AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR ~~2024~~

This is a formal request by IDPH for full, complete and accurate information as stated herein. This request is made under the authority of the 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 is divided into 2 sections:

Section I
Collects information on your facility and facility utilization.
This part must be reported for CALENDAR YEAR 2024.

Section II
Collects Financial and Capital Expenditure information for your facility.
This part must be reported for the MOST RECENT FISCAL YEAR AVAILABLE.

This survey must be completed and submitted by April 1, 2025.
No exceptions or extensions will be allowed.

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

If you have problems or questions concerning the survey, please contact this office via e-mail to DPH.FacilitySurvey@illinois.gov, or by telephone at 217-782-3516.

Please enter the following information on for your facility:

ASTC License	7002082			
ASTC Name	Ambu;latory Surgicentet of Downers Grove			
ASTC Address	4333 Main Street			
ASTC City	Downers Grove	**IL**	**Zip Code**	60525

Federal Employer Identification Number (FEIN) 36-4106726

Instructions for Completing and Submitting this Questionnaire
Fill in the questionnaire information.
Download and complete Patient Origin spreadsheet (optional).

Save completed questionnaire (and spreadsheet, if used) to your computer for your records and future reference, if follow-up is required.

Send Email, with completed file(s) attached, to DPH.FacilitySurvey@illinois.gov.
Please put "ASTC Questionnaire" in the subject line.

If you have any questions, please call 217/782-3516, or send email to DPH.FacilitySurvey@illinois.gov

Thank you

Section I - Facility Data

1. FACILITY OWNERSHIP INFORMATION

A. Indicate the type of ownership for your ASTC (Choose only one):

FOR PROFIT	NOT FOR PROFIT
○ **Sole Proprietorship**	○ **Church Related**
◉ **Corporation (*RA)**	○ **State**
○ **Partnership (registered with county)**	○ **County**
○ **Limited Partnership (*RA)**	○ **City**
○ **Limited Liability Partnership (*RA)**	○ **Township**
○ **Limited Liability Company (*RA)**	○ **Other Not for Profit (Specify below)**
○ **Other For Profit (specify below)**	

Other Ownership Type

*RA - Registered Agent Required

B. If your facility ownership requires a Registered Agent with the Illinois Secretary of State (marked *RA above), indicate the name, address and telephone number of this person or company (must be an Illinois resident or company).

Name of Registered Agent:	Amos E. Madanes M.D.
Address:	1810 N. Orleans
City. State and Zip Code (plus Four):	Chicago, Il 60614
Telephone Number:	(312) 664-5100

C. Provide the name and relational interest of all organizations or entities that are legally, financially or otherwise related to the licensee (e.g., parent, subsidiary, affiliate, management agreement, etc.)

	Name	**Relationship**	**Type of Interest**
1			
2			
3			
4			
5			

D. Indicate the name, address and telephone number of the legal owners/operators of the facility.
If you have more than 25 owners to report, please enter the information into an Excel spreadsheet using the format below and email with completed questionnaire to DPH.FacilitySurvey@illinois.gov

	Owner Name	Address	City, State Zip Code-Plus 4	Telephone Number (xxx) xxx-xxxx.xxxx)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				

2. PROPERTY OWNERSHIP INFORMATION

If the facility property is not owned by the facility legal owner/operator, indicate the name, address (including Zip Code plus Four) and telephone number of the property owner:

	Property Owner	Address	City, State Zip Code-plus 4	Telephone (xxx) xxx-xxxx.xxxx)
1	4339 Main LLC.	1814 N. Orleans	Chicago, Il 60614	(312) 664-5100

3. CONTRACTUAL MANAGEMENT

If management of this facility is performed by independent contractor(s), not by an employee of the facility, list the individual name(s) and address(es) of each independent contractor. If management is NOT done by independent contractor(s), indicate by checking the box provided.

✔ **No Contractual Management**

	Contractor Name	Full Address
1		
2		
3		
4		
5		

4. FACILITY STAFFING

A. Indicate the number of hours in a work week for a full-time employee of your facility: 34.0

B. Staffing Patterns

Please indicate the number of Full-Time Equivalent employees (FTEs), paid directly by the facility, working at your facility during the first pay period of December, 2024.

