

APPENDIX 3. SURVEY INSTRUMENTS

**2005 ANNUAL SURVEY OF HOSPITALS
FY 2005 HOSPITAL FISCAL SURVEY**

2005 ANNUAL SURVEY OF HOSPITALS
WHA Information Center, LLC / American Hospital Association

INSTRUCTIONS: All blank data items must be completed. See Instructions on page two for details.

Instructions and definitions are available at the end of the survey, unless otherwise noted. Additional information may be reported in **SUPPLEMENTAL INFORMATION** 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. For further information on such facilities, refer to page six of the survey.

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	
Administrator or CEO _____	
Hospital Name _____	
Address _____	P.O. Box _____
City, State _____	ZIP Code _____ ZIP _____
Contact Person (Name and Title) _____	Telephone Number () - Ext. _____
	E-mail address _____
	Fax Number () - _____
Organization and Address (if different from mailing label above) _____	
FY 2006 Beginning Date _____	FY 2006 Ending Date _____
Mo. / Day / Yr.	Mo. / Day / Yr.

II. CLASSIFICATION

Type or print all information

Control

1 Indicate the type of organization responsible for establishing policy concerning overall hospital operation.

CHECK ONLY ONE CODE

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

2 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)

3 Is the hospital a division or subsidiary of a holding company? Yes No

4 Does the hospital itself operate subsidiary corporations? Yes No

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

(Name) (City) (State)

6 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 XI.**

(Name) (City) (State)

7 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 XI.**

(Name) (City) (State)

8 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)

9 Does the hospital own or operate a primary group practice? Yes No

Service

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

- | | |
|--|---|
| <input type="checkbox"/> 10 General medical and surgical | <input type="checkbox"/> 22 Psychiatric |
| <input type="checkbox"/> 15 GMS – Critical Access Hospital | <input type="checkbox"/> 46 Rehabilitation |
| <input type="checkbox"/> 20 GMS – Long-Term Acute Care | <input type="checkbox"/> 82 Alcoholism and other drug abuse |

11 Does the hospital restrict admissions primarily to children? Yes No

Accreditation/Licensure Status (Check all that apply).

- 12 JCAHO AOA Title 18 certified and HFS 124 licensed
Date of last survey ___/___ (mm/yy) HFS 124 licensed only
 Other (specify) ACCOTH _____

II. CLASSIFICATION (continued) Type or print any information

Certification Status

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

13 Medicare (Title 18) Yes No

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

14 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

15 Health Maintenance Organization (HMO)? Yes No **If Yes**, how many contracts?

16 Preferred Provider Organization (PPO)? Yes No **If Yes**, how many contracts?

17 Other managed care or prepaid plan? Yes No **If Yes**, how many contracts?

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

	(1) Hospital	(2) Health Care System	(3) Network	(4) Joint Venture With Insurer
Health Maintenance Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preferred Provider Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indemnity Fee-for-Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19 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.)

20 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

21 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

22 Does the hospital own and operate a nursing home facility under HFS 132? Yes No

If YES, answer the question on line 23.

If NO, go to Section III. DO NOT fill out columns (2) and (3) for lines 148-159.

23 Are the hospital and nursing home governed by a common Board of Directors? Yes No

24 If answers to both 22 and 23 are YES, check the appropriate box regarding the location of the nursing home facility.

Attached/within hospital Freestanding on hospital campus Freestanding off campus

If answers to both 22 and 23 are YES, submit data for columns (1), (2), and (3) on lines 148-159.

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.

NOTE: Service Code numbering changed as of the 1999 Annual Survey of Hospitals.

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 in the community.
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.
O	Service is provided by the hospital but IS HOUSED IN BUILDINGS OTHER THAN THE MAIN HOSPITAL BUILDING .
B	Service is provided by the hospital and IS HOUSED AT BOTH THE MAIN HOSPITAL BUILDING AND IN BUILDINGS OTHER THAN THE MAIN HOSPITAL BUILDING .

