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	7003207			
ASTC Name	Rush Copley Surgicenter dba Castle Surgicenter			
ASTC Address	2111 Ogden Avenue			
ASTC City	Aurora	**IL**	**Zip Code**	60504

Federal Employer Identification Number (FEIN) 38-4012268

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

- ○ **Sole Proprietorship**
- ○ **Corporation (*RA)**
- ○ **Partnership (registered with county)**
- ○ **Limited Partnership (*RA)**
- ○ **Limited Liability Partnership (*RA)**
- ◉ **Limited Liability Company (*RA)**
- ○ **Other For Profit (specify below)**

NOT FOR PROFIT

- ○ **Church Related**
- ○ **State**
- ○ **County**
- ○ **City**
- ○ **Township**
- ○ **Other Not for Profit (Specify below)**

Other Ownership Type: 501c3-Parent

*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:	John Diederich
Address:	2000 Ogden Avenue
City. State and Zip Code (plus Four):	Aurora, IL 60504
Telephone Number:	(630) 978-4941

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	Copley Memorial Hospital	Partner	99%
2	Rush Copley Medical Center	Partner	1%
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	HCII-2111 Ogden Ave	101 Water Street	Tampa, FL 33602	(813) 316-4318

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: 40.0

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	
Physicians	
Nurse Anesthetists	
Director of Nursing	1.00
Registered Nurses	4.00
Certified Aides	
Other Health Professionals	1.00
Other Non-Health Professionals	

TOTAL FACILITY PERSONNEL 6.00

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	4	2	
15-44 Years	133	150	
45-64 Years	349	393	TOTAL PATIENTS SERVED
65-74 Years	207	262	
75+ Years	171	368	
TOTALS	864	1,175	2,039

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	2	
Medicare	338	623	
Other Public*	0	0	
Private Insurance	526	549	
Private Payment	0	1	TOTAL PATIENTS SERVED
Charity Care*	0	0	
TOTALS	864	1,175	2,039

***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	34746	Osceola	1
2	43055	Kendall	1
3	49058	Barry	2
4	53558	Aquas Buenas	1
5	53711	Dane	2
6	54401	Marathon	1
7	54521	Oneida	1
8	60008	Cook	1
9	60010	Lake	1
10	60013	McHenry	1
11	60045	Lake	1
12	60056	Cook	6
13	60103	Cook	2
14	60111	DeKalb	1
15	60115	DeKalb	8
16	60119	Kane	10
17	60120	Cook	1
18	60124	Kane	1
19	60134	Kane	10
20	60137	DuPage	4
21	60138	DeKalb	1
22	60139	DuPage	1
23	60142	Kane	1
24	60151	Kane	2
25	60153	Cook	2

	Zip Code Area	County Name	Number of Patients
26	60174	Kane	1
27	60175	Kane	7
28	60178	DeKalb	3
29	60181	DuPage	1
30	60184	DuPage	1
31	60185	DuPage	1
32	60188	DuPage	1
33	60302	Cook	1
34	60304	Cook	2
35	60305	Cook	1
36	60402	Cook	1
37	60403	Will	3
38	60404	Will	2
39	60408	Will	1
40	60410	Will	2
41	60410	Grundy	1
42	60431	Kendall	6
43	60431	Will	5
44	60435	Will	2
45	60439	Cook	1
46	60440	Will	4
47	60446	Will	6
48	60447	Grundy	4
49	60450	Grundy	7
50	60451	Will	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
51	60457	Cook	2
52	60464	Cook	2
53	60467	Cook	1
54	60477	Cook	2
55	60490	Will	10
56	60491	Will	3
57	60502	DuPage	55
58	60502	Kane	17
59	60503	DuPage	1
60	60503	Kane	3
61	60503	Kendall	17
62	60503	Will	34
63	60504	DuPage	81
64	60504	Kane	36
65	60504	Kendall	1
66	60505	Kane	127
67	60506	Kane	175
68	60506	Kent	1
69	60506	Kendall	3
70	60507	Kane	4
71	60510	Kane	23
72	60511	Kane	6
73	60512	Kendall	11
74	60515	DuPage	6
75	60517	DuPage	2

