THE 2007
ANNUAL AMBULATORY SURGICAL TREATMENT CENTER
QUESTIONNAIRE

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PREFACE TO THE 2007
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. While the data are submitted electronically, for the submittal to be complete a signature page must be received, signed the Administrator of the facility attesting that, to the best of his or her knowledge, the "…data contained in the questionnaire are true and accurate."

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 March 24, 2008 as a formal request for information, with a due date of May 5, 2008 (6 weeks for completion). Facilities that did not return their questionnaires or signature pages by May 13, 2008 received a certified letter informing them that they had been put on our non-compliance list and that referrals would be made to the Health Facilities Planning Board for the issuance of fine, for those facilities who did not submit their complete questionnaires by June 2, 2008. The facilities from whom either the survey or the signature page was not received within this time frame was later issued Notices of Intent to Fine, as authorized under the Act.

Differences from Previous ASTCQs to 2007 ASTCQs

This year's survey has 2 sections: Part I, the utilization of the surgical treatment center; and Part II, financial information of the facility. Part I is collected based on the calendar year, where as the financial Part II is based on the individual facility's fiscal year. Financial data were requested to be derived from the respondents' most recent audited financial statements or review or compilation of the financial statements or tax return for the most recent fiscal year available to them.

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 for the entire year calendar.

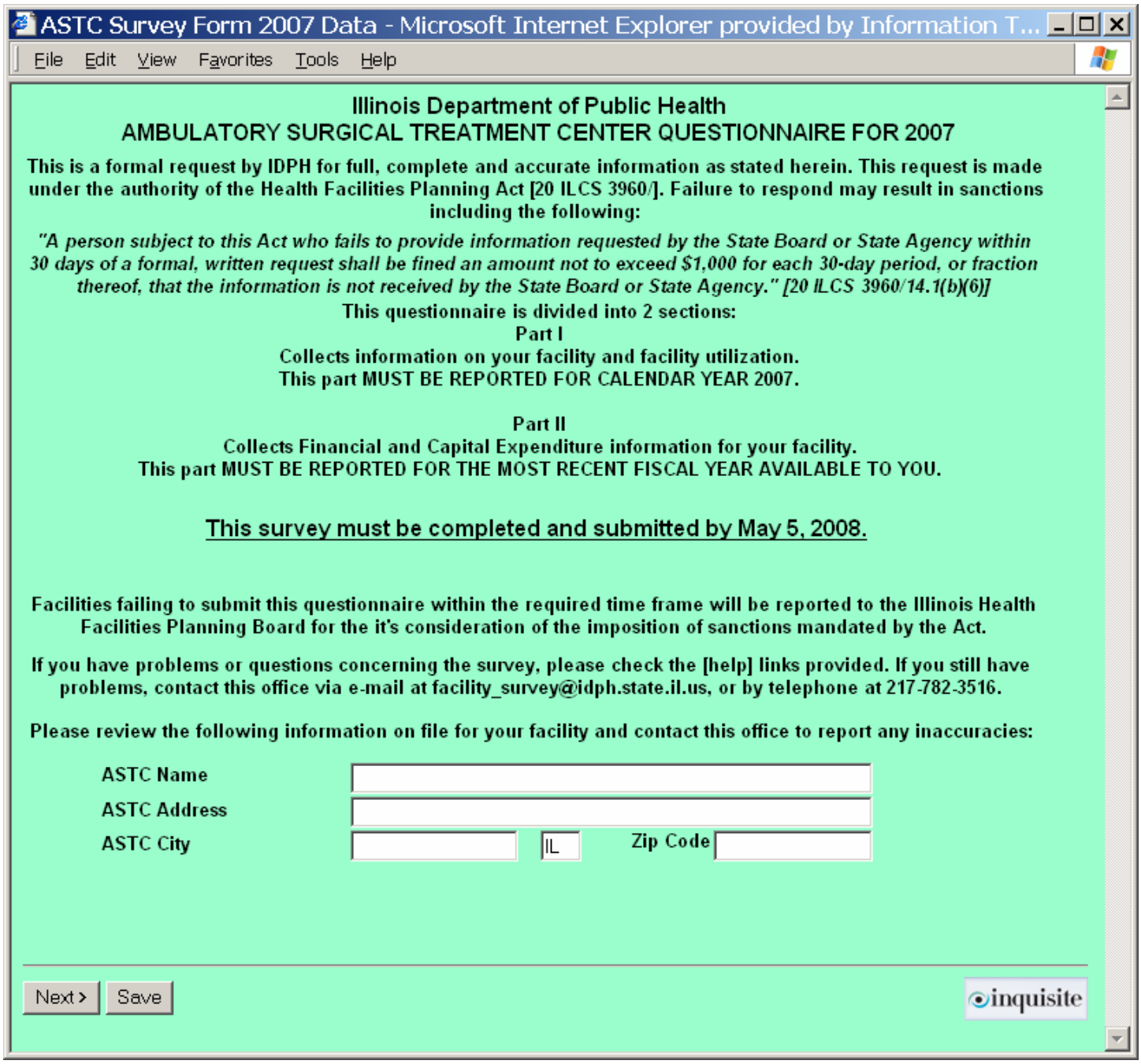
Financial Data In the ASTCQ (Fiscal Year)

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.

Questions may be addressed to:

