

**Hospital Fiscal Survey Manual  
Fiscal Year 2010**

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P.O. Box 259038  
Madison, Wisconsin 53725-9038**

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## Introduction – Data and Submission Deadlines

Hospitals are required to annually submit their revenue, expense, and balance sheet data to the WHA Information Center under Wisconsin statute.

### **CURRENT ASSETS:**

Question 72 has been expanded to include a breakout of payers for net patient accounts receivable. In previous years, a total net patient accounts receivable was the only item reported.

Payer Breakout:

- Medicare (T18) – Including HMOs reimbursed by T-18
- Medical Assistance (T19) – Including HMOs reimbursed by T-19
- Self-Pay
- All other pay sources

### **PAY SOURCE:**

A pay source of Self-Pay has been added to questions 104 and 108.

### **TYPE OF DATA**

Financial data are submitted in the form of the Hospital Fiscal Survey. Each hospital should complete the survey using data from its final audited financial statements. If these data do not appear on the audited financial statements, the hospital should gather the data from Medicare Cost Reports, notes to the financial statements or other internal hospital financial records. So that the data collected are complete and accurate, hospitals must submit data for every item. If an item is not applicable, enter “0” for that item. “Not available” or “missing” is not acceptable. Round all amounts to the nearest dollar. Failure to report all data may result in forfeitures of up to \$100 per day.

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

### **AICPA GUIDELINES**

This instruction manual provides information about completing form FY 2010 Hospital Fiscal Survey. All financial data questions are based on the AICPA audit and accounting guidelines; for example, those found in “*AICPA Audit and Accounting Guide: Health Care Organizations (2000)*.” This guide applies to organizations (including hospitals) whose principal operations consist of providing or agreeing to provide health care services. It also applies to organizations whose primary activities are the planning, organization, and oversight of such organizations, such as parent or holding companies of health care providers. Government-owned health care facilities that use enterprise fund accounting should also use these guidelines.

**SUBMITTAL DEADLINE**

<b>FISCAL SURVEY DUE DATES</b>	
<b>If the hospital fiscal year ends:</b>	<b>Survey must be returned by:</b>
February 28, 2010	June 29, 2010
March 31, 2010	July 29, 2010
April 30, 2010	August 29, 2010
June 30, 2010	October 29, 2010
July 31, 2010	November 30, 2010
August 31, 2010	December 29, 2010
September 30, 2010	January 28, 2011
December 31, 2010	April 30, 2011

The fiscal survey form must be completed and returned to the WHA Information Center within 120 calendar days following the close of the hospital's 2010 fiscal year. Hospitals that merge, close, or change their reporting fiscal year shall submit a partial survey for the applicable partial year.

A hospital may request an extension for up to 30 calendar days. The request must be made in writing to the WHA Information Center, P.O. Box 259038, Madison WI 53725-9038, and be received at least ten days before the due date.

**ELECTRONIC SUBMISSION OPTION**

The fiscal survey may be completed in either paper or electronic format. Electronic survey submission requires a username and password to access the survey submission web site <http://survey.whainfocenter.com/Register.aspx>. For assistance, contact WHA Information Center as described below.

**ADDRESS**

If you choose the option of completing a paper survey, send the survey form to the WHA Information Center, P.O. Box 259038, Madison WI 53725-9038.

**RESOURCE PERSON**

If you have any questions about completing this form, contact Brian Competente at [bcompetente@wha.org](mailto:bcompetente@wha.org) or (608) 274-1820.

## **SECTION I - HOSPITAL INFORMATION**

Note: \* The web survey tool provides hospital information from previous year. If a change is needed, click on the “update information” section via the home page.

### **\*ADMINISTRATOR NAME**

Enter the name of the administrator.

### **\*HOSPITAL NAME AND ADDRESS**

Enter the name and address of the hospital, including street address, city, state, and zip code.

### **\*CONTACT PERSON, TELEPHONE, FAX, AND E-MAIL**

Enter the name and title of the person who has primary responsibility for completing and submitting the survey. Also enter this person’s direct telephone number, fax number, and e-mail address.

### **\*ORGANIZATION AND ADDRESS**

Enter the name of the organization and the business address of the contact person (above) if this information differs from the hospital name and address.

### **HOSPITAL FISCAL YEAR**

Enter the beginning and ending dates of the hospital’s 2010 fiscal year.

### **CHANGES IN HOSPITAL INFORMATION**

A hospital is required to report certain changes to the WHA Information Center within 45 days after the event occurs. Changes that must be reported include the opening or closing of a hospital; the merger of two or more hospitals; and a change in the hospital’s name, address, fiscal year, or chief executive (or administrative) officer. A letter stating the changes should be sent to the WHA Information Center, P.O. Box 259038, Madison WI 53725-9038.

## SECTION II – GENERAL INFORMATION

### COMBINATION FACILITY

Enter “Yes” if the hospital is jointly operated in connection with a nursing home, home health agency, or other organization, and is governed by a common Board of Directors. A hospital is not considered to be a “Combination Facility” if the hospital operates a home health agency or other organization as a department within the hospital. If entering “Yes,” refer to the Appendix for reporting information.

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

### GENERAL FUND INFORMATION: STATEMENT OF REVENUE AND EXPENSES

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

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

Therefore, classify and report revenue, expenses, gains, and losses on the appropriate survey line in a manner consistent with the hospital’s financial statements that have been prepared following generally accepted accounting principles. However, since no separate lines have been provided for operating gains and losses, include these in “all other operating revenue” (line 3) and in “all other operating expenses” (line 22), respectively.

