ANNUAL HOSPITAL QUESTIONNAIRE FOR 2024

This is a formal request by the Illinois Department of Public Health for full, complete and accurate information as stated herein. This request is made under the authority of the Illinois Health Facilities Planning Act [20 ILCS 3960]. Failure to respond may result in sanctions including the following:
"A person subject to this Act who fails to provide information requested by the State Board or State Agency within 30 days of a formal, written request shall be fined an amount not to exceed $1,000 for each 30-day period, or fraction thereof, that the information is not received by the State Board or State Agency". [20 ILCS 3960/14.1(b)(6)]

This questionnaire consists of two sections:
Section I
This section collects information relating to the facility, its operation and utilization.
Utilization data must be reported for the Calendar Year 2024.

Section II
This section collects financial and capital expenditure data for the facility.
This information must be reported for the most recent Fiscal Year available.

If Contact and certification fields on page 19 are not completed, the form will not be accepted.

THIS QUESTIONNAIRE MUST BE COMPLETED AND SUBMITTED BY APRIL 15, 2025.

To submit the questionnaire, attach the completed PDF form to an email to DPH.FacilitySurvey@illinois.gov Please include the words 'Annual Hospital Questionnaire' in the subject line.

Facilities failing to submit this information within the time frame specified will be reported to the Illinois Health Facilities and Services Review Board for its consideration of the imposition of sanctions as mandated by the Act.

If you have problems or questions related to this data collection form, please contact this office by telephone at 217/782-3516, or by email to DPH.FacilitySurvey@illinois.gov

Thank you for your cooperation.

FACILITY INFORMATION

Facility IDPH License Number

Facility Name

Facility Address

Facility City

Facility Zip Code

Facility FEIN Number

Legal Entity which operates the facility

Legal Entity which owns the physical plant

FACILITY OWNERSHIP AND OPERATION

Is your ENTIRE hospital characterized as any of the following? (Check applicable selection)

- ◯ General Hospital
- ◯ Rehabilitation Hospital
- ◯ Children's Specialty Care Hospital
- ◯ Psychiatric Hospital

Is your ENTIRE facility CERTIFIED by the Center for Medicare and Medicaid Services (CMS) as either of the following? (Check applicable certification)

- ◯ Critical Access Hospital
- ◯ Long-Term Acute Care Hospital (LTACH)

Indicate the type of organization managing this hospital (Mark only one selection)

FOR PROFIT

- ◯ Corporation
- ◯ Limited Partnership
- ◯ Limited Liability Partnership
- ◯ Limited Liability Company
- ◯ Other For Profit (please specify below)

GOVERNMENT

- ◯ County
- ◯ City
- ◯ Township
- ◯ Hospital District
- ◯ Other Government (please specify below)

NOT FOR PROFIT

- ◯ Church-Related
- ◯ Corporation (Not Church-Related)
- ◯ Other Not for Profit (please specify below)

Other Ownership Details

Under Section 501(r)(3), a hospital organization must conduct a community health needs assessment (CHNA) at least once every three taxable years. The statute also requires that a hospital organization widely publicize the results of the CHNA to the public served by the hospital.

If you facility has prepared a CHNA, please provide one of the following:

1. If you have posted a copy of your CHNA on the Internet, please provide the URL for the document or web page where the document can be accessed:

2. If the CHNA is not posted online, please submit a copy of the CHNA by email to DPH.FacilitySurvey@illinois.gov

Please indicate any contacts for management of listed hospital services:

	Management Contractor
Emergency Services	
Psychiatric Services	
Rehabilitation Services	

Please provide the following information regarding the Calendar Year 2024 utilization of all categories of service your hospital is authorized to provide:

NOTE: OBSERVATION DAYS are defined as days provided to outpatients prior to admission for the purpose of determining whether a patient requires admission as an inpatient. Observation Days = Observation Hours ÷ 24.

PEAK BEDS SET UP AND STAFFED is defined as the highest number of authorized service beds available for inpatient use at any point in the Calendar Year.

PEAK CENSUS is defined as the highest number of inpatients being provided care at any point in the Calendar Year.

MEDICAL-SURGICAL CATEGORY OF SERVICE
If your facility has an authorized Pediatrics care unit, report that utilization in section B below.

	Admissions	Inpatient Days	Beds Set Up and Staffed Oct. 1, 2024	Peak Beds Set Up and Staffed	Peak Daily Census	Observation Days in Unit
0-14 Years	0	0				
15-44 Years	0	0				
45-64 Years	0	0				
65-74 Years	0	0				
75 Years or more	0	0				
TOTALS	0	0	0	0	0	0

PEDIATRICS CATEGORY OF SERVICE
Pediatric Care is defined as non-intensive Medical-Surgical care for inpatients aged 0-14 years.

	Admissions	Inpatient Days	Beds Set Up and Staffed Oct. 1, 2024	Peak Beds Set Up and Staffed	Peak Daily Census	Observation Days in Unit
Pediatrics	0	0	0	0	0	0

INTENSIVE CARE CATEGORY OF SERVICE
Neonatal Intensive Care is not to be included here; report it in the Neonatal Level III section below.
If an inpatient is sent directly into Intensive Care upon admission, report that patient as Directly Admitted to ICU.
If an inpatient is admitted into a different category of service and later transferred into ICU, report that inpatient as Transferred into ICU.

	Admissions	Inpatient Days	Beds Set Up and Staffed Oct. 1, 2024	Peak Beds Set Up and Staffed	Peak Daily Census	Observation Days in Unit
Directly Admitted into ICU	0	0				
Transferred into ICU*	0	0				
Total Intensive Care	0	0	0	0	0	0

*Inpatients transferred into ICU are not counted as additional admissions to the hospital.

OBSTETRICS CATEGORY OF SERVICE
Obstetrics care includes both Ante-Partum and Post-Partum. Clean Gynecology is non-maternity care.