25 Are any patient services provided by the hospital housed in buildings in which the hospital has a financial interest, other than the main hospital building? Yes No
 If YES, 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	Circle one for each line	O or B
GENERAL MEDICAL/SURGICAL					
26 Adult medical / surgical, acute (include gynecology)	_____	_____	_____	1 2 3 4 5	_____
27 Orthopedic	_____	_____	_____	1 2 3 4 5	_____
28 Rehabilitation and physical medicine	_____	_____	_____	1 2 3 4 5	_____
29 Hospice	_____	_____	_____	1 2 3 4 5	_____
30 Acute Long-Term Care (Hospital Only)	_____	_____	_____	1 2 3 4 5	_____
31 All Other Acute (specify types) [_____]	_____	_____	_____	1 2 3 4 5	_____
32 Pediatrics General medical/surgical	_____	_____	_____	1 2 3 4 5	_____
Level of care (1, 2 or 3) 	_____	_____	_____	1 2 3 4 5	_____
33 Obstetrics (include LDRP, exclude gynecology)	_____	_____	_____	1 2 3 4 5	_____
34 Psychiatric Inpatient care	_____	_____	_____	1 2 3 4 5	_____
35 Alcoholism / Chemical Dependency Inpatient 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	Circle one for each line	O or B
ICU/CCU					
36 Medical / surgical intensive care	_____	_____	_____	1 2 3 4 5	_____
37 Cardiac intensive care	_____	_____	_____	1 2 3 4 5	_____
38 Pediatric intensive care	_____	_____	_____	1 2 3 4 5	_____
39 Burn Care	_____	_____	_____	1 2 3 4 5	_____
40 Mixed intensive care	_____	_____	_____	1 <input checked="" type="checkbox"/> 3 4 5	_____
41 Step-down (special care)	_____	_____	_____	1 2 3 4 5	_____
42 Neonatal intensive / intermediate care (exclude normal newborns)	_____	_____	_____	1 2 3 4 5	_____
43 All other intensive care [specify type(s)] _____	_____	_____	_____	1 2 3 4 5	_____
44 SUBACUTE CARE Inpatient care	_____	_____	_____	1 2 3 4 5	_____
45 ALL OTHER INPATIENT UNITS [specify treatment area(s)] _____	_____	_____	_____	1 2 3 4 5	_____
46 TOTAL HOSPITAL FACILITY (Exclude Medicare-certified swing bed inpatient days and Non-Medicare-certified, swing-bed inpatient days).	_____	_____	_____		
	(add lines 26-45)	(add lines 26-45)	(add lines 26-45)		
47 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)		
47a 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)		
48 Newborn nursery (Bassinets and utilization should be reported on lines 145-147)	_____	_____	_____	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.

- 49 AIDS/HIV – Specialized outpatient program for AIDS/HIV 1 2 3 4 5 _____
- 50 Alcoholism/chemical dependency outpatient services (*psych/social*) 1 2 3 4 5 _____
- Ambulance/transportation services- Non-emergency**
- 51 - **Non-emergency** inter-facility transports by ground ambulance 1 2 3 4 5 _____
- 52 - **Non-emergency** inter-facility transports by air ambulance 1 2 3 4 5 _____
- 53 Arthritis treatment center 1 2 3 4 5 _____
- 54 Assisted living 1 2 3 4 5 _____
- 55 Auxiliary 1 2 3 4 5 _____
- 56 Bariatric Services: Bariatric/Weight Control Issues 1 2 3 4 5 _____
- 57 Birthing Room/Labor, delivery, recovery, post-partum room (LDR or LDRP room) 1 2 3 4 5 _____
- Cardiac services**
- 58 - Cardiac angioplasty (*percutaneous transluminal*) 1 2 3 4 5 _____
- 59 - Cardiac catheterization laboratory 1 2 3 4 5 _____
- 60 - Cardiac rehabilitation program 1 2 3 4 5 _____
- 61 - Non-invasive cardiac assessment services 1 2 3 4 5 _____
- 62 - Open-heart surgery 1 2 3 4 5 _____
- 63 Case management 1 2 3 4 5 _____
- 64 Crisis prevention 1 2 3 4 5 _____
- 65 Complementary Services 1 2 3 4 5 _____
- Dialysis services:**
- 66 - Hemodialysis 1 2 3 4 5 _____
- 67 - Peritoneal dialysis 1 2 3 4 5 _____
- Emergency/urgent care:**
- 68 - Emergency department (*general medical and surgical*) 1 2 3 4 5 _____
- 69 - Trauma center [**Self-designated level**] 1 2 3 4 5 _____
- 70 - Urgent care center 1 2 3 4 5 _____
- 71 Ethics committee 1 2 3 4 5 _____

Selected Ancillary and Other Services

Circle One

O or B

72	Extracorporeal shock wave lithotripter (ESWL) CHECK ONE Fixed <input type="checkbox"/> Mobile <input type="checkbox"/>	1 2 3 4 5	
73	Fitness center	.....	1 2 3 4 5	
Food service				
74	- Meals on wheels	.....	1 2 3 4 5	
75	- Nutrition programs	.....	1 2 3 4 5	
76	Genetic counseling/screening	.....	1 2 3 4 5	
Geriatric services				
77	- Adult day care program	.....	1 2 3 4 5	
78	- Alzheimer's diagnosis/assessment	.....	1 2 3 4 5	
79	- Comprehensive geriatric assessment	.....	1 2 3 4 5	
80	- Emergency response system	.....	1 2 3 4 5	
81	- Geriatric acute care unit	.....	1 2 3 4 5	
82	- Geriatric clinics	.....	1 2 3 4 5	
83	- Respite care	.....	1 2 3 4 5	
84	- Retirement housing	.....	1 2 3 4 5	
85	- Senior membership program	.....	1 2 3 4 5	
Health promotion				
86	- Community health promotion	.....	1 2 3 4 5	
87	- Patient education	.....	1 2 3 4 5	
88	- Worksite health promotion	.....	1 2 3 4 5	
89	Home health services	.....	1 2 3 4 5	
90	Home hospice services	.....	1 2 3 4 5	
Mammography services				
91	- Diagnostic mammography	.....	1 2 3 4 5	
92	- Mammography screening	.....	1 2 3 4 5	
93	Occupational health services	.....	1 2 3 4 5	
Occupational, physical, and/or rehabilitation services				
94	- Audiology	.....	1 2 3 4 5	
95	- Occupational therapy	.....	1 2 3 4 5	
96	- Physical therapy	.....	1 2 3 4 5	

