WHA | INFORMATION CENTER

Fiscal Survey Manual

WHA Information Center Website: https://www.whainfocenter.com/

WHAIC Staff and Contact Information

(608) 274-1820 (Madison area)

(800) 231-8340 (Toll Free)

WHA Information Center Staff:

Brian Competente

WHAIC Vice President and Privacy Officer

WHAIC Data Submissions and General Questions

Cindy Case, Director of Data Management

Heather Scambler, Program Specialist (Survey Primary Contact)

For general questions email us at:

whainfocenter@wha.org

Website WHA Information Center: https://www.whainfocenter.com/

FISCAL SURVEY

TABLE OF CONTENTS

INFORMATION AND DEFINITIONS

All Wisconsin licensed, Medicare-certified hospitals, including psychiatric hospitals, are required to submit annual survey data to the Wisconsin Hospital Association Information Center (WHAIC). This submission encompasses data related to utilization, fiscal operations, and personnel, which will be utilized in various publications, datasets, and workforce development initiatives. WHAIC collects this data under Chapter 153 of the Wisconsin State Statutes, adhering to the terms outlined in ss. DHS 120.12.

The Fiscal Survey Manual provides comprehensive instructions, definitions, and expectations for completing the Fiscal online survey application. This manual is designed to assist hospitals in submitting their revenue, expense, and balance sheet data to the WHAIC as mandated by Wisconsin statute. For details on submission deadlines for the current year, please refer to the Survey Submission Calendar.

Data collected by WHAIC is disseminated through various online publications, available under the Data Products Tab at WHA Information Center.

The WHA Chief Financial Officer and Vice President uses the Fiscal survey data along with the Medicare Cost Report (MCR) detail to provide to the State of Wisconsin financial assessment taxes.

Financial Data

All financial data inquiries are structured according to the AICPA audit and accounting guidelines, such as those outlined in the "AICPA Audit and Accounting Guide: Health Care Organizations." Financial data must be submitted via the Hospital Fiscal Survey, using information derived from final audited financial statements. If specific data is absent from these statements, hospitals should reference Medicare Cost Reports, financial statement notes, or other internal financial records.

Key Submission Guidelines:

- *Completeness and Accuracy*: WI Hospitals must ensure all data items are fully completed. For items deemed not applicable, enter “0.” Responses of “not available” or “missing” are unacceptable.
- *Rounding:* Round all financial figures to the nearest dollar.
- *Submission Timeline:* The online fiscal survey must be completed and submitted to the WHA Information Center within 120 calendar days following the close of the hospital’s previous fiscal year.
- *Extensions:* Hospitals may request a submission extension of up to 30 calendar days.
- ***Hospital changes*: Hospitals that merge, close, or change their reporting fiscal year are still required to submit data covering a full 12-month period.**
- *Separate Submissions*: Hospitals affiliated with a healthcare system must submit individual surveys for each entity unless otherwise arranged.
- For additional guidance, refer to the Frequently Asked Questions.

Behavioral Health Facilities

State-operated and county-owned facilities must submit revenue and expense data but are not required to provide balance sheets. Behavioral health facilities must submit data as requested for the fiscal year from the audited or unaudited financial statements. If the audit report is not yet available, the State Behavioral health facility may provide unaudited financial statements for the specified fiscal year. If audited statements are unavailable, unaudited statements or data from Medicare Cost reports or internal records may be used.

Government-Owned Healthcare Facilities & Parent or Holding Companies

This guide applies to entities providing healthcare services and their overseeing parent organizations. Government-owned health care facilities using enterprise fund accounting must also use these guidelines.

Compliance

Failure to comply with the requirements outlined in the Statutes, or submission deadlines as defined by State Statute, may result in a non-compliance letter to the Wisconsin Department of Administration and may include significant penalties and forfeitures.

Electronic Submission

All surveys must be completed using the online survey application. Effective 11/1/2024 WHAIC moved to multi-factor or single sign-on system access, whereby users are no longer required to maintain a separate username or password, rather they will use their own facility login credentials. In addition, this process will initiate an Account Verification Code in the user email account that will be required in order to access the system. This process will occur every 30 days.

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 login credentials. Click here for more information on roles and registration.

I. GENERAL INFORMATION

WHAIC will calculate Subtotal and TOTAL fields for you. In general, anything **highlighted green** in the Fiscal Survey is a field that is totaled up for you. We encourage you to review those TOTALS to verify the numbers are accurate.

Before you get started, review the first few sections of the survey, and be prepared to provide your hospital's 3-digit facility ID when corresponding with WHAIC.

To reference your facility ID – click here: 3-digit WHA Information Center Hospital ID Number.

STATEMENT OF REVENUE

This section covers general information and revenue information for your facility.

GENERAL FUND INFORMATION: STATEMENT OF REVENUE AND EXPENSES

General funds are used to account for resources not restricted for specific purposes by donors and grantors. These funds include all resources and obligations not recorded in donor-restricted funds, such as assets whose use is limited, agency funds, and property and equipment related to the general operations of the facility.

Activities associated with the provision of health care services constitute the ongoing major or central operations of health care service providers. Revenue, expenses, gains, and losses arising from these activities are classified as "operating." Gains and losses from transactions that are peripheral or incidental to the provision of health care services, as well as from other events largely beyond the control of the facility and its management, are classified as "non-operating." The classification of items as revenue or gain and expense or loss depends on the individual hospital. The same transaction may result in revenue for one hospital and a gain for another.

Classify and report revenue, expenses, gains, and losses on the appropriate survey line in a manner consistent with the hospital's financial statements, prepared in accordance with generally accepted accounting principles (GAAP). Since no separate lines are provided for operating gains and losses, include these in "all other operating revenue" (line 5) and "all other operating expenses" (line 24), respectively.

Other Instructions and Guidelines

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 must submit the required information from the final audited financial statements of the hospital, except where such information cannot be disaggregated [ss. DHS 120.12.] All hospital services must be reported if they are included as hospital revenue and contained in net revenue from services to patients.

1. WHO IS YOUR HOSPITAL'S PUBLIC CONTACT FOR QUESTIONS?

Who should the public contact about questions related to your data in the hospital Fiscal Survey? For example, if the media has questions about the data contained in one of the online publications, who does he/she contact?

2. IS YOUR FACILITY A COMBINATION FACILITY?

Enter "Yes" if the 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.

Enter "No" if the hospital does not meet the definition of a "Combination Facility."

SPECIAL INSTRUCTIONS FOR THE BALANCE SHEET

For hospitals that meet the definition of a "Combination Facility," the general rule is that, whenever possible, report hospital data only.

3. NET REVENUE FROM SERVICES TO PATIENTS (INCLUDING MEDICAID ACCESS PAYMENTS)

Enter the net revenue from service to patients. Report the estimated net realizable amounts from patients, third-party payers, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers.

Retroactive adjustments are accrued on an estimated basis during the period in which related services are rendered and adjusted in future periods as final settlements are determined. Include Medicaid access payments. Hospitals should report bad debt as a revenue deduction. Hospitals should net out bad debt.

