

**THE 2011  
ANNUAL AMBULATORY SURGICAL  
TREATMENT CENTER QUESTIONNAIRE**

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# **PREFACE TO THE 2011 ANNUAL AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE**

The Annual Ambulatory Surgical Treatment Center Questionnaire (ASTCQ) is administered by the Division of Health Systems Development, Office of Policy, Planning and Statistics, of the Illinois Department of Public Health under the authority of the Illinois Health Facilities Planning Act (20 ILCS 3960/). This survey is conducted on an annual basis and its results are published in the form of the Annual Ambulatory Surgical Treatment Center Profiles and other reports, posted on the website: <http://www.idph.state.il.us/about/hfpb.htm>.

## **Overview and Time Frame**

The questionnaire is administered electronically to all ambulatory surgical treatment centers in the state of Illinois licensed under the Ambulatory Surgical Treatment Center Licensing Act. The completed data, along with signature verification, are submitted electronically to IDPH. Signature of the Executive Officer of the facility attesting to the best of his or her knowledge that "...data contained in the questionnaire are true and accurate" is mandatory for the data to be deemed complete. This year the signature page was part of the questionnaire and, by checking the tick mark on the last page, the officer of each facility attested to the validity of the data being submitted.

Email contacts were tested prior to the original submittal of the survey. The questionnaire was sent by email to all ambulatory surgical treatment centers on January 27, 2012 as a formal request for information, with a due date of February 29, 2012 (5 weeks for completion). Facilities that did not return their questionnaires by March 30, 2012 received a certified letter informing them they had been entered on our non-compliance list and that referrals would be made to the Health Facilities and Services Review Board for the issuance of fine, for those facilities who did not submit their complete questionnaires by April 14, 2012. There were no facilities from whom the survey was not received within this extended time frame.

## **Differences from Previous ASTCQs to 2011 ASTCQs**

This year's survey has no major changes from past questionnaires.

## **Validation and Compilation of Data**

The submitted questionnaires are checked for data irregularities in regards to high surgical prep and clean-up times, staffing and matching of patients and surgeries. Facilities with irregularity in surgical times, staffing and matching numbers for patients and surgeries automatically received calls from staff. High surgical times are checked against the previous year profile to see if it is a trend. If not, the surgical center is then called by staff to verify the average surgical time for the procedure.

Summary reports are run to make sure data matches in the appropriate places and averages for any data are in acceptable ranges. If not, suspect data is identified and either verified or corrected by the appropriate facility.

Data for surgeries are for the entire calendar year. Staffing numbers are for all full time equivalent employee positions for the first pay period of December. All patient demographic information is for patients during the entire year calendar.

## **Financial Data in the ASTCQ (Fiscal Year)**

Detailed financial information for each ASTC is available on their individual profiles. The profiles indicate "Net Revenue by Payor Source" (Medicaid, Medicare, Private Pay, Other Public and Private Insurance). Charity Care expense is also listed for their population. At the time of this posting, some of the charity care expenses are still being verified. Those facilities have notes indicating that their data is still being reviewed.

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Questions may be addressed to:

Data Section  
Division of Health Systems Development  
525 W. Jefferson St., 2<sup>nd</sup> Floor  
Springfield, IL 62761

Or email: [IHFPB\\_data@idph.state.il.us](mailto:IHFPB_data@idph.state.il.us)

### Illinois Health Facilities and Services Review Board AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2011

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:

**Part I**

Collects information on your facility and facility utilization.  
**THIS PART MUST BE REPORTED FOR CALENDAR YEAR 2011.**

**Part II**

Collects Financial and Capital Expenditure information for your facility.  
**THIS PART MUST BE REPORTED FOR THE MOST RECENT FISCAL YEAR AVAILABLE TO YOU.**

The Certification Statement on page 15 must be completed before the survey data can be submitted.

**This survey must be completed and submitted by February 29, 2012.**

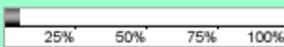
Facilities failing to submit this questionnaire within the required time frame will be reported to the Illinois Health Facilities and Services Review Board for the its consideration of the imposition of sanctions mandated by the Act.

