WHA | INFORMATION CENTER

Fiscal Survey Manual

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FISCAL SURVEY
INSTRUCTIONS AND DEFINITIONS

The 'Fiscal Survey Manual' includes instructions, definitions, and what to expect while completing the Fiscal online survey application. WHAIC collects and distributes survey data in multiple online publications that can be found under the Data Products Tab at http://www.whainfocenter.com/.

Hospitals are required to annually submit their revenue, expense, and balance sheet data to the WHA Information Center under Wisconsin statute. For more information on the deadlines for the current year see the Survey Submission Calendar.

TYPE OF FINANCIAL DATA

Financial data are submitted in the form of the Hospital Fiscal Survey. Each hospital should complete the survey using data from its final audited financial statements. If these data do not appear on the audited financial statements, the hospital should gather the data from Medicare Cost Reports, notes to the financial statements or other internal hospital financial records. So that the data collected are complete and accurate, hospitals must submit data for every item. If an item is not applicable, enter "0" for that item. "Not available" or "missing" is not acceptable. Round all amounts to the nearest dollar.

The fiscal survey form must be submitted to the WHA Information Center within 120 calendar days following the close of the hospital's previous reporting fiscal year. Hospitals that merge, close, or change their reporting fiscal year still need to submit 12-months of data. A hospital may request an extension for up to 30 calendar days.

The WHA Information Center Fiscal Survey is to be completed with hospital data only. Hospitals who are part of, or affiliated with a system, must submit separate surveys for each hospital. Chapter 153 of the Wisconsin Statutes directs what information must be submitted to WHAIC.

Hospitals are required to submit 12-months of data. Hospitals that merge or become part of a system, close, or change their fiscal year during the reporting year should reference Question 2 of the General Section in the Frequently Asked Questions for instructions on how to submit data.

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I. INTRODUCTION

BEHAVIORAL HEALTH FACILITIES

State behavioral health facilities operated by the Department of Health and Family Services and county-owned psychiatric or alcohol or other drug abuse hospitals are not required to submit balance sheet data to the WHA Information Center but must submit their revenue and expense data. If the hospital is reporting as a "Combination Facility," refer to the definitions and instructions in the Appendix of this manual.

GOVERNMENT-OWNED HEALTHCARE FACILITIES & PARENT OR HOLDING COMPANIES

This instruction manual provides information about completing the Hospital Fiscal Survey for the current survey year. All financial data questions are based on the AICPA audit and accounting guidelines; for example, those found in "AICPA Audit and Accounting Guide: Health Care Organizations." This guide applies to organizations

(including hospitals) whose principal operations consist of providing or agreeing to provide health care services. It also applies to organizations whose primary activities are the planning, organization, and oversight of such organizations, such as parent or holding companies of health care providers. Government-owned health care facilities that use enterprise fund accounting should also use these guidelines.

COMPLIANCE

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

ELECTRONIC SUBMISSION

The fiscal survey must be completed using the online survey application. Electronic survey submission requires a username and password to access the survey submission web site. For assistance, contact WHA Information Center.

In addition to this survey instruction manual, users may view the survey questions in advance of completing the online tool by:

- Logging into the Secured Portal and printing off or downloading the entire survey or specific sections to pass along to the appropriate staff.
- Encouraging multiple staff to register to the secured portal to complete specific sections online. There is no limit to the number of people that can register.

RESOURCE PERSON

If you have any questions about completing this form, contact the WHAIC at whainfocenter@wha.org.

CHANGES IN HOSPITAL INFORMATION

A hospital is required to report certain changes (as defined below) to the WHA Information Center within 45 days after the event occurs. Changes that must be reported include the opening or closing of a hospital; the merger of two or more hospitals; and a change in the hospital's name, address, fiscal year, or chief executive (or administrative) officer. An email stating the changes should be sent to the WHA Information Center at whainfocenter@wha.org.

For more information about additional surveys required, newsletters, and training materials, visit the WHA Survey website.

II. GENERAL INFORMATION

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 username and password. Click here for more information on roles and registration.

Any changes to hospital information such as access changes; the opening or closing of a hospital; the merger of two or more hospitals; and a change in the hospital's name, address, fiscal year, or CEO should be communicated with WHAIC by emailing whainfocenter@wha.org.

