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	7003244			
ASTC Name	OAK ASC, LLC			
ASTC Address	6712 N. CONVENT ST. SUITE 200			
ASTC City	BOURBONNAIS	**IL**	**Zip Code**	60914

Federal Employer Identification Number (FEIN) 83-3101804

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: MICHAEL CORCORAN

*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:	MICHAEL CORCORAN,MD
Address:	6712 N. CONVENT ST. SUITE 100
City. State and Zip Code (plus Four):	BOURBONNAIS, IL 60914
Telephone Number:	

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

	Name	Relationship	Type of Interest
1			
2			
3			
4			
5			

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

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

2. PROPERTY OWNERSHIP INFORMATION

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

	Property Owner	Address	City, State Zip Code-plus 4	Telephone (xxx) xxx-xxxx.xxxx)
1	IBJI, LLC	900 RAND RD SUITE 300	DESPLAINES, IL 60016	(847) 375-3000

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: 30.0

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	
Registered Nurses	14.00
Certified Aides	
Other Health Professionals	5.00
Other Non-Health Professionals	6.00

TOTAL FACILITY PERSONNEL 26.00

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	19	9	
15-44 Years	398	301	
45-64 Years	665	824	
65-74 Years	548	803	TOTAL PATIENTS SERVED
75+ Years	407	709	
TOTALS	2,037	2,646	4,683

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	1	1	
Medicare	844	1,415	
Other Public*	138	85	
Private Insurance	1,034	1,130	
Private Payment	20	15	TOTAL PATIENTS SERVED
Charity Care*	0	0	
TOTALS	2,037	2,646	4,683

***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	20110	MANASSAS CIT	1
2	22314	ALEXANDRIA CI	1
3	32127	VOLUSIA	1
4	34114	COLLIER	1
5	34145	COLLIER	1
6	37866	UNION	1
7	42064	CHRISTIAN	1
8	46304	PORTER	1
9	46307	CROWN POINT	7
10	46311	LAKE	8
11	46319	LAKE	1
12	46322	LAKE	3
13	46323	LAKE	2
14	46324	LAKE	1
15	46341	HEBRON	1
16	46349	NEWTON	7
17	46356	LAKE	11
18	46360	LAPORTE	1
19	46373	LAKE	7
20	46392	JASPER	7
21	47951	NEWTON	1
22	47960	WHITE	1
23	47963	NEWTON	3
24	49022	BERRIEN	1
25	55044	DAKOTA	1

	Zip Code Area	County Name	Number of Patients
26	60185	DUPAGE	2
27	60401	WILL	93
28	60403	WILL	1
29	60404	WILL	3
30	60406	COOK	1
31	60407	GRUNDY	5
32	60408	WILL	74
33	60410	WILL	13
34	60411	COOK	7
35	60415	COOK	1
36	60416	GRUNDY	42
37	60417	WILL	31
38	60418	COOK	7
39	60419	COOK	4
40	60420	LIVINGSTON	35
41	60421	WILL	3
42	60422	COOK	9
43	60423	WILL	222
44	60424	GRUNDY	16
45	60426	COOK	1
46	60428	COOK	1
47	60429	COOK	2
48	60430	COOK	18
49	60431	WILL	3
50	60432	WILL	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
51	60433	WILL	3
52	60435	WILL	1
53	60436	WILL	4
54	60438	COOK	6
55	60439	COOK	5
56	60441	WILL	16
57	60442	WILL	57
58	60443	COOK	23
59	60444	GRUNDY	7
60	60445	COOK	5
61	60446	WILL	2
62	60448	WILL	74
63	60449	WILL	60
64	60450	GRUNDY	15
65	60451	WILL	113
66	60452	COOK	13
67	60453	COOK	2
68	60455	COOK	1
69	60460	LIVINGSTON	3
70	60461	COOK	5
71	60462	COOK	18
72	60463	COOK	9
73	60464	COOK	7
74	60465	COOK	2
75	60466	COOK	14

	Zip Code Area	County Name	Number of Patients
76	60467	COOK	13
77	60468	WILL	113
78	60471	COOK	5
79	60472	COOK	1
80	60473	COOK	2
81	60474	GRUNDY	6
82	60475	COOK	3
83	60476	COOK	1
84	60477	COOK	57
85	60478	COOK	5
86	60481	WILL	146
87	60482	COOK	1
88	60484	WILL	3
89	60487	COOK	53
90	60491	WILL	20
91	60543	KENDALL	2
92	60586	WILL	4
93	60610	COOK	1
94	60613	COOK	1
95	60618	COOK	1
96	60619	COOK	1
97	60622	COOK	1
98	60629	COOK	1
99	60633	COOK	1
100	60638	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
101	60643	COOK	4
102	60655	COOK	5
103	60707	COOK	1
104	60803	COOK	7
105	60901	KANKAKEE	571
106	60910	KANKAKEE	19
107	60911	IROQUOIS	53
108	60912	IROQUOIS	5
109	60913	KANKAKEE	60
110	60914	KANKAKEE	749
111	60915	KANKAKEE	254
112	60917	KANKAKEE	14
113	60918	IROQUOIS	2
114	60919	FORD	16
115	60921	LIVINGSTON	7
116	60922	IROQUOIS	54
117	60924	IROQUOIS	10
118	60927	IROQUOIS	94
119	60928	IROQUOIS	12
120	60929	LIVINGSTON	6
121	60930	IROQUOIS	25
122	60931	IROQUOIS	12
123	60934	LIVINGSTON	2
124	60935	KANKAKEE	28
125	60936	FORD	4

