APPENDIX 3: SURVEY INSTRUMENTS

FY 2022 ANNUAL SURVEY OF HOSPITALS

FY 2022 HOSPITAL FISCAL SURVEY

ANNUAL SURVEY OF HOSPITALS TEMPLATE
WHA Information Center

NOTE: Refer to the detailed instructions contained in the Annual Survey Manual.

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

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

This information can also be printed from the survey portal.

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

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

I. GENERAL INFORMATION

WHA Info Center 3-digit ID _____ _____

Hospital Name _____

Address _____ P.O. Box _____

City, State _____ ZIP Code _____

FY Beginning Date	FY Ending Date
____ / ____ / ____	____ / ____ / ____
Mo. Day Yr.	Mo. Day Yr.

II. HOSPITAL INFORMATION AND CLASSIFICATION

Organization Information

1 Communications Contact and Reporting Period

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

Hospital / Organization Type

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

Government, Nonfederal	Non-government, Not-for-profit	Investor-owned For-profit	Government, Federal
☐ 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 ☐ The Joint Commission
Date of last survey
__/__ (mm/yy) DNV

☐ AOA

☐

☐ Title 18 certified and HFS 124 licensed

☐ DHS 124 licensed

☐ Other (specify) _____

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

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

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

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

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

Managed Care Information

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

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

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

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

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

	(1) Hospital	(2) Health Care System	(3) Network	(4) Joint Venture With Insurer
Health Maintenance Organization	☐	☐	☐	☐
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.

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

Code	Description
O	**Service is provided by the hospital IN BUILDINGS OTHER THAN THE MAIN HOSPITAL BUILDING and is billed under.**
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 2 3 4 5	
42 Step-down *(special care)*					1 2 3 4 5	

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

IV. SELECTED ANCILLARY AND OTHER SERVICES

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.

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

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

	Selected Ancillary and Other Services	**Circle One**	**O or B**
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 2 3 4 5	
107	- Outpatient services – on hospital campus, but in freestanding center	1 2 3 4 5	
108	- Outpatient services – freestanding off hospital campus	1 2 3 4 5	
109	Pain Management Program	1 2 3 4 5	
110	Patient Representative Services	1 2 3 4 5	
	Psychiatric services		
111	- Psychiatric Child / Adolescent Services	1 2 3 4 5	
112	- Psychiatric Consultation – Liaison Services	1 2 3 4 5	
113	- Psychiatric Education Services	1 2 3 4 5	
114	- Psychiatric Emergency Services	1 2 3 4 5	
115	- Psychiatric Geriatric Services	1 2 3 4 5	
116	- Psychiatric Outpatient Services	1 2 3 4 5	
117	- Psychiatric Partial Hospitalization Program	1 2 3 4 5	
118	Radiation Therapy	1 2 3 4 5	
	Radiology, diagnostic		
119	- CT Scanner (*Computed Tomagraphic Scanner)* **Check One:** ☐ **Fixed** ☐ **Mobile** ☐ **Both**	1 2 3 4 5	
120	- Nuclear Medicine Department	1 2 3 4 5	
121	- Magnetic Resonance Imaging (*MRI)* **Check One:** ☐ **Fixed** ☐ **Mobile** ☐ **Both**	1 2 3 4 5	
122	- Positron Emission Tomography Scanner (*PET)*	1 2 3 4 5	
123	- Single Photon Emission Computerized Tomography (*SPECT)* **Check One:** ☐ **Fixed** ☐ **Mobile** ☐ **Both**	1 2 3 4 5	

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

142 Are additional non-listed **patient** services provided by the hospital? ☐ Yes ☐ No
If YES, list and indicate with O or B if provided in other buildings
(If more room is needed, go to Section XIV)

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

Number of other locations ☐

Street address _____ Street address _____

City _____ City _____

Service _____ Line ____ Service _____ Line ____

Service _____ Line ____ Service _____ Line ____

Service _____ Line ____ Service _____ Line ____

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

If YES, indicate the number of facilities. ☐

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

Street address _____

City _____

V. SELECTED SERVICE UTILIZATION

DO NOT SKIP THIS PAGE. FILL IN ALL LINES.