OTHER REVENUE (Questions 4 – 6)

This category consists of operating gains, revenue from services other than health care provided to patients, as well as sales and services to non-patients. Include tax appropriations, revenue from services to patients that are not patient care services, and sales and activities made available to persons other than patients that are normally part of the day-to-day operation of a hospital.

4. TAX APPROPRIATIONS

Enter the amount of revenue from government tax appropriations.

Appropriated revenues consist of fees and charges, together with support payments and reimbursements (including Federal funds). Because these revenues are routinely credited to the General Fund appropriation for the operation of the applicable department rather than being appropriable for other General Fund expenditures, they are referred to as "appropriated."

5. ALL OTHER OPERATING REVENUE

Enter the amount of operating revenue from the aggregation of all other operating revenue, including operating gains, including but not limited to cafeteria sales, gift shop sales, donated supplies, parking lot fees, rental of hospital space, tuition from educational programs, research grants, and income related to borrowed funds.

6. TOTAL OTHER REVENUE

Add only lines 4 & 5 (tax appropriations & other operating revenue); do not include line 3 (Net Revenue from Services to Patients) in line 6.

7. TOTAL REVENUE

Add lines 3 (Net Revenue from Services to Patients) & 6 (Total Other Revenue).

EXPENSES

Expenses include all expired costs for goods and services that have been used or consumed in carrying on activity during the fiscal year and from which no benefit will extend beyond the current year.

PAYROLL EXPENSES

Lines 8 through 13 refer to salaries for full-time and part-time hospital personnel.

This section covers hospital personnel and payroll expenses.

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 [ss. HFS 120.12 (2) (b) 5. b., c. Wis. Adm. Code]. (See special instructions for combination facilities at the end of this 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.

8. PHYSICIANS AND DENTISTS

Enter TOTAL payroll for physicians and dentists. Also enter the information below.

- Number of physicians employed.
- Number of dentists employed.
- Number of Physician FTEs
- Number of Dentist FTEs

Enter the number and salary expense for employed physicians and dentists engaged in clinical practice, either full- or part-time. And the number of FTEs of said physicians and dentists. The salaries for physicians and dentists who hold full-time, or part-time administrative positions should be included under “All other personnel” on line 12.

**Exclude physicians and dentists whose clinical work is totally financed by outside research grants or fellowships*.

9. MEDICAL AND DENTAL RESIDENTS AND INTERNS

Enter the salary expense for medical and dental residents and interns.

10. TRAINEES

Enter the salary expense for trainees; for example, those in medical technology, x-ray therapy, administrative residency, and trainees of other specialties who have not completed the necessary requirements for certification or qualifications required for full salary under the related title.

11. REGISTERED NURSES AND LICENSED PRACTICAL NURSES

Enter the salary expense for registered nurses (RN/BSN) and licensed practical nurses (LPN).

12. ALL OTHER PERSONNEL

Enter the salary expense for all other personnel.

Examples include, but are not limited to, administrators, ancillary nursing personnel, physician assistants, nurse practitioners, technicians, pharmacists, technologists, therapists, therapy assistants, psychologists, medical social workers, kitchen personnel, laundry personnel, maintenance personnel, secretaries, file clerks, etc.

13. TOTAL PAYROLL EXPENSES

Add lines 8 through 12.

NON-PAYROLL EXPENSES

14. EMPLOYEE BENEFITS

Enter the expense for employee benefits (employer-paid fringe benefits). Examples include, but are not limited to, Federal Insurance Contributions Act (FICA), state and federal unemployment insurance, group health insurance, group life insurance, pension and retirement benefits, workers' compensation, group disability insurance, and other similar employee benefits.

15. PROFESSIONAL FEES

Enter the expenses for professional fees, including those billed to hospitals by specialists such as radiologists, pathologists, anesthesiologists, cardiologists, and emergency room physicians. Include fees for both contracted and non-contracted medical personnel like registered physical therapists, nurse anesthetists, and consultants. Also, incorporate fees for legal, auditing, and non-medical consulting services. Do not include expenses for salaried staff physicians, interns, or residents.

16. CONTRACTED NURSING SERVICES

Enter the expense for contracted nursing services. This includes all nursing staff who provided services within the hospital, but who were not on the hospital payroll, such as nursing staff from nursing registries, temporary help agencies, etc.

17. DEPRECIATION EXPENSE

Include the depreciation expense for reporting period only. This includes depreciation on hospital-related buildings, equipment, fixtures, land improvements, and leasehold improvements, recorded on a historical cost basis. Include both the depreciation expenses that have been assigned to specific hospital departments and the amounts that have not been assigned.

Do not include amortization of financing expenses (this should be entered on line 21) or assets not related to the operation of the hospital.

18. INTEREST EXPENSE

Enter interest expense. This includes all interest incurred on loans for working capital purposes and for capital debt purposes.

19. MEDICAL MALPRACTICE INSURANCE PREMIUMS

Enter the expense for medical malpractice insurance premiums.

A specialized type of professional liability insurance, medical malpractice insurance provides coverage to physicians and other medical professionals for liability arising from disputed services that result in a patient's injury or death.

20. AMORTIZATION OF FINANCING EXPENSES

Enter the expense for amortization of financing. This includes the actual expenses used to secure a loan (bond), such as attorney fees and discounts. This expense is usually amortized over the life of the loan. Amortization of financing expenses is also referred to as bond issuance costs or bond discounts.

21. RENTS AND LEASES

Enter expense for rents and leases. This includes all rental and lease expenses relating to buildings, equipment, fixtures, and leasehold equipment. Include both the rental and lease expense that has been assigned to specific departments and the amount that has not been assigned.

22. CAPITAL COMPONENT OF INSURANCE PREMIUM

Enter the expense for the capital component of insurance premiums. To derive this figure, refer to the Medicare Cost Report, worksheet A-6 (reclassifications) or the most current worksheet providing that information. Under line item “other insurance,” report the dollar value for capital-related costs, for example, buildings and fixtures. This amount should have been reclassified from the dollar value listed under the category “administrative and general.”

23. ALL OTHER OPERATING EXPENSES (I.E. UTILITIES, SUPPLIES, INSURANCE, ETC.)

Enter all other operating expenses. Report all other expenses not included in the above categories; for example, utility expenses, supplies, purchased services, property insurance, general liability insurance, license fees, operating losses, etc.

Include Medicaid assessments paid.

24. TOTAL NONPAYROLL EXPENSES

Enter the total nonpayroll expenses by adding the amounts on lines 14 through 23.

25. TOTAL EXPENSES

Enter the total expenses by adding the amounts on lines 13 and 24.

26. EXCESS (OR DEFICIT) OF REVENUE OVER EXPENSES

Subtract line 25 (Total Expenses) from line 7 (Total Revenue).

NON-OPERATING GAINS/LOSSES

27. INVESTMENT INCOME

Enter the amount of investment income. Report all income from investments other than income related to borrowed funds.

28. OTHER NONOPERATING GAINS

Enter the amount of other nonoperating gains, including extraordinary gains, for example, unrestricted gifts, donated services, contributions from donors, unrestricted income from endowment funds, etc.