Selected Ancillary and Other Services

Circle One

O or B

Occupational, physical, and/or rehabilitation services (continued)

- 97 - Recreational therapy 1 2 3 4 5 _____
- 98 - Rehabilitation inpatient services (service does not have beds) 1 2 3 4 5 _____
- 99 - Rehabilitation outpatient services 1 2 3 4 5 _____
- 100 - Respiratory therapy 1 2 3 4 5 _____
- 101 - Speech pathology / therapy 1 2 3 4 5 _____
- 102 Oncology services 1 2 3 4 5 _____
- 103 - Outpatient services – within the hospital 1 2 3 4 5 _____
- 104 - Outpatient services – on hospital campus, but in freestanding center 1 3 4 5 _____
- 104 - Outpatient services – freestanding off hospital campus 1 3 4 5 _____
- 106 Pain Management Program 1 2 3 4 5 _____
- 107 Patient representative services 1 2 3 4 5 _____

Psychiatric services

- 108 - Psychiatric child / adolescent services 1 2 3 4 5 _____
- 109 - Psychiatric consultation – liaison services 1 2 3 4 5 _____
- 110 - Psychiatric education services 1 2 3 4 5 _____
- 111 - Psychiatric emergency services (report utilization on line 138) 1 2 3 4 5 _____
- 112 - Psychiatric geriatric services 1 2 3 4 5 _____
- 113 - Psychiatric outpatient services 1 2 3 4 5 _____
- 114 - Psychiatric partial hospitalization program 1 2 3 4 5 _____
- 115 Radiation therapy 1 2 3 4 5 _____

Radiology, diagnostic

- 116 - CT scanner (Computed Tomographic Scanner) 1 2 3 4 5 _____
Check One: Fixed Mobile Both
- 117 - Diagnostic radioisotope facility 1 2 3 4 5 _____
- 118 - Magnetic resonance imaging (MRI) 1 2 3 4 5 _____
Check One: Fixed Mobile Both
- 119 - Positron emission tomography scanner (PET) 1 2 3 4 5 _____

Selected Ancillary and Other Services

Circle One

O or B

Radiology, diagnostic (continued)

120 - Single photon emission computerized tomography (SPECT) 1 2 3 4 5
Check One: Fixed Mobile Both

121 - Ultrasound 1 2 3 4 5

Reproductive health

122 - Fertility counseling 1 2 3 4 5

123 - In vitro fertilization 1 2 3 4 5

124 Social work services 1 2 3 4 5

125 Sports medicine clinic/services 1 2 3 4 5

126 Surgery, ambulatory or outpatient (day surgery) 1 2 3 4 5

Transplant services

127 - Bone marrow transplant program 1 2 3 4 5

128 - Heart and/or lung transplant 1 2 3 4 5

129 - Kidney transplant 1 2 3 4 5

130 - Tissue transplant 1 2 3 4 5

131 Women's health center/services 1 2 3 4 5

132 Are additional non-listed **patient** services provided by the hospital?
If YES, list and indicate with O or B if provided in other buildings
(If more room is needed, go to Section XI)

.....

Yes No

133 If **O** or **B** is used on lines **26-131**, indicate the number of locations and the address(es) and service(s) provided. (If more room is needed, go to Section XI.)

Number of other locations

Street address _____

Street address _____

City _____

City _____

Service _____ Line _____

Service _____ Line _____

Service _____ Line _____

Service _____ Line _____

Service _____ Line _____

Service _____ Line _____

134 Are there any physicians' clinics that use the hospital's Medicare provider number reported on line 13, for Medicare billing?
.....

Yes No

If YES, indicate the number of clinics.

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

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)

- 135 Inpatient surgical operations (not procedures) _____
- 136 Outpatient surgical operations (not procedures) _____
- 137 TOTAL surgical operations (not procedures) [line 135 + line 136] _____

Outpatient Visits

- 138 Emergency visits _____
- Number of emergency visits that resulted in inpatient admissions (Subset of line 138)
- 139 Other visits (all non-emergency visits, including physician referrals and outpatient surgeries) _____
- 140 Observation visits _____
- 141 TOTAL outpatient visits [Add Line 138 + Line 139 + Line 140] _____

Non-emergency Ambulance/Transport Services

- 142 Non-emergency inter-facility transports by ground ambulance _____
- 143 Non-emergency inter-facility transports by air ambulance _____
- 144 TOTAL non-emergency transports by ambulance [Add Line 142 + Line 143] _____

