Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

By FedEX

November 24, 2014

Mr. Michael Constantino
c/o Illinois Health Facilities and
Services Review Board
525 West Jefferson
Springfield, IL 62761

RE: E-038-14 Rockford Memorial Hospital
E-39-014 Mercy Harvard Hospital

Dear Mike:

During the Board hearing on a project earlier this year where the applicant owned a hospital outside of Illinois, a Board member requested that the applicant provide the information typically provided by Illinois hospitals through the IDPH *Annual Hospital Questionnaire*.

The above-referenced COE applications name Mercy Alliance, Inc. as an applicant. Mercy Alliance, Inc. owns and operates two hospitals in Wisconsin, Mercy Hospital and Trauma Center in Janesville and Mercy Walworth Hospital in Lake Geneva.

Enclosed are replica *Annual Hospital Questionnaires* completed for Mercy Alliance, Inc.'s two Wisconsin hospitals. The applicants would appreciate your inclusion of this information in the packet that you will be forwarding to the Board members prior to the Board's December 16, 2014 meeting.

Sincerely,

Jacob M. Axel
President

enclosures

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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
ANNUAL HOSPITAL QUESTIONNAIRE FOR CALENDAR YEAR 2013

SURVEY INSTRUCTIONS

NOTE: Validation rules have been met 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 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. COMPLETING. YOU DO NOT NEED TO SAVE AFTER EACH PAGE.

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 blank survey. When you are ready to continue, use the bookmark or Favorite to own 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:

Hospital Name Mercy Walworth Hospital
Hospital Address N2950 State Road 67
Hospital City Lake Geneva State WI Zip Code 53147

	Information
Health Service Area	DNA
Hospital Planning Area	DNA
County	Walworth County, WI
Approved for LTC Swing Beds?	No

Available Hospital Bed Capacity

	June 30, 2013	June 30, 2014
Medical-Surgical	17	17
Pediatrics	0	0
Intensive Care	4	4
Obstetrics	4	4
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
Total Available Beds	25	25

Note: "Authorized CON beds" is not a statistic that applies to Wisconsin facilities. The statistics above represent the number of beds set up and available on each unit. Staffed beds are reported in Part I, Items A-K.

Note: In order to provide the most recent data available and to ensure consistency between survey reporting sections, FY 2014 data has been submitted for both Sections I and II.

ANNUAL HOSPITAL QUESTIONNAIRE - PART I

QUESTION I. INPATIENT SERVICES UTILIZATION - 2013

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
A1. Medical-Surgical 0-14 years	16	28
A2. Medical-Surgical 15-44 years	286	326
A3. Medical-Surgical 45-&4 years	90	330
A4. Medical-Surgical 55-74 years	253	1,288
A5. Medical-Surgical 75+ years	224	935
Medical-Surgical Totals	869	2,907

Beds Set Up and Staffed on July 1, 2014	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Pediatric Nursing Unit
12	16	16	859

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 years on line A1.

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2013	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Pediatric Nursing Unit
B. Pediatric Utilization	DNA	DNA	DNA	DNA	DNA	DNA

C. INTENSIVE CARE UTILIZATION: In this section, report the utilization of your Intensive Care unit, if you have one.
Neonatal Level (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 another unit of the hospital and subsequently moved into ICU, report ICU utilization for that inpatient on line C2.

	Admissions	Inpatient Days
C1. Inpatients Admitted Directly to ICU		
C2. Patients Transferred to ICU from Another Unit of the Hospital		
ICU Totals	30	68

Beds Set Up and Staffed on July 1, 2014	Peak Beds Set Up and Staffed	Peak Census	Observation Days in ICU Nursing Unit
1	3	3	10

D. OBSTETRICS/GYNECOLOGY UTILIZATION: Obstetrics care includes both Ante-Partum and Post-Partum. Clean Gynecology is the non-maternity care.

	Admissions	Inpatient Days
D1. Obstetrics Patients		
D2. Clean Gynecology Patients		
Obstetrics/Gynecology Totals	181	400

Beds Set Up and Staffed on July 1, 2014	Peak Beds Set Up and Staffed	Peak Census	Observation Days in OB/Gyne Nursing Unit
2	5	5	9

ANNUAL HOSPITAL QUESTIONNAIRE - PART 1

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

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2013	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Neonatal Level III Nursing Unit
E. Neonatal Level III	DNA	DNA	DNA	DNA	DNA	DNA

F. LONG-TERM NURSING CARE UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2013	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Long-Term Care Nursing Unit
F. Long-Term Care (LTC)	DNA	DNA	DNA	DNA	DNA	DNA