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 contact this office to report any inaccuracies:

ASTC Name	<input type="text"/>		
ASTC Address	<input type="text"/>		
ASTC City	<input type="text"/>	IL	Zip Code <input type="text"/>

Next > Save



## Illinois Health Facilities and Services Review Board AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2011

### 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.**

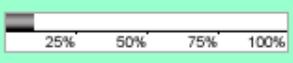
#### IMPORTANT

When 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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Illinois Health Facilities and Services Review Board  
AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2011  
Part 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

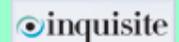
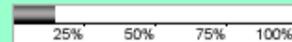
- Church Related
- State
- County
- City
- Township
- Other Not for Profit (Specify below)

Other Ownership Type  \*RA - Registered Agent Required

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

	Name	Relationship	Type of Interest
1	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>	<input type="text"/>

< Back Next > Save

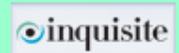
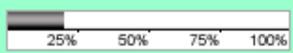


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AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2011  
Part I - Facility Data

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 a spreadsheet using the format below and email to DPH.FacilitySurvey@illinois.gov:

	Owner Name	Address	City, State Zip Code-Plus 4	Telephone Number (xxx/xxx-xxxx.xxxx)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				

< Back Next > Save



**Illinois Health Facilities and Services Review Board  
 AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2011  
 Part I - Facility Data**

**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)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**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	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>

**4. FACILITY STAFFING**

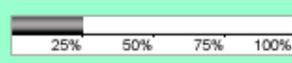
A. Please indicate the number of hours in a work week for a full-time employee of your facility:

**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, 2011.

Personnel	Full-Time Equivalents
Administrators	<input type="text" value="0"/>
Physicians	<input type="text" value="0"/>
Nurse Anesthetists	<input type="text" value="0"/>
Director of Nursing	<input type="text" value="0"/>
Registered Nurses	<input type="text" value="0"/>
Certified Aides	<input type="text" value="0"/>
Other Health Professionals	<input type="text" value="0"/>
Other Non-Health Professionals	<input type="text" value="0"/>
<b>TOTAL FACILITY PERSONNEL</b>	<input type="text" value="0"/>

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**Illinois Health Facilities and Services Review Board  
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 Part I - Facility Data**

**INFORMATION CONCERNING PATIENTS SERVED - CALENDAR YEAR 2011**

**5. Patients by Age Groups**

Please indicate the number of patients during the calendar year 2011 by age and sex. If the patient was seen more than once, he/she should be counted for each new incident.

	MALE	FEMALE	
0-14 Years	<input type="text" value="0"/>	<input type="text" value="0"/>	
15-44 Years	<input type="text" value="0"/>	<input type="text" value="0"/>	
45-64 Years	<input type="text" value="0"/>	<input type="text" value="0"/>	
65-74 Years	<input type="text" value="0"/>	<input type="text" value="0"/>	
75+ Years	<input type="text" value="0"/>	<input type="text" value="0"/>	
<b>TOTALS</b>	<input type="text" value="0"/>	<input type="text" value="0"/>	<b>TOTAL PATIENTS SERVED</b> <input type="text" value="0"/>

**6. Source of Payment**

Please indicate the numbers of patients your ASTC saw during calendar year 2011, by sex and PRIMARY PAYOR. The Total Male and Total Female patients reported must be the same as those reported in Question 5.

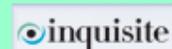
	Male	Female
Medicaid	<input type="text" value="0"/>	<input type="text" value="0"/>
Medicare	<input type="text" value="0"/>	<input type="text" value="0"/>
Other Public*	<input type="text" value="0"/>	<input type="text" value="0"/>
Private Insurance	<input type="text" value="0"/>	<input type="text" value="0"/>
Private Payment	<input type="text" value="0"/>	<input type="text" value="0"/>
Charity Care*	<input type="text" value="0"/>	<input type="text" value="0"/>
<b>TOTALS</b>	<input type="text" value="0"/>	<input type="text" value="0"/>

[\[Definitions\]](#)

\*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 2011**

**Preferred Reporting Method:**

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

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

If you do not wish to use the Patient Origin worksheet, please use the spaces below to report the places of origin of the patients seen at your ASTC during Calendar Year 2011, 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

**Illinois Health Facilities and Services Review Board  
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 Part I - Facility Data**

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

Please report the places of origin of the patients seen at your ASTC during Calendar Year 2011, 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.

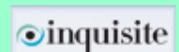
	Zip Code Area	County Name	Number of Patients
51			0
52			0
53			0
54			0
55			0
56			0
57			0
58			0
59			0
60			0
61			0
62			0
63			0
64			0
65			0
66			0
67			0
68			0
69			0
70			0
71			0
72			0
73			0
74			0
75			0

	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

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**Illinois Health Facilities and Services Review Board  
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**7. Patients by Place of Origin (Page 3)**

Please report the places of origin of the patients seen at your ASTC during Calendar Year 2011, 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

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**7. Patients by Place of Origin (Page 4)**

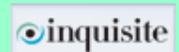
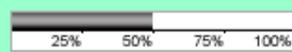
Please report the places of origin of the patients seen at your ASTC during Calendar Year 2011, and the number of patients from each area. 5-digit Zip Code areas are preferred; if Zip Code information is not available, please report counties of origin. If you need more spaces, click on 'More Patients', 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



**Illinois Health Facilities and Services Review Board**  
**AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2011**  
**Part I - Facility Data**