29. PROVISION FOR INCOME TAXES (FOR-PROFIT ORGANIZATIONS ONLY)

Enter the provision for state and federal corporate income taxes (applicable to for profit organizations only); enter absolute values only. *Do not enter negative numbers*.

This question applies to for profit organizations only, all others enter a zero value.

30. OTHER NONOPERATING LOSSES

Enter the amount of nonoperating losses. This includes real estate taxes (if applicable), as well as all other losses not directly related to patient care or hospital-related patient services, such as apartment buildings and physician offices if they are considered part of the hospital. Include extraordinary losses. Enter Absolute Values only.

Do not enter negative numbers.

31. TOTAL NONOPERATING GAINS / LOSSES

Enter the total nonoperating gains/losses obtained by subtracting the sum of the amounts from line 29 (Provision for Income Taxes) and 30 (Other Nonoperating Losses) from the sum of the amounts from lines 27 and 28 (Investment Income and Other Nonoperating Gains).

32. NET INCOME

Enter the net income (revenue and gains more than expenses and losses) by adding the amounts from lines 26 (Excess or Deficit of Revenue Over Expenses) and 31 (Total Nonoperating Gains/Losses).

II. DETAIL OF PATIENT SERVICE REVENUE

GROSS PATIENT SERVICE REVENUE AND ITS SOURCES

Lines 33 through 49 are based on the accrual system of accounting and at the hospital's full established rates (normal charges billed to the patient) for all services rendered; regardless of the amounts (if any) the hospital expects to collect.

33. GROSS REVENUE FROM ROOM, BOARD, MEDICAL/NURSING SERVICES TO INPATIENTS

Enter the gross revenue generated from daily room, board, and medical and nursing services to inpatients based on fully established rates.

34. GROSS INPATIENT ANCILLARY REVENUE

Enter the gross inpatient ancillary revenue. This is inpatient revenue for services other than room, board, and medical and nursing services that the hospital provides. Examples include, but are not limited to, laboratory, radiology, pharmacy, and therapy services. Refer to the ancillary cost centers on the Medicare Cost Report for more examples.

*Sum of lines 33 and 34 must equal sum of inpatient breakouts, lines 37-49.

35. GROSS REVENUE FROM SERVICE TO OUTPATIENTS

Enter on line 35 the gross revenue generated from services to outpatients based on full established rates.

*Must equal sum of outpatient breakouts lines 37-48.

36. TOTAL GROSS REVENUE FROM SERVICE TO PATIENTS

Enter on line 36 the total gross revenue from services (inpatient and outpatient) to patients obtained by adding the amounts from lines 33 through 35.

SOURCES OF GROSS PATIENT REVENUE

Lines 37 through 49 (see below) pertain to gross patient revenue from public sources (any government-funded program), commercial, and other sources. Enter the total dollar amounts (or reasonable estimates based upon

the hospital's internal records) and **separate them by inpatient and outpatient dollar amounts on the lines indicated.**

The sum of dollar values on lines 33 (Gross revenue from room, board, and medical and nursing services to INPATIENTS) and 34 (Gross INPATIENT ancillary revenue) should equal the sum of dollar values for inpatient breakouts on lines 37 through 49. The dollar value on line 35 (gross revenue from service to OUTPATIENTS) should equal the sum of dollar values for outpatient breakouts on lines 37 through 49.

This section (Lines 37-49) 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 website.

PUBLIC SOURCES

37. MEDICARE

Enter the total gross patient revenue billed to Medicare. Medicare is also known as MCR, MED, Title 18, Title XVIII, or T-18.

Exclude HMOs reimbursed by Medicare (e.g., Medicare Advantage Plans). Collected on line #38

38. HMOS REIMBURSED BY MEDICARE UNDER 42 CFR PT. 417

Enter the total gross patient revenue billed to Medicare Part C / Medicare Advantage HMOs that are reimbursed by Medicare.

39. MEDICAL ASSISTANCE

Enter the total gross patient revenue billed to Medical Assistance. Exclude HMOs reimbursed by Medical Assistance (BadgerCare Plus HMO). Medical Assistance is also known as MA, Medicaid, Title 19, Title XIX, or T-19 and includes BadgerCare.

40. HMOS REIMBURSED BY MEDICAL ASSISTANCE UNDER S. 49.45 (3) (B), WIS. STATS

Enter the total gross patient revenue billed to HMOs that are reimbursed by Medical Assistance, including BadgerCare. Hospitals in counties serving "out of plan" T-19 HMO patients should enter the billed amounts on this line.

Separate the dollar amounts on lines 37 through 40 into INPATIENT and OUTPATIENT dollar amounts and enter on the corresponding lines.

41. COUNTY 51.42 / 51.437 PROGRAMS

Enter the total gross patient revenue billed to county programs under s. 51.42 and 51.437, Wis. Stats. This also includes programs under s. 46.23, Wis. Stats. These programs provide community services and facilities for the prevention or amelioration of mental disabilities, including but not limited to mental illness, developmental

disabilities, alcoholism, and drug abuse. These programs are the responsibility of the county unified services or human services board. This funding source is sometimes referred to as a 51.42 Board.

https://docs.legis.wisconsin.gov/statutes/statutes/51/42

42. ALL OTHER PUBLIC PROGRAMS

Enter the total gross patient revenue billed to all other public programs. Examples include non-Wisconsin Medical Assistance; the primary health care program known as WisconCare; TriCare, Optum VA (refers to Civilian Health and Medical Program of the Uniformed Services - Veterans Administration: health benefits for military personnel and dependents).

Separate the sum of lines 42 and 43 into INPATIENT and OUTPATIENT dollar amounts and enter on the line indicated in parentheses.

COMMERCIAL SOURCES

Lines 43 through 49. Include all **non-governmental** sources of revenue.

43. GROUP AND INDIVIDUAL ACCIDENT AND HEALTH INSURANCE, SELF-FUNDED PLANS

Enter the total gross patient revenue billed to group and individual accident and health insurance sources (also referred to as commercial or private insurance or indemnity health care plans), employer self-funded plans, and other organization self-funded plans such as benefit plan administrators or third-party administrators.

44. WORKER'S COMPENSATION

Enter the total gross patient revenue billed to workers' compensation. If your hospital truly has zero workers' compensation to report, check the "check if zero" box. Some hospitals have noted workers' compensation is categorized into another category, please enter workers' compensation here.

45. HMOS AND ALL OTHER ALTERNATIVE HEALTH CARE PAYMENT SYSTEMS

Exclude lines 38 (HMOs reimbursed by Medicare) and 40 (HMOs reimbursed by Medical Assistance).

Enter the total gross patient revenue billed to Health Maintenance Organizations (HMOs) and all other alternative health care payment systems. This does not include revenue from HMOs reimbursed by Medical Assistance or HMOs reimbursed by Medicare. These are defined as follows:

**Separate the sum of lines 45 through 48 into INPATIENT and OUTPATIENT dollar amounts and enter on the lines indicated in parentheses.*

46. SELF-PAY

Enter the total gross patient revenue billed directly to the patient for self-payment. This category generally applies to people who do not have health insurance coverage.

All Other Sources

Enter the total gross patient revenue billed to all other sources. These sources must be specified in the space provided on the form.

*Separate the sum of lines 47 and 48 into INPATIENT and OUTPATIENT dollar amounts.

47. OTHER PAYERS 1

Examples include Direct contracts, Business Health, and Company Accounts

48. OTHER PAYERS 2

Examples include Capitation/Risk, Military, and Hospice

49. TOTAL GROSS REVENUE FROM SERVICE TO PATIENTS, BY SOURCE

*Enter the TOTAL GROSS revenue from service to patients, by source (total for Inpatient and Outpatient). These totals should come from the sum of lines 37 through 48. The total should equal the dollar amount on line 36 (Total Gross Revenue from Service to Patients).

DEDUCTIONS FROM PATIENT SERVICE REVENUE AND ITS SOURCES

*Lines 50 through 65 (see below) are based on revenues uncollectible by reason of contractual adjustments, courtesy and policy discounts, charity care, or other unspecified adjustments and deductions. Enter the actual dollar amounts, or reasonable estimates based on the hospital's internal records, by inpatient and outpatient breakouts.

CONTRACTUAL ADJUSTMENTS

*Lines 50 through 65 refer to the difference between a hospital's normal charges for patient services and the discounted charge or payment received by the hospital from the payer.

This section has data elements that are used to calculate the percentage of charges that are collected by the facility. These calculated percentages are displayed under Fiscal Information under the Payer Mix heading on WHA Information Center's PricePoint website.

NOTE: Contractual Adjustments are by TOTAL dollar amounts and by separate INPATIENT and OUTPATIENT breakouts.

PUBLIC SOURCE CONTRACTUAL ADJUSTMENTS

For more information on Medicare see CMS.gov

50. MEDICARE

Enter the total difference between billed and received (or receivable) amounts for Medicare. Exclude HMOs reimbursed by Medicare (Medicare Advantage Plans). Medicare is also known as MCR, MED, Title 18, Title XVIII, or T-18.

51. HMOS REIMBURSED BY MEDICARE UNDER 42 CFR PT. 417

Enter the total difference between billed and received (or receivable) amounts for HMOs that are reimbursed by Medicare.

52. MEDICAL ASSISTANCE

Medical Assistance (include effect of enhanced Medical Assistance payments) - Enter the total difference between billed and received (or receivable) amounts for Medical Assistance. Exclude HMOs reimbursed by Medical Assistance. Medical Assistance is also known as MA, Medicaid, Title 19, Title XIX, or T-19, and includes BadgerCare. Include effect of Enhanced Medical Assistance payments.

Enhanced Federal Medical Assistance Percentages are for the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. Section 2105(b) of the Act.

53. HMOS REIMBURSED BY MEDICAL ASSISTANCE UNDER S. 49.45 (3) (B), WIS STAT.

HMOs reimbursed by Medical Assistance under s. 49.45 (3) (b), Wis Stat. (include effect of enhanced Medical Assistance payments) - Enter the total difference between billed and received or receivable amounts for HMOs that are reimbursed by Medical Assistance. Hospitals in other counties serving “out of plan” T-19 HMO patients may not have contractual adjustments for those charges. Include effect of Enhanced Medical Assistance payments.

Separate the dollar amounts into INPATIENT and OUTPATIENT and enter on the corresponding lines.

54. COUNTY 51.42 / 51.437 PROGRAMS

Enter the total difference between billed and received or receivable amounts for county programs under s. 51.42 and 51.437, Wis. Stat. This also includes programs under s. 46.23, Wis. Stat. These programs provide community services and facilities for the prevention or amelioration of mental disabilities, including but not limited to mental illness, developmental disabilities, alcoholism, and drug abuse. These programs are the responsibility of the county unified services or human services board. This funding source is sometimes referred to as a 51.42 Board.

55. ALL OTHER PUBLIC PROGRAMS

Enter the total difference between billed and received or receivable amounts for all other public programs. Examples include Non-Wisconsin Medical Assistance; the primary health care program known as WisconCare;

CHAMPUS or CHAMPVA (refers to Civilian Health and Medical Program of the Uniformed Services - Veterans Administration: health benefits for military personnel and dependents).

Separate the dollar amounts into INPATIENT and OUTPATIENT and enter on the corresponding lines.

COMMERCIAL SOURCE CONTRACTUAL ADJUSTMENTS

56. GROUP AND INDIVIDUAL ACCIDENT AND HEALTH INSURANCE, SELF-FUNDED PLANS

Enter the total difference between billed and received or receivable amounts for group and individual accident and health insurance sources (also referred to as commercial or private insurance or indemnity health care plans), employer self-funded plans, and other organization self-funded plans.

57. WORKER'S COMPENSATION

Enter the total difference between billed and received or receivable amounts for workers' compensation. If your hospital truly has zero workers' compensation to report, check the "check if zero" box. Some hospitals have noted workers' compensation is categorized into another category, please enter workers' compensation here.

58. HMOS AND ALL OTHER ALTERNATIVE HEALTH CARE PAYMENT SYSTEMS

*Enter the total difference between billed and received or receivable amounts for Health Maintenance Organizations (HMOs) and all other alternative health care payment systems. **Exclude lines 51 and 53** - revenue from HMOs reimbursed by *Medicare and* Medical Assistance.

Definitions can be found in Appendix VIII.

59. SELF-PAY

Enter the total difference between billed and received or receivable amounts for self-pay.

Separate the dollar amounts into INPATIENT and OUTPATIENT and enter on the corresponding lines.

OTHER SOURCE CONTRACTUAL ADJUSTMENTS/CHARITY CARE/BAD DEBT

Other Source Contractual Adjustments

Enter the total difference between billed and received (or receivable) amounts for all other nonpublic sources. These sources must be specified in the space provided.

Separate the dollar amounts into INPATIENT and OUTPATIENT and enter on the corresponding lines.

60. OTHER ADJUSTMENTS 1

Examples: Direct Contract and Public Health

61. OTHER ADJUSTMENTS 2

Examples: Military and Capitation/Risk

62. OTHER ADJUSTMENTS 3

Charity Care/Bad Debt

Charity care is health services that were never expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge or at reduced charges to individuals who meet certain financial criteria. For the purposes of this survey, charity care is measured based on revenue foregone, at fully established rates.

63. CHARITY CARE

*Enter the amount of "charity care" as defined above. Revenue foregone at fully established rates. Must equal line 120 (charges for charity care provided for the fiscal year).

64. BAD DEBT

Bad debt is defined as claims arising from rendering patient care services that the hospital, using a sound credit and collection policy, determines are not collectible. Bad debt does not include charity care and is now treated as a deduction from revenue. The total dollar amount on line 64 (bad debt) should equal the dollar amount on line 123 (bad debt for the fiscal year).

Enter the charges determined to be bad debt as reported on the final audited financial statements.

65. ALL OTHER NON-CONTRACTUAL DEDUCTIONS.

Enter uncollectible revenue due to all other noncontractual deductions. Examples include, but are not limited to, physician or clergy courtesy discounts, employee discounts, administrative adjustments, and research grants.

66. TOTAL DEDUCTIONS FROM REVENUE

*Enter total deductions from revenue. Add totals, not breakouts, for lines 50 through 65.