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

Or email: IHFPB_data@idph.state.il.us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Illinois Department of Public Health
AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
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 2007.
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.
This survey must be completed and submitted by May 5, 2008.
Facilities failing to submit this questionnaire within the required time frame will be reported to the Illinois Health Facilities Planning Board for the it's 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 at facility_survey@idph.state.il.us, 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
ASTC Address
ASTC City
IL
Zip Code
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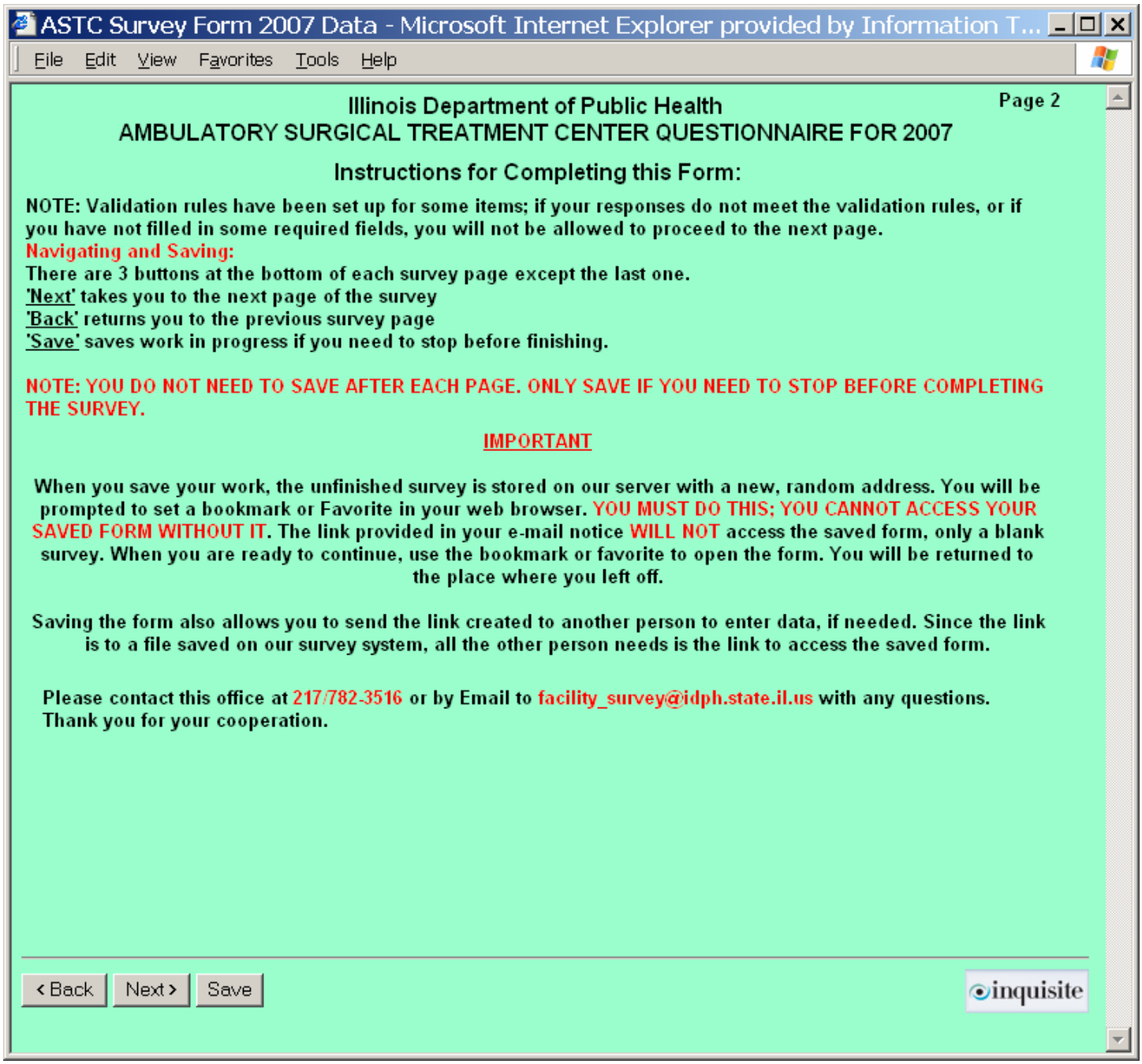
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AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
Instructions for Completing this Form:
NOTE: Validation rules have been set up for some items; if your responses do not meet the validation rules, or if you have not filled in some required 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 facility_survey@idph.state.il.us with any questions.
Thank you for your cooperation.
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AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
Part I - Facility Data

1. FACILITY OWNERSHIP INFORMATION

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

FOR PROFIT	NOT FOR PROFIT
○ Sole Proprietorship	○ Church Related
○ Corporation (*RA)	○ State
○ Partnership (registered with county)	○ County
○ Limited Partnership (*RA)	○ City
○ Limited Liability Partnership (*RA)	○ Township
○ Limited Liability Company (*RA)	○ Other Not for Profit (Specify below)
○ Other For Profit (specify below)	

Other Ownership Type _____ *RA - Registered Agent Required

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

Name of Registered Agent: _____

Address: _____

City. State and Zip Code (plus Four): _____

Telephone Number: _____

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

	Name	Relationship	Type of Interest
1			
2			
3			
4			
5			

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AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
Part I - Facility Data

D. Indicate the name, address and telephone number of the legal owners/operators of the facility:

	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				

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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)
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. Please indicate the number of hours in a work week for a full-time employee of your facility: 0

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, 2007.

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

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AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
Part I - Facility Data

INFORMATION CONCERNING PATIENTS SERVED - CALENDAR YEAR 2007

5. Patients by Age Groups

Please indicate the number of patients during the year 2007 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	0	0
15-44 Years	0	0
45-64 Years	0	0
65-74 Years	0	0
75+ Years	0	0
TOTALS	0	0

TOTAL PATIENTS SERVED: 0

6. Source of Payment

Please indicate the numbers of patients your ASTC saw during the reporting period, by sex and PRIMARY payment source. The Total Male and Total Female patients reported must be the same as those reported in Question 5.

	Male	Female
Medicaid	0	0
Medicare	0	0
Other Public*	0	0
Private Insurance	0	0
Private Payment	0	0
Charity Care*	0	0
TOTALS	0	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 is care for which the provider does not expect to receive payment from the patient or a third-party payer. 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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AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
Part I - Facility Data

7. Patients by Place of Origin

Please report the places of origin of the patients seen at your ASTC during Calendar Year 2007, 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
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

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AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
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 2007, 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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AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
Part I - Facility Data

7. Patients by Place of Origin (Page 3)

Please report the places of origin of the patients seen at your ASTC during Calendar Year 2007, 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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AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
Part I - Facility Data

7. Patients by Place of Origin (Page 4)

Please report the places of origin of the patients seen at your ASTC during Calendar Year 2007, 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

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AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
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 2007, 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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AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
Part I - Facility Data