### LINE-BY-LINE INSTRUCTIONS, LINES 1 THROUGH 31

Line 1      Enter the net revenue from service to patients. Report the estimated net realizable amounts from patients, third-party payers, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis during the period in which related services are rendered, and adjusted in future periods as final settlements are determined.  
**Include Medicaid access payments.**

### OTHER REVENUE

This category consists of operating gains, revenue from services other than health care provided to patients, as well as sales and services to non-patients. Include tax appropriations, revenue from services to patients

that are not patient care services, and sales and activities made available to persons other than patients that are normally part of the day-to-day operation of a hospital.

- Line 2 Enter the amount of revenue from government tax appropriations.
- Line 3 Enter the amount of operating revenue from the aggregation of all other operating revenue, including operating gains, including but not limited to cafeteria sales, gift shop sales, donated supplies, parking lot fees, rental of hospital space, tuition from educational programs, research grants, and income related to borrowed funds.
- Line 4 Enter the “total other revenue” by adding lines 2 and 3.
- Line 5 Add lines 1 and 4.

## EXPENSES

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

## PAYROLL EXPENSES

Lines 6 through 11 refer to salaries for full-time and part-time hospital personnel.

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

- Line 6 Enter the salary expense for physicians and dentists engaged in clinical practice, either full- or part-time. Exclude those physicians and dentists whose clinical work is totally financed by outside research grants or fellowships. The salaries for physicians and dentists who hold full-time or part-time administrative positions should be included under “All other personnel” on line 10.
- Line 7 Enter the salary expense for medical and dental residents and interns.
- Line 8 Enter the salary expense for trainees; for example, those in medical technology, x-ray therapy, administrative residency, and trainees of other specialties who have not completed the necessary requirements for certification or qualifications required for full salary under the related title.
- Line 9 Enter the salary expense for registered nurses (RNs) and licensed practical nurses (LPNs). The salary expense for nurses who hold full- or part-time administrative positions should be included under “All other personnel” on line 10.

“**Registered nurses**” are nurses who have graduated from an approved school of nursing and who are currently state registered. They are responsible for the nature and quality of all nursing care that patients receive.

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

- Line 10 Enter the salary expense for all other personnel. Examples include, but are not limited to, administrators, ancillary nursing personnel, physician assistants, nurse practitioners, technicians, pharmacists, technologists, therapists, therapy assistants, psychologists, medical social workers, kitchen personnel, laundry personnel, maintenance personnel, secretaries, file clerks, etc.
- Line 11 Add lines 6 through 10.

### **NONPAYROLL EXPENSES**

- Line 12 Enter the expense for employee benefits (employer-paid fringe benefits). Examples include, but are not limited to, Federal Insurance Contributions Act (FICA), state and federal unemployment insurance, group health insurance, group life insurance, pension and retirement benefits, workers’ compensation, group disability insurance, and other similar employee benefits.
- Line 13 Enter the expense for professional fees. Include fees billed to hospitals by radiologists, pathologists, anesthesiologists, cardiologists, emergency room physicians, and other contracted and non-contracted medical personnel such as registered physical therapists, nurse anesthetists, and consultants. Also include fees for legal, auditing, and non-medical consulting. Do not include salaried staff physicians, interns, or residents.
- Line 14 Enter the expense for contracted nursing services. This includes all nursing staff who provided services within the hospital, but who was not on the hospital payroll, such as nursing staff from nursing registries, temporary help agencies, etc.
- Line 15 Enter depreciation expense. This includes depreciation on hospital-related buildings, equipment, fixtures, land improvements, and leasehold improvements, recorded on a historical cost basis. Include both the depreciation expenses that have been assigned to specific hospital departments and the amounts that have not been assigned. Do not include amortization of financing expenses (this should be entered on line 19) or assets not related to the operation of the hospital.
- Line 16 Enter interest expense. This includes all interest incurred on loans for working capital purposes and for capital debt purposes.
- Line 17 Enter the charges determined to be bad debt expense as reported on the final audited financial statements. This is the provision for actual or expected uncollectible expenses resulting from the extension of credit. The dollar amount on line 17 should equal the dollar amount on line 115.
- Line 18 Enter the expense for medical malpractice insurance premiums.
- Line 19 Enter the expense for amortization of financing. This includes the actual expenses used to secure a loan (bond), such as attorney fees and discounts. This expense is usually amortized

over the life of the loan. Amortization of financing expense is also referred to as bond issuance costs or bond discounts.

- Line 20 Enter expense for rents and leases. This includes all rental and lease expenses relating to buildings, equipment, fixtures, and leasehold equipment. Include both the rental and lease expense that has been assigned to specific departments and the amount that has not been assigned.
- Line 21 Enter the expense for the capital component of insurance premiums. To derive this figure, refer to the Medicare Cost Report, worksheet A-6 (reclassifications) or the most current worksheet providing that information. Under line item “other insurance,” report the dollar value for capital-related costs; for example, buildings and fixtures. This amount should have been reclassified from the dollar value listed under the category “administrative and general.”
- Line 22 Enter all other operating expenses. Report all other expenses not included in the above categories; for example, utility expenses, supplies, purchased services, property insurance, general liability insurance, license fees, operating losses, etc. **Include Medicaid assessments paid.**
- Line 23 Enter the total nonpayroll expenses by adding the amounts on lines 12 through 22.
- Line 24 Enter the total expenses by adding the amounts on lines 11 and 23.
- Line 25 Enter the excess (or deficit) of operating revenue over operating expenses obtained by subtracting the amount on line 24 from line 5.

