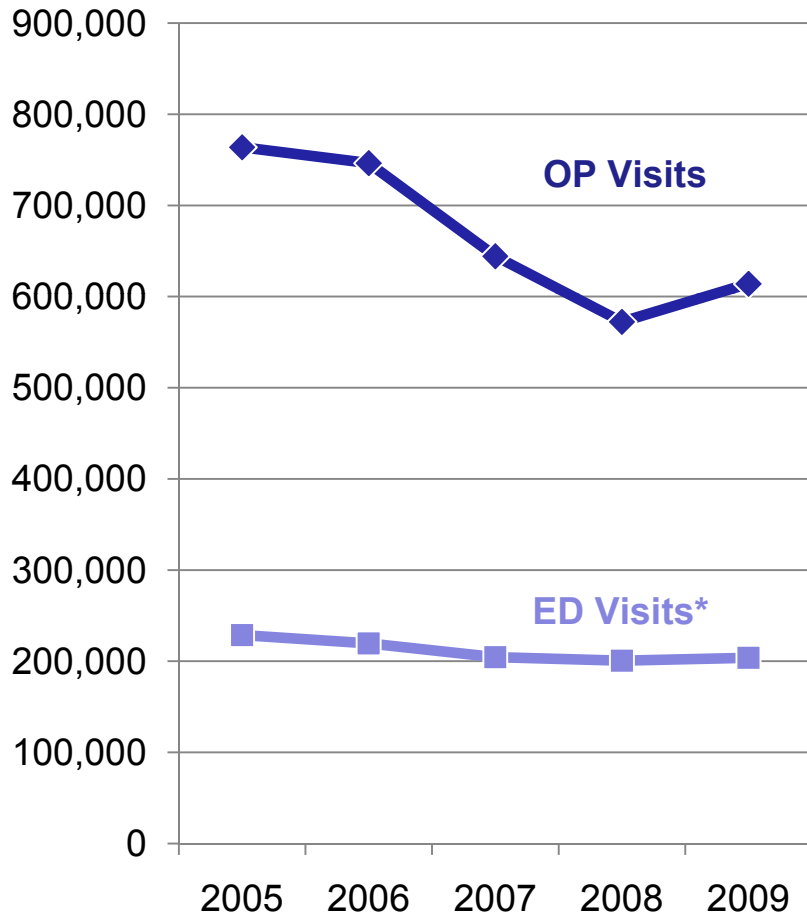


Source: CCHHS



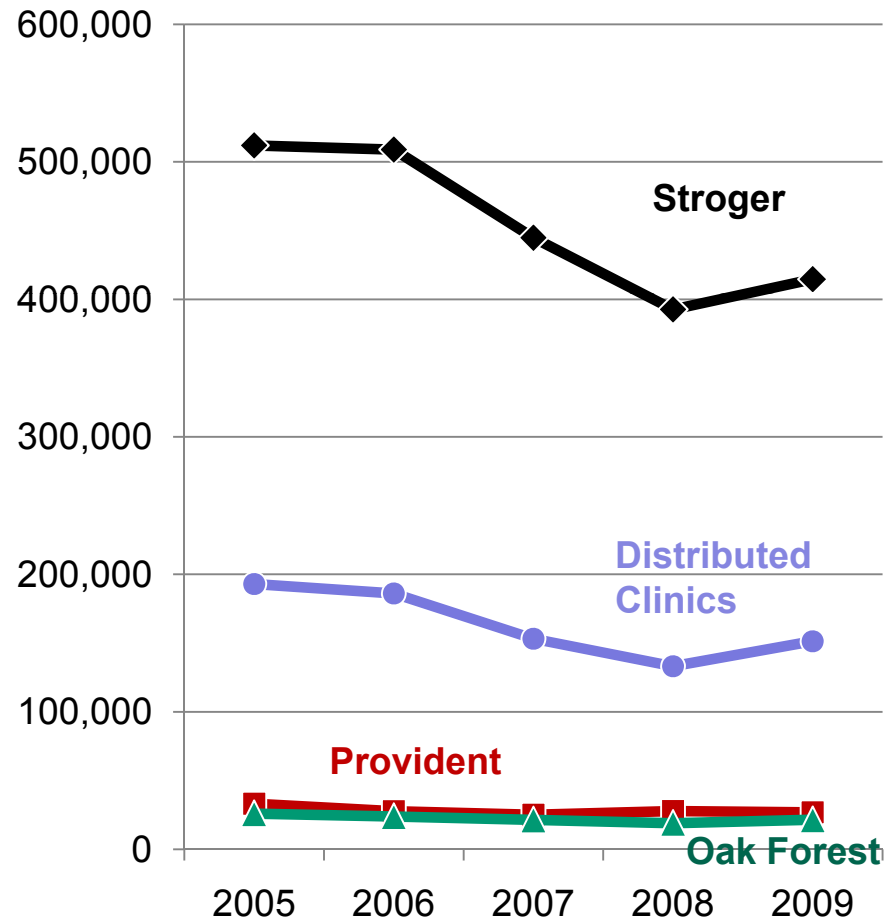
*OP activity also has seen a considerable decline over the last five years, primarily due to budget cuts and related staffing reductions*

**Trended OP and ER Visits**



\* Excludes Trauma  
Source: CCHHS

**Trended OP Visits by Site**



## 5. CCHHS access points are not aligned geographically

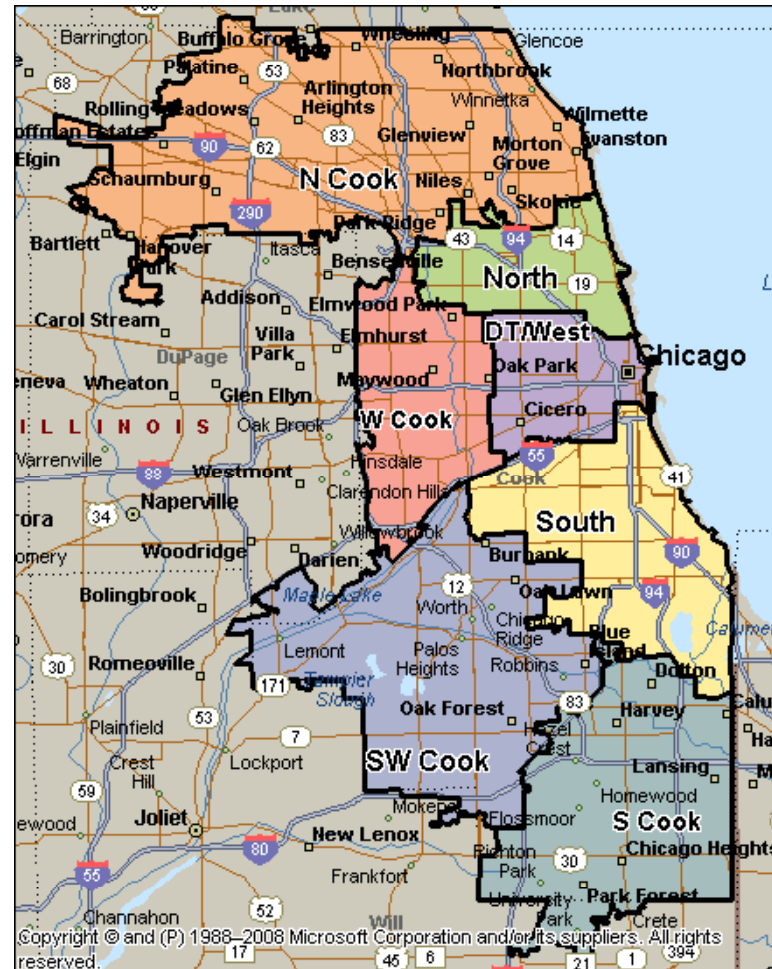
There has been a significant geographic redistribution of the vulnerable population over the past 20+ years, with significant shifts to:

- South/South Cook
- Downtown/West
- North Cook

Population (2007) by Region

Region	Population
North	918,942
DT/West	898,509
South	1,116,319
N Cook	981,695
W Cook	444,107
S Cook	398,037
SW Cook	484,294
<b>TOTAL</b>	<b>5,241,903</b>

