# 2017 ANNUAL SURVEY OF HOSPITALS
## WHA Information Center, LLC / American Hospital Association

**INSTRUCTIONS**:  All blank data items must be completed. See Instructions document for details.

Instructions and definitions are available in the instructions document, unless otherwise noted.
Additional information may be reported in the **SUPPLEMENTAL INFORMATION** section on the last page of the survey.

Fill out the survey using **hospital data only,** except when the hospital owns and operates a nursing home **AND** a common Board of Directors governs both the hospital and nursing home.

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**If information for a category is zero, fill in 0.  If information for a category is Not Applicable, fill in 0.  Do NOT use dashes, N/A, N/AV, M, or decimals on any line in this survey.**

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| Return To: | WHA Information Center |
|---|---|
| | **5510 Research Park Drive** |
| | **P.O. Box 259038** |
| | **Madison, WI  53725-9038 or Fax to: 608-274-8554** |

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## I. GENERAL INFORMATION                                              *Type or print clearly all information*

**WHA Information Center Hospital ID** _____      **AHA Hospital ID** _____

**Hospital Mailing Label**

Hospital Name _____

Address _____  P.O. Box _____

City, State _____  ZIP Code _____

| FY 2017 Beginning Date | | | FY 2017 Ending Date | | |
|---|---|---|---|---|---|
| ____ / ____ / ____ | | | ____ / ____ / ____ | | |
| Mo. | Day | Yr. | Mo. | Day | Yr. |

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Questions? Contact WHA Information Center at WHAInfoCenter@wha.org or (608) 274-1820/(800) 231-8340.

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**II. CLASSIFICATION**                                             **Type or print all information**

1  **Public Contact**  (provide First and Last Name of individual you want listed in the public data sets)

_____

        **First Name**            **Last Name**

**Control**

2  Indicate the type of organization responsible for establishing policy concerning overall hospital operation.
**CHECK ONLY ONE CODE**

| Government, Nonfederal | Non-government, Not-for-profit | Investor-owned For-profit | Government, Federal |
|---|---|---|---|
| ☐ 12 State | ☐ 21 Religious organization | ☐ 31 Individual | ☐ 45 Veterans Affairs |
| ☐ 13 County | ☐ 23 Other not-for-profit | ☐ 32 Partnership | |
| ☐ 14 City | | ☐ 33 Corporation | |

3  Is the hospital part of a health care system? .......................................... ☐ Yes ☐ No
If YES, give name, city, and state of the system headquarters.

_____
*(Name)*                                                   *(City)*                    *(State)*

4  Is the hospital a division or subsidiary of a holding company? ................. ☐ Yes ☐ No

5  Does the hospital itself operate subsidiary corporations? ....................... ☐ Yes ☐ No

6  Is the hospital contract managed? ........................................................ ☐ Yes ☐ No
If YES, give name, city, and state of organization that manages the hospital.

_____
*(Name)*                                                   *(City)*                    *(State)*

7  Is the hospital a member of an alliance? .............................................. ☐ Yes ☐ No
If YES, give name, city, and state of the alliance headquarters. **If more than one, list in Section XIV.**

_____
*(Name)*                                                   *(City)*                    *(State)*

8  Is the hospital a participant in a health care network? ........................... ☐ Yes ☐ No
If YES, give name, city, and state of the network headquarters. **If more than one, list in Section XIV.**

_____
*(Name)*                                                   *(City)*                    *(State)*

9  Does the hospital participate in a group purchasing arrangement? .......... ☐ Yes ☐ No
If YES, give name, city, and state of the group purchasing organization.

_____
*(Name)*                                                   *(City)*                    *(State)*

10  Does the hospital own or operate a primary group practice? ................. ☐ Yes ☐ No

**Service**

11  Indicate the ONE category that BEST describes the type of service that the hospital provides to the MAJORITY of admissions.

☐ 10 General medical and surgical    ☐ 22 Psychiatric

☐ 15 GMS – Critical Access Hospital    ☐ 46 Rehabilitation

☐ 20 GMS – Long-Term Acute Care    ☐ 82 Alcoholism and other drug abuse

12  Does the hospital restrict admissions primarily to children? .................. ☐ Yes ☐ No

**Accreditation/Licensure Status** (Check all that apply). *Note for "Other," do not specify State of Wisconsin*

**13** ☐ JCAHO ☐ AOA ☐ Title 18 certified and HFS 124 licensed
Date of last survey __/__ (mm/yy) ☐ HFS 124 licensed only
☐ Other (specify) _____

**Certification Status**
**If more than one provider number, list in Section XIV.**

**14** Medicare (Title 18) ................................................................................................ ☐ Yes ☐ No

If YES, **Provider Number** 52 - ____ ____ ____ ____

**15** Medicaid (Title 19) ............................................................................................... ☐ Yes ☐ No

If YES, **Provider Number** ____ ____ - ____ ____ ____ ____ ____ ____

**Managed Care Information**

Does the hospital have a formal written contract that specifies the obligations of each party with:

**16** Health Maintenance Organization *(HMO)*? ............................... ☐ Yes ☐ No **If Yes,** how many contracts? ▭

**17** Preferred Provider Organization *(PPO)*? ............................... ☐ Yes ☐ No **If Yes,** how many contracts? ▭

**18** Other managed care or prepaid plan? ............................... ☐ Yes ☐ No **If Yes,** how many contracts? ▭

**19** Indicate whether any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer *(check all that apply)*:

|  | (1) Hospital | (2) Health Care System | (3) Network | (4) Joint Venture With Insurer |
|---|---|---|---|---|
| Health Maintenance Organization | ☐ | ☐ | ☐ | ☐ |
| Preferred Provider Organization | ☐ | ☐ | ☐ | ☐ |
| Indemnity Fee-for-Service Plan | ☐ | ☐ | ☐ | ☐ |

**20** What percentage of the hospital's NET patient revenue is paid on a capitated basis? ▭ %
(If the hospital does not participate in capitated arrangements, **enter "0."**) (Round; do not use decimals.)

**21** Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared-risk basis? ............................... ☐ Yes ☐ No

**22** If your hospital has arrangements to care for a specific group of enrollees in exchange for a capitated premium, how many lives are covered? ▭

**Criteria to Determine If Nursing Home Data Should Be Submitted**
**23** Does the hospital own and operate a nursing home facility under HFS 132? ............................... ☐ Yes ☐ No
**If YES**, answer the question on line 24.

**24** Are the hospital and nursing home governed by a common Board of Directors? ............................... ☐ Yes ☐ No

**25** If answers to both 23 and 24 are YES, check the appropriate box regarding the location of the nursing home facility.

Attached/within hospital ☐ Freestanding on hospital campus ☐ Freestanding off campus ☐

Questions? Contact WHA Information Center at WHAInfoCenter@wha.org or (608) 274-1820/(800) 231-8340.

