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	7003183			
ASTC Name	WESTERN DIVERSEY SURGICAL CENTER			
ASTC Address	2744 N WESTERN AVE			
ASTC City	CHICAGO	**IL**	**Zip Code**	60647

Federal Employer Identification Number (FEIN) 362768527

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 [ ]

*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 BOLAND
Address:	2824 MCKENNA DRIVE
City. State and Zip Code (plus Four):	NEW LENOX, IL 60451
Telephone Number:	(815) 462-0305

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	RENLIN XIA	2744 N WESTERN AVE	CHICAGO IL 60647	(773) 772-7726
2	TIAN XIA	2744 N WESTERN AVE	CHICAGO IL 60647	(773) 772-7726
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
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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				

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	1.00
Physicians	1.00
Nurse Anesthetists	0.00
Director of Nursing	1.00
Registered Nurses	9.00
Certified Aides	2.00
Other Health Professionals	7.00
Other Non-Health Professionals	11.00
TOTAL FACILITY PERSONNEL	32.00

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	TOTAL PATIENTS SERVED
0-14 Years	0	5	
15-44 Years	98	759	
45-64 Years	99	133	
65-74 Years	21	11	
75+ Years	2	1	
TOTALS	220	909	1,129

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	TOTAL PATIENTS SERVED
Medicaid	0	222	
Medicare	4	0	
Other Public*	0	0	
Private Insurance	189	198	
Private Payment	27	480	
Charity Care*	0	9	
TOTALS	220	909	1,129

***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	03275	MERIMACK	1
2	06032	HARTFORD	1
3	16823	CENTRE	1
4	30039	GWINNETT	1
5	30281	HENRY	1
6	30293	MERIWETHER	1
7	30296	CLAYTON	1
8	31052	BIBB	1
9	31201	BIBB	1
10	32413	BAY	1
11	32811	ORANGE	1
12	32927	BREVARD	1
13	33023	BROWARD	1
14	33068	BROWARD	1
15	33132	MIAMI DADE	1
16	33179	MIAMI DADE	1
17	33196	DADE	1
18	34772	OSCEOLA	1
19	35216	JEFFERSON	1
20	35235	JEFFERSON	1
21	36116	MONTGOMERY	1
22	36832	LEE	1
23	37042	MONTGOMERY	1
24	37130	RUTHERFORD	1
25	37172	ROBETSON	1

	Zip Code Area	County Name	Number of Patients
26	37201	DAVIDSON	1
27	37211	DAVIDSON	1
28	37219	DAVIDSON	1
29	37412	HAMILTON	1
30	38018	SHELBY	1
31	38732	BOLIVAR	1
32	38801	LEE	1
33	40019	HENRY	1
34	40206	JEFFERSON	1
35	40208	JEFFERSON	1
36	40214	JEFFERSON	1
37	40215	JEFFERSON	1
38	40219	JEFFERSON	1
39	40220	JEFFERSON	1
40	40222	JEFFERSON	1
41	40229	JEFFERSON	1
42	40291	JEFFERSON	1
43	42001	MCCRACKEN	1
44	42701	HARDIN	1
45	46032	HAMILTON	2
46	46038	HAMILTON	1
47	46064	MADISON	1
48	46077	BOON	1
49	46107	MARION	1
50	46112	HENDRICKS	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	46143	JOHNSON	1
52	46203	MARION	1
53	46205	MARION	2
54	46208	MARION	2
55	46217	MARION	1
56	46222	MARION	4
57	46224	MARION	1
58	46226	MARION	1
59	46227	MARION	2
60	46229	MARION	1
61	46235	MARION	1
62	46239	MARION	5
63	46241	MARION	1
64	46250	MARION	1
65	46254	MARION	2
66	46260	MARION	3
67	46268	BOONE	1
68	46300	LAKE	2
69	46307	LAKE	1
70	46312	COOK	4
71	46319	LAKE	1
72	46320	LAKE	2
73	46321	LAKE	1
74	46323	LAKE	4
75	46324	LAKE	4

	Zip Code Area	County Name	Number of Patients
76	46342	LAKE	1
77	46360	LAPORTE	1
78	46368	PORTER	1
79	46383	PORTER	2
80	46385	LAKE	1
81	46391	LAPORTE	2
82	46407	LAKE	1
83	46409	LAKE	1
84	46410	LAKE	7
85	46516	ELKHART	1
86	46517	ELKHART	1
87	46524	KOSCIASKO	1
88	46545	ST JOSEPH	1
89	46563	MARSHALL	1
90	46580	KOSCIUSKO	1
91	46613	ST JOSEPH	1
92	46614	ST JOSEPH	1
93	46637	ST JOSEPH	1
94	46737	STEUBEN	1
95	46806	ALLEN	1
96	46814	ALLEN	1
97	46819	ALLEN	1
98	46992	WABASH	1
99	47130	CLARK	1
100	47167	WASHINGTON	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
101	47243	JEFFERSON	1
102	47244	BARTH	1
103	47265	JENNINGS	2
104	47348	BLACKFORD	1
105	47429	MONROE	1
106	47905	TIPPECANOE	2
107	47906	TIPPECANOE	1
108	47909	TIPPECANOE	2
109	49001	KALAMAZOO	1
110	49022	BERREN	1
111	49091	ST JOSEPH	2
112	50021	POLK	1
113	52001	DUBUQUE	2
114	52246	JOHNSON	1
115	52732	CLINTON	1
116	53132	MILWAUKEE	1
117	53140	KENOSHA	1
118	53142	KENOSHA	1
119	53144	KENOSHA	1
120	53186	WAUKESHA	1
121	53204	MILWAUKEE	1
122	53206	MILWAUKEE	2
123	53208	MILWAUKEE	2
124	53211	MILWAUKEE	1
125	53212	MILWAUKEE	2