The figure for TOTAL FACILITY PERSONNEL in green is automatically calculated. You cannot change this total.

Personnel	Full-Time Equivalents
Administrators	1.00
Physicians	0.00
Nurse Anesthetists	0.00
Director of Nursing	0.00
Registered Nurses	7.00
Certified Aides	1.00
Other Health Professionals	4.00
Other Non-Health Professionals	6.00

TOTAL FACILITY PERSONNEL 19.00

INFORMATION CONCERNING PATIENTS SERVED - CALENDAR YEAR 2024

5. Patients by Age Groups

Please indicate the number of patients during the calendar year 2024 by age and sex. If the patient was seen more than once, he/she should be counted for each new incident. Figures in green on the TOTAL line are automatically calculated and must match the green calculated figures in Question 6.

	Male	Female	
0-14 Years	0	0	
15-44 Years	9	2,318	
45-64 Years	4	122	TOTAL PATIENTS SERVED
65-74 Years	0	0	
75+ Years	0	0	
TOTALS	13	2,440	2,453

6. Source of Payment

Please indicate the numbers of patients your ASTC saw during calendar year 2024, by sex and PRIMARY PAYMENT SOURCE. If the patient was seen more than once, he/she should be counted for each new incident. Figures in green on the TOTAL line are automatically calculated and must match the corresponding green calculated totals in Question 5 above.

	Male	Female	
Medicaid	0	0	
Medicare	0	0	
Other Public*	0	0	
Private Insurance	0	1,972	
Private Payment	13	468	TOTAL PATIENTS SERVED
Charity Care*	0	0	
TOTALS	13	2,440	2,453

***Other Public** payment includes individuals whose primary payment source is Veterans Administration, County Boards, Community Aid Agencies, grants, CHAMPUS, CHAMP-VA, and other government-sponsored programs, excluding Medicare and Medicaid.

"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, Section 3] 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.

7. Patients by Place of Origin - Calendar Year 2024

Optional Reporting Method:

For your ease of reporting, we have supplied a Microsoft Excel worksheet for the entry of Patient Origin Data:

1. **CLICK HERE to ACCESS THE WORKSHEET**.
2. Save the worksheet to your computer.
3. Follow the directions on the worksheet to enter your data.
4. Email the completed spreadsheet to DPH.FacilitySurvey@illinois.gov
5. Retain a copy of the worksheet in case follow-up is required.

If you do not wish to use the Patient Origin worksheet, please use the spaces below to report the place of origin of the patients seen at your ASTC during Calendar Year 2024, and the number of patients from each area. 5-digit Zip Code areas are preferred; if Zip Code information is not available, please report by county name.

	Zip Code Area	County Name	Number of Patients
1	30168	COBB	1
2	31324	BRYAN	1
3	33543	PASCO	1
4	33573	HILLSBOROUGH	1
5	37206	DAVIDSON	1
6	44102	CUYAHOGA	1
7	45419	MONTGOMERY	1
8	46127		1
9	46236	MARION	1
10	46303	LAKE	17
11	46304	PORTER	23
12	46307	LAKE	70
13	46310	JASPER	6
14	46311	LAKE	23
15	46312	LAKE	7
16	46319	LAKE	13
17	46320	LAKE	2
18	46321	LAKE	17
19	46322	LAKE	17
20	46323	LAKE	14
21	46324	LAKE	12
22	46327	LAKE	3
23	46340	LAPORTE	2
24	46341	PORTER	10
25	46342	LAKE	21

	Zip Code Area	County Name	Number of Patients
26	46346	LAPORTE	1
27	46347	PORTER	3
28	46348	LAPORTE	1
29	46349	NEWTON	2
30	46350	LAPORTE	18
31	46356	LAKE	18
32	46360	LAPORTE	16
33	46365	LAPORTE	1
34	46366	STARKE	3
35	46368	PORTER	35
36	46371	LAPORTE	2
37	46373	LAKE	20
38	46374		1
39	46375	LAKE	20
40	46376	LAKE	1
41	46382		1
42	46383	PORTER	48
43	46385	PORTER	40
44	46390	LAPORTE	3
45	46392	JASPER	5
46	46394	LAKE	4
47	46302	LAKE	4
48	46403	LAKE	4
49	46404	LAKE	2
50	46405	LAKE	2

7. **Patients by Place of Origin (Continued)**
Please report the places of origin of the patients seen at your ASTC during Calendar Year 2024, and the number of patients from each area.
5-digit Zip Code areas are preferred; if Zip Code information is not available, please report by county of origin.

