

APPENDIX 3: SURVEY INSTRUMENTS

FY 2021 ANNUAL SURVEY OF HOSPITALS

FY 2021 HOSPITAL FISCAL SURVEY

2021 ANNUAL SURVEY OF HOSPITALS
WHA Information Center, LLC / American Hospital Association

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

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

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

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

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

I. GENERAL INFORMATION

Type or print clearly all information

WHA Information Center Hospital ID _____	AHA Hospital ID _____
Hospital Mailing Label	
Hospital Name _____	
Address _____	P.O. Box _____
City, State _____	ZIP Code _____
FY 2021 Beginning Date _____	
FY 2021 Ending Date _____	
Mo. / Day / Yr.	Mo. / Day / Yr.

II. HOSPITAL INFORMATION AND CLASSIFICATION

Type or print all information

Organization Information**1 Communications Contact and Reporting Period**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ 10 General medical and surgical	☐ 22 Psychiatric
☐ 15 GMS – Critical Access Hospital	☐ 46 Rehabilitation

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

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

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

- 13 ☐ JCAHO ☐ AOA ☐ Title 18 certified and HFS 124 licensed
 Date of last survey ☐ ☐ DHS 124 licensed
 ____/____ (mm/yy) DNV ☐ Other (specify) _____

Certification Status

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

14 Medicare (Title 18) ☐ Yes ☐ No

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

15 Medicaid (Title 19) ☐ Yes ☐ No

If YES, **Provider Number** _____ - _____

Managed Care Information

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

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

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

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

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

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

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

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

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

Criteria to Determine If Nursing Home Data Should Be Submitted

- 23** Does the hospital own and operate a nursing home facility under HFS 132? ☐ Yes ☐ No
If YES, answer the question on line 24.
- 24** Are the hospital and nursing home governed by a common Board of Directors? ☐ Yes ☐ No
- 25** If answers to both 23 and 24 are YES, check the appropriate box regarding the location of the nursing home facility.
- Attached/within hospital ☐ Freestanding on hospital campus ☐ Freestanding off campus ☐

III. SELECTED INPATIENT UNITS

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

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

<u>Code</u>	<u>Description</u>
1	Service is provided in or by the hospital in a DISTINCT AND SEPARATE UNIT. The number of beds and utilization information MUST be provided for inpatient units.
2	Service is provided in or by the hospital but NOT IN A DISTINCT AND SEPARATE UNIT.
3	Service is provided by the hospital's Health Care System.
4	Service IS NOT MAINTAINED by the hospital but is available, in the hospital or another facility, through a FORMAL CONTRACTUAL arrangement with another hospital or provider, including networks and joint ventures.
5	SERVICE NOT AVAILABLE either by the hospital or through a formal contractual arrangement with another hospital or provider.
<u>Code</u>	<u>Description</u>
O	Service is provided by the hospital IN BUILDINGS OTHER THAN THE MAIN HOSPITAL BUILDING and is billed under.
B	Service is provided by the hospital IN BOTH THE MAIN HOSPITAL BUILDING AND IN BUILDINGS OTHER THAN THE MAIN HOSPITAL BUILDING).
NOTE:	If the hospital has beds of more than one type in a mixed unit, all bed and utilization data for all bed types found in that unit should be reported on the line corresponding to the mixed unit. Code the "mixed unit" with a "1," and code each individual bed type line for that unit with a "2." Example: If "Mixed intensive care" is the main unit for intensive care beds, code it "1" and the types of beds that may be found there "2." All bed and utilization data should be reported on line 40, "Mixed intensive care." For a unit coded "2," utilization may be reported only if beds, discharges, and inpatient days are all available.

26 Are any patient services provided by the hospital in buildings other than the main hospital bldg

.....