MEDICARE-APPROVED MEDICAL EDUCATION ACTIVITIES

Of TOTAL expenses in line 25, the reimbursable expenses for Medicare approved medical education activities separated into the following categories:

67. DIRECT MEDICAL EDUCATION EXPENSES

Enter the direct medical education expenses that have been included in "TOTAL expenses" on line 25. **"Direct medical education expenses"** are the direct medical education costs in approved programs based upon the amounts that are reimbursed by Medicare. Approved programs include programs to train interns and residents,

nursing schools, and medical education of paraprofessionals (e.g., radiologic technicians). They do not include on-the-job or "in-service" training, or other activities that do not involve the actual operation or support by the provider, except through tuition or similar payments, of an approved education program. To derive this figure, refer to the Medicare Cost Report, Worksheet B, Part I.

68. INDIRECT MEDICAL EDUCATION EXPENSES

Enter the indirect medical education expenses that have been included in "TOTAL expenses" on line 25. **"Indirect medical education expenses"** are those costs designed to cover the increased operating, or patient care, costs that are associated with approved intern and resident programs. Among other factors, this figure is based upon the number of residents and the number of patients in the hospital. To derive this figure, refer to the Medicare Cost Report, Worksheet E.

69. TOTAL REIMBURSABLE EXPENSES FOR MEDICARE APPROVED MEDICAL EDUCATION ACTIVITIES

*Add lines 67 and 68 for the total Medicare-approved medical education expenses.

III. BALANCE SHEET GENERAL FUNDS

BALANCE SHEET

The AICPA Guide allows both desegregated (funds that are layered) and aggregated (funds that are combined) balance sheets. This survey utilizes the desegregated, layered approach whereby several funds are reported in self-balancing layers. The two major divisions of the layered balance sheet are labeled "general" (or "unrestricted") and "restricted." Only the "general" (unrestricted) funds should be reported in this section of the survey.

If the hospital prepares an aggregated balance sheet and combines all its funds into a single non-layered balance sheet, the restricted funds must be separated (usually from assets whose use is limited). They should be reported in the RESTRICTED HOSPITAL FUNDS section to conform to the format of this survey.

State mental health institutes operated by the Department of Health and Family Services and county-owned psychiatric or alcohol and other drug abuse hospitals are not required to complete a balance sheet. These facilities should continue with "Section IV, HOSPITAL INPATIENT UTILIZATION BY PAY SOURCE."

If a hospital is a "Combination Facility" as defined in the Appendix of this manual for additional instructions for reporting balance sheet data.

DEFINITIONS

UNRESTRICTED ASSETS

All unrestricted assets that are carried on the hospital's balance sheet at the end of the fiscal year. List funds from inter-corporate accounts. DO NOT report negative values except in cash. Include actual or estimated value of the plant and/or equipment that is leased.

Donated assets should be recorded at fair market value. Not-for-profit health care organizations should depreciate donated assets in accordance with generally accepted accounting principles.

Donated services should in some cases be recorded. Hospitals should follow generally accepted accounting principles.

CURRENT ASSETS

70. CASH AND CASH EQUIVALENTS

Enter the total amount of cash and cash equivalents. This includes actual money and other immediately available resources, or credit instruments generally accepted as media of exchange and considered cash equivalents; for example, coin and paper currency, demand deposits in banks, checks and money orders, bank savings accounts, certificates of deposit, U.S. treasury bills, etc. Also included are temporary investments in stocks and bonds which are readily marketable and which management intends to hold for only a brief period (as defined by hospital auditors).

71. INTER-CORPORATE ACCOUNT(S)

Enter any inter-corporate account(s). Intercorporate investment can occur when a company makes any investment in another company. These types of investments can be accounted for in a few different ways depending on the investment.

72. NET PATIENT AR: MEDICARE (T18) -INCLUDING HMOS REIMBURSED BY T-18 *

Enter net patient accounts receivable (AR) for Medicare (T-18) – Including HMOs reimbursed by T-18.

Example: Medicare Advantage Plans, AARP, Senior Insurance Carriers

73. NET PATIENT AR: MA (T-19)- INCLUDING HMOS REIMBURSED BY T-19 *

Enter net patient accounts receivable (AR) for Medicaid (T-19) – Including HMOs reimbursed by T-19.

Example: Wisconsin Medicaid

74. NET PATIENT AR: SELF-PAY

Enter net patient accounts receivable (AR) for self-pay patients.

75. NET PATIENT AR: ALL OTHER PAY SOURCES

Enter net patient accounts receivable (AR) for all other pay sources.

76. NET PATIENT AR: TOTAL NET PATIENT ACCOUNTS RECEIVABLE

*Add lines 72 thru 75.

77. OTHER AR

Enter the total of other accounts receivable. These include estimated third-party payer settlements, accounts due from other funds, related-party receivables, employee receivables, etc.

78. OTHER CURRENT ASSETS

Enter all other current assets. These are defined as those assets that will be consumed in the normal operations of the hospital within one year of the balance sheet date. This may include the current portion (i.e., required for current liabilities) of assets whose use is limited, prepaid expenses, supplies inventory, and short-term investments.

79. TOTAL CURRENT ASSETS

*Enter total current assets by adding lines 70, 71, 76, 77, 78.

80. NONCURRENT ASSETS WHOSE USE IS LIMITED

Enter total noncurrent assets whose use is limited. This is defined as the noncurrent portion of general fund assets that are:

♦ Set aside by the governing board for identified purposes (also referred to as board-designated assets).

♦ Proceeds of debt issues and funds of the health care institution deposited with a trustee and limited to use in accordance with the requirements of an indenture or a similar agreement.

♦ Other assets limited to use for identified purposes through an agreement between the health care entity and outside party other than a donor or grantor (includes assets set aside under a self-insurance funding arrangement and assets set aside under agreements with third-party payers to meet depreciation funding requirements).

PROPERTY, PLANT AND EQUIPMENT GROSS PLANT ASSETS

Assets not intended for sale in the normal course of business but held for use over a period of years in the provision of hospital services. Include actual or estimated value of property and equipment that is leased under a capital lease.

GROSS PLANT ASSETS

Lines 81 through 87. Defined as physical properties used for hospital purposes (i.e., land, land improvements, buildings and building improvements, construction in progress, and equipment). The term excludes real estate or properties of restricted or unrestricted funds not used for hospital operations.

81. LAND

Enter the cost or other basis of total land assets. Land includes the earth surface owned by the hospital and used in the ordinary course of hospital operations. Examples include all land used for building sites, yards and grounds, and parking areas, but not land acquired for future expansion and not currently in use.

82. LAND IMPROVEMENTS

Enter the cost or other basis of all land improvements.

83. BUILDINGS AND BUILDING IMPROVEMENTS

Enter the cost or other basis of all buildings and building improvements owned by the hospital and used in its normal day-to-day activities. Examples include hospital buildings, personnel residences, garages and storage houses, and utility structures such as an outlying heating and cooling plant.

84. CONSTRUCTION IN PROGRESS

Enter the cost or other basis of all construction in progress.