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

	Admissions	Inpatient Days	Peak Census
F. LTC Swing Beds (Medicare-certified)	DNA	DNA	DNA

H. ACUTE MENTAL ILLNESS UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2013	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Acute Mental Illness Nursing Unit
H. Acute Mental Illness	DNA	DNA	DNA	DNA	DNA	DNA

I. REHABILITATION UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2013	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Rehabilitation Nursing Unit
I. Rehabilitation	DNA	DNA	DNA	DNA	DNA	DNA

J. LONG-TERM ACUTE CARE UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2013	Peak Beds Set Up and Staffed	Peak Census	Observation Days in LTACH Nursing Unit
J. Long-Term Acute Care (LTACH)	DNA	DNA	DNA	DNA	DNA	DNA

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 observation 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	DNA	DNA

FACILITY TOTAL UTILIZATION:

	Total Admissions	Total Inpatient Days	Total Beds Set Up and Staffed on July 1, 2014	Total Observation Days in Hospital
Total Hospital Utilization	1,080	3,375	15	878

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 2013 by the Racial Group and Ethnicity of the patient.

Figures in GREEN are automatically generated. TOTAL INPATIENTS ADMITTED AND TOTAL PATIENT DAYS IN SECTION I as well as in SECTION 2 (not a combination) MUST AGREE with the TOTAL ADMISSIONS and TOTAL INPATIENT DAYS INDICATED ON PAGE 4 (0 and 0).

SECTION 1. RACIAL GROUPS	**Inpatients Admitted**	**Patient Days**
Asian	1	3
American Indian or Native Alaskan	2	5
Black or African American	13	52
Native Hawaiian or Pacific Islander	0	0
White	1,062	3,311
Unknown	2	4
TOTALS - SECTION I	1,080	3,375
TOTALS FROM PAGE 4	1,080	3,375

SECTION 2. ETHNIC GROUPS	**Inpatients Admitted**	**Patient Days**
Hispanic or Latino	69	165
Not Hispanic or Latino	1,009	3,202
Unknown	2	8
TOTALS- SECTION 2	1,080	3,375
TOTALS FROM PAGE 4	1,080	3,375

Question II. FACILITY OWNERSHIP AND ADMINISTRATION:

A. Legal Entity that operates the facility	Mercy Health System Corporation
B. Legal Entity that owns the physical plant	Mercy Health System Corporation

C. 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	X	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)		

Other Ownership Type

Under Section 5D1(r)(3), a hospital organization must conduct a community health needs assessment (CHNA) at least once every three taxable years. The statute also requires that the hospital organization widely publicize the results of the CHNA to the public served by the hospital facility.

If your facility has prepared a Community Health Needs Assessment, please provide one of the following:

1. (preferred) If you have a copy of your CHNA posted on the Internet, please provide the web address of the document or the Internet page where the CHNA is posted (not the home page of the facility web site):

http://mercyhealthsystem.org/body.cfm?id=710

2. Alternatively, if the CHNA is available as a PDF or Microsoft Word file, please submit a copy of the assessment by email to DPH.FacilitySurvey@illinois.gov no later than March 28, 2014.

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

	Contract Management
Psychiatric Service	DNA
Rehabilitation Service	DNA
Emergency Service	DNA

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

X	Critical Access Hospital
	Long-Term Acute Care Hospital (LTACH)

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

X	General Hospital
	Rehabilitation Hospital
	Children's Specialty Care Hospital
	Psychiatric Hospital

ANNUAL HOSPITAL QUESTIONNAIRE - PART I

Question III. SURGICAL PROCEDURES - 2013 - Operating Rooms (Class C):

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 dived try &0 = 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	X	X	X	X	0	0	0	0	0
Dermatology	X	X	X	X	2	0	3	0	3
General Surgery	X	X	X	X	11	21	26	34	60
Gastroenterology	X	X	X	X	60	195	72	176	248
Neurology	X	X	X	X	0	98	0	216	216
OB/Gynecology	X	X	X	X	49	48	123	77	199
Oral/Maxillofacial	X	X	X	X	0	0	0	0	0
Ophthalmology	X	X	X	X	0	9	0	9	9
Orthopedic	X	X	X	X	266	902	745	1714	2,459
Otolaryngology	X	X	X	X	0	104	0	146	146
Plastic Surgery	X	X	X	X	2	122	7	244	251
Podiatry	X	X	X	X	0	0	0	0	0
Thoracic	X	X	X	X	1	2	3	3	7
Urology	X	X	X	X	3	36	8	47	54
TOTALS	X	X	4	4	394	1,537	986	2,664	3,650

Question IIIA. SURGICAL PROCEDURES - Invasive, Non OR

DEDICATED SURGICAL PROCEDURE ROOMS-Class B:

Surgical Procedure room is defined as a setting designed and equipped for major or minor surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs.