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

Surgical Operations *(whether major or minor)*

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

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

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

Outpatient Visits

148 Emergency visits .....

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

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

150 Observation visits .....

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

Non-emergency Ambulance/Transport Services

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

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

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

Newborn Nursery

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

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

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

VI. TOTAL FACILITY UTILIZATION AND BEDS

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

Utilization and Beds

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

Utilization and Beds

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

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

Utilization and Beds

		(1) Hospital	(2) Nursing Home
	Medicare / Medicaid Primary Payer Utilization		
166	Total Medicare *(Title 18)* **Inpatient Discharges**	_____	_____
167	Total Medicare (Title 18) **Outpatient Visits**	_____	
168	Total Medicare Inpatient **Days**	_____	_____
169	Total Medicaid *(Titles 19 & 21)* **Inpatient Discharges**	_____	_____
170	Total Medicaid (*Titles 19 & 21)* **Outpatient Visits**	_____	
171	Total Medicaid Inpatient **Days**	_____	_____

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

VII. MEDICAL STAFF – September 30.

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

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

Selected Specialty

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

Active/Associate Medical Staff	(1) Medical Staff **as of Sept. 30** *(Includes Board Certified)*	(2) Board Certified Staff **As of Sept. 30** *[Not to exceed column (1)]*
Medical Specialties		
182 General and Family Practice		
183 Internal Medicine *(general)*		
184 Internal Medicine *subspecialties*		
185 Pediatrics *(general)*		
186 Pediatric *subspecialties*		
Surgical Specialties		
187 General Surgery		
188 Obstetrics/Gynecology		
189 All other surgical *specialties*		
Other		
190 Anesthesiology		
191 Emergency Medicine		
192 Pathology		
193 Radiology		
194 Addiction Medicine		
195 Psychiatry		
196 All other specialties *(use valid specialties below)*		

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

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

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

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

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

DO NOT USE DASHES, N/A, N/AV, OR M.
PLEASE ROUND TO NEAREST WHOLE NUMBER. DO NOT USE DECIMALS.

	Occupational Categories	FULL TIME Total No. of Persons *(35 Hr/Wk or more)*	PART TIME Total No. of Persons *(less than 35 Hr/Wk)*	PART TIME Total No. of P-T hours *(week of Sept 30)*
199	Administrators and assistant administrators			
	Physician And Dental Services			
200	Physicians / Dentists			
201	Dental Hygienists			
202	Hospitalists			
203	**Please select the category below that best describes the employment model for your hospitalists.**			
	☐ Independent provider group ☐ Employed by a physician group ☐ Employed by your hospital ☐ Employed by a university or school program ☐ Other			
204	Intensivists			
205	Medical and dental residents/interns			
	Nursing Services			
206	Registered nurses			
207	Certified nurse midwives			
208	Licensed practical *(vocational)* nurses			
209	Paraprofessionals: Nursing Assistants (CNA)			
210	Medical assistants			
211	Physician assistants			
212	Nurse practitioners			
213	Pharmacists			
214	Pharmacy Technician/Aides			
215	Medical & Clinical Laboratory Technologists			
216	Medical & Clinical Laboratory Technicians			
217	Surgical Technologists & Technicians			
218	Certified registered nurse anesthetists			
219	Clinical Nurse Specialists			
	Therapeutic Services			
220	Respiratory Therapists			
221	Radiologic Technologists			

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

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

	Feature	Fully Implemented	Partially Implemented	Planning	Not at All
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 TEMPLATE
WHA Information Center

NOTE: Refer to the detailed instructions contained in the Fiscal Survey Manual.

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

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

This information can also be printed from the survey portal.

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

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

I. HOSPITAL INFORMATION

Hospital Name and Address

FY Beginning Date

FY Ending Date

II. GENERAL INFORMATION

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

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

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

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

STATEMENT OF REVENUE AND EXPENSES

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

Other Revenue

4 Tax appropriations ..... $ _____

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

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

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

Payroll Expenses

8 Physicians and dentists ..... $ _____

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

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

10 Trainees ..... $ _____

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

12 All other personnel ..... $ _____

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

Nonpayroll Expenses

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

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

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

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

18 Interest expense ..... $ _____

19 Medical malpractice insurance premiums ..... $ _____

20 Amortization of financing expenses ..... $ _____

21 Rents and leases ---------- $ _____

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

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

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

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

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

Nonoperating Gains / Losses

27 Investment income ---------- $ _____

28 Other nonoperating gains (including extraordinary gains) ---------- $ _____

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

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

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

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

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

Gross Patient Service Revenue and Its Sources

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

34 Gross INPATIENT ancillary revenue = ---------- $ _____

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

35 Gross revenue from service to OUTPATIENTS ---------- $ _____

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

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

(add lines 33-35)

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

	Public Sources	**TOTAL**	**INPATIENT**	**OUTPATIENT**
37	Medicare ----------	$ _____	$ _____	$ _____
38	HMOs reimbursed by Medicare under 42 CFR pt. 417 ----------	$ _____	$ _____	$ _____
39	Medical Assistance (Including BadgerCare) ----------	$ _____	$ _____	$ _____

40	HMOs reimbursed by Medical Assistance under s. 49.45 (3) (b), Wis. Stats …….	$	$	$
41	OBSOLETE	$	$	$
42	County 51.42 / 51.437 programs	$	$	$
43	All other public programs	$	$	$