85. FIXED EQUIPMENT

Enter the cost or other basis of all fixed equipment. This includes equipment that is affixed to, and constitutes a structural component of, the hospital building, not subject to transfer or removal from its fixed location. Examples include mechanical and electrical systems, elevators, generators, pumps, boilers, and refrigeration machinery.

86. MOVEABLE EQUIPMENT

Enter the cost or other basis of all movable equipment. Moveable equipment can be readily moved from one location to another in the hospital. Examples include equipment costing $500 or more, such as computer systems, beds, automobiles and trucks, operating tables, x-ray apparatus, and other medical equipment.

87. TOTAL GROSS PLANT ASSETS

*Enter total gross plant assets obtained by adding the amounts from lines 81 through 86.

LESS ACCUMULATED DEPRECIATION

This is depreciation accumulated over the years, including the depreciation applicable to the current year. This includes depreciation on land improvements, buildings and building improvements, and equipment. Enter absolute values only – do not use negative numbers.

88. LAND IMPROVEMENTS

Enter the accumulated depreciation on all land improvements.

89. BUILDINGS AND BUILDING IMPROVEMENTS

Enter the accumulated depreciation on all buildings and building improvements.

90. FIXED EQUIPMENT

Enter the accumulated depreciation on all fixed equipment.

91. MOVEABLE EQUIPMENT

Enter the accumulated depreciation on all moveable equipment. See question 86 for definition.

92. TOTAL ACCUMULATED DEPRECIATION

Enter all total accumulated depreciation, by adding the amounts from (Land improvements, Building improvements, Fixed and Moveable equipment).

93. NET PROPERTY, PLANT, AND EQUIPMENT ASSETS

*Enter the net property, plant, and equipment assets, by subtracting line 92 (total accumulated appreciation) from line 87 (gross plant assets). If net plant and equipment assets equal zero, explain on an attached sheet.

94. LONG-TERM INVESTMENTS

Enter the amount of all long-term investments. These long-term investments are generally reported at the lower of cost or market value. Examples include government bonds, corporate bonds, and corporate stocks, either preferred or common; or land acquired for future expansion that is not currently in use.

95. OTHER UNRESTRICTED ASSETS

Enter the amount of all other unrestricted assets. These may include deferred financing costs, unamortized bond issue costs, investment in affiliated company partnership, deferred third-party reimbursement, deferred pension expense, deferred pension assets and long-term receivables. Should include transfers or amounts due from restricted funds. Examples include transfers from specific purpose funds, endowment funds, or Plant Replacement and Expansion Fund(s) for Plant Asset Acquisitions.

96. TOTAL UNRESTRICTED ASSETS

*The system will total all unrestricted assets by adding the amounts from lines 79, 80, 93, 94, 95 (total current assets), (total noncurrent assets), (net property, plant, and equipment assets), (long-term investments), and (all other unrestricted assets).

UNRESTRICTED LIABILITIES, DEFERRED REVENUES, AND FUND BALANCES

97. CURRENT LIABILITIES

Enter the amount of all current liabilities. These are defined as those obligations that mature and normally will be paid within approximately one year from the balance sheet date. Examples include notes payable, accounts payable, accrued expenses, current portion of long-term debt, loans against a line of credit, estimated third-party settlements, advances from third-party payers, accounts due to donor restricted funds, accrued interest payable, unexpended grants/gifts income, accrued payroll, and related liabilities. Enter liabilities from inter-corporate accounts on line 101.

98. INTER-CORPORATE ACCOUNT(S)

Enter all inter-corporate accounts.

99. LONG-TERM DEBT

Enter all long-term debt. This includes only debts for which the hospital has responsibility for repayment. May include revenue and other bonds, mortgages payable, notes payable, and loan contracts payable. Examples include long-term notes, mortgages, and bonds payable that are not due within one year of the balance sheet date.

100. OTHER NONCURRENT LIABILITIES AND DEFERRED REVENUES

Enter all other noncurrent liabilities and deferred revenues. These may include estimated malpractice/self-insurance costs, deferred compensation amounts payable, deferred third-party reimbursements, accrued pensions, and deferred pension liabilities.

101. FUND BALANCES

Enter all fund balances. This is the excess of assets over liabilities (net equity). An excess of liabilities is reflected as a deficit. Restricted Funds from Lines 106-108 should also be included in this line.

102. TOTAL UNRESTRICTED LIABILITIES, DEFERRED REVENUES, AND FUND BALANCES

*Enter the total unrestricted liabilities, deferred revenues, and fund balances by adding lines 97 through 101. Lines 96 (TOTAL unrestricted assets) and 102 (TOTAL unrestricted liabilities, deferred revenues, and fund balances) should be equal.

RESTRICTED HOSPITAL FUNDS

Report dollar amounts for each fund balance only (assets minus liabilities).

103. SPECIFIC PURPOSE FUNDS

Enter the amount of all specific-purpose funds. These are resources restricted by donors for purposes other than plant asset acquisitions or endowments. Examples include funds for specific purposes such as charity service, research activities, working capital, or educational programs conducted by the hospital. DO NOT include "board-restricted" or "board-designated funds." If a board wishes to earmark certain assets for a particular purpose, they should be described as "board designated assets" rather than "board-restricted assets." Board-designated assets are unrestricted assets and must be reported as a part of the hospital's unrestricted fund.

104. PLANT REPLACEMENT AND EXPANSION FUNDS

Enter all plant replacement and expansion funds. This includes cash and other assets received by the hospital from donors and other external authorities who restrict the use of those resources to the acquisition of plant assets. Examples include cash and pledges from donors to contribute to future purchases of plant assets.

105. ENDOWMENT FUNDS

Enter all endowment funds. These are contributed resources that, by donor restriction, are not to be expended but are to be held intact to produce income.

IV. HOSPITAL INPATIENT UTILIZATION BY PAY SOURCE

PAY SOURCE

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

** Exclude fetal deaths.

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

The following lines and columns refer to hospital inpatient utilization and are divided into four shaded collection blocks, one for acute-care patients (inpatients), one for discharge days, one for newborns, and one for Newborn Discharge Days.

The next set of questions are divided into 2 columns: number of discharges from Medicare-certified swing-bed patients and number of discharge days. Refer to the notes indicated by asterisks.

PAY SOURCE CATEGORIES

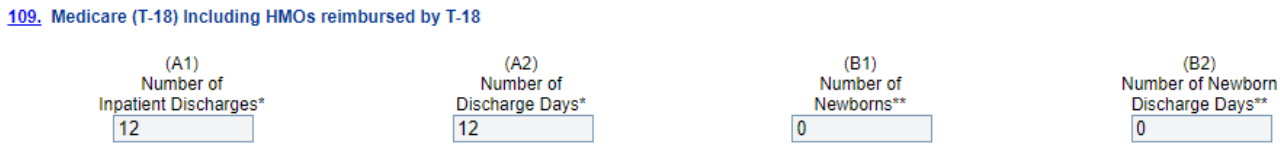
Utilization data for the shaded blocks—discharges (columns A1, B1, and C1) and days (columns A2, B2, and C2)—should be entered for expected primary payers using the following groupings:

- Medicare (include HMOs reimbursed by Medicare).
- Medical Assistance (include HMOs reimbursed by Medical Assistance).
- Self-Pay
- All Other Pay Sources. This includes:
    - Commercial sources (group and individual accident and health insurance, self-funded plans; HMOs and all other alternative health care payment systems; and workers' compensation).
    - All other public programs (county general relief; county programs under ss. 51.42, 51.437, 46.23, Wis. Stats.; and any other public program); and
    - Other nonpublic sources.