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

Please report the places of origin of the patients seen at your ASTC during Calendar Year 2011, 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



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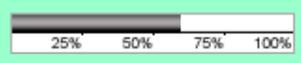
**7. Patients by Place of Origin (Page 6)**

Please report the places of origin of the patients seen at your ASTC during Calendar Year 2011, 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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## Illinois Health Facilities and Services Review Board AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2011 Part I - Facility Data

### 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 TIME.

	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. Special 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

### 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

\***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)

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## Illinois Health Facilities and Services Review Board AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2011 Part I - Facility Data

**SURGICAL UTILIZATION FOR CALENDAR YEAR 2011 - OPERATING ROOMS (Class C)\* - Definition**

11. For each listed surgical category, indicate the number of surgical cases, the number of hours spent in setting up the surgery rooms for use, the hours of actual surgical time, and the number of hours spent in clean-up after the surgery was completed. Round the time reported to the nearest quarter of an hour. For example, a total of 318 hours and 40 minutes would be rounded to 318.75 hours for reporting purposes.

	Number of Cases	Surgery Room Set-Up Time (in Hours)	Actual Surgery Time (in Hours)	Surgery Room Clean-Up Time (in Hours)
Cardiovascular	0	0	0	0
Dermatology	0	0	0	0
General Surgery	0	0	0	0
Gastroenterology	0	0	0	0
Neurological	0	0	0	0
OB/Gynecology	0	0	0	0
Oral/Maxillofacial	0	0	0	0
Ophthalmology	0	0	0	0
Laser Eye Surgery	0	0	0	0
Orthopedic	0	0	0	0
Otolaryngology	0	0	0	0
Pain Management	0	0	0	0
Plastic	0	0	0	0
Podiatry	0	0	0	0
Thoracic	0	0	0	0
Urology	0	0	0	0
<b>TOTALS</b>	0	0	0	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.  
(Source: Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons)

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**Illinois Health Facilities and Services Review Board  
 AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2011  
 Part I - Facility Data**

**SURGICAL UTILIZATION FOR CALENDAR YEAR 2011 - PROCEDURE (not operating) ROOMS**

12. 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.

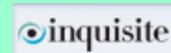
NOTE - For reporting purposes, a case is defined as a PATIENT TREATED. If a patient has 3 procedures performed, that is counted as 1 CASE. TOTAL PROCEDURE ROOMS must equal Procedure Rooms reported on line b., Question 9. Total Procedure Room Cases plus Total Operating Room Cases from Question 10 must equal Total Patients Served from Question 5.

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	0				
<b>TOTALS - ALL PROCEDURE ROOMS</b>	0	0	0	0	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 Part II - Financial and Capital Expenditures Data

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Illinois Health Facilities and Services Review Board  
AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2011  
Part II - Financial and Capital Expenditures Data

THE DATA REQUESTED BY THIS QUESTIONNAIRE ARE AUTHORIZED  
PURSUANT TO THE ILLINOIS HEALTH FACILITIES PLANNING ACT [20 ILCS 3960/5.3]

THESE DOLLAR AMOUNTS MUST BE TAKEN 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 FINANCIAL STATEMENTS, OR TAX RETURN** FOR THE MOST  
RECENT FISCAL YEAR AVAILABLE TO YOU.

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.**

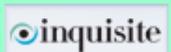
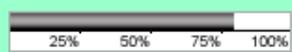
If you have problems providing the information requested, contact this office via e-mail at  
DPH.FacilitySurvey@illinois.gov, or by telephone at 217-782-3516.

INDICATE THE STARTING AND ENDING DATES  
OF YOUR MOST RECENT FISCAL YEAR (mm/dd/yyyy)

Starting  Ending

Source of Financial Data Used

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### Illinois Health Facilities and Services Review Board AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2011 Part II - Financial and Capital Expenditures Data

#### A. CAPITAL EXPENDITURES

Provide the following information for all projects / capital expenditures in excess of \$303,000 obligated by or on behalf of the health care facility for your reported Fiscal Year (click the link below the table for definitions of terms):

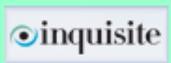
	Description of Project/ Capital Expenditure	Amount Obligated	Method of Financing	CON Project Number (if reviewed)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

[\[Definitions\]](#)

Report the TOTAL of ALL Capital Expenditures for your reported Fiscal Year:

TOTAL ACTUAL CAPITAL EXPENDITURES FOR YOUR REPORTED FISCAL YEAR  
(including those below \$303,000)

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**Illinois Health Facilities and Services Review Board  
 AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2011  
 Part II - Financial and Capital Expenditures Data**

**B. NET REVENUE BY PAYMENT SOURCE - REPORTED FISCAL YEAR**

Please indicate your Net Revenue during your reported Fiscal Year, by payment source.