#### **NONOPERATING GAINS/LOSSES**

- Line 26 Enter the amount of investment income. Report all income from investments other than income related to borrowed funds.
- Line 27 Enter the amount of other nonoperating gains; for example, unrestricted gifts, donated services, contributions from donors, unrestricted income from endowment funds, etc.
- Line 28 Enter the provision for state and federal corporate income taxes (applicable to for-profit organizations only); enter absolute values only. Do not enter negative numbers.
- Line 29 Enter the amount of nonoperating losses. This includes real estate taxes (if applicable), as well as all other losses not directly related to patient care or hospital-related patient services, such as apartment buildings and physician offices if they are considered part of the hospital; enter absolute values only. Do not enter negative numbers.
- Line 30 Enter the total nonoperating gains/losses obtained by subtracting the sum of the amounts from line 28 and 29 from the sum of the amounts from lines 26 and 27.
- Line 31 Enter the net income (revenue and gains in excess of expenses and losses) by adding the amounts from lines 25 and 30.

## SECTION III - DETAIL OF PATIENT SERVICE REVENUE

### GROSS PATIENT SERVICE REVENUE AND ITS SOURCES

Lines 32 through 50 are based on the accrual system of accounting and at the hospital's **full established rates** (normal charges billed to the patient) for all services rendered; regardless of the amounts (if any) the hospital actually expects to collect.

#### LINE-BY-LINE INSTRUCTIONS, LINES 32 THROUGH 66:

Line 32 Enter the gross revenue generated from daily room, board, and medical and nursing services to inpatients based on full established rates.

Line 33 Enter the gross inpatient ancillary revenue. This is inpatient revenue for services other than room, board, and medical and nursing services that the hospital provides. Examples include, but are not limited to, laboratory, radiology, pharmacy, and therapy services. Refer to the ancillary cost centers on the Medicare Cost Report for more examples.

*THE SUM OF LINES 32 + 33 SHOULD EQUAL THE SUM OF LINES 36 THROUGH 49, INPATIENT.*

Line 34 Enter on line 34 the gross revenue generated from services to outpatients based on full established rates.

*LINE 34 SHOULD EQUAL THE SUM OF LINES 36 THROUGH 49, OUTPATIENT.*

Line 35 Enter on line 35 the total gross revenue from service to patients obtained by adding the amounts from lines 32 through 34.

*LINE 35 SHOULD EQUAL LINE 50, TOTAL GROSS REVENUE FROM SERVICE TO PATIENTS.*

### SOURCES OF GROSS PATIENT REVENUE

Lines 36 through 50 pertain to gross patient revenue from public, commercial, and other sources. Enter the total dollar amounts (or reasonable estimates based upon the hospital's internal records) and by separate inpatient and outpatient dollar amounts on the lines indicated.

The sum of dollar values on lines 32 and 33 should equal the sum of dollar values for inpatient breakouts on lines 36 through 49. The dollar value on line 34 should equal the sum of dollar values for outpatient breakouts on lines 36 through 49.

### PUBLIC SOURCES

Lines 36 through 42. Public source means any program funded with government funds.

Line 36 Enter the total gross patient revenue billed to Medicare. Exclude HMOs reimbursed by Medicare. Medicare is also known as MR, Title 18, Title XVIII, or T-18.

- Line 37 Enter the total gross patient revenue billed to HMOs that are reimbursed by Medicare.
- Line 38 Enter the total gross patient revenue billed to Medical Assistance. Exclude HMOs reimbursed by Medical Assistance. Medical Assistance is also known as MA, Medicaid, Title 19, Title XIX, or T-19 and includes BadgerCare.
- Line 39 Enter the total gross patient revenue billed to HMOs that are reimbursed by Medical Assistance, including BadgerCare. Hospitals in counties serving “out of plan” T-19 HMO patients should enter the billed amounts on this line.

Separate the dollar amounts on lines 36 through 39 into INPATIENT and OUTPATIENT dollar amounts and enter on the corresponding lines.

- Line 40 Enter the total gross patient revenue billed to county general relief. General relief means such services, commodities, or money as are reasonable and necessary under the circumstances to provide food; housing; clothing; fuel; light; water; medicine; medical, dental, and surgical treatment (including hospital care); optometrical services; nursing; transportation; funeral expenses; and includes wages for work relief. Generally, hospital care is paid for by the county for indigent patients who do not qualify for Medical Assistance.
- Line 41 Enter the total gross patient revenue billed to county programs under s. 51.42 and 51.437, Wis. Stats. This also includes programs under s. 46.23, Wis. Stats. These programs provide community services and facilities for the prevention or amelioration of mental disabilities, including but not limited to mental illness, developmental disabilities, alcoholism, and drug abuse. These programs are the responsibility of the county unified services or human services board. This funding source is sometimes referred to as a 51.42 Board.
- Line 42 Enter the total gross patient revenue billed to all other public programs. Examples include non-Wisconsin Medical Assistance; the primary health care program known as WisconCare; CHAMPUS or CHAMPVA (refers to Civilian Health and Medical Program of the Uniformed Services - Veterans Administration: health benefits for military personnel and dependents).

Separate the sum of lines 40 through 42 into INPATIENT and OUTPATIENT dollar amounts and enter on the line indicated in parentheses.