Source: MapPoint Population data



**Over 60% of CCHHS' clinical activity comes from patients residing in the South and Downtown/West regions**

### CCHHS Clinical Activity by Region, 2008

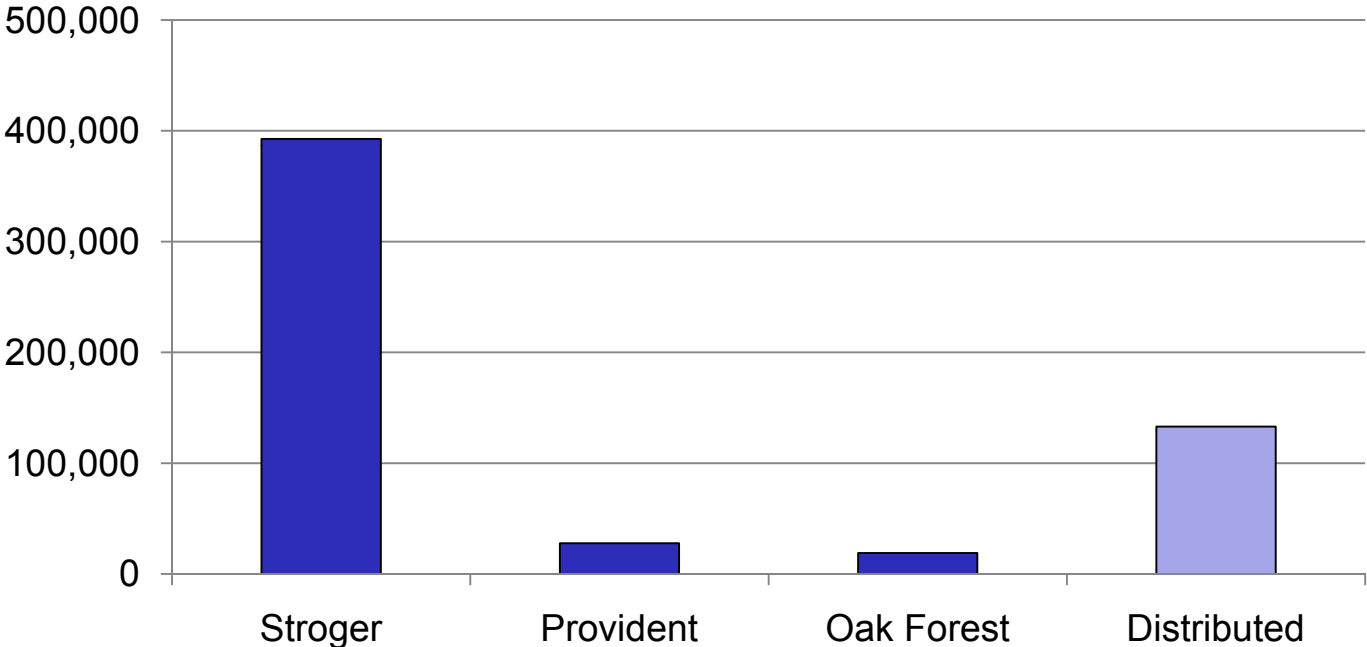
Region	Population	ACHN Visits	ED Visits	IP Dischgs	OP Surgeries	Existing ACHN Locations
South	1,116,319	249,137	71,001	13,809	3,195	3 PC and 1 Spec. Care
DT/West	898,509	183,579	45,603	8,685	1,757	6 PC and 1 Spec. Care
North	918,942	78,110	14,077	3,033	1,170	No Locations
S Cook	398,037	48,398	16,709	2,205	620	2 PC Sites
N Cook	981,695	35,244	3,341	976	396	1 PC Site
W Cook	444,107	32,687	5,817	1,190	437	No Locations
SW Cook	484,294	28,827	9,925	1,336	430	1 PC and 1 Spec. Care
Other/NA		22,678	7,945	436	450	
<b>TOTAL</b>	<b>5,241,903</b>	<b>678,660</b>	<b>174,418</b>	<b>31,670</b>	<b>8,455</b>	
Region	Population	ACHN Visits	ED Visits	IP Dischgs	OP Surgeries	Existing ACHN Locations
South	21%	37%	41%	44%	38%	3 PC and 1 Spec. Care
DT/West	17%	27%	26%	27%	21%	6 PC and 1 Spec. Care
North	18%	12%	8%	10%	14%	No Locations
S Cook	8%	7%	10%	7%	7%	2 PC Sites
N Cook	19%	5%	2%	3%	5%	1 PC Site
W Cook	8%	5%	3%	4%	5%	No Locations
SW Cook	9%	4%	6%	4%	5%	1 PC and 1 Spec. Care
Other/NA		3%	5%	1%	5%	
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	

Source: CCHHS Experian database

**6. System resources are disproportionately centered around the hospital environment...**

*CCHHS has devoted considerable resources at the John H. Stroger, Jr. Hospital campus for outpatient care, contributing to congestion, backlogs, and patient dissatisfaction.*

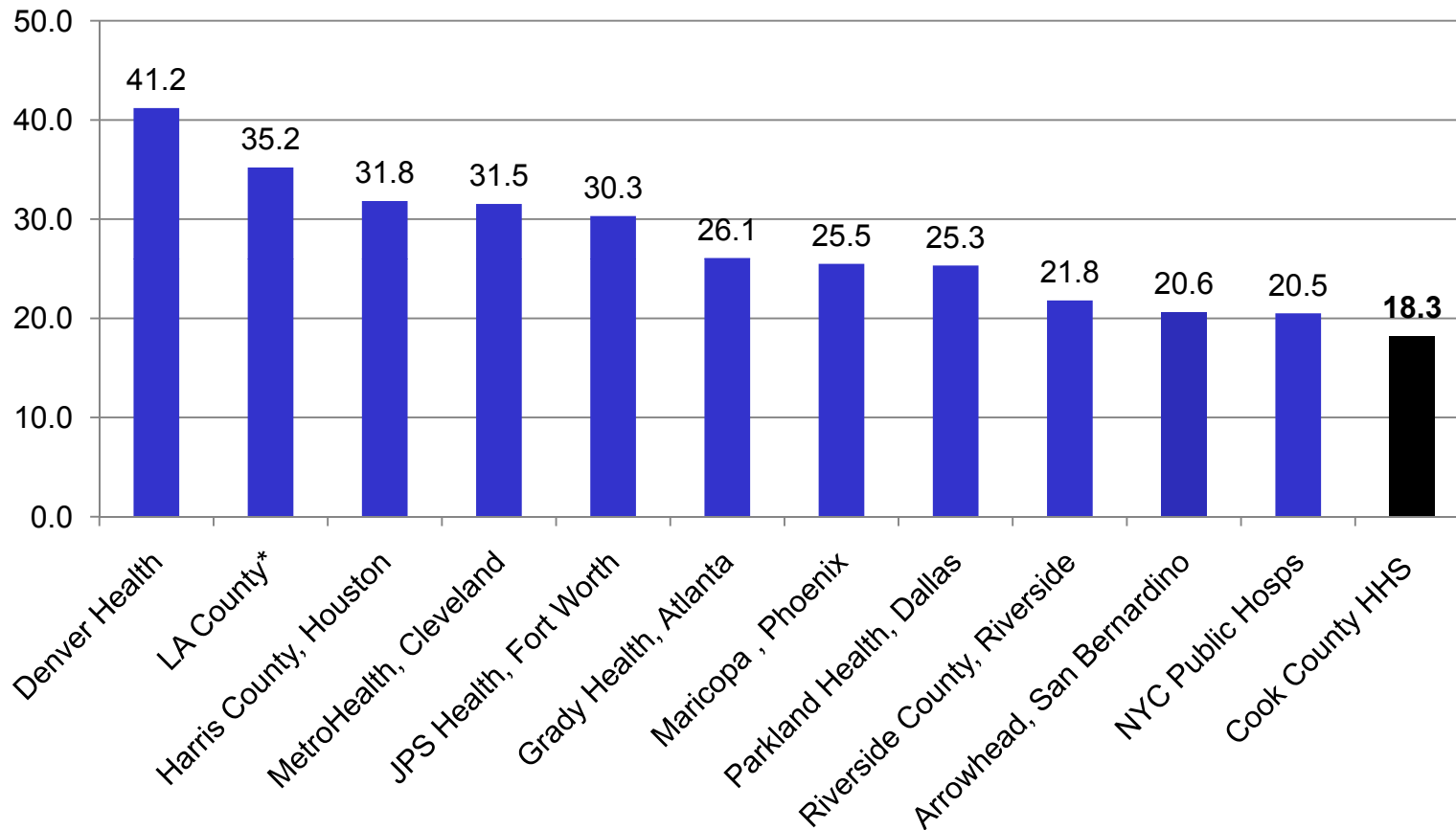
**CCHHS Clinic Visits by Location, 2008**



Source: CCHHS

*...and fewer resources are devoted to outpatient care in general, compared to other public health systems*

