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	7003124			
ASTC Name	CENTER FOR HEALTH AMBULATORY SURGERY CENTER, LL			
ASTC Address	8800 N STATE ROUTE 91			
ASTC City	PEORIA	**IL**	**Zip Code**	61615

Federal Employer Identification Number (FEIN) 20-5557171

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:	ILLINOIS COPORATION SERVICE COMPANY
Address:	801 ADLAI STEVENSON DR
City. State and Zip Code (plus Four):	SPRINGFIELD, IL 62703-4261
Telephone Number:	(314) 444-7873

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	OSF HEALTHCARE ST. FRANCIS MEDIL	MANAGEMENT	OWNER
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	OSF HEALTHCARE	520 NE GLEN OAK AVE	PEORIA, IL 61637-0002	(309) 655-2000
2	ILLINOIS EYE CENTER	8921 N WOOD SAGE RD	PEORIA, IL 61615-7822	(309) 243-2400
3	MUSCULOSKELETAL INV	303 N WILLIAM KUMPF BLVD	PEORIA, IL 61605-2507	(309) 272-0267
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	OSF HEALTHCARE	530 NE GLEN OAK AVE	PEORIA, IL 61637-000	(309) 655-2000

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	1.00
Physicians	
Nurse Anesthetists	
Director of Nursing	1.00
Registered Nurses	23.30
Certified Aides	2.00
Other Health Professionals	14.70
Other Non-Health Professionals	13.70
TOTAL FACILITY PERSONNEL	55.70

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	412	342	
15-44 Years	314	510	
45-64 Years	760	1,062	TOTAL PATIENTS SERVED
65-74 Years	1,042	1,476	
75+ Years	896	924	
TOTALS	3,424	4,314	7,738

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	56	54	
Medicare	1,620	2,248	
Other Public*	322	67	
Private Insurance	1,392	1,791	
Private Payment	29	150	TOTAL PATIENTS SERVED
Charity Care*	5	4	
TOTALS	3,424	4,314	7,738

***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	07032		1
2	19073		1
3	30134		1
4	30290		1
5	32733		1
6	32934		1
7	33026		2
8	33496		1
9	33706		2
10	33850		2
11	33912		2
12	33928		1
13	34110		1
14	34119		2
15	34135		2
16	34231		1
17	34480		1
18	34736		1
19	35756		1
20	37066		1
21	37083		2
22	37110		2
23	38464		1
24	38506		1
25	39456		1

	Zip Code Area	County Name	Number of Patients
26	42025		1
27	45242		1
28	46143		1
29	46304		1
30	46307		1
31	46311		1
32	46410		1
33	47805		1
34	49008		1
35	52302		2
36	52404		1
37	52722		4
38	52773		1
39	52803		1
40	53081		1
41	54547		1
42	54901		1
43	55446		1
44	56468		1
45	60053		1
46	60076		1
47	60102		1
48	60103		1
49	60156		1
50	60193		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	60416		1
52	60420		2
53	60429		1
54	60451		1
55	60452		1
56	60460		1
57	60470		2
58	60513		1
59	60544		2
60	60564		1
61	60613		1
62	60622		1
63	60652		1
64	60659		1
65	60924		1
66	60929		1
67	60942		1
68	60953		1
69	60955		3
70	60957		4
71	60962		2
72	60970		2
73	61021		6
74	61031		1
75	61071		1

	Zip Code Area	County Name	Number of Patients
76	61081		1
77	61201		2
78	61234		3
79	61235		2
80	61240		1
81	61244		2
82	61254		1
83	61264		4
84	61265		1
85	61279		1
86	61301		9
87	61310		1
88	61314		7
89	61315		2
90	61319		4
91	61321		1
92	61322		3
93	61325		2
94	61326		5
95	61327		8
96	61329		1
97	61330		4
98	61333		1
99	61334		3
100	61335		2

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

	Zip Code Area	County Name	Number of Patients
101	61336		7
102	61337		3
103	61338		1
104	61340		2
105	61341		3
106	61342		3
107	61345		10
108	61348		14
109	61349		3
110	61350		19
111	61354		13
112	61356		61
113	61359		1
114	61360		1
115	61361		10
116	61362		12
117	61364		29
118	61368		6
119	61369		25
120	61370		2
121	61372		1
122	61373		3
123	61374		1
124	61375		11
125	61376		3

	Zip Code Area	County Name	Number of Patients
126	61377		2
127	61379		10
128	61401		168
129	61410		19
130	61412		6
131	61413		1
132	61414		8
133	61415		7
134	61417		3
135	61419		1
136	61420		3
137	61421		19
138	61422		3
139	61423		4
140	61424		3
141	61426		2
142	61427		27
143	61428		13
144	61430		8
145	61431		3
146	61432		15
147	61433		2
148	61434		16
149	61435		1
150	61436		8