## COMMERCIAL SOURCES

Lines 43 through 45. Include all non-governmental sources of revenue.

- Line 43 Enter the total gross patient revenue billed to group and individual accident and health insurance sources (also referred to as commercial or private insurance or indemnity health care plans), employer self-funded plans, and other organization self-funded plans.
- Line 44 Enter the total gross patient revenue billed to workers' compensation.

Line 45 Enter the total gross patient revenue billed to Health Maintenance Organizations (HMOs) and all other alternative health care payment systems. This does not include revenue from HMOs reimbursed by Medical Assistance or HMOs reimbursed by Medicare. These are defined as follows:

“**HMO**” means a health care plan that makes available to its participants, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers selected by the organization.

“**Other alternative health care payment system**” means a negotiated health plan other than an HMO or an indemnity health care plan.

Examples of other alternative payment systems: preferred provider organization (PPO), preferred provider arrangement (PPA), preferred provider plan (PPP), limited service health organization (LSHO).

Separate the sum of lines 43 through 45 into INPATIENT and OUTPATIENT dollar amounts and enter on the lines indicated in parentheses.

Line 46 Enter the total gross patient revenue billed directly to the patient for self-payment. This category generally applies to persons who do not have health insurance coverage.

#### **ALL OTHER SOURCES**

Lines 47-49 Enter the total gross patient revenue billed to all other sources. These sources must be specified in the space provided on the form. For Milwaukee Hospitals, the reporting of GAMP post-capitated revenue must be reported in Line 49. Indicate GAMP in description field. For non-Milwaukee hospitals, if this field is used, please identify description of source. (Please note: Line 64 should include the post-cap GAMP allowances. It should not be reported in Line 61 thru 63).

Separate the sum of lines 46 through 49 into INPATIENT and OUTPATIENT dollar amounts and enter on the line indicated in parentheses.

#### **TOTAL GROSS REVENUE FROM SERVICE TO PATIENTS**

Line 50 Enter the total gross revenue from service to patients, by source. Add totals, not breakouts, for lines 36 through 49. The total should equal the dollar amount on line 35.

#### **DEDUCTIONS FROM PATIENT SERVICE REVENUE AND ITS SOURCES**

Lines 51 through 66 are based on revenues uncollectible by reason of contractual adjustments, courtesy and policy discounts, charity care, or other unspecified adjustments and deductions. Enter the actual dollar amounts, or reasonable estimates based on the hospital's internal records, by inpatient and outpatient breakouts.

#### **CONTRACTUAL ADJUSTMENTS**

Lines 51 through 63 refer to the difference between a hospital's normal charges for patient services and the discounted charge or payment received by the hospital from the payer.

## PUBLIC SOURCE CONTRACTUAL ADJUSTMENTS

- Line 51 Enter the total difference between billed and received (or receivable) amounts for Medicare. Exclude HMOs reimbursed by Medicare. Medicare is also known as MR, Title 18, Title XVIII, or T-18.
- Line 52 Enter the total difference between billed and received (or receivable) amounts for HMOs that are reimbursed by Medicare.
- Line 53 Enter the total difference between billed and received (or receivable) amounts for Medical Assistance. Exclude HMOs reimbursed by Medical Assistance. Medical Assistance is also known as MA, Medicaid, Title 19, Title XIX, or T-19, and includes BadgerCare. **Include effect of enhanced Medical Assistance payments.**
- Line 54 Enter the total difference between billed and received or receivable amounts for HMOs that are reimbursed by Medical Assistance. Hospitals in other counties serving "out of plan" T-19 HMO patients may not have contractual adjustments for those charges. **Include effect of enhanced Medical Assistance payments.**

Separate the dollar amounts on lines 51 through 54 into INPATIENT and OUTPATIENT dollar amounts and enter on the corresponding lines.

- Line 55 Enter the total difference between billed and received or receivable amounts for county general relief. General relief means such services, commodities, or money as are reasonable and necessary under the circumstances to provide food; housing; clothing; fuel; light; water; medicine; medical, dental, and surgical treatment (including hospital care); optometrical services; nursing; transportation; funeral expenses; and includes wages for work relief. Generally, the county pays for hospital care for indigent patients who do not qualify for Medical Assistance. Line 55 should include pre-capitated GAMP allowances only. Post-capitated allowances must be reported in Line 64.
- Line 56 Enter the total difference between billed and received or receivable amounts for county programs under s. 51.42 and 51.437, Wis. Stat. This also includes programs under s. 46.23, Wis. Stat. These programs provide community services and facilities for the prevention or amelioration of mental disabilities, including but not limited to mental illness, developmental disabilities, alcoholism, and drug abuse. These programs are the responsibility of the county unified services or human services board. This funding source is sometimes referred to as a 51.42 Board.
- Line 57 Enter the total difference between billed and received or receivable amounts for all other public programs. Examples include Non-Wisconsin Medical Assistance; the primary health care program known as WisconCare; CHAMPUS or CHAMPVA (refers to Civilian Health and Medical Program of the Uniformed Services - Veterans Administration: health benefits for military personnel and dependents).

Separate the sum of lines 55 through 57 into INPATIENT and OUTPATIENT dollar amounts and enter on the lines indicated in parentheses.

## COMMERCIAL SOURCE CONTRACTUAL ADJUSTMENTS

Line 58 Enter the total difference between billed and received or receivable amounts for group and individual accident and health insurance sources (also referred to as commercial or private insurance or indemnity health care plans), employer self-funded plans, and other organization self-funded plans.