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**III. SELECTED INPATIENT UNITS**

> **If information for a category is zero, fill in 0.  If information for a category is**
> **Not Applicable, fill in 0.  Do NOT use dashes, NA, N/AV, or M.**

Account for all adult and pediatric inpatient beds set-up-and-staffed on the last day of the fiscal year (*excluding weekends or holidays*).  Do not include "normal newborn" bassinets.  List beds for a line only if a unit is specifically designated for the service area.  The number of discharges should include deaths and unit transfers.  For each service listed, circle the code number (*see codes 1-5 below*) that best describes the status of the service as of the last day of the fiscal year.

| Code | Description |
|---|---|
| **1** | **Service is provided in or by the hospital in a DISTINCT AND SEPARATE UNIT.  The number of beds and utilization information MUST be provided for inpatient units.** |
| **2** | **Service is provided in or by the hospital but NOT IN A DISTINCT AND SEPARATE UNIT.** |
| **3** | **Service is provided by the hospital's Health Care System.** |
| **4** | **Service IS NOT MAINTAINED by the hospital but is available, in the hospital or another facility, through a FORMAL CONTRACTUAL arrangement with another hospital or provider, including networks and joint ventures.** |
| **5** | **SERVICE NOT AVAILABLE either by the hospital or through a formal contractual arrangement with another hospital or provider.** |

| Code | Description |
|---|---|
| **O** | **Service is provided by the hospital IN BUILDINGS OTHER THAN THE MAIN HOSPITAL BUILDING and is billed under the hospital's Medicare provider number.** |
| **B** | **Service is provided by the hospital IN BOTH THE MAIN HOSPITAL BUILDING AND IN BUILDINGS OTHER THAN THE MAIN HOSPITAL BUILDING (which is billed under the hospital's Medicare provider number).** |
| **NOTE:** | If the hospital has beds of more than one type in a mixed unit, all bed and utilization data for all bed types found in that unit should be reported on the line corresponding to the mixed unit. Code the "mixed unit" with a "1," and code each individual bed type line for that unit with a "2." |
| | Example: If "Mixed intensive care" is the main unit for intensive care beds, code it "1" and the types of beds that may be found there "2." All bed and utilization data should be reported on line 40, "Mixed intensive care." |
| | **For a unit coded "2," utilization may be reported only if beds, discharges, and inpatient days are all available.** |

**26**  Are any patient services provided by the hospital in buildings other than the main hospital bldg **and is billed under the hospital's Medicare's provider number**?

.................................................................................................  ☐ Yes    ☐ No

If YES, in addition to circling code numbers 1-5, **circle O or B, if applicable.  See Instructions.**

| Selected Inpatient Units | Beds-set-up-&-staffed last day of fiscal year | Number of discharges / transfers for fiscal year | Inpatient days for fiscal year | Discharge Days | Circle one for each line | O or B |
|---|---|---|---|---|---|---|
| **GENERAL MEDICAL/SURGICAL** | | | | | | |
| 27 **Adult Medical / Surgical, Acute** (include gynecology) | | | | | 1 2 3 4 5 | |
| 28 **Orthopedic** | | | | | 1 2 3 4 5 | |
| 29 **Rehabilitation and Physical Medicine** | | | | | 1 2 3 4 5 | |
| 30 **Hospice** | | | | | 1 2 3 4 5 | |
| 31 **Acute Long–Term Care** (Hospital Only) | | | | | 1 2 3 4 5 | |
| 32 **All Other Acute** (Specify types) [                    ] | | | | | 1 2 3 4 5 | |
| 33 **Pediatrics** General Medical/Surgical | | | | | 1 2 3 4 5 | |
| 34 **Obstetrics** Level of care (1, 2 or 3) (include LDRP, exclude gynecology) | | | | | 1 2 3 4 5 | |
| 35 **Psychiatric** Inpatient Care | | | | | 1 2 3 4 5 | |
| 36 **Alcoholism / Chemical Dependency** Inpatient Care | | | | | 1 2 3 4 5 | |
| **ICU/CCU** | | | | | | |
| 37 **Medical / Surgical Intensive Care** | | | | | 1 2 3 4 5 | |
| 38 **Cardiac Intensive Care** | | | | | 1 2 3 4 5 | |
| 39 **Pediatric Intensive Care** | | | | | 1 2 3 4 5 | |
| 40 **Burn Care** | | | | | 1 2 3 4 5 | |
| 41 **Mixed Intensive Care** | | | | | 1 ▮ 3 4 5 | |
| 42 **Step-down** (special care) | | | | | 1 2 3 4 5 | |

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| Selected Inpatient Units | Beds-set-up-&-staffed last day of fiscal year | Number of discharges / transfers for fiscal year | Inpatient days for fiscal year | Discharge Days | Circle one for each line | O or B |
|---|---|---|---|---|---|---|
| **43 Neonatal Intensive / Intermediate Care** *(exclude normal newborns)* .............. | | | | | 1 2 3 4 5 | |
| **44 All Other Intensive Care** [specify type(s)] | | | | | 1 2 3 4 5 | |
| **45 Subacute Care** Inpatient care .................... | | | | | 1 2 3 4 5 | |
| **46 ALL OTHER INPATIENT UNITS** [specify treatment area(s)] | | | | | 1 2 3 4 5 | |
| **47 TOTAL HOSPITAL FACILITY** (**Exclude** Medicare-certified swing bed inpatient days and Non-Medicare-certified, swing-bed inpatient days). .................... | (add lines 27-46) | (add lines 27-46) | (add lines 27-46) | (add lines 27-46) | | |
| **48 MEDICARE-CERTIFIED SWING UNIT** (Medicare patients only) (Report **average** number of beds used, rounded to whole number) | (average # beds used) | (discharges and transfers) | (inpatient days) | (discharge days) | 1 2 3 4 5 | |
| **49 NON- MEDICARE-CERTIFIED SWING UNIT** (Non-Medicare patients only) (Report **average** number of beds used, rounded to whole number) | (average # beds used) | (discharges and transfers) | (inpatient days) | (discharge days) | 1 2 3 4 5 | |
| **50 Newborn Nursery** (Bassinets and utilization should be reported on lines 155-157) | | | | | 1 2 3 4 5 | |

## IV. SELECTED ANCILLARY AND OTHER SERVICES

| | | Circle One | O or B |
|---|---|---|---|

For each service, circle the code number that best describes the status of the service as of the last day of the fiscal year, except weekends and holidays.