Newborn Nursery

- 145 Number of bassinets set-up-and-staffed as of the last day of the fiscal year
 (exclude neonatal beds) _____
- 146 Total births (exclude fetal deaths) _____
- 147 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	ALL HOSPITALS FILL OUT COLUMN (1) (1) Total Facility	ONLY hospitals that answered YES to questions on lines 22 and 23 should fill out columns (2) and (3)	
		(2) Hospital	(3) Nursing Home
148 Admissions <i>(exclude newborns; include Medicare-certified and Non-Medicare swing admissions)</i>	_____	_____	_____
149 Inpatient days <i>(exclude newborns; include Medicare-certified and Non-Medicare swing days)</i>	_____	_____	_____ Skilled nursing _____ Intermediate care _____ Residential / Elderly housing
150 Discharges/deaths <i>(exclude newborns; include Medicare-certified and Non-Medicare swing discharges)</i>	_____	_____	_____
151 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	ALL HOSPITALS FILL OUT COLUMN (1)	ONLY hospitals that answered YES to questions on lines 22 and 23 should fill out columns (2) and (3)	
Indicate Beds set-up-and-staffed (NOT number of licensed beds) on the last day <i>excluding weekends or holidays</i> of the hospital's fiscal year quarter (every 3 months).			
152 1 st Quarter	_____	_____	_____ Skilled nursing _____ Residential / Elderly housing
153 2 nd Quarter	_____	_____	_____ Skilled nursing _____ Residential / Elderly housing
154 3 rd Quarter	_____	_____	_____ Skilled nursing _____ Residential / Elderly housing
155 4 th Quarter (Hospital beds must equal line 46, col.1)	_____	_____	_____ Skilled nursing _____ Residential / Elderly housing

**ALL HOSPITALS
FILL OUT COLUMN
(1)**

**ONLY hospitals that answered YES to questions on lines
22 and 23 should fill out columns (2) and (3)**

Medicare / Medicaid Primary Payer Utilization

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

* 156	Total Medicare (Title 18) inpatient discharges	_____	_____	_____
*157	Total Medicare inpatient days	_____	_____	_____
* 158	Total Medicaid (Title 19) Inpatient discharges	_____	_____	_____
*159	Total Medicaid inpatient days	_____	_____	_____

Note for lines 155, 156, 157 and 158: Because of transfers between the hospital and nursing home, column (1) may be less than the sum of columns (2) and (3).

VII. MEDICAL STAFF – September 30, 2006

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

	Hospital	Health Care System	Network
160a Independent practice association (IPA)	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
160b Group practice without walls	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
160c Open Physician Hospital Organization (PHO)	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
160d Closed Physician Hospital Organization (PHO)	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
160e Management service organization (MSO)	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
160f Integrated salary model	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
160g Equity model	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
160h Foundation	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>

Selected Specialty

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

Active/Associate Medical Staff	(1) Medical Staff as of Sept. 30, 2006 <i>(Includes Board Certified)</i>	(2) Board Certified Staff As of Sept. 30, 2006 <i>[Not to exceed column (1)]</i>
Medical Specialties		
161 General and family practice	_____	_____
162 Internal medicine (general)	_____	_____
163 Internal medicine subspecialties	_____	_____
164 Pediatrics (general)	_____	_____
165 Pediatric subspecialties	_____	_____
Surgical Specialties		
166 General surgery	_____	_____
167 Obstetrics/Gynecology	_____	_____
168 All other surgical specialties	_____	_____

Selected Specialty Active/Associate Medical Staff (continued)	(1) Medical Staff as of Sept. 30, 2006 (Includes Board Certified)	(2) Board Certified Staff As of Sept. 30, 2006
Other		
169 Anesthesiology	_____	_____
170 Emergency medicine	_____	_____
171 Pathology	_____	_____
172 Radiology	_____	_____
173 All other specialties (use valid specialties below)	_____	_____
Line 173a - codes for valid specialties- circle all codes that apply:		
01 Addiction Medicine	05 Dental	09 Podiatry
02 Aerospace Medicine	06 General Preventive Medicine	10 Psychiatry
03 Behavioral Medicine	07 Nuclear Medicine	11 Physical Med&Rehab (includes Physiatry)
04 Chiropractic Services	08 Occupational Medicine	12 Public health
174 TOTAL Medical Staff	_____ (add lines 161-173)	_____ (add lines 161-173)

VIII. PERSONNEL ON HOSPITAL PAYROLL – September 30, 2006 - 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, 2006 regardless of the hospitals' fiscal year end date**. Treat shared hospital/nursing home staff as part-time and report only hospital hours. Do not include contracted staff or nursing home personnel.

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

Occupational Categories	FULL TIME		PART TIME	
	Total No. of Persons (35 Hr/Wk or more)	Total No. of Persons (less than 35 Hr/Wk)	Total No. of P-T hours (week of Sept 30, 2006)	
175 Administrators and assistant administrators	_____	_____	_____	
Physician And Dental Services				
176 Physicians / Dentists	_____	_____	_____	
177 Medical and dental residents/interns	_____	_____	_____	
Nursing Services				
178 Registered nurses	_____	_____	_____	
179 Certified nurse midwives	_____	_____	_____	
180 Licensed practical (<i>vocational</i>) nurses	_____	_____	_____	
181 Paraprofessionals: Nursing Assistants (CNAs)	_____	_____	_____	
182 Physician assistants	_____	_____	_____	
183 Nurse practitioners	_____	_____	_____	
184 Pharmacists	_____	_____	_____	
185 Pharmacy Technician/Aides	_____	_____	_____	
186 Medical & Clinical Laboratory Technologists	_____	_____	_____	
187 Medical & Clinical Laboratory Technicians	_____	_____	_____	
188 Surgical Technologists & Technicians	_____	_____	_____	
Therapeutic Services				
189 Respiratory Therapists	_____	_____	_____	
190 Radiologic Technologists	_____	_____	_____	
191 All other Radiologic Personnel	_____	_____	_____	
192 Occupational Therapists	_____	_____	_____	
193 Occupational therapy assistants/aides	_____	_____	_____	
194 Physical therapists	_____	_____	_____	
195 Physical therapy assistants/aides	_____	_____	_____	
196 Recreational therapists	_____	_____	_____	
197 Medical Record Administrators/Technicians	_____	_____	_____	
198 Dieticians and Nutritionists	_____	_____	_____	