Line 59 Enter the total difference between billed and received or receivable amounts for workers' compensation.

Line 60 Enter the total difference between billed and received or receivable amounts for Health Maintenance Organizations (HMOs) and all other alternative health care payment systems. This does not include revenue from HMOs reimbursed by Medical Assistance. These are defined as follows:

“HMO” is a health care plan that makes available to its participants, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers selected by the organization.

“Other alternative health care payment system” is a negotiated health plan other than an HMO or an indemnity health care plan.

Examples of other alternative payment systems: preferred provider organization (PPO), preferred provider arrangement (PPA), preferred provider plan (PPP), limited service health organization (LSHO).

Separate the sum of lines 58 through 60 into INPATIENT and OUTPATIENT dollar amounts and enter on the lines indicated in parentheses.

## OTHER SOURCE CONTRACTUAL ADJUSTMENTS

Lines 61-65 Enter on lines 61 through 63 the total difference between billed and received (or receivable) amounts for all other nonpublic sources. These sources must be specified in the space provided.

Separate the sum of lines 61 through 63 into INPATIENT and OUTPATIENT dollar amounts and enter on the lines indicated in parentheses.

## CHARITY CARE

Charity care is health services that were never expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge or at reduced charges to individuals who meet certain financial criteria. For purposes of this survey, charity care is measured on the basis of revenue foregone, at full established rates. Include Hill-Burton figures. The total dollar amount on line 64 should equal the dollar amount on line 114.

- Line 64 Enter the amount of “charity care” as defined above. Line 64 should include post-capitated GAMP allowances. Do NOT include post-capitated in Line 55.
- Line 65 Enter uncollectible revenue due to all other noncontractual deductions. Examples include, but are not limited to, physician or clergy courtesy discounts, employee discounts, administrative adjustments, and research grants.
- Line 66 Enter total deductions from revenue. Add totals, not breakouts, for lines 51 through 65.  
**MEDICARE-APPROVED MEDICAL EDUCATION ACTIVITIES, LINES 67 THROUGH 69.**
- Line 67 Enter the direct medical education expenses that have been included in “TOTAL expenses” on line 24. **“Direct medical education expenses”** are the direct medical education costs in approved programs based upon the amounts that are reimbursed by Medicare. Approved programs include programs to train interns and residents, nursing schools, and medical education of paraprofessionals (e.g., radiologic technicians). They do not include on-the-job or “in-service” training, or other activities that do not involve the actual operation or support by the provider, except through tuition or similar payments, of an approved education program. To derive this figure refer to the Medicare Cost Report, Worksheet B, Part I.
- Line 68 Enter the indirect medical education expenses that have been included in “TOTAL expenses” on line 24. **“Indirect medical education expenses”** are those costs designed to cover the increased operating, or patient care, costs that are associated with approved intern and resident programs. Among other factors, this figure is based upon the number of residents and the number of patients in the hospital. To derive this figure, refer to the Medicare Cost Report, Worksheet E.
- Line 69 Add lines 67 and 68 for the total Medicare-approved medical education expenses.

## SECTION IV - BALANCE SHEET - GENERAL FUNDS

### BALANCE SHEET

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

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

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

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

### DEFINITIONS

“**Balance Sheet**” means a statement of financial position showing the hospital’s assets, liabilities, and fund balances on a given date.

“**Combination Facility**” means a hospital jointly operated in connection with a nursing home, home health agency or other organization, and governed by a common Board of Directors. A facility is not considered to be a “Combination Facility” if the hospital operates a home health agency or other organization as a department within the hospital. Also see the Appendix at the end of this manual for additional instructions.

“**Fund**” means a self-contained accounting entity set up to account for a specific activity or project.

“**Fund Balance**” means the excess of assets over liabilities (net equity). An excess of liabilities over assets is reflected as a deficit.

### LINE-BY-LINE INSTRUCTIONS, LINES 70 THROUGH 101

#### UNRESTRICTED ASSETS

Enter on lines 70 through 92 all unrestricted assets that are carried on the hospital’s balance sheet at the end of the fiscal year. List funds from inter-corporate accounts on line 71. DO NOT report negative values except in cash. Include actual or estimated value of the plant and/or equipment that is leased.

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

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

## CURRENT ASSETS

- Line 70 Enter the total amount of cash and cash equivalents. This includes actual money and other immediately available resources or credit instruments generally accepted as media of exchange and considered cash equivalents; for example, coin and paper currency, demand deposits in banks, checks and money orders, bank savings accounts, certificates of deposit, U.S. treasury bills, etc. Also included are temporary investments in stocks and bonds which are readily marketable and which management intends to hold for only a brief period (as defined by hospital auditors).
- Line 71 Enter any inter-corporate account(s).
- Line 72a\* Enter net patient accounts receivable for Medicare (T-18) – Including HMOs reimbursed by T-18.
- Line 72b\* Enter net patient accounts receivable for Medical Assistance (T-19) – Including HMOs reimbursed by T-19.
- Line 72c\* Enter net patient accounts receivable for self-pay patients.
- Line 72d\* Enter net patient accounts receivable for all other pay sources.
- Line 72e Enter total of lines 72a-72d.
- Line 73 Enter the total of other accounts receivable. These include estimated third-party payer settlements, accounts due from other funds, related-party receivables, employee receivables, etc.
- Line 74 Enter all other current assets. These are defined as those assets that will be consumed in the normal operations of the hospital within one year of the balance sheet date. This may include the current portion (i.e., required for current liabilities) of assets whose use is limited, prepaid expenses, supplies inventory, and short-term investments.
- Line 75 Enter total current assets by adding lines 70 through 74.
- Line 76 Enter total noncurrent assets whose use is limited. This is defined as the noncurrent portion of general fund assets that are:
- ◆ Set aside by the governing board for identified purposes (also referred to as board-designated assets);