**51** AIDS/HIV – Specialized Outpatient Program for AIDS/HIV     1 2 3 4 5    _____

**52** Alcoholism/Chemical Dependency Outpatient Services *(psych/social)*     1 2 3 4 5    _____

**Ambulance/Transportation Services- Non-emergency**

**53**    - **Non-emergency** inter-facility transports by ground ambulance     1 2 3 4 5    _____

**54**    - **Non-emergency** inter-facility transports by air ambulance     1 2 3 4 5    _____

**55** Arthritis Treatment Center     1 2 3 4 5    _____

**56** Assisted Living     1 2 3 4 5    _____

**57** Auxiliary     1 2 3 4 5    _____

**58** Bariatric Services:  Bariatric/Weight Control Issues     1 2 3 4 5    _____

**59** Birthing Room/Labor, Delivery, Recovery, Post-partum Room (LDR or LDRP room)     1 2 3 4 5    _____

**Cardiac services**

**60**    - Cardiac Angioplasty *(percutaneous transluminal)*     1 2 3 4 5    _____

**61**    - Cardiac Catheterization Laboratory     1 2 3 4 5    _____

**62**    - Cardiac Rehabilitation Program     1 2 3 4 5    _____

**63**    - Non-invasive Cardiac Assessment Services     1 2 3 4 5    _____

**64**    - Open-heart Surgery     1 2 3 4 5    _____

**65** Case Management     1 2 3 4 5    _____

**66** Crisis Prevention     1 2 3 4 5    _____

**67** Complementary Services     1 2 3 4 5    _____

**68** Dental Services     1 2 3 4 5    _____

**Dialysis services:**

**69**    - Hemodialysis     1 2 3 4 5    _____

**70**    - Peritoneal dialysis     1 2 3 4 5    _____

**Emergency/urgent care:**

**71**    - Emergency Department *(general medical and surgical)*     1 2 3 4 5    _____

**72**    - Trauma Center     **[ Self-designated Level       ]**     1 2 3 4 5    _____

**73**    - Urgent Care Center     1 2 3 4 5    _____

**74** Ethics Committee     1 2 3 4 5    _____

**75** Extracorporeal Shock Wave Lithotripter *(ESWL)* **CHECK ONE**     Fixed     Mobile     1 2 3 4 5

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| *Selected Ancillary and Other Services* | Circle One | O or B |
|---|---|---|
| **76** Fitness Center | 1 2 3 4 5 | ———— |
| **Food service** | | |
| **77** - Meals on Wheels | 1 2 3 4 5 | ———— |
| **78** - Nutrition Programs | 1 2 3 4 5 | ———— |
| **79** Genetic Counseling/Screening | 1 2 3 4 5 | ———— |
| **Geriatric services** | | |
| **80** - Adult Day Care Program | 1 2 3 4 5 | ———— |
| **81** - Alzheimer's Diagnosis/Assessment | 1 2 3 4 5 | ———— |
| **82** - Comprehensive Geriatric Assessment | 1 2 3 4 5 | ———— |
| **83** - Emergency Response System | 1 2 3 4 5 | ———— |
| **84** - Geriatric Acute Care Unit | 1 2 3 4 5 | ———— |
| **85** - Geriatric Clinics | 1 2 3 4 5 | ———— |
| **86** - Respite Care | 1 2 3 4 5 | ———— |
| **87** - Retirement Housing | 1 2 3 4 5 | ———— |
| **88** - Senior Membership Program | 1 2 3 4 5 | ———— |
| **Health Promotion** | | |
| **89** - Community Health Promotion | 1 2 3 4 5 | ———— |
| **90** - Patient Education | 1 2 3 4 5 | ———— |
| **91** - Worksite Health Promotion | 1 2 3 4 5 | ———— |
| **92** Home Health Services | 1 2 3 4 5 | |
| **93** Home Hospice Services | 1 2 3 4 5 | ———— |
| **Mammography services** | | |
| **94** - Diagnostic Mammography | 1 2 3 4 5 | ———— |
| **95** - Mammography Screening | 1 2 3 4 5 | ———— |
| **96** Occupational Health Services | 1 2 3 4 5 | ———— |
| **Occupational, physical, and/or rehabilitation services** | | |
| **97** - Audiology | 1 2 3 4 5 | ———— |
| **98** - Occupational Therapy | 1 2 3 4 5 | ———— |
| **99** - Physical Therapy | 1 2 3 4 5 | ———— |

| | | | |
|---|---|---|---|
| 100 | - Recreational Therapy | 1 2 3 4 5 | |
| 101 | - Rehabilitation Inpatient Services *(service does not have beds)* | 1 2 3 4 5 | |
| 102 | - Rehabilitation Outpatient Services | 1 2 3 4 5 | |
| 103 | - Respiratory Therapy | 1 2 3 4 5 | |
| 104 | - Speech Pathology / Therapy | 1 2 3 4 5 | |
| 105 | Oncology Services | 1 2 3 4 5 | |
| 106 | - Outpatient services – within the hospital | 1 � 3 4 5 | |
| 107 | - Outpatient services – on hospital campus, but in freestanding center | 1 ▮ 3 4 5 | |
| 108 | - Outpatient services – freestanding off hospital campus | 1 2 3 4 5 | |
| 109 | Pain Management Program | 1 2 3 4 5 | |
| 110 | Patient Representative Services | 1 2 3 4 5 | |

**Psychiatric services**

| | | | |
|---|---|---|---|
| 111 | - Psychiatric Child / Adolescent Services | 1 2 3 4 5 | |
| 112 | - Psychiatric Consultation – Liaison Services | 1 2 3 4 5 | |
| 113 | - Psychiatric Education Services | 1 2 3 4 5 | |
| 114 | - Psychiatric Emergency Services | 1 2 3 4 5 | |
| 115 | - Psychiatric Geriatric Services | 1 2 3 4 5 | |
| 116 | - Psychiatric Outpatient Services | 1 2 3 4 5 | |
| 117 | - Psychiatric Partial Hospitalization Program | 1 2 3 4 5 | |
| 118 | Radiation Therapy | 1 2 3 4 5 | |

**Radiology, diagnostic**

| | | | |
|---|---|---|---|
| 119 | - CT Scanner (*Computed Tomagraphic Scanner*) | 1 2 3 4 5 | |

**Check One:** ☐ **Fixed**   ☐ **Mobile**   ☐ **Both**

| | | | |
|---|---|---|---|
| 120 | - Diagnostic Radioisotope Facility | 1 2 3 4 5 | |
| 121 | - Magnetic Resonance Imaging (*MRI*) | 1 2 3 4 5 | |

**Check One:** ☐ **Fixed**   ☐ **Mobile**   ☐ **Both**

| | | | |
|---|---|---|---|
| 122 | - Positron Emission Tomography Scanner (*PET*) | 1 2 3 4 5 | |
| 123 | - Single Photon Emission Computerized Tomography (*SPECT*) | 1 2 3 4 5 | |

**Check One:** ☐ **Fixed**   ☐ **Mobile**   ☐ **Both**

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**124**     - Ultrasound .................................................... 1 2 3 4 5 _____

**Reproductive health**

**125**     - Fertility Counseling .................................................... 1 2 3 4 5 _____

**126**     - In Vitro Fertilization .................................................... 1 2 3 4 5 _____

**127**   Social Work Services .................................................... 1 2 3 4 5 _____

**128**   Sports Medicine Clinic/Services .................................................... 1 2 3 4 5 _____

**129**   Surgery, Ambulatory or Outpatient *(day surgery)* 1 2 3 4 5 _____

**Telemedicine**

**130**   Teleradiology or Other Store and Forward Services .................................................... 1 2 3 4 5 _____

**131**   Tele ICU .................................................... 1 2 3 4 5 _____

**132**   Tele Stroke .................................................... 1 2 3 4 5 _____

**133**   Tele Psychiatry .................................................... 1 2 3 4 5 _____

**134**   E-Visits .................................................... 1 2 3 4 5 _____

**135**   Remote Patient Monitoring .................................................... 1 2 3 4 5 _____

**136**   Specialist Consultation .................................................... _____

**Transplant services**

**137**     - Bone Marrow Transplant Program .................................................... 1 2 3 4 5 _____

**138**     - Heart and/or Lung Transplant .................................................... 1 2 3 4 5 _____

**139**     - Kidney Transplant .................................................... 1 2 3 4 5 _____

**140**     - Tissue Transplant .................................................... 1 2 3 4 5 _____

**141**   Women's Health Center/Services .................................................... 1 2 3 4 5 _____

**142**   Are additional non-listed **patient** services provided by the hospital?   ...................................... ☐ Yes    ☐ No

   If YES, list and indicate with O or B if provided in other buildings
   *(If more room is needed, go to Section XIV)*

**143**   If **O** or **B** is used on lines **27-141**, indicate the number of locations and the address(es) and
   service(s) provided.  *(If more room is needed, go to Section XIV.)*

   Number of other locations      ☐

   Street address  _____          Street address  _____

   City  _____          City  _____

   Service  _____  Line  ____          Service  _____  Line  ____

   Service  _____  Line  ____          Service  _____  Line  ____

   Service  _____  Line  ____          Service  _____  Line  ____

**144**   Does the hospital have provider-based facilities that are billed using the hospital's Medicare provider number,
   reported on Line 14?   .................................................................................... ☐ Yes    ☐ No

   If YES, indicate the number of facilities.      ☐

   If YES, indicate the street address and city.  *(If more than one address, go to Section XII.)*

   Street address  _____

   City  _____

Questions? Contact WHA Information Center at WHAInfoCenter@wha.org or (608) 274-1820/(800) 231-8340.