	Zip Code Area	County Name	Number of Patients
51	46406	LAKE	1
52	46407	LAKE	1
53	46408	LAKE	1
54	46409	LAKE	2
55	46410	LAKE	28
56	46504		1
57	46511	MARSHALL	2
58	46514	ELKHART	6
59	46516	ELKHART	2
60	46517	ELKHART	1
61	46526	ƷLKHART	1
62	46530	ST. JOSEPH	2
63	46532		4
64	46534	STARKE	4
65	46536	SWT. JOSEPH	1
66	46543	ELKHART	1
67	46544	ST. JOSEPH	6
68	46545	ST. JOSEPH	2
69	46554		2
70	46561	ST. JOSEPH	2
71	46563	MARSHALL	5
72	46567	IBIBDAGA	1
73	46574	ST. JOSEPH	2
74	46582	KOSCIUSKO	2
75	46613	ST. JOSEPH	1

	Zip Code Area	County Name	Number of Patients
76	46614	ST. JOSEPH	4
77	46615	ST. JOSEPH	1
78	46617	ST. JOSEPH	1
79	46619	ST. JOSEPH	1
80	46628	ST. JOSEPH	3
81	46637	ST. JOSEPH	1
82	46748	ALLEN	1
83	46825	ALLEN	3
84	46923	CARROLL	1
85	46947	CASS	1
86	46952	GRANT	1
87	46996	PULASKI	2
88	47274	JACKSON	1
89	47714	VANDERBURHGH	1
90	47950	WHITE	1
91	47951	NEWTON	1
92	47963	NEWTON	2
93	47978	JASPER	5
94	48045	CLARE	1
95	48198	WASHTENAW	1
96	48381	OAKLAND	1
97	48811	MONTCALM	1
98	49022		2
99	49043	VAN BJREN	1
100	49047		2

7. **Patients by Place of Origin (Continued)**
Please report the places of origin of the patients seen at your ASTC during Calendar Year 2024, and the number of patients from each area.
5-digit Zip Code areas are preferred; if Zip Code information is not available, please report by county of origin.

	Zip Code Area	County Name	Number of Patients
101	49085	BERRIEN	1
102	49087	KALA,AZZOO	1
103	49103		1
104	49107	BERRIEN	2
105	49113	BERRIEN	1
106	49117	BERRIEN	1
107	49120	BERRIEN	1
108	49127		1
109	49441		1
110	49442	MUSWKKEGON	1
111	50208	JASPER	1
112	50211	WARREN	1
113	51050	PLYMOUTH	1
114	52240	JOHNSTON	1
115	52722	SCOTT	1
116	53144	KENOSHA	2
117	53190	WALWORTH	1
118	53215	MILWAUKEE	1
119	53217	MILWAUKEE	1
120	53219	MILWAUKEE	1
121	53566	GREEN	1
122	53713	DANE	1
123	53719	DANE	1
124	54311	BROWN	1
125	54494	WOOD	1

	Zip Code Area	County Name	Number of Patients
126	54724		1
127	60004	COOK	2
128	60005	COOK	1
129	60007	COOK	1
130	60008	COOK	1
131	60012	MCHENRY	1
132	60014	MCHENRY	1
133	60015	LAKE	1
134	60016	COOK	3
135	60018	COOK	2
136	60025	COOK	1
137	60041	LAKE	2
138	60045	LAKE	1
139	60046	LAKE	1
140	60050	MCHENRY	1
141	60056	COOK	4
142	60062	COOK	1
143	60067	COOK	1
144	60070	COOK	2
145	60073	LAKE	2
146	60074	COOK	3
147	60077	COOK	1
148	60083	LAKE	1
149	60090	COOK	1
150	60099	LAKE	1

7. **Patients by Place of Origin (Continued)**
Please report the places of origin of the patients seen at your ASTC during Calendar Year 2024, and the number of patients from each area.
5-digit Zip Code areas are preferred; if Zip Code information is not available, please report by county of origin.