Commercial Sources

		TOTAL	INPATIENT	OUTPATIENT
44	Group and individual accident and health insurance, self-funded plans	$	$	$
45	Worker's compensation	$	$	$
46	HMOs and all other alternative health care payment systems (exclude lines 38 and 40)	$	$	$
47	Self-pay ……..	$	$	$
	All other sources (specify below):			
48	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	OBSOLETE	$	$	$
57	County 51.42 / 51.437 programs	$	$	$

58	All other public programs	$	$	$
	Commercial Source Contractual Adjustments			
59	Group and individual accident and health insurance, self-funded plans	$	$	$
60	Worker's compensation	$	$	$
		TOTAL	**INPATIENT**	**OUTPATIENT**
61	HMOs and all other alternative health care payment systems (exclude lines 53 and 55)	$	$	$
62	Self-Pay	$	$	$
	Other Source Contractual Adjustments All other sources (specify below)			
63	Other Adjustments 1	$	$	$
64	Other Adjustments 2	$	$	$
65	Other Adjustments 3	$	$	$
	Charity Care / Bad Debt			
66	Charity care (revenue foregone at full established rates) (must equal line 123)	$	$	$
67	Bad Debt	$	$	$
68	All other noncontractual deductions	$	$	$
69	**TOTAL** DEDUCTIONS FROM REVENUE (add lines 52-68) (total, not breakouts)	$	$	$

Medicare-Approved Medical Education Activities

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

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

IV. BALANCE SHEET – GENERAL FUNDS

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

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

Current Assets

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

Net patient accounts receivable

75	Medicare (T18) -Including HMOs reimbursed by T-18 *	$	
76	Medical Assistance (T-19)- Including HMOs reimbursed by T-19 *	$	
77	Self-Pay*	$	
78	All other pay sources*	$	
79	Total Net patient accounts receivable (add lines 75 thru 78)	$	
80	Other accounts receivable	$	
81	Other current assets	$	
82	**TOTAL** current assets (add lines 73 through 81)		$
83	Noncurrent assets whose use is limited		$

Property, Plant and Equipment

Gross Plant Assets

84	Land	$	
85	Land improvements	$	
86	Buildings and building improvements	$	
87	Construction in progress	$	
88	Fixed equipment	$	
89	Moveable equipment	$	
90	**TOTAL** gross plant assets (add lines 84 through 89)		$

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

91	Land improvements	$	
92	Buildings and building improvements	$	
93	Fixed equipment	$	
94	Moveable equipment	$	
95	**TOTAL** accumulated depreciation (add lines 91 through 94)		$
96	**NET** property, plant, and equipment assets (subtract line 95 from line 90)		$
97	Long-term investments		$
98	Other unrestricted assets		$
99	**TOTAL** unrestricted assets (add lines 82, 83, 96, 97 and 98)		$

Unrestricted Liabilities, Deferred Revenues, and Fund Balances

100	Current liabilities	$	
101	Inter-corporate account(s)	$	
102	Long-term debt	$	
103	Other noncurrent liabilities and deferred revenues	$	
104	Fund balances	$	
105	TOTAL unrestricted liabilities, deferred revenues, and fund balances (add lines 100 through 104). (**NOTE:** lines 99 and 105 should be equal. Combination facilities, see manual instructions)		$

Restricted Hospital Funds (report fund balances only)

106 Specific-purpose funds $_____

107 Plant replacement and expansion funds $_____

108 Endowment funds $_____

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

PAY SOURCE		(A1) NUMBER OF INPATIENT DISCHARGES**	(A2) NUMBER OF DISCHARGE DAYS**	(B1) NUMBER OF NEWBORNS***	(B2) 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) NUMBER OF DISCHARGES FROM MEDICARE-CERTIFIED SWING BEDS****	(C2) NUMBER OF DISCHARGE DAYS FROM MEDICARE-CERTIFIED SWING BEDS****
114	Medicare (T-18) Including HMOs reimbursed by T-18		
115	Medical Assistance (T-19) Including HMOs reimbursed by T-19		
116	Self- Pay		
117	All other pay sources		
118	**TOTALS**		

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

VI. SUMMARY AND EXPLANATION OF REVENUE DOLLAR DIFFERENCES BETWEEN PREVIOUS FY AND CURRENT FY

		GROSS REVENUE	NET REVENUE
119	Current Fiscal Year [line 36 (gross) and line 3 (net)]	$	$
120	Previous Fiscal Year line 36 (gross) and line 3 (net)]	$	$
121	Increase / Decrease CFY v. PFY (subtract line 120 from line 119) [indicate + or -]	$	$

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

VII. UNCOMPENSATED HEALTH CARE

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

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

Number of "Patients" Receiving Uncompensated Health Care

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

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

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

Hill-Burton Uncompensated Health Care Information

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

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

Effective beginning date(s)	Projected satisfaction date(s)
Month / Year	Month / Year
Month / Year	Month / Year
Month / Year	Month / Year

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

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

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

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