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## V. SELECTED SERVICE UTILIZATION

**DO NOT SKIP THIS PAGE.  FILL IN ALL LINES.**

> **If information for a category is zero, fill in 0.**
> **If information for a category is Not Applicable, fill in 0.**
> **Do NOT use dashes, N/A, N/AV, or M.**

### Surgical Operations *(whether major or minor)*

**145** Inpatient surgical operations *(not procedures)* ........................................................

**146** Outpatient surgical operations *(not procedures)* .....................................................

**147** TOTAL surgical operations *(not procedures)* [line 145 + line 146] .........................................

### Outpatient Visits

**148** Emergency visits ............................................................................

-Number of emergency visits that resulted in inpatient admissions  (Subset of line 148)

**149** Other visits *(all non-emergency visits, including urgent care, physician referrals and outpatient surgeries)* ...................

**150** Observation visits ............................................................................

**151** TOTAL outpatient visits [Add *Line 148 + Line 149 + Line 150*] .........................................

### Non-emergency Ambulance/Transport Services

**152** Non-emergency inter-facility transports by ground ambulance ...........................................

**153** Non-emergency inter-facility transports by air ambulance ...............................................

**154** TOTAL non-emergency transports by ambulance [*Add Line 152 + Line 153]* ...........................................

### Newborn Nursery

**155** Number of bassinets set-up-and-staffed as of the last day of the fiscal year *(exclude neonatal beds )* ........................................

**156** Total births *(exclude fetal deaths)* ........................................................

**157** Newborn days *(exclude neonatal days )* ........................................................

> **DO NOT USE DASHES, N/A, N/AV, OR M.**
> **IF INFORMATION FOR A CATEGORY IS ZERO, FILL IN 0.**
> **IF INFORMATION FOR A CATEGORY IS NOT APPLICABLE, FILL IN 0.**
> **DO NOT MAKE ALTERATIONS TO SURVEY QUESTIONS**

**Utilization and Beds**

|  |  | (1) Hospital | (2) Nursing Home |  |
|---|---|---|---|---|
| 158 | Admissions *(exclude newborns; include Medicare-certified and Non-Medicare swing admissions)* | _____ | _____ |  |
| 159 | Inpatient days *(exclude newborns; include Medicare-certified and Non-Medicare swing days)* | _____ | _____ | Skilled nursing |
|  |  |  | _____ | Intermediate care |
|  |  |  | _____ | Residential / Elderly housing |
| 160 | Discharges/Deaths *(exclude newborns; include Medicare-certified and Non-Medicare swing discharges)* | _____ | _____ |  |
| 161 | Census [*The number of inpatients occupying beds at midnight on the last day* (**exclude weekends or holidays**) *of the fiscal year. Exclude newborns; include Medicare-Certified and Non-Medicare swing patients.*] | _____ | _____ |  |

**Utilization and Beds**

**Indicate Beds set-up-and-staffed** (**NOT number of licensed beds**) on the last day *excluding weekends or holidays*) of the hospital's fiscal year quarter *(every 3 months)*.

|  |  | (1) Hospital | (2) Nursing Home |  |
|---|---|---|---|---|
| 162 | 1st Quarter | _____ | _____ | Skilled nursing |
|  |  |  | _____ | Residential / Elderly housing |
| 163 | 2nd Quarter | _____ | _____ | Skilled nursing |
|  |  |  | _____ | Residential / Elderly housing |
| 164 | 3rd Quarter | _____ | _____ | Skilled nursing |
|  |  |  | _____ | Residential / Elderly housing |
| 165 | 4th Quarter (Hospital beds must equal line 47, col.1) | _____ | _____ | Skilled nursing |
|  |  |  | _____ | Residential / Elderly housing |

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**Utilization and Beds**

|  | (1) Hospital | (2) Nursing Home |
|---|---|---|

**Medicare / Medicaid Primary Payer Utilization**

**166** Total Medicare *(Title 18)*
**Inpatient Discharges**

**167** Total Medicare (Title 18)
**Outpatient Visits**

**168** Total Medicare Inpatient **Days**

**169** Total Medicaid *(Titles 19 & 21)*
**Inpatient Discharges**

**170** Total Medicaid (*Titles 19 & 21)*
**Outpatient Visits**

**171** Total Medicaid Inpatient **Days**
*(Exclude newborns; include Medicare-certified swing bed utilization, neonatal and deaths. Include T-18 and T-19 HMO utilization.)*

### VII. MEDICAL STAFF – September 30, 2017

Indicate which of the following physician arrangements the hospital, health care system, and/or network participate in:

| # | | Hospital | Health Care System | Network |
|---|---|---|---|---|
| **172** | Independent practice association (IPA) | ☐ # physicians: _____ | ☐ | ☐ |
| **173** | Group practice without walls | ☐ # physicians: _____ | ☐ | ☐ |
| **174** | Open Physician Hospital Organization (PHO) | ☐ # physicians: _____ | ☐ | ☐ |
| **175** | Closed Physician Hospital Organization (PHO) | ☐ # physicians: _____ | ☐ | ☐ |
| **176** | Management Service Organization (MSO) | ☐ # physicians: _____ | ☐ | ☐ |
| **177** | Integrated Salary Model | ☐ # physicians: _____ | ☐ | ☐ |
| **178** | Equity Model | ☐ # physicians: _____ | ☐ | ☐ |
| **179** | Foundation | ☐ # physicians: _____ | ☐ | ☐ |
| **180** | Accountable Care Organization (ACO) | ☐ # physicians: _____ | ☐ | ☐ |
| **181** | Other | ☐ # physicians: _____ | ☐ | ☐ |

**Selected Specialty**

| | If information for a category is zero, fill in 0. If information for a category is Not Applicable, fill in 0.  Do NOT use dashes, N/A, N/AV, or M. | |
|---|---|---|
| **Active/Associate Medical Staff** | (1) Medical Staff **as of Sept. 30, 2017** *(Includes Board Certified)* | (2) Board Certified Staff **As of Sept. 30, 2017** *[Not to exceed column (1)]* |

**Medical Specialties**

| | | |
|---|---|---|
| 182 | General and Family Practice ................. | |
| 183 | Internal Medicine *(general)* ......................... | |
| 184 | Internal Medicine *subspecialties* .................. | |
| 185 | Pediatrics *(general)* ............................... | |
| 186 | Pediatric *subspecialties* ............................... | |