7. Patients by Place of Origin (Page 6)

Please report the places of origin of the patients seen at your ASTC during Calendar Year 2007, 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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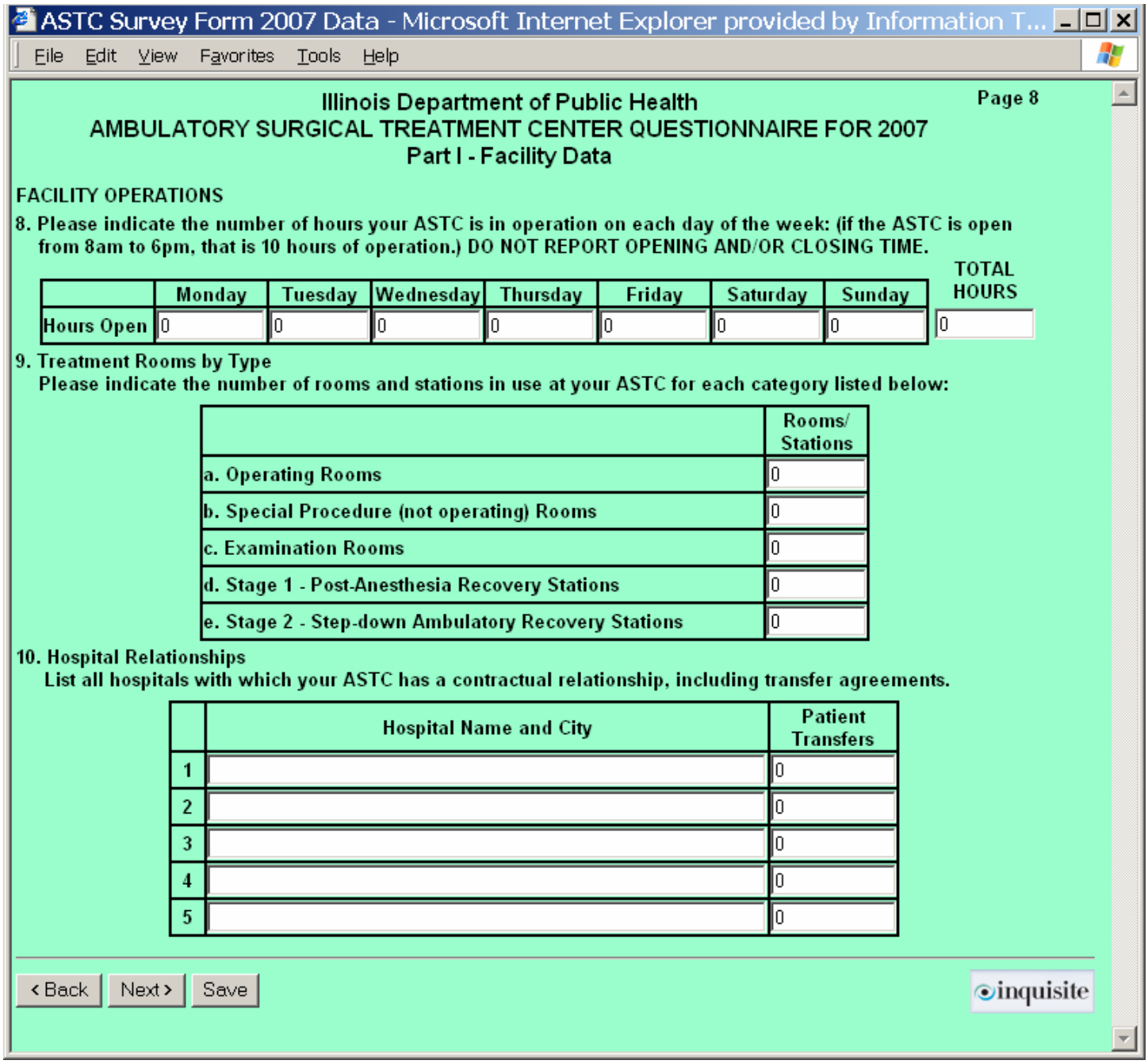
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AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
Part I - Facility Data
FACILITY OPERATIONS
8. Please indicate the number of hours your ASTC is in operation on each day of the week: (if the ASTC is open from 8am to 6pm, that is 10 hours 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 0
b. Special Procedure (not operating) Rooms 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
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AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
Part I - Facility Data

SURGICAL UTILIZATION FOR CALENDAR YEAR 2007 - 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
TOTALS	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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AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
Part I - Facility Data

SURGICAL UTILIZATION FOR CALENDAR YEAR 2007 - 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 (Type 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				
TOTALS - ALL PROCEDURE ROOMS	0	0	0	0	0