- ◆ Proceeds of debt issues and funds of the health care institution deposited with a trustee and limited to use in accordance with the requirements of an indenture or a similar agreement; and
- ◆ Other assets limited to use for identified purposes through an agreement between the health care entity and outside party other than a donor or grantor (includes assets set aside under a self-insurance funding arrangement and assets set aside under agreements with third-party payers to meet depreciation funding requirements).

## **PROPERTY, PLANT, AND EQUIPMENT**

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

### **GROSS PLANT ASSETS**

Lines 77 through 83. Defined as physical properties used for hospital purposes (i.e., land, land improvements, buildings and building improvements, construction in progress, and equipment). The term excludes real estate or properties of restricted or unrestricted funds not used for hospital operations.

- Line 77      Enter the cost or other basis of total land assets. Land includes the earth surface owned by the hospital and used in the ordinary course of hospital operations. Examples include all land used for building sites, yards and grounds, and parking areas, but not land acquired for future expansion and not currently in use.
- Line 78      Enter the cost or other basis of all land improvements.
- Line 79      Enter the cost or other basis of all buildings and building improvements owned by the hospital and used in its normal day-to-day activities. Examples include hospital buildings, personnel residences, garages and storage houses, and utility structures such as an outlying heating and cooling plant.
- Line 80      Enter the cost or other basis of all construction in progress.
- Line 81      Enter the cost or other basis of all fixed equipment. This includes equipment that is affixed to, and constitutes a structural component of, the hospital building, not subject to transfer or removal from its fixed location. Examples include mechanical and electrical systems, elevators, generators, pumps, boilers, and refrigeration machinery.
- Line 82      Enter the cost or other basis of all moveable equipment. Moveable equipment can be readily moved from one location to another in the hospital. Examples include equipment costing \$500 or more, such as computer systems, beds, automobiles and trucks, operating tables, x-ray apparatus, and other medical equipment.
- Line 83      Enter total gross plant assets obtained by adding the amounts from lines 77 through 82.

**ACCUMULATED DEPRECIATION**

Lines 84 through 88. This is depreciation accumulated over the years, including the depreciation applicable to the current year. This includes depreciation on land improvements, buildings and building improvements, and equipment. Enter absolute values only; do not use negative numbers.

- Line 84 Enter the accumulated depreciation on all land improvements.
- Line 85 Enter the accumulated depreciation on all buildings and building improvements.
- Line 86 Enter the accumulated depreciation on all fixed equipment.
- Line 87 Enter the accumulated depreciation on all moveable equipment.
- Line 88 Enter all total accumulated depreciation, by adding the amounts from lines 84 through 87.
- Line 89 Enter the net property, plant, and equipment assets, by subtracting line 88 from line 83. If net plant and equipment assets equal zero, explain on an attached sheet.
- Line 90 Enter the amount of all long-term investments. These long-term investments are generally reported at the lower of cost or market value. Examples include government bonds, corporate bonds, and corporate stocks, either preferred or common; or land acquired for future expansion that is not currently in use.
- Line 91 Enter the amount of all other unrestricted assets. These may include deferred financing costs, unamortized bond issue costs, investment in affiliated company partnership, deferred third-party reimbursement, deferred pension expense, deferred pension assets and long-term receivables. Should include transfers or amounts due from restricted funds. Examples include transfers from specific purpose funds, endowment funds, or Plant Replacement and Expansion Fund(s) for Plant Asset Acquisitions.
- Line 92 Enter the total of all unrestricted assets by obtained by adding the amounts from lines 75, 76, 89, 90, and 91.

**UNRESTRICTED LIABILITIES, DEFERRED REVENUES, AND FUND BALANCES**

- Line 93 Enter the amount of all current liabilities. These are defined as those obligations that mature and normally will be paid within approximately one year from the balance sheet date. Examples include notes payable, accounts payable, accrued expenses, current portion of long-term debt, loans against a line of credit, estimated third-party settlements, advances from third-party payers, accounts due to donor-restricted funds, accrued interest payable, unexpended grants/gifts income, accrued payroll, and related liabilities. Enter liabilities from inter-corporate accounts on line 94.
- Line 94 Enter all inter-corporate accounts.
- Line 95 Enter all long-term debt. This includes only debts for which the hospital has responsibility for repayment. May include revenue and other bonds, mortgages payable, notes payable, and loan contracts payable. Examples include long-term notes, mortgages, and bonds payable that are not due within one year of the balance sheet date.

- Line 96 Enter all other noncurrent liabilities and deferred revenues. These may include estimated malpractice/self-insurance costs, deferred compensation amounts payable, deferred third-party reimbursements, accrued pensions, and deferred pension liabilities.
- Line 97 Enter all unrestricted fund balances. This is the excess of assets over liabilities (net equity). An excess of liabilities is reflected as a deficit.
- Line 98 Enter the total unrestricted liabilities, deferred revenues, and fund balances by adding lines 93 through 97.

**RESTRICTED HOSPITAL FUNDS**

Lines 99 through 101. Report dollar amounts for each fund balance only (assets minus liabilities).

