

# AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2015

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 2015.**

### 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 15 must be completed before the survey data can be submitted.**

**This survey must be completed and submitted by March 11, 2016.**

**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 check the [help] links provided. If you still have problems, contact this office via e-mail to [DPH.FacilitySurvey@illinois.gov](mailto:DPH.FacilitySurvey@illinois.gov), or by telephone at 217-782-3516.**

**Please review the following information on file for your facility and correct or supply incorrect and missing data:**

<b>ASTC Name</b>	<input type="text"/>		
<b>ASTC Address</b>	<input type="text"/>		
<b>ASTC City</b>	<input type="text"/>	IL	<b>Zip Code</b> <input type="text"/>
<b>Federal Employer Identification Number (FEIN)</b>	<input type="text"/>		



**Instructions for Completing this Form:**

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

**Navigating and Saving:**

There are 3 buttons at the bottom of each survey page except the last one.

'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.

**NOTE: YOU DO NOT NEED TO SAVE AFTER EACH PAGE.**

**ONLY SAVE IF YOU NEED TO STOP BEFORE COMPLETING THE SURVEY.**

**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; YOU CANNOT ACCESS YOUR SAVED FORM WITHOUT IT.** The link provided in your e-mail notice **WILL NOT** access the saved form, only a blank survey. When you are ready to continue, use the bookmark or favorite to open the form. You will be returned to the place where you left off.

Saving the form also allows you to send the link created to another person to enter data, if needed. Since the link is to a file saved on our survey system, all the other person needs is the link to access the saved form.

Please contact this office at **217/782-3516** or by Email to **DPH.FacilitySurvey@illinois.gov** with any questions.  
Thank you for your cooperation.

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### Section I - Facility Data

**1. FACILITY OWNERSHIP INFORMATION**

**A. Indicate the type of ownership for your ASTC (Choose only one):**

**FOR PROFIT**

- Sole Proprietorship
- Corporation (\*RA)
- Partnership (registered with county)
- Limited Partnership (\*RA)
- Limited Liability Partnership (\*RA)
- Limited Liability Company (\*RA)
- Other For Profit (specify below)

**NOT FOR PROFIT**

- Church Related
- State
- County
- City
- Township
- Other Not for Profit (Specify below)

**Other Ownership Type**

\*RA - Registered Agent Required

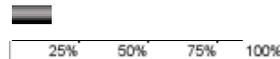
**B. If your facility ownership requires a Registered Agent with the Illinois Secretary of State (marked \*RA above), indicate the name, address and telephone number of this person or company (must be an Illinois resident or company).**

<b>Name of Registered Agent:</b>	
<b>Address:</b>	
<b>City, State and Zip Code (plus Four):</b>	
<b>Telephone Number:</b>	

**C. Provide the name and relational interest of all organizations or entities that are legally, financially or otherwise related to the licensee (e.g., parent, subsidiary, affiliate, management agreement, etc.)**

	Name	Relationship	Type of Interest
1			
2			
3			
4			
5			

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**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 to [DPH.FacilitySurvey@illinois.gov](mailto: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:

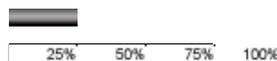
**B. Staffing Patterns**

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, 2015.

The figure for TOTAL FACILITY PERSONNEL in green is automatically generated.

Personnel	Full-Time Equivalents
Administrators	0
Physicians	0
Nurse Anesthetists	0
Director of Nursing	0
Registered Nurses	0
Certified Aides	0
Other Health Professionals	0
Other Non-Health Professionals	0

**TOTAL FACILITY PERSONNEL 0**



**INFORMATION CONCERNING PATIENTS SERVED - CALENDAR YEAR 2015**

**5. Patients by Age Groups**

Please indicate the number of patients during the calendar year 2015 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 generated and must match the corresponding figures in Question 6.