	Net Revenue (in Dollars)
Medicaid	0
Medicare	0
Other Public*	0
Private Insurance	0
Private Payment	0
<b>Total Revenues</b>	0

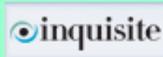
\*Other Public payment includes individuals whose primary payment source is Veterans Administration, County Boards, Community Aid Agencies, grants, CHAMPUS, CHAMP-VA, and other government-sponsored programs, excluding Medicare and Medicaid.

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

	Amount (in Dollars)
<b>Total Actual Cost of Services Provided to Charity Care* Cases</b>	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.

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### Illinois Health Facilities and Services Review Board AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2011

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

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

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

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

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

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### Illinois Health Facilities and Services Review Board AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2011

#### CERTIFICATION OF SURVEY DATA

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

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

Person Certifying

Job Title

Certification Date

**Thank you for Completing the ASTC Questionnaire**

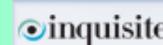
**WE STRONGLY RECOMMEND THAT YOU PRINT OUT EACH PAGE OF THIS FORM WITH YOUR ANSWERS FOR FUTURE REFERENCE.**

**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 PRINTED YOUR RESPONSES, CLICK THE 'SUBMIT FORM' BUTTON TO SEND YOUR COMPLETED QUESTIONNAIRE BACK TO OUR OFFICE. YOU WILL BE ROUTED TO A CONFIRMATION PAGE.**

**IF YOU HAVE ANY PROBLEMS, PLEASE CONTACT THIS OFFICE IMMEDIATELY AT 217-782-3516 OR BY EMAIL AT [DPH.FacilitySurvey@illinois.gov](mailto:DPH.FacilitySurvey@illinois.gov)**



<b>Term</b>	<b>Definition</b>	<b>Comments</b>
<p>Cardiac Catheterization</p> <p>a. Diagnostic and Interventional Cardiac Catheterization</p> <p>b. Electrophysiology Studies (EPS)</p>	<p>Diagnosis and/or treatment of cardiac diseases associated with the blockage or narrowing of the blood vessels and diseases of the heart.</p> <p>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.</p> <p>Electrophysiology studies are conducted to determine the focus of arrhythmias in the heart. Electrodes are placed in the heart during a cardiac catheterization, making it possible to measure the electrical potential of different locations within the heart and determine the area responsible for an arrhythmia and ability to destroy abnormal cells causing rhythm disturbances.</p>	<p>According to Administrative rule 1110.1320</p>





b. Stage 2	Stage 2 are used for less intensive procedures which involve less anesthesia there by need less time to recuperate.	
<p>Revenue by payment source</p> <p>a. Private Pay</p> <p>b. Other Public</p> <p>Source of Financial Data Used</p>	<p>Include the amount of <b>net revenue</b> of the facility during the fiscal year for the inpatients and outpatients served by the payment type.</p> <p>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.</p> <p>Other public 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 should be recorded here.</p> <p>Indicate the source from which the financial information has been taken. The sources include audited financial statements, review or compilation of financial statements or tax return for most recent fiscal year.</p>	

### **Financial/Capital Expenditures Definitions:**

1. **ON BEHALF OF HEALTH CARE FACILITY:** Any transactions undertaken by the facility or by any other entity other than the facility which results in constitution 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.
2. **CAPITAL EXPENDITURE:** Any expenditure : (A) made by or on behalf of a health care facility .....and (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made to obtain by lease or comparable arrangement any facility or part there of 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 of facilities or a transfer of equipment or facilities at fair market value.
3. **CONSTRUCTION OR MODIFICATION:** The establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership, of or by a health care facility, or the purchase or acquisition by or through a health care facility of equipment of 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.
4. **METHOD OF FINANCING:** The source of funds required to undertake the project or capital expenditure. Forms of financing include equity (cash and securities), lease, mortgages, general obligation bonds, revenue bonds, appropriations and gifts/donations/bequests.
5. **OBLIGATION:** The commitment of funds directly or indirectly through the execution of construction or other contracts, purchase order, lease agreements of other means for any construction or modification project.

NOTE: Funds obligated in a given year should not be carried forward to subsequent years due to phased or periodic payouts. For example, a facility signs a \$2 million contract in 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.

6. **PROJECT:** Any proposed construction or modification of a health care facility or any proposed acquisition of equipment undertaken by or on behalf of a health care facility regardless of whether or not the transaction required a certificate of need. Components of construction or modification, which are interdependent, must be grouped together for reporting purposes. Interdependence occurs when components of construction or modification are architecturally and/or programmatically interrelated to the extent that undertaking one of 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.

7. **NET REVENUE:** Net Revenue is the result of gross revenue less provision for contractual adjustments from third party payors (Source: AICPA).