	Admissions	Inpatient Days	Beds Set Up and Staffed Oct. 1, 2024	Peak Beds Set Up and Staffed	Peak Daily Census	Observation Days in Unit
Obstetrics	0	0				
Clean Gynecology	0	0				
Total Obstetrics/Gyne	0	0	0	0	0	0

NEONATAL LEVEL III (NEONATAL INTENSIVE CARE) CATEGORY OF SERVICE						
	Admissions	Inpatient Days	Beds Set Up and Staffed Oct. 1, 2024	Peak Beds Set Up and Staffed	Peak Daily Census	Observation Days in Unit
Neonatal Intensive Care	0	0	0	0	0	0

LONG-TERM NURSING CARE CATEGORY OF SERVICE						
	Admissions	Inpatient Days	Beds Set Up and Staffed Oct. 1, 2024	Peak Beds Set Up and Staffed	Peak Daily Census	Observation Days in Unit
Long-Term Care	0	0	0	0	0	0

LONG-TERM CARE SWING BEDS (MEDICARE-CERTIFIED)						
	Admissions	Inpatient Days			Peak Daily Census	
LTC Swing Beds	0	0			0	

ACUTE MENTAL ILLNESS CATEGORY OF SERVICE						
	Admissions	Inpatient Days	Beds Set Up and Staffed Oct. 1, 2024	Peak Beds Set Up and Staffed	Peak Daily Census	Observation Days in Unit
Adolescent (0-17 years)	0	0	0	0	0	0
Adult (18 years +)	0	0	0	0	0	0
Total Acute Mental Illness	0	0	0			0

REHABILITATION CATEGORY OF SERVICE						
	Admissions	Inpatient Days	Beds Set Up and Staffed Oct. 1, 2024	Peak Beds Set Up and Staffed	Peak Daily Census	Observation Days in Unit
Rehabilitation	0	0	0	0	0	0

LONG-TERM ACUTE CARE CATEGORY OF SERVICE						
	Admissions	Inpatient Days	Beds Set Up and Staffed Oct. 1, 2024	Peak Beds Set Up and Staffed	Peak Daily Census	Observation Days in Unit
Long-Term Acute Care	0	0	0	0	0	0

TOTAL FACILITY UTILIZATION						
	Admissions	Inpatient Days	Beds Set Up and Staffed Oct. 1, 2024			Observation Days in Unit
FACILITY TOTALS	0	0	0			0

DEDICATED OBSERVATION UNIT	
Dedicated Observation Beds	0
Dedicated Observation Days	0

Hospital in the Home

For a hospital that has been approved for HOSPITAL IN-HOME SERVICES, please provide the following:

Total Number of Patients that received hospital in the home services in 2024:

Total Number of Patient Days in 2024:

Provide the Top 10 Diagnosis Codes for these patients:

INPATIENT UTILIZATION BT RACIAL GROUP AND ETHNICITY

Report the number of inpatients admitted to the hospital and the number of inpatient days of care provided during Calendar Year 2024 by the Racial Group and Ethnicity of the inpatient. The total inpatients and patient days of care must be the same for the racial and ethnic totals, and must equal the total admissions and inpatient days reported in the previous section:

RACIAL GROUPS

	Inpatients	Inpatient Days
Asian	0	0
American Indian/ Native Alaskan	0	0
Black/African-American	0	0
Native Hawaiian/ Pacific Islander	0	0
White	0	0
Race Unknown	0	0
TOTALS	0	0

ETHNICITY

	Inpatients	Inpatient Days
Hispanic/Latino	0	0
Not Hispanic	0	0
Ethnicity Unknown	0	0
TOTALS	0	0

OUTPATIENTS SERVED

Report all outpatient visits for service, including emergency, surgical, radiological, etc., provided/billed by the hospital:

Outpatient Visits at Hospital/Hospital Campus	0
Outpatient Visits to facilities off site / off campus	0
TOTAL OUTPATIENT VISITS	0

Report the inpatients and outpatients served during Calendar Year 2024 by the Primary Source of Payment Total inpatients and outpatients must equal previously reported total admissions and outpatient visits.

	MEDICARE	MEDICAID	OTHER PUBLIC	PRIVATE INSURANCE	PRIVATE PAYMENT	TOTALS BY PAYMENT	TOTALS INCLUDING CHARITY CARE
INPATIENTS	0	0	0	0	0	0	0
OUTPATIENTS	0	0	0	0	0	0	0

OTHER PUBLIC payment includes all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH/DD, VA and other public programs paying directly to the facility should be included in this category.
PRIVATE PAYMENT includes all payments from private accounts (such as medical savings accounts) and any out-of-pocket payments, including government payments made out to the patient, then transferred to the facility

CHARITY CARE PATIENTS

Report inpatients and outpatients where Charity Care made up more than half of the cost of services provided:

	INPATIENTS	OUTPATIENTS
	0	0

CHARITY CARE means care provided by the facility for which the provider does not expect to receive payment from the patient or a third-party payer. [20 ILCS 1960/3]. Charity Care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, or other Federal, State or local indigent health care programs.

SURGICAL PROCEDURES – OPERATING ROOMS (Class C*)

Please report the number of operating rooms (ORs) by type, surgical cases by type, and surgical hours by type for your facility. Report each operating room only ONCE. If an operating room is dedicated to one category of surgery, report it under that category; if a room is used for more than one type of surgery, report it under General Surgery. A Combined OR is one used for both inpatient and outpatient procedures, NOT the sum of inpatient and outpatient ORs.

A Surgical Case is defined as a patient encounter in a surgical setting; if 3 surgical procedures are performed on a patient in one OR session, that would count as 1 Surgical Case, unless the procedures were for different surgical categories.

When reporting Surgical Hours include time spent in setting up, actual surgery time, and clean-up time for each surgical category. Round the times to the nearest hour (For example, a total of 318 hours and 40 minutes would be rounded to 319 hours.

