

APPENDIX 3: SURVEY INSTRUMENTS

FY 2022 ANNUAL SURVEY OF HOSPITALS

FY 2022 HOSPITAL FISCAL SURVEY

ANNUAL SURVEY OF HOSPITALS TEMPLATE

WHA Information Center

NOTE: Refer to the detailed instructions contained in the [Annual Survey Manual](#).

This is a blank template to use to share the basic questions of the survey with other people in the organization in preparation for gathering all the necessary information to complete the online survey.

All survey data must be entered and submitted through the online [secured portal](#). Each staff member completing a portion of the survey must have their own username and password. [Click here for more information on roles and registration](#).

This information can also be printed from the survey portal.

*Disclaimer-the annual survey manual and the online portal contains the most accurate up-to-date information.

This template does not reference a specific year as all data is submitted through the online portal for the current year.

I. GENERAL INFORMATION

WHA Info Center 3-digit ID	_____	_____
Hospital Name	_____	
Address	_____	P.O. Box _____
City, State	_____	ZIP Code _____
FY Beginning Date		FY Ending Date
Mo. / Day / Yr.	_____	Mo. / Day / Yr.
Mo.	Day	Yr.
Mo.	Day	Yr.

Organization Information

1 Communications Contact and Reporting Period

- A. Identify the main primary contact responsible for communications related to the data.
- B. Indicate the beginning of your current fiscal year.
- C. Reporting period begin date.
- D. Were you in operation 12 full months at the end of your reporting period?
 Yes---
 No---If no, number of days open during reporting period.

Hospital / Organization Type

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 |
| <input type="checkbox"/> 12 State | <input type="checkbox"/> 21 Religious organization | <input type="checkbox"/> 31 Individual | <input type="checkbox"/> 45 Veterans Affairs |
| <input type="checkbox"/> 13 County | <input type="checkbox"/> 23 Other not-for-profit | <input type="checkbox"/> 32 Partnership | |
| <input type="checkbox"/> 14 City | | <input type="checkbox"/> 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.

- | | |
|--|--|
| <input type="checkbox"/> 10 General medical and surgical | <input type="checkbox"/> 22 Psychiatric |
| <input type="checkbox"/> 15 GMS – Critical Access Hospital | <input type="checkbox"/> 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 (Check all that apply). *Note for "Other," do not specify State of Wisconsin

13 The Joint Commission AOA Title 18 certified and HFS 124 licensed
 Date of last survey _____
 ___/___ (mm/yy) DNV DHS 124 licensed
 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preferred Provider Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indemnity Fee-for-Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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.

<u>Code</u>	<u>Description</u>
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.
<u>Code</u>	<u>Description</u>
O	Service is provided by the hospital IN BUILDINGS OTHER THAN THE MAIN HOSPITAL BUILDING and is billed under.
B	Service is provided by the hospital IN BOTH THE MAIN HOSPITAL BUILDING AND IN BUILDINGS OTHER THAN THE MAIN HOSPITAL BUILDING).
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
 Yes No

If YES, enter address(es) of other buildings:
 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 (include LDRP, exclude gynecology)	_____	_____	_____	_____	1 2 3 4 5	_____
35 Psychiatric Inpatient Care 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	_____

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 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 _____

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	_____

Circle One

100	- Recreational Therapy	1 2 3 4 5	_____
101	- Rehabilitation Inpatient Services (<i>service does not have beds</i>)	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 <input checked="" type="checkbox"/> 3 4 5	_____
107	- Outpatient services – on hospital campus, but in freestanding center	1 <input checked="" type="checkbox"/> 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 (<i>Computed Tomographic Scanner</i>) Check One: <input type="checkbox"/> Fixed <input type="checkbox"/> Mobile <input type="checkbox"/> Both	1 2 3 4 5	_____
120	- Nuclear Medicine Department	1 2 3 4 5	_____
121	- Magnetic Resonance Imaging (<i>MRI</i>) Check One: <input type="checkbox"/> Fixed <input type="checkbox"/> Mobile <input type="checkbox"/> Both	1 2 3 4 5	_____
122	- Positron Emission Tomography Scanner (<i>PET</i>)	1 2 3 4 5	_____
123	- Single Photon Emission Computerized Tomography (<i>SPECT</i>) Check One: <input type="checkbox"/> Fixed <input type="checkbox"/> Mobile <input type="checkbox"/> Both	1 2 3 4 5	_____

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 (<i>day surgery</i>)	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	1 2 3 4 5	_____
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 _____

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 <i>(exclude newborns; include Medicare-certified and Non-Medicare swing admissions)</i>	_____	_____
159 Inpatient days <i>(exclude newborns; include Medicare-certified and Non-Medicare swing days)</i>	_____	_____ Skilled nursing _____ Intermediate care _____ Residential / Elderly housing
160 Discharges/Deaths <i>(exclude newborns; include Medicare-certified and Non-Medicare swing discharges)</i>	_____	_____
161 Census <i>[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.]</i>	_____	_____

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

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, . Include T-18 and T-19 HMO utilization.)