Occupational Categories (continued)	FULL TIME	PART TIME	
	Total No. of Persons (35 Hr/Wk or more)	Total No. of Persons (less than 35 Hr/Wk)	Total No. of P-T hours (week of Sept 30, 2006)
Psychology / Social Work Services			
199 Psychologists	_____	_____	_____
200 Social Workers	_____	_____	_____
Other Personnel			
201 All other health professional / technical personnel	_____	_____	_____
202 All other personnel	_____	_____	_____
203 TOTAL hospital personnel	_____	_____	_____
	(add lines 175-202)	(add lines 175-202)	(add lines 175-202)
204 Workweek Indicate the average 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 205-212)

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

- 205 Does your hospital's mission statement include a focus on community benefit? Yes No
- 206 Does your hospital have a long-term plan for improving the health status of its community? Yes No
- 207 Does your hospital have resources for its community benefit activities? Yes No
- 208 Does your hospital work with other providers, public agencies, or community representatives to conduct a health status assessment of the community? Yes No
- 209 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
- 210a 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
- 210b **IF YES**, have you used the assessment to identify unmet health needs, excess capacity, or duplicative services in the community? Yes No
- 211 Does your hospital work with other providers to collect, track, and communicate clinical and health information across cooperating organizations? Yes No
- 212 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 (Lines 213-219)

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

- 213 Identify which of the following your facility uses.

<input type="checkbox"/> CheckPoint (WHA's public reporting program) <input type="checkbox"/> MetaStar Seventh Scope <input type="checkbox"/> Reporting Hospital Quality Data for Annual Payment Update (RGQDAPU)	<input type="checkbox"/> Leapfrog <input type="checkbox"/> National Voluntary Hospital Reporting Initiative <input type="checkbox"/> Other specify _____
---	---
- 214 Has your organization integrated quality evaluation projects involving

National Council on Quality Assurance (NCQA)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
- 215 Does your facility provide 24-hour pharmacy services? Yes No
- 216 If Yes, specify the method of coverage (check the one best answer).

<input type="checkbox"/> On-site pharmacist, 24/7 <input type="checkbox"/> Telephone access (on-call staff)	<input type="checkbox"/> Contractual arrangement with a community pharmacy <input type="checkbox"/> Other, specify _____
--	---

- 217** Prior to dispensing medication, does your pharmacy enter all medication orders into a pharmacy- based computerized processing system when the order is received in the pharmacy? Yes No
- 218a** Has your facility evaluated the feasibility of adopting a Computerized Prescriber Order Entry (CPOE) system? Yes No
- 218b** If Yes, what conclusion did you reach?
- CPOE system already in place. Y
 - Proceed with the acquisition by January 1, 2006. J
 - Proceed with the acquisition after January 1, 2006. A
 - Awaiting HIPAA compliance clarification. W
 - Chose not to purchase due to (check one box bellow):
- 218c**
- Decided CPOE is not necessary. N
 - Cost C
 - Lack of acceptable product P
 - Both cost and lack of acceptable product B
 - Other, specify _____ O
Specify, _____
- 219** Has your hospital implemented a plan, during the last 12-18 months, to eliminate the use of abbreviations and symbols when ordering medication? Yes No

XI. SUPPLEMENTAL INFORMATION

220

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 2005

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 2005*.

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.

Items marked with an asterisk (*) are new for 2005.

Complete and return this form to the address below (or e-mail to WHAInfoCenter@wha.org within 120 days following the close of your hospital's fiscal year. This date can also be found in the "Submittal Deadline" paragraph, page 4, in the manual.

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

Type or print in black ink.

Hospital Administrator / CEO «CONTACT»
Hospital Name and Address «REHOSPN»
«REHOSPAD»
«REHOSCTY», «REHOSPST» «REHOSPZP»

«REHOSPID»

Contact Person (Name and Title)

«CONTACT»
«CONTITLE»

Telephone () «PHONE» - Ext.
Fax Number () -
E-mail Address

Organization and Address (if different from hospital address above)

FY 2005 Beginning Date «REBEGDT»

FY 2005 Ending Date «REENDDT»

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 2005*). 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 1.

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 2005*.