☐ Yes

☐ No

If YES, enter address(es) of other buildings:

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

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

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

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

IV. SELECTED ANCILLARY AND OTHER SERVICES

Circle One

O or B

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

51	AIDS/HIV – Specialized Outpatient Program for AIDS/HIV	1 2 3 4 5	_____
52	Alcoholism/Chemical Dependency Outpatient Services (<i>psych/social</i>)	1 2 3 4 5	_____
Ambulance/Transportation Services- Non-emergency			
53	- Non-emergency inter-facility transports by ground ambulance	1 2 3 4 5	_____
54	- Non-emergency inter-facility transports by air ambulance	1 2 3 4 5	_____
55	Arthritis Treatment Center	1 2 3 4 5	_____
56	Assisted Living	1 2 3 4 5	_____
57	Auxiliary	1 2 3 4 5	_____
58	Bariatric Services: Bariatric Weight	1 2 3 4 5	_____
59	Birth Room/Labor, Delivery, Recovery, Post-partum Room (LDR or LDRP room)	1 2 3 4 5	_____
Cardiac services			
60	- Cardiac Angioplasty (<i>percutaneous transluminal</i>)	1 2 3 4 5	_____
61	- Cardiac Catheterization Laboratory	1 2 3 4 5	_____
62	- Cardiac Rehabilitation Program	1 2 3 4 5	_____
63	- Non-invasive Cardiac Assessment Services	1 2 3 4 5	_____
64	- Open-heart Surgery	1 2 3 4 5	_____
65	Case Management	1 2 3 4 5	_____
66	Crisis Prevention	1 2 3 4 5	_____
67	Complementary Services	1 2 3 4 5	_____
68	Dental Services	1 2 3 4 5	_____
Dialysis services:			
69	- Hemodialysis	1 2 3 4 5	_____
70	- Peritoneal dialysis	1 2 3 4 5	_____
Emergency/urgent care:			
71	- Emergency Department (<i>general medical and surgical</i>)	1 2 3 4 5	_____
72	- Trauma Center [Self-designated Level]	1 2 3 4 5	_____
73	- Urgent Care Center	1 2 3 4 5	_____
74	Ethics Committee	1 2 3 4 5	_____
75	Extracorporeal Shock Wave Lithotripter (ESWL) CHECK ONE Fixed Mobile	1 2 3 4 5	_____

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

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

		Circle One	
100	- Recreational Therapy	1 2 3 4 5	_____
101	- Rehabilitation Inpatient Services (service does not have beds)	1 2 3 4 5	_____
102	- Rehabilitation Outpatient Services	1 2 3 4 5	_____
103	- Respiratory Therapy	1 2 3 4 5	_____
104	- Speech Pathology / Therapy	1 2 3 4 5	_____
105	Oncology Services	1 2 3 4 5	_____
106	- Outpatient services – within the hospital	1 ☒ 3 4 5	_____
107	- Outpatient services – on hospital campus, but in freestanding center	1 ☒ 3 4 5	_____
108	- Outpatient services – freestanding off hospital campus	1 2 3 4 5	_____
109	Pain Management Program	1 2 3 4 5	_____
110	Patient Representative Services	1 2 3 4 5	_____
Psychiatric services			
111	- Psychiatric Child / Adolescent Services	1 2 3 4 5	_____
112	- Psychiatric Consultation – Liaison Services	1 2 3 4 5	_____
113	- Psychiatric Education Services	1 2 3 4 5	_____
114	- Psychiatric Emergency Services	1 2 3 4 5	_____
115	- Psychiatric Geriatric Services	1 2 3 4 5	_____
116	- Psychiatric Outpatient Services	1 2 3 4 5	_____
117	- Psychiatric Partial Hospitalization Program	1 2 3 4 5	_____
118	Radiation Therapy	1 2 3 4 5	_____
Radiology, diagnostic			
119	- CT Scanner (Computed Tomographic Scanner)	1 2 3 4 5	_____
	Check One: ☐ Fixed ☐ Mobile ☐ Both		
120	- Nuclear Medicine Department	1 2 3 4 5	_____
121	- Magnetic Resonance Imaging (MRI)	1 2 3 4 5	_____
	Check One: ☐ Fixed ☐ Mobile ☐ Both		
122	- Positron Emission Tomography Scanner (PET)	1 2 3 4 5	_____
123	- Single Photon Emission Computerized Tomography (SPECT)	1 2 3 4 5	_____
	Check One: ☐ Fixed ☐ Mobile ☐ Both		