### Ratio of OP Visits to IP Discharges, 2008



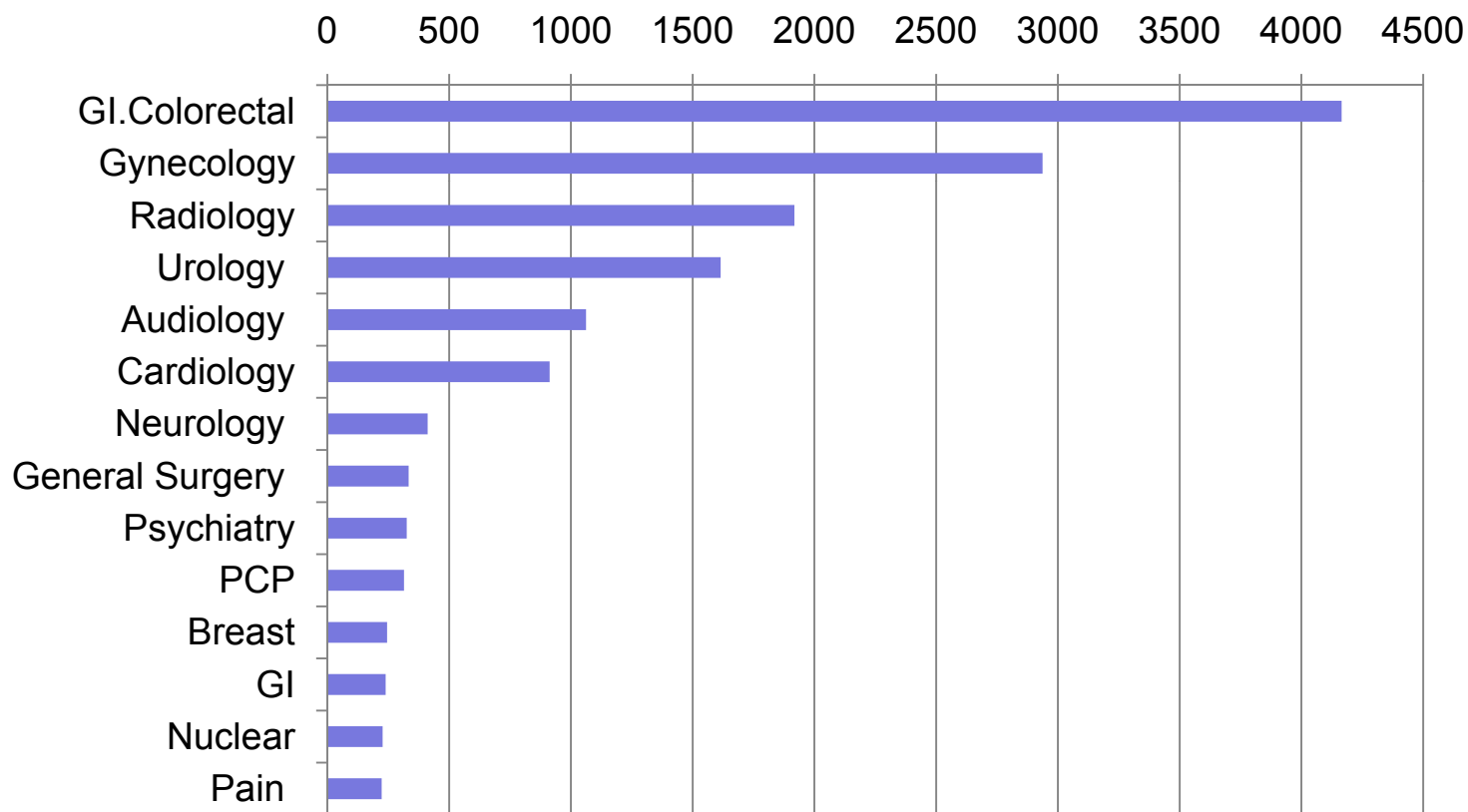
\* Includes 600,000 visits paid by LACDHS to private community clinics for uninsured low-income patients.

Source: Data from "America's Public Hospitals and Health Systems, 2008", Results of the Annual NAPH Hospital Characteristics Survey, February 2010

## 7. System not deploying providers and facilities effectively...

*There is a substantial backlog for procedural and other services*

### Specialties and Associated Clinics, IRIS Referrals Greater Than 21 Days Old (as of Feb. 2010)

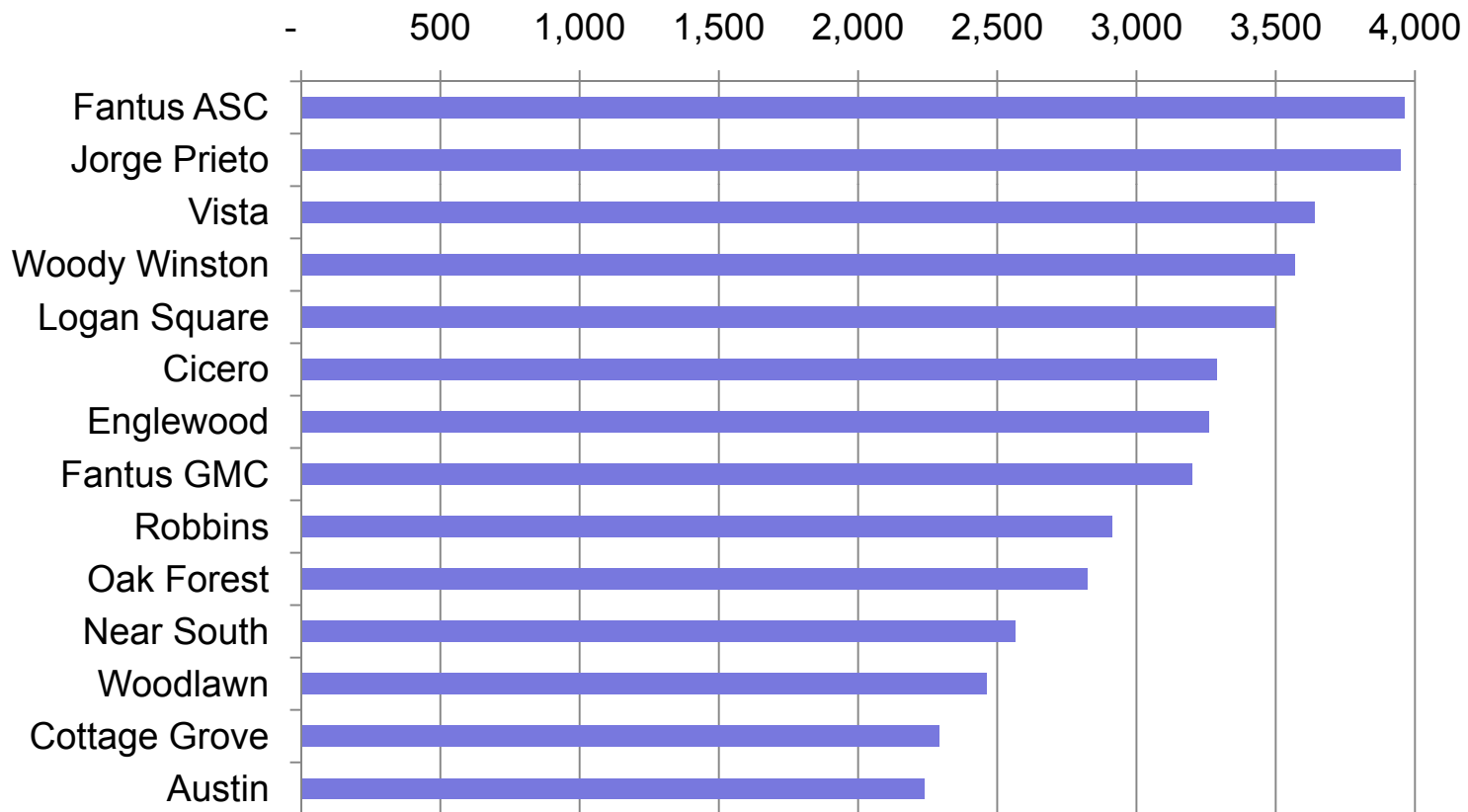


Source: IRIS, CCHHS

***...backlog and productivity issues highlight need for stronger outpatient capability and performance***

*Primary care productivity varies greatly by location, which is sometimes a function of the availability of support staff*

**Visits per Provider FTE by ACHN Clinic, 2009**



Source: CCHHS

## 8. Current CCHHS delivery configuration is not sustainable

*Health care reform...how will it impact CCHHS?*

### Market Impacts

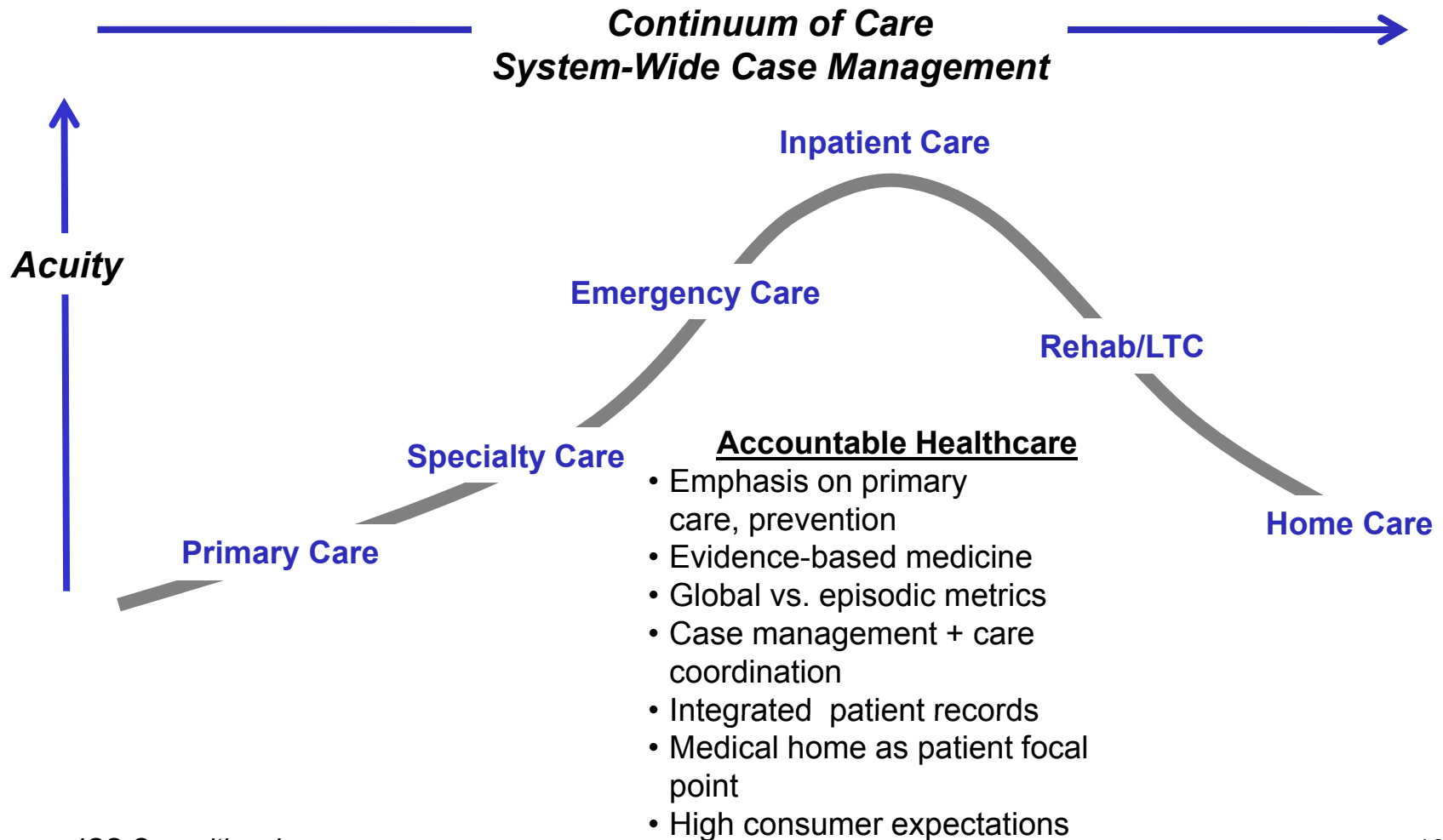
- ✓ Fewer un-/underinsured
- ✓ Medicaid expansion
- ✓ More healthcare \$\$
- ✓ Increased demand for healthcare
- ✓ More “choice-enabled” patients

