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	7003167			
ASTC Name	Barrington Ambulatory Surgery Center			
ASTC Address	600 Hart Road Ste 300			
ASTC City	Barrington	**IL**	**Zip Code**	60010

Federal Employer Identification Number (FEIN) 27-3091392

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:	Owen Prunskis JOIL IPI Practice Management
Address:	431 Summit Street
City. State and Zip Code (plus Four):	Elgin , IL 60120
Telephone Number:	(847) 289-8822

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	Chadi Yaacoub	Member	Management / Provider
2	JOIL IPI Practice Management	Member	Management
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	Chadi Yaacoub	65 Coventry Ln	North Barrington,IL 60010	(847) 810-2000
2	JOIL IPI Practice Manage	431 Summit Street	Elgin IL 60120	(847) 289-8822
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	RCG Management	1000 Hart Rd	Barrington,IL60010261	(773) 484-3660

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:

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	
Registered Nurses	
Certified Aides	
Other Health Professionals	
Other Non-Health Professionals	

TOTAL FACILITY PERSONNEL 0.00

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	158	243	
45-64 Years	519	834	TOTAL PATIENTS SERVED
65-74 Years	339	515	
75+ Years	263	624	
TOTALS	1,279	2,216	3,495

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	6	13	
Medicare	641	1,286	
Other Public*	0	0	
Private Insurance	617	894	
Private Payment	15	23	TOTAL PATIENTS SERVED
Charity Care*	0	0	
TOTALS	1,279	2,216	3,495

***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.

Patient Zip	
33069	4
34103	2
34242	5
44115	1
46304	7
46311	4
46342	1
53105	4
53115	3
53128	15
53140	6
53144	9
53147	1
53158	3
53179	17
53181	19
53217	14
53403	1
53585	5
57104	3
60002	3
60004	3
60005	8
60007	18
60008	1
60010	166
60011	2
60012	41
60013	97
60014	164
60016	3
60018	2
60020	43
60021	23
60025	2
60030	80
60031	15
60033	33
60034	9
60035	4
60039	3
60041	36
60042	24
60044	1
60045	4
60046	20

60047	115
60048	13
60050	169
60051	135
60056	9
60060	24
60061	16
60062	1
60064	7
60067	50
60069	1
60071	20
60072	5
60073	93
60074	28
60081	51
60084	30
60085	8
60087	13
60089	6
60090	12
60097	75
60098	102
60099	8
60101	4
60102	116
60103	24
60106	16
60107	33
60108	21
60109	3
60110	50
60115	7
60118	40
60119	18
60120	86
60123	97
60124	81
60126	1
60131	1
60133	25
60134	28
60135	3
60136	14
60137	2
60139	20

60140	34
60142	155
60143	11
60148	2
60151	3
60152	23
60154	6
60156	84
60157	3
60162	1
60164	6
60169	21
60171	3
60172	27
60173	3
60174	28
60175	43
60177	31
60178	12
60181	5
60185	26
60187	2
60188	13
60189	12
60190	15
60191	12
60192	23
60193	20
60194	24
60202	3
60302	3
60439	2
60440	1
60441	5
60446	3
60451	4
60452	3
60453	4
60458	1
60463	2
60467	3
60473	4
60477	6
60504	1
60505	11
60506	7

60510	16
60520	2
60523	10
60532	4
60540	4
60542	6
60543	3
60545	4
60546	2
60552	1
60554	3
60555	2
60559	1
60560	2
60586	4
60601	2
60613	2
60614	3
60634	1
60638	1
60640	9
60641	2
60644	5
60651	2
60656	6
60659	7
60706	1
60707	2
60803	3
60950	1
61008	10
61016	1
61032	4
61054	1
61065	5
61071	7
61072	3
61080	3
61102	13
61108	1
61241	1
61319	2
61350	6
61356	1
71909	1
82070	4

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			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			

	Zip Code Area	County Name	Number of Patients
26			
27			
28			
29			
30			
31			
32			
33			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49			
50			

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			
252			
253			
254			
255			
256			
257			
258			
259			
260			
261			
262			
263			
264			
265			
266			
267			
268			
269			
270			
271			
272			
273			
274			
275			

	Zip Code Area	County Name	Number of Patients
276			
277			
278			
279			
280			
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	9	9	9	9	9	4		49

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)*	1
c. Examination Rooms	12
d. Stage 1 - Post-Anesthesia Recovery Stations	5
e. Stage 2 - Step-down Ambulatory Recovery Stations	12

*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	Advocate Good Shepherd Hospital, Barrington IL 6001	0
2	Alexian Brothers, Elk Grove IL 60007	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	4	4.00	361.00	2.00
Gastroenterology				
Neurological				
OB/Gynecology				
Oral/Maxillofacial				
Ophthalmology				
Laser Eye Surgery				
Orthopedic	1	1.00	0.50	1.00
Otolaryngology				
Pain Management	465	465.00	414.53	235.50
Plastic				
Podiatry	6	6.00	5.50	6.00
Thoracic				
Urology				
TOTALS	476	476.00	781.53	244.50

*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	1	3,019	622.00	1,232.75	295.97
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	1	3,019	622.00	1,232.75	295.97

TOTAL CASES Questions 11 and 12 TOTAL	3,495	These two figures must match.
PATIENTS Reported on Page 6	3,495	