**Surgical Specialties**

| | | |
|---|---|---|
| 187 | General Surgery ..................................... | |
| 188 | Obstetrics/Gynecology ............................ | |
| 189 | All other surgical *specialties* ...................... | |

**Other**

| | | |
|---|---|---|
| 190 | Anesthesiology ......................................... | |
| 191 | Emergency Medicine ................................ | |
| 192 | Pathology ............................................... | |
| 193 | Radiology ............................................. | |
| 194 | Addiction Medicine ................................. | |
| 195 | Psychiatry ........................................... | |
| 196 | All other specialties *(use valid specialties below)* .................. | |

*Line 197* - codes for valid specialties- check all codes that apply:

| ☐ Aerospace Medicine | ☐ General Preventive Medicine | ☐ Podiatry |
|---|---|---|
| ☐ Chiropractic Services | ☐ Nuclear Medicine | ☐ Physical Med&Rehab (includes Physiatry) |
| ☐ Dental | ☐ Occupational Medicine | ☐ Public health |

| | | |
|---|---|---|
| 198 | **TOTAL** Medical Staff ............................... | |
| | (add lines 182-196) | (add lines 182-196) |

Questions? Contact WHA Information Center at WHAInfoCenter@wha.org or (608) 274-1820/(800) 231-8340.

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**VIII. PERSONNEL ON HOSPITAL PAYROLL – September 30, 2017 - DATA FOR ONE WEEK ONLY.**

Report the number of full-time and part-time personnel, **including trainees**, in the categories specified below.  Report part-time hours for each category.  All data must be for **the week of September 30, 2017 regardless of the hospitals' fiscal year end date.** Treat shared hospital/nursing home staff as part-time and report only hospital hours. **Do not include contracted staff or nursing home** personnel.

| | DO NOT USE DASHES, N/A, N/AV, OR M. PLEASE ROUND TO NEAREST WHOLE NUMBER.  DO NOT USE DECIMALS. | | |
|---|---|---|---|
| | **FULL TIME** | **PART TIME** | |
| **Occupational Categories** | Total No. of Persons *(35 Hr/Wk or more)* | Total No. of Persons *(less than 35 Hr/Wk)* | Total No. of P-T hours *(week of Sept 30, 2017)* |
| **199** Administrators and assistant administrators | | | |
| **Physician And Dental Services** | | | |
| **200** Physicians / Dentists | | | |
| **201** Dental Hygienists | | | |
| **202** Hospitalists | | | |

**203** **Please select the category below that best describes the employment model for your hospitalists.**

☐ Independent provider group
☐ Employed by a physician group
☐ Employed by your hospital

☐ Employed by a university or school program
☐ Other

| | | | |
|---|---|---|---|
| **204** Intensivists | | | |
| **205** Medical and dental residents/interns | | | |
| **Nursing Services** | | | |
| **206** Registered nurses | | | |
| **207** Certified nurse midwives | | | |
| **208** Licensed practical *(vocational)* nurses | | | |
| **209** Paraprofessionals: Nursing Assistants (CNA) | | | |
| **210** Medical assistants | | | |
| **211** Physician assistants | | | |
| **212** Nurse practitioners | | | |
| **213** Pharmacists | | | |
| **214** Pharmacy Technician/Aides | | | |
| **215** Medical & Clinical Laboratory Technologists | | | |
| **216** Medical & Clinical Laboratory Technicians | | | |
| **217** Surgical Technologists & Technicians | | | |
| **218** Certified registered nurse anesthetists | | | |
| **219** Clinical Nurse Specialists | | | |
| **Therapeutic Services** | | | |
| **220** Respiratory Therapists | | | |
| **221** Radiologic Technologists | | | |

| Occupational Categories (*continued*) | **FULL TIME** Total No. of Persons *(35 Hr/Wk or more)* | **PART TIME** Total No. of Persons *(less than 35 Hr/Wk)* | Total No. of P-T hours *(week of Sept 30, 2017)* |
|---|---|---|---|
| 222 Sonographer | | | |
| 223 All other Radiologic Personnel | | | |
| 224 Occupational Therapists | | | |
| 225 Occupational therapy assistants/aides | | | |
| 226 Physical therapists | | | |
| 227 Physical therapy assistants/aides | | | |
| 228 Recreational therapists | | | |
| 229 Health Information Management Administrators/Technicians | | | |
| 230 Dieticians and Nutritionists | | | |
| **Psychology / Social Work Services** 231 Psychologists | | | |
| 232 Social Workers | | | |
| **Other Personnel** 233 All other health professional / technical personnel | | | |
| 234 All other personnel | | | |
| 235 **TOTAL** hospital personnel | (add lines 199-234) | (add lines 199-234) | (add lines 199-234) |

236 **Workweek**
Indicate the **average or definition of** WORKWEEK (number of hours per week) of the full-time employees engaged in direct patient care (**40, 38, 35**, etc.) **Do not use decimals.**

(Average **full-time** hours per week)

### IX. OTHER *(Lines 237-245)*

Check the appropriate box to indicate the answer to each question.

237 Does your hospital's mission statement include a focus on community benefit? ☐ Yes ☐ No

238 Does your hospital have a long-term plan for improving the health status of its community? ☐ Yes ☐ No

239 Does your hospital have resources for its community benefit activities? ☐ Yes ☐ No

240 Does your hospital work with other providers, public agencies, or community representatives to conduct a health status assessment of the community? ☐ Yes ☐ No

241 Does your hospital use health status indicators *(such as rates of health problems or surveys of self-reported health)* for defined populations to design new services or modify existing services? ☐ Yes ☐ No

242 Does your hospital work with other local providers, public agencies, or community representatives to conduct/develop a written health status assessment of the needed capacity for health services in the community? ☐ Yes ☐ No

243 **IF YES,** have you used the assessment to identify unmet health needs, excess capacity, or duplicative services in the community? ☐ Yes ☐ No

244 Does your hospital work with other providers to collect, track, and communicate clinical and health

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information across cooperating organizations? ........................................................... ☐ Yes ☐ No

**245** Does your hospital either by itself or in conjunction with others disseminate reports to the community on the comparative quality and costs of health care services? ........................................................... ☐ Yes ☐ No

## X. SERVICE QUALITY / PATIENT SAFETY

**246** **Please identify the amount of resources allocated to quality and risk management functions.  If a position is split between two or more roles, indicate the portion of the FTE dedicated to each function.**

**Dedicated FTEs**

Quality management & improvement _____

Clinical safety _____

Case management _____

Accreditation _____

Infection control _____

Risk Management _____

**247** Does your facility provide 24-hour pharmacy services?

☐ Yes          ☐ No

## XI.  eHealth
Please indicate if you have the following features fully implemented, partially implemented, in the planning process, or not at all with your facility's electronic health record implementation.
.