	Zip Code Area	County Name	Number of Patients
151	60101	DU PAGE	1
152	60102	MC HENRY	1
153	60103	COOK	8
154	60104	COOK	3
155	60106	DU PAGE	2
156	60107	COOK	4
157	60108	DU PAGE	4
158	60110	KANE	5
159	60112	DE KALB	3
160	60115	DE KALB	11
161	60118	KANE	3
162	60119	KANE	8
163	60120	KANE	10
164	60123	KANE	9
165	60124	KANE	8
166	60126	DU PAGE	3
167	60131	COOK	2
168	60133	COOK	2
169	60134	KANE	19
170	60136	KANE	5
171	60137	DU PAGE	5
172	60139	DU PAGE	5
173	60140	KANE	4
174	60142	MC HENRY	2
175	60143	DU PAGE	1

	Zip Code Area	County Name	Number of Patients
176	60145	DE KALB	1
177	60146	DE KALB	1
178	60148	DU PAGE	11
179	60150	DE KALB	1
180	60151	KANE	3
181	60152	MC HENRY	1
182	60154	COOK	1
183	60155	COOK	2
184	60160	COOK	1
185	60162	COOK	1
186	60163	COOK	1
187	60164	COOK	2
188	60169	COOK	1
189	60171	COOK	1
190	60172	DU PAGE	1
191	60173	COOK	1
192	60174	KANE	13
193	60175	KANE	34
194	60176	COOK	2
195	60177	KANE	8
196	60178	DE KALB	3
197	60180	MC HENRY	1
198	60181	DU PAGE	6
199	60185	DU PAGE	6
200	60188	DU PAGE	8

7. **Patients by Place of Origin (Continued)**
Please report the places of origin of the patients seen at your ASTC during Calendar Year 2024, and the number of patients from each area.
5-digit Zip Code areas are preferred; if Zip Code information is not available, please report by county of origin.

	Zip Code Area	County Name	Number of Patients
201	60189	DU PAGE	1
202	60190	DUPAGE	2
203	60193	COOK	3
204	60194	COOK	1
205	60195	COOK	1
206	60201	COOK	3
207	60301	COOK	1
208	60302	COOK	2
209	60401	WILL	1
210	60402	COOK	2
211	60403	WILL	6
212	60404	WILL	10
213	60406	COOK	5
214	60408	WILL	2
215	60409	COOK	3
216	60410	WILL	1
217	60411	COOK	7
218	60415	COOK	1
219	60417	WILL	9
220	60418	COOK	7
221	60419	COOK	9
222	60422	COOK	4
223	60423	WILL	2
224	60425	COOK	2
225	60426	COOK	5

	Zip Code Area	County Name	Number of Patients
226	60428	COOK	2
227	60429	COOK	2
228	60430	COOK	2
229	60431	WILL	4
230	60432	WILL	3
231	60433	WILL	3
232	60435	WILL	6
233	60436	WILL	1
234	60438	COOK	7
235	60439	DU PAGE	8
236	60440	WILL	6
237	60441	WILL	16
238	60442	WILL	5
239	60443	COOK	5
240	60445	COOK	5
241	60446	WILL	6
242	60447	GRUNDY	3
243	60448	WILL	11
244	60449	WILL	4
245	60450	GRUNDY	3
246	60451	WILL	14
247	60452	COOK	14
248	60453	COOK	18
249	60455	COOK	3
250	60456	COOK	1

7. **Patients by Place of Origin (Continued)**
Please report the places of origin of the patients seen at your ASTC during Calendar Year 2024, and the number of patients from each area.
5-digit Zip Code areas are preferred; if Zip Code information is not available, please report by county of origin.