124	- Ultrasound	1 2 3 4 5	_____
Reproductive health			
125	- Fertility Counseling	1 2 3 4 5	_____
126	- In Vitro Fertilization	1 2 3 4 5	_____
127	Social Work Services	1 2 3 4 5	_____
128	Sports Medicine Clinic/Services	1 2 3 4 5	_____
129	Surgery, Ambulatory or Outpatient (<i>day surgery</i>)	1 2 3 4 5	_____
Telemedicine			
130	Teleradiology or Other Store and Forward Services	1 2 3 4 5	_____
131	Tele ICU	1 2 3 4 5	_____
132	Tele Stroke	1 2 3 4 5	_____
133	Tele Psychiatry	1 2 3 4 5	_____
134	E-Visits	1 2 3 4 5	_____
135	Remote Patient Monitoring	1 2 3 4 5	_____
136	Specialist Consultation		_____
Transplant services			
137	- Bone Marrow Transplant Program	1 2 3 4 5	_____
138	- Heart and/or Lung Transplant	1 2 3 4 5	_____
139	- Kidney Transplant	1 2 3 4 5	_____
140	- Tissue Transplant	1 2 3 4 5	_____
141	Women's Health Center/Services	1 2 3 4 5	_____

142 Are additional non-listed **patient** services provided by the hospital?

☐ Yes ☐ No

If YES, list and indicate with O or B if provided in other buildings

(If more room is needed, go to Section XIV)

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

Number of other locations

Street address

Street address

City

City

Service _____ Line _____

Service _____ Line _____

Service _____ Line _____

Service _____ Line _____

Service _____ Line _____

Service _____ Line _____

144 Does the hospital have provider-based facilities that are billed using the hospital's Medicare provider number, reported on Line 14?

☐ Yes ☐ No

If YES, indicate the number of facilities.

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

Street address

City

DO NOT SKIP THIS PAGE. FILL IN ALL LINES.

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

Surgical Operations (whether major or minor)

- 145 Inpatient surgical operations (*not procedures*) _____
- 146 Outpatient surgical operations (*not procedures*) _____
- 147 TOTAL surgical operations (*not procedures*) [line 145 + line 146] _____

Outpatient Visits

- 148 Emergency visits _____
- Number of emergency visits that resulted in inpatient admissions (Subset of line 148)
- 149 Other visits (*all non-emergency visits, including urgent care, physician referrals and outpatient surgeries*) _____
- 150 Observation visits _____
- 151 TOTAL outpatient visits [Add Line 148 + Line 149 + Line 150] _____

Non-emergency Ambulance/Transport Services

- 152 Non-emergency inter-facility transports by ground ambulance _____
- 153 Non-emergency inter-facility transports by air ambulance _____
- 154 TOTAL non-emergency transports by ambulance [Add Line 152 + Line 153] _____

Newborn Nursery

- 155 Number of bassinets set-up-and-staffed as of the last day of the fiscal year
(*exclude neonatal beds*) _____
- 156 Total births (*exclude fetal deaths*) _____
- 157 Newborn days (*exclude neonatal days*) _____

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

Utilization and Beds

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

Utilization and Beds

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

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

Utilization and Beds

(1) Hospital

(2) Nursing Home

Medicare / Medicaid Primary Payer Utilization

166 Total Medicare (Title 18)
Inpatient Discharges

167 Total Medicare (Title 18)
Outpatient Visits

168 Total Medicare Inpatient Days

169 Total Medicaid (Titles 19 & 21)
Inpatient Discharges

170 Total Medicaid (Titles 19 & 21)
Outpatient Visits

171 Total Medicaid Inpatient Days

(Exclude newborns; include Medicare-certified swing bed utilization, . Include T-18 and T-19 HMO utilization.)