*Surgical Procedure Room (Type 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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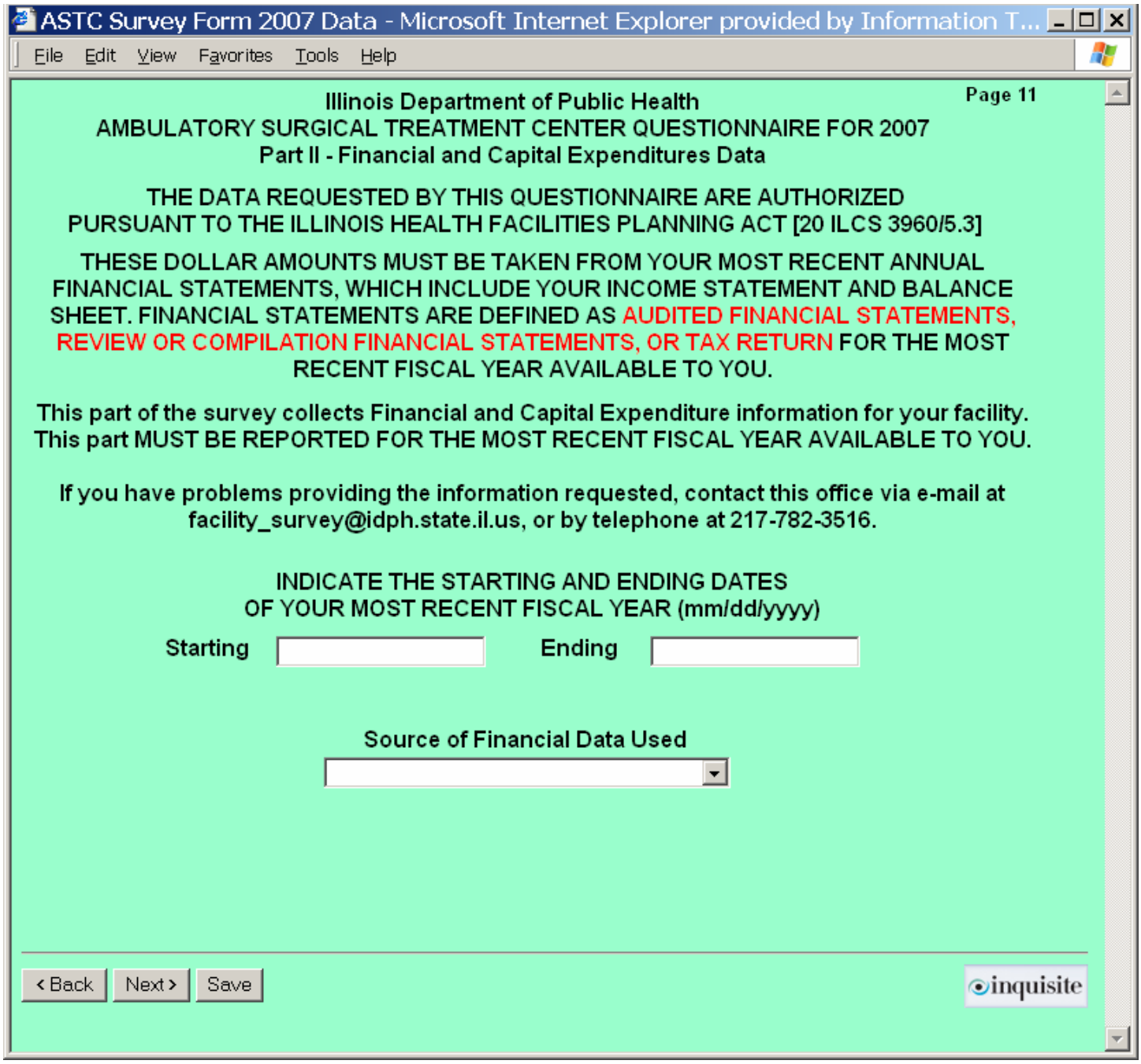
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Illinois Department of Public Health
AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
Part II - Financial and Capital Expenditures Data
THE DATA REQUESTED BY THIS QUESTIONNAIRE ARE AUTHORIZED PURSUANT TO THE ILLINOIS HEALTH FACILITIES PLANNING 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 facility_survey@idph.state.il.us, 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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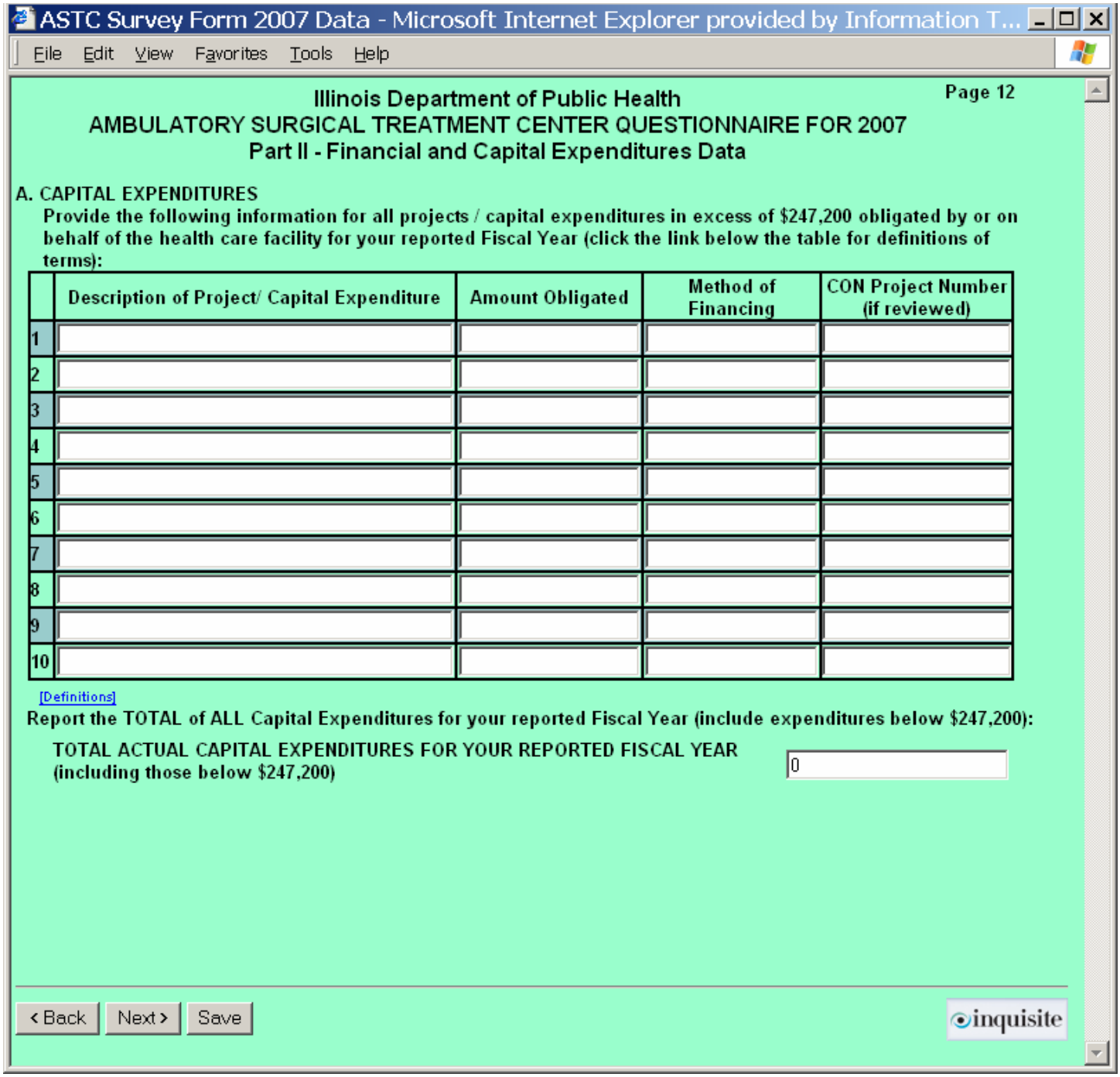
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Illinois Department of Public Health
AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
Part II - Financial and Capital Expenditures Data
A. CAPITAL EXPENDITURES
Provide the following information for all projects / capital expenditures in excess of $247,200 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 (include expenditures below $247,200):
TOTAL ACTUAL CAPITAL EXPENDITURES FOR YOUR REPORTED FISCAL YEAR (including those below $247,200)
0
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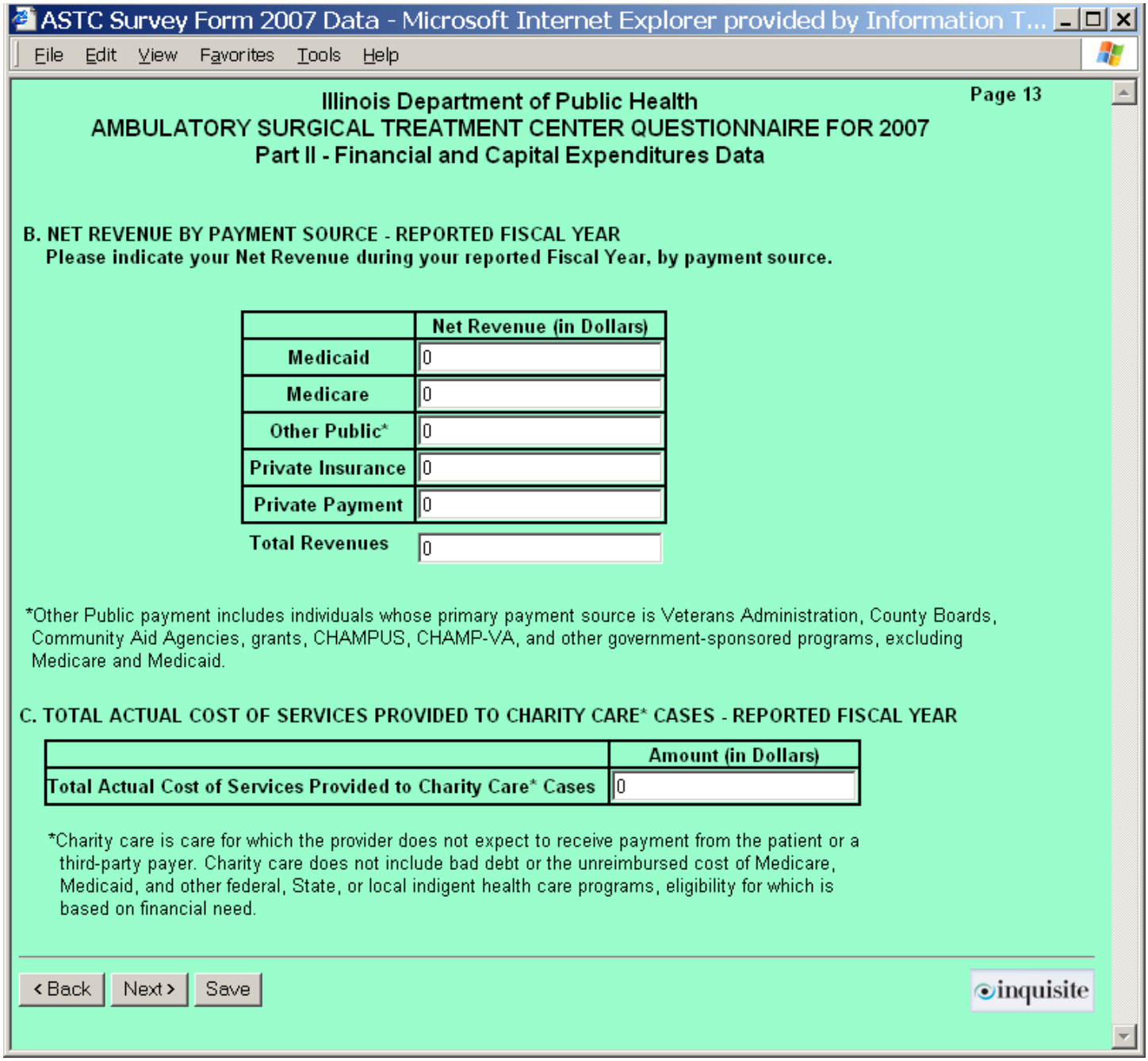
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Illinois Department of Public Health
AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
Part II - Financial and Capital Expenditures Data
B. NET REVENUE BY PAYMENT SOURCE - REPORTED FISCAL YEAR
Please indicate your Net Revenue during your reported Fiscal Year, by payment source.
Net Revenue (in Dollars)
Medicaid 0
Medicare 0
Other Public* 0
Private Insurance 0
Private Payment 0
Total Revenues 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)
Total Actual Cost of Services Provided to Charity Care* Cases 0
*Charity care is care for which the provider does not expect to receive payment from the patient or a third-party payer. 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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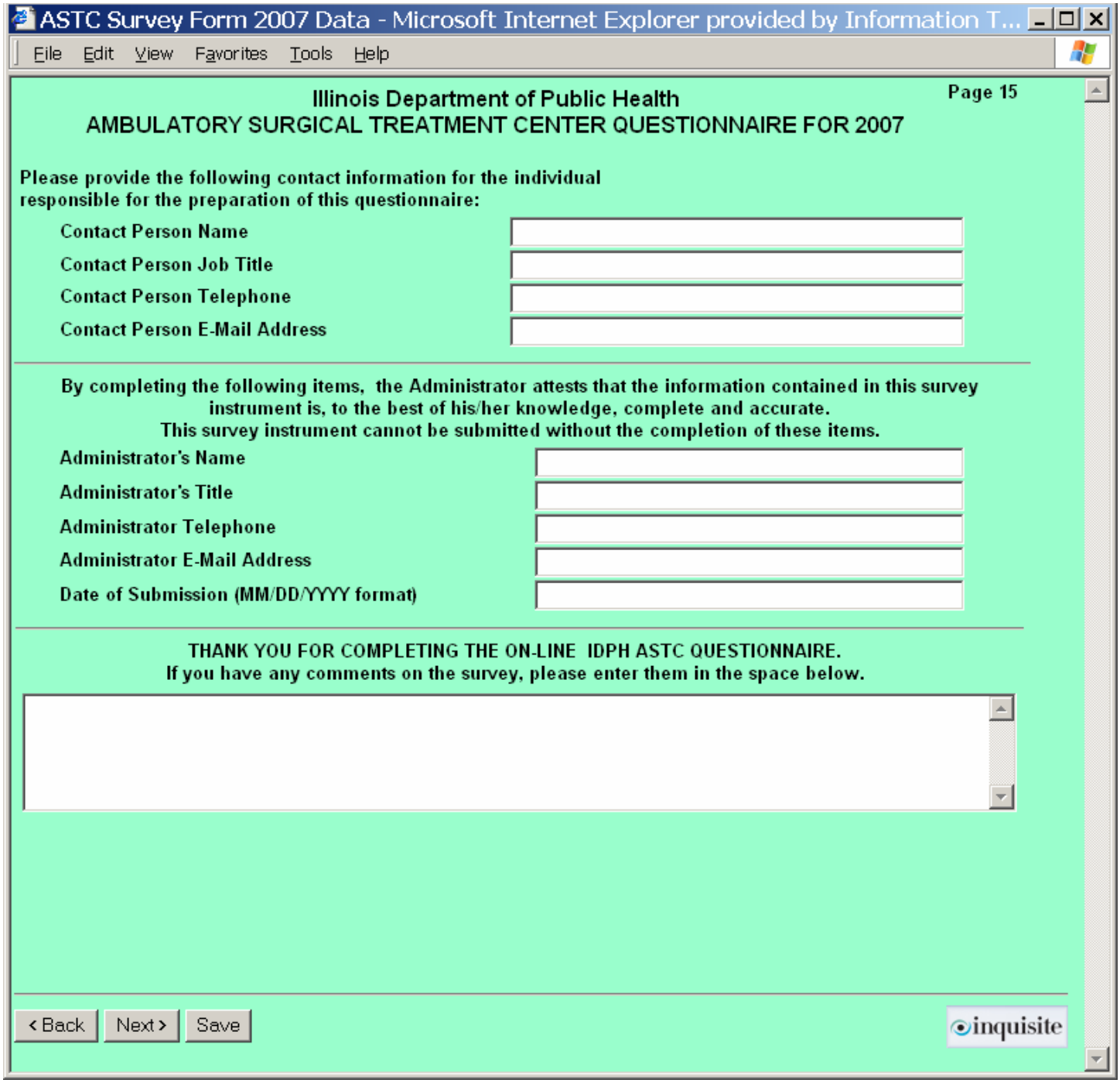
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Illinois Department of Public Health
AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
Please provide the following contact information for the individual responsible for the preparation of this questionnaire:
Contact Person Name
Contact Person Job Title
Contact Person Telephone
Contact Person E-Mail Address
By completing the following items, the Administrator attests that the information contained in this survey instrument is, to the best of his/her knowledge, complete and accurate.
This survey instrument cannot be submitted without the completion of these items.
Administrator's Name
Administrator's Title
Administrator Telephone
Administrator E-Mail Address
Date of Submission (MM/DD/YYYY format)
THANK YOU FOR COMPLETING THE ON-LINE IDPH ASTC QUESTIONNAIRE.
If you have any comments on the survey, please enter them in the space below.
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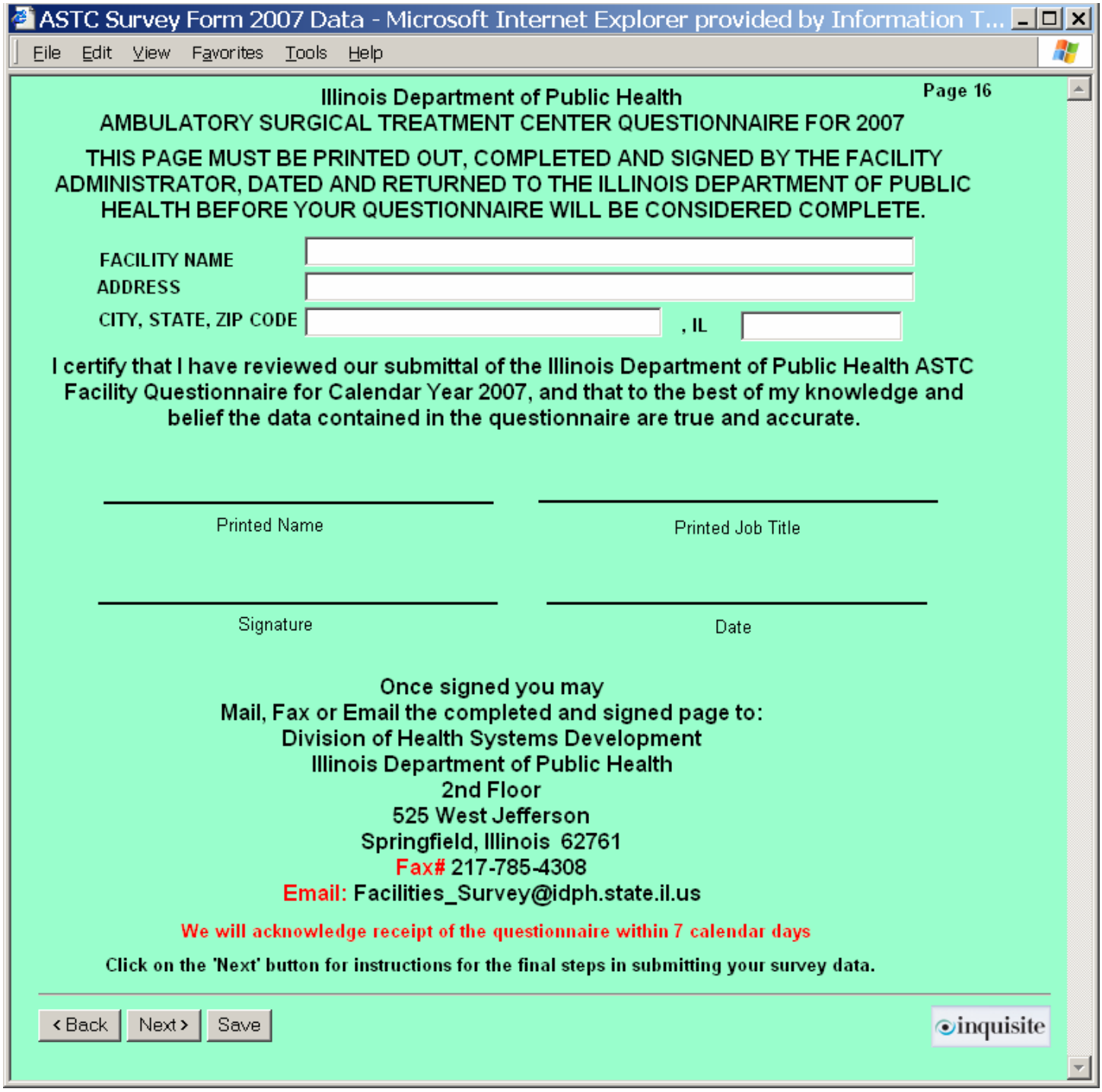
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Illinois Department of Public Health
AMBULATORY SURGICAL TREATMENT CENTER QUESTIONNAIRE FOR 2007
THIS PAGE MUST BE PRINTED OUT, COMPLETED AND SIGNED BY THE FACILITY ADMINISTRATOR, DATED AND RETURNED TO THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH BEFORE YOUR QUESTIONNAIRE WILL BE CONSIDERED COMPLETE.