| | Feature | Fully Implemented | Partially Implemented | Planning | Not at All |
|---|---|---|---|---|---|
| **248** | Core MPI database with admission/discharge/transfer | ☐ | ☐ | ☐ | ☐ |
| **249** | Lab information system | ☐ | ☐ | ☐ | ☐ |
| **250** | Pharmacy system | ☐ | ☐ | ☐ | ☐ |
| **251** | E-MAR (real-time enterprise medication administration record) | ☐ | ☐ | ☐ | ☐ |
| **252** | Medication dispensing | ☐ | ☐ | ☐ | ☐ |
| **253** | RIS (Radiology information system) | ☐ | ☐ | ☐ | ☐ |
| **254** | Computerized radiography (digital x-ray) | ☐ | ☐ | ☐ | ☐ |
| **255** | PACS (Picture archiving and communication system) | ☐ | ☐ | ☐ | ☐ |
| **256** | Order entry/resulting | ☐ | ☐ | ☐ | ☐ |
| **257** | Inpatient charting | ☐ | ☐ | ☐ | ☐ |
| **258** | Bedside medication verification | ☐ | ☐ | ☐ | ☐ |
| **259** | CPOE (Computerized physician order entry) | ☐ | ☐ | ☐ | ☐ |
| **260** | EHR portal | ☐ | ☐ | ☐ | ☐ |

| Feature | Fully Implemented | Partially Implemented | Planning | Not at All |
|---|---|---|---|---|
| **261** Bulk scanning | | | | |
| **262** Surgery management system | | | | |
| **263** Interface engine/expertise | | | | |
| **264** Physician Practice Management Systems | | | | |
| **265** Physician Practice EMR Systems | | | | |
| **266** Long Term Care EMR System | | | | |
| **267** Home Health EMR System | | | | |

## XII. Health Information Technology

### Expenditures

**268**     Total Health Information Technology Expenditures - Capital     $_____

**269**     Total Health Information Technology Expenditures- Operating   $_____

**270**     **What type of internet connection comes into your hospital?**

☐ No internet service
☐ Dial-up service (slower speed through a telephone line)
☐ A cable model
☐ A telephone company DSL line (high speed)
☐ A fiber-optic connection
☐ A wireless connection that requires an outside antenna (does not refer to a WiFi router)
☐ Satellite dish
☐ Other
      If Other, please explain:

## XIII. HIM Coding Function

**Does your hospital outsource the HIM coding function under any of the following conditions?**

| | YES | NO |
|---|---|---|
| **271** To handle backlog due to staff vacations or shortages | | |
| **272** Partially outsourced during normal operations | | |
| **273** Completely outsourced during normal operations | | |
| **274** To handle backlog during the ICD-10 transition / training | | |

## XIV. SUPPLEMENTAL INFORMATION

*275       Use this space or an additional sheet if more space is needed to elaborate on any of the information supplied on the survey. Refer to each response by page, section, and line number.*

Questions? Contact WHA Information Center at WHAInfoCenter@wha.org or (608) 274-1820/(800) 231-8340.

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# HOSPITAL FISCAL SURVEY
# FISCAL YEAR 2017

Completion of this form is required.  Failure to complete and return this form to the **WHA Information Center** within 120 calendar days following the close of your hospital's fiscal year may result in a $100 per day forfeiture.

## GENERAL INSTRUCTIONS - Read before completing form.

**NOTE:** Refer to the detailed instructions contained in the *Hospital Fiscal Survey Manual, Fiscal Year 2017.*

**Fill in all lines**.  If information for a category is zero, fill in 0.  If information for a category is not applicable, fill in 0.  Do NOT use dashes.  Do NOT use N/A.  Do NOT use N/AV.  Do not leave any lines blank.

**Round all amounts to the nearest dollar.**

**Complete the survey online within 120 days following the close of your hospital's fiscal year.  This date can also be found in the "Submittal Deadline" paragraph, page 3, in the manual.**

WHA Information Center
P.O. Box 259038
Madison WI  53725-9038

## I.     HOSPITAL INFORMATION                                                                *Type or print in black ink.*

Hospital Name and Address

FY 2017 Beginning Date                              FY 2017 Ending Date

## II.      GENERAL INFORMATION

If your hospital is jointly operated in connection with a nursing home, home health agency, or other organization, and is governed by a common Board of Directors, the hospital shall submit the required information from the final audited financial statements of the **hospital only** except where such information cannot be disaggregated.  **(See special instructions for combination facilities in the accompanying *Hospital Fiscal Survey Manual, Fiscal Year 2017*)**. All hospital services must be reported if they are included as hospital revenue and contained in net revenue from services to patients.   Refer to page 2 - line 3.

**1      Public Contact**  (provide First and Last Name of individual you want listed in the public data sets)

**2      Is your facility a combination facility?  (Enter Yes or No in the box.)**

For definitions and instructions, see the ***Hospital Fiscal Survey Manual, Fiscal Year 2017.***

**STATEMENT OF REVENUE AND EXPENSES**

**3      NET** REVENUE FROM SERVICES TO PATIENTS **(INCLUDING MEDICAID ACCESS PAYMENTS)**                                                                                                               $ _____

**Other Revenue**

**4**      Tax appropriations                                                             $ _____

**5**      All other operating revenue (including operating gains)                 $ _____

**6**      TOTAL Other Revenue (add **only** lines 4 and 5; do **not** include line 3 in line 6)        $ _____

**7      TOTAL** REVENUE (add lines 3 and 6)                                     $ _____

**Payroll Expenses**

**8**      Physicians and dentists                                                     $ _____

Number of physicians employed _____         Number of physician FTEs _____
Number of dentists employed     _____         Number of dentist FTEs     _____

**9**      Medical and dental residents and interns                             $ _____

**10**
Trainees                                                             $ _____

**11**      Registered nurses and licensed practical nurses                 $ _____

**12**   All other personnel                                                        $ _____

**13**      TOTAL Payroll Expenses (add lines 8 through 12)                 $ _____

**Nonpayroll Expenses**

**14**   Employee benefits (Social Security, group insurance, retirement benefits, etc.)                                                                             $ _____

**15**   Professional fees (medical, dental, legal, auditing, consultant, etc.)        $ _____

**16**   Contracted nursing services (include staff from nursing registries and temporary help agencies)                                                   $ _____

**17**   Depreciation expense (for reporting period only)                 $ _____

**18**   Interest expense                                                           $ _____

**19**   Medical malpractice insurance premiums                           $ _____

**20**   Amortization of financing expenses                                 $ _____

**21**   Rents and leases                                                           $ _____

**22**   Capital component of insurance premium                           $ _____

**23**   All other operating expenses – (including Medicaid assessments paid, supplies, purchased services, utilities, property taxes, etc., and operating loses)                                                                      $ _____

**24** TOTAL Nonpayroll Expenses (add lines 14 through 23) ............................................... $ _____

**25** **TOTAL** EXPENSES (add lines 13 and 24) ............................................... $ _____

**26** Excess (or deficit) of revenue over expenses (subtract line 25 from line 7; see manual) ............ $ _____

**Nonoperating Gains / Losses**

**27** Investment income ............................................... $ _____

**28** Other nonoperating gains (including extraordinary gains) ............ $ _____

**29** Provision for income taxes (for-profit organizations)
(absolute values only – no negative values) ............ $ _____

**30** Other nonoperating losses (including extraordinary losses)
(absolute values only – no negative values) ............ $ _____

**31** TOTAL Nonoperating Gains / Losses (subtract sum of lines 29 and 30 from sum of lines 27 and 28) ............ $ _____