For more detailed descriptions of these pay sources, refer to Section III of this manual.

106. MEDICARE (T-18) INCLUDING HMOS REIMBURSED BY T-18.

Utilization data - Medicare:



107. MEDICAL ASSISTANCE (T-19) INCLUDING HMOS REIMBURSED BY T-19.

Utilization data - Medical Assistance:

108. SELF-PAY

Utilization data - Self-Pay:

109. ALL OTHER PAY SOURCES

Utilization data - for all other pay sources:

110. TOTALS

Totals will be calculated for the user in the online survey tool.

In column C1, enter the discharges from Medicare-certified swing beds. Include both skilled and intermediate care swing beds. In column C2, enter the corresponding number of discharge days from Medicare-certified swing beds.

111. MEDICARE (T-18) INCLUDING HMOS REIMBURSED BY T-18.

Provide the number of discharges from Medicare Certified Swing Beds and the number of Discharge DAYS from Medicare Certified Swing Beds.

112. MEDICAL ASSISTANCE (T-19) INCLUDING HMOS REIMBURSED BY T-19.

Provide the number of discharges from Medicare Certified Swing Beds and the number of Discharge DAYS from Medicare Certified Swing Beds.

113. SELF-PAY

Provide the number of discharges from Medicare Certified Swing Beds and the number of Discharge DAYS from Medicare Certified Swing Beds.

114. ALL OTHER PAY SOURCES

Provide the number of discharges from Medicare Certified Swing Beds and the number of Discharge DAYS from Medicare Certified Swing Beds.

115. TOTALS

The online tool will calculate the totals.

V. SUMMARY AND EXPLANATION OF REVENUE DOLLAR DIFFERENCES

This section refers to a summary and explanation of total gross and net revenue dollar differences between designated hospital fiscal years.

116. CURRENT SURVEY YEAR

Enter the total gross and net revenue from service to patients for ***current*** survey year. Use the figures reported on **line 36 (gross) and line 3 (net)** of this survey.

117. PREVIOUS SURVEY YEAR

Enter the total gross and net revenue from service to patients for ***previous*** survey year. Use the figures reported on **line 36 (gross) and line 3 (net)** of the CURRENT SURVEY YEAR Hospital Fiscal Survey.

118. INCREASE/DECREASE CURRENT SURVEY YEAR VS. PREVIOUS SURVEY YEAR

*Enter the dollar differences between the designated revenue figures, by subtracting line 117 (previous Survey Year) from line 116 (current Survey Year). Indicate whether these dollar differences are positive or (negative) numbers.

119. NARRATIVE DIFFERENCE BETWEEN LINES 116 (CURRENT YEAR) AND 117 (PREVIOUS YEAR)

*Enter in the space provided a short narrative explaining what caused the dollar differences between lines 116 (Current Year) and 117 (Previous Year). You may use percentages to break down the differences by price changes, utilization changes, and other causes. Be as specific as possible. Attach additional pages if needed.

VI. UNCOMPENSATED HEALTH CARE

CHARGES FOR UNCOMPENSATED HEALTH CARE

The section below 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 website.

In the first column, enter the actual amounts for CURRENT SURVEY YEAR. In the second column, list projections for the UPCOMING SURVEY YEAR. Hospitals may use their own methods for determining CURRENT SURVEY YEAR projections. A rationale for these projections must be provided.

120. CHARGES FOR CHARITY CARE PROVIDED FOR THE FISCAL YEAR

Enter the amount of charges for charity care provided in CURRENT SURVEY YEAR. For the purposes of this survey, charity care is measured based on revenue foregone, at fully established rates.

*WHAIC will populate the total from line 63. Enter in column 2 the projected charges for charity care for UPCOMING SURVEY YEAR.

121. CHARITY CARE COST (USING HOSPITAL COST TO CHARGE RATIO)

In the first column, enter the charity care cost, using hospital cost to charge ratio, determined in CURRENT SURVEY YEAR. Enter in column 2 the projected charity care cost projected for UPCOMING SURVEY YEAR. Cost-to-Charge Ratio – (Total Expenses divided by Total Gross Patient Revenue Plus Other Operating Revenue).

* Multiply the CCR by the charges on line 120 to get your charity care cost.

122. CHARGES DETERMINED TO BE A BAD DEBT FOR THE FISCAL YEAR

Enter the amount of charges determined to be bad debt in CURRENT SURVEY YEAR as reported on the final audited financial statements. Enter in column 2 the projected charges for bad debt for UPCOMING SURVEY YEAR.

123. BAD DEBT COST (USING HOSPITAL COST TO CHARGE RATIO)

In the first column, enter the bad debt cost using hospital cost to charge ratio determined to be bad debt in CURRENT SURVEY YEAR. Enter in column 2 the projected bad debt cost for UPCOMING SURVEY YEAR. Cost-to-Charge Ratio- (Total Expenses divided by Total Gross Patient Revenue plus Other Operating Revenue).

* Multiply the CCR by the charges on line 122 to get your charity care cost.

124. TOTAL CHARGES FOR UNCOMPENSATED HEALTH CARE FOR THE FISCAL YEAR

*Add lines 120 and 122 for the total charges for uncompensated health care for CURRENT SURVEY YEAR and projected charges for UPCOMING SURVEY YEAR.

125. TOTAL COST (USING HOSPITAL COST TO CHARGE RATIO)

In the first column enter the total cost for uncompensated cost for CURRENT SURVEY YEAR. Enter in column 2 the projected total uncompensated cost for UPCOMING SURVEY YEAR.

126. HOSPITAL COST-TO-CHARGE RATIO

*Provide the hospital cost-to-charge ratio used for calculating lines 121, 123, and 125 (e.g., .458).

NOTE: Cost-to-Charge Ratio - Total Expenses Divided by (Total Gross Patient Revenue + Other Operating Revenue)

NUMBER OF "PATIENTS" RECEIVING UNCOMPENSATED HEALTH CARE

127. NUMBER OF INDIVIDUAL PATIENT VISIT LEDGERS THAT RECEIVED CHARITY CARE FOR THE FISCAL YEAR

Enter the number of individual patient visit ledgers that received charity care in CURRENT SURVEY YEAR and the number of projected ledgers that are expected to receive charity care in CURRENT SURVEY YEAR.

Although there are exceptions, one "patient visit ledger" could apply to each of the following:

♦ An entire inpatient stay.

♦ All services rendered to an outpatient on a calendar day.

♦ An ambulance run pertaining to the transfer of a Medicare inpatient to another facility, or the transport of a Medicare patient to this facility for urgent, emergent, or inpatient service.

♦ Monthly durable medical equipment rentals; or

♦ An entire swing-bed stay.

The hospital should create a new ledger for each individual patient registration/visit. It should include all patient charges pertaining to that visit. Do not record figures for a separate ledger for each patient or for family ledgers.