(Source: Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons)

Report how many rooms your hospital has dedicated for Class B surgical procedures not included in the table above (Question III), by Inpatient, Outpatient and Combined Inpatient/Outpatient rooms. Also report the number of Inpatients and Outpatients special procedure cases in the reporting year, and the number of surgical hours the procedures required, for both Inpatient and Outpatient procedures.

TOTAL ROOMS should be the sum of Inpatient. Outpatient and Combined rooms.

CASE is defined as a patient encountered in an inpatient or outpatient setting. For example, if 3 surgical 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 roam.

TOTAL- SURGICAL HOURS should be the total of Inpatient and Outpatient surgical hours.

	DEDICATED PROCEDURE ROOMS				CASES		SURGICAL PROCEDURE HOURS		
	Inpatient	Outpatient	Combined	TOTAL	Inpatient	Outpatient	Inpatient	Outpatient	TOTAL
Gastro-Intestinal Procedures	0	0	2	2	43	137	66	43	109
Laser Eye Procedures	DNA	DNA	DNA	DNA	DNA	DNA	DNA	DNA	DNA
Pain Management Procedures	0	0	2	2	12	488	7	293	300
Cystoscopy Procedures	DNA	DNA	DNA	DNA	DNA	DNA	DNA	DNA	DNA

Multipurpose (Non-Dedicated) Procedure Rooms

enter data for each surgical specialty (e.g., Ophthalmology, General surgery, Minor procedures, etc.)

DNA									
DNA									
DNA									

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?	4	18

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

a. Number of Labor Rooms	DNA	b. Number of Delivery	DNA	c. Number of Birthing Rooms	DNA
d. Labor-Delivery-Recovery (LDR) Rooms	DNA	e. Labor-Delivery-Recovery-Post Partum (LDRP) Rooms			4
f. Number of Dedicated C-Section Rooms	1	g. Number of Total C-Sections Performed			43

h. Births and Newborn Care

Report the number of Total Births (Live and Stillborn) and Live Births occurring at the hospital in 2013.

	Total Births	Live Births
Number	170	168

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 III
BEDS	6	0	0
PATIENT DAYS	227	79	8

Question V. Organ Transplantation:

A. Does your hospital perform organ transplants? [ ] Yes [X] No

	Heart	Heart/Lung	Kidney	Liver	Lung	Pancreas
B. Transplants Performed in 2013	DNA	DNA	DNA	DNA	DNA	DNA

Question VI. Cardiac Surgery (Open Heart Surgery)

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

Question VII. Cardiac Catheterization

	LABS
PHYSICAL SET UP:	
1. Total Cardiac Catheterization labs (includes Dedicated and Non-Dedicated labs far diagnostic Interventional/EP)	DNA
a. Catheterization tabs dedicated to only Diagnostic procedures	DNA
b. Catheterization labs dedicated to only Interventional procedures	DNA
c. Catheterization tabs dedicated to only Electro-Physiological procedures	DNA
d. Of the catheterization labs listed in line 1. the number shared with radiology for Angiography procedures	DNA
UTILIZATION (Procedures Performed by Age Group)	
2. Indicate the total catheterization procedures performed including all diagnostic, interventional, and EP procedures for all age groups.	DNA

	Age 0-14	Age 15 and Over
a. Diagnostic Cardiac Catheterizations	DNA	DNA
b. Interventional Cardiac Catheterizations	DNA	DNA
c. Electro-Physiological (EP) Procedures	DNA	DNA

Question VIII. Emergency/Trauma Care:

A. Category of EMERGENCY Services: (as defined by IL Hospital Licensing Act) [X] Comprehensive [ ] Basic

B. Are you a designated trauma center (by Emergency Medical Services (EMS)): [ ] Yes [X] No

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

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):	12

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	12,579	157	12,736
Admissions to Hospital (subset of visits that resulted in admission)	720	93	

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

Number of Treatment Rooms/Stations	DNA	Number of Patients Treated	DNA	Number of Patients Treated Who Were Admitted to Hospital	DNA

Question IX. OUTPATIENT SERVICE/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	42,263
B. Visits in the facilities Off site/Off Campus	
Total Outpatient Care Visits	42,263

Question X. Patients Served during Calendar Year 2013 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 (0).