**32** **NET** INCOME (revenue and gains in excess of expenses and losses) (add lines 26 and 31) ............ $ _____

## III. DETAIL OF PATIENT SERVICE REVENUE (based on full established rates)

**Gross Patient Service Revenue and Its Sources**

**33** Gross revenue from room, board, and
medical and nursing services to INPATIENTS ............ $ _____

(sum of lines 33 and 34 must equal sum of inpatient breakouts, lines 37-50)

**34** Gross INPATIENT ancillary revenue = ............ $ _____

**35** Gross revenue from service to OUTPATIENTS ............ $ _____

(must equal sum of outpatient breakouts, lines 37-50)

**36** **TOTAL GROSS** revenue from service to patients ............ $ _____

(add lines 33-35)

NOTE: The following sources of gross patient revenue are by **TOTAL** dollar amounts and by separate **INPATIENT** and **OUTPATIENT** breakouts. *This section (Lines 37-51) has data elements that are used to calculate the percentage of charges that are collected by the facility. These calculated percentages are displayed on WHA Information Center's PricePoint Web site.*

| *Public Sources* | TOTAL | INPATIENT | OUTPATIENT |
|---|---|---|---|
| **37** Medicare | $ _____ | $ _____ | $ _____ |
| **38** HMOs reimbursed by Medicare under 42 CFR pt. 417 | $ _____ | $ _____ | $ _____ |
| **39** Medical Assistance (Including BadgerCare) | $ _____ | $ _____ | $ _____ |
| **40** HMOs reimbursed by Medical Assistance under s. 49.45 (3) (b), Wis. Stats ……. | $ _____ | $ _____ | $ _____ |
| **41** County General Relief (Should include pre-capitated GAMP revenue) | $ _____ | $ _____ | $ _____ |

| | TOTAL | INPATIENT | OUTPATIENT |
|---|---|---|---|
| **42** County 51.42 / 51.437 programs | $ | $ | $ |
| **43** All other public programs | $ | $ | $ |

### *Commercial Sources (GAMP)*

| | TOTAL | INPATIENT | OUTPATIENT |
|---|---|---|---|
| **44** Group and individual accident and health insurance, self-funded plans | $ | $ | $ |
| **45** Worker's compensation | $ | $ | $ |
| **46** HMOs and all other alternative health care payment systems (exclude lines 38 and 40) | $ | $ | $ |
| **47** Self-pay ……………………………………... | $ | $ | $ |

**All other sources (specify below):**

| | TOTAL | INPATIENT | OUTPATIENT |
|---|---|---|---|
| **48** _____ | $ | $ | $ |
| **49** _____ | $ | $ | $ |
| **50** Milwaukee Hospitals Report Post-Capitated GAMP (see instructions) | $ | $ | $ |
| **51** Total Gross revenue from service to patients, by source (add lines 37-50, should equal value on line 36) ...……… | $ | $ | $ |

## Deductions from Patient Service Revenue and Its Sources

NOTE: Contractual Adjustments are by **TOTAL** dollar amounts **and** by separate **INPATIENT** and **OUTPATIENT** breakouts. *This section (Lines 52-69) has data elements that are used to calculate the percentage of charges that are collected by the facility. These calculated percentages are displayed on WHA Information Center's PricePoint Web site.*

### *Public Source Contractual Adjustments*

| | TOTAL | INPATIENT | OUTPATIENT |
|---|---|---|---|
| **52** Medicare | $ | $ | $ |
| **53** HMOs reimbursed by Medicare under 42 CFR pt. 417 | $ | $ | $ |
| **54** Medical Assistance (include effect of enhanced Medical Assistance payments) | $ | $ | $ |
| **55** HMOs reimbursed by Medical Assistance under s. 49.45 (3) (b), Wis Stats. (include effect of enhanced Medical Assistance payments) | $ | $ | $ |
| **56** County General Relief (Should include pre-capitated GAMP allowances)(Line 66 – report any post-cap GAMP, do not report in Line 65) | $ | $ | $ |
| **57** County 51.42 / 51.437 programs | $ | $ | $ |
| **58** All other public programs | $ | $ | $ |

*Commercial Source Contractual Adjustments*

**59** Group and individual accident and health insurance, self-funded plans   $_____   $_____   $_____

**60** Worker's compensation   $_____   $_____   $_____

| | TOTAL | INPATIENT | OUTPATIENT |
|---|---|---|---|
| **61** HMOs and all other alternative health care payment systems (exclude lines 53 and 55) | $_____ | $_____ | $_____ |
| **62** Self-Pay | $_____ | $_____ | $_____ |

*Other Source Contractual Adjustments*
All other sources (specify below)

**63** _____   $_____   $_____   $_____

**64** _____   $_____   $_____   $_____

**65** _____   $_____   $_____   $_____

*Charity Care / Bad Debt*

**66** Charity care (revenue foregone at full established rates) (must equal line 123) … (Should include post-capitated GAMP allowances)   $_____   $_____   $_____

**67** Bad Debt   $_____   $_____   $_____

**68** All other noncontractual deductions   $_____   $_____   $_____

**69** **TOTAL** DEDUCTIONS FROM REVENUE   $_____   $_____   $_____
(add lines 52-68) (total, not breakouts)

**Medicare-Approved Medical Education Activities**
NOTE:  Of TOTAL expenses in line 25, the reimbursable expenses for Medicare-approved medical education activities separated into the following categories:

**70** Direct medical education expenses   $_____

**71** Indirect medical education expenses   $_____

**72** **TOTAL** reimbursable expenses for Medicare-approved medical education activities (add lines 70 and 71)   $_____


**IV.      BALANCE SHEET – GENERAL FUNDS**
NOTE: For combination facilities, state-operated mental health institutes, or county-operated psychiatric or alcohol or other drug abuse hospitals, see special instructions in the *Hospital Fiscal Survey Manual, Fiscal Year 2017*.
**Unrestricted Assets** (recorded on the balance sheet at the end of each reporting period)
**Current Assets**

**73** Cash and cash equivalents   $_____

**74** Inter-corporate account(s)   $_____

### *Net patient accounts receivable*

**75**      Medicare (T18) -Including HMOs reimbursed by T-18 *     $ _____

**76**      Medical Assistance (T-19)- Including HMOs reimbursed by T-19 *     $ _____

**77**      Self-Pay*     $ _____

**78**      All other pay sources*     $ _____

**79**      Total Net patient accounts receivable (add lines 75 thru 78)     $ _____

**80**   Other accounts receivable     $ _____

**81**   Other current assets     $ _____

**82**    **TOTAL** current assets (add lines 73 through 81)     $ _____

**83**   Noncurrent assets whose use is limited     $ _____

**Property, Plant and Equipment**
**Gross Plant Assets**

**84**   Land     $ _____

**85**   Land improvements     $ _____

**86**   Buildings and building improvements     $ _____

**87**   Construction in progress     $ _____

**88**   Fixed equipment     $ _____

**89**   Moveable equipment     $ _____

**90**    **TOTAL** gross plant assets (add lines 84 through 89)     $ _____

**LESS Accumulated Depreciation** (absolute values only – no negative values)

**91**   Land improvements     $ _____

**92**   Buildings and building improvements     $ _____

**93**   Fixed equipment     $ _____

**94**   Moveable equipment     $ _____

**95**    **TOTAL** accumulated depreciation (add lines 91 through 94)     $ _____

**96**    **NET** property, plant, and equipment assets (subtract line 95 from line 90)     $ _____

**97**   Long-term investments     $ _____

**98**   Other unrestricted assets     $ _____

**99**    **TOTAL** unrestricted assets (add lines 82, 83, 96, 97 and 98)     $ _____

**Unrestricted Liabilities, Deferred Revenues, and Fund Balances**

**100**   Current liabilities     $ _____

**101**   Inter-corporate account(s)     $ _____

**102**   Long-term debt     $ _____

**103**   Other noncurrent liabilities and deferred revenues     $ _____

**104**   Fund balances     $ _____

**105**   TOTAL unrestricted liabilities, deferred revenues, and fund balances (add lines 100 through 104).
(**NOTE:** lines 99 and 105 should be equal. Combination facilities, see manual instructions)     $ _____