FACILITY NAME
ADDRESS
CITY, STATE, ZIP CODE
, IL
I certify that I have reviewed our submittal of the Illinois Department of Public Health ASTC Facility Questionnaire for Calendar Year 2007, and that to the best of my knowledge and belief the data contained in the questionnaire are true and accurate.
Printed Name
Printed Job Title
Signature
Date
Once signed you may
Mail, Fax or Email the completed and signed page to:
Division of Health Systems Development
Illinois Department of Public Health
2nd Floor
525 West Jefferson
Springfield, Illinois 62761
Fax# 217-785-4308
Email: Facilities_Survey@idph.state.il.us
We will acknowledge receipt of the questionnaire within 7 calendar days
Click on the 'Next' button for instructions for the final steps in submitting your survey data.
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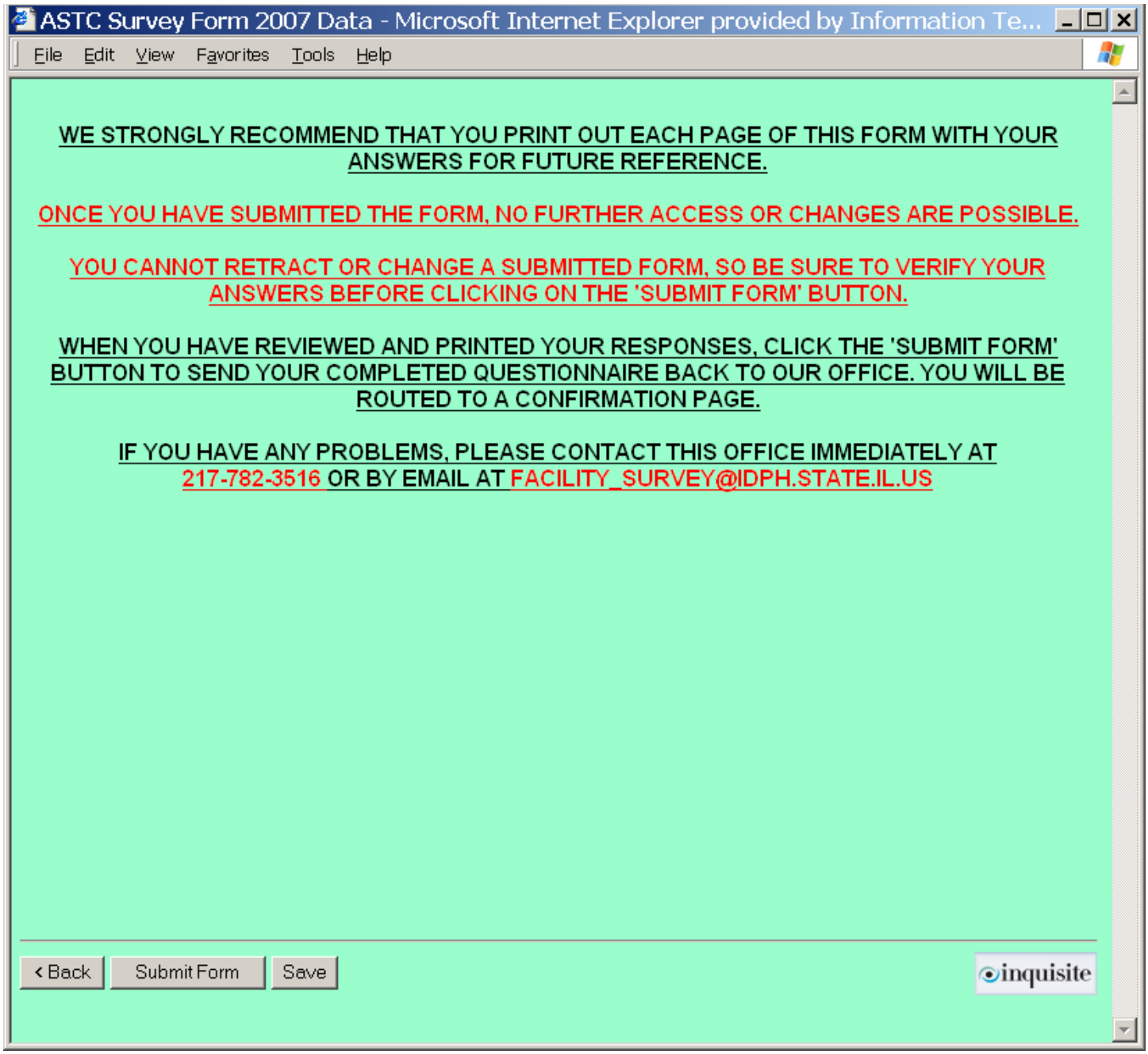
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WE STRONGLY RECOMMEND THAT YOU PRINT OUT EACH PAGE OF THIS FORM WITH YOUR ANSWERS FOR FUTURE REFERENCE.
ONCE YOU HAVE SUBMITTED THE FORM, NO FURTHER ACCESS OR CHANGES ARE POSSIBLE.
YOU CANNOT RETRACT OR CHANGE A SUBMITTED FORM, SO BE SURE TO VERIFY 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 FACILITY_SURVEY@IDPH.STATE.IL.US
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Term	Definitions	Reference
Adult cardiac catheterization	Cardiac catheterization of patients 15 years of age and older	According to Administrative rule 1110.1320
By or on behalf of a Health Care facility	By or on behalf of a Health Care facility Any transactions undertaken by the facility or by any other entity other than the facility which results in construction or modification of the facility and directly or indirectly results in the facility billing or receiving reimbursement, or in participating or assuming responsibility for the retirement of debt or the provision of any services associated with the transaction.	
Case	Case is defined as a patient encountered in an inpatient or outpatient setting. For example, if 3 surgical procedures are performed on an individual, only 1 case is counted.	
Cardiac Catheterization Labs	Includes labs that are dedicated as well as non dedicated cardiac labs for diagnostic, interventional and electrophysiology procedures. Total cardiac labs will be more than or equal to the sum of dedicated cardiac labs.	
Cardiovascular Intervention or treatment	All interventional cardiac procedures performed on a patient during one session in the laboratory (one patient visit equals one intervention regardless of number of procedures performed.	
Capital Expenditure	Capital Expenditure Any expenditure: (A) made by or on behalf of a health care facility . . . and (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part . . . and includes the cost of any studies, surveys, designs, plans, working drawings, specification and other activities essential to the acquisition, improvement, expansion or replacement of any plant or equipment with respect to which an expenditure is made . . . and includes donations of equipment or facilities or a transfer of equipment or facilities at fair market value.	
Charity Care	"Charity Care" is defined as care for which the provider does not expect to receive payment from the patient or a third party	CMS 2552-96 Worksheet C, Part 1 PPS