### CCHHS Impacts

- ✓ Substantial #'s remain uncovered
- ✓ DSH cuts + state freezes
- ✓ Declining special payments & subsidy revenues
- ✓ Growing volumes, esp. OP care
- ✓ Higher consumer expectations

**Health reform will emphasize accountability for healthcare across the delivery spectrum.**

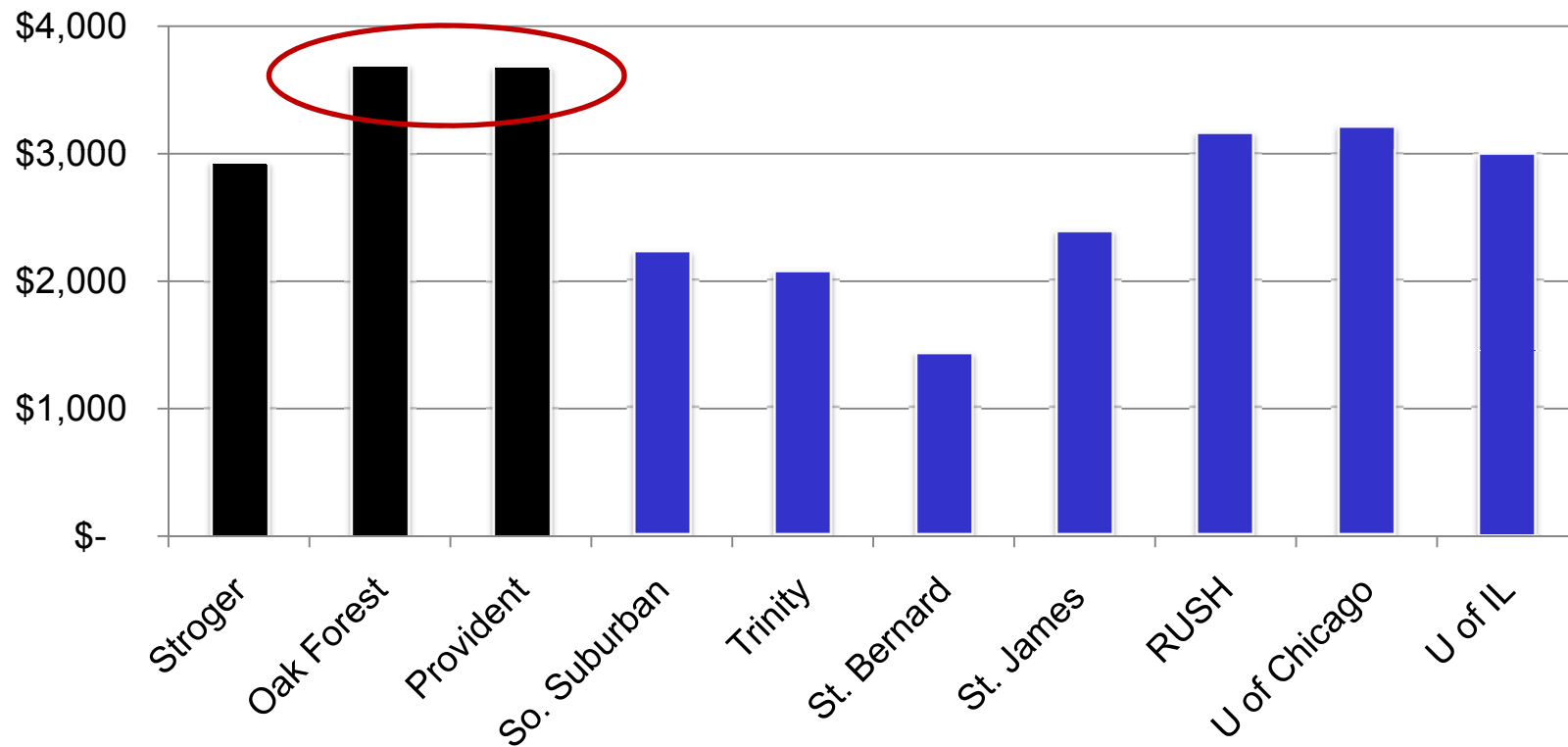
*The future-state evolution of health care will place increased emphasis on the non-acute/outpatient spectrum of care...*



## 9. Current cost structure is not sustainable

*Provident and Oak Forest Hospitals have a much higher IP cost per patient day, even when compared to area teaching hospitals*

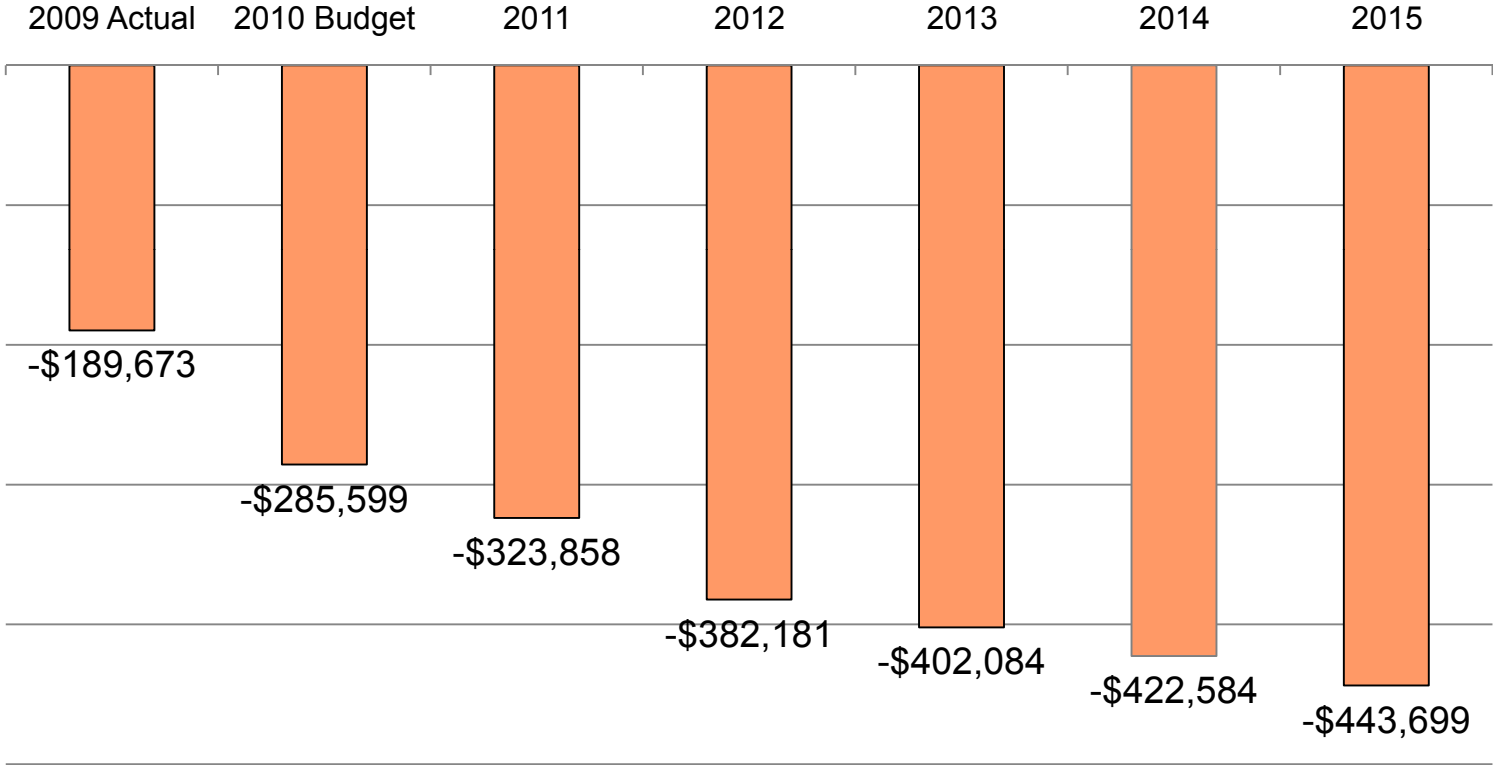
**Calculated IP Cost per Patient Day, 2007**



