McDermott
Will & Emery

Boston Brussels Chicago Dallas Düsseldorf Frankfurt Houston London Los Angeles Miami
Milan Munich New York Orange County Paris Rome Seoul Silicon Valley Washington, D.C.
Strategic alliance with MWE China Law Offices (Shanghai)

Clare E. Connor
Attorney at Law
cconnori@mwe.com
+1 312 984 3365

August 21, 2017

VIA FEDEX

Mike Constantino
Illinois Health Facilities & Services Review Board
525 W. Jefferson, 2nd Fl.
Springfield, IL 62761

Re: Project 15-026

Dear Mike:

With respect to the condition on the permit issued with respect to the above referenced project, please see attached 2016 response to survey for Vista Medical Center East's medical surgical utilization. In 2017, through July 31 the patient days totaled 19,561 and the admissions 4,732. If you have any questions, please feel free to contact me.

Thank you.

Sincerely,

Clare E Connor

Clare E. Connor

cc: Courtney Avery
Norm Stephens, CEO, Vista East

Attachments

CONFIRMATION OF RECEIPT OF ANNUAL HOSPITAL QUESTIONNAIRE

Thank you for submitting your Annual Hospital Questionnaire for 2016.
Your information has been received.

If you have any questions, please contact this office by telephone at 217-782-3516 or email at DPH.FacilitySurvey@illinois.gov

If you would like a dated receipt to keep for your records, please CLICK HERE.

If you have not done so, don't forget to complete and submit your Annual Bed Report by **March 17, 2017**.

ANNUAL HOSPITAL QUESTIONNAIRE FOR CALENDAR YEAR 2016

This is a formal request 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 consists of 2 parts.

Part I

Collects information on your facility and facility utilization.
This part must be reported for CALENDAR YEAR 2016.

Part II

Collects Financial and Capital Expenditure information for your facility.
This part must be reported for the MOST RECENT FISCAL YEAR AVAILABLE.

The questionnaire must be completed and submitted by March 17, 2017.
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 the Board's consideration of imposition of sanctions mandated by the Health Facilities Planning 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 below marked 'Next' to begin the survey.

Page 1 | Next > | Save

25% 50% 75% 100%

inquisite

SURVEY INSTRUCTIONS

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

If 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.

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	Vista Medical Center East				
Hospital Address	1324 North Sheridan Road				
Hospital City	Waukegan	**State**	IL	**Zip Code**	60085

	Information
Health Service Area	8
Hospital Planning Area	A-09
County	LAKE
Approved for LTC Swing Beds?	no

[Help]

Authorized Hospital Bed Capacity (CON)

	December 31, 2015	December 31, 2016
Medical-Surgical	165	165
Pediatrics	11	11
Intensive Care	23	23
Obstetrics	29	29
Neonatal Level III	0	0
Long-Term Care	0	0
Acute Mental Illness	0	0
Rehabilitation	0	0
Long-Term Acute Care (LTACH)	0	0
[Help]		
Total Authorized Beds	**228**	**228**

Page 2 | < Back | Next > | Save

25% 50% 75% 100%

inquisite

ANNUAL HOSPITAL QUESTIONNAIRE - PART I

QUESTION I. INPATIENT SERVICES UTILIZATION - 2016

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 the calendar year.
PEAK CENSUS is the highest number of inpatients in the unit at any point in the calendar year.
Figures in GREEN are automatically generated from reported data.

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, 2016	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	1697	5048				
A3. Medical-Surgical 45-64 years	3383	12466				
A4. Medical-Surgical 65-74 years	1347	6230				
A5. Medical-Surgical 75 +	1873	9339				
Medical-Surgical Totals	8300	33083	130	130	130	2734

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, 2016	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Pediatric Nursing Unit
B. Pediatric Utilization	353	1048	10	10	5	0

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, 2016	Peak Beds Set Up and Staffed	Peak Census	Observation Days in ICU Nursing Unit
C1. Inpatients Admitted Directly to ICU	948	4042				
C2. Patients Transferred to ICU from another Unit of the Hospital	380	1376				
ICU Totals		5418	23	23	23	0

D. OBSTETRIC/GYNECOLOGY UTILIZATION:

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

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2016	Peak Beds Set Up and Staffed	Peak Census	Observation Days in OB/Gyne Nursing Unit
D1. Obstetrics Patients	1196	2843				
D2. Clean Gynecology Patients	0	0				
Obstetrics/Gynecology Totals	1196	2843	27	27	18	33

Page 3 | < Back | Next > | Save

25% 50% 75% 100%

inquisite

ANNUAL HOSPITAL QUESTIONNAIRE - PART I

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

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2016	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, 2016	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, 2016	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Acute Mental Illness Nursing Unit
H1. Adolescent (0-17 years) [Help]	0	0	0	0	0	0
H2. Adult (18+ years) [Help]	0	0	0	0	0	0
Total Acute Mental Illness	0	0	0			0

I. REHABILITATION UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2016	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Rehabilitation Nursing Unit
I. Rehabilitation [Help]	0	0	0	0	0	0

J. LONG-TERM ACUTE CARE UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2016	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Long-Term Acute Care Nursing Unit
J. Long-Term Acute Care (LTACH) [Help]	0	0	0	0	0	0

K. OBSERVATION DAYS OUTSIDE A NURSING UNIT:

If patient observation prior to admission takes place in dedicated observation beds 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	0	0

FACILITY TOTAL UTILIZATION:

	Total Admissions	Total Inpatient Days	Total Beds Set Up and Staffed on Oct. 1, 2016	Total Observation Days in Hospital
Total Hospital Utilization	10797	42392	190	2767

Page 4 | < Back | Next > | Save

25% 50% 75% 100%

inquisite

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 during Calendar Year 2016 by the Racial Group and Ethnicity of the patient.

Figures in GREEN are automatically generated. TOTAL INPATIENTS ADMITTED AND TOTAL PATIENT DAYS IN SECTION 1 as well as in SECTION 2 (not a combination) MUST AGREE WITH THE TOTAL ADMISSIONS and TOTAL INPATIENT DAYS INDICATED ON PAGE 4 (10797 and 42392).

SECTION 1. RACIAL GROUPS	Inpatients Admitted	Patient Days
Asian	114	513
American Indian or Native Alaskan	25	91
Black or African American	3102	12067
Native Hawaiian or Pacific Islander	84	331
White	6827	27043
Unknown	645	2347

TOTALS - SECTION 1	**10797**	**42392**
TOTALS FROM PAGE 4	**10797**	**42392**

SECTION 2. ETHNIC GROUPS	Inpatients Admitted	Patient Days
Hispanic or Latino	2190	7318
Not Hispanic or Latino	7942	32711
Unknown	665	2363

TOTALS - SECTION 2	**10797**	**42392**
TOTALS FROM PAGE 4	**10797**	**42392**

ANNUAL HOSPITAL QUESTIONNAIRE - PART I

Question II. FACILITY OWNERSHIP AND ADMINISTRATION:

A. Legal Entity that operates the facility [Help] QUORUM HEALTH CORPORATION

B. Legal Entity that owns the physical plant [Help] QUORUM HEALTH CORPORATION

C. Federal Employer Identification Number (FEIN) [Help] 20-3978521

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

FOR PROFIT	GOVERNMENTAL	NOT FOR PROFIT
(●) For Profit Corporation	( ) County	( ) Church-Related
( ) Limited Partnership	( ) City	( ) Not for Profit Corporation (Not Church-Related)
( ) Limited Liability Partnership	( ) Township	( ) Other Not For Profit (specify below)
( ) Limited Liability Company	( ) Hospital District	
( ) Other For Profit (specify below)	( ) Other Governmental (specify below)	

E. 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	EMER MEDICAL ASSOC AND ALIGN MD

F. 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
- [ ] Long-Term Acute Care Hospital (LTACH)

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

- [x] General Hospital
- [ ] Rehabilitation Hospital
- [ ] Children's Speciality Care Hospital
- [ ] Psychiatric Hospital

Page 6 | < Back | Next > | Save

25% 50% 75% 100%

inquisite

ANNUAL HOSPITAL QUESTIONNAIRE - PART I

Question III. SURGICAL PROCEDURES - 2016 - Operating Rooms (Class C):

PLEASE REPORT EACH OPERATING ROOM ONLY ONCE.
IF A ROOM IS DEDICATED FOR A SPECFIC TYPE OF SURGERY, RECORD IT THERE.
IF A ROOM IS USED FOR MULTIPLE TYPES OF SURGERY, RECORD IT UNDER GENERAL.
OPERATING ROOM (CLASS C): Operating Room (Class C) 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.
(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. Record times in WHOLE 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 ROOMS (CLASS C)				SURGICAL CASES TREATED		SURGICAL HOURS		
	Inpatient	Outpatient	Combined	TOTAL	Inpatient	Outpatient	Inpatient	Outpatient	TOTAL
Cardiovascular	0	0	0	0	175	80	241	5	246
Dermatology	0	0	0	0	0	0	0	0	0
General Surgery	0	0	3	3	2221	931	3690	1092	4782
Gastroenterology	0	0	0	0	4	1340	4	665	669
Neurology	0	0	0	0	1	14	5	33	38
OB/Gynecology	0	0	0	0	184	413	300	404	704
Oral/Maxillofacial	0	0	0	0	0	3	0	4	4
Ophthalmology	0	0	0	0	0	50	0	53	53
Orthopedic	0	0	0	0	28	385	77	623	700
Otolaryngology	0	0	0	0	7	226	19	238	257
Plastic Surgery	0	0	0	0	1	19	1	23	24
Podiatry	0	0	0	0	2	39	3	59	62
Thoracic	0	0	0	0	0	0	0	0	0
Urology	0	0	0	0	8	151	26	116	142
TOTALS	0	0	3	3	2631	3651	4366	3315	7681

ANNUAL HOSPITAL QUESTIONNAIRE - PART I

Page 8 of 18

Question IIIA. SURGICAL PROCEDURES - Invasive, Non OR

DEDICATED SURGICAL PROCEDURE ROOMS - Class B are 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 Class B surgical procedures (rooms not included in the table above (Question III)), by Inpatient, Outpatient and Combined Inpatient/Outpatient rooms.
Combined rooms are used for both Inpatient and Oupatient cases (not the total of Inpatient and 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	0	0	0	0	0	0	0
Laser Eye Procedures	0	0	0	0	0	0	0	0	0
Pain Management Procedures	0	0	1	1	17	34	20	39	59
Cystoscopy Procedures	0	0	0	0	0	0	0	0	0
Multipurpose (Non-Dedicated) Procedure Rooms Enter data for each surgical specialty (e.g., Opthalmology, General surgery, Minor procedures, etc.)									
	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0

SURGICAL RECOVERY STATIONS	Stage 1 - Post-Anesthesia Recovery Stations	Stage 2 - Step-down Ambulatory Recovery Stations
How many surgical recovery stations does your hospital maintain?	15	12

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: 15
f. Number of Dedicated C-Section Rooms: 2
g. Number of Total C-Sections Performed: 302

h. Births and Newborn Care

Report the number of Total Births (Live and Stillborn) and Live Births occurring at the hospital in 2015.

	Total Births	Live Births
Number	1088	0

Report the number of beds available for Newborn Level I, Level II and Level II+ care and the patient days of care provided at each level, as defined by the Perinatal Advisory Committee.

	NEWBORN LEVEL I	NEWBORN LEVEL II	NEWBORN LEVEL II+
BEDS	0	0	0
PATIENT DAYS	2114	274	19

Page 8 | < Back | Next > | Save

25% 50% 75% 100%

inquisite

ANNUAL HOSPITAL QUESTIONNAIRE - PART I

Question V. Organ Transplantation:

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

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	63
b. Total Cardiac Surgery Cases (All ages)		63
c. Of Cases in b., Number of Coronary Artery Bypass Grafts (CABGs) [Help]		0

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)	3
a. Catheterization labs dedicated to only Diagnostic procedures	1
b. Catheterization labs dedicated to only Interventional procedures	1
c. Catheterization labs dedicated to only Electro-Physiological procedures	1
d. Of the catheterization labs listed in line 1, the number shared with radiology for Angiography procedures	1

UTILIZATION (Procedures Performed by Age Group)

2. Indicate the total catheterization procedures performed including all diagnostic, interventional, and EP procedures for all age groups. 1054

	Age 0-14	Age 15 and Over
a. Diagnostic Cardiac Catheterizations	0	767
b. Interventional Cardiac Catheterizations	0	267
c. Electro-Physiological (EP) Procedures [Help]		20

Question VIII: Emergency/Trauma Care:

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

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

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

D. List the number of Operating rooms dedicated or reserved (24/7) for trauma: 1

E. List the number of stations in Emergency Room (ER): 31

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	45381	2	45383
Admissions to Hospital (subset of visits that resulted in admission)	7737	2	

If your hospital owns/operates a Free-Standing Emergency Center, please provide the following information for the free-standing center:

Number of Treatment Rooms/Stations: 7 | Number of Patients Treated: 11908 | Number of Patients Treated Who Were Admitted to Hospital: 8

Page 9 | < Back | Next > | Save

25% 50% 75% 100%

inquisite

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.

A. Visits at the Hospital/Hospital Campus	91662
B. Visits in the facilities Off site/Off Campus	45805
Total Outpatient Care Visits	**137467**

Question X. Patients Served during Calendar Year 2016 by Primary Payor:

Patients are to be reported by PRIMARY PAYOR - Primary Payor is the one responsible for most of the charges (generally, 50% or more).
TOTAL INPATIENTS REPORTED (including Charity Care Inpatients) MUST EQUAL THE NUMBER OF TOTAL HOSPITAL ADMISSIONS INDICATED ON PAGE 4 (10797).

	MEDICARE	MEDICAID	OTHER PUBLIC*	PRIVATE INSURANCE*	PRIVATE PAYMENT*	ROW TOTALS	Total Including Charity Care
INPATIENTS	4650	3742	120	1981	338	10831	**10968**
OUTPATIENTS	35352	58192	1236	38282	4405	137467	**137771**

* 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* PATIENTS

	INPATIENTS	OUTPATIENTS
Charity Care Patients	137	304

**"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.

A Charity Care Patient is one without third-party coverage who received charity care as defined above.

Charity Care patients are not to be included in the above chart on Primary Payor.

As per AICPA guidelines, determination of charity care can be made at any time during the entire process, although it is preferred to be done when the patient presents.

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	372050	255218	0

ANNUAL HOSPITAL QUESTIONNAIRE - PART I

Question XII. 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 treatments 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 number of times a machine is used per exam/procedure or treatment. 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.

DIAGNOSTIC/IMAGING	PIECES OF EQUIPMENT: Hospital Owned	PIECES OF EQUIPMENT: Contracted (list below)	EXAMS/ PROCEDURES: Inpatient	EXAMS/ PROCEDURES: Outpatient	Contractual Agreement: Inpatient	Contractual Agreement: Outpatient
1. General Radiography/Fluoroscopy	19	0	15185	42785	0	0
2. Nuclear Medicine	8	0	840	936	0	0
3. Mammography	6	0	10	10236	0	0
4. Ultrasound	11	0	2171	8001	0	0
5. CT Tomography	5	0	6092	9269	0	0
6. PET Tomography	0	1	0	0	0	179
7. Magnetic Resonance Imaging (MRI)	4	0	1123	1984	0	0
8. Angiography Equipment*	3	0				
a. Diagnostic Angiography			0	0	0	0
b. Interventional Angiography			1269	762	0	0

*Report Angiography Equipment on line 8, and Angiography Procedures on lines a and b.

INTERVENTIONAL & RADIATION THERAPIES	Hospital Owned	Contracted (list below)	Treatments
9. Lithotripsy	0	0	0
Radiation Therapy Equipment			
10. Linear Accelerators*	0	0	0
a. Image Guided Radiation Therapy (IGRT)			0
b. Intensity Modulated Radio-therapy (IMRT)			0
11. High Dose Brachytherapy	0	0	0
12. Proton Beam Therapy	0	0	0
13. Gamma knife	0	0	0
14. Cyber knife	0	0	0

*Report Linear Accelerators and Treatments on line 10.
Specialized use of linear accelerators for IGRT and IMRT should be reported on lines a and b.

B. List contractors for each type of contractual equipment reported in Question XII, Part 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.	PET-CT	Shared Medical Services
2.		
3.		

Page 11 | < Back | Next > | Save

25% 50% 75% 100%

inquisite

ANNUAL HOSPITAL QUESTIONNAIRE - PART I Page 12 of 18

Question XIII. INFECTION PREVENTION AND CONTROL

Please provide the following information regarding Infection Prevention and Control staff. If a staff member fills multiple positions, use the percentage of their time that is devoted to Infection Prevention and Control, e.g., if a staff member spends 2 days a week working on Infection Control and 3 days a week working on Employee Health, only 2 days per week, or 0.4 FTE, shoudl be counted for Infection Prevention and Control activities. Categories of employees to exclude: administrative support and data entry personnel and physician hospital epidemiologists

Infection Prevention and Control Staff	FTEs
How many full-time equivalent staff (FTEs) were employed in your facility's infection prevention and control department, as of December 31, 2016?	1
How many of the FTEs indicated in the previous question were filled by an individual who is certified in infection control (CIC), as determined by the Certification Board in Infection Control, as of December 31, 2016?	1

CONTACT FOR INFECTION PREVENTION AND CONTROL INFORMATION

Please provide a contact person for information regarding Infection Prevention and Control efforts at your facility. If you have any comments pertaining to Infection Control and/or your efforts in this area, please enter them into space provided.

Name	Karen Obenauf, RN
Telephone	847-360-4052
Email	Karen_obenauf@quorumhealth.com
Comments	None

Page 12 < Back Next > Save

25% 50% 75% 100%

inquisite

ANNUAL HOSPITAL QUESTIONNAIRE - PART I

LACTATION SPECIALIST

Does your facility employ a Lactation Specialist(s)? ◉ Yes ○ No

If yes, are they available to the Maternity unit for breast feeding consultation & support? ○ Yes ○ No

Please provide the following information regarding specially trained or certified Breast Feeding support staff. If a staff member fills multiple positions or is part time, use the percentage of their time that is devoted to *dedicated* Breast Feeding support. For example, if 30% of a full-time staff member's time is devoted to *dedicated* Breast Feeding support, count that staff member as 0.3 FTE. Categories of employees to exclude: administrative support and data entry personnel.

Lactation Specialists	FTEs
1. As of December 31, 2016, how many specially trained or certified full-time equivalent staff (FTEs) were employed in your facility who have dedicated time and responsibility for educating and supporting women with breast feeding?	1
2. As of December 31, 2016, how many of the FTEs indicated in question 1 were filled by an individual who was board certified in breast feeding consultation by the International Board of Lactation Consultant Examiners?	1

BREAST IMAGING

Which, if any, of the following breast imaging equipment does your facility currently use, and what procedures are performed using this equipment? Please record total facility equipment and procedures, both within the hospital and at affiliated outpatient/satellite centers, performed during calendar year 2016.

If you did not perform breast imaging in 2016, please check the None of the Above box.

Mammography

Total Units	5
Screening mammogram procedures performed	8260
Diagnostic mammogram procedures performed	1986

Breast Ultrasound

Total Units	2
Breast Ultrasound procedures performed	1887
Ultrasound-guided Breast Biopsy procedures performed	0

Stereotactic Biopsy

Total Units	0
Stereotactic Biopsy procedures performed	0

Breast MRI

Total Units	1
Breast MRI procedures performed	19

None of the Above ☐

ANNUAL HOSPITAL QUESTIONNAIRE - PART II Page 14 of 18

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]

Information for this Section must be provided from your Most Recent Annual Financial Statements, which include 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.

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 01/01/2016 **Ending** 12/31/2016

Source of Financial Data Used

Review or Compilation of the financial statements

Page 14 | < Back | Next > | Save

25% 50% 75% 100%

inquisite

ANNUAL HOSPITAL QUESTIONNAIRE - PART II Page 15 of 18

FINANCIAL & CAPITAL EXPENDITURES DATA FOR FISCALYEAR

1. TOTAL CAPITAL EXPENDITURES

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

TOTAL CAPITAL EXPENDITURES FOR REPORTED FISCAL YEAR 4473539

DETAILED CAPITAL EXPENDITURES

Provide the following information for all projects / capital expenditures IN EXCESS OF $350,000 obligated by or on behalf of the health care facility in 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.	DaVinci Surgical Robot	1964504	LEASE	
2.		0		
3.		0		
4.		0		
5.		0		
6.		0		
7.		0		
8.		0		
9.		0		
10.		0		
11.		0		
12.		0		
13.		0		
14.		0		
15.		0		
16.		0		
17.		0		
18.		0		
19.		0		
20.		0		

[Help]

Page 15 < Back Next > Save

25% 50% 75% 100%

inquisite

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 PAYOR

If you reported inpatients or outpatients for a particular source of payment in question X on page 10, you should have revenues to report for that payment source. If you are reporting patients with no corresponding revenues, please give a brief explanation in the Comments box on page 17.

	MEDICARE	MEDICAID	OTHER PUBLIC*	PRIVATE INSURANCE	PRIVATE PAYMENT*	
INPATIENT REVENUE ($)	41266648	36002783	6492087	20683943	11296691	115742152
OUTPATIENT REVENUE ($)	15551925	8766613	8141848	20733627	8835528	62029541

* 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. AMOUNT OF CHARITY CARE* SERVICES PROVIDED DURING THE FISCAL YEAR

	INPATIENTS	OUTPATIENTS
Amount of Charity Care Services Provided at Cost ($)	720881	267667

***"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 amount of charity care provided, the reporting entity must report the amount of charity care based on cost, not charges (per CMS 2552-96 Worksheet C, Part 1, PPS Inpatient Ratios).

As per American Institute of Certified Public Accountants (AICPA) guidelines, charity care can be determined at any time during the process.

ANNUAL HOSPITAL QUESTIONNAIRE

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

Contact Person Name	Heidar Thordarson
Contact Person Job Title	Interim CFO
Contact Person Telephone Number	847-360-4333 x5514
Contact Person E-Mail Address	Heidar_Thordarson@QuorumHealth.com

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

Administrator's Name	Barbara Martin
Administrator's Title	President/CEO
Administrator's Telephone	847-360-3000
Administrator's Email Address	barbara_martin@quorumhealth.com

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

Responses saved. Add this page to your favorites or bookmarks.

ANNUAL HOSPITAL QUESTIONNAIRE Page 18 of 18

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	Heidar Thordarson		
Job Title	Interim CFO	Certification Date	03/15/17

THANK YOU FOR COMPLETING THE ANNUAL HOSPITAL QUESTIONNAIRE

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 verified your responses, click the 'Submit Form' button to send your completed questionnaire back to us. 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

Page 18 | < Back | Submit Form | Save

25% 50% 75% 100%

inquisite