VII. MEDICAL STAFF – September 30.

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)	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
173 Group practice without walls	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
174 Open Physician Hospital Organization (PHO)	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
175 Closed Physician Hospital Organization (PHO)	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
176 Management Service Organization (MSO)	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
177 Integrated Salary Model	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
178 Equity Model	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
179 Foundation	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
180 Accountable Care Organization (ACO)	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
181 Other	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>

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.**

	(1) Medical Staff as of Sept. 30 <i>(Includes Board Certified)</i>	(2) Board Certified Staff As of Sept. 30
		<i>[Not to exceed column (1)]</i>
Medical Specialties		
182 General and Family Practice	_____	_____
183 Internal Medicine <i>(general)</i>	_____	_____
184 Internal Medicine <i>subspecialties</i>	_____	_____
185 Pediatrics <i>(general)</i>	_____	_____
186 Pediatric <i>subspecialties</i>	_____	_____
Surgical Specialties		
187 General Surgery	_____	_____
188 Obstetrics/Gynecology	_____	_____
189 All other surgical <i>specialties</i>	_____	_____
Other		
190 Anesthesiology	_____	_____
191 Emergency Medicine	_____	_____
192 Pathology	_____	_____
193 Radiology	_____	_____
194 Addiction Medicine	_____	_____
195 Psychiatry	_____	_____
196 All other specialties <i>(use valid specialties below)</i>	_____	_____
Line 197 - codes for valid specialties- check all codes that apply:		
<input type="checkbox"/> Aerospace Medicine	<input type="checkbox"/> General Preventive Medicine	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Chiropractic Services	<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> Physical Med&Rehab (includes Physiatry)
<input type="checkbox"/> Dental	<input type="checkbox"/> Occupational Medicine	<input type="checkbox"/> Public health
198 TOTAL Medical Staff	_____ (add lines 182-196)	_____ (add lines 182-196)

VIII. PERSONNEL ON HOSPITAL PAYROLL – September 30 - 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, 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.**

Occupational Categories	FULL TIME		PART TIME	
	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)	
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.				
<input type="checkbox"/> Independent provider group			<input type="checkbox"/> Employed by a university or school program	
<input type="checkbox"/> Employed by a physician group			<input type="checkbox"/> Other	
<input type="checkbox"/> Employed by your hospital				
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		PART TIME	
	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)	
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.	<div style="border: 1px solid black; width: 100px; height: 60px; margin: 0 auto;"></div>		(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
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.

	<u>Dedicated FTEs</u>
Quality management & improvement	_____
Clinical safety	_____
Case management	_____
Accreditation	_____
Infection control	_____
Risk Management	_____

247 Does your facility provide 24-hour pharmacy services?

Yes No

XI. E-HEALTH

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
249 Lab information system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
250 Pharmacy system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
251 E-MAR (real-time enterprise medication administration record)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
252 Medication dispensing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
253 RIS (Radiology information system)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
254 Computerized radiography (digital x-ray)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
255 PACS (Picture archiving and communication system)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
256 Order entry/resulting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
257 Inpatient charting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
258 Bedside medication verification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
259 CPOE (Computerized physician order entry)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
260 EHR portal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
261 Bulk scanning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Feature	Fully Implemented	Partially Implemented	Planning	Not at All
262 Surgery management system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
263 Interface engine/expertise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
264 Physician Practice Management Systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
265 Physician Practice EMR Systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
266 Long Term Care EMR System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
267 Home Health EMR System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?