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

	Zip Code Area	County Name	Number of Patients
151	61437		1
152	61439		1
153	61440		1
154	61441		6
155	61442		1
156	61443		103
157	61447		2
158	61448		32
159	61449		4
160	61451		3
161	61452		1
162	61453		3
163	61454		4
164	61455		10
165	61455-3331		1
166	61458		5
167	61459		1
168	61462		32
169	61465		1
170	61466		4
171	61467		7
172	61469		2
173	61470		1
174	61472		10
175	61473		6

	Zip Code Area	County Name	Number of Patients
176	61474		1
177	61477		3
178	61478		2
179	61479		6
180	61480		1
181	61483		27
182	61484		5
183	61485		4
184	61488		1
185	61489		15
186	61490		3
187	61491		34
188	61501		12
189	61516		8
190	61517		77
191	61519		3
192	61520		186
193	61523		188
194	61523-9192		1
195	61524		3
196	61525		240
197	61526		23
198	61528		88
199	61529		44
200	61530		82

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	61531		42
202	61532		6
203	61533		39
204	61534		28
205	61535		38
206	61536		58
207	61537		55
208	61539		4
209	61540		56
210	61542		42
211	61544		11
212	61545		16
213	61546		47
214	61546-7700		1
215	61547		80
216	61548		280
217	61550		353
218	61552		4
219	61553		3
220	61554		555
221	61559		68
222	61560		9
223	61561		31
224	61562		3
225	61563		7

	Zip Code Area	County Name	Number of Patients
226	61564		10
227	61565		27
228	61567		6
229	61567-9539		1
230	61568		75
231	61569		16
232	61570		24
233	61571		494
234	61572		18
235	61601		1
236	61602		8
237	61603		108
238	61604		365
239	61605		106
240	61606		27
241	61606-1034		1
242	61607		231
243	61610		81
244	61610-3247		1
245	61611		493
246	61611-9547		2
247	61611-4004		1
248	61612		5
249	61614		474
250	61615		437

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	61616		72
252	61625		1
253	61651		2
254	61652		1
255	61659		2
256	61701		35
257	61702		1
258	61704		54
259	61705		23
260	61720		1
261	61723		5
262	61725		6
263	61726		5
264	61727		9
265	61728		3
266	61729		14
267	61732		5
268	61733		19
269	61734		32
270	61737		1
271	61738		4
272	61739		8
273	61742		18
274	61744		1
275	61745		7

	Zip Code Area	County Name	Number of Patients
276	61747		23
277	61748		2
278	61752		3
279	61753		3
280	61754		1
281	61755		52
282	61756		2
283	61758		5
284	61759		7
285	61760		17
286	61761		44
287	61764		23
288	61769		2
289	61771		1
290	61773		1
291	61774		3
292	61776		1
293	61777		1
294	61778		4
295	61801		5
296	61802		5
297	61814		1
298	61816		1
299	61820		2
300	61821		7

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)*	6
b. Procedure (not operating) Rooms (Class B)*	0
c. Examination Rooms	0
d. Stage 1 - Post-Anesthesia Recovery Stations	8
e. Stage 2 - Step-down Ambulatory Recovery Stations	16

*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	OSF ST. FRANCIS MEDICAL CENTER	9
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	288	96.00	128.50	48.00
Gastroenterology				
Neurological				
OB/Gynecology	166	55.00	24.00	28.00
Oral/Maxillofacial				
Ophthalmology	4,558	380.00	3,444.75	380.00
Laser Eye Surgery				
Orthopedic	1,549	516.00	1,868.25	258.00
Otolaryngology	876	292.00	372.00	146.00
Pain Management	14	2.30	15.75	2.30
Plastic	179	50.00	618.00	29.00
Podiatry	85	28.00	68.50	14.00
Thoracic				
Urology	23	4.00	13.25	4.00
TOTALS	7,738	1,423.30	6,553.00	909.30

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

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

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

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

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

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

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

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

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

TOTAL CASES Questions 11 and 12 TOTAL	7,738	These two figures must match.
PATIENTS Reported on Page 6	7,738	

*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:

Review or Compilation Financial Statemen

A. CAPITAL EXPENDITURES

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

TOTAL CAPITAL EXPENDITURES FOR YOUR REPORTED FISCAL YEAR $ 1,023,419

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	Power equipment	$ 496,008		
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	$ 4,321
Medicare	$ 6,963,828
Other Public*	$ 356,857
Private Insurance	$ 17,538,017
Private Payment	$ 1,020,058
Total Revenue	$ 25,883,080

***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	$ 53,835

"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)