	MEDICARE	MEDICAID	OTHER PUBLIC[1]	PRIVATE INSURANCE[1]	PRIVATE PAYMENT[1]	ROW TOTALS	Total Including Charity Care
INPATIENTS	494	186	6	351	15	1,052	1,080
OUTPATIENTS	10,050	8,814	271	19,087	3,237	41,459	41,911

OTHER PUBLIC includes all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH.IDD 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, AI4D 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	28	452

"Charity care" means care provided by a health care Facility for which the provider does not expect try receive payment from the patient or a third party payer .[20 iLCS 39&Q, Section 31 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 far 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	24,115	71,084	6,664*

*estimate

Question X11. 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 exam1procedure 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	Contracted (list below)	EXAMS/ PROCEDURES Inpatient	Outpatient	Contractual Agreement Inpatient	Outpatient
1. General Radiography/Fluoroscopy	6	0	1,193	12,399	0	0
2. Nuclear Medicine	0	0	0	0	0	0
3. Mammography	1	0	0	1,915	0	0
4 Ultrasound	2	0	208	3,473	0	0
5. CT Tomography	1	0	536	4,146	0	0
6. PET Tomography	0	0	0	0	0	0
7. Magnetic Resonance Imaging (MRI)	1	0	82	2,040	0	0
8. Angiography Equipment*	0	0				
a. Diagnostic Angiography			0	0	0	0
b. Interventional Angiography			0	0	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
THERAPIES			
9. Lithotripsy	0	0	0
Radiation Therapy Equipment			
10. Linear Accelerators*	0	0	0
a. Image Guided Radiation Therapy (IGRT)	0	0	0
b. Intensity Modulated Radio-therapy (IMRT)	0	0	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 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.	DNA	DNA
2.	DNA	DNA
3.	DNA	DNA

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, should 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, 2013?	0.5
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, 2013?	0.5

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 Ruth Yarbrough

Telephone (608) 756-6161

Email ryarbrough@mhsjvl.org

Comments:

Does your facility employ a Lactation Specialist(s)? ___ Yes _X_ No

If yes, are they available on the Maternity unit for breast feeding consultation and support? ___ Yes _X_ 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 members 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. How many specially trained or certified full-time equivalent staff (FTEs) are employed in your facility who have dedicated time and responsibility for educating and supporting women with breast feeding?	0
2. How many of the FTEs indicated in question 1 are filled by an individual who is board certified in breast feeding consultation by the International Board of Lactation Consultant Examiners?	0

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 2013.
If you did not perform breast imaging in 2011 please check the None of the Above box.

Mammography	
Total Units	1
Screening mammogram procedures performed	1,531
Diagnostic mammogram procedures performed	191
Breast Ultrasound	
Total Units	1
Breast Ultrasound procedures performed	226
Ultrasound-guided Breast Biopsy procedures performed	40
Stereotactic Biopsy	
Total Units	0
Stereotactic Biopsy procedures performed	0
Breast MRI	
Total Units	0
Breast MRI procedures performed	0

None of the Above ____

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

FINANCIAL & CAPITAL EXPENDITURES DATA FOR FISCALYEAR

THE DATA REQUESTED BY THIS QUESTIONNAIRE ARE AUTHORIZED PURSUANT TO THE ILLINOIS HEALTH FACILITIES PLANNING ACT [20 ILLS 396015.3]

These Dollar Amounts 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.

This part of the survey collects Financial and Capital Expenditure information for your facility. This part MUST be reported for the MOST RECENT FISCAL YEAR AVAILABLE to you.

If you have problems providing the information requested, contact this office via e-mail at DPH.FacilitySurvey@illinois.gov, or by telephone at 217-782-3516.

Indicate the Starting and Ending Dates
of Your Most Recent Fiscal Year (mm/dd/yyyy)

Starting	07/01/2013	Ending	06/30/2014

Source of Financial Data Used

Audited Financial Statements

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
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 2,486,305

DETAILED CAPITAL EXPENDITURES

Provide the following information for all projects 1 capital expenditures IN EXCESS OF $320,000 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.	Hospital Expansion	1,464,571		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

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	PRIVATE	TOTAL
INPATIENT REVENUE ($)	3,895,479	1,043,172	120,520	6,455,437	488,600	12,003,208
OUTPATIENT REVENUE ($)	5,174,987	2,351,894	310,774	22,708,134	3,843,557	34,389,346

* 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 PAYMMENT 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 ($)	147,301	397,887

** '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 far 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.

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

Contact Person Name	Kathy Wynes
Contact Person Job Title	Planning Manager
Contact Person Telephone Number	(608) 756-6697
Contact Person E-Mail Address	kwynes@mhsjvl.org

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

Administrator's Name	John Cook
Administrator's Title	Vice President and CFO
Administrator's Telephone	(608) 756-6642
Administrator's Email Address	jcook@mhsjvl.org

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

CERTIFICATION OF SURVEY DATA

Pursuant to the Health Facilities Planning Act (20 ILC S 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.