	Male	Female
0-14 Years	0	0
15-44 Years	0	0
45-64 Years	0	0
65-74 Years	0	0
75+ Years	0	0

**TOTAL  
PATIENTS  
SERVED**

**TOTALS      0                      0                      0**

**6. Source of Payment**

Please indicate the numbers of patients your ASTC saw during calendar year 2015, by sex and **PRIMARY PAYMENT SOURCE**.

Figures in green on the **TOTAL** line are automatically generated and must match the corresponding figures in Question 5 above.

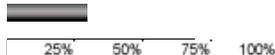
	Male	Female
Medicaid	0	0
Medicare	0	0
Other Public*	0	0
Private Insurance	0	0
Private Payment	0	0
Charity Care*	0	0

**TOTAL  
PATIENTS  
SERVED**

**TOTALS      0                      0                      0**

\***Other Public** payment includes individuals whose primary payment source is Veterans Administration, County Boards, Community Aid Agencies, grants, CHAMPUS, CHAMP-VA, and other government-sponsored programs, excluding Medicare and Medicaid.

*"Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. [20 ILCS 3960, Section 3] Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other federal, State, or local indigent health care programs, eligibility for which is based on financial need.*



**7. Patients by Place of Origin - Calendar Year 2015**

**Preferred Reporting Method:**

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

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

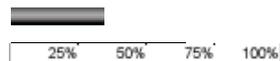
If you do not wish to use the Patient Origin worksheet, please use the spaces below to report the places of origin of the patients seen at your ASTC during Calendar Year 2015, and the number of patients from each area. 5-digit Zip Code areas are preferred; if Zip Code information is not available, please report counties of origin. **If you need more spaces, click 'More Patients' at the bottom of this page, otherwise click 'Finished' to go on to the next question.**

	Zip Code Area	County Name	Number of Patients
1			0
2			0
3			0
4			0
5			0
6			0
7			0
8			0
9			0
10			0
11			0
12			0
13			0
14			0
15			0
16			0
17			0
18			0
19			0
20			0
21			0
22			0
23			0
24			0
25			0

	Zip Code Area	County Name	Number of Patients
26			0
27			0
28			0
29			0
30			0
31			0
32			0
33			0
34			0
35			0
36			0
37			0
38			0
39			0
40			0
41			0
42			0
43			0
44			0
45			0
46			0
47			0
48			0
49			0
50			0

More Patients

Finished



**7. Patients by Place of Origin (Page 2)**

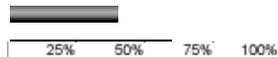
Please report the places of origin of the patients seen at your ASTC during Calendar Year 2015, and the number of patients from each area. 5-digit Zip Code areas are preferred; if Zip Code information is not available, please report counties of origin. **If you need more spaces, click on 'More Patients', otherwise click 'Finished' to go on to the next question.**

	Zip Code Area	County Name	Number of Patients
51			0
52			0
53			0
54			0
55			0
56			0
57			0
58			0
59			0
60			0
61			0
62			0
63			0
64			0
65			0
66			0
67			0
68			0
69			0
70			0
71			0
72			0
73			0
74			0
75			0

	Zip Code Area	County Name	Number of Patients
76			0
77			0
78			0
79			0
80			0
81			0
82			0
83			0
84			0
85			0
86			0
87			0
88			0
89			0
90			0
91			0
92			0
93			0
94			0
95			0
96			0
97			0
98			0
99			0
100			0

More Patients

Finished



**7. Patients by Place of Origin (Page 3)**

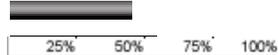
Please report the places of origin of the patients seen at your ASTC during Calendar Year 2015, and the number of patients from each area. 5-digit Zip Code areas are preferred; if Zip Code information is not available, please report counties of origin. **If you need more spaces, click on 'More Patients', otherwise click 'Finished' to go on to the next question.**

	Zip Code Area	County Name	Number of Patients
101			0
102			0
103			0
104			0
105			0
106			0
107			0
108			0
109			0
110			0
111			0
112			0
113			0
114			0
115			0
116			0
117			0
118			0
119			0
120			0
121			0
122			0
123			0
124			0
125			0