«COMFAC»

STATEMENT OF REVENUE AND EXPENSES

1	NET REVENUE FROM SERVICES TO PATIENTS		<u>«TOTNETRV»</u>
Other Revenue			
2	Tax appropriations	\$ «OORTAX»	<u> </u>
3	All other operating revenue (including operating gains)	\$ «OORALL»	<u> </u>
4	TOTAL Other Revenue (add only lines 2 and 3; do not include line 1 in line 4)		<u>\$ «TOTOOR»</u>
5	TOTAL REVENUE (add lines 1 and 4)		<u>«TOTALREV»</u>
Payroll Expenses			
6	Physicians and dentists	\$ «PAYPHYD»	<u> </u>
7	Medical and dental residents and interns	\$ «PAYINT»	<u> </u>
8	Trainees	\$ «PAYTRA»	<u> </u>
9	Registered nurses and licensed practical nurses	\$ «PAYRNLP»	<u> </u>
10	All other personnel	\$ «PAYALLO»	<u> </u>
11	TOTAL Payroll Expenses (add lines 6 through 10)		<u>\$ «TOTPAYE»</u>
Nonpayroll Expenses			
12	Employee benefits (Social Security, group insurance, retirement benefits, etc.)	\$ «NONPBEN»	<u> </u>
13	Professional fees (medical, dental, legal, auditing, consultant, etc.)	\$ «NONPFEE»	<u> </u>
14	Contracted nursing services (include staff from nursing registries and temporary help agencies)	\$ «NONPCNS»	<u> </u>
15	Depreciation expense (for reporting period only)	\$ «NONPDEP»	<u> </u>
16	Interest expense	\$ «NONPINT»	<u> </u>
17	Bad debt expense (must equal line 115)	\$ «ODBADDB»	<u> </u>
18	Medical malpractice insurance premiums	\$ «NONMALP»	<u> </u>
19	Amortization of financing expenses	\$ «NONPAMO»	<u> </u>
20	Rents and leases	\$ «NONPRL»	<u> </u>
21	Capital component of insurance premium	\$ «NONPCAP»	<u> </u>
22	All other operating expenses (include supplies, purchased services, utilities, property taxes, etc., and operating losses)	\$ «OTHOPEXP»	<u> </u>
23	TOTAL Nonpayroll Expenses (add lines 12 through 22)		<u>\$ «TOTNPEXP»</u>
24	TOTAL EXPENSES (add lines 11 and 23)		<u>«TOTEXPNS»</u>
25	Excess (or deficit) of revenue over expenses (subtract line 24 from line 5; see manual)		<u>\$ «EXCESS»</u>
Nonoperating Gains / Losses			
26	Investment income	\$ «NONOPINV»	<u> </u>
27	Other nonoperating gains (including extraordinary gains)	\$ «NONOPOTH»	<u> </u>
28	Provision for income taxes (for-profit organizations) (absolute values only – no negative values)	\$ «NONOPTAX»	<u> </u>
29	Other nonoperating losses (including extraordinary losses) (absolute values only – no negative values)	\$ «NONOPLOS»	<u> </u>
30	TOTAL Nonoperating Gains / Losses (subtract sum of lines 28 and 29 from sum of lines 26 and 27)		<u>\$ «TOTNONOP»</u>
31	NET INCOME (revenue and gains in excess of expenses and losses) (add lines 25 and 30)		<u>\$ «NETINCOM»</u>

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

Gross Patient Service Revenue and Its Sources

32	Gross revenue from room, board, and medical and nursing services to INPATIENTS	\$ «GRINPAT»	} (sum of lines 32 and 33 must equal sum of inpatient breakouts, lines 36-49)
33	Gross INPATIENT ancillary revenue	\$ «GRINPAN»	
34	Gross revenue from service to OUTPATIENTS	\$ «GROUTPAT» (must equal sum of outpatient breakouts, lines 36-49)	
35	TOTAL GROSS revenue from service to patients		\$ «TOTGR» (add lines 32-34)

NOTE: The following sources of gross patient revenue are by **TOTAL** dollar amounts and by separate **INPATIENT** and **OUTPATIENT** breakouts.

<i>Public Sources</i>	TOTAL	INPATIENT	OUTPATIENT
36 Medicare	\$ «SRCMDCR»	\$ «SINMDCR»	\$ «SOUTMDC»
37 HMOs reimbursed by Medicare under 42 CFR pt. 417	\$ «SRCSEP»	\$ «SINSEP»	\$ «SOUTSEP»
38 Medical Assistance (Including BadgerCare)	\$ «SRCMAS»	\$ «SINMAS»	\$ «SOUTMAS»
39 HMOs reimbursed by Medical Assistance under s. 49.45 (3) (b), Wis. Stats	\$ «SRCHMOR»	\$ «SINHMOR»	\$ «SOUTHMOR»
40 County General Relief	\$ «SRCCGR»		
41 County 51.42 / 51.437 programs	\$ «SRCCTYP»	\$ «SINPUB»	\$ «SOUTPUB»
42 All other public programs	\$ «SRCALLP»	(add lines 40-42 for Inpatient)	(add lines 40-42 for Outpatient)
<i>Commercial Sources</i>			
43 Group and individual accident and health insurance, self-funded plans	\$ «SRCINS»		
44 Worker's compensation	\$ «SRCWCOM»	\$ «SINCOM»	\$ «SOUTCOM»
45 HMOs and all other alternative health care payment systems (exclude lines 37 and 39)	\$ «SRCHMO»	(add lines 43-45 for Inpatient)	(add lines 43-45 for Outpatient)
46 Self-pay	\$ «SRSELF»		
All other sources (specify below)			
47 _____	\$ «SRCNP1»	\$ «SINNPS»	\$ «SOUTNPS»
48 _____	\$ «SRCNP2»	(add lines 46-49 for Inpatient)	(add lines 46-49 for Outpatient)
49 _____	\$ «SRCNP3»		
50 TOTAL GROSS revenue from service to patients, by source	\$ «TOTLA4» (add lines 36-49) [should equal dollar value on line 35]		

