

AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2021

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 2021.

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 April 1, 2022.

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 |
| <input type="radio"/> Sole Proprietorship | <input type="radio"/> Church Related |
| <input type="radio"/> Corporation (*RA) | <input type="radio"/> State |
| <input type="radio"/> Partnership (registered with county) | <input type="radio"/> County |
| <input type="radio"/> Limited Partnership (*RA) | <input type="radio"/> City |
| <input type="radio"/> Limited Liability Partnership (*RA) | <input type="radio"/> Township |
| <input type="radio"/> Limited Liability Company (*RA) | <input type="radio"/> Other Not for Profit (Specify below) |
| <input type="radio"/> 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:	<input style="width: 350px; height: 20px;" type="text"/>
Address:	<input style="width: 350px; height: 20px;" type="text"/>
City, State and Zip Code (plus Four):	<input style="width: 350px; height: 20px;" type="text"/>
Telephone Number:	<input style="width: 350px; height: 20px;" type="text"/>

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	<input style="width: 250px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>
2	<input style="width: 250px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>
3	<input style="width: 250px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>
4	<input style="width: 250px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>
5	<input style="width: 250px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>

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, 2021.

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

INFORMATION CONCERNING PATIENTS SERVED - CALENDAR YEAR 2021

5. Patients by Age Groups

Please indicate the number of patients during the calendar year 2021 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		

TOTAL
PATIENTS
SERVED

TOTALS

6. Source of Payment

Please indicate the numbers of patients your ASTC saw during calendar year 2021, 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*		

TOTAL
PATIENTS
SERVED

TOTALS

***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 2021

Optional Reporting Method:

[For your ease of reporting, we have supplied a Microsoft Excel worksheet for the entry of Patient Origin Data:](#)

- 1. CLICK HERE to ACCESS THE WORKSHEET.**
2. Save the worksheet to your computer.
3. Follow the directions on the worksheet to enter your data.
4. Email the completed spreadsheet to DPH.FacilitySurvey@illinois.gov
5. Retain a copy of the worksheet in case follow-up is required.

If you do not wish to use the Patient Origin worksheet, please use the spaces below to report the place of origin of the patients seen at your ASTC during Calendar Year 2021, 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 2021, 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 2021, 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 2021, 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 2021, 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 2021, 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								

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 2021 - 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

*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 2021 - 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

TOTAL CASES Questions 11 and 12 TOTAL
 PATIENTS Reported on Page 6

These two figures must match.

*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	<input type="text"/>
Ending Date	<input type="text"/>

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

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

	Net Revenue (in Dollars)
Medicaid	
Medicare	
Other Public*	
Private Insurance	
Private Payment	

Total Revenue

***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 2021 continued to be a challenge for your facility, your staff and your patients. We would like to get some perspectives on the issues 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	<input type="text"/>
Contact Person Job Title	<input type="text"/>
Contact Person Telephone ((xxx) xxx-xxxx)	<input type="text"/>
Contact Person E-Mail Address	<input type="text"/>

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

Administrator's Name	<input type="text"/>
Administrator's Title	<input type="text"/>
Administrator Telephone ((xxx) xxx-xxxx)	<input type="text"/>
Administrator E-Mail Address	<input type="text"/>

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 providing the information below, 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 (type in name)
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 optional Patient Origin spreadsheet (see page 6).

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. 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 or 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)