CONFIRMATION OF RECEIPT OF IDPH ANNUAL HOSPITAL QUESTIONNAIRE FOR 2009 DATA

The 2009 Data Questionnaire for your hospital has been received by the Illinois Department of Public Health.

Thank you for your cooperation.

Please print out a copy of this confirmation notice for your records.

April 22, 2010

Welcome to the
ILLINOIS DEPARTMENT OF PUBLIC HEALTH (IDPH)
ANNUAL HOSPITAL QUESTIONNAIRE FOR CALENDAR YEAR 2009

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)]

PLEASE NOTE

This questionnaire is divided into 2 sections.

Part I
Collects information on your facility and facility utilization.
This part MUST BE REPORTED FOR CALENDAR YEAR 2009.

Part II
Collects Financial and Capital Expenditure information for your facility.
This part MUST BE REPORTED FOR THE MOST RECENT FISCAL YEAR AVAILABLE TO YOU.

This survey must be completed and submitted by May 20, 2010.

Facilities failing to submit this questionnaire within the required time frame will be reported to the State Board for the State Board's consideration of the imposition of sanctions mandated by the Act.

If you have problems or questions concerning the survey, please check the [help] links provided. If you still have problems, contact this office via e-mail at DPH.FacilitySurvey@illinois.gov, or by telephone at 217-782-3516.

Click the button marked 'Next' at the bottom of this page to begin the survey.

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SURVEY INSTRUCTIONS

NOTE: Validation rules have been set up for some items; if your responses do not meet the validation rules, or if you have not filled in some required fields, you will not be allowed to proceed to the next page.

There are 3 buttons at the bottom of each survey page:
'Next' takes you to the the next page of the survey.
'Back' returns you to the previous survey page.
'Save' saves work in progress if you need to stop before finishing.
YOU DO NOT NEED TO SAVE AFTER EACH PAGE.
ONLY SAVE THE FORM IF YOU NEED TO STOP BEFORE COMPLETING.

IMPORTANT

When you save your work, the unfinished survey is stored on our server with a new, random address. You will be prompted to set a bookmark or Favorite in your web browser. YOU MUST DO THIS ONLY ONCE; YOU CANNOT ACCESS YOUR SAVED FORM WITHOUT IT. The link provided in your e-mail notice WILL NOT access the saved form, only a blank survey. When you are ready to continue, use the bookmark or favorite to open the form. You will be returned to the place where you left off.

The information below is for REFERENCE PURPOSES ONLY.
DO NOT MAKE CHANGES TO ANY OF THE LISTED INFORMATION.
If you have questions about any of the information listed, please contact us via e-mail or telephone:
E-mail: DPH.FacilitySurvey@illinois.gov Telephone: 217-782-3516

Hospital Name	Swedish Covenant Hospital			
Hospital Address	5145 North California Avenue			
Hospital City	Chicago	**State** IL	**Zip Code** 60625	

Authorized Hospital Bed Capacity (CON)

	Information		December 31, 2008	December 31, 2009
		Medical-Surgical	182	182
		Pediatrics	6	6
Health Service Area	6	Intensive Care	18	18
Hospital Planning Area	A-01	Obstetrics	21	21
County	COOK	Neonatal Level III	0	0
Approved for LTC Swing Beds?		Long-Term Care	46	37
[Help]		Acute Mental Illness	36	34
		Rehabilitation	25	25
		Long-Term Acute Care (LTACH)	0	0
		[Help]		

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IDPH ANNUAL HOSPITAL QUESTIONNAIRE - PART I

QUESTION I. INPATIENT SERVICES UTILIZATION

Report the utilization data for each category of service in the spaces below.
OBSERVATION DAYS are defined as days provided to outpatients prior to admission for the purpose of determining whether a patient requires admission as an Inpatient. OBSERVATION DAYS = OBSERVATION HOURS divided by 24.
PEAK BEDS SET UP AND STAFFED is the highest number of authorized service beds available for use at any point in time in the calendar year.
PEAK CENSUS is the highest number of Inpatients in the unit at any point in time in the calendar year.