Deductions from Patient Service Revenue and Its Sources

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

	TOTAL	INPATIENT	OUTPATIENT
Public Source Contractual Adjustments			
51 Medicare	\$ «DEDMDCR»	\$ «CINMDCR»	\$ «COUTMDC»
52 HMOs reimbursed by Medicare under 42 CFR pt. 417	\$ «DEDSP»	\$ «CINSEP»	\$ «COUTSEP»
53 Medical Assistance	\$ «DEDMAS»	\$ «CINMAS»	\$ «COUTMAS»
54 HMOs reimbursed by Medical Assistance under s. 49.45 (3) (b), Wis Stats.	\$ «DEDHMOR»	\$ «CINHMO»	\$ «COUTHMO»
55 County General Relief	\$ «DEDCGR»	} \$ «CINPUB» (add lines 55-57 for Inpatient)	} \$ «COUTPUB» (add lines 55-57 for Outpatient)
56 County 51.42 / 51.437 programs	\$ «DEDCTY»		
57 All other public programs	\$ «DEDALLO»		
Commercial Source Contractual Adjustments			
58 Group and individual accident and health insurance, self-funded plans	\$ «DEDINS»	} \$ «CINCMP» (add lines 58-60 for Inpatient)	} \$ «COUTCMP» (add lines 58-60 for Outpatient)
59 Worker's compensation	\$ «DEDWCOM»		
60 HMOs and all other alternative health care payment systems (exclude lines 52 and 54)	\$ «DEDHMO»		
Other Source Contractual Adjustments			
All other sources (specify below)			
61 _____	\$ «DEDNPU1»	} \$ «CINNPS» (add lines 61-63 for Inpatient)	} \$ «COUTNPS» (add lines 61-63 for Outpatient)
62 _____	\$ «DEDNPU2»		
63 _____	\$ «DEDNPU3»		
64 Charity care (revenue foregone at full established rates) (must equal line 114)	\$ «ODCHAR»		
65 All other noncontractual deductions	\$ «ODNONC»		
66 TOTAL DEDUCTIONS FROM REVENUE	\$ «TOTDFRV»		
	(add lines 51-65) (total, not breakouts)		

Medicare-Approved Medical Education Activities

NOTE: Of TOTAL expenses in line 24, the reimbursable expenses for Medicare-approved medical education activities separated into the following categories:

67 Direct medical education expenses	\$ «EDDIRM»
68 Indirect medical education expenses	\$ «EDIDIRM»
69 TOTAL reimbursable expenses for Medicare-approved medical education activities (add lines 67 and 68)	\$ «TOTMEDA»

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 2005*.

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

Current Assets

70	Cash and cash equivalents	\$ «CCSTINVS»	_____
71	Inter-corporate account(s)	\$ «INCORPAC»	_____
72	Net patient accounts receivable Total Net patient accounts receivable«REHOSPID»	\$ «NTPATAR»	_____
73	Other accounts receivable	\$ «OTHAR»	_____
74	Other current assets	\$ «OTCURAST»	_____
75	TOTAL current assets (add lines 70 through 74)	\$ «TOTCURAS»	_____
76	Noncurrent assets whose use is limited	\$ «NCLTDUSE»	_____

Property, Plant and Equipment

Gross Plant Assets

77	Land	\$ «LAND»	_____
78	Land improvements	\$ «LANDIMP»	_____
79	Buildings and building improvements	\$ «BUILD»	_____
80	Construction in progress	\$ «CIP»	_____
81	Fixed equipment	\$ «FIXEQP»	_____
82	Moveable equipment	\$ «MOVEQP»	_____
83	TOTAL gross plant assets (add lines 77 through 82)	\$ «TOTGPA»	_____

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

84	Land improvements	\$ «LSLANDIM»	_____
85	Buildings and building improvements	\$ «LSBUILD»	_____
86	Fixed equipment	\$ «LSFXEQP»	_____
87	Moveable equipment	\$ «LSMVEQP»	_____
88	TOTAL accumulated depreciation (add lines 84 through 87)	\$ «TOTACCDP»	_____
89	NET property, plant, and equipment assets (subtract line 88 from line 83)	\$ «NTPTEQAS»	_____
90	Long-term investments	\$ «LTINVST»	_____
91	Other unrestricted assets	\$ «OTHENRES»	_____
92	TOTAL unrestricted assets (add lines 75, 76, 89, 90 and 91)	\$ «TOTUNRES»	_____