	Zip Code Area	County Name	Number of Patients
126			0
127			0
128			0
129			0
130			0
131			0
132			0
133			0
134			0
135			0
136			0
137			0
138			0
139			0
140			0
141			0
142			0
143			0
144			0
145			0
146			0
147			0
148			0
149			0
150			0

More Patients

Finished



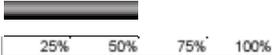
7. Patients by Place of Origin (Page 4)

Please report the places of origin of the patients seen at your ASTC during Calendar Year 2015, and the number of patients from each area. 5-digit Zip Code areas are preferred; if Zip Code information is not available, please report counties of origin. If you need more spaces, click on 'More Patients', otherwise click 'Finished' to go on to the next question.

	Zip Code Area	County Name	Number of Patients
151			0
152			0
153			0
154			0
155			0
156			0
157			0
158			0
159			0
160			0
161			0
162			0
163			0
164			0
165			0
166			0
167			0
168			0
169			0
170			0
171			0
172			0
173			0
174			0
175			0

	Zip Code Area	County Name	Number of Patients
176			0
177			0
178			0
179			0
180			0
181			0
182			0
183			0
184			0
185			0
186			0
187			0
188			0
189			0
190			0
191			0
192			0
193			0
194			0
195			0
196			0
197			0
198			0
199			0
200			0

More Patients       Finished



**7. Patients by Place of Origin (Page 5)**

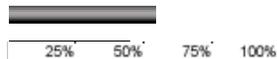
Please report the places of origin of the patients seen at your ASTC during Calendar Year 2015, and the number of patients from each area. 5-digit Zip Code areas are preferred; if Zip Code information is not available, please report counties of origin. **If you need more spaces, click on 'More Patients', otherwise click 'Finished' to go on to the next question.**

	Zip Code Area	County Name	Number of Patients
201			0
202			0
203			0
204			0
205			0
206			0
207			0
208			0
209			0
210			0
211			0
212			0
213			0
214			0
215			0
216			0
217			0
218			0
219			0
220			0
221			0
222			0
223			0
224			0
225			0

	Zip Code Area	County Name	Number of Patients
226			0
227			0
228			0
229			0
230			0
231			0
232			0
233			0
234			0
235			0
236			0
237			0
238			0
239			0
240			0
241			0
242			0
243			0
244			0
245			0
246			0
247			0
248			0
249			0
250			0

More Patients

Finished



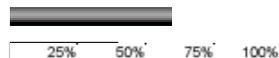
**7. Patients by Place of Origin (Page 6)**

Please report the places of origin of the patients seen at your ASTC during Calendar Year 2015, and the number of patients from each area. 5-digit Zip Code areas are preferred; if Zip Code information is not available, please report counties of origin. **If you do not have enough spaces to report all your patients, contact this office at 217/782-3516 for instructions.**

	Zip Code Area	County Name	Number of Patients
251			0
252			0
253			0
254			0
255			0
256			0
257			0
258			0
259			0
260			0
261			0
262			0
263			0
264			0
265			0
266			0
267			0
268			0
269			0
270			0
271			0
272			0
273			0
274			0
275			0

	Zip Code Area	County Name	Number of Patients
276			0
277			0
278			0
279			0
280			0
281			0
282			0
283			0
284			0
285			0
286			0
287			0
288			0
289			0
290			0
291			0
292			0
293			0
294			0
295			0
296			0
297			0
298			0
299			0
300			0

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**FACILITY OPERATIONS**

8. Please indicate the number of hours your ASTC is in operation on each day of the week: (if the ASTC is open from 8am to 6pm, that is 10 hours of operation.) **DO NOT REPORT OPENING AND/OR CLOSING TIMES.**

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	TOTAL HOURS
Hours Open	0	0	0	0	0	0	0	0

9. Treatment Rooms by Type

Please indicate the number of rooms and stations in use at your ASTC for each category listed below:

	Rooms/ Stations
a. Operating Rooms (Class C)*	0
b. Procedure (not operating) Rooms (Class B)*	0
c. Examination Rooms	0
d. Stage 1 - Post-Anesthesia Recovery Stations	0
e. Stage 2 - Step-down Ambulatory Recovery Stations	0

\*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		0
2		0
3		0
4		0
5		0

**11. SURGICAL UTILIZATION FOR CALENDAR YEAR 2015 - 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)	Average Time per Case (hours)
Cardiovascular	0	0	0	0	NaN
Dermatology	0	0	0	0	NaN
General Surgery	0	0	0	0	NaN
Gastroenterology	0	0	0	0	NaN
Neurological	0	0	0	0	NaN
OB/Gynecology	0	0	0	0	NaN
Oral/Maxillofacial	0	0	0	0	NaN
Ophthalmology	0	0	0	0	NaN
Laser Eye Surgery	0	0	0	0	NaN
Orthopedic	0	0	0	0	NaN
Otolaryngology	0	0	0	0	NaN
Pain Management	0	0	0	0	NaN
Plastic	0	0	0	0	NaN
Podiatry	0	0	0	0	NaN
Thoracic	0	0	0	0	NaN
Urology	0	0	0	0	NaN
<b>TOTALS</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	

\*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 2015 - 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.**

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	0	0	0	0	0
b. Dedicated Laser Eye Procedures	0	0	0	0	0
c. Dedicated Pain Management Procedures	0	0	0	0	0
d. Cardiac Catheterization Procedures	0	0	0	0	0

	Multipurpose Rooms (Specify Procedure)	Cases	Procedure Room Set-Up Time	Actual Surgery Time	Procedure Room Clean-Up Time
e.		0	0	0	0
f.		0	0	0	0
g.		0	0	0	0
h.		0	0	0	0

Total Multi-Purpose Procedure Rooms

**TOTALS - PROCEDURE ROOMS**      0      0      0      0      0

**TOTAL CASES Questions 11 and 12**      0      These two figures must match.

**TOTAL PATIENTS Reported on Page 6**      0

\*Surgical Procedure Room (Class B): Surgical Procedure room is defined as a setting designed and equipped for major or minor surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs. (Source: Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons)

**Click on 'Next' to continue to Section II - Financial and Capital Expenditures Data**

25%  50%  75%  100%



## Section II - Fiscal Year Financial and Capital Expenditures Data

The data requested in this questionnaire are authorized pursuant to the Illinois Health Facilities Planning Act [20 ILCS 3960/5.3]

This information must be taken from your **MOST RECENT ANNUAL FINANCIAL STATEMENTS**, which include your **INCOME STATEMENT** and **BALANCE SHEET**. Allowable sources of financial information include **AUDITED FINANCIAL STATEMENTS, REVIEW OR COMPILATION FINANCIAL STATEMENTS**, or **TAX RETURN** for the **MOST RECENT FISCAL YEAR AVAILABLE**.

This part of the survey collects Financial and Capital Expenditure information for your facility. This part **MUST BE REPORTED FOR THE MOST RECENT FISCAL YEAR AVAILABLE**.

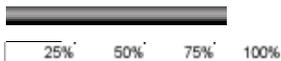
If you have problems providing the information requested, contact this office via email at **DPH.FacilitySurvey@illinois.gov**, or by telephone at **217-782-3516**.

Indicate the Starting and Ending Dates of Your **MOST RECENT FISCAL YEAR** (mm/dd/yyyy)

Starting Date

Ending Date

Indicate 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 \$336,330** 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		0		
2		0		
3		0		
4		0		
5		0		
6		0		
7		0		
8		0		
9		0		
10		0		

[\[Definitions\]](#)



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

	Net Revenue (in Dollars)
Medicaid	0
Medicare	0
Other Public*	0
Private Insurance	0
Private Payment	0

**Total Revenue 0**

\*Other Public payment includes individuals whose primary payment source is Veterans Administration, County Boards, Community Aid Agencies, grants, CHAMPUS, CHAMP-VA, and other government-sponsored programs, excluding Medicare and Medicaid.