A. MEDICAL-SURGICAL UTILIZATION:

If you have an authorized Pediatrics unit, report utilization on line B below, not on line A1.

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2009	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Medical-Surgical Nursing Unit
A1. Medical-Surgical 0-14 years	0	0				
A2. Medical-Surgical 15-44 years	1328	4745				
A3. Medical-Surgical 45-64 years	2768	12170				
A4. Medical-Surgical 65-74 years	2055	10803				
A5. Medical-Surgical 75 +	4271	23227				
A6. Medical-Surgical Totals	10422	50945	156	156	156	1921

B. PEDIATRIC UTILIZATION:

Pediatric care is defined as non-intensive Medical-Surgical care for patients aged 0-14 years.

If this service is provided in an AUTHORIZED Pediatric Unit, the data is to be recorded in this section on line B.
If there is no AUTHORIZED Pediatric Unit, report Medical Surgical care for 0-14 year olds on line A1.

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2009	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Pediatric Nursing Unit
B. Pediatric Utilization	392	812	6	6	6	291

C. INTENSIVE CARE UTILIZATION:

In this section, report the utilization of your Intensive Care unit, if you have one.
Neonatal Level III (Neonatal Intensive Care) is not to be reported here.
Intermediate care units are components of Medical-Surgical care and should be included in section A.
If an inpatient is sent directly to ICU upon admission to the hospital, report the patient in line C1; if an inpatient is admitted to another unit of the hospital and subsequently moved into ICU, report ICU utilization for that inpatient on line C2.

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2009	Peak Beds Set Up and Staffed	Peak Census	Observation Days in ICU Nursing Unit
C1. Inpatients Admitted Directly to ICU	632	2460				
C2. Patients Transferred to ICU from another Unit of the Hospital	297	2353				
C3. TOTAL ICU UTILIZATION	929	4813	18	18	18	0

D. OBSTETRIC/GYNECOLOGY UTILIZATION:

Obstetrics care includes both Ante-Partum and Post-Partum.
Clean Gynaecology is the non-maternity care.

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2009	Peak Beds Set Up and Staffed	Peak Census	Observation Days in OB/Gyne Nursing Unit
D1. Obstetrics Patients	2662	6119				
D2. Clean Gynecology Patients	221	656				
D3. Total Obstetrics/Gynecology Patients	2883	6775	21	21	21	102

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IDPH ANNUAL HOSPITAL QUESTIONNAIRE - PART I

E. NEONATAL LEVEL III (NEONATAL INTENSIVE CARE) UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2009	Peak Beds Set Up and Staffed	Peak Census	Observation Days In Neonatal Level III Nursing Unit
E. Neonatal Level III [Help]	0	0	0	0	0	0

F. LONG-TERM NURSING CARE UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2009	Peak Beds Set Up and Staffed	Peak Census	Observation Days In Long-Term Care Nursing Unit
F. Long-Term Care (LTC) [Help]	0	0	0	0	0	0

G. LONG-TERM CARE SWING BEDS (MEDICARE-CERTIFIED) UTILIZATION:

	Admissions	Inpatient Days	Peak Census
G. LTC Swing Beds (Medicare-certified) [Help]	0	0	0

H. ACUTE MENTAL ILLNESS UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2009	Peak Beds Set Up and Staffed	Peak Census	Observation Days In Acute Mental Illness Nursing Unit
H. Acute Mental Illness [Help]	1090	8013	31	31	31	0

I. REHABILITATION UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2009	Peak Beds Set Up and Staffed	Peak Census	Observation Days In Rehabilitation Nursing Unit
I. Rehabilitation [Help]	325	4100	25	25	19	0

J. LONG-TERM ACUTE CARE UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2009	Peak Beds Set Up and Staffed	Peak Census	Observation Days In Rehabilitation Nursing Unit
J. Long-Term Acute Care (LTACH) [Help]	721	5770	24	24	24	0

K. OBSERVATION DAYS OUTSIDE A NURSING UNIT:

If patient observation prior to admission takes place in dedicated observation beds and/or stations (not occurring in inpatient nursing units listed in A through I), report the number of dedicated observations beds or stations and the number of observation days here:

	Dedicated Observation Beds or Stations	Observation Days In Dedicated Observation Beds or Stations
K. Dedicated Observation Beds or Stations	13	1026

FACILITY TOTAL UTILIZATION:

Report the Total Hospital Utilization Statistics in the spaces provided. TOTALS MUST INCLUDE ALL AUTHORIZED HOSPITAL SERVICES.
The sub-totals reported below must equal the sum of the categories of service figures entered on Lines A6, B, C3, D3, E, F, G, H, I, J and K.
Total Hospital Utilization is the same as on the Sub-Total line, except that Intensive Care Transfers (line C2) are deducted from Admissions.

	Total Admissions	Total Inpatient Days	Total Beds Set Up and Staffed on Oct. 1, 2009	Total Observation Days in Hospital
SUB-TOTAL OF ITEMS A - K	16762	81228	281	3340
Minus ICU Transfers from C2	297			
L. TOTAL HOSPITAL UTILIZATION	16465	81228	281	3340

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IDPH ANNUAL HOSPITAL QUESTIONNAIRE - PART I

L. INPATIENT UTILIZATION BY RACIAL GROUP AND ETHNICITY:

Report the number of Inpatients admitted to the hospital and the number of Patient Days of Care provided to Inpatients by the hospital by the Racial Group and Ethnicity of the patient.

TOTAL ADMISSIONS AND INPATIENT DAYS IN SECTION 1 as well as in SECTION 2 (not a combination) MUST AGREE WITH THE FIGURES REPORTED ON LINE L, PAGE 4.

SECTION 1. RACIAL GROUPS	Inpatients Admitted	Patient Days
Asian	2936	13188
American Indian or Native Alaskan	56	253
Black or African American	1179	6173
Native Hawaiian or Pacific Islander	0	0
White	11222	57030
Unknown	1072	4584
TOTALS - SECTION 1	16465	81228

SECTION 2. ETHNIC GROUPS	Inpatients Admitted	Patient Days
Hispanic or Latino	2971	12401
Not Hispanic or Latino	12422	64243
Unknown	1072	4584
TOTALS - SECTION 2	16465	81228

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IDPH ANNUAL HOSPITAL QUESTIONNAIRE - PART I

Question II. FACILITY OWNERSHIP AND ADMINISTRATION:

A. Legal Entity that operates the facility [Help] Swedish Covenant Hospital

B. Legal Entity that owns the physical plant [Help] Swedish Covenant Hospital

C. Indicate the type of organization managing the facility (MARK ONLY ONE SELECTION):

FOR PROFIT	NOT FOR PROFIT
○ Sole Proprietorship	◉ Church-Related
○ For Profit Corporation	○ Not for Profit Corporation
○ Partnership (registered with county)	○ County
○ Limited Partnership	○ City
○ Limited Liability Partnership	○ Township
○ Limited Liability Company	○ Hospital District
○ Other For Profit (specify below)	○ Other Not For Profit (specify below)

Other Ownership Type

D. Indicate any contracts for management of services: List any contractors who manage the selected services performed in the hospital.

	Contract Management
Psychiatric Service	
Rehabilitation Service	
Emergency Service	

E. Is your ENTIRE facility CERTIFIED by the Center for Medicare and Medicaid Services (CMS) as either of the following? (Check to indicate certification)

- ☐ Critical Access Hospital
- ☐ LongTerm Acute Care Hospital (LTACH)

F. Is your ENTIRE facility characterized as any of the following? (Check if applicable)

- ☑ General Hospital
- ☐ Rehabilitation Hospital
- ☐ Children's Speciality Care Hospital
- ☐ Psychiatric Hospital

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IDPH ANNUAL HOSPITAL QUESTIONNAIRE - PART I

Question III. SURGICAL PROCEDURES - O.R. (Class C):

Record times in HOURS. Round ALL reported times UP to the next full hour. For example: 1927 minutes of surgery divided by 60 = 32.11 hours, rounds up to 33 hours. Hours of surgery are ACTUAL hours, not SCHEDULED hours.

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)

'COMBINED' O.R.s are operating rooms used for BOTH inpatient and outpatient surgeries, NOT the sum of inpatient and outpatient operating rooms.

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.

SURGICAL HOURS include the time to perform the surgical procedure plus time for set-up and clean-up of the operating room.

	OPERATING ROOMS (CLASS C)				SURGICAL CASES TREATED		SURGICAL HOURS		
	Inpatient	Outpatient	Combined	TOTAL	Inpatient	Outpatient	Inpatient	Outpatient	TOTAL
Cardiovascular	0	0	1	1	576	149	2327	318	2645
Dermatology	0	0	0	0	0	0	0	0	0
General Surgery	0	0	6	6	934	697	2029	1201	3230
Gastroenterology	0	0	0	0	0	0	0	0	0
Neurology	0	0	0	0	176	679	475	557	1032
OB/Gynecology	0	0	0	0	291	441	644	522	1166
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0
Ophthalmology	0	0	0	0	0	0	0	0	0
Orthopedic	0	0	0	0	455	654	1094	1052	2146
Otolaryngology	0	0	0	0	105	249	163	368	531
Plastic Surgery	0	0	0	0	13	180	41	512	553
Podiatry	0	0	0	0	61	145	85	203	288
Thoracic	0	0	0	0	390	81	318	73	391
Urology	0	0	0	0	45	140	125	208	333
TOTAL SURGERIES	0	0	7	7	3046	3415	7301	5014	12315

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IDPH ANNUAL HOSPITAL QUESTIONNAIRE - PART I

Question IIIA. SURGICAL PROCEDURES - Invasive, Non OR

DEDICATED SURGICAL PROCEDURE ROOMS - 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)
Report how many rooms your hospital has dedicated for surgical procedures not included in the table above (Question III), by Inpatient, Outpatient and Combined Inpatient/Outpatient rooms. Also report the number of Inpatients and Outpatients special procedure cases in the reporting year, and the number of surgical hours the procedures required, for both Inpatient and Outpatient procedures.
TOTAL ROOMS should be the sum of Inpatient, Outpatient and Combined rooms.
CASE is defined as a patient encountered in an inpatient or outpatient setting. For example, if 3 surigcal procedures are performed on an individual, only 1 CASE is counted.
SURGICAL HOURS include the time to perform the surgical procedure plus time to set-up and clean-up the procedure room.
TOTAL SURGICAL HOURS should be the total of Inpatient and Outpatient surgical hours.

	DEDICATED PROCEDURE ROOMS				CASES		SURGICAL PROCEDURE HOURS		
	Inpatient	Outpatient	Combined	TOTAL	Inpatient	Outpatient	Inpatient	Outpatient	TOTAL
Gastro-Intestinal Procedures	0	0	2	2	1889	3879	1389	2861	4250
Laser Eye Procedures	0	0	1	1	0	172	0	59	59
Pain Management Procedures	0	0	0	0	0	0	0	0	0
Cystoscopy Procedures	0	0	1	1	189	277	240	341	581
Multipurpose (Non- Dedicated) Procedure Rooms (enter data for surgical speciality eg., Opthalmology, General surgery, Minor procedures etc)									
Minor Surgery	0	0	1	1	0	249	0	187	187
Ophthmology	0	0	1	1	3	740	3	611	614
	0	0	0	0	0	0	0	0	0

SURGICAL RECOVERY STATIONS

How many surgical recovery stations does your hospital maintain?	Stage 1 - Post-Anesthesia Recovery Stations	Stage 2 - Step-down Ambulatory Recovery Stations
	13	7

Question IV. Labor, Delivery and Recovery/Newborn Care:

a. Number of Labor Rooms: 0
b. Number of Delivery Rooms: 0
c. Number of Birthing Rooms: 0
d. Labor-Delivery-Recovery (LDR) Rooms: 9
e. Labor-Delivery-Recovery-PostPartum (LDRP) Rooms: 0
f. Number of Dedicated C-Section Rooms: 2
g. Number of Total C-Sections Performed: 583

h. Births and Newborn Care

Report the number of Total Births (Live and Stillborn), Live Births, Newborn Level I, Level II and Level II+ patient days of care, as defined by the Perinatal Advisory Committee, in the spaces provided.

	Total Births	Live Births	Newborn Level I Patient Days	Newborn Level II Patient Days	Newborn Level II+ Patient Days
Number	2495	2483	4308	1379	0

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IDPH ANNUAL HOSPITAL QUESTIONNAIRE - PART I

Question V. Organ Transplantation:

A. Does your hospital perform organ transplants? ○ Yes ◉ No

	Heart	Heart/Lung	Kidney	Liver	Lung	Pancreas
B. Transplants Performed in 2009	0	0	0	0	0	0

Question VI. Cardiac Surgery (Open Heart Surgery) For definitions and information, click the [Help] link.

	Age 0-14	Age 15 and Over
a. Cardiac Surgery Cases by Age Group	0	132
b. Total Cardiac Surgery Cases (All ages)		132
c. Of Cases in b., Number of Coronary Artery Bypass Grafts (CABGs) [Help]		116

Question VII. Cardiac Catheterization For definitions and information, click the [Help] link.

PHYSICAL SET UP:

	LABS
1. Total Cardiac Catheterization labs (includes Dedicated and Non-Dedicated labs for diagnostic/interventional/EP)	2
a. Catheterization labs dedicated to only Diagnostic procedures	0
b. Catheterization labs dedicated to only interventional procedures	0
c. Catheterization labs dedicated to only Electro-Physiological procedures	0
d. Of the catheterization labs listed in line 1, the number shared with radiology for Angiography procedures	0

UTILIZATION (Procedures Performed by Age Group)

2. Indicate the total catheterization procedures performed including all diagnostic, interventional, and EP procedures for all age groups.		1409
	Age 0-14	Age 15 and Over
a. Diagnostic Cardiac Catheterizations	0	971
b. Interventional Cardiac Catheterizations	0	259
c. Electro-Physiolоigcai (EP) Procedures [Help]		179

Question VIII: Emergency/Trauma Care:

A. Category of EMERGENCY Services : (as defined by IL Hospital Licensing Act) ◉ COMPREHENSIVE ○ STAND BY ○ BASIC

B. Are you a certified trauma center (by Emergency Medical Services (EMS)): ○ YES ◉ NO

	LEVEL 1	LEVEL 2
C. Type of the trauma center:		

D. List the number of Operating rooms dedicated or reserved (24/7) for trauma: 0

E. List the number of stations in Emergency Room (ER): 4

F. Indicate the number of visits to Emergency and Trauma. Also list the number that resulted in admissions to the hospital.

	EMERGENCY (ED)	TRAUMA	TOTAL VISITS
Number of Visits	48800	0	48800
Admissions to Hospital (subset of visits that resulted in admission)	12282	0	

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IDPH ANNUAL HOSPITAL QUESTIONNAIRE - PART I

Question IX. OUTPATIENT SERVICES/VISITS:

All services or visits to all OUTPATIENT services including emergency, surgical, radiological etc provided by and billed by the hospital should be reported under outpatient visits.

A. Visits at the Hospital/Hospital Campus	222688
B. Visits in the facilities Off site/Off Campus	178
C. TOTAL	222866

Question X. Patients Served during Calendar Year 2009 by Payment Source:

Patients should be reported by PRIMARY source of payment.
TOTAL INPATIENTS REPORTED (Including Charity Care) MUST EQUAL THE NUMBER OF ADMISSIONS REPORTED IN QUESTION I ON LINE L, PAGE 4.

	MEDICARE	MEDICAID	OTHER PUBLIC*	PRIVATE INSURANCE*	PRIVATE PAYMENT*	ROW TOTALS
INPATIENTS	6819	4981	0	3872	51	15723
OUTPATIENTS	54771	66361	0	83254	11333	215719

* **OTHER PUBLIC** includes all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH/DD and Veterans Administration funds and other public funds paid directly to a facility should be recorded here.
PRIVATE INSURANCE includes any payments made through private insurance policies.
PRIVATE PAYMENT 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.