	Operating Rooms (Class C*)				Surgical Cases		Surgical Hours		
SURGICAL CATEGORY	Inpatient	Outpatient	Combined	Total	Inpatient	Outpatient	Inpatient	Outpatient	TOTAL
Cardiovascular	0	0	0	0	0	0	0	0	0
Dermatology	0	0	0	0	0	0	0	0	0
General Surgery	0	0	0	0	0	0	0	0	0
Gastroenterology	0	0	0	0	0	0	0	0	0
Neurology	0	0	0	0	0	0	0	0	0
Obstetrics/Gynecology	0	0	0	0	0	0	0	0	0
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0
Ophthalmology	0	0	0	0	0	0	0	0	0
Orthopedic	0	0	0	0	0	0	0	0	0
Otolaryngology	0	0	0	0	0	0	0	0	0
Plastic	0	0	0	0	0	0	0	0	0
Podiatry	0	0	0	0	0	0	0	0	0
Thoracic	0	0	0	0	0	0	0	0	0
Urology	0	0	0	0	0	0	0	0	0
TOTALS	0	0	0	0	0	0	0	0	0

*Class C operating rooms are defined as a setting designed and equipped for major surgical procedures that require general or regional block anesthesia and support of vital bodily functions. (Source: Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons)

SURGICAL PROCEDURES – Class B*, Invasive, non-OR

For each listed procedure category, please report the number of dedicated Class B* procedure rooms by type, the number of procedure cases by type, and the number of procedure hours, including time spent in setting up the room(s, the actual procedure time, and the time spent in cleaning up the room for each surgical category. Round the times to the nearest hour (For example, a total of 318 hours and 40 minutes would be rounded to 319 hours.

If your facility has non-dedicated, multipurpose procedure rooms, use the lines under Multipurpose to report those procedures. Indicate the type of procedure, with number of cases of that type and procedure hours, including set-up, procedure and clean-up times, for each procedure type performed in the multipurpose room(s. Indicate the total number of multipurpose procedure rooms in the TOTALS line.

NOTE – For reporting purposes, a procedure case is defined as a PATIENT TREATED. If a patient has 3 procedures within the same category performed, that would count as 1 CASE. If there are different categories of procedures performed for an individual patient, report each type of case by category.

	Dedicated Procedure Rooms – Class B*				Procedure Cases		Procedure Hours		
	Inpatient	Outpatient	Combined	TOTAL	Inpatient	Outpatient	Inpatient	Outpatient	TOTAL
Dedicated Gastro-Intestinal	0	0	0	0	0	0	0	0	0
Dedicated Laser Eye	0	0	0	0	0	0	0	0	0
Dedicated Pain Management	0	0	0	0	0	0	0	0	0
Dedicated Cystoscopy	0	0	0	0	0	0	0	0	0

MULTIPURPOSE ROOMS (Specify Procedure Type)						
		0	0	0	0	0
		0	0	0	0	0
		0	0	0	0	0
		0	0	0	0	0
		0	0	0	0	0
		0	0	0	0	0
TOTAL MULTIPURPOSE ROOMS	0					

*Class B Procedure Rooms are defined as a setting designed and equipped for major or minor surgical procedures performed in conjunction with oral, parenteral or intravenous sedation or under analgesic or dissociative drugs. (Source: Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons)

SURGICAL RECOVERY STATIONS

Report the number of surgical recovery stations by type at your facility

Stage 1 – Post-Anesthesia Recovery Stations	0
Stage 2 – Step-Down Ambulatory Recovery Stations	0

LABOR, DELIVERY AND RECOVERY – NEWBORN CARE:

Please report the following information

Labor-Delivery-Recovery Rooms		Births		C-Sections	
Labor Rooms	0	Total Deliveries	0	C-Section Rooms	0
Delivery Rooms	0	Live Births	0	C-Sections Performed	0
Birthing Rooms	0	Newborn Care*	Level I	Level II	Level II+
LDR Rooms	0	Beds	0	0	0
LDRP Rooms	0	Patient Days	0	0	0

As defined by the Perinatal Advisory Committee.

ORGAN TRANSPLANTATION

Does your facility perform organ transplants? ◯ YES ◯ NO

If so, report the number of transplants by type performed in Calendar year 2024:

Heart	Heart/Lung	Lung	Kidney	Liver	Pancreas
0	0	0	0	0	0

CARDIAC SURGERY – OPEN HEART SURGERY

Report the following for cardiac surgery:

Cardiac Surgeries by Age Group	
0-14 Years Old	0
15 Years and Over	0
TOTALS	**0**
Coronary Artery Bypass Grafts (CABGs)	0

CARDIAC CATHETERIZATION

Report the following information for cardiac catheterization

Cardiac Catheterization	
Total Cardiac Catheterization Labs	0
Dedicated Diagnostic Labs	0
Dedicated Interventional Labs	0
Dedicated Electro-Physiological Labs	0
Labs used for Angiography procedures	0

Catheterization Procedures by Type		
	Age 0-14	Age 15+
Diagnostic	0	0
Interventional	0	0
Electro-Physiological (EP)		0
Total Cardiac Catheterizations		**0**

EMERGENCY CARE

For your hospital's Emergency services, please answer the following:

What category of Emergency services do you provide (as defined by the Illinois Hospital Licensing Act

◯ Comprehensive ◯ Basic ◯ Stand-by

How many stations do you have in your Emergency Room (ER)? 0

How many Emergency Room visits did you have in Calendar Year 2024? 0

How many of these Emergency Room visits resulted in an admission to the hospital? 0

IF YOUR FACILITY OWNS/OPERATES A FREE-STANDING EMERGENCY CENTER, PLEASE REPORT THE FOLLOWING:

How many Treatment Rooms/Stations does the Free-Standing Emergency Center operate? 0

How many Emergency visits to the Free-Standing Center occurred in Calendar Year 2024? 0

How many of these visits resulted in an admission to the hospital? 0

TRAUMA

Is your hospital designated as a Trauma Center by Emergency Medical Services? ◯ YES ◯ NO

If YES, indicate the Level and Type of Trauma Center

LEVEL 1 ◯ Adult ◯ Child ◯ Both Adult and Child

LEVEL 2 ◯ Adult ◯ Child ◯ Both Adult and Child

How many Operating Rooms does your facility have dedicated/reserved for Trauma Care? 0

How many Trauma visits did you have in Calendar Year 2024? 0

How many of these Trauma visits resulted in an admission to the hospital? 0

LABORATORY STUDIES

Report the number of laboratory studies performed for inpatients (excluding newborns) and outpatients during Calendar Year 2024. A Laboratory Study is defined as a billable examination, such as CBC, lipid profile, etc. A series of laboratory tests performed on a patient in one visit is considered to be a single laboratory study.

Inpatient Laboratory Studies 0

Outpatient Laboratory Studies 0

Many hospitals have standing contracts with private laboratories to perform laboratory studies. If you hospital has such a contract, please report the number of laboratory studies performed under this contract

Laboratory Studies Performed Under Contract (Referrals) 0

HOSPITAL DIAGNOSTIC AND THERAPEUTIC EQUIPMENT

Indicate the number of pieces of equipment your hospital owned/leased on-site during Calendar Year 2024, and the number of examinations/treatments performed using this equipment during Calendar Year 2024. Please report EXAMINATIONS (NOT patients. If an individual patient had several examinations during the course of the year, EACH examination is counted separately. We want to know the number of times the piece of equipment was used. If the hospital has a contract with an equipment supplier to provide services on the hospital campus, those examinations/ treatments are to be listed in the Contractual Agreement columns.

			EXAMINATIONS/PROCEDURES			
	PIECES OF EQUIPMENT				CONTRACTUAL AGREEMENT	
DIAGNOSTIC/IMAGING	OWNED	CONTRACTED	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT
General Radiology/ Fluoroscopy	0	0	0	0	0	0
Nuclear Medicine	0	0	0	0	0	0
Mammography	0	0	0	0	0	0
Ultrasound	0	0	0	0	0	0
CT Tomography	0	0	0	0	0	0
PET Tomography	0	0	0	0	0	0
Magnetic Resonance Imaging (MRI)	0	0	0	0	0	0
Angiography Equipment	0	0				
Diagnostic			0	0	0	0
Interventional			0	0	0	0

THERAPEUTIC	OWNED	CONTRACTED	TREATMENTS
Lithotripters	0	0	0
Radiation Therapy			
Linear Accelerators	0	0	0
IGRT Treatments			0
IMRT Treatments			0
High Dose Brachytherapy	0	0	0
Proton Beam Therapy	0	0	0
Gamma Knife	0	0	0
Cyber Knife	0	0	0

For contracted equipment reported above, please indicate the type of equipment and the contractor

Type of Equipment	Company or Individual Supplying Equipment

FINANCIAL INFORMATION AND CAPITAL EXPENDITURES FOR FISCAL YEAR

Please report the following for the Most Recent Available Facility Fiscal Year:

Financial records which may be used to report this information include Audited Financial Statements, Review or Compilation Financial Statements, and Tax Return Documents.

Please indicate the Starting Date and Ending Date for the Fiscal Year used for this report:

Starting Date Ending Date

Please indicate the Financial Records used as the source of the reported data (select using drop-down):

Audited Financial Records

CAPITAL EXPENDITURES

Capital expenditures are defined as "Any expenditure : (A) made by or on behalf of a health care facility …….and (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made to obtain by lease or comparable arrangement any facility or part there of or any equipment for a facility or part… and includes the cost of any studies, surveys, designs, plans, working drawings, specification and other activities essential to the acquisition, improvement, expansion or replacement of any plant or equipment with respect to which an expenditure is made… and includes donations of equipment of facilities or a transfer of equipment or facilities at fair market value."

Please report the TOTAL CAPITAL EXPENDITURES DURING YOUR REPORTING YEAR: $ 0.00

Please provide the following information ONLY FOR PROJECTS/EXPENDITURES IN EXCESS OF $350,000 financially committed by, or on behalf of, the facility during the reporting year. If you need to report additional expenditures, please email the additional information to DPH.FacilitySurvey@illinois.gov.

Description of Project/Expenditure	Amount Obligated	Method of Financing	CON Project Number
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		

CAPITAL EXPENDITURES TO FEMALE-OWNED, MINORITY-OWNED, VETERAN-OWNED AND SMALL BUSINESS ENTERPRISES

Under the provisions of the Illinois Health Facilities Planning Act (20 ILCS 3960/5.3 (b) (2)), **any hospital having more than 100 authorized beds, and having any capital expenditures in excess of $350,000 for the erection, building, alteration, reconstruction, modernization, improvement, extension, or demolition of or by the hospital,** is required to complete this section of the annual hospital questionnaire (items A through J). The hospital may include capital expenditures below the $350,000 threshold, if desired.

A health care system may develop a system-wide annual report that includes all hospitals in order to comply with this requirement. If the health care system chooses to report in this manner, please indicate the health care system as the reporting entity. The health care system shall use as much State-specific data as possible in this report. If State-specific data is not available, the health care system shall include national data and explain why State-specific data is not available, and what steps the system will take to provide State-specific data in future reports.

If information pertaining to the open-ended questions in this section is currently available for the hospital or health care system on-line, the hospital or health care system may provide the on-line reference for the pertinent information.

Hospital or Health Care System*	
Contact Person for this Section	
Contact Telephone	
Contact E-Mail	

* If the reported information is for a Health Care System, please indicate in the space below the hospitals included in the Health Care system.

If the reporting entity cannot provide all State-specific data, explain why State-specific data is not available, and what steps will be taken to provide State-specific data in future reports:

Please provide the following information based on your hospital or health system's most recently completed fiscal year

For this section, **Qualifying capital expenditures** include "only expenditures ... for the erection, building, alteration, reconstruction, modernization, improvement, extension, or demolition of or by a hospital" [20 ILCS 3960/5.3(b)(1)].

A. What was your organization's goal for qualifying capital expenditures to the following categories of businesses?

	Percentage
Female-Owned Businesses	0.0 %
Minority-Owned Businesses	0.0 %
Veteran-Owned Businesses	0.0 %
Small Business Enterprises	0.0 %

B. What was the amount of your organization's total qualifying capital expenditures for the reporting period? **If your organization had no qualifying capital expenditures, proceed to question D.**

Total Qualifying Capital Expenditures for the Reporting Period (Dollars)	$	1.00

C. What amount of your organization's qualifying capital expenditures actually were to the following types of businesses?

	Actual Amount Expended (Dollars)	Percentage of Total (Calculated)
Female-Owned Businesses	$ 0.00	0.00 %
Minority-Owned Businesses	$ 0.00	0.00 %
Veteran-Owned Businesses	$ 0.00	0.00 %
Small Business Enterprises	$ 0.00	0.00 %

D. For what type or types of qualifying capital expenditures is/are your organization actively seeking supplier diversity?