**C. TOTAL ACTUAL COST OF SERVICES PROVIDED TO CHARITY CARE\* CASES DURING THE REPORTED FISCAL YEAR**

	Amount (in Dollars)
Total Actual Cost of Services Provided to Charity Care* Cases	0

\*"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.



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

<b>Contact Person Name</b>	<input type="text"/>
<b>Contact Person Job Title</b>	<input type="text"/>
<b>Contact Person Telephone</b>	<input type="text"/>
<b>Contact Person E-Mail Address</b>	<input type="text"/>

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

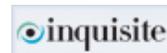
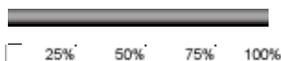
<b>Administrator's Name</b>	<input type="text"/>
<b>Administrator's Title</b>	<input type="text"/>
<b>Administrator Telephone</b>	<input type="text"/>
<b>Administrator E-Mail Address</b>	<input type="text"/>

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

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<input type="button" value=" &lt; Back"/>	<input type="button" value=" Next &gt;"/>	<input type="button" value=" Save"/>
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### CERTIFICATION OF SURVEY DATA

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

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

Person Certifying   
Job Title  Certification Date

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**Thank you for Completing the ASTC Questionnaire**

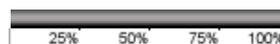
We **Strongly** Recommend You Print Out Each Page of This Form with Your Answers for Future Reference.

**Once You Have Submitted This Form, No Further Access or Changes are Possible.  
Be Sure to Verify Your Answers Before Clicking On the 'SUBMIT FORM' Button.**

When You Have Reviewed and Printed Your Responses, Click the 'SUBMIT FORM' Button to Send Your Completed Questionnaire to Our Server. You Will Be Routed to a Confirmation Page.

If You Have Any Problems, Please Contact This Office  
By Phone at 217-782-3516 or By Email to [DPH.FacilitySurvey@illinois.gov](mailto:DPH.FacilitySurvey@illinois.gov)

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Term	Definition	Reference
<b>Adult cardiac catheterization</b>	Cardiac catheterization of patients 15 years of age and older	According to Administrative rule 1110.1320
<b>By or On Behalf of a Health Care facility</b>	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.	
<b>Case</b>	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.	
<b>Cardiac Catheterization Labs</b>	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.	
<b>Cardiovascular Intervention or Treatment</b>	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).	
<b>Capital Expenditure</b>	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.	
<b>Charity Care</b>	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
<b>Construction or Modification</b>	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....	
<b>Diagnostic Cardiac Catheterization (DCC)</b>	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.	
<b>Full Time Equivalent</b>	A unit of measurement which is equal to one filled, full time, annual-salaried position.	
<b>Interventional Cardiac Catheterization (ICC)</b>	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.	
<b>Method of Financing</b>	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.	
<b>Net Revenue</b>	Net Revenue is the result of gross revenue less provision for contractual adjustments from third party payers.	American Institute of Certified Public Accountants (AICPA)
<b>Other Public Payment</b>	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.	
<b>Operating Room (Class C)</b>	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
<b>Obligation</b>	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 2006 for construction of a new bed wing. Construction takes approximately three years with payments being made to the contractor during 2006, 2007 and 2008. The entire \$2 million would be listed once as an obligation for 2006 and would not be listed in subsequent years.	
<b>Patients Served by payment source</b>	Include number of inpatients and outpatients served by their payment type.	Payment sources are defined within the questionnaire.
<b>Project</b>	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.	
<b>Pediatric cardiac Catheterization</b>	Cardiac Catheterization of patients 0-14 years.	According to Administrative rule 1110.1320
<b>Private Pay</b>	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.	
<b>Revenue by payment source</b>	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
<b>Stage 1 and Stage 2 Recovery Stations</b>	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).
<b>Surgical Procedure Room (Class B)</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)