Unrestricted Liabilities, Deferred Revenues, and Fund Balances

93	Current liabilities	\$ «CURRLIAB»	_____
94	Inter-corporate account(s)	\$ «INCORLIB»	_____
95	Long-term debt	\$ «LTDEBT»	_____
96	Other noncurrent liabilities and deferred revenues	\$ «OTHLIAB»	_____
97	Unrestricted fund balances	\$ «UNREFUND»	_____
98	TOTAL unrestricted liabilities, deferred revenues, and fund balances (add lines 93 through 97). (NOTE: lines 92 and 98 should be equal. Combination facilities, see manual instructions)	\$ «TOTUNLIB»	_____

Restricted Hospital Funds (report fund balances only)

99 Specific-purpose funds	\$ «SPECPURP»
100 Plant replacement and expansion funds	\$ «PTRPEXF»
101 Endowment funds	\$ «ENDOWFD»

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**
102 Medicare (T-18) Including HMOs reimbursed by T-18	«DISMEDA»	«DIDMEDA»	«BIRMEDA»	«BIDMEDA»
103 Medical Assistance (T-19) Including HMOs reimbursed by T-19	«DISMASA»	«DIDMASA»	«BIRMASA»	«BIDMASA»
104 Self-Pay*	«DISSPAY»	«DIDSPAY»	«BIRSPAY»	«BIDSPAY»
104 a All other pay sources	«DISAOTH»	«DIDAOTH»	«BIRAOTH»	«BIDAOTH»
105 TOTALS	«DISTOT»	«DIDTOT»	«BIRTOT»	«BIDTOT»

* 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.

* **New item for 2005**

** Exclude fetal deaths.

PAY SOURCE	(C1)	(C2)
	NUMBER OF DISCHARGES FROM MEDICARE-CERTIFIED SWING BEDS***	NUMBER OF DISCHARGE DAYS FROM MEDICARE-CERTIFIED SWING BEDS***
106 Medicare (T-18) Including HMOs reimbursed by T-18	«SWGMedA»	«SWIDMedA»
107 Medical Assistance (T-19) Including HMOs reimbursed by T-19	«SWGMA SA»	«SWIDMA SA»
108 Self- Pay*	«SWGSPAY»	«SWIDSPAY»
108a All other pay sources	«SWG AO TH»	«SWID AO TH»
109 TOTALS	«SWG TOT»	«SWID TOT»

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

VI. SUMMARY AND EXPLANATION OF REVENUE DOLLAR DIFFERENCES BETWEEN FY 2004 AND FY 2005

	GROSS REVENUE	NET REVENUE
110 Fiscal Year 2005 [line 35 (gross) and line 1 (net)]	\$ «TOTGRCY» _____	\$ «TOTNRCY» _____
111 Fiscal Year 2004 [FY 2004 Fiscal Survey form line 35 (gross) and line 1 (net)]	\$ «TOTGRPY» _____	\$ «TOTNRPY» _____
112 Increase / Decrease 2005 v. 2004 (subtract line 111 from line 110) [indicate + or -]	\$ «TOTDDG» _____	\$ «TOTDDN» _____
113 Explain in a short narrative the relative importance of various causes for the dollar differences (lines 110 and 111) in the fiscal year revenue figures (price change, utilization change, other causes?). Attach additional page(s) if necessary.		

VII. UNCOMPENSATED HEALTH CARE

Charges for Uncompensated Health Care

	FY 2005	FY 2006(Projected)
114 Charges for charity care provided for the fiscal year	\$ «CHCHRCY» _____	\$ «CHCHRNY» _____
	(from line 64)	
115 Charges determined to be a bad debt expense for the fiscal year	\$ «BDCHRCY» _____	\$ «BDCHRNY» _____
	(from line 17)	
116 TOTAL charges for uncompensated health care for the fiscal year	\$ «TOTCHCY» _____	\$ «TOTCHNY» _____
	(add lines 114 and 115)	(add lines 114 and 115)

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 2005	FY 2006 (Projected)
117 Number of individual patient visit ledgers that received charity care for the fiscal year	«VLCHACY» _____	«VLCHANY» _____
118 Number of individual patient visit ledgers whose charges were determined to be bad debt for the fiscal year	«VLBDACY» _____	«VLBDNY» _____

119 Provide a **rationale** for the hospital's fiscal year 2006 projections in the space below. Explain how the projections used "patients" and total charges for fiscal year 2005, 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.

Hill-Burton Uncompensated Health Care Information

120 Does the hospital have current obligations under this program?
Enter Yes, No, or C (for conditional) on this line. «CURROB»

121 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 «OBMOYR1»/«OBYR1» _____	Month / Year «SATOBMOYR1»/«SATOBYR1» _____
Month / Year «OBMOYR2»/«OBYR2» _____	Month / Year «SATOBMOYR2»/«SATOBYR2» _____
Month / Year	Month / Year

«OBMO3»/«OBYR3»

«SATO BMO3»/«SATO BYR3»

122 If YES, enter the amount of total federal assistance believed to remain under obligation. \$ «TOTOB»