**Restricted Hospital Funds** (report fund balances only)

**106**  Specific-purpose funds  _____  $ _____

**107**  Plant replacement and expansion funds  _____  $ _____

**108**  Endowment funds  _____  $ _____


## V.     HOSPITAL INPATIENT UTILIZATION BY PAY SOURCE (for current reporting period)

| | (A1) | (A2) | (B1) | (B2) |
|---|---|---|---|---|
| | **NUMBER OF INPATIENT DISCHARGES**** | **NUMBER OF DISCHARGE DAYS**** | **NUMBER OF NEWBORNS***** | **NUMBER OF NEWBORN DISCHARGE DAYS***** |
| **PAY SOURCE** | | | | |
| **109**  Medicare (T-18) Including HMOs reimbursed by T-18 | _____ | _____ | _____ | _____ |
| **110**  Medical Assistance (T-19) Including HMOs reimbursed by T-19 | _____ | _____ | _____ | _____ |
| **111**  Self-Pay | _____ | _____ | _____ | _____ |
| **112**  All other pay sources | _____ | _____ | _____ | _____ |
| **113  TOTALS** | _____ | _____ | _____ | _____ |

\*\*   This figure should include all inpatients discharged during the reporting period. Report the number of adult, pediatric, and intensive and intermediate care neonatal patients (including deaths).   Exclude newborn, Medicare-certified swing bed, and hospital unit transfer patients.

\*\*\* Exclude fetal deaths.

| | (C1) | (C2) |
|---|---|---|
| | **NUMBER OF DISCHARGES FROM MEDICARE-CERTIFIED SWING BEDS****** | **NUMBER OF DISCHARGE DAYS FROM MEDICARE-CERTIFIED SWING BEDS****** |
| **PAY SOURCE** | | |
| **114**  Medicare (T-18) Including HMOs reimbursed by T-18 | _____ | _____ |
| **115**  Medical Assistance (T-19) Including HMOs reimbursed by T-19 | _____ | _____ |
| **116**  Self- Pay | _____ | _____ |
| **117**  All other pay sources | _____ | _____ |
| **118  TOTALS** | _____ | _____ |

\*\*\*\*      Include both skilled and intermediate Medicare-certified swing beds.

## VI.    SUMMARY AND EXPLANATION OF REVENUE DOLLAR DIFFERENCES BETWEEN FY 2016 AND FY 2017

|  |  | GROSS REVENUE | NET REVENUE |
|---|---|---|---|
| **119** | Fiscal Year 2017<br>[line 36 (gross) and line 3 (net)] | $ | $ |
| **120** | Fiscal Year 2016<br>[FY 2016 Fiscal Survey -<br>line 36 (gross) and line 3 (net)] | $ | $ |
| **121** | Increase / Decrease 2017 v. 2016<br>(subtract line 120 from line 119)<br>[indicate + or -] | $ | $ |

**122** **Explain** in a short narrative the relative importance of various causes for the dollar differences (lines 119 and 120) in the fiscal year revenue figures (price change, utilization change, other causes?).  Attach additional page(s) if necessary.

## VII.    UNCOMPENSATED HEALTH CARE

*This section (Lines 125 and 127) has data elements that are used to calculate the percentage of charges that are collected by the facility.  These calculated percentages are displayed on WHA Information Center's PricePoint Web site.*

| Charges for Uncompensated Health Care | FY 2017 | FY 2018 (Projected) |
|---|---|---|
| **123** Charges for charity care provided for the fiscal year | $<br>(from line 66) | $ |
| **124** Charity care cost (using hospital cost to charge ratio) | $ | $ |
| **125** Charges determined to be a bad debt for the fiscal year …. | $<br>(from line 67) | $ |
| **126** Bad debt cost (using hospital cost to charge ratio) | $ | $ |
| **127** **TOTAL** charges for uncompensated health care for the fiscal year …. | $<br>(add lines 123 and 125) | $<br>(add lines 123 and 125) |
| **128** Total cost (using hospital cost to charge ratio) | $ | $ |
| **129** Hospital cost-to-charge ratio (used for calculations of lines 124, 126 and 128) (e.g. .458) |  |  |

**Number of "Patients" Receiving Uncompensated Health Care**
    (See manual for definitions – the number of "patients" should be reported as the number of individual patient visit ledgers.)

|  | FY 2017 | FY 2018 (Projected) |
|---|---|---|
| **130** Number of individual patient visit ledgers that received charity care for<br>the fiscal year ……………………………………………………………… |  |  |
| **131** Number of individual patient visit ledgers whose charges were determined to be bad debt for the fiscal year …………………….. |  |  |

**132** Provide a **rationale** for the hospital's fiscal year 2018 projections in the space below.  Explain how the projections used "patients" and total charges for fiscal year 2017, if at all.  It could also include a description of the socioeconomic climate of your hospital's market and how that affects your hospital's Uncompensated Health Care Plan.  Attach additional page(s) if necessary. (Using cost to charge ratio)

**Hill-Burton Uncompensated Health Care Information**

**133** Does the hospital have current obligations under this program?
Enter Yes, No, or C (for conditional) on this line _____    _____

**134** If YES, enter date(s) the obligation(s) went into effect and date(s) the obligation(s) will be satisfied.

| Effective beginning date(s) | Projected satisfaction date(s) |
|---|---|
| Month / Year | Month / Year |
| _____ | _____ |
| Month / Year | Month / Year |
| _____ | _____ |
| Month / Year | Month / Year |
| _____ | _____ |

**135** If YES, enter the amount of total federal assistance believed to remain under    …………...
obligation.                                                                                                                     $ _____

**WISCONSIN HOSPITAL MEDICAL ASSISTANCE (MA) ASSESSMENT PROGRAM**
*This section has a data element that is used to calculate the percentage of charges that are collected by the facility.  These calculated percentages are displayed on WHA Information Center's PricePoint Web site.*

|  | TOTAL |
|---|---|
| **136** Medicaid Assistance assessments paid to State of Wisconsin | $ _____ |

| PAY SOURCE | TOTAL | INPATIENT | OUTPATIENT |
|---|---|---|---|
| **137** Enhanced MA fee-for-service payments **(estimates)** | $ _____ | $ _____ | $ _____ |
| **138** Actual access payments received through HMOs Reimbursed by Medical Assistance under Ch. 49, Wis. Stats. | $ _____ | $ _____ | $ _____ |
| **139** TOTAL MA reimbursement  enhancements | $ _____ | $ _____ | $ _____ |