	Zip Code Area	County Name	Number of Patients
251	60457	COOK	5
252	60458	COOK	3
253	60459	COOK	3
254	60461	COOK	2
255	60462	COOK	24
256	60463	COOK	11
257	60464	COOK	4
258	60465	COOK	8
259	60466	COOK	3
260	60467	COOK	13
261	60466	WILL	3
262	60469	COOK	1
263	60470	LA SALLE	1
264	60471	COOK	2
265	60473	COOK	11
266	60475	COOK	4
267	60476	COOK	2
268	60477	COOK	22
269	60478	COOK	3
270	60480	COOK	3
271	60481	WILL	5
272	60482	COOK	2
273	60484	WILL	1
274	60487	COOK	10
275	60490	WILL	4

	Zip Code Area	County Name	Number of Patients
276	60491	WILL	10
277	60501	COOK	1
278	60502	DU PAGE	2
279	60503	WILL	2
280	60504	DU PAGE	5
281	60505	KANE	10
282	60506	KANE	8
283	60510	KANE	6
284	60513	COOK	2
285	60515	DU PAGE	3
286	60516	DU PAGE	3
287	60517	DU PAGE	6
288	60521	DU PAGE	2
289	60525	COOK	1
290	60532	DU PAGE	1
291	60534	COOK	2
292	60538	KENDALL	3
293	60540	DUPAGE	2
294	60541	KENDAL	1
295	60542	KANE	6
296	60543	KENDAL	5
297	60544	WILL	4
298	60545	KENDAL	3
299	60548	DE KALB	1
300	60549	LA SALLE	1

If you had patients from more than 300 areas, please use the Microsoft Excel Patient Origin Spreadsheet, or record the extra information in your own Excel spreadsheet, using the format above, and email to DPH.FacilitySurvey@illinois.gov
Please enter "ASTC Patient Origin Data" into the subject line of the message.

FACILITY OPERATIONS

8. Please indicate the number of hours your ASTC is in operation on each day of the week: (for example, if the ASTC is open from 8 a.m. to 6 p.m., that is 10 hours of operation.) REPORT NUMBER OF HOURS, NOT OPENING AND/OR CLOSING TIMES.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	TOTAL HOURS
Hours Open	9	9	9	9	9			45

9. Treatment Rooms by Type

Please indicate the number of rooms and stations in use at your ASTC for each category listed below:

	Rooms/ Stations
a. Operating Rooms (Class C)*	3
b. Procedure (not operating) Rooms (Class B)*	1
c. Examination Rooms	1
d. Stage 1 - Post-Anesthesia Recovery Stations	6
e. Stage 2 - Step-down Ambulatory Recovery Stations	4

*Operating Room (Class C): 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.

Surgical Procedure Room (Class B): Surgical Procedure room is 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)

10. Hospital Relationships

List all hospitals with which your ASTC has a contractual relationship, including transfer agreements.

	Hospital Name and City	Patient Transfers
1	Good Samaritan Hospital Downers Grove	0
2		
3		
4		
5		

11. SURGICAL UTILIZATION FOR CALENDAR YEAR 2024 - OPERATING ROOMS - CLASS C*

For each listed surgical category, indicate the number of surgical cases, the number of hours spent in setting up the surgery rooms for use, the hours of actual surgical time, and the number of hours spent in clean-up after the surgery was completed. Round the time reported to the nearest quarter of an hour. For example, a total of 318 hours and 40 minutes would be rounded to 318.75 hours for reporting purposes.

	Number of Cases	Surgery Room Set-Up Time (in Hours)	Actual Surgery Time (in Hours)	Surgery Room Clean-Up Time (in Hours)
Cardiovascular				
Dermatology				
General Surgery				
Gastroenterology				
Neurological				
OB/Gynecology	2,440	610.00	1,342.00	244.00
Oral/Maxillofacial				
Ophthalmology				
Laser Eye Surgery				
Orthopedic				
Otolaryngology				
Pain Management				
Plastic				
Podiatry				
Thoracic				
Urology	13	3.25	7.15	1.30
TOTALS	2,453	613.25	1,349.15	245.30

***Operating Room (Class C): 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.**
(Source: Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons)

12. SURGICAL UTILIZATION FOR CALENDAR YEAR 2024 - PROCEDURE ROOMS (Class B)*

For each listed surgical procedure category, indicate the number of dedicated procedure (non-operating) rooms, the number of surgical cases, the number of hours spent in setting up the procedure rooms for use, the hours of actual surgical time, and the number of hours spent in clean-up after the procedure was completed. Round the time reported to the nearest quarter of an hour. For example, a total of 318 hours and 40 minutes would be rounded to 318.75 hours for reporting purposes.