VII. MEDICAL STAFF – September 30, 2021

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

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

Selected Specialty

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

	(1) Medical Staff as of Sept. 30, 2021 (Includes Board Certified)	(2) Board Certified Staff As of Sept. 30, 2021
Active/Associate Medical Staff		
Medical Specialties		
182 General and Family Practice	_____	_____
183 Internal Medicine (general)	_____	_____
184 Internal Medicine subspecialties	_____	_____
185 Pediatrics (general)	_____	_____
186 Pediatric subspecialties	_____	_____
Surgical Specialties		
187 General Surgery	_____	_____
188 Obstetrics/Gynecology	_____	_____
189 All other surgical specialties	_____	_____
Other		
190 Anesthesiology	_____	_____
191 Emergency Medicine	_____	_____
192 Pathology	_____	_____
193 Radiology	_____	_____
194 Addiction Medicine	_____	_____
195 Psychiatry	_____	_____
196 All other specialties (use valid specialties below)	_____	_____

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

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

198 TOTAL Medical Staff	_____	_____
	(add lines 182-196)	(add lines 182-196)

VIII. PERSONNEL ON HOSPITAL PAYROLL – September 30, 2021 - DATA FOR ONE WEEK ONLY.

Report the number of full-time and part-time personnel, **including trainees**, in the categories specified below. Report part-time hours for each category. All data must be for **the week of September 30, 2021 regardless of the hospitals' fiscal year end date**. Treat shared hospital/nursing home staff as part-time and report only hospital hours. **Do not include contracted staff or nursing home personnel.**

		DO NOT USE DASHES, N/A, N/AV, OR M. PLEASE ROUND TO NEAREST WHOLE NUMBER. DO NOT USE DECIMALS.		
Occupational Categories		FULL TIME Total No. of Persons (35 Hr/Wk or more)	PART TIME Total No. of Persons (less than 35 Hr/Wk)	Total No. of P-T hours (week of Sept 30, 2021)
199	Administrators and assistant administrators	_____	_____	_____
Physician And Dental Services				
200	Physicians / Dentists	_____	_____	_____
201	Dental Hygienists	_____	_____	_____
202	Hospitalists	_____	_____	_____
203	Please select the category below that best describes the employment model for your hospitalists.			
	☐ Independent provider group	☐ Employed by a university or school program		
	☐ Employed by a physician group	☐ Other		
	☐ Employed by your hospital			
204	Intensivists	_____	_____	_____
205	Medical and dental residents/interns	_____	_____	_____
Nursing Services				
206	Registered nurses	_____	_____	_____
207	Certified nurse midwives	_____	_____	_____
208	Licensed practical (vocational) nurses	_____	_____	_____
209	Paraprofessionals: Nursing Assistants (CNA)	_____	_____	_____
210	Medical assistants	_____	_____	_____
211	Physician assistants	_____	_____	_____
212	Nurse practitioners	_____	_____	_____
213	Pharmacists	_____	_____	_____
214	Pharmacy Technician/Aides	_____	_____	_____
215	Medical & Clinical Laboratory Technologists	_____	_____	_____
216	Medical & Clinical Laboratory Technicians	_____	_____	_____
217	Surgical Technologists & Technicians	_____	_____	_____
218	Certified registered nurse anesthetists	_____	_____	_____
219	Clinical Nurse Specialists	_____	_____	_____
Therapeutic Services				
220	Respiratory Therapists	_____	_____	_____
221	Radiologic Technologists	_____	_____	_____

Occupational Categories (continued)		FULL TIME Total No. of Persons (35 Hr/Wk or more)	PART TIME Total No. of Persons (less than 35 Hr/Wk)	Total No. of P-T hours (week of Sept 30, 2021)
222	Sonographer	_____	_____	_____
223	All other Radiologic Personnel	_____	_____	_____
224	Occupational Therapists	_____	_____	_____
225	Occupational therapy assistants/aides	_____	_____	_____
226	Physical therapists	_____	_____	_____
227	Physical therapy assistants/aides	_____	_____	_____
228	Recreational therapists	_____	_____	_____
229	Health Information Management Administrators/Technicians	_____	_____	_____
230	Dieticians and Nutritionists	_____	_____	_____
Psychology / Social Work Services				
231	Psychologists	_____	_____	_____
232	Social Workers	_____	_____	_____
Other Personnel				
233	All other health professional / technical personnel	_____	_____	_____
234	All other personnel	_____	_____	_____
235	TOTAL hospital personnel	_____	_____	_____
		(add lines 199-234)	(add lines 199-234)	(add lines 199-234)
236	Workweek Indicate the average or definition of WORKWEEK (number of hours per week) of the full-time employees engaged in direct patient care (40, 38, 35 , etc.) Do not use decimals.			(Average full-time hours per week)