NEW: Subtotal and TOTAL fields will calculate for you. Please review those TOTALs to be certain the numbers are accurate.

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

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

This document follows the outline of the online survey in the WHAIC Portal. Each question corresponds to the questions online.

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 those that are used to account for resources not restricted for identified purposes by donors and grantors. General funds account for all resources and obligations not recorded in donor-restricted funds, including 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 providers of health care services. Revenue, expenses, gains, and losses arising from those activities are classified as "operating." Gains and losses from transactions that are peripheral or incidental to the provision of health care services and from other events stemming from the environment that may be 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 to one hospital and gain to another.

Therefore, classify and report revenue, expenses, gains, and losses on the appropriate survey line in a manner consistent with the hospital's financial statements that have been prepared following generally accepted accounting principles. However, since no separate lines have been provided for operating gains and losses, include these in "all other operating revenue" (line 5) and in "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 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 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.

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 contacts the hospital to inquire about survey data posted online in one of the public publications, who would the media speak to?

2. IS YOUR FACILITY A COMBINATION FACILITY?

This is a yes or no question.

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. 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. If entering "Yes," refer to the Appendix for reporting information.

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

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.

"**Salaries**" includes all remuneration for services performed by an employee for the employer (hospital), payable in cash; and the fair market value of unpaid workers, who work more than 20 hours per week in various full-time positions that are normally occupied by paid personnel. It excludes providers who are operated by or related to religious orders. Vacation pay, holiday pay, sick pay, and other non-work compensation should be included.

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 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.

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. Please also enter the number of FTEs of said physicians and dentists.

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

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 and licensed practical nurses.

“Registered nurses” are 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.

“Licensed practical nurses” are nurses who have graduated from an approved school of practical (vocational) nursing who work under the supervision of registered nurses or physicians.

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 expense for professional fees. Include fees billed to hospitals by radiologists, pathologists, anesthesiologists, cardiologists, emergency room physicians, and other contracted and non-contracted medical personnel such as registered physical therapists, nurse anesthetists, and consultants. Also include fees for legal, auditing, and non-medical consulting.

Do not include 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 was 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.

Enter depreciation expense. 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 expense 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

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.

Examples include Mortgage and Utilities.

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).

III. DETAIL OF PATIENT SERVICE REVENUE

GROSS PATIENT SERVICE REVENUE AND ITS SOURCES

Lines 33 through 51 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, AND MEDICAL AND NURSING SERVICES TO INPATIENTS.

Enter the gross revenue generated from daily room, board, and medical and nursing services to inpatients based on full 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 37-49.

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.

*This line should equal line 51, total gross revenue from service to patients.

SOURCES OF GROSS PATIENT REVENUE

Lines 37 through 51 (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 separated by inpatient and outpatient dollar amounts on the lines indicated.

For example, this section requires total values for inpatient and outpatient.

37. Medicare

	Total	Inpatient	Outpatient
	$ 35,315,109	$ 8,247,746	$ 27,067,363

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, 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

37. MEDICARE

Enter the total gross patient revenue billed to Medicare. Exclude HMOs reimbursed by Medicare (e.g., Medicare Advantage Plans). Medicare is also known as MCR, MED, Title 18, Title XVIII, or T-18.

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

Enter the total gross patient revenue billed to 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.

https://docs.legis.wisconsin.gov/statutes/statutes/49/iv/45

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

41. OBSOLETE

42. 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

43. 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 44 through 46. Include all **non-governmental** sources of revenue.

44. 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.

45. 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.

46. 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:

“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.

“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).

Separate the sum of lines 45 through 47 into INPATIENT and OUTPATIENT dollar amounts and enter on the lines indicated in parentheses.

47. SELF-PAY

Enter the total gross patient revenue billed directly to the patient for self-payment. This category generally applies to persons 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 48 and 49 into INPATIENT and OUTPATIENT dollar amounts.