If your facility performs other, unlisted non-operating room procedures, use lines e. - h. to report these procedures. Indicate the type(s) of procedure(s), the number of surgical cases, the number of hours spent in setting up the procedure rooms for use, the hours of actual surgical time, and the number of hours spent in clean-up after the procedure was completed. Total multi-purpose procedure rooms are to be reported in the line below the table.

NOTE - For reporting purposes, a case is defined as a **PATIENT TREATED**. If a patient has 3 procedures performed, that is counted as **1 CASE**. **TOTAL PROCEDURE ROOMS** must equal Procedure Rooms reported on line b., Question 9. Total Procedure Room Cases shown here plus Total Operating Room Cases from Question 11 on Page 9 must equal Total Patients Served reported in Questions 5 and 6.

The green figures on the last three lines are automatically calculated. You cannot change these figures.

Dedicated Procedure Rooms (Class B)*	Rooms	Cases	Procedure Room Set-Up Time	Actual Surgery Time	Procedure Room Clean-Up Time
a. Dedicated Gastro-Intestinal Procedures					
b. Dedicated Laser Eye Procedures					
c. Dedicated Pain Management Procedures					
d. Cardiac Catheterization Procedures					

	Multipurpose Rooms (Specify Procedure)	Cases	Procedure Room Set-Up Time	Actual Surgery Time	Procedure Room Clean-Up Time
e.					
f.					
g.					
h.					

Total Multi-Purpose Procedure Rooms					
TOTALS - PROCEDURE ROOMS	0	0	0.00	0.00	0.00

TOTAL CASES Questions 11 and 12 TOTAL	2,453	These two figures must match.
PATIENTS Reported on Page 6	2,453	

*Surgical Procedure Room (Class B): Surgical Procedure room is 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)

Section II - Fiscal Year Financial and Capital Expenditures Data

The data requested in this questionnaire are authorized
pursuant to the Illinois Health Facilities Planning Act [20 ILCS 3960/5.3]

This information must be taken from your MOST RECENT ANNUAL FINANCIAL STATEMENTS, which include your INCOME STATEMENT and BALANCE SHEET. Allowable sources of financial information include AUDITED FINANCIAL STATEMENTS, REVIEW OR COMPILATION FINANCIAL STATEMENTS, or TAX RETURN for the MOST RECENT FISCAL YEAR AVAILABLE.
This part of the survey collects Financial and Capital Expenditure information for your facility. This part MUST BE REPORTED FOR THE MOST RECENT FISCAL YEAR AVAILABLE.

If you have problems providing the information requested, contact this office via email at DPH.FacilitySurvey@illinois.gov or by telephone at 217-782-3516.

Indicate the Starting and Ending Dates of Your MOST RECENT FISCAL YEAR (mm/dd/yyyy)

Starting Date	01/01/2024
Ending Date	12/31/2024

Use this drop-down list to select the source of the Financial Information Reported in this Section:

Audited Financial Statements

A. CAPITAL EXPENDITURES

Report the TOTAL of ALL CAPITAL EXPENDITURES for your reported Fiscal Year:

TOTAL CAPITAL EXPENDITURES FOR YOUR REPORTED FISCAL YEAR

Provide the following information for ONLY projects/capital expenditures in excess of $350,000 obligated by or on behalf of the health care facility for your reported Fiscal Year (click the link below the table for definitions of terms):

	Description of Project/ Capital Expenditure	Amount Obligated	Method of Financing	CON Project Number (if reviewed)
1				
2				
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B. NET REVENUE BY PAYMENT SOURCE - REPORTED FISCAL YEAR

Please indicate your Net Revenue during your reported Fiscal Year, by payment source. If you reported any patients for a given payment source in Question 6 on Page 6, but do not have matching Net Revenue to report for that payment source, please provide a brief explanation in the Comments box on Page 14.