IX. OTHER (Lines 237-245)

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

- 237 Does your hospital's mission statement include a focus on community benefit? ☐ Yes ☐ No
- 238 Does your hospital have a long-term plan for improving the health status of its community? ☐ Yes ☐ No
- 239 Does your hospital have resources for its community benefit activities? ☐ Yes ☐ No
- 240 Does your hospital work with other providers, public agencies, or community representatives to conduct a health status assessment of the community? ☐ Yes ☐ No
- 241 Does your hospital use health status indicators (such as rates of health problems or surveys of self-reported health) for defined populations to design new services or modify existing services? ☐ Yes ☐ No
- 242 Does your hospital work with other local providers, public agencies, or community representatives to conduct/develop a written health status assessment of the needed capacity for health services in the community? ☐ Yes ☐ No
- 243 **IF YES**, have you used the assessment to identify unmet health needs, excess capacity, or duplicative services in the community? ☐ Yes ☐ No
- 244 Does your hospital work with other providers to collect, track, and communicate clinical and health

information across cooperating organizations?

☐ Yes ☐ No

- 245** Does your hospital either by itself or in conjunction with others disseminate reports to the community on the comparative quality and costs of health care services?

☐ Yes ☐ No**X. SERVICE QUALITY / PATIENT SAFETY**

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

Dedicated FTEs

Quality management & improvement _____

Clinical safety _____

Case management _____

Accreditation _____

Infection control _____

Risk Management _____

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

☐ Yes ☐ No**XI. E-HEALTH**

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

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

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

XII. HEALTH INFORMATION TECHNOLOGY**Expenditures**

268 Total Health Information Technology Expenditures - Capital \$ _____

269 Total Health Information Technology Expenditures- Operating \$ _____

270 What type of internet connection comes into your hospital?

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

If Other, please explain:

XIII. SOCIAL DETERMINANTS OF HEALTH (SDOH)

271 Does your facility screen patients for social needs?

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

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

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

Other, please describe _____

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

Yes No

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

Yes No

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

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

XIII. SUPPLEMENTAL INFORMATION

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

HOSPITAL FISCAL SURVEY FISCAL YEAR 2021

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

GENERAL INSTRUCTIONS - Read before completing form.

NOTE: Refer to the detailed instructions contained in the *Hospital Fiscal Survey Manual, Fiscal Year 2021*.

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

Round all amounts to the nearest dollar.

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

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

I. HOSPITAL INFORMATION

Type or print in black ink.

Hospital Name and Address

FY 2021 Beginning Date

FY 2021 Ending Date

II. GENERAL INFORMATION

If your hospital is jointly operated in connection with a nursing home, home health agency, or other organization, and is governed by a common Board of Directors, the hospital shall submit the required information from the final audited financial statements of the **hospital only** except where such information cannot be disaggregated. **(See special instructions for combination facilities in the accompanying Hospital Fiscal Survey Manual, Fiscal Year 2021).** All hospital services must be reported if they are included as hospital revenue and contained in net revenue from services to patients. Refer to page 2 - line 3.

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

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

For definitions and instructions, see the *Hospital Fiscal Survey Manual, Fiscal Year 2021*.

STATEMENT OF REVENUE AND EXPENSES

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

\$ _____

Other Revenue

4 Tax appropriations _____ \$ _____

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

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

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

Payroll Expenses

8 Physicians and dentists _____ \$ _____

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

9 Medical and dental residents and interns _____ \$ _____

10 Trainees _____ \$ _____

11 Registered nurses and licensed practical nurses _____ \$ _____

12 All other personnel _____ \$ _____

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

Nonpayroll Expenses

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

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

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

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

18 Interest expense _____ \$ _____

19 Medical malpractice insurance premiums _____ \$ _____

20 Amortization of financing expenses _____ \$ _____

21 Rents and leases _____ \$ _____

22 Capital component of insurance premium _____ \$ _____

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

24	TOTAL Nonpayroll Expenses (add lines 14 through 23) _____	\$ _____
25	TOTAL EXPENSES (add lines 13 and 24) _____	\$ _____
26	Excess (or deficit) of revenue over expenses (subtract line 25 from line 7; see manual) _____	\$ _____