CAPITAL EXPENDITURES TO FEMALE-OWNED, MINORITY-OWNED, VETERAN-OWNED AND SMALL BUSINESS ENTERPRISES

E. What is your organization's plan for alerting and encouraging enterprises of your efforts to promote supplier diversity in your planned qualifying capital expenditures?

F. What challenges has your organization encountered in its efforts to promote and encourage supplier diversity?

G. What could the Illinois Health Facilities and Services Review Board do to assist your efforts to increase supplier diversity?

H. What certifications does your organization recognize in the recruitment of diversely-owned vendors/suppliers?

CAPITAL EXPENDITURES TO FEMALE-OWNED, MINORITY-OWNED, VETERAN-OWNED AND SMALL BUSINESS ENTERPRISES

I. How should a potential vendor/supplier contact your organization (point of contact)?

J. How would a vendor/supplier enroll with your organization to be recognized as a vendor/supplier of diversity ownership?

K. Do you have particular examples of successful recruitment of diversely-owned vendors/suppliers which could be instructive to other organizations to emulate in their efforts to recruit diversely-owned vendors/suppliers?

INPATIENT AND OUTPATIENT NET REVENUES BY SOURCE FOR THE FACILITY FISCAL YEAR

NET REVENUE	MEDICARE	MEDICAID	OTHER PUBLIC*	PRIVATE INSURANCE	PRIVATE PAYMENT	TOTALS
INPATIENT	$ 0	$ 0	$ 0	$ 0	$ 0	**$ 0**
OUTPATIENT	$ 0	$ 0	$ 0	$ 0	$ 0	**$ 0**

OTHER PUBLIC payments include all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH/DD, VA and other public payments directly to the facility should be included in this amount.

PRIVATE IINSURANCE includes any payments made through private health insurance policies.

PRIVATE PAYMENT includes money from a private account, such as a Medical Savings Account, and any out-of-pocket payments. Any government funding paid to the patient which is then transferred to the facility should be included.

CHARITY CARE SERVICES PROVIDED VALUED AT COST

	INPATIENTS	OUTPATIENTS
CHARITY CARE SERVICES PROVIDED AT COST	$ 0	$ 0

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 does NOT include bad debts or the unreimbursed cost of Medicare, Medicaid or other Federal, State or local indigent health care programs, eligibility for which is based on financial need.

In reporting Charity Care, the facility must report the amount of care provided based on cost, not charges (per CMS 2552-96 Worksheet C, Part 1, PPS Inpatient Ratios)

As per the American Institute of Certified Public Accountants (AICPA) standards, charity care can be determined at any time during the process.

INFECTION PREVENTION AND CONTROL

Please provide the following information regarding Infection Prevention and Control staff. If a staff member fills multiple positions, use the percentage of their time that is devoted to Infection Prevention and Control, e.g., if a staff member spends 2 days a week working on Infection Control and 3 days a week working on Employee Health, only 2 days per week, or 0.4 FTE, shoudl be counted for Infection Prevention and Control activities. Categories of employees to exclude: administrative support and data entry personnel and physician hospital epidemiologists.

Infection Prevention and Control Staff	FTEs
How many full-time equivalent staff (FTEs) were employed in your facility's infection prevention and control department, as of December 31, 2024?	
How many of the FTEs indicated in the previous question were filled by an individual who is certified in infection control (CIC), as determined by the Certification Board in Infection Control, as of December 31, 2024?	

CONTACT FOR INFECTION PREVENTION AND CONTROL INFORMATION

Please provide a contact person for information regarding Infection Prevention and Control efforts at your facility. If you have any comments pertaining to Infection Control and/or your efforts in this area, please enter them into space provided.

Name	
Telephone	
Email	

LACTATION SPECIALIST SERVICES

Does your hospital employ a Lactation Specialist or Specialists? ◯ YES ◯ NO

If yes, is a Specialist available to the Maternity unit for breast feeding support? ◯ YES ◯ NO

Please provide the following information concerning specially trained or certified Breast Feeding support staff. If a staff member fills multiple positions or is employed part-time, use the percentage of their time devoted to dedicated Breast Feeding support services. For example, if a support staff member devotes 12 hours of a weekly 40 hour schedule to support, then that individual should be counted as 12/40 = 0.3 of a full-time support staff. Categories of employment to exclude: Administrative support and data entry personnel.

Lactation Specialists	Full-Time Equivalents (FTEs)
As of December 31, 2024, how many specially trained or certified full-time equivalent (FTE staff were employed in your facility who devote dedicated time and responsibility for educating and supporting women with breast feeding?	0
As of December 31, 2024, how many of the full-time equivalents (FTEs) indicated above were filled by an individual who was board-certified in Breast Feeding consultation by the International Board of Lactation Consultant Examiners?	0

BREAST IMAGING SERVICES

Which, if any, of the following breast imaging equipment does your hospital currently have in service, and how many procedures were performed with this equipment during Calendar Year 2024?

Mammography Equipment	
Pieces of Equipment	0
Screening Mammogram procedures	0
Diagnostic Mammogram Procedures	0
Breast Ultrasound Equipment	
Pieces of Equipment	0
Breast Ultrasound procedures	0
Ultrasound-guided Breast Biopsy procedures	0
Stereotactic Biopsy Equipment	
Pieces of Equipment	0
Stereotactic Biopsy procedures	0
Breast Magnetic Resonance Imaging (MRI)	
Pieces of Equipment	0
Breast MRI procedures	0

If your hospital did not have any of the above equipment or procedures performed, please indicate by checking this box:

☐ No Breast Imaging Equipment or Procedures

CONTACT INFORMATION AND DATA CERTIFICATION

Please provide the following contact information for the administrator of this facility:

Administrator Name	
Administrator Job Title	
Administrator Telephone	
Administrator Email	

Please provide the following contact information for the individual responsible for completion of this form:

Contact Person Name	
Contact Person Job Title	
Contact Person Telephone	
Contact Person Email	

By completing this certification, you agree to the following statement

CERTIFICATION OF DATA CONTAINED IN THIS FORM

Pursuant to the Health Facilities Planning Act [20 ILCS 3960/13], the State Board requires "all health facilities operating in the State of Illinois to provide such reasonable reports at such times and containing such information as is needed" by the Board to carry out the purposes and provisions of this Act. The individual named below certifies that he/she has reviewed this document, that he/she is authorized to make this certification on behalf of this facility, and that the information contained in this report is accurate, truthful and complete to the best of his/her knowledge and belief. Please note that the State Board will be relying on the information contained in this document as being truthful and accurate information. Any misrepresentation will be considered material.