	Net Revenue (in Dollars)
Medicaid	$ 0
Medicare	$ 0
Other Public*	$ 0
Private Insurance	$ 3,770,375
Private Payment	$ 942,544
Total Revenue	$ 4,712,919

***Other Public** payment includes individuals whose primary payment source is Veterans Administration, County Boards, Community Aid Agencies, grants, CHAMPUS, CHAMP-VA, and other government-sponsored programs, excluding Medicare and Medicaid.

C. TOTAL ACTUAL COST OF SERVICES PROVIDED TO CHARITY CARE* CASES DURING THE REPORTED FISCAL YEAR

	Amount (in Dollars)
Total Actual Cost of Services Provided to Charity Care* Cases	$ 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, Section 3] 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.*

Term	Definition	Reference
Adult cardiac catheterization	Cardiac catheterization of patients 15 years of age and older	According to Administrative rule 1110.1320
By or On Behalf of a Health Care facility	Any transactions undertaken by the facility or by any other entity other than the facility which results in construction 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.	
Case	Case is defined as a patient encountered in an inpatient or outpatient setting. For example, if 3 surgical procedures are performed on an individual, only 1 case is counted.	
Cardiac Catheterization Labs	Includes labs that are dedicated as well as non dedicated cardiac labs for diagnostic, interventional and electrophysiology procedures. Total cardiac labs will be more than or equal to the sum of dedicated cardiac labs.	
Cardiovascular Intervention or Treatment	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).	
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 thereof 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 or facilities or a transfer of equipment or facilities at fair market value.	
Charity Care	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 un-reimbursed 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 from the hospital's Medicare cost report (see Reference), and not the actual charges for the services.	CMS 2552-96 Worksheet C, Part 1 PPS, Inpatient Ratios

Term	Definition	Reference
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 or 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….	
Diagnostic Cardiac Catheterization (DCC)	Performance of Catheterization procedures associated with determining the blockage of blood vessels and the diagnosis of cardiac diseases that are performed in a cardiac catheterization lab or special procedures lab with cardiac catheterization capabilities.	
Full Time Equivalent	A unit of measurement which is equal to one filled, full time, annual-salaried position.	
Interventional Cardiac Catheterization (ICC)	Treatment of cardiac diseases associated with the blockage or narrowing of the blood vessels and diseases of the heart by the performance of percutaneous coronary intervention or similar procedures in a cardiac catheterization lab or special procedures lab with cardiac catheterization capabilities. 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.	
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.	
Net Revenue	Net Revenue is the result of gross revenue less provision for contractual adjustments from third party payers.	American Institute of Certified Public Accountants (AICPA)
Other Public Payment	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.	
Operating Room (Class C)	A setting designed and equipped for major surgical procedures that require general or regional block anesthesia and support of vital bodily functions	Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons)

Term	Definition	Reference
Obligation	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 obligated 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 2019 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 an obligation for 2019 and would not be listed in subsequent years.	
Patients Served by payment source	Include number of inpatients and outpatients served by their payment type.	Payment sources are defined within the questionnaire.
Project	Any proposed construction or 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 or 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.	
Pediatric cardiac Catheterization	Cardiac Catheterization of patients 0-14 years.	According to Administrative rule 1110.1320
Private Pay	Private pay includes money from a private account (for example, a medical savings account) 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.	
Revenue by payment source	Revenue by payment source: Include the amount of net revenue of the facility during the fiscal year for the patients served by the payment type.	

Term	Definition	Reference
Stage 1 and Stage 2 Recovery Stations	Stations/units within the room providing post operative/post anesthetic care soon after surgery. Stage 1 recovery is used for patients who received intensive anesthesia for major surgical procedures which would take more time to recuperate, while Stage 2 are used for less intensive procedures which involve less anesthesia there by need less time to recuperate.	American College of Anesthesiologists (ACOA).
Surgical Procedure Room (Class B)	Surgical Procedure room is 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.	Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons)