# AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2020

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 2020.

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

Certification Statement on page 19 must be completed before the survey data can be submitted.

This survey must be completed and submitted by Friday, April 2, 2021.
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**
**ASTC Name**
**ASTC Address**
**ASTC City** **IL** **Zip Code**

**Federal Employer Identification Number (FEIN)**

**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

*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: | |
| Address: | |
| City. State and Zip Code (plus Four): | |
| 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 | | | | |

3. CONTRACTUAL MANAGEMENT

If management of this facility is performed by independent contractor(s), not by an employee of the facility, list the individual name(s) and address(es) of each independent contractor. If management is NOT done by independent contractor(s), indicate by checking the box provided.

**No Contractual Management**

| | Contractor Name | Full Address |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

4. FACILITY STAFFING

A. Indicate the number of hours in a work week for a full-time employee of your facility:

B. Staffing Patterns

Please indicate the number of Full-Time Equivalent employees (FTEs), paid directly by the facility, working at your facility during the first pay period of December, 2020.

The figure for TOTAL FACILITY PERSONNEL in green is automatically calculated. You cannot change this total.

| Personnel | Full-Time Equivalents |
|---|---|
| **Administrators** | |
| **Physicians** | |
| **Nurse Anesthetists** | |
| **Director of Nursing** | |
| **Registered Nurses** | |
| **Certified Aides** | |
| **Other Health Professionals** | |
| **Other Non-Health Professionals** | |

TOTAL FACILITY PERSONNEL 0.00

INFORMATION CONCERNING PATIENTS SERVED - CALENDAR YEAR 2020

5. Patients by Age Groups

Please indicate the number of patients during the calendar year 2020 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** | | | |
| **15-44 Years** | | | |
| **45-64 Years** | | | |
| **65-74 Years** | | | |
| **75+ Years** | | | |
| TOTALS | 0 | 0 | TOTAL PATIENTS SERVED 0 |

6. Source of Payment

Please indicate the numbers of patients your ASTC saw during calendar year 2020, 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** | | | |
| **Medicare** | | | |
| **Other Public*** | | | |
| **Private Insurance** | | | |
| **Private Payment** | | | |
| **Charity Care*** | | | |
| TOTALS | 0 | 0 | TOTAL PATIENTS SERVED 0 |

*__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 2020

**Preferred 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 2020, 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 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |
| 11 | | | |
| 12 | | | |
| 13 | | | |
| 14 | | | |
| 15 | | | |
| 16 | | | |
| 17 | | | |
| 18 | | | |
| 19 | | | |
| 20 | | | |
| 21 | | | |
| 22 | | | |
| 23 | | | |
| 24 | | | |
| 25 | | | |

| | Zip Code Area | County Name | Number of Patients |
|---|---|---|---|
| 26 | | | |
| 27 | | | |
| 28 | | | |
| 29 | | | |
| 30 | | | |
| 31 | | | |
| 32 | | | |
| 33 | | | |
| 34 | | | |
| 35 | | | |
| 36 | | | |
| 37 | | | |
| 38 | | | |
| 39 | | | |
| 40 | | | |
| 41 | | | |
| 42 | | | |
| 43 | | | |
| 44 | | | |
| 45 | | | |
| 46 | | | |
| 47 | | | |
| 48 | | | |
| 49 | | | |
| 50 | | | |

7. **Patients by Place of Origin (Continued)**
Please report the places of origin of the patients seen at your ASTC during Calendar Year 2020, 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 | | | |
| 52 | | | |
| 53 | | | |
| 54 | | | |
| 55 | | | |
| 56 | | | |
| 57 | | | |
| 58 | | | |
| 59 | | | |
| 60 | | | |
| 61 | | | |
| 62 | | | |
| 63 | | | |
| 64 | | | |
| 65 | | | |
| 66 | | | |
| 67 | | | |
| 68 | | | |
| 69 | | | |
| 70 | | | |
| 71 | | | |
| 72 | | | |
| 73 | | | |
| 74 | | | |
| 75 | | | |

| | Zip Code Area | County Name | Number of Patients |
|---|---|---|---|
| 76 | | | |
| 77 | | | |
| 78 | | | |
| 79 | | | |
| 80 | | | |
| 81 | | | |
| 82 | | | |
| 83 | | | |
| 84 | | | |
| 85 | | | |
| 86 | | | |
| 87 | | | |
| 88 | | | |
| 89 | | | |
| 90 | | | |
| 91 | | | |
| 92 | | | |
| 93 | | | |
| 94 | | | |
| 95 | | | |
| 96 | | | |
| 97 | | | |
| 98 | | | |
| 99 | | | |
| 100 | | | |

7. **Patients by Place of Origin (Continued)**

Please report the places of origin of the patients seen at your ASTC during Calendar Year 2020, 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 | | | |
| 102 | | | |
| 103 | | | |
| 104 | | | |
| 105 | | | |
| 106 | | | |
| 107 | | | |
| 108 | | | |
| 109 | | | |
| 110 | | | |
| 111 | | | |
| 112 | | | |
| 113 | | | |
| 114 | | | |
| 115 | | | |
| 116 | | | |
| 117 | | | |
| 118 | | | |
| 119 | | | |
| 120 | | | |
| 121 | | | |
| 122 | | | |
| 123 | | | |
| 124 | | | |
| 125 | | | |

| | Zip Code Area | County Name | Number of Patients |
|---|---|---|---|
| 126 | | | |
| 127 | | | |
| 128 | | | |
| 129 | | | |
| 130 | | | |
| 131 | | | |
| 132 | | | |
| 133 | | | |
| 134 | | | |
| 135 | | | |
| 136 | | | |
| 137 | | | |
| 138 | | | |
| 139 | | | |
| 140 | | | |
| 141 | | | |
| 142 | | | |
| 143 | | | |
| 144 | | | |
| 145 | | | |
| 146 | | | |
| 147 | | | |
| 148 | | | |
| 149 | | | |
| 150 | | | |

7. **Patients by Place of Origin (Continued)**
Please report the places of origin of the patients seen at your ASTC during Calendar Year 2020, 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 | | | |
| 152 | | | |
| 153 | | | |
| 154 | | | |
| 155 | | | |
| 156 | | | |
| 157 | | | |
| 158 | | | |
| 159 | | | |
| 160 | | | |
| 161 | | | |
| 162 | | | |
| 163 | | | |
| 164 | | | |
| 165 | | | |
| 166 | | | |
| 167 | | | |
| 168 | | | |
| 169 | | | |
| 170 | | | |
| 171 | | | |
| 172 | | | |
| 173 | | | |
| 174 | | | |
| 175 | | | |

| | Zip Code Area | County Name | Number of Patients |
|---|---|---|---|
| 176 | | | |
| 177 | | | |
| 178 | | | |
| 179 | | | |
| 180 | | | |
| 181 | | | |
| 182 | | | |
| 183 | | | |
| 184 | | | |
| 185 | | | |
| 186 | | | |
| 187 | | | |
| 188 | | | |
| 189 | | | |
| 190 | | | |
| 191 | | | |
| 192 | | | |
| 193 | | | |
| 194 | | | |
| 195 | | | |
| 196 | | | |
| 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 2020, 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 | | | |
| 244 | | | |
| 245 | | | |
| 246 | | | |
| 247 | | | |
| 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 2020, 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 | | | |
| 294 | | | |
| 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 | | | | | | | | 0 |

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

*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 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

**11. SURGICAL UTILIZATION FOR CALENDAR YEAR 2020 - 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** | | | | |
| **Otolaryngology** | | | | |
| **Pain Management** | | | | |
| **Plastic** | | | | |
| **Podiatry** | | | | |
| **Thoracic** | | | | |
| **Urology** | | | | |
| TOTALS | 0 | 0.00 | 0.00 | 0.00 |

***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 2020 - 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 | 0 | These two figures must match. |
| PATIENTS Reported on Page 6 | 0 | |

*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 | |
| Ending Date | |

Use this drop-down list to select the source of the Financial Information Reported in this Section:

Audited Financial Statements

A. CAPITAL EXPENDITURES

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

TOTAL CAPITAL EXPENDITURES FOR YOUR REPORTED FISCAL YEAR

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 2018 patients for a given payment source in Question 6 on Page 6, but do not have matching Net Revenue to report for that payment source, please provide a brief explanation in the Comments box on Page 14.

| | Net Revenue (in Dollars) |
|---|---|
| **Medicaid** | |
| **Medicare** | |
| **Other Public*** | |
| **Private Insurance** | |
| **Private Payment** | |
| **Total Revenue** | $ 0 |

***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** | |

**"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.*

## COVID-19 PANDEMIC AND EFFECTS

**The Covid-19 pandemic which began in early 2020 affected all aspects of our lives, health care services probably more than any other. We understand that 2020 was far from a typical year for your facility, your staff and your patients. We would like to get some perspectives on the challenges this pandemic posed for you, your staff and patients. Please use the space provided below to share these challenges and your responses to the difficulties of operating during the pandemic. Thank you for your efforts to cope with these trying circumstances.**

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

| | |
|---|---|
| Contact Person Name | |
| Contact Person Job Title | |
| Contact Person Telephone ((xxx) xxx-xxxx) | |
| Contact Person E-Mail Address | |

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

| | |
|---|---|
| Administrator's Name | |
| Administrator's Title | |
| Administrator Telephone ((xxx) xxx-xxxx) | |
| Administrator E-Mail Address | |

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

## 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

Job Title

Certification Date

---

**Thank you for Completing the Annual ASTC Questionnaire**

**Be Sure to Review Your Answers Before Submitting Questionnaire.**

**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**

| 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.<br>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 2019, 2020 and 2021. 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) |