☒ I certify that the information in this report is accurate, truthful and complete to the best of my knowledge.

Person Certifying _____

Job Title _____ Certification Date _____

If you have any comments regarding this survey or the information contained herein, please enter them below:

To submit the questionnaire, attach the completed PDF form to an email to DPH.FacilitySurvey@illinois.gov
Please include the words 'Hospital Questionnaire' in the subject line.
This questionnaire is due by Friday, April 15, 2024.

Term	Definition	Comments
Authorized Hospital Bed Capacity (CON)	Number of beds recognized for planning purposes at a hospital facility, as determined by HFSRB and licensed by Illinois Department of Public Health.	According to Administrative Rule 1100.220
Annual Admissions	Number of patients accepted/admitted for inpatient service during a 12-month period.	According to Administrative Rule 1100.220
Annual Inpatient Days	"Inpatient Days" means the total number of days of service provided to inpatients in a facility over a 12-month period. Inpatient days of care are counted as beds occupied at the time the daily census is counted. Total Inpatient days is Inpatient days+ Observation days	According to Administrative Rule 1100.220
Average Length of Stay (ALOS)	Over a 12-month period the average duration of inpatient stay expressed in days as determined by dividing total inpatient days by total admissions.	According to Administrative Rule 1100.220
Average Daily Census	Over a 12-month period the average number of inpatients receiving service on any given day.	According to Administrative Rule 1100.220
Category of Service: a. Medical-Surgical	Assemblage of inpatient beds of M/S categories and Age groups include 15 and over usually. If a hospital has an authorized pediatric unit, report the 0-14 years utilization under the pediatric category. Then M/S under 0-14 category should be zero.	According to Administrative Rule 1110.520. If your facility operates telemetry beds, they should be part of Med/ Surg beds. Please note: They cannot be considered as an add-on

	If the facility is not authorized for pediatric beds then the utilization should be reported under Med-Surg 0-14 years.	to existing Med-Surg beds that your facility is authorized for.
b. Neonatal ICU (NICU)	NICU is a designated Level III nursery as designed by the IL Perinatal Advisory Committee.	According to Administrative Code 1110.920
	NICU is designed, equipped and operated to deliver care to high risk infants identified in the neo-natal period.	According to 77 IL Administrative Code 640 – Regionalized Perinatal Healthcare code.
c. Obstetrics/Gynecology (OB/Gyn)	OB/Gyn unit designed, equipped, organized and operated in accordance with Hospital License Act.	According to Administrative Rule 1110.520
	i. Maternity care is subcategory of obstetric. Medical care of a patient prior to and during the act of giving birth either to a living child or a dead fetus. Provides care to both patient and newborn infant under the direction of medical personnel.	According to Administrative Rule 1110.520 subsection (b)(3)
	ii. Gynecology (clean Gynecology) is deals with gynecological, surgical medical cases which are admitted to a post partum section of an obstetric (maternity) unit.	According to Administrative Rule 1110.520 subsection (b)(5)
d. Pediatric	Entire facility or distinct unit of a facility which is designed, equipped, organized and operated	According to Administrative Rule 1110.520

	to provide non intensive medical surgical care to 0-14 years of age.	
e. Intensive Care Unit	Designed, equipped, organized and operated to deliver optimal medical care for critically ill. Includes all age groups. The Intensive Care category of service includes sub categories Like MICU, SICU, CCU, PICU etc.	According to Administrative Rule 1110.520 Burn beds are part of intensive care unit and have been added to the ICU inventory (effective Feb 15, 2003)
f. Comprehensive Rehabilitation (Rehab)	Comprehensive rehabilitation is a special referral unit which is designed, equipped, organized and operated to deliver inpatient rehabilitation services.	According to Administrative Rule 1110.620
g. Acute/Chronic Mental Illness (AMI)	Acute Mental Illness is a distinct unit in a facility designed, equipped, organized and operated to deliver inpatient and supportive acute AMI treatment services. AMI is typified by an average length of stay of 45 days or less for adults and 60 days or less for children and adolescents.	According to Administrative Rule 1110.720
Cardiac Catheterization Laboratory	Cardiac Cath lab is a distinct lab that is staffed equipped and operated solely for the provision of dedicated or non-dedicated cardiac diagnostic, interventional and electrophysiology procedures.	

a. Diagnostic Cardiac Cath Lab (DCC)	Labs where dedicated catheterization procedures associated with determining the blockage of blood vessels and the diagnosis of cardiac diseases that are performed	
b. Interventional Cardiac Cath Lab (ICC)	Labs where percutaneous coronary interventional procedures are performed	
c. Angio or Multiuse Labs	Lab that has equipment, staff, and support services required to perform other angiographic procedures.	
Cardiac catheterizations a. Diagnostic and Interventional Cardiac Catheterization	Diagnosis and/or treatment of cardiac diseases associated with the blockage or narrowing of the blood vessels and diseases of the heart. Cardiovascular interventions include but not limited to Percutaneous Transluminal Coronary Angioplasty (PTCA), rotational atherectomy, directional atherectomy, extraction atherectomy, laser angioplasty, implantation of intracoronary stents and other catheter devices for treating coronary atherosclerosis.	According to Administrative Rule 1110.1320
b. Electrophysiology Studies (EPS)	Electrophysiology studies are conducted to determine the focus of arrhythmias in the heart.	