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

Person Certifying , John Cook

Job Title Vice President Certification Date 10/27/14

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

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
ANNUAL HOSPITAL QUESTIONNAIRE FOR CALENDAR YEAR 2013

SURVEY INSTRUCTIONS

NOTE: Validation rules have been met 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 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. COMPLETING. YOU DO NOT NEED TO SAVE AFTER EACH PAGE.

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 blank survey. When you are ready to continue, use the bookmark or Favorite to own 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:

Hospital Name Mercy Hospital and Trauma Center
Hospital Address 1000 Mineral Point Avenue
Hospital City Janesville State WI Zip Code 53547

	Information
Health Service Area	DNA
Hospital Planning Area	DNA
County	Rock County, WI
Approved for LTC Swing Beds?	No

Available Hospital Bed Capacity

	June 30, 2013	June 30, 2014
Medical-Surgical	89	90
Pediatrics	0	0
Intensive Care	15	15
Obstetrics	18	18
Neonatal Level III	0	0
Long-Term Care	27	27
Acute Mental Illness	12	12
Rehabilitation	14	14
Long-Term Acute Care (LTACH)	0	0
Total Available Beds	175	176

Note: "Authorized CON beds" is not a statistic that applies to Wisconsin facilities. The statistics above represent the number of beds set up and available on each unit. Staffed beds are reported in Part I, Items A-K.

Note: In order to provide the most recent data available and to ensure consistency between survey reporting sections, FY 2014 data has been submitted for both Sections I and II.

ANNUAL HOSPITAL QUESTIONNAIRE - PART I

QUESTION I. INPATIENT SERVICES UTILIZATION - 2013

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 (INCLUDING PEDIATRICS, ORTHOPEDIC SURGERY, AND SPECIAL CARE UNIT):
If you have an authorized Pediatrics unit, report utilization on line B below, not on line A1.

Note: Medical-Surgical utilization includes Medical, Surgical-Pediatrics, Orthopedics, and Special Care Units

	Admissions	Inpatient Days
A1. Medical-Surgical 0-14 years	84	115
A2. Medical-Surgical 15-44 years	682	2,758
A3. Medical-Surgical 45-&4 years	510	2,464
A4. Medical-Surgical 55-74 years	1,453	7,849
A5. Medical-Surgical 75+ years	1,128	5,093
Medical-Surgical Totals	3,857	18,279

Beds Set Up and Staffed on July 1, 2014	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Pediatric Nursing Unit
64	70	70	2,498

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 years on line A1.

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2013	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Pediatric Nursing Unit
B. Pediatric Utilization	DNA	DNA	DNA	DNA	DNA	DNA

C. INTENSIVE CARE UTILIZATION: In this section, report the utilization of your Intensive Care unit, if you have one.
Neonatal Level (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 another unit of the hospital and subsequently moved into ICU, report ICU utilization for that inpatient on line C2.

	Admissions	Inpatient Days
C1. Inpatients Admitted Directly to ICU		
C2. Patients Transferred to ICU from Another Unit of the Hospital		
ICU Totals	778	3,481

Beds Set Up and Staffed on July 1, 2014	Peak Beds Set Up and Staffed	Peak Census	Observation Days in ICU Nursing Unit
10	10	10	10

D. OBSTETRICS/GYNECOLOGY UTILIZATION: Obstetrics care includes both Ante-Partum and Post-Partum.
Clean Gynecology is the non-maternity care.

Beds Set Up and Staffed includes Post-Partum and Labor & Delivery; peak beds and census is lower because patients move from one bed to the other during the course of their stay.

	Admissions	Inpatient Days
D1. Obstetrics Patients		
D2. Clean Gynecology Patients		
Obstetrics/Gynecology Totals	850	1,744

Beds Set Up and Staffed on July 1, 2014	Peak Beds Set Up and Staffed	Peak Census	Observation Days in OB/Gyne Nursing Unit
18	13	13	51

ANNUAL HOSPITAL QUESTIONNAIRE - PART 1

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

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2013	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Neonatal Level III Nursing Unit
E. Neonatal Level III	DNA	DNA	DNA	DNA	DNA	DNA

F. LONG-TERM NURSING CARE UTILIZATION (MERCY MANOR TRANSITION CENTER):

	Admissions	Inpatient Days	Beds Set Up and Staffed on July 1, 2014	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Long-Term Care Nursing Unit
F. Long-Term Care (LTC)	319	5,446	27	24	24	