	Zip Code Area	County Name	Number of Patients
126	60938	IROQUOIS	26
127	60940	KANKAKEE	85
128	60940-7206	KANKAKEE	2
129	60941	KANKAKEE	74
130	60950	KANKAKEE	374
131	60951	IROQUOIS	12
132	60953	IROQUOIS	23
133	60954	KANKAKEE	129
134	60955	IROQUOIS	9
135	60957	FORD	8
136	60958	KANKAKEE	5
137	60959	FORD	17
138	60961	KANKAKEE	9
139	60964	KANKAKEE	135
140	60966	IROQUOIS	24
141	60968	IROQUOIS	4
142	60970	IROQUOIS	76
143	60974	IROQUOIS	2
144	61108	WINNEBAGO	1
145	61319	LIVINGSTON	3
146	61360	LASALLE	1
147	61364	LASALLE	3
148	61704	MCLEAN	2
149	61739	LIVINGSTON	2
150	61753	MCLEAN	5

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	61764	LIVINGSTON	1
152	61866	CHAMPAIGN	3
153	61874	CHAMPAIGN	1
154	62501	MACON	1
155	62996	PULASKI	3
156	78133	COMAL	1
157	78641	WILLIAMSON	1
158	92028	SAN DIEGO	1
159	93611	FRESNO	1
160	94901	MARIN	1
161	99999	OUTSIDE US	1
162	01089	HAMPDEN	1
163	46534	STARKE	2
164	61802	CHAMPAIGN	2
165	60946	KEMPTON	5
166	60458	COOK	1
167	60654	COOK	1
168	60948	IROQUOIS	1
169	62898	JEFFERSON	1
170	60657	COOK	1
171	63469	SHELBY	1
172	61834	VERMILION	2
173	60620	COOK	1
174	60969	KANKAKEE	2
175	60010	LAKE	1

	Zip Code Area	County Name	Number of Patients
176	60160	COOK	1
177	46310	DE MOTTE	4
178	46303	LAKE	1
179	60628	COOK	1
180	34285	SARASOTA	1
181	74962	SEQUOYAH	1
182	60617	COOK	1
183	33040	MONROE	2
184	60805	COOK	1
185	46374	STARKE	1
186	60157	DUPAGE	1
187	98042	KING	1
188	60920	LIVINGSTON	1
189	61350	LASALLE	1
190	46375	LAKE	1
191	60409	COOK	1
192	60621	COOK	1
193	60527	DUPAGE	1
194	61354	LASALLE	1
195	60440	WILL	1
196	61822	CHAMPAIGN	1
197			
198			
199			
200			

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			
202			
203			
204			
205			
206			
207			
208			
209			
210			
211			
212			
213			
214			
215			
216			
217			
218			
219			
220			
221			
222			
223			
224			
225			

	Zip Code Area	County Name	Number of Patients
226			
227			
228			
229			
230			
231			
232			
233			
234			
235			
236			
237			
238			
239			
240			
241			
242			
243			
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248			
249			
250			

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			
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295			
296			
297			
298			
299			
300			

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

FACILITY OPERATIONS

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

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	TOTAL HOURS
Hours Open	10	10	10	10	10	0	0	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)*	3
b. Procedure (not operating) Rooms (Class B)*	0
c. Examination Rooms	0
d. Stage 1 - Post-Anesthesia Recovery Stations	15
e. Stage 2 - Step-down Ambulatory Recovery Stations	0

*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	ASCENSION SAINT MARYS KANKAKEE	4
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				
Oral/Maxillofacial				
Ophthalmology				
Laser Eye Surgery				
Orthopedic	1,839	460.00	1,216.50	460.00
Otolaryngology				
Pain Management	2,647	211.75	269.00	211.75
Plastic				
Podiatry	197	49.25	145.75	49.25
Thoracic				
Urology				
TOTALS	4,683	721.00	1,631.25	721.00

***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					
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	4,683	These two figures must match.
PATIENTS Reported on Page 6	4,683	

*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 Statem

A. CAPITAL EXPENDITURES

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

TOTAL CAPITAL EXPENDITURES FOR YOUR REPORTED FISCAL YEAR $ 165,026

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	$ 20,822
Medicare	$ 10,339,831
Other Public*	$ 2,458,158
Private Insurance	$ 16,536,810
Private Payment	$ 58,174
Total Revenue	$ 29,413,796

***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)