	Zip Code Area	County Name	Number of Patients
76	60518	DeKalb	2
77	60518	LaSalle	4
78	60520	DeKalb	14
79	60527	DuPage	1
80	60531	DeKalb	4
81	60531	LaSalle	3
82	60532	DuPage	4
83	60536	Kendall	6
84	60537	Kendall	1
85	60538	DuPage	2
86	60538	Kane	38
87	60538	Kendall	102
88	60540	DuPage	12
89	60541	Kendall	17
90	60542	DeKalb	2
91	60542	Kane	38
92	60543	Kane	4
93	60543	Kendall	241
94	60543	Will	2
95	60544	Kendall	5
96	60544	Will	22
97	60545	Kendall	55
98	60548	DeKalb	31
99	60548	Kendall	5
100	60548	LaSalle	18

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	60549	LaSalle	2
102	60550	DeKalb	3
103	60551	LaSalle	8
104	60552	DeKalb	11
105	60552	LaSalle	4
106	60554	Kane	66
107	60555	DuPage	2
108	60556	DeKalb	3
109	60559	DuPage	1
110	60560	Kane	1
111	60560	Kendall	178
112	60563	DuPage	14
113	60564	DuPage	5
114	60564	Will	51
115	60565	DuPage	13
116	60585	Kendall	2
117	60585	Will	8
118	60586	DuPage	2
119	60586	Kendall	1
120	60586	Will	13
121	60605	Cook	1
122	60608	Cook	2
123	60609	Cook	2
124	60616	Cook	1
125	60619	Cook	1

	Zip Code Area	County Name	Number of Patients
126	60636	Cook	1
127	60651	Cook	2
128	60655	Cook	4
129	60657	Kendall	1
130	60961	Kankakee	1
131	61021	Lee	1
132	61102	Winnebago	2
133	61107	Winnebago	1
134	61108	Winnebago	2
135	61109	Winnebago	1
136	61115	Winnebago	1
137	61301	LaSalle	1
138	61311	Livingston	2
139	61325	LaSalle	4
140	61326	Putnam	2
141	61341	LaSalle	1
142	61350	LaSalle	14
143	61353	Lee	1
144	61354	LaSalle	1
145	61360	LaSalle	2
146	61362	Bureau	6
147	61364	LaSalle	4
148	61401	Knox	1
149	80432	Park	1
150	86413	Mohave	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	94523	Contra Costa	1
152	44060-3970	Lake	1
153	57744-0452	Custer	1
154	60137-6495	DuPage	1
155	60178-0141	DeKalb	1
156	60178-8947	DeKalb	1
157	60403-1933	Will	1
158	60447-4520	Grundy	4
159	60450-9627	Grundy	1
160	60502-9033	Kane	2
161	60503-6751	Will	4
162	60504-3713	Kane	2
163	60504-3717	Kane	2
164	60504-4325	Kane	1
165	60504-4373	Kane	3
166	60504-4849	Kane	1
167	60504-5960	DuPage	1
168	60504-6046	DuPage	1
169	60504-6068	DuPage	1
170	60504-6157	DuPage	1
171	60505-1408	Kane	1
172	60505-1597	Kane	1
173	60505-1931	Kane	1
174	60505-2145	Kane	3
175	60505-2302	Kane	3

	Zip Code Area	County Name	Number of Patients
176	60505-2637	Kane	1
177	60505-3105	Kane	1
178	60505-4634	Kane	1
179	60505-4903	Kane	2
180	60505-4951	Kane	1
181	60505-5237	Kane	1
182	60505-9785	Kane	1
183	60506-1118	Kane	3
184	60506-1541	Kane	1
185	60506-1804	Kane	1
186	60506-2803	Kane	2
187	60506-3239	Kane	1
188	50506-3517	Kane	1
189	60506-3818	Kane	1
190	60506-4147	Kane	2
191	60506-5370	Kane	1
192	60506-5750	Kane	3
193	60506-7307	Kane	1
194	60511-0052	Kane	1
195	60511-9376	Kane	2
196	60517-1634	DuPage	1
197	60518-6275	LaSalle	3
198	60518-6284	LaSalle	2
199	60518-6299	LaSalle	1
200	60518-8106	LaSalle	3