CHARITY CARE*

	INPATIENTS	OUTPATIENTS
Number of Charity Care Patients Provided Service	742	7147

**"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. 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 (CMS 2552-96 Worksheet C, Part 1, PPS Inpatient Ratios), and not the actual charges for the services.

Question XI. LABORATORY STUDIES:

Report the number of laboratory studies performed for BOTH inpatients (excluding newborns) and outpatients. The total number of laboratory studies are to be reported. A STUDY is defined as a billable examination, such as CBCs, lipid profiles, etc. a series of tests performed in one visit on one person is all considered to be a single study.
Many hospitals have standing contracts with one or more private laboratories to perform laboratory studies. Report the total number of laboratory studies performed under such a contract in the last column.

	Inpatient Studies	Outpatient Studies	Studies Performed Under Contract (Referrals)
Laboratory Studies Performed	540526	498116	41131

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IDPH ANNUAL HOSPITAL QUESTIONNAIRE - PART I

Question XI. DIAGNOSTIC AND THERAPEUTIC EQUIPMENT:

A. Indicate the number of pieces of equipment your hospital had in operation on site (Fixed owned/ Fixed leased during the reporting year and the number of inpatient, outpatient and contractually-performed examinations or treatment courses performed during the reporting year.

EXAMINATIONS are to be reported - NOT patients served. If one patient had several examinations during the reporting year, EACH examination is counted separately. It is the the number of times a machine is used per exam/procedure or treatment course.
If the hospital has a contract with an equipment supplier to provide inpatient or outpatient services on the campus of the hospital, the examinations are to be listed under exams by contractual agreement column.

	PIECES OF EQUIPMENT		EXAMS/ PROCEDURES			
					Contractual Agreement	
DIAGNOSTIC/IMAGING	Hospital Owned	Contracted (list below)	Inpatient	Outpatient	Inpatient	Outpatient
1. General Radiography/Fluoroscopy	24	0	26184	59195	0	0
2. Nuclear Medicine	3	0	1984	4243	0	0
3. Mammography	3	0	6	9281	0	0
4. Ultrasound	9	0	6303	18169	0	0
5. CT Tomography	3	0	10563	18028	0	0
6. PET Tomography	1	0	13	228	0	0
7. Magnetic Resonance Imaging (MRI)	2	0	2024	5341	0	0

INTERVENTIONAL & RADIATION THERAPIES	Hospital Owned	Contracted (list below)	Treatment Courses
8. Lithotripsy	0	0	0
9. Radiation Therapy Equipment			
a. Linear Accelerator	1	0	159
b. Image Guided Radiation Therapy (IGRT)	0	0	0
c. Intensity Modulated Radiotherapy (IMRT)	1	0	29
d. High Dose Brachytherapy	1	0	9
e. Proton Beam Therapy	0	0	0
f. Gamma knife	0	0	0
g. Cyber knife	0	0	0

B. List contractors for each type of equipment reported in section A.

If you reported any Contracted Equipment in Section A, column 3 above, list the type of equipment and the name(s) of the companies or persons with whom your hospital has contracted for equipment.

	Type of Equipment	Company/Individual Contracted With
1.		
2.		
3.		

PROCEED TO THE NEXT PAGE TO BEGIN PART II - FINANCIAL & CAPITAL EXPENDITURES

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IDPH ANNUAL HOSPITAL QUESTIONNAIRE - PART II

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
FINANCIAL & CAPITAL EXPENDITURES DATA FOR FISCALYEAR

THE DATA REQUESTED BY THIS QUESTIONNAIRE ARE AUTHORIZED PURSUANT TO THE ILLINOIS HEALTH FACILITIES PLANNING ACT [20 ILCS 3960/5.3]

THESE DOLLAR AMOUNTS MUST BE TAKEN FROM YOUR MOST RECENT ANNUAL FINANCIAL STATEMENTS WHICH INCLUDES YOUR INCOME STATEMENT AND BALANCE SHEET. FINANCIAL STATEMENTS ARE DEFINED AS AUDITED FINANCIAL STATEMENTS, REVIEW OR COMPILATION of the FINANCIAL STATEMENTS, OR TAX RETURN FOR THE MOST RECENT FISCAL YEAR AVAILABLE TO YOU.