128. NUMBER OF PATIENT VISIT LEDGERS DETERMINED TO BE BAD DEBT FOR THE FY

In the first column, enter the number of **individual** patients visit ledgers whose charges were determined to be bad debt expense in CURRENT SURVEY YEAR. In the second column, enter the number of projected ledgers

expected to be a bad debt expense in UPCOMING SURVEY YEAR. Be prepared to provide a rationale for these projections.

129. PROVIDE A RATIONALE FOR THE HOSPITAL'S UPCOMING SURVEY YEAR PROJECTIONS

Explain how the projections used "patients" and TOTAL charges for UPCOMING SURVEY YEAR, if at all. Provide a rationale for the hospital's current survey year projections. This may be based upon past fiscal information and projected growth. It could also include a description of the socioeconomic climate of the hospital's market area and how that affects the hospital's uncompensated health care plan.

VII. WISCONSIN MEDICAID PROGRAM

Hospital Data Only. See Hospital Survey FAQ General Question Section #3 for more information.

ASSESSMENT PROGRAM

Medical Assistance (MA), also known as Medicaid, pays for health care services for eligible individuals. 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.

130. MEDICAID ASSESSMENTS PAID TO STATE OF WISCONSIN

Enter the total assessments paid to the State of Wisconsin for the current survey year. This data element 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 website.

PAY SOURCE

131. ENHANCED MEDICAID FEE-FOR-SERVICE PAYMENTS (ESTIMATES)

Enter inpatient, outpatient, and total Medicaid Assistance fee-for-service payments for the current survey year.

132. ACTUAL ACCESS PAYMENTS RECEIVED THROUGH HMOS REIMBURSED BY MEDICAID

Actual access payments received through HMOs reimbursed by Medical Assistance under Ch. 49, Wis. Stats. Enter inpatient, outpatient, and total Medicaid, HMO payments for the current survey year.

133. TOTAL MEDICAID REIMBURSEMENT ENHANCEMENTS

*Total MA reimbursement enhancements. Add lines 131 and 132 for inpatient, outpatient, and total. Provide values in line 133.

VIII. APPENDIX – DEFINITIONS & INFORMATION FOR COMBINATION FACILITIES

Name	Definition
Balance Sheet	Means a statement of financial position showing the hospital's assets, liabilities, and fund balances on a given date.
Behavioral Health / Mental Health Facility	State-operated and county-owned facilities must submit revenue and expense data but are not required to provide balance sheets. Mental health facilities must submit data as requested for the fiscal year from the audited or unaudited financial statements. If the audit report is not yet available, the mental health facility may provide unaudited financial statements for the specified fiscal year. If audited statements are unavailable, unaudited statements or data from Medicare Cost reports or internal records may be used.
Combination Facility	A hospital that is jointly operated in connection with a nursing home, a home health agency, or other organization, and is governed by a common Board of Directors. A hospital is not considered to be a "Combination Facility" if the hospital operates a home health agency or other organization as a department within the hospital. For further instructions and examples see below.
Fund	Means a self-contained accounting entity set up to account for a specific activity or project.
Fund Balance	Means the excess of assets over liabilities (net equity). An excess of liabilities over assets is reflected as a deficit.
HMO	Means a health care plan that makes available to its participants, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers selected by the organization.
Licensed practical nurses	Nurses who have graduated from an approved school of practical (vocational) nurses who work under the supervision of registered nurses or physicians.
Other alternative health care payment system	Means a negotiated health plan other than an HMO or an indemnity health care plan. Examples of other alternative payment systems: preferred provider organization (PPO), preferred provider arrangement (PPA), preferred provider plan (PPP), limited-service health organization (LSHO).
Registered nurses	Nurses who have graduated from an approved school of nursing and who are currently state registered. They are responsible for the nature and quality of all nursing care that patients receive.
Salaries	Means all compensation for services performed by an employee including vacation pay, holiday pay, sick pay, and other non-work compensation. It excludes providers who are operated by or related to religious orders.

More Information on Combination Facility:

Hospital and Nursing Home:

♦ When a nursing home is part of the hospital, information about the nursing home must not be included in Section I (Revenue and Expenses) and Section II (Patient Service Revenue and Deductions). For Section III (Balance Sheet), see "Special Instructions for the Balance Sheet" below.

Hospital and Clinics:

♦ If a hospital considers a clinic as one of its departments and manages it as such, then the clinic information is included with the hospital information. This includes onsite and PBL locations. The key consideration: Is the clinic, as a hospital department, controlled by the hospital Board of Directors? In this situation, a hospital reports the data for both entities together in the fiscal survey.

♦ If the clinic is incorporated as a separate entity, then do not include the clinic information with the hospital.

- Section I (Revenue and Expenses) and Section II (Patient Service Revenue and Deductions) should be reported for the hospital unit only.
- For Section III, see "Special Instructions for the Balance Sheet" below.
- If a hospital is jointly operated in connection with a nursing home, a HHA, or other organization, the hospital shall submit the data specified for revenue and expenses for the hospital unit only.
- The hospital shall also submit the data specified for unrestricted assets and unrestricted liabilities and fund balances (balance sheet data) for the hospital unit only.

Follow the steps below to fill out SECTION III - BALANCE SHEET.

Step 1:

If a hospital meets the definition of a combination facility, the hospital should use the balance sheet data from the hospital's final audited financial statements for the hospital unit alone. If that information is not available, the hospital shall use data from its most recent Medicare Cost Report to derive the required data for the hospital unit for the following lines (the following table provides additional reference material in the manual.

Net Patient Accounts Receivable	Property, Plant and Equipment	Long-term Debt

If the information for these lines is combined on both the hospital financial statement and on the Medicare Cost Report, the hospital shall report these data based upon the total facility.

Step 2:

If the assets and funds on the following lines relate directly to the hospital unit, a hospital shall report these data for the hospital unit only; otherwise, a hospital shall report data based on the total facility for the following lines.

95. Other Unrestricted Assets	103. Specific Purpose Funds	

Step 3:

If hospital unit data cannot be separated from total facility data for the following categories, then a hospital shall report data based on the total facility for the following lines:

70. Cash and Cash Equivalents	71. Inter-Corporate Accounts	78. Other Current Assets
94. Long-term Investments	97. Current Liabilities	98. Inter-corporate Accounts
100. Other Noncurrent Liabilities and Deferred revenues	101. Fund Balances	104. Plant Replacement and Expansion Funds
105. Endowment Funds		

Note: Lines 96 and 102 should be equal. However, Combination Facility totals may not balance due to the mixture of hospital-specific and total facility data.

CHANGE MANAGEMENT

Change Number	Date	Author	Update
1	10/29/21	SS	Question 41, 50, and 56 marked as obsolete because they referenced GAMP.
2	11/04/22	HS	Manual was reviewed, all references to current year removed. The Fiscal Template was updated to better reflect the current manual.
3	5/17/24	HS	Manual was reviewed and screen shots were updated with new Fiscal survey.
4	11/2024	CC/HS	Updated Manual removed obsolete questions and renumbered. Removed Hill Burton Section as it's no longer funded and the last hospital to use it is closed.