- Line 99 Enter the amount of all specific-purpose funds. These are resources restricted by donors for purposes other than plant asset acquisitions or endowments. Examples include funds for specific purposes such as charity service, research activities, working capital, or educational programs conducted by the hospital. DO NOT include “board-restricted” or “board-designated funds.” If a board wishes to earmark certain assets for a particular purpose, they should be described as “board-designated assets” rather than “board-restricted assets.” Board-designated assets are unrestricted assets and must be reported as a part of the hospital’s unrestricted fund.
- Line 100 Enter all plant replacement and expansion funds. This includes cash and other assets received by the hospital from donors and other external authorities who restrict the use of those resources to the acquisition of plant assets. Examples include cash and pledges from donors to contribute to future purchases of plant assets.
- Line 101 Enter all endowment funds. These are contributed resources that, by donor restriction, are not to be expended but are to be held intact for the production of income.

## SECTION V - HOSPITAL INPATIENT UTILIZATION BY PAY SOURCE

### PAY SOURCE

The following lines and columns refer to hospital inpatient utilization. Lines 102 through 109 are divided into three shaded blocks, one for acute-care patients (inpatients), one for newborns, and one for Medicare-certified swing-bed patients. The first column of each block is for counts of discharges; the second column is for the number of days. Refer to the notes indicated by asterisks.

### PAY SOURCE CATEGORIES (LINES 102-104a, 106-108a)

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

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

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

### LINE-BY-LINE INSTRUCTIONS, LINES 102 THROUGH 109

For lines 102 through 104a, and 106 through 108a, enter the information for each pay category:

Lines 102-104a In column A1, enter the total number of acute-care patients (inpatients) who were discharged during the fiscal year. Discharges include adult, pediatric, intensive and intermediate care, and neonatal patients (including deaths). Exclude newborn, Medicare-certified swing bed, and hospital unit transfer patients. In column A2, enter the corresponding number of discharge days. If discharge days are not available, use inpatient days. Enter an "I" next to the figure if inpatient days are used.

Lines 102-104a In column B1, enter the total number of newborns. Exclude fetal deaths. In column B2, enter the corresponding number of newborn discharge days.

Line 105 Enter totals of lines 102 – 104a.

Lines 106-108a In column C1, enter the discharges from Medicare-certified swing beds. Include both skilled and intermediate care swing beds. In column C2, enter the corresponding number of discharge days from Medicare-certified swing beds.

Line 109 Enter totals of lines 106 – 108a.

## **SECTION VI - SUMMARY AND EXPLANATION OF REVENUE DOLLAR DIFFERENCES BETWEEN FY 2009 AND FY 2010**

Lines 110 through 113 refer to a summary and explanation of total gross and net revenue dollar differences between designated hospital fiscal years.

### **LINE-BY-LINE INSTRUCTIONS, LINES 110 THROUGH 113**

Line 110 Enter the total gross and net revenue from service to patients for fiscal year 2010. Use the figures reported on line 35 (gross) and line 1 (net) of this survey.

Line 111 Enter the total gross and net revenue from service to patients for fiscal year 2009 (last year). Use the figures reported on line 35 (gross) and line 1 (net) of the FY 2009 Hospital Fiscal Survey.

Line 112 Enter the dollar differences between the designated revenue figures, by subtracting line 111 from line 110. Indicate whether these dollar differences are positive or (negative) numbers.

Line 113 Enter in the space provided a short narrative explaining what caused the dollar differences between lines 110 and 111. You may use percentages to break down the differences by price changes, utilization changes, and other causes. Be as specific as possible. Attach additional pages if needed.

## SECTION VII - UNCOMPENSATED HEALTH CARE

### LINE-BY-LINE INSTRUCTIONS, LINES 114 THROUGH 122

#### CHARGES FOR UNCOMPENSATED HEALTH CARE

Lines 114-118 In the first column, enter the actual amounts for FY 2010. In the second column, list projections for the FY 2011. Hospitals may use their own methods for determining FY 2011 projections. A rationale for these projections must be provided on line 119.

Line 114 Enter the amount of charges for charity care provided in FY 2010. For purposes of this survey, charity care is measured on the basis of revenue foregone, at full established rates. Line 114, column 1 must equal line 64. Enter in column 2 the projected charges for charity care for FY 2011.

Line 114a\* In the first column, enter the charity care cost, using hospital cost to charge ratio, determined in FY 2010. Enter in column 2 the projected charity care cost projected for FY 2011. Cost-to-Charge Ratio – (Total Expenses minus Bad Debt divided by (Total Gross Patient Revenue Plus Other Operating Revenue)

Line 115 Enter the amount of charges determined to be bad debt in FY 2010 as reported on the final audited financial statements. Line 115, column 1 must equal line 17. Enter in column 2 the projected charges for bad debt for FY 2011.

Line 115a\* In the first column, enter the bad debt cost using hospital cost to charge ratio determined to be bad debt in FY 2010. Enter in column 2 the projected bad debt cost for FY 2011. Cost-to-Charge Ratio- (Total Expenses minus Bad Debt divided by (Total Gross Patient Revenue plus Other Operating Revenue)

Line 116 Add lines 114 and 115 for the total charges for uncompensated health care for FY 2010 and projected charges for FY 2011.

Line 116a\* In the first column enter the total cost for uncompensated cost for FY 2010 (add lines 114a and 115a). Enter in column 2 the projected total uncompensated cost for FY 2011.