- T1
 T3
 A telephone company DSL line (high speed)
 A fiber-optic connection
 Other

If Other, please explain:

XIII. SOCIAL DETERMINANTS OF HEALTH (SDOH)

271 Does your facility screen patients for social needs?

Yes, for all patients Yes, for some patients No, (skip to question 274)

272 If yes, please indicate which social needs are assessed. (Check all that apply)

- Housing (instability, quality, financing)
 Food insecurity or hunger
 Utility Needs
 Interpersonal violence
 Transportation
 Employment and income
 Education
 Social isolation (lack of family and social support)
 Health behaviors

Other, please describe _____

273 If yes, does your facility record the social needs screening results in your EHR?

Yes No

274 Does your facility utilize outcome measures (for example, cost of care or readmission rates) to assess the effectiveness of the interventions to address patients' social needs?

Yes No

275 Has your facility been able to gather data indicating that activities used to address the SDOH and patient social needs have resulted in any of the following? (Check all that apply)

- Better health outcomes for patients
- Decreased utilization of hospital or health system services
- Decreased health care costs
- Improved community health status

XIII. SUPPLEMENTAL INFORMATION

276 *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.*

HOSPITAL FISCAL SURVEY TEMPLATE

WHA Information Center

NOTE: Refer to the detailed instructions contained in the [Fiscal Survey Manual](#).

This is a blank template to use to share the basic questions of the survey with other people in the organization in preparation for gathering all the necessary information to complete the online survey.

All survey data must be entered and submitted through the online [secured portal](#). Each staff member completing a portion of the survey must have their own username and password. [Click here for more information on roles and registration](#).

This information can also be printed from the survey portal.

*Disclaimer-the fiscal survey manual and the online portal contains the most accurate up-to-date information.

This template does not reference a specific year as all data is submitted through the online portal for the current year. Abbreviations Previous Fiscal Year denoted with PFY and Current Fiscal Year denoted with CFY.

I. HOSPITAL INFORMATION

Hospital Name and Address

FY Beginning Date

FY 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).** 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*.

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 losses)	\$ _____	
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 OBSOLETE	\$ _____	\$ _____	\$ _____
42 County 51.42 / 51.437 programs	\$ _____	\$ _____	\$ _____
43 All other public programs	\$ _____	\$ _____	\$ _____

Commercial Sources

	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):

48 <u>Other Payers 1</u>	\$ _____	\$ _____	\$ _____
49 <u>Other Payers 2</u>	\$ _____	\$ _____	\$ _____
50 <u>OBSOLETE</u>	\$ _____	\$ _____	\$ _____
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.

	TOTAL	INPATIENT	OUTPATIENT
Public Source Contractual Adjustments			
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 OBSOLETE	\$ _____	\$ _____	\$ _____
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 Other Adjustments 1 \$ _____ \$ _____ \$ _____

64 Other Adjustments 2 \$ _____ \$ _____ \$ _____

65 Other Adjustments 3 \$ _____ \$ _____ \$ _____

Charity Care / Bad Debt

66 Charity care (revenue foregone at full established rates) (must equal line 123) \$ _____ \$ _____ \$ _____

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*.

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)
PAY SOURCE	NUMBER OF INPATIENT DISCHARGES**	NUMBER OF DISCHARGE DAYS**	NUMBER OF NEWBORNS***	NUMBER OF NEWBORN DISCHARGE DAYS***
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)
PAY SOURCE	NUMBER OF DISCHARGES FROM MEDICARE- CERTIFIED SWING BEDS****	NUMBER OF DISCHARGE DAYS FROM MEDICARE- CERTIFIED SWING BEDS****
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 PREVIOUS FY AND CURRENT FY

	GROSS REVENUE	NET REVENUE
119 Current Fiscal Year [line 36 (gross) and line 3 (net)]	\$ _____	\$ _____
120 Previous Fiscal Year line 36 (gross) and line 3 (net)]	\$ _____	\$ _____
121 Increase / Decrease CFY v. PFY (subtract line 120 from line 119) [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	CFY	CFY (Projected)
123 Charges for charity care provided for the fiscal year	\$ _____ (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	\$ _____ (from line 67)	\$ _____
126 Bad debt cost (using hospital cost to charge ratio)	\$ _____	\$ _____
127 TOTAL charges for uncompensated health care for the fiscal year	\$ _____ (add lines 123 and 125)	\$ _____ (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.)

	CFY	CFY (Projected)
130 Number of individual patient visit ledgers that received charity care for 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 current fiscal year projections in the space below. Explain how the projections used "patients" and total charges for current fiscal year, 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.

<u>Effective beginning date(s)</u>	<u>Projected satisfaction date(s)</u>
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	\$ _____	\$ _____	\$ _____