Nonoperating Gains / Losses

27	Investment income _____	\$ _____
28	Other nonoperating gains (including extraordinary gains) _____	\$ _____
29	Provision for income taxes (for-profit organizations) (absolute values only – no negative values) _____	\$ _____
30	Other nonoperating losses (including extraordinary losses) (absolute values only – no negative values) _____	\$ _____
31	TOTAL Nonoperating Gains / Losses (subtract sum of lines 29 and 30 from sum of lines 27 and 28) _____	\$ _____
32	NET INCOME (revenue and gains in excess of expenses and losses) (add lines 26 and 31) _____	\$ _____

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

Gross Patient Service Revenue and Its Sources

33	Gross revenue from room, board, and medical and nursing services to INPATIENTS _____	\$ _____	} (sum of lines 33 and 34 must equal sum of inpatient breakouts, lines 37-50)
34	Gross INPATIENT ancillary revenue = _____	\$ _____	
35	Gross revenue from service to OUTPATIENTS _____	\$ _____	
		(must equal sum of outpatient breakouts, lines 37-50)	
36	TOTAL GROSS revenue from service to patients _____	\$ _____	(add lines 33-35)

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

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

42	County 51.42 / 51.437 programs	\$	\$	\$
43	All other public programs	\$	\$	\$

Commercial Sources (GAMP)

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

All other sources (specify below):

48	Other Payers 1	\$	\$	\$
49	Other Payers 2	\$	\$	\$
50	OBSOLETE	\$	\$	\$
51	Total Gross revenue from service to patients, by source (add lines 37-50, should equal value on line 36)	\$	\$	\$

Deductions from Patient Service Revenue and Its Sources

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

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

Commercial Source Contractual Adjustments

59	Group and individual accident and health insurance, self-funded plans	\$ _____	\$ _____	\$ _____
60	Worker's compensation	\$ _____	\$ _____	\$ _____

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

Other Source Contractual Adjustments

All other sources (specify below)

63	Other Adjustments 1	\$ _____	\$ _____	\$ _____
64	Other Adjustments 2	\$ _____	\$ _____	\$ _____
65	Other Adjustments 3	\$ _____	\$ _____	\$ _____

Charity Care / Bad Debt

66	Charity care (revenue foregone at full established rates) (must equal line 123) (Should include post-capitated GAMP allowances) ...	\$ _____	\$ _____	\$ _____
67	Bad Debt	\$ _____	\$ _____	\$ _____
68	All other noncontractual deductions	\$ _____	\$ _____	\$ _____
69	TOTAL DEDUCTIONS FROM REVENUE	\$ _____	\$ _____	\$ _____
		(add lines 52-68) (total, not breakouts)		

Medicare-Approved Medical Education Activities

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

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

IV. BALANCE SHEET – GENERAL FUNDS

NOTE: For combination facilities, state-operated mental health institutes, or county-operated psychiatric or alcohol or other drug abuse hospitals, see special instructions in the *Hospital Fiscal Survey Manual, Fiscal Year 2021*.

Unrestricted Assets (recorded on the balance sheet at the end of each reporting period)

Current Assets

73	Cash and cash equivalents	\$ _____
74	Inter-corporate account(s)	\$ _____

Net patient accounts receivable

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

76	Medical Assistance (T-19)- Including HMOs reimbursed by T-19 *	\$	
77	Self-Pay*	\$	
78	All other pay sources*	\$	
79	Total Net patient accounts receivable (add lines 75 thru 78)	\$	
80	Other accounts receivable	\$	
81	Other current assets	\$	
82	TOTAL current assets (add lines 73 through 81)		\$
83	Noncurrent assets whose use is limited		\$
Property, Plant and Equipment			
Gross Plant Assets			
84	Land	\$	
85	Land improvements	\$	
86	Buildings and building improvements	\$	
87	Construction in progress	\$	
88	Fixed equipment	\$	
89	Moveable equipment	\$	
90	TOTAL gross plant assets (add lines 84 through 89)		\$
LESS Accumulated Depreciation (absolute values only – no negative values)			
91	Land improvements	\$	
92	Buildings and building improvements	\$	
93	Fixed equipment	\$	
94	Moveable equipment	\$	
95	TOTAL accumulated depreciation (add lines 91 through 94)		\$
96	NET property, plant, and equipment assets (subtract line 95 from line 90)		\$
97	Long-term investments		\$
98	Other unrestricted assets		\$
99	TOTAL unrestricted assets (add lines 82, 83, 96, 97 and 98)		\$
Unrestricted Liabilities, Deferred Revenues, and Fund Balances			
100	Current liabilities	\$	
101	Inter-corporate account(s)	\$	
102	Long-term debt	\$	
103	Other noncurrent liabilities and deferred revenues	\$	
104	Fund balances	\$	
105	TOTAL unrestricted liabilities, deferred revenues, and fund balances (add lines 100 through 104).		\$
	(NOTE: lines 99 and 105 should be equal. Combination facilities, see manual instructions)		\$