Source: Mike Koetting analysis using data from the Medicare Cost Reports

**Maintaining the current hospital-centered model will continue to demand substantial subsidy requirements in a period where contributions from the County are declining**

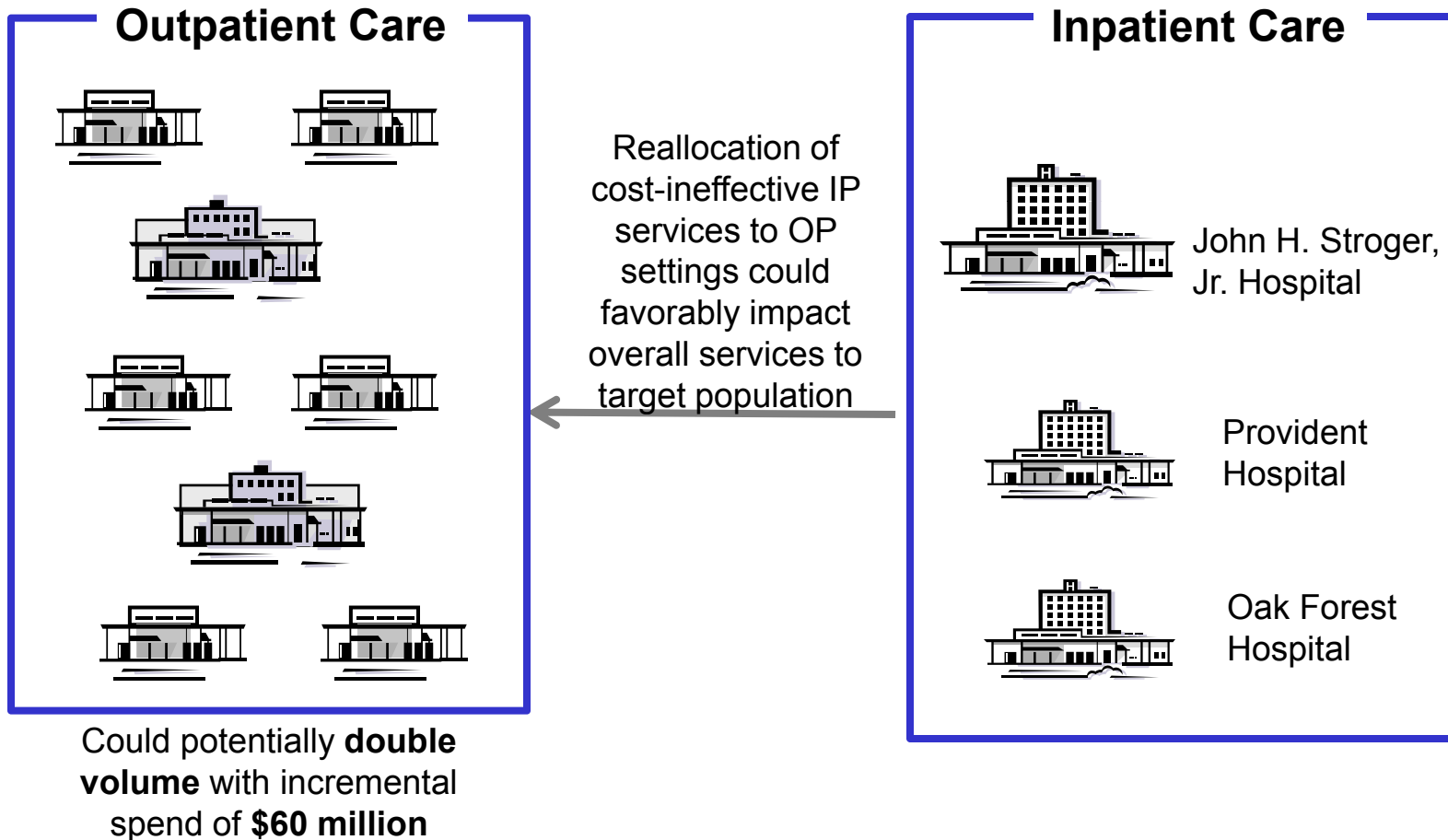
**Forecasted CCHHS Pro Forma – Momentum Scenario**



Source: ICS analysis

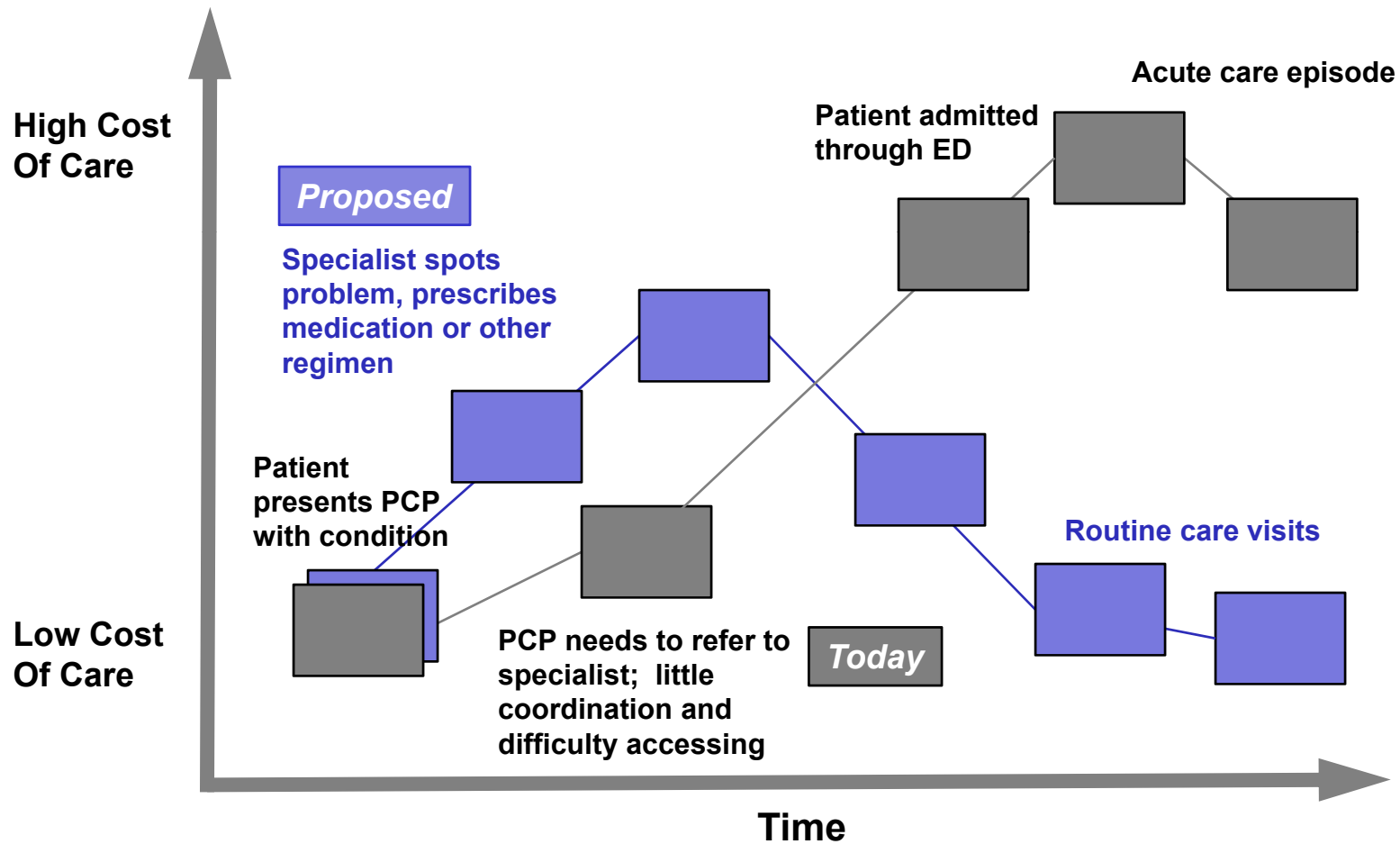
## 10. Redirection of inefficient IP resources to OP modalities could substantially increase the volumes of services overall...

*A portion of reallocated capital can support substantial outpatient expansion.*



# Primary care and specialty access will be key to managing cost and quality...

Adequate access to primary care and specialty care is key to managing cost and quality...



APPENDIX B  
Cook County Health and Hospitals System  
STRATEGIC PLAN  
Five-Year Financial Overview  
June 25, 2010

**INTRODUCTION**

Overall Guiding Principle:

Deliver the best possible health care for the vulnerable population of Cook County within the constraints of dollar resources available to the System. As such the strategic plan is not a plan to reduce expenses; rather the plan seeks to better allocate current resources to best serve the vulnerable population of Cook County.

This financial overview integrates three dynamics:

1. Relying on a set of base line assumptions, it rolls-forward FY2010 anticipated results across the next five years to illustrate the financial impacts of no major organizational changes. It is a "momentum" or "status quo" projection.
2. Management estimated the likely performance improvements by considering the opportunities in improving revenue cycle, productivity and supply chain management. Management anticipates engaging Price Waterhouse Coopers (PWC) to assist in achieving the performance improvements. The Performance Improvement projects are to be undertaken over the next two fiscal years.
3. Using estimates developed by Integrated Clinical Solutions (ICS), the model then layers in estimated consequences of various strategic initiatives.