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 to you.

If you have problems providing the information requested, contact this office via e-mail 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 10/01/2008 **Ending** 09/30/2010

Source of Financial Data Used

Review or Compilation of the financial statements

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IDPH ANNUAL HOSPITAL QUESTIONNAIRE - PART II

ILLINOIS HEALTH FACILITIES PLANNING BOARD
FINANCIAL & CAPITAL EXPENDITURES DATA FOR FISCALYEAR

1. CAPITAL EXPENDITURES

Provide the following information for all projects / capital expenditures IN EXCESS OF $292,000 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.	Chillers	3,950,930	cash/debt	N/A
2.	Land purchase	3,000,800	Cash	N/A
3.	Building purchase	2,993,194	Cash	N/A
4,	5 East Renovation	1,674,692	Cash/debt	N/A
5.	Digital Radiology	1,491,890	Cash/Debt	N/A
6.	Building Buildout	1,405,267	Cash	N/A
7.	Network Replacement - Phase 2	460,868	Cash/Debt	N/A
8.	Building Purchase	443,114	Cash	N/A
9.	Endoscopy Equipment	419,368	Cash/Debt	N/A
10.	Roof Replacement	393,275	Cash/Debt	N/A
11.	AC Unit Computer Room	392,047	Cash/Debt	N/A
12.	Network Replacement - Phase 1	374,744	Cash/Debt	N/A
13.	Siemens Luminous Pro RF System	362,135	Cash/Debt	N/A
14.	AP Dishwasher & Room Remodeling	330,148	Cash/Debt	N/A
15.	East Wing Renovation	326,013	Cash/Debt	N/A
16.				
17.				
18.				
19.				
20.				

[Help]

Report the TOTAL of ALL Capital Expenditures for your reported FISCAL YEAR

TOTAL CAPITAL EXPENDITURES FOR REPORTED FISCAL YEAR (including those below $292,000) 19,960,000

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IDPH ANNUAL HOSPITAL QUESTIONNAIRE - PART II

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD FINANCIAL & CAPITAL EXPENDITURES DATA FOR FISCAL YEAR

2. INPATIENT AND OUTPATIENT NET REVENUES DURING YOUR REPORTED FISCAL YEAR BY PAYMENT SOURCE

	MEDICARE	MEDICAID	OTHER PUBLIC*	PRIVATE INSURANCE	PRIVATE PAYMENT*	ROW TOTALS
INPATIENT REVENUE ($)	79,074,941	36,682,184	0	36,525,346	311,007	152,593,478
OUTPATIENT REVENUE ($)	15,518,780	6,645,020	0	37,575,979	1,478,877	61,218,656

* **OTHER PUBLIC** includes all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH/DD and Veterans Administration funds and other public funds paid directly to a facility should be recorded here.
PRIVATE INSURANCE includes any payments made through private insurance policies.
PRIVATE PAYMENT 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.

3. ACTUAL COST OF SERVICES PROVIDED TO CHARITY CARE* INPATIENTS AND OUTPATIENTS DURING YOUR REPORTED FISCAL YEAR

	INPATIENTS	OUTPATIENTS
Actual Cost of Services Provided to Charity Care Patients ($)	4,188,993	1,630,007

****"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. 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 (CMS 2552-96 Worksheet C, Part 1, PPS Inpatient Ratios), and not the actual charges for the services.

IDPH ANNUAL HOSPITAL QUESTIONNAIRE - PART II

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
FINANCIAL & CAPITAL EXPENDITURES DATA FOR FISCAL YEAR

4. Community Benefits:

Report the dollar amounts spent on various community benefit programs offered by your facility to the community. All hospitals must complete these items immaterial of whether they are Non profit facilities or not.