Restricted Hospital Funds (report fund balances only)

106	Specific-purpose funds _____	\$ _____
107	Plant replacement and expansion funds _____	\$ _____
108	Endowment funds _____	\$ _____

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

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

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

*** Exclude fetal deaths.

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

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

VI. SUMMARY AND EXPLANATION OF REVENUE DOLLAR DIFFERENCES BETWEEN FY 2020 AND FY 2021

	GROSS REVENUE	NET REVENUE
119 Fiscal Year 2021 [line 36 (gross) and line 3 (net)]	\$ _____	\$ _____
120 Fiscal Year 2020 [FY 2020 Fiscal Survey - line 36 (gross) and line 3 (net)]	\$ _____	\$ _____
121 Increase / Decrease 2021 v. 2020 (subtract line 120 from line 119) [indicate + or -]	\$ _____	\$ _____
122 Explain in a short narrative the relative importance of various causes for the dollar differences (lines 119 and 120) in the fiscal year revenue figures (price change, utilization change, other causes?). Attach additional page(s) if necessary.		

VII. UNCOMPENSATED HEALTH CARE

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

Charges for Uncompensated Health Care	FY 2021	FY 2021 (Projected)
123 Charges for charity care provided for the fiscal year	\$ _____ (from line 66)	\$ _____
124 Charity care cost (using hospital cost to charge ratio)	\$ _____	\$ _____
125 Charges determined to be a bad debt for the fiscal year	\$ _____ (from line 67)	\$ _____
126 Bad debt cost (using hospital cost to charge ratio)	\$ _____	\$ _____
127 TOTAL charges for uncompensated health care for the fiscal year	\$ _____ (add lines 123 and 125)	\$ _____ (add lines 123 and 125)
128 Total cost (using hospital cost to charge ratio)	\$ _____	\$ _____
129 Hospital cost-to-charge ratio (used for calculations of lines 124, 126 and 128) (e.g. .458)	_____	_____

Number of "Patients" Receiving Uncompensated Health Care

(See manual for definitions – the number of "patients" should be reported as the number of individual patient visit ledgers.)

	FY 2021	FY 2021 (Projected)
130 Number of individual patient visit ledgers that received charity care for the fiscal year	_____	_____
131 Number of individual patient visit ledgers whose charges were determined to be bad debt for the fiscal year	_____	_____

- 132** Provide a **rationale** for the hospital's fiscal year 2021 projections in the space below. Explain how the projections used "patients" and total charges for fiscal year 2021, if at all. It could also include a description of the socioeconomic climate of your hospital's market and how that affects your hospital's Uncompensated Health Care Plan. Attach additional page(s) if necessary. (Using cost to charge ratio)

Hill-Burton Uncompensated Health Care Information

- 133** Does the hospital have current obligations under this program?

Enter Yes, No, or C (for conditional) on this line _____

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

<u>Effective beginning date(s)</u>	<u>Projected satisfaction date(s)</u>
Month / Year	Month / Year
_____	_____
Month / Year	Month / Year
_____	_____
Month / Year	Month / Year
_____	_____

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

\$ _____

WISCONSIN HOSPITAL MEDICAL ASSISTANCE (MA) ASSESSMENT PROGRAM

This section has a data element that is used to calculate the percentage of charges that are collected by the facility. These calculated percentages are displayed on WHA Information Center's PricePoint Web site.

TOTAL

- 136** Medicaid Assistance assessments paid to State of Wisconsin

\$ _____

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