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

	Admissions	Inpatient Days	Peak Census
F. LTC Swing Beds (Medicare-certified)	DNA	DNA	DNA

H. ACUTE MENTAL ILLNESS UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on July 1, 2014	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Acute Mental Illness Nursing Unit
H. Acute Mental Illness	760	2,205	12	12	12	

I. REHABILITATION UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on July 1, 2014	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Rehabilitation Nursing Unit
I. Rehabilitation	198	2,157	6	11	11	

J. LONG-TERM ACUTE CARE UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2013	Peak Beds Set Up and Staffed	Peak Census	Observation Days in LTACH Nursing Unit
J. Long-Term Acute Care (LTACH)	DNA	DNA	DNA	DNA	DNA	DNA

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 observation 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	DNA	DNA

FACILITY TOTAL UTILIZATION:

	Total Admissions	Total Inpatient Days	Total Beds Set Up and Staffed on July 1, 2014	Total Observation Days in Hospital
Total Hospital Utilization	6,762	33,312	137	2,559

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 2013 by the Racial Group and Ethnicity of the patient.

Figures in GREEN are automatically generated. TOTAL INPATIENTS ADMITTED AND TOTAL PATIENT DAYS IN SECTION I as well as in SECTION 2 (not a combination) MUST AGREE with the TOTAL ADMISSIONS and TOTAL INPATIENT DAYS INDICATED ON PAGE 4 (0 and 0).

SECTION 1. RACIAL GROUPS	**Inpatients Admitted**	**Patient Days**
Asian	26	92
American Indian or Native Alaskan	2	8
Black or African American	267	1,095
Native Hawaiian or Pacific Islander	4	41
White	6,316	31,501
Unknown	147	575
TOTALS - SECTION I	6,672	33,312
TOTALS FROM PAGE 4	6,672	33,312

SECTION 2. ETHNIC GROUPS	**Inpatients Admitted**	**Patient Days**
Hispanic or Latino	199	972
Not Hispanic or Latino	6,547	32,240
Unknown	16	100
TOTALS- SECTION 2	6,672	33,312
TOTALS FROM PAGE 4	6,672	33,312

Question II. FACILITY OWNERSHIP AND ADMINISTRATION:

A. Legal Entity that operates the facility	Mercy Health System Corporation
B. Legal Entity that owns the physical plant	Mercy Health System Corporation

C. 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	X	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)		

Other Ownership Type

Under Section 5D1(r)(3), a hospital organization must conduct a community health needs assessment (CHNA) at least once every three taxable years. The statute also requires that the hospital organization widely publicize the results of the CHNA to the public served by the hospital facility.

If your facility has prepared a Community Health Needs Assessment, please provide one of the following:

1. (preferred) If you have a copy of your CHNA posted on the Internet, please provide the web address of the document or the Internet page where the CHNA is posted (not the home page of the facility web site):

http://mercyhealthsystem.org/body.cfm?id=710

2. Alternatively, if the CHNA is available as a PDF or Microsoft Word file, please submit a copy of the assessment by email to DPH.FacilitySurvey@illinois.gov no later than March 28, 2014.

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

	Contract Management
Psychiatric Service	DNA
Rehabilitation Service	DNA
Emergency Service	DNA

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

	Critical Access Hospital
	Long-Term Acute Care Hospital (LTACH)

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

X	General Hospital
	Rehabilitation Hospital
	Children's Specialty Care Hospital
	Psychiatric Hospital

ANNUAL HOSPITAL QUESTIONNAIRE - PART I

Question III. SURGICAL PROCEDURES - 2013 - Operating Rooms (Class C):

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 dived try &0 = 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	X	X	X	X	420	137	1848	260	2,108
Dermatology	X	X	X	X	15	7	20	8	28
General Surgery	X	X	X	X	176	119	422	190	613
Gastroenterology	X	X	X	X	329	670	395	603	998
Neurology	X	X	X	X	243	223	972	491	1,463
OB/Gynecology	X	X	X	X	282	534	705	854	1,559
Oral/Maxillofacial	X	X	X	X	0	0	0	0	0
Ophthalmology	X	X	X	X	0	1,425	0	1,425	1,425
Orthopedic	X	X	X	X	549	1,090	1537	2,071	3,608
Otolaryngology	X	X	X	X	5	690	14	966	980
Plastic Surgery	X	X	X	X	33	254	112	508	620
Podiatry	X	X	X	X	0	0	0	0	0
Thoracic	X	X	X	X	38	22	129	37	167
Urology	X	X	X	X	90	323	225	420	645
TOTALS	X	X	11	11	2,180	5,494	6,379	7,834	14,213