**ICS**

Each of these layers builds on the previous layer so that the interactive effects of these activities can be understood.



The results are not necessarily precise forecasts of what will happen because many things that are not currently known will intervene. But they provide a working model of the underlying dynamics and the relative impacts of various factors. The model also can show how changes in various elements can influence the five year outcome.

The following sections describe the above steps and specify the assumptions used. It is important to note that because of layering in the results of the Performance Improvement initiatives some of the strategic initiatives have different costs or savings estimates than previous shown. For example, if there is a belief that Performance Improvement initiatives could lower the cost of

providing care at Oak Forest, the model now assumes the savings from reducing services at Oak Forest would save only the amount *after* the Performance Improvement initiatives.

**1. MOMENTUM SCENARIO**

This scenario uses the estimated 2010 financial results as a base and rolls forward across the next five years. Note, that in order to be consistent with the existing budgeting formats, cost estimates do not include malpractice, benefit costs or depreciation.

**A. 2010 Results**

Based on fiscal year to date data, the FY10 projections are:

- Patient service revenue (including the additional FMAP) will end the year at \$253M, roughly \$45M below budget due to continuing shortfall in Medicaid activity
- Other revenue sources will be at the budgeted levels
- Expenses will end the year at budgeted level

**B. FY11 to FY15**

Revenue

- Patient volume is assumed flat for the forecast period.
- Payor mix is assumed to stay constant from FY10 and no explicit assumptions have been incorporated for impacts of PPACA (Health Reform)
- Increases in patient revenue reimbursement rate assumptions:

<b>Patient Service Revenue Assumed Rate Increase</b>				
FY11	FY12	FY13	FY14	FY15
Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
2%	0%	2%	0%	2%

- The additional ARRA/stimulus funds are eliminated after the first month of FY11 as bills to extend this funding are not moving in Congress.
- Based on discussion with state Medicaid officials, disproportionate share payments (DSH) are estimated \$150M for FY10, then held constant at \$138M for FY11-13, \$128M for FY14 and \$126M for FY15.
- Other operating revenue is based on 2010 estimate and inflated by 3% per year for the forecasted period.
- The model makes no assumptions about subsidies from the County, but since there are material operating losses every year under all scenarios, there will be a continued need for substantial subsidies.

Expenses

- Salaries and wages are projected to increase 5.0% annually throughout the forecasted period, no assumed change in FTEs.
- Supplies are based 2010 estimate and inflated by 3% per year for the forecasted period.
- Purchased services are based 2010 estimate and inflated by 3% per year for the forecasted period.

- Utilities are based 2010 estimate and inflated by 3% per year for the forecasted period.

#### Routine Capital

- Routine capital is assumed at \$25M annually throughout the forecasted period.

## **2. PERFORMANCE IMPROVEMENT IMPACTS**

Management anticipates engaging PWC to assist them in implementing the performance improvement initiatives. PWC, based on limited information, has estimated the potential financial benefit from performance improvement initiatives. Management took PWC's estimated financial benefits and spread them over the likely years they will impact and separated one time benefits from recurring benefits. Lastly, management made a risk adjustment to the estimated financial benefit based on their comfort of achievability. The result was assuming 33% of the estimated financial impact for 2011 and 50% estimated financial impact for the subsequent years was achievable.

Additional points on how the estimated improvements are included in the model:

- Performance improvement estimates are only for the System as a whole. The model spreads these improvements to entity on the basis of each entity's share of total costs or revenue.
- PWC fees are calculated as a percentage of financial improvements and are netted against the related financial improvements in the model.

## **3. STRATEGIC INITIATIVES**

Each of major strategic initiatives was modeled individually, then combined into the overall strategic plan summary. Except as specifically noted, the assumptions of the momentum scenario were incorporated in this layer of the model. (For instance, the same assumptions were made about rate increases and all expenditures were assumed to inflate at 5% for wages and 3% for everything else. Each section below describes how modeling was done by initiative.

#### Oak Forest Hospital Reconfiguration

- *Strategic initiative description:* assumes all services are discontinued at Oak Forest Campus mid year 2011 with the exception of a large ambulatory clinic included select ancillary services. Services will be housed in Building E.
- Assumes that DSH payments currently allocated to Oak Forest are not impacted by closure of inpatient unit and will be retained by CCHHS.
- Assumes annual carrying cost for Oak Forest campus is roughly \$5M annually. While based on specific detailed assumptions about which costs would be retained, the number is of necessity approximate because it depends on working through with the County the exact mechanisms of decommissioning buildings, arrangements for non-CCHHS occupants, and the specific plant engineering costs that are required for maintenance.
- Assumes mail order pharmacy will continue, if not at Oak Forest, somewhere else and costs of that service (about \$15M) are not considered as a savings.
- Provision for displaced patients (transfer agreements/transition costs) is estimated at \$7M for FY11 and \$3M for FY12
- No specific provision was included for relocation of five remaining nursing home patients.

- Currently Rehab services operate at roughly a \$4M operating loss annually. It is assumed that these services could be relocated or outsourced at the same CCHHS cost.
- Expansion of ambulatory services results in the following assumed volumes and staffing:

Oak Forest Ambulatory Clinic Forecasted Increased Volume and Staffing						
Forecasted Volumes	FY10	FY11	FY12	FY13	FY14	FY15
Primary Care Visits	-	4,420	12,768	19,152	19,643	19,643
Specialty Care Visits	-	7,955	22,982	34,473	35,357	35,357
Urgent Care Visits	-	6,188	17,875	26,813	27,500	27,500
<b>Total Visits</b>	-	<b>18,563</b>	<b>53,625</b>	<b>80,438</b>	<b>82,500</b>	<b>82,500</b>
Forecasted FTEs						
Physicians	-	6.3	18.1	27.2	27.9	27.9
Support Staff	-	25.6	69.0	96.6	97.7	97.7
Other Ancillary Staff	-	4.3	8.8	11.8	12.0	12.0
<b>Total FTEs</b>	-	<b>36.2</b>	<b>95.9</b>	<b>135.6</b>	<b>137.6</b>	<b>137.6</b>

- Volume assumptions are based on following:
  - Urgent care volume is assumed to grow to the current level of ED activity
  - Primary care provision is in high demand throughout the System. Systematic primary care at this site has been limited even though a very large proportion of current CCHHS patients live in the South Suburbs
  - Specialty care activity has historically been limited more by the number of specialists that were assigned there than external demand. Moreover, improving partnerships with FQHCs, which are expanding their primary care offerings but do not provide specialty care, will be a key source of patients.
- Ambulatory payor mix is not modeled to improve. (This is a conservative assumption as there are many possibilities for revenue cycle improvement.)
- Physician productivity here (and elsewhere in the model) was assumed to be midway between current levels and prevailing community standards:
  - 3,800 primary care visits per physician FTE
  - 3,200 urgent care visits per physician FTE
  - 2,500 specialty care visits per physician FTE
- Ambulatory support staff was assumed at 4.3 staff members per FTE physician, but to gradually decrease to 3.5 staff per physician as the practice sizes grew larger and therefore able to experience economies of scale.

Capital Investment Associated with Oak Forest reconfiguration:

- Capital costs for retro fitting Building E for ambulatory services is estimated at \$14M for building (55,000 feet at 250 per sq foot) and \$5M for equipping clinic, including some advanced imaging capabilities.

Provident Hospital Reconfiguration

- *Strategic initiative description:* assumes inpatient services are scaled back eliminating ICU and OB/GYN units. Remaining inpatient operations is assumed to be 36 med/surg beds with an overflow unit of an additional 18 beds. Outpatient services are relocated to

vacated inpatient units and expanded. Expansion of ambulatory services results in the following assumed volumes and staffing:

- Assumes that DSH payments currently allocated to Provident are not impacted by closure of inpatient unit and will be retained by CCHHS
- Assumes 35% of volume has insurance, primarily Medicaid. This payor mix assumption is held constant throughout the forecasted period.
- Assumes the following productivity levels:
  - For PCP, 3,800 patients visit annually per FTE.
  - For specialists, 2,500 patients visits annually per FTE.
  - For urgent care physicians, 2,800 patients visits annually per FTE.
  - For support staff, a ratio of 4.3 FTEs for every physician FTE, phasing down to 3.5 as volume bases increase
- Expansion of ambulatory services results in the following assumed incremental volumes and staffing:

Provident Ambulatory Clinic Forecasted Increase in Volume and Staffing						
Forecasted Volumes	FY10	FY11	FY12	FY13	FY14	FY15
Primary Care Visits	-	7,088	15,750	27,956	31,500	31,500
Specialty Care Visits	-	13,163	29,250	51,919	58,500	58,500
Urgent Care Visits	-	5,063	11,250	19,969	22,500	22,500
<b>Total Visits</b>	-	<b>25,313</b>	<b>56,250</b>	<b>99,844</b>	<b>112,500</b>	<b>112,500</b>
Forecasted FTEs						
Physicians	-	8.7	19.4	34.4	38.7	38.7
Support Staff	-	35.5	73.5	121.9	135.5	135.5
Other Ancillary Staff	-	11.0	22.9	39.3	44.0	44.0
<b>Total FTEs</b>	-	<b>55.2</b>	<b>115.8</b>	<b>195.5</b>	<b>218.2</b>	<b>218.2</b>

Capital Investment Associated with Provident Reconfiguration

- The model assumes \$12M for retrofit of Provident to accommodate new ambulatory activity.

Other Ambulatory Care Initiatives

- Strategic initiative description: assumes general strengthening of ambulatory services including the following:
  - Expansion of at least two ACHN current sites (most likely Cottage Grove and Cicero) into Comprehensive Community Health Centers (CCHCs), including addition of rotating specialty physicians and some additional ancillary capability
  - Creation of a third CCHC in a new site somewhere in northwest Cook County where there is a growing concentration of uninsured patients
  - Additional support staff to strengthen all the ACHN primary care clinics
- Modeling does not assume closure of any ACHN clinics, although it is likely that as CCHHS gets into implementation phase, there may be economies of scale without loss of service from a limited number of strategic consolidations.
- Modeling assumes material growth in volumes at new CCHCs (a total of 40K additional visits at Cottage Grove and Cicero and 34K at the new Northwest site between 2013 and 2015). Expansion of ambulatory services results in the following assumed incremental volumes and staffing:

Cicero & Cottage Grove Clinics Forecasted Increase in Volume and Staffing						
Forecasted Volumes	FY10	FY11	FY12	FY13	FY14	FY15
Primary Care Visits	-	3,900	11,000	16,000	16,000	16,000
Specialty Care Visits	-	5,850	16,500	24,000	24,000	24,000
Urgent Care Visits	-	-	-	-	-	-
Total Visits	-	9,750	27,500	40,000	40,000	40,000
Forecasted FTEs						
Physicians	-	3.4	9.5	13.8	13.8	13.8
Support Staff	-	14.5	39.9	56.4	55.2	55.2
Other Ancillary Staff	-	9.2	12.3	13.2	13.2	13.2
Total FTEs	-	27.0	61.7	83.4	82.2	82.2

New Northwest Clinic Forecasted Volume and Staffing						
Forecasted Volumes	FY10	FY11	FY12	FY13	FY14	FY15
Primary Care Visits	-	-	-	1,600	12,400	16,000
Specialty Care Visits	-	-	-	1,800	13,950	18,000
Urgent Care Visits	-	-	-	-	-	-
Total Visits	-	-	-	3,400	26,350	34,000
Forecasted FTEs						
Physicians	-	-	-	1.1	8.8	11.4
Support Staff	-	-	-	4.6	35.4	45.6
Other Ancillary Staff	-	-	-	3.3	3.3	3.3
Total FTEs	-	-	-	9.1	47.6	60.4

- Model does not assume any change in payor mix and incorporates the same rates of payment growth and expense inflation as used elsewhere in model--including the additional costs of ambulatory support staff strengthening.

Capital Investment Associated with other ACHN Clinic Improvements

- Capital costs for ambulatory strengthening include:
  - \$6M for turning Cottage Grove and Cicero into CCHCs
  - \$7M for creating a new CCHC in the Northwest
  - \$9M in general rehab and refresh of remaining ACHN clinics

Improvements on Stroger Campus

- Strategic initiative description: Major items include:
  - Rebuilding of Fantus Facility
  - Investment in information system infrastructure
  - General service line strengthening, especially OB and Surgical Services
- Model assumes no additional staff costs for new Fantus clinic as it is primarily a relocation of existing services.
- Model assumes no reduction in ambulatory activity at Fantus. That is, it assumes that growth at distributed sites will be incremental to the System. (In reality, it is likely that some patients currently using Fantus will use sites closer to their home, but that new patients will come to Fantus since the backlog for services--particularly specialty services--is so large.

- Model assumes \$57M for the development of infrastructure systems that are necessary to improve access and service throughout the system. Much of this capital spending relates to updating old technologies, software and hardware which is needed to improve access, efficiencies and patient quality.

Capital Investment Associated with Stroger Improvements

- The only specific capital investment associated with strengthening of the Stroger campus is the Fantus rebuild. This is estimated at a cost of \$500/square foot for 180K square feet to be opened in 2015. This is a complete cost estimate, including such new equipment as is necessary.

**Cook County Health and Hospital System:  
Forecast after Performance Improvements and Strategic Plan**

<b>Forecast after Performance Improvement/Strategic Plan: System Rollup</b>							
<i>Annual, in 000's</i>							
	FY09	FY10	FY11	FY12	FY13	FY14	FY15
	Actual (Unaudited)	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
<b>Operating revenue</b>							
Patient Service Revenue (includes IGT)	\$ 371,262	\$ 341,996	\$ 389,617	\$ 378,540	\$ 390,314	\$ 394,080	\$ 399,963
ARRA/Stimulus Funds	36,000	38,582	3,215	-	-	-	-
NetDSH	225,000	150,000	138,000	138,000	138,000	128,000	126,000
Total Patient Service Revenue	632,262	530,578	530,832	516,540	528,314	522,080	525,963
Other revenue	3,768	5,467	5,398	5,560	5,727	5,899	6,075
Total operating revenue	636,030	536,045	536,230	522,100	534,041	527,978	532,038
<b>Operating expenses</b>							
Salaries and wages	526,330	546,911	467,308	489,923	529,649	562,240	589,492
Supplies	125,772	129,119	108,425	105,932	109,978	113,548	116,955
Purchased services, rental and other	145,293	169,342	168,300	133,175	132,591	136,701	140,802
Utilities	18,235	18,633	15,402	15,864	16,387	17,159	17,674
Total operating expenses	815,630	864,005	759,435	744,894	788,604	829,649	864,923
<b>Operating Loss</b>	<b>\$ (179,601)</b>	<b>\$ (327,960)</b>	<b>\$ (223,205)</b>	<b>\$ (222,795)</b>	<b>\$ (254,563)</b>	<b>\$ (301,671)</b>	<b>\$ (332,885)</b>
Capital requirement - Routine	-	-	(25,000)	(25,000)	(25,000)	(25,000)	(25,000)
Capital requirement - Strategic	-	-	(41,000)	(27,500)	(21,500)	(8,500)	(103,900)

<b>Forecast after Performance Improvement/Strategic Plan: Stroger Hospital</b>							
<i>Annual, in 000's</i>							
	FY09	FY10	FY11	FY12	FY13	FY14	FY15
	Actual/ Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
<b>Operating revenue</b>							
Patient Service Revenue (includes IGT)	\$ 256,830	\$ 245,393	\$ 288,625	\$ 277,257	\$ 280,828	\$ 280,804	\$ 284,441
ARRA/Stimulus Funds	26,939	29,094	1,112	-	-	-	-
NetDSH	168,368	112,245	103,265	103,265	103,265	95,782	94,286
Total Patient Service Revenue	452,136	386,732	393,002	380,523	384,093	376,587	378,727
Other revenue	3,491	5,127	5,281	5,439	5,602	5,770	5,943
Total operating revenue	455,627	391,858	398,283	385,962	389,695	382,357	384,670
<b>Operating expenses</b>							
Salaries and wages	280,238	284,917	265,658	276,154	289,903	304,339	319,494
Supplies	77,987	79,161	67,006	65,109	67,063	69,075	71,147
Purchased services, rental and other	52,700	55,359	58,304	47,426	48,200	49,646	51,135
Utilities	11,002	12,138	11,182	11,517	11,863	12,219	12,585
Total operating expenses	421,927	431,575	402,150	400,206	417,029	435,278	454,362
<b>Operating Loss</b>	<b>\$ 33,700</b>	<b>\$ (39,716)</b>	<b>\$ (3,867)</b>	<b>\$ (14,245)</b>	<b>\$ (27,334)</b>	<b>\$ (52,921)</b>	<b>\$ (69,692)</b>
Capital requirement - Routine	-	-	(17,308)	(17,308)	(17,308)	(17,308)	(17,308)
Capital requirement - Strategic	-	-	-	-	-	-	-

<b>Forecast after Performance Improvement/Strategic Plan: Provident Hospital</b>							
<i>Annual, in 000's</i>							
	FY09	FY10	FY11	FY12	FY13	FY14	FY15
	Actual/ Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
<b>Operating revenue</b>							
Patient Service Revenue (includes IGT)	\$ 40,542	\$ 31,294	\$ 36,673	\$ 31,010	\$ 31,374	\$ 31,424	\$ 31,796
ARRA/Stimulus Funds	3,726	3,726	1,044	-	-	-	-
NetDSH	23,288	15,525	14,283	14,283	14,283	13,248	13,041
Total Patient Service Revenue	67,555	50,545	52,000	45,293	45,657	44,672	44,837
Other revenue	83	114	117	121	125	128	132
Total operating revenue	67,638	50,659	52,117	45,414	45,781	44,800	44,969
<b>Operating expenses</b>							
Salaries and wages	54,910	54,371	45,479	36,716	38,582	40,543	42,602
Supplies	7,037	9,011	7,066	5,626	5,795	5,969	6,148
Purchased services, rental and other	17,862	20,082	19,761	15,139	15,358	15,819	16,294
Utilities	2,306	2,112	1,945	2,004	2,064	2,126	2,190
Total operating expenses	82,115	85,576	74,253	59,485	61,800	64,457	67,233
<b>Operating Loss</b>	<b>\$ (14,477)</b>	<b>\$ (34,917)</b>	<b>\$ (22,135)</b>	<b>\$ (14,071)</b>	<b>\$ (16,019)</b>	<b>\$ (19,657)</b>	<b>\$ (22,264)</b>
Capital requirement - Routine	-	-	(3,846)	(3,846)	(3,846)	(3,846)	(3,846)
Capital requirement - Strategic	-	-	-	-	-	-	-