	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 (CMS 2552-96 Worksheet C, Part 1 PPS Inpatient Ratios), and not the actual charges for the services.	
Construction or Modification	Construction or Modification The establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership, of or by a health care facility, or the purchase or acquisition by or through a health care facility of equipment or service for diagnostic or therapeutic purpose or for facility administration or operation, or any capital expenditures made by or on behalf of a health care facility….	
Diagnostic Cardiac Catheterization (DCC)	Performance of Catheterization procedures associated with determining the blockage of blood vessels and the diagnosis of cardiac diseases that are performed in a cardiac cath lab or special procedures lab with cardiac cath capabilities.	
Full Time Equivalent	Full Time Equivalent is a unit of measure which is equal to one filled, full time, annual-salaried position.	
Interventional Cardiac Catheterization (ICC)	Treatment of cardiac diseases associated with the blockage or narrowing of the blood vessels and diseases of the heart by the performance of percutaneous coronary intervention or similar procedures in a cardiac cath lab or special procedures lab with cardiac cath capabilities. Cardiovascular interventions include but not limited to Percutaneous Transluminal Coronary Angioplasty (PTCA), rotational atherectomy, directional atherectomy, extraction atherectomy, laser angioplasty, implantation of intracoronary stents and other catheter devices for treating coronary atherosclerosis.	
Method of Financing	The source of funds required to undertake the project or capital expenditure. Forms of financing include equity (cash and securities), lease, mortgages, general obligation bonds, revenue bonds, appropriations and gifts/donations/bequests.	