Question IIIA. SURGICAL PROCEDURES - Invasive, Non OR

DEDICATED SURGICAL PROCEDURE ROOMS-Class B:

Surgical Procedure room is defined as a setting designed and equipped for major or minor surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs.
(Source: Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons)
Report how many rooms your hospital has dedicated for Class B surgical procedures not included in the table above (Question III), by Inpatient, Outpatient and Combined Inpatient/Outpatient rooms. Also report the number of Inpatients and Outpatients special procedure cases in the reporting year, and the number of surgical hours the procedures required, for both Inpatient and Outpatient procedures.
TOTAL ROOMS should be the sum of Inpatient. Outpatient and Combined rooms.
CASE is defined as a patient encountered in an inpatient or outpatient setting. For example, if 3 surgical 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 roam.
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	5	0	5	254	424	305	382	687
Laser Eye Procedures	DNA	DNA	DNA	DNA	DNA	DNA	DNA	DNA	DNA
Pain Management Procedures	0	2	0	2	82	72	65	43	108
Cystoscopy Procedures	DNA	DNA	DNA	DNA	DNA	DNA	DNA	DNA	DNA

Multipurpose (Non-Dedicated) Procedure Rooms
enter data for each surgical specialty (e.g., Ophthalmology, General surgery, Minor procedures, etc.)

DNA									
DNA									
DNA									

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?	11	26

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

a. Number of Labor Rooms	DNA	b. Number of Delivery	DNA	c. Number of Birthing Rooms	DNA
d. Labor-Delivery-Recovery (LDR) Rooms	6			e. Labor-Delivery-Recovery-Post Partum (LDRP) Rooms	12
f. Number of Dedicated C-Section Rooms	1			g. Number of Total C-Sections Performed	229

h. Births and Newborn Care
Report the number of Total Births (Live and Stillborn) and Live Births occurring at the hospital in 2013.

	Total Births	Live Births
Number	836	830

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 III
BEDS	0	0	18
PATIENT DAYS	1,127	374	38

Question V. Organ Transplantation:

A. Does your hospital perform organ transplants? [ ] Yes [X] No

	Heart	Heart/Lung	Kidney	Liver	Lung	Pancreas
B. Transplants Performed in 2013	DNA	DNA	DNA	DNA	DNA	DNA

Question VI. Cardiac Surgery (Open Heart Surgery)

	Age 0-14	Age 15 and over
a. Cardiac Surgery Cases by Age Group	0	45
b. Total Cardiac Surgery Cases (All ages)	45	
c. Of Cases in b., Number of Coronary Artery Bypass Grafts (CABGs)	45	

Question VII. Cardiac Catheterization

PHYSICAL SET UP:

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

UTILIZATION (Procedures Performed by Age Group)

2. Indicate the total catheterization procedures performed including all diagnostic, interventional, and EP procedures for all age groups.	556

	Age 0-14	Age 15 and Over
a. Diagnostic Cardiac Catheterizations	0	20
b. Interventional Cardiac Catheterizations	0	531
c. Electro-Physiological (EP) Procedures	0	0

Question VIII. Emergency/Trauma Care:

A. Category of EMERGENCY Services: (as defined by IL Hospital Licensing Act) [X] Comprehensive [ ] Basic

B. Are you a designated trauma center (by Emergency Medical Services (EMS)): [x] Yes [ ] No

	LEVEL 1	LEVEL 2
C. Type of the trauma center:		ACS Level II Trauma Center

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): 16

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	23,337	414	23,751
Admissions to Hospital (subset of visits that resulted in admission)	3,385	198	

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

Number of Treatment Rooms/Stations	Number of Patients Treated	Number of Patients Treated Who Were Admitted to Hospital
9	6,173	95

Question IX. OUTPATIENT SERVICE/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	92,060
B. Visits in the facilities Off site/Off Campus	19,951
Total Outpatient Care Visits	112,011

Question X. Patients Served during Calendar Year 2013 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 (0).

	MEDICARE	MEDICAID	OTHER PUBLIC[1]	PRIVATE INSURANCE[1]	PRIVATE PAYMENT[1]	ROW TOTALS	Total Including Charity Care
INPATIENTS	3,187	1,209	40	1,928	265	6,629	6,762
OUTPATIENTS	30,043	20,874	1,123	50,442	7,876	110,358	111,103

OTHER PUBLIC includes all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH.IDD 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, AI4D 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	133	745

"Charity care" means care provided by a health care Facility for which the provider does not expect try receive payment from the patient or a third party payer .[20 iLCS 39&Q, Section 31 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	258,755	657,602	64,145*

*estimate

Question X11. 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 exam1procedure 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.