48. OTHER PAYERS 1

Examples include Direct contracts, Business Health, and Company Accounts

Specify Source:	Total	Inpatient	Outpatient
n/a	$ 0	$ 0	$ 0

49. OTHER PAYERS 2

Examples include Capitation/Risk, Military, and Hospice

Specify Source:	Total	Inpatient	Outpatient
Company Accounts	$ 447,375	$ 0	$ 447,375

50. OBSOLETE

51. 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 52 through 69 (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 52 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 (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 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

52. 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.

53. 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.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c01.pdf

54. 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.

55. 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 on lines 52 through 55 into INPATIENT and OUTPATIENT dollar amounts and enter on the corresponding lines.

56. OBSOLETE

57. 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.

58. 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 sum of lines 56 through 58 into INPATIENT and OUTPATIENT dollar amounts and enter on the lines indicated in parentheses.

COMMERCIAL SOURCE CONTRACTUAL ADJUSTMENTS

59. 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.

60. 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.

61. 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 53 and 55** - revenue from HMOs reimbursed by Medical Assistance.

These are defined as follows:

"HMO" is 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.

"Other alternative health care payment system" is 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).

62. SELF-PAY

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

Separate the sum of lines 59 through 62 into INPATIENT and OUTPATIENT dollar amounts and enter on the lines indicated in parentheses.

OTHER SOURCE CONTRACTUAL ADJUSTMENTS/CHARITY CARE/BAD DEBT

Other Source Contractual Adjustments

Enter on lines 63 through 65 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 sum of lines 63 through 65 into INPATIENT and OUTPATIENT dollar amounts and enter on the lines indicated in parentheses.

63. OTHER ADJUSTMENTS 1

Examples: Direct Contract and Public Health

Specify Source:	Total	Inpatient	Outpatient
n/a	$ 0	$ 0	$ 0

64. OTHER ADJUSTMENTS 2

Examples: Military and Capitation/Risk

Specify Source:	Total	Inpatient	Outpatient
n/a	$ 0	$ 0	$ 0

65. OTHER ADJUSTMENTS 3

Specify Source:	Total	Inpatient	Outpatient
n/a	$ 0	$ 0	$ 0

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 purposes of this survey, charity care is measured based on revenue foregone, at full established rates. Include Hill-Burton figures. The total dollar amount on line 66 (charity care) should equal the dollar amount on line 123 (charity care provided for the fiscal year).

66. CHARITY CARE

Enter the amount of "charity care" as defined above.

Revenue foregone at full established rates. Must equal line 123 (charges for charity care provided for the fiscal year).

Total	Inpatient	Outpatient	If Total Charity Care is a negative dollar amount, enter a brief explanation:
$ 1,221,881	$ 230,841	$ 991,040	

67. 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 67 (bad debt) should equal the dollar amount on line 125 (bad debt for the fiscal year).

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

Total	Inpatient	Outpatient	If Total Bad Debt is a negative dollar amount, enter a brief explanation:
$ 2,301,601	$ 374,283	$ 1,927,318	

68. 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.

69. TOTAL DEDUCTIONS FROM REVENUE

Enter total deductions from revenue. Add totals, not breakouts, for lines 52 through 68. Add lines 52-68. TOTAL, not breakouts.

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:

70. DIRECT MEDICAL EDUCATION EXPENSES

Enter the direct medical education expenses that have been included in “TOTAL expenses” on line 26. **“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.

71. 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.

72. TOTAL REIMBURSABLE EXPENSES FOR MEDICARE APPROVED MEDICAL EDUCATION ACTIVITIES

Add lines 70 and 71 for the total Medicare-approved medical education expenses.

IV. 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 V, HOSPITAL INPATIENT UTILIZATION BY PAY SOURCE."

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

DEFINITIONS

"Balance Sheet" means a statement of financial position showing the hospital's assets, liabilities, and fund balances on a given date.

"Combination Facility" means a hospital jointly operated in connection with a nursing home, home health agency or other organization, and governed by a common Board of Directors. A facility 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. Also see the Appendix at the end of this manual for additional instructions.

"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.

UNRESTRICTED ASSETS

Enter on lines 73 through 99 - 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 on line 74. 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

73. 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).

74. 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.