	Zip Code Area	County Name	Number of Patients
126	53215	MILWAUKEE	1
127	53216	MILWAUKEE	1
128	53217	MILWAUKEE	1
129	53218	MILWAUKEE	8
130	53220	MILWAUKEE	1
131	53221	MILWAUKEE	2
132	53223	MILWAUKEE	1
133	53224	MILWAUKEE	1
134	53225	MILWAUKEE	1
135	53402	RACINE	2
136	53405	RACINE	2
137	53511	ROCK	1
138	53803	LAFAYETTE	1
139	53954	COLUMBIA	1
140	54115	BROWN	1
141	54302	BROWN	1
142	54915	OUTAGAMIE	1
143	54935	FOND DU LAC	1
144	54952	WINNEBAGO	1
145	57501	HUGHES	1
146	60002	LAKE	1
147	60004	COOK	2
148	60005	COOK	1
149	60007	COOK	2
150	60008	COOK	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
151	60010	LAKE	1
152	60014	MCHENRY	1
153	60016	COOK	4
154	60018	COOK	4
155	60020	LAKE	1
156	60021	MCHENRY	1
157	60022	COOK	1
158	60025	COOK	1
159	60030	LAKE	5
160	60031	LAKE	1
161	60040	LAKE	1
162	60042	MCHENRY	1
163	60047	LAKE	1
164	60050	MCHENRY	1
165	60051	MCHENRY	1
166	60056	COOK	3
167	60060	LAKE	2
168	60067	COOK	1
169	60070	COOK	1
170	60073	LAKE	6
171	60074	COOK	3
172	60076	COOK	1
173	60077	COOK	1
174	60083	LAKE	1
175	60084	LAKE	1

	Zip Code Area	County Name	Number of Patients
176	60085	COOK	9
177	60087	LAKE	3
178	60089	COOK	3
179	60090	COOK	7
180	60098	MCHENRY	1
181	60101	DUPAGE	5
182	60102	MCHENRY	1
183	60103	DUPAGE	1
184	60104	COOK	8
185	60106	COOK	3
186	60107	COOK	5
187	60110	KANE	4
188	60115	DEKALB	1
189	60120	COOK	7
190	60123	KANE	4
191	60126	DUPAGE	1
192	60130	COOK	2
193	60131	COOK	6
194	60133	COOK	3
195	60139	DUPAGE	1
196	60148	DUPAGE	8
197	60150	DEKALB	1
198	60153	COOK	6
199	60154	COOK	2
200	60155	COOK	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	60156	MCHENRY	1
202	60157	DUPAGE	1
203	60160	COOK	9
204	60162	COOK	2
205	60163	COOK	2
206	60165	COOK	1
207	60169	COOK	3
208	60171	COOK	1
209	60173	COOK	1
210	60176	COOK	1
211	60177	KANE	2
212	60181	DUPAGE	1
213	60185	DUPAGE	3
214	60193	COOK	1
215	60194	COOK	4
216	60195	COOK	1
217	60201	COOK	1
218	60202	COOK	1
219	60302	COOK	2
220	60402	COOK	9
221	60406	COOK	5
222	60407	GRUNDY	1
223	60409	COOK	9
224	60410	WILL	1
225	60411	COOK	11

	Zip Code Area	County Name	Number of Patients
226	60416	GRUNDY	1
227	60417	WILL	1
228	60419	COOK	1
229	60426	COOK	4
230	60428	COOK	3
231	60429	COOK	2
232	60431	WILL	4
233	60432	WILL	5
234	60433	WILL	4
235	60435	WILL	5
236	60436	WILL	2
237	60438	COOK	4
238	60440	WILL	4
239	60441	WILL	1
240	60443	COOK	2
241	60445	COOK	3
242	60446	WILL	2
243	60447	GRUNDY	1
244	60448	WILL	1
245	60450	GRUNDY	2
246	60451	WILL	1
247	60452	COOK	1
248	60453	COOK	5
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	60458	COOK	2
252	60459	COOK	1
253	60462	COOK	3
254	60465	COOK	1
255	60466	COOK	1
256	60471	COOK	2
257	60473	COOK	4
258	60478	COOK	5
259	60481	WILL	2
260	60484	WILL	1
261	60489	COOK	1
262	60490	WILL	1
263	60491	WILL	1
264	60501	COOK	2
265	60504	DUPAGE	1
266	60505	KANE	6
267	60506	KANE	1
268	60515	DUPAGE	2
269	60516	DUPAGE	2
270	60517	DUPAGE	1
271	60525	COOK	4
272	60527	DUPAGE	2
273	60532	DUPAGE	1
274	60534	COOK	2
275	60543	KENDALL	1