Net Revenue	Net Revenue: Net Revenue is the result of gross revenue less provision for contractual adjustments from third party payors (Source: AICPA).	
Other Public	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.	
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	(Source: Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons)
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.	
Patients served by payment source	Include number of inpatients and outpatients served by their payment type.	Payment sources are defined within the questionnaire too.
Peak bed set up and staffed	Number of beds by category of service the facility considers appropriate to place in patient rooms taking into account patient care requirements and ability to perform the regular functions of patient care required for patients	According to Administrative rule 1100.220
Peak Beds Occupied	Indicate your facility's maximum number of patients in CON Authorized beds at any one time during the reporting calendar year.	Measures the facility's peak utilization.

Project	Project Any proposed construction or modification of a health care facility or any proposed acquisition of equipment undertaken by or on behalf of a health care facility regardless of whether or not the transaction required a certificate of need. Components of construction or modification, which are interdependent, must be grouped together for reporting purposes. Interdependence occurs when components of construction or modification are architecturally and/or programmatically interrelated to the extent that undertaking one or more of the components compels the other components to be undertaken. If components of construction or modification are undertaken by means of a single construction contract, those components must be grouped together. Projects involving acquisition of equipment, which are linked with construction for the provision of a service cannot be segmented. When a project or any component of a project is to be accomplished by lease, donation, gift or any other means, the fair market value or dollar value, which would have been required for purchase, construction or acquisition, is considered a capital expenditure.	
Pediatric cardiac Catheterization	Cardiac Catheterization of patients 0-14 years.	According to Administrative rule 1110.1320
Private Pay	Private pay includes money from a private account (for example, a medical savings account) and any government funding made out and paid to the resident which is then transferred to the facility to pay for services. It also includes all the Self pay payments.	
Revenue by payment source	Revenue by payment source: Include the amount of net revenue of the facility during the fiscal year for the patients served by the payment type.	Revenue to be listed
Stage 1 and Stage 2 Recovery Stations	Stage 1 and Stage 2 Recovery Stations are defined as the stations/units within the room providing post operative/post anesthetic care soon after the 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	According to ACOA (American College of Anesthesiologists).