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	60520-0785	DeKalb	2
202	60538-1003	Kane	1
203	60538-1340	Kane	1
204	60538-1851	Kane	2
205	60538-2315	Kendall	4
206	60538-2410	Kendall	1
207	60538-2423	Kane	1
208	60538-2460	Kendall	1
209	60538-2520	Kendall	3
210	60538-2915	Kendall	3
211	60538-2930	Kendall	1
212	60538-3024	Kendall	1
213	60538-3048	Kane	1
214	60538-3437	Kendall	1
215	60538-3717	Kendall	1
216	60538-4026	Kane	2
217	60538-4112	Kane	3
218	60540-5900	DuPage	1
219	60540-7831	DuPage	1
220	60541-8403	Kendall	1
221	60541-9145	Kendall	1
222	60541-9714	Kendall	1
223	60542-2010	Kane	1
224	60542-4611	Kane	1
225	60543-5500	Kendall	1

	Zip Code Area	County Name	Number of Patients
226	60543-6049	Kendall	1
227	60543-6051	Kendall	2
228	60543-6052	Kendall	3
229	60543-7306	Kendall	2
230	60543-7501	Kendall	1
231	60543-8140	Kendall	2
232	60543-8284	Kendall	1
233	60543-8478	Kendall	1
234	60543-8652	Kendall	6
235	60543-8751	Kendall	3
236	60543-8759	Kendall	5
237	60543-9131	Kendall	2
238	60543-9144	Kendall	1
239	60543-9464	Kendall	1
240	60543-9471	Kendall	1
241	60543-9523	Kendall	1
242	60543-9589	Kendall	2
243	60543-9728	Kendall	1
244	60544-2130	Will	4
245	60454-1032	Kendall	1
246	60545-2107	Kendall	1
247	60545-2164	Kendall	3
248	60545-9599	Kendall	1
249	60545-9632	Kendall	1
250	60545-9643	Kendall	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
251	60545-9741	Kendall	1
252	60548-7030	Kendall	1
253	60548-9305	LaSalle	4
254	60552-3060	DeKalb	1
255	60552-3208	LaSalle	4
256	60554-4306	Kane	1
257	60554-9694	Kane	1
258	60560-0488	Kendall	1
259	60560-1027	Kendall	1
260	60560-1212	Kendall	1
261	60560-1443	Kendall	2
262	60560-2113	Kendall	3
263	60560-2366	Kendall	1
264	60560-4767	Kendall	1
265	60560-5801	Kendall	1
266	60560-9228	Kendall	1
267	60560-9457	Kendall	1
268	60560-9531	Kendall	1
269	60560-9718	Kendall	1
270	60564-4716	Will	1
271	60564-6032	Will	1
272	60564-8445	Will	1
273	60565-2562	DuPage	2
274	60585-1335	Kendall	1
275	60585-5169	Will	1

	Zip Code Area	County Name	Number of Patients
276	60586-6523	Will	1
277	60586-6642	Will	1
278	60586-7232	Will	1
279	61078-9317	Carroll	1
280	61354-2118	LaSalle	1
281			
282			
283			
284			
285			
286			
287			
288			
289			
290			
291			
292			
293			
294			
295			
296			
297			
298			
299			
300			

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	10	10	10	10	10			50

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)*	2
b. Procedure (not operating) Rooms (Class B)*	
c. Examination Rooms	
d. Stage 1 - Post-Anesthesia Recovery Stations	3
e. Stage 2 - Step-down Ambulatory Recovery Stations	7

*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	Copley Memorial Hospital	0
2	Amita Health Mercy Medical Center	0
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				
Oral/Maxillofacial				
Ophthalmology				
Laser Eye Surgery				
Orthopedic	617	163.08	359.89	163.08
Otolaryngology				
Pain Management	1,398	233.00	297.66	233.00
Plastic				
Podiatry	24	3.60	27.03	3.60
Thoracic				
Urology				
TOTALS	2,039	399.68	684.58	399.68

***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	0				
b. Dedicated Laser Eye Procedures	0				
c. Dedicated Pain Management Procedures	0				
d. Cardiac Catheterization Procedures	0				

	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	2,039	These two figures must match.
PATIENTS Reported on Page 6	2,039	

*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	07/01/2023
Ending Date	06/30/2024

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 $ 63,600

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				
3				
4				
5				
6				
7				
8				
9				
10				

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	$ 9,458
Medicare	$ 1,355,723
Other Public*	$ 0
Private Insurance	$ 1,899,779
Private Payment	$ 11,916
Total Revenue	$ 3,276,876

***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	$ 10,662

"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)