Cardiac Surgery	Cardiac Surgery is surgical procedure or procedures on heart and thoracic great vessels performed on a patient during a single session in a cardiac surgery operating room including but not limited to coronary artery bypass graft, myocardiac revascularization, aortic and mitral valve replacement, ventricular aneurysm repair, and pulmonary valvuloplasty. All interventional cardiac procedures performed on a patient during one session in the laboratory (one patient visit equals one intervention regardless of number of procedures performed.)	For purposes of this section, cardiac surgery does not include heart transplantation and diagnostic and interventional cardiac catheterization.
Charity Care	**"Charity Care"** is defined as care for which the provider does not expect to receive payment from the patient or a third party payor. Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other Federal, State, or local indigent health care programs, eligibility for which is based on financial need. In reporting charity care, the reporting entity must report the actual cost of services provided, based on the total cost to charge ratio derived	CMS 2552-96 Worksheet C, Part 1 PPS

	from the hospital's Medicare cost report (CMS 2552-96 Worksheet C, Part 1 PPS Inpatient Ratios), and not the actual charges for the services.	
Actual cost of services provided to charity care patients	Include the dollar amount spent by the facility to care for the charity care inpatients and outpatients. **Medicare Cost to Charge Ratio** dollar value should be used while figuring this amount.	Actual cost of service to be reported.
Diagnostic/Imaging Equipment a. Hospital Owned	Equipment that is purchased through capital dollars under the hospital's accounting measures.(value may depreciate)	It is considered to be Fixed/Owned
b. Contracted	Equipment that is contracted through a vendor which is paid through operating dollars. This would include system within a mobile trailer	
Diagnostic/ Imaging a. Fluoroscopy	Imaging technique or procedure used to get real time moving of internal structures.	Used in OB/Gyn, vascular, cardiac (ECHO cardiogram) etc areas often.
b. Nuclear Medicine	Branch of medical imaging that uses radioisotopes (radionuclides) in the disease diagnosis	According to American College of Radiologists (ACR)
c. Ultrasound	Is a diagnostic medical imaging technique using high frequency sound	

	waves to get visual images of internal organs. Unlike X-rays these do not involve exposure to radiation.	
d. CT Tomography	It is also a non-invasive medical imaging employing tomography. It is of much use in bodily structures based on their ability to block Rontgen/X-ray beams.	
e. PET Tomography	Positron Emission Tomography is a nuclear medicine imaging technique producing 3-D images of functional processes in the body. The system detects pairs of gamma rays emitted indirectly by a positron-emitting radionuclide (tracer), which is introduced into the body.	
f. Mammography	Is a diagnostic procedure/ exam in which low dose amplitude –X rays are utilized to examine the human breast.	
g. Magnetic Resonance Imaging (MRI)	Non-invasive medical imaging technique used in radiology to visualize the structure and function of the body. Has much greater precision than CT on soft tissues. Offers greater uses in Neurology and Oncology. MRI uses magnetic fields and not ionizing radiation	

h. Angiography	Angiography could be both a diagnostic as well as an interventional procedure. It is inclusive of, but not limited to, x-rays with catheters computed tomography (CTA) and Magnetic Resonance (MRA)	American College of Cardiology/Society for Cardiac Angiography and Interventions
Laboratory Studies	A study is defined as billable examination. A series of related tests performed in one visit on a person is considered as one study.	
a. Inpatient Studies	Inpatient lab studies done on inpatients except for newborns. Newborns are not patients admitted hence newborn studies are excluded.	
b. Outpatient Studies	Outpatient lab studies are studies done on patients that come into outpatient services and may include non-patients (those get tested on preventive care).	
c. Studies Performed Under Contract (Referrals)	Studies performed under contract at another laboratory are termed as referral studies	
Observation Days	Number of days of service provided to outpatients for the purpose of determining whether a patient requires admission as an inpatient or other treatment. The observation period shall not exceed 48 hours. OBSERVATION DAYS	According to Administrative Rule 1100.220

	= OBSERVATION HOURS divided by 24	
Observation Beds/stations (Dedicated)	Indicate the number of observation beds or stations if operating and available anywhere but not occurring in inpatient nursing units.	May or may not be admitted into the hospital
Observation Days in dedicated observation beds/stations outside the nursing unit	Indicate the number of days spent in those operating observation beds or stations available anywhere **but** within the given specific nursing unit.	May/may not be billed for observation.
Observation days in a particular nursing unit	Indicate number of beds/stations if available and operating in a given nursing unit (like OB, ICU, and Med-Surg etc) in your facility.	These beds do not count toward the Authorized Hospital Bed Capacity (CON beds). The days will be added into calculation of ALOS
Occupancy Rate	Measure of inpatient health facility use, determined by dividing average daily census by the calculated capacity. It measures average percentage of facility's beds occupied and may be institution-wide or specific for one department or service.	According to Administrative Rule 1100.220
Operating Rooms a. Class C – Main ORs	Operating Room is defined as a setting designed and equipped for major surgical procedures that require general or regional block anesthesia and support of vital bodily functions.	According to ACOA (American College of Anesthesiologists)
b. Class B - Invasive, Non OR rooms	Designed and equipped for major or minor surgical procedures performed in conjunction with oral, parenteral, or	

	intravenous sedation or under analgesic or dissociative drugs	
Surgical Procedures - Class B	Dedicated surgical procedures done in dedicated surgical rooms and suites which come under Classification B, needs to be listed here.	According to Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons.
Surgical Hours	It is the time taken to perform the surgical procedure plus time taken for set up and clean up of the operating room and **not the patient**.	
Recovery Stations	Recovery Stations are defined as the stations/units within the room providing post operative/post anesthetic care soon after the surgery.	According to ACOA (American College of Anesthesiologists)
a. Stage 1	Stage 1 recovery is used for patients who received intensive anesthesia for major surgical procedures which would take more time to recuperate.	
b. Stage 2	Stage 2 are used for less intensive procedures which involve less anesthesia there by need less time to recuperate.	
Outpatient Visits	All services or visits provided by physician to all outpatient services including emergency, surgical, radiological provided by and billed by the hospital.	
a. Hospital/Campus	Visits provided by physician to all	

b. Off site/off campus	outpatient services including emergency, surgical, radiological provided by and billed by the hospital and occurring at the hospital or hospital campus. Visits provided by physician to all outpatient services including emergency, surgical, radiological provided by and billed by the hospital and occurring off site/off campus.	
Peak bed set up and staffed	Maximum number of beds by category of service the facility considers appropriate to place in patient rooms taking into account patient care requirements and ability to perform the regular functions of patient care required for patients	According to Administrative Rule 1100.220
Peak Census	Indicate your facility's maximum number of patients in Authorized Hospital Bed Capacity (CON Beds) at any one time during the reporting calendar year.	Measures the facility's peak utilization.
Revenue by payment source a. Private Pay	Include the amount of **net revenue** of the facility during the fiscal year for the inpatients and outpatients served by the payment type. Private pay includes money from a private account (for example, a medical savings account)	Revenue to be listed

	and any government funding made out and paid to the resident which is then transferred to the facility to pay for services. It also includes all the Self pay payments.	
b. Other Public	Other public includes all forms of direct public payment excluding Medicare and Medicaid. DMH/DD and veterans' administration funds and other funds paid directly to a facility should be recorded here.	
Source of Financial Data Used	Indicate the source from which the financial information has been taken. The sources include: audited financial statements, review or compilation of financial statements, or tax return for most recent fiscal year.	The fiscal year and the source of financial data could be quite different to each hospital.
Radiation Therapy	Radiation Oncology uses ionizing radiation to control malignant/cancer causing cells.	According to ACR
a. Linear Accelerator	Produces high velocity/energy to atomic particles in radiation therapy.	
b. Gamma Knife	Device used to treat brain tumors. It aims gamma radiation and contains cobalt -60.	
c. Lithotripsy	Lithotripsy is a non-invasive treatment course, uses high	

	intensity, focused acoustic pulse to break Kidney and Biliary Calculi.	
d. Proton Beam Therapy	A beam of protons are used to radiate the tumors. However, they are targeted very precisely and release most of their energy causing less damage to healthy tissue.	
Labor-Delivery-Recovery-Postpartum rooms	Rooms dedicated to complete maternity suites.	These beds can be counted towards OB-Gyn beds
Total Births	Total number of babies born vaginally or by C-Section, including both live births and fetal deaths/stillborn. It is not number of moms being brought into delivery room. If a mother gives birth to twins, it would be two births and not one.	According to American Academy of Pediatrics (College of Obstetricians and Gynecologists) Perinatal Advisory Committee, Administrative Rule 77 Ill. Adm. Code 640. (720 ILCS 510/2) (from Ch. 38, par. 81‑22)
Live Births	"Born alive", "live born", and "live birth", when applied to homo sapiens species, each mean complete expulsion or extraction from his or her mother and after such separation breathed or showed evidence of any of the following: beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, irrespective of the duration of pregnancy and whether or not the	According to American Academy of Pediatrics (College of Obstetricians and Gynecologists)

	umbilical cord has been cut or the placenta is attached.	
Trauma	Trauma – any significant injury which involves single or multiple organ systems. (Section 3.5 of the Act)	Section 3.90 of the EMS Act
a. Trauma Center	hospital with designated capabilities provides care to trauma patients; approved EMS System;	Can be Level 1 for Adult but is Level 2 for Pediatric trauma.
b. Trauma Level I	According to section 515.2030, Ob/Gyn, pediatric surgery or cardiovascular surgical sub specialist must arrive within 30 minutes	Section 515.2030 of the Emergency Medical Services, Trauma Center, Comprehensive Stroke Center, Primary Stroke Center and Acute Stroke Ready Hospital Code
c. Trauma Level II	Pursuant to Section 515.2040, essential services available in-house 24 hours per day, and to provide other essential services readily available 24 hours a day and specialist to arrive in 60 minutes	Section 515.2040 of the Emergency Medical Services, Trauma Center, Comprehensive Stroke Center, Primary Stroke Center and Acute Stroke Ready Hospital Code
Treatments	Course of events (procedures) that needs to be completed for a specific patient that undergoes radiation therapy.	The frequency and/or utilization of the machine to be recorded.

Financial/Capital Expenditures Definitions:

1. **ON BEHALF OF HEALTH CARE FACILITY**: Any transactions undertaken by the facility or by any other entity other than the facility which results in establishment or modification of the facility and directly or indirectly results in the facility billing or receiving reimbursement, or in participating or assuming responsibility for the retirement of debt or the provision of any services associated with the transaction.

2. **CAPITAL EXPENDITURE**: Any expenditure : (A) made by or on behalf of a health care facility …….and (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made to obtain by lease or comparable arrangement any facility or part there of or any equipment for a facility or part… and includes the cost of any studies, surveys, designs, plans, working drawings, specification and other activities essential to the acquisition, improvement, expansion or replacement of any plant or equipment with respect to which an expenditure is made… and includes donations of equipment of facilities or a transfer of equipment or facilities at fair market value.

3. **CONSTRUCTION OR MODIFICATION**: The establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership, of or by a health care facility, or the purchase or acquisition by or through a health care facility of equipment of service for diagnostic or therapeutic purpose or for facility administration or operation, or any capital expenditures made by or on behalf of a health care facility.

4. **METHOD OF FINANCING**: The source of funds required to undertake the project or capital expenditure. Forms of financing include equity (cash and securities), lease, mortgages, general obligation bonds, revenue bonds, appropriations and gifts/donations/bequests.

5. **FINANCIAL COMMITMENT**: The commitment of funds directly or indirectly through the execution of construction or other contracts, purchase order, lease agreements of other means for any construction or modification project.
   NOTE: Funds financially committed in a given year should not be carried forward to subsequent years due to phased or periodic payouts. For example, a facility signs a $2 million contract in 2020 for construction of a new bed wing. Construction takes approximately three years with payments being made to the contractor during 2020, 2021 and 2024. The entire $2 million would be listed once as a financial commitment for 2019 and would not be listed in subsequent years.

6. **PROJECT**: Any proposed construction of modification of a health care facility or any proposed acquisition of equipment undertaken by or on behalf of a health care facility regardless of whether or not the transaction required a certificate of need. Components of construction or modification, which are interdependent, must be grouped together for reporting purposes. Interdependence occurs when components of construction or modification are architecturally and/or programmatically interrelated to the extent that undertaking one of more of the components compels the other components to be undertaken. If components of construction or modification are undertaken by means of a single construction contract, those components must be grouped together. Projects involving acquisition of equipment, which are linked with construction for the provision of a service cannot be segmented. When a project or any component of a project is to be accomplished by lease, donation, gift or any other means, the fair market value or dollar value, which would have been required for purchase, construction or acquisition, is considered a capital expenditure.

7. **NET REVENUE**: Net Revenue is the result of gross revenue less provision for contractual adjustments from third party payors (Source: AICPA).