	there by need less time to recuperate.	
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)

ANNUAL QUESTIONNAIRE
CHARITY CARE DISCUSSION

IDPH has received a number of questions regarding the reporting of "Charity Care". The following is intended to assist the respondents in the reporting of this figure. If any additional information is needed, the facility should consult its financial experts.

Part I, Page 10, Question #10

Number of patients by payer source should be reported as the PRIMARY payer source, (If two payment sources, the one that is greater than 50 percent).

Part II Page 14, Question #3

1. ALL FINANCIAL DATA is to be reported based upon the most recent audited fiscal year.

2. The questionnaire should relate as closely as possible to the pronouncements of the AICPA (American Institute of Certified Public Accountants) and the HFMA (Healthcare Financial Management Association).

3. New AICPA Health Care Organizations' ***AICPA Audit and Accounting Guide with conforming changes as of May 1, 2007, page 153. ISBN 978-0-87051-687-0***

   Chapter 10: Distinguishing Charity Care from Bad Debt Expense or Allowance 10.03: (Page 153) "Charity care represents health care services that are provided but are never expected to result in cash flows. As a result, charity care does not qualify for recognition as receivables or revenue in the financial statements. Distinguishing charity care from bad-debt expense (or allowance, for governmental health care entities) requires the exercise of judgment. Charity care is provided to a patient with demonstrated inability to pay. Each organization establishes its own criteria for charity care consistent with its mission statement and financial ability. Only the portion of a patient's account that meets the organization's charity care criteria is recognized as charity. Although it is not necessary for the entity to make this determination upon admission or registration of an individual, at some point the entity must determine that the individual meets the established criteria for charity care."

   10.28: (page 162) "As discussed in paragraph 10.03, patient service revenue does not include charity care. Management's policy for providing charity care, as well as the level of charity care provided, should be disclosed in the financial statements. Such disclosure generally is made in the notes to the financial

statements and is measured based on the provider's rates, costs, units of service, or other statistical measure."

Charity care should be reported at cost, using the Medicare cost report's cost to charges ratio when possible. Please attach a work sheet documenting your calculation(s) of charity care costs. NOTE: Instructions and examples for non-hospitals may be different.