As this is the first time we are asking this question, if the data is not available for your reporting year then mark the appropriate box (Not Available) next to each item. However, every effort needs to be made to provide the requested information.

Community Benefit Definitions

a. Language Assistant Services	342,169	Not Available ☐
b. Government Sponsored Indigent Health Care	13,890,000	Not Available ☐
c. Donations	1,644,000	Not Available ☐
d. Volunteer Services		
i) Employee Volunteer Services	0	Not Available ☐
ii) Non-Employee Voulnteer Services	162,324	Not Available ☐
e. Education	0	Not Available ☐
f. Government Sponsored program services	0	Not Available ☐
g. Research	0	Not Available ☐
h. Subsidized health services	2,652,589	Not Available ☐
I. Bad Debts	12,225,000	Not Available ☐
j. Other Community Benefits	2,416,143	Not Available ☐

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IDPH ANNUAL HOSPITAL QUESTIONNAIRE

Please provide the following information for the individual responsible for the preparation of this questionnaire:

Contact Person Name	Gary Krugel
Contact Person Job Title	Senior Vice President/CFO
Contact Person Telephone Number	773-907-1075
Contact Person E-Mail Address	gkrugel@schosp.org

Please provide the following information for the facility Administrator/CEO:

Administrator's Name	Mark Newton
Administrator's Title	President/CEO
Administrator's Telephone	773-907-1000
Administrator's Email Address	mnewton@schosp.org

If you have any comments on the survey, please enter them in the space provided below.

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IDPH ANNUAL HOSPITAL QUESTIONNAIRE Page 17 of 17

CERTIFICATION OF SURVEY DATA

Pursuant to the Health Facilities Planning Act (20 ILCS 3960/13), the State Board requires "all health facilities operating in the State to provide such reasonable reports at such times and containing such information as is needed" by the Board to carry out the purposes and provisions of this Act. By completing this section, the named individual is certifying that he/she has read the foregoing document, that he/she is authorized to make this certification on behalf of this facility, and that the information contained in this report is accurate, truthful and complete to the best of his/her knowledge and belief. Please note that the State Board will be relying on the information contained in this document as being truthful and accurate information. Any misrepresentations will be considered material.

☑ I certify that the information in this report is accurate, truthful and complete to the best of my knowledge.

Person Certifying	Gary Krugel		
Job Title	Senior Vice President/CFO	Certification Date	04/22/2010

THANK YOU FOR COMPLETING THE ANNUAL HOSPITAL QUESTIONNAIRE

WE STRONGLY RECOMMEND THAT YOU PRINT OUT EACH PAGE OF THIS FORM WITH YOUR ANSWERS FOR FUTURE REFERENCE.

ONCE YOU HAVE SUBMITTED THE FORM, NO FURTHER ACCESS OR CHANGES ARE POSSIBLE.

YOU CANNOT RETRACT OR CHANGE A SUBMITTED FORM, SO BE SURE TO VERIFY YOUR ANSWERS BEFORE CLICKING ON THE 'SUBMIT FORM' BUTTON.

WHEN YOU HAVE REVIEWED AND PRINTED YOUR RESPONSES, CLICK THE 'SUBMIT FORM' BUTTON TO SEND YOUR COMPLETED QUESTIONNAIRE BACK TO OUR OFFICE. YOU WILL BE ROUTED TO A CONFIRMATION PAGE.

You will see an acknowledgment on the web page you are viewing. A dated receipt is also available for printing purposes.

IF YOU HAVE ANY PROBLEMS, PLEASE CONTACT THIS OFFICE IMMEDIATELY AT 217-782-3516 OR BY EMAIL AT DPH.FacilitySurvey@illinois.gov

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CONFIRMATION OF RECEIPT OF ANNUAL HOSPITAL QUESTIONNAIRE FOR 2009 DATA

The Annual Hospital Questionnaire for 2009 Data for your hospital has been received by the Illinois Department of Public Health.

Don't forget to complete and submit your Annual Hospital Bed Report.

Thank you for your cooperation.

Click this link for a dated confirmation notice for your records.