*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

		MOM												FY
	$	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	2024
	Total Revenue	**$619**	**$465**	**($229)**	**$1,010**	**$590**	**$398**	**$779**	**$943**	**$676**	**$989**	**$370**	**$963**	**$7,572**
	Total Cost of Revenue	161	80	84	276	143	274	261	50	128	150	145	287	2,039
1	**Total Gross Profit**	**$458**	**$385**	**($313)**	**$733**	**$447**	**$123**	**$519**	**$893**	**$547**	**$839**	**$225**	**$677**	**$5,533**
	Payroll & Benefit Expense													
	Physicians	–	–	–	–	–	–	–	–	–	–	–	–	–
	APP	–	–	–	0	0	–	–	–	0	0	–	–	0
	Clinical Staff	70	108	319	143	145	143	145	(30)	81	82	81	79	1,366
	Non-Clinical Staff	–	–	–	–	–	–	–	–	–	–	–	–	–
	Billing Staff	33	16	9	39	17	21	20	40	38	22	24	27	307
	Corporate	–	–	–	–	–	–	–	–	–	–	–	–	–
2	**Total Payroll & Benefit Expense**	**$103**	**$124**	**$328**	**$183**	**$162**	**$164**	**$165**	**$10**	**$119**	**$103**	**$105**	**$106**	**$1,673**
	Other Operating Expenses													
	Advertising & Promotion	5	5	3	–	–	–	–	–	0	0	0	0	12
	Telecommunications	3	3	3	0	5	3	3	3	3	3	4	3	35
	Utilities & Facilities	38	40	30	50	31	42	44	39	40	44	43	102	543
	Other Operating Expense	2	4	2	3	10	2	4	3	6	3	3	3	46
	Operating Taxes	1	1	1	1	4	1	1	1	1	1	1	1	15
	Insurance	1	1	1	0	0	0	0	4	14	1	2	4	29
	General & Administrative	5	7	6	19	5	14	21	14	15	3	11	11	132
3	**Other Operating Expenses**	**$54**	**$61**	**$46**	**$73**	**$55**	**$62**	**$72**	**$64**	**$80**	**$56**	**$64**	**$123**	**$812**
4	**Total Operating Expense**	**$157**	**$185**	**$375**	**$256**	**$217**	**$227**	**$237**	**$74**	**$198**	**$159**	**$170**	**$230**	**$2,485**
5	**Operating Income (Loss)**	**$300**	**$199**	**($688)**	**$478**	**$230**	**($103)**	**$281**	**$818**	**$349**	**$680**	**$56**	**$447**	**$3,048**

GAAP financials presented

Figures shown in 000's	MOM												
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Dec-24
Current Assets													
Cash	$674	$720	($107)	$257	$176	$219	$216	$373	$397	$517	$699	$645	$645
Accounts Receivable	718	786	835	823	1,014	870	1,084	1,014	1,047	1,158	838	1,202	1,202
Prepaid Expenses	47	45	41	38	40	39	38	38	41	43	47	56	56
Total Current Assets	**$1,438**	**$1,551**	**$770**	**$1,118**	**$1,229**	**$1,128**	**$1,338**	**$1,426**	**$1,485**	**$1,718**	**$1,584**	**$1,903**	**$1,903**
Fixed Assets (Net)	1,797	1,775	1,754	1,739	1,716	1,695	1,672	1,656	1,636	1,631	1,607	1,604	1,604
Intangible Assets (Net)	10,388	10,249	10,111	9,972	9,834	9,696	9,557	9,419	9,280	9,142	9,003	8,865	8,865
Other Assets	0	0	0	0	0	2	2	3	2	10	10	10	10
Total Assets	**$13,623**	**$13,576**	**$12,635**	**$12,830**	**$12,780**	**$12,521**	**$12,569**	**$12,503**	**$12,403**	**$12,501**	**$12,204**	**$12,381**	**$12,381**
Current Liabilities													
Accounts Payable	366	308	348	163	80	280	322	300	350	253	333	561	$561
Accrued Liabilities	443	429	368	470	542	602	702	515	465	478	484	587	587
Other Current Liabilities	(592)	(434)	(445)	(433)	(499)	(707)	(726)	(1,031)	(774)	(849)	(809)	(949)	(949)
Total Current Liabilities	**$216**	**$303**	**$271**	**$199**	**$123**	**$175**	**$298**	**($217)**	**$41**	**($118)**	**$8**	**$199**	**$199**
Long Term Liabilities													
Lease Liability	716	704	694	683	672	660	648	637	625	613	600	588	588
Total Liabilities	**$932**	**$1,008**	**$965**	**$882**	**$794**	**$835**	**$946**	**$420**	**$665**	**$495**	**$609**	**$787**	**$787**
Equity													
Partners Equity	13,109	12,958	12,933	12,904	12,883	12,858	12,685	12,506	11,988	11,748	11,432	11,160	11,160
Retained Earnings	(546)	(417)	(389)	(1,263)	(956)	(897)	(1,172)	(1,062)	(423)	(250)	258	163	163
Net Income (Loss)	129	28	(874)	307	59	(274)	110	639	173	508	(94)	271	271
Total Liabilities & Equity	**$13,623**	**$13,576**	**$12,635**	**$12,830**	**$12,780**	**$12,521**	**$12,569**	**$12,503**	**$12,403**	**$12,501**	**$12,204**	**$12,381**	**$12,381**

A. CAPITAL EXPENDITURES

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

TOTAL CAPITAL EXPENDITURES FOR YOUR REPORTED FISCAL YEAR $ 0

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	
Medicare	$ 3,564,125
Other Public*	$ 131,648
Private Insurance	$ 3,555,683
Private Payment	$ 320,586
Total Revenue	$ 7,572,042

***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)