	PIECES OF EQUIPMENT		EXAMS/ PROCEDURES			
	Hospital	Contracted			Contractual Agreement	
DIAGNOSTIC/IMAGING	Owned	(list below)	Inpatient	Outpatient	Inpatient	Outpatient
1. General Radiography/Fluoroscopy	3	0	10,670	15,500	0	0
2. Nuclear Medicine	1	0	250	2,690	0	0
3. Mammography	2	0	3	7,780	0	0
4 Ultrasound	4	0	6,150	11,000	0	0
5. CT Tomography	2	0	3,750	11,310	0	0
6. PET Tomography		1	0	0	10	430
7. Magnetic Resonance Imaging (MRI)	2	0	740	6,040	0	0
8. Angiography Equipment*	2	0				
a. Diagnostic Angiography					0	0
b. Interventional Angiography			2,140	2,170	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
THERAPIES			
9. Lithotripsy	1	0	95
Radiation Therapy Equipment			
10. Linear Accelerators*	2	0	
a. Image Guided Radiation Therapy (IGRT)			2797
b. Intensity Modulated Radio-therapy (IMRT)			2820
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 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 ICT	Allinxs Imaging, Inc.
2.		
3.		

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, should 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, 2013?	1.0
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, 2013?	1.0

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 Ruth Yarbrough

Telephone (608) 756-6161

Email ryarbrough@mhsjvl.org

Comments:

Does your facility employ a Lactation Specialist(s)? ___ Yes X No

If yes, are they available on the Maternity unit for breast feeding consultation and support? ___ Yes X 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 members 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. How many specially trained or certified full-time equivalent staff (FTEs) are employed in your facility who have dedicated time and responsibility for educating and supporting women with breast feeding?	0
2. How many of the FTEs indicated in question 1 are filled by an individual who is board certified in breast feeding consultation by the International Board of Lactation Consultant Examiners?	0* *2.0 Certified Staff RNs

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 2013.
If you did not perform breast imaging in 2011 please check the None of the Above box.

Mammography	
Total Units	2
Screening mammogram procedures performed	6,610
Diagnostic mammogram procedures performed	1,170
Breast Ultrasound	
Total Units	1
Breast Ultrasound procedures performed	775
Ultrasound-guided Breast Biopsy procedures performed	110
Stereotactic Biopsy	
Total Units	1
Stereotactic Biopsy procedures performed	9
Breast MRI	
Total Units	1
Breast MRI procedures performed	9

None of the Above ____

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD

FINANCIAL & CAPITAL EXPENDITURES DATA FOR FISCALYEAR

THE DATA REQUESTED BY THIS QUESTIONNAIRE ARE AUTHORIZED PURSUANT TO THE ILLINOIS HEALTH FACILITIES PLANNING ACT [20 ILLS 396015.3]

These Dollar Amounts 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.

This part of the survey collects Financial and Capital Expenditure information for your facility. This part MUST be reported for the MOST RECENT FISCAL YEAR AVAILABLE to you.

If you have problems providing the information requested, contact this office via e-mail at DPH.FacilitySurvey@illinois.gov, or by telephone at 217-782-3516.

Indicate the Starting and Ending Dates
of Your Most Recent Fiscal Year (mm/dd/yyyy)

Starting	07/01/2013	Ending	06/30/2014

Source of Financial Data Used

Audited Financial Statements

ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
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 4,820,868

DETAILED CAPITAL EXPENDITURES

Provide the following information for all projects 1 capital expenditures IN EXCESS OF $320,000 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.	CV/OR Room Equip	393,013		
2.	Electrical in Angio Area	1,510,682		
3.	Ambulance Bay	988,855		
4.	Nurse Call System	922,967		
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

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	PRIVATE	TOTAL
INPATIENT REVENUE ($)	33,849,863	8,075,714	655,371	49,319,561	10,046,227	101,946,736
OUTPATIENT REVENUE ($)	25,708,121	8,459,804	1,887,616	81,804,736	9,350,126	127,210,403

* 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 PAYMMENT 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 ($)	1,528,468	933,918

** '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 far 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.

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

Contact Person Name	Kathy Wynes
Contact Person Job Title	Planning Manager
Contact Person Telephone Number	(608) 756-6697
Contact Person E-Mail Address	kwynes@mhsjvl.org

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

Administrator's Name	John Cook
Administrator's Title	Vice President and CFO
Administrator's Telephone	(608) 756-6642
Administrator's Email Address	jcook@mhsjvl.org

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

CERTIFICATION OF SURVEY DATA

Pursuant to the Health Facilities Planning Act (20 ILC S 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.

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

Person Certifying , John Cook

Job Title Vice President Certification Date 10/27/14

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