**Cook County Health and Hospital System:  
Forecast after Performance Improvements and Strategic Plan**

<b>Forecast after Performance Improvement/Strategic Plan: Oak Forest Hospital</b>							
<i>Annual, in 000's</i>							
	FY09	FY10	FY11	FY12	FY13	FY14	FY15
	Actual/ Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
<b>Operating revenue</b>							
Patient Service Revenue (includes IGT)	\$ 46,573	\$ 37,173	\$ 26,756	\$ 26,831	\$ 26,992	\$ 27,067	\$ 27,230
ARRA/Stimulus Funds	5,335	5,762	1,059	-	-	-	-
NetDSH	33,345	22,230	20,452	20,452	20,452	18,970	18,673
Total Patient Service Revenue	85,253	65,165	48,266	47,282	47,444	46,037	45,903
Other revenue	193	226	-	-	-	-	-
Total operating revenue	85,447	65,391	48,266	47,282	47,444	46,037	45,903
<b>Operating expenses</b>							
Salaries and wages	60,240	59,403	9,131	9,588	10,067	10,571	11,099
Supplies	20,463	20,611	16,947	17,455	17,979	18,518	19,074
Purchased services, rental and other	10,517	11,043	9,227	5,294	2,363	2,434	2,507
Utilities	4,220	3,366	1,286	1,324	1,364	1,405	1,447
Total operating expenses	95,441	94,424	36,591	33,662	31,773	32,928	34,127
<b>Operating Loss</b>	<b>\$ (9,994)</b>	<b>\$ (29,033)</b>	<b>\$ 11,675</b>	<b>\$ 13,620</b>	<b>\$ 15,670</b>	<b>\$ 13,109</b>	<b>\$ 11,776</b>
Capital requirement - Routine	-	-	(3,846)	(3,846)	(3,846)	(3,846)	(3,846)
Capital requirement - Strategic	-	-	-	-	-	-	-

<b>Forecast after Performance Improvement/Strategic Plan: ACHN Clinics</b>							
<i>Annual, in 000's</i>							
	FY09	FY10	FY11	FY12	FY13	FY14	FY15
	Actual/ Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
<b>Operating revenue</b>							
Patient Service Revenue (includes IGT)	\$ 27,317	\$ 28,137	\$ 37,563	\$ 43,442	\$ 51,121	\$ 54,784	\$ 56,495
ARRA/Stimulus Funds	-	-	-	-	-	-	-
NetDSH	-	-	-	-	-	-	-
Total Patient Service Revenue	27,317	28,137	37,563	43,442	51,121	54,784	56,495
Other revenue	-	-	-	-	-	-	-
Total operating revenue	27,317	28,137	37,563	43,442	51,121	54,784	56,495
<b>Operating expenses</b>							
Salaries and wages	75,883	80,654	88,585	106,678	127,234	139,695	145,811
Supplies	4,200	4,408	4,226	4,952	5,968	6,418	6,611
Purchased services, rental and other	6,092	6,211	6,376	5,485	5,919	6,229	6,416
Utilities	205	408	427	440	500	796	820
Total operating expenses	86,381	91,681	99,613	117,556	139,621	153,139	159,658
<b>Operating Loss</b>	<b>\$ (59,064)</b>	<b>\$ (63,544)</b>	<b>\$ (62,050)</b>	<b>\$ (74,114)</b>	<b>\$ (88,500)</b>	<b>\$ (98,355)</b>	<b>\$ (103,163)</b>
Capital requirement - Routine	-	-	-	-	-	-	-
Capital requirement - Strategic	-	-	(25,000)	(18,000)	(10,000)	-	(92,000)

<b>Forecast after Performance Improvement/Strategic Plan: Cermak</b>							
<i>Annual, in 000's</i>							
	FY09	FY10	FY11	FY12	FY13	FY14	FY15
	Actual/ Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
<b>Operating revenue</b>							
Patient Service Revenue (includes IGT)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
ARRA/Stimulus Funds	-	-	-	-	-	-	-
NetDSH	-	-	-	-	-	-	-
Total Patient Service Revenue	-	-	-	-	-	-	-
Other revenue	-	-	-	-	-	-	-
Total operating revenue	-	-	-	-	-	-	-
<b>Operating expenses</b>							
Salaries and wages	30,704	35,402	32,352	33,643	35,345	37,133	39,011
Supplies	4,190	4,223	3,494	3,391	3,493	3,597	3,705
Purchased services, rental and other	8,927	8,134	8,186	6,562	6,663	6,863	7,069
Utilities	-	-	-	-	-	-	-
Total operating expenses	43,821	47,759	44,032	43,596	45,501	47,593	49,785
<b>Operating Loss</b>	<b>\$ (43,821)</b>	<b>\$ (47,759)</b>	<b>\$ (44,032)</b>	<b>\$ (43,596)</b>	<b>\$ (45,501)</b>	<b>\$ (47,593)</b>	<b>\$ (49,785)</b>
Capital requirement - Routine	-	-	-	-	-	-	-
Capital requirement - Strategic	-	-	-	-	-	-	-

**Cook County Health and Hospital System:  
Forecast after Performance Improvements and Strategic Plan**

<b>Forecast after Performance Improvement/Strategic Plan: Bureau of Health</b>							
<i>Annual, in 000's</i>							
	FY09	FY10	FY11	FY12	FY13	FY14	FY15
	Actual/ Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
<b>Operating revenue</b>							
Patient Service Revenue (includes IGT)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
ARRA/Stimulus Funds	-	-	-	-	-	-	-
NetDSH	-	-	-	-	-	-	-
Total Patient Service Revenue	-	-	-	-	-	-	-
Other revenue	-	-	-	-	-	-	-
Total operating revenue	-	-	-	-	-	-	-
<b>Operating expenses</b>							
Salaries and wages	8,751	15,727	11,257	11,706	12,299	12,921	13,574
Supplies	5,890	5,749	4,757	4,616	4,755	4,898	5,044
Purchased services, rental and other	45,770	64,728	62,707	50,271	51,044	52,575	54,152
Utilities	-	-	-	-	-	-	-
Total operating expenses	60,411	86,203	78,722	66,594	68,097	70,393	72,771
<b>Operating Loss</b>	<b>\$ (60,411)</b>	<b>\$ (86,203)</b>	<b>\$ (78,722)</b>	<b>\$ (66,594)</b>	<b>\$ (68,097)</b>	<b>\$ (70,393)</b>	<b>\$ (72,771)</b>
Capital requirement - Routine	-	-	-	-	-	-	-
Capital requirement - Strategic	-	-	(16,000)	(9,500)	(11,500)	(8,500)	(11,900)

<b>Forecast after Performance Improvement/Strategic Plan: Core</b>							
<i>Annual, in 000's</i>							
	FY09	FY10	FY11	FY12	FY13	FY14	FY15
	Actual/ Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
<b>Operating revenue</b>							
Patient Service Revenue (includes IGT)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
ARRA/Stimulus Funds	-	-	-	-	-	-	-
NetDSH	-	-	-	-	-	-	-
Total Patient Service Revenue	-	-	-	-	-	-	-
Other revenue	-	-	-	-	-	-	-
Total operating revenue	-	-	-	-	-	-	-
<b>Operating expenses</b>							
Salaries and wages	4,399	4,925	4,448	4,626	4,860	5,105	5,364
Supplies	5,759	5,692	4,710	4,571	4,708	4,849	4,994
Purchased services, rental and other	187	169	167	134	136	140	144
Utilities	430	535	493	507	523	538	555
Total operating expenses	10,774	11,321	9,818	9,838	10,226	10,633	11,057
<b>Operating Loss</b>	<b>\$ (10,774)</b>	<b>\$ (11,321)</b>	<b>\$ (9,818)</b>	<b>\$ (9,838)</b>	<b>\$ (10,226)</b>	<b>\$ (10,633)</b>	<b>\$ (11,057)</b>
Capital requirement - Routine	-	-	-	-	-	-	-
Capital requirement - Strategic	-	-	-	-	-	-	-

<b>Forecast after Performance Improvement/Strategic Plan: Dept of Health</b>							
<i>Annual, in 000's</i>							
	FY09	FY10	FY11	FY12	FY13	FY14	FY15
	Actual/ Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted	Forecasted
<b>Operating revenue</b>							
Patient Service Revenue (includes IGT)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
ARRA/Stimulus Funds	-	-	-	-	-	-	-
NetDSH	-	-	-	-	-	-	-
Total Patient Service Revenue	-	-	-	-	-	-	-
Other revenue	-	-	-	-	-	-	-
Total operating revenue	-	-	-	-	-	-	-
<b>Operating expenses</b>							
Salaries and wages	11,205	11,511	10,397	10,812	11,359	11,933	12,537
Supplies	245	263	218	211	218	224	231
Purchased services, rental and other	3,238	3,617	3,572	2,864	2,908	2,995	3,085
Utilities	71	75	69	71	73	75	78
Total operating expenses	14,759	15,467	14,256	13,958	14,557	15,228	15,930
<b>Operating Loss</b>	<b>\$ (14,759)</b>	<b>\$ (15,467)</b>	<b>\$ (14,256)</b>	<b>\$ (13,958)</b>	<b>\$ (14,557)</b>	<b>\$ (15,228)</b>	<b>\$ (15,930)</b>
Capital requirement - Routine	-	-	-	-	-	-	-
Capital requirement - Strategic	-	-	-	-	-	-	-