	Zip Code Area	County Name	Number of Patients
276	60544	COOK	2
277	60545	KENDALL	2
278	60555	DUPAGE	1
279	60560	KENDALL	1
280	60564	DUPAGE	1
281	60585	WILL	3
282	60586	WILL	2
283	60607	COOK	2
284	60608	COOK	15
285	60609	COOK	8
286	60610	COOK	2
287	60611	COOK	2
288	60612	COOK	11
289	60613	COOK	4
290	60614	COOK	4
291	60615	COOK	4
292	60616	COOK	8
293	60617	COOK	16
294	60618	COOK	18
295	60619	COOK	14
296	60620	COOK	14
297	60621	COOK	4
298	60622	COOK	5
299	60623	COOK	18
300	60624	COOK	16

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.

60625	Cook	18
60626	Cook	8
60627	Cook	1
60628	Cook	9
60629	Cook	29
60630	Cook	5
60631	Cook	2
60632	Cook	16
60633	Cook	2
60634	Cook	18
60636	Cook	7
60637	Cook	13
60638	Cook	4
60639	Cook	36
60640	Cook	8
60641	Cook	6
60642	Cook	8
60643	Cook	7
60644	Cook	17
60645	Cook	10
60647	Cook	21
60649	Cook	8
60651	Cook	26
60652	Cook	1
60653	Cook	5
60654	Cook	1
60655	Cook	2
60656	Cook	4

additional zip codes

60657	Cook	10
60659	Cook	10
60660	Cook	3
60706	Cook	1
60707	Cook	12
60709	Cook	1
60714	Cook	2
60803	Cook	4
60804	Cook	11
60805	Cook	3
60827	Cook	3
60901	Cook	5
60950	KANKAKEE	1
61008	BOONE	4
61032	STEPHENSON	2
61048	Dupage	3
61068	Cook	3
61101	WINNEBAGO	5
61102	WINNEBAGO	2
61104	WINNEBAGO	1
61109	WINNEBAGO	1
61111	WINNEBAGO	1
61115	WINNEBAGO	1
61265	ROCK ISLAND	1
61301	LASALLE	3
61401	KNOX	1
61443	HENRY	2
61615	PEORIA	2
61822	CHAMPAIGN	1
62521	MALON	1

70068	ST.JOHN THE BAPTI	1
70114	ORLEANS	1
70131	ORLEANS	1
70802	WAST BOTTOM	1
70817	BATON ROUGE	1
71270	LINCOLN PARISH	1
72211	PULASKI	1
72335	ST FANCIS	1
72730	WASHINGTON	1
74601	KAY	1
75001	DALLAS	1
75207	DALLAS	1
75409	COLLIN	1
76115	TARRANT	1
77056	HARRIS	1
77068	HARRIS	1
77079	HARRIS	1
77082	ELDRIDGE	1
77093	HARRIS	1
77355	MONTGOMERY	1
77388	HARRIS	2
77407	FORT BEND	1
77573	GALVESTON	1
78643	Llano	1
85042	MARICOPA	1
94568	ALAMEDA	1
Grand Total		**1129**

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	8	8	8	8	8	0	0	40

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)*	0
c. Examination Rooms	2
d. Stage 1 - Post-Anesthesia Recovery Stations	8
e. Stage 2 - Step-down Ambulatory Recovery Stations	8

*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	HUMBOLT PARK HEALTH, CHICAGO	1
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	682	132.00	275.00	119.00
Oral/Maxillofacial				
Ophthalmology				
Laser Eye Surgery				
Orthopedic				
Otolaryngology				
Pain Management	447	110.00	224.00	98.00
Plastic				
Podiatry				
Thoracic				
Urology				
TOTALS	1,129	242.00	499.00	217.00

*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	0	0.00	0.00	0.00
b. Dedicated Laser Eye Procedures	0	0	0.00	0.00	0.00
c. Dedicated Pain Management Procedures	0	0	0.00	0.00	0.00
d. Cardiac Catheterization Procedures	0	0	0.00	0.00	0.00

	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 0				
	TOTALS - PROCEDURE ROOMS 0	0	0.00	0.00	0.00

TOTAL CASES Questions 11 and 12 TOTAL	1,129	These two figures must match.
PATIENTS Reported on Page 6	1,129	

*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 $ 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	$ 5,889
Other Public*	$ 19,040
Private Insurance	$ 838,723
Private Payment	$ 102,666
Total Revenue	$ 966,318

***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	$ 28,000

**"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)