75. 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

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

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

Example: Wisconsin Medical Assistance (Medicaid)

77. NET PATIENT AR: SELF-PAY

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

78. NET PATIENT AR: ALL OTHER PAY SOURCES

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

79. NET PATIENT AR: TOTAL NET PATIENT ACCOUNTS RECEIVABLE

Add lines 75 thru 78.

80. 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.

81. 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.

82. TOTAL CURRENT ASSETS

Enter total current assets by adding lines 73 through 81.

83. 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 84 through 90. 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.

84. 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.

85. LAND IMPROVEMENTS

Enter the cost or other basis of all land improvements.

86. 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.

87. CONSTRUCTION IN PROGRESS

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

88. 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.

89. MOVEABLE EQUIPMENT

Enter the cost or other basis of all moveable 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.

90. TOTAL GROSS PLANT ASSETS

Enter total gross plant assets obtained by adding the amounts from lines 84 through 89.

LESS ACCUMULATED DEPRECIATION

Lines 91 through 95. 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.

91. LAND IMPROVEMENTS

Enter the accumulated depreciation on all land improvements.

92. BUILDINGS AND BUILDING IMPROVEMENTS

Enter the accumulated depreciation on all buildings and building improvements.

93. FIXED EQUIPMENT

Enter the accumulated depreciation on all fixed equipment.

94. MOVEABLE EQUIPMENT

Enter the accumulated depreciation on all moveable equipment. Reference question 89 above for definition of moveable equipment.

95. TOTAL ACCUMULATED DEPRECIATION

Enter all total accumulated depreciation, by adding the amounts from lines 91 through 94.

96. NET PROPERTY, PLANT, AND EQUIPMENT ASSETS

Enter the net property, plant, and equipment assets, by subtracting line 95 (total accumulated appreciation) from line 90 (gross plant assets). If net plant and equipment assets equal zero, explain on an attached sheet.

97. 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.

98. 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.

99. TOTAL UNRESTRICTED ASSETS

Enter the total of all unrestricted assets by obtained by adding the amounts from lines 82 (total current assets), 83 (total noncurrent assets), 96 (net property, plant, and equipment assets), 97 (long-term investments), and 98 (all other unrestricted assets).

UNRESTRICTED LIABILITIES, DEFERRED REVENUES, AND FUND BALANCES

100. 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.

101. INTER-CORPORATE ACCOUNT(S)

Enter all inter-corporate accounts.

102. 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.

103. 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.

104. 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.

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

Enter the total unrestricted liabilities, deferred revenues, and fund balances by adding lines 100 through 104. Lines 99 (TOTAL unrestricted assets) and 105 (TOTAL unrestricted liabilities, deferred revenues, and fund balances) should be equal.

RESTRICTED HOSPITAL FUNDS

Lines 106 through 108. Report dollar amounts for each fund balance only (assets minus liabilities).

106. 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.

107. 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.

108. 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.

V. HOSPITAL INPATIENT UTILIZATION BY PAY SOURCE

PAY SOURCE

The following lines and columns refer to hospital inpatient utilization. Lines 109 - 112 are divided into four shaded 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, lines 114 – 117 are divided are divided into 2 columns number of discharge Medicare-certified swing-bed patients and number of discharge days. The first column of each block counts of discharges; the second column is for the number of discharge days. Refer to the notes indicated by asterisks.

PAY SOURCE CATEGORIES (LINES 109-112, 114-117)

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:
  - 1. Commercial sources (group and individual accident and health insurance, self-funded plans; HMOs and all other alternative health care payment systems; and workers' compensation).
  - 2. 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
  - 3. Other nonpublic sources.

109. Medicare (T-18) Including HMOs reimbursed by T-18

(A1) Number of Inpatient Discharges*	(A2) Number of Discharge Days*	(B1) Number of Newborns**	(B2) Number of Newborn Discharge Days**
624	2,632	0	0

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

LINE-BY-LINE INSTRUCTIONS, LINES 109 THROUGH 118

For lines 109 through 112and 114 through 117 (below), enter the information for each pay category:

Lines 109-112

In column A1, enter the total number of acute-care patients (inpatients) who were discharged during the fiscal year. Discharges include adult, pediatric, intensive, and intermediate care, and neonatal patients (including deaths). Exclude newborn, Medicare-certified swing bed, and hospital unit transfer patients. In column A2, enter the corresponding number of discharge days. If discharge days are not available, use inpatient days. Enter an "I" next to the figure if inpatient days are used.

In column B1, enter the total number of newborns. Exclude fetal deaths. In column B2, enter the corresponding number of newborn discharge days.

Line 113
Enter totals of lines 109 – 112.

Lines 114-117

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. Line 118 Enter totals of lines 114 – 117.

LINES 109-113

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

Example of fields for Medicare:

109. Medicare (T-18) Including HMOs reimbursed by T-18

(A1) Number of Inpatient Discharges*	(A2) Number of Discharge Days*	(B1) Number of Newborns**	(B2) Number of Newborn Discharge Days**
624	2,632	0	0

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

Example of fields for Medical Assistance:

110. Medical Assistance (T-19) Including HMOs reimbursed by T-19

(A1) Number of Inpatient Discharges*	(A2) Number of Discharge Days*	(B1) Number of Newborns**	(B2) Number of Newborn Discharge Days**
211	932	48	95

111. SELF-PAY

Example of fields for Self-Pay:

111. Self-Pay

(A1) Number of Inpatient Discharges*	(A2) Number of Discharge Days*	(B1) Number of Newborns**	(B2) Number of Newborn Discharge Days**
40	165	6	9

112. ALL OTHER PAY SOURCES

Example of fields for all other pay sources:

112. All other pay sources

(A1) Number of Inpatient Discharges*	(A2) Number of Discharge Days*	(B1) Number of Newborns**	(B2) Number of Newborn Discharge Days**
263	945	39	74

113. TOTALS

Enter totals of lines 109 – 112.

LINES 114-117

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.

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

(C1) Number of Discharges from Medicare Certified Swing Beds***	(C2) Number of Discharge Days from Medicare Certified Swing Beds***
73	549

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

(C1) Number of Discharges from Medicare Certified Swing Beds***	(C2) Number of Discharge Days from Medicare Certified Swing Beds***
2	15

116. SELF-PAY

(C1) Number of Discharges from Medicare Certified Swing Beds***	(C2) Number of Discharge Days from Medicare Certified Swing Beds***
0	0

117. ALL OTHER PAY SOURCES

(C1) Number of Discharges from Medicare Certified Swing Beds***	(C2) Number of Discharge Days from Medicare Certified Swing Beds***
2	8

118. TOTALS

Enter totals of lines 114 – 117.

(C1) Number of Discharges from Medicare Certified Swing Beds***	(C2) Number of Discharge Days from Medicare Certified Swing Beds***
77	572

VI. SUMMARY AND EXPLANATION OF REVENUE DOLLAR DIFFERENCES

Lines 117 through 120 refer to a summary and explanation of total gross and net revenue dollar differences between designated hospital fiscal years.

119. 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.

120. PREVIOUS SURVEY YEAR

Enter the total gross and net revenue from service to patients for ***previous*** survey year. Use the figures reported on **line 37 (gross) and line 3 (net)** of the CURRENT SURVEY YEAR Hospital Fiscal Survey.

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

Enter the dollar differences between the designated revenue figures, by subtracting line 120 (previous Survey Year) from line 119 (current Survey Year). Indicate whether these dollar differences are positive or (negative) numbers.

122. NARRATIVE DIFFERENCE BETWEEN LINES 119 (CURRENT YEAR) AND 120 (PREVIOUS YEAR).

Enter in the space provided a short narrative explaining what caused the dollar differences between lines 119 (Current Year) and 120 (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.

VII. 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 Web site.

Lines 123-131 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 on line 132.

123. CHARGES FOR CHARITY CARE PROVIDED FOR THE FISCAL YEAR

Enter the amount of charges for charity care provided in CURRENT SURVEY YEAR. For purposes of this survey, charity care is measured based on revenue foregone, at full established rates. Line 123, column 1 must equal line 66. Enter in column 2 the projected charges for charity care for UPCOMING SURVEY YEAR.

123. Charges for charity care provided for the fiscal year

Fiscal Year 2020 (from line 66)	Fiscal Year 2021 (Projected)
$ 1,221,881	$ 800,281

124. 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 123 to get your charity care cost.

125. 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.

126. 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 125 to get your charity care cost.

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

Add lines 123 and 125 for the total charges for uncompensated health care for CURRENT SURVEY YEAR and projected charges for UPCOMING SURVEY YEAR.

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

In the first column enter the total cost for uncompensated cost for CURRENT SURVEY YEAR (add lines 124 and 126). Enter in column 2 the projected total uncompensated cost for UPCOMING SURVEY YEAR.

129. HOSPITAL COST-TO-CHARGE RATIO

Provide the hospital cost-to-charge ratio used for calculating lines 124, 126, and 128 (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

130. 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.

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

In the first column, enter the number of **individual** patient 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. Provide a rationale for these projections on line 132.

132. 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 as reported on lines 123 through 131. 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.

HILL-BURTON UNCOMPENSATED HEALTH CARE INFORMATION

133. DOES THE HOSPITAL HAVE CURRENT OBLIGATIONS UNDER HILL-BURTON?

Enter Yes, No, or C (for conditional).

Check the appropriate box indicating whether the facility has current obligations under Hill-Burton Uncompensated Health Care Program. Those hospitals that believe they have satisfied their obligations but are awaiting the results of a final federal audit may enter "C" for "conditional." Between 1946 and 1974 several Wisconsin hospitals participated in the Hill-Burton program, which provided federal funds to assist in the construction of new or renovation of existing public or nonprofit hospital facilities. In return, the federal government required these hospitals to provide a reasonable amount of care without charge or at reduced rates to those persons who could not afford health care.

134. IF YES IS ENTERED ON LINE 133 – SEE BELOW.

If "yes" is entered on line 133 enter date(s) the obligation(s) went into effect and the date(s) the obligation(s) will be satisfied.

135. IF YES, ENTER THE AMOUNT OF TOTAL FEDERAL ASSISTANCE BELIEVED TO REMAIN UNDER OBLIGATION.

If "yes" is entered on line 133, enter the outstanding amount of the obligation believed to be remaining or the most recent figure from the federal government. For multiple entries on line 134, the amount on line 135 should be the combined total of outstanding obligations. If certain items are disallowed under federal audit, this figure may increase in current survey year.

VIII. WISCONSIN HOSPITAL MEDICAL ASSISTANCE (MA) - MEDICAID ASSESSMENT 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.

136. MEDICAID ASSESSMENTS PAID TO STATE OF WISCONSIN

Enter the total assessments paid to 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 web site.

PAY SOURCE

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

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

138. 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.

139. TOTAL MEDICAID REIMBURSEMENT ENHANCEMENTS

Total MA reimbursement enhancements. Add lines 137 and 138 for inpatient, outpatient, and total. Provide values in line 139.

IX. APPENDIX – INFORMATION FOR COMBINATION FACILITIES DEFINITION

"Combination Facility" is 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.

Examples:

Hospital and Nursing Home:

♦ When a nursing home is part of the hospital, information about the nursing home must not be included in Section II (Revenue and Expenses) and Section III (Patient Service Revenue and Deductions). For Section IV (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 the clinic information is not included with the hospital information.

- Section II (Revenue and Expenses) and Section III (Patient Service Revenue and Deductions) should be reported for the hospital unit only.
- For Section IV, see "Special Instructions for the Balance Sheet" below.

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.

- If a hospital is jointly operated in connection with a nursing home, a home health agency, 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 IV - 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 links will take you to reference material in the manual).

- 75-78 Net patient accounts receivable
- 84-98 Property, plant, and equipment
- 102 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 (each line item is linked back to the original question).

98 Other unrestricted assets

106 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 (each line item is linked back to the original question):

73 Cash and cash equivalents

74 Inter-corporate account(s)

81 Other current assets

97 Long-term investments

100 Current liabilities

101 Inter-corporate account(s)

103 Other concurrent liabilities and deferred revenues

104 Unrestricted fund balances

107 Plant replacement and expansion funds

108 Endowment funds

Note: Lines 99 and 105 should be equal. However, Combination Facility totals may not balance due to the mixture of hospital-specific and total facility data.

Change Number	Date	Author	Update
1	10/29/21	SS	Question 41, 50, and 56 marked as obsolete
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.