Line 116b\* Provide the hospital cost-to-charge ratio used for calculating lines 114a, 115a, and 116a (e.g. .458)

#### NUMBER OF “PATIENTS” RECEIVING UNCOMPENSATED HEALTH CARE

Line 117 Enter the number of individual patient visit ledgers that received charity care in FY 2010. and the number of projected ledgers that are expected to receive charity care in FY 2011.

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

- ◆ An entire inpatient stay;

- ◆ All services rendered to an outpatient on a calendar day;
- ◆ An ambulance run pertaining to the transfer of a Medicare inpatient to another facility, or the transport of a Medicare patient to this facility for urgent, emergent, or inpatient service;
- ◆ Monthly durable medical equipment rentals; or
- ◆ An entire swing-bed stay.

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

NOTE - The FY 1991 Hospital Uncompensated Health Care Plan asked a series of research questions. Those questions were an attempt to find out how hospitals tracked “patients” receiving uncompensated health care. Based on the response and input that were received, most hospitals (74%) track individual patient visit ledgers or accounts. Therefore, the WHA Information Center is requiring that all hospitals report using this method.

Line 118      In the first column, enter the number of individual patient visit ledgers whose charges were determined to be bad debt expense in FY 2010. In the second column, enter the number of projected ledgers expected to be a bad debt expense in FY 2011. Provide a rationale for these projections on line 119.

Line 119      Provide a rationale for the hospital’s FY 2011 projections as reported on lines 114 through 118. This may be based upon past fiscal information and projected growth. It could also include a description of the socioeconomic climate of the hospital’s market area and how that affects the hospital’s uncompensated health care plan.

### **HILL-BURTON UNCOMPENSATED HEALTH CARE INFORMATION**

Line 120      Check the appropriate box indicating whether the facility has current obligations under Hill-Burton. Those hospitals that believe they have satisfied their obligations but are awaiting the results of a final federal audit may enter “C” for “conditional.”

Between 1946 and 1974 a number of Wisconsin hospitals participated in the Hill-Burton program, which provided federal funds to assist in the construction of new or renovation of existing public or nonprofit hospital facilities. In return, the federal government required these hospitals to provide a reasonable amount of care without charge or at reduced rates to those persons who could not afford health care.

Line 121      If “yes” is entered on line 120, enter the beginning date and projected ending date for each obligation.

Line 122      If “yes” is entered on line 120, enter the outstanding amount of the obligation believed to be remaining or the most recent figure from the federal government. For multiple entries on line 121, the amount on line 122 should be the combined total of outstanding obligations. If certain items are disallowed under federal audit, this figure may increase in FY 2010.

- Line 123      Medicaid Assistance assessments paid to State of Wisconsin. Enter the total assessments paid to State of Wisconsin for FY 2010.
- Line 124      Enhanced MA fee-for-service payments (**estimates**). Enter inpatient, outpatient, and total MA fee-for-service payments in 2010.
- Line 125      Actual access payments received through HMOs reimbursed by Medical Assistance under Ch. 49, Wis. Stats. Enter inpatient, outpatient, and total Medicaid, HMO payments in 2010.
- Line 126      Total MA reimbursement enhancements. Add lines 124 and 125 for inpatient, outpatient, and total. Provide values in line 126.

## APPENDIX – INFORMATION FOR COMBINATION FACILITIES

### DEFINITION

“**Combination Facility**” is a hospital that is jointly operated in connection with a nursing home, a home health agency, or other organization, and is governed by a common Board of Directors. A hospital is not considered to be a “Combination Facility” if the hospital operates a home health agency or other organization as a department within the hospital.

### Examples:

#### Hospital and Nursing Home:

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

#### Hospital and Clinics:

- ◆ If a hospital considers a clinic as one of its departments and manages it as such, then the clinic information is included with the hospital information. This includes onsite and offsite clinic locations. The key consideration: Is the clinic, as a hospital department, controlled by the hospital Board of Directors? In this situation, a hospital reports the data for both entities together in the fiscal survey.
- ◆ If the clinic is incorporated as a separate entity, then the clinic information is not included with the hospital information. Section II (Revenue and Expenses) and Section III (Patient Service Revenue and Deductions) should be reported for the hospital unit only. For Section IV, see “Special Instructions for the Balance Sheet” below.

### SPECIAL INSTRUCTIONS FOR THE BALANCE SHEET

For hospitals that meet the definition of a “Combination Facility,” the general rule is that, whenever possible, report hospital data only. If a hospital is jointly operated in connection with a nursing home, a home health agency, or other organization, the **hospital shall submit the data specified for revenue and expenses for the hospital unit only**. The hospital shall also submit the data specified for unrestricted assets and unrestricted liabilities and fund balances (**balance sheet data**) **for the hospital unit only**.

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

#### Step 1:

If a hospital meets the definition of a combination facility, the hospital should use the balance sheet data from the hospital’s final audited financial statements for the hospital unit alone. If that information is not available, the hospital shall use data from its most recent Medicare Cost Report to derive the required data for the hospital unit for the following lines:

72	Net patient accounts receivable
77-89	Property, plant, and equipment
95	Long-term debt

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

**Step 2:**

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

91	Other unrestricted assets
99	Specific purpose funds

**Step 3:**

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

70	Cash and cash equivalents
71	Inter-corporate account(s)
74	Other current assets
90	Long-term investments
93	Current liabilities
94	Inter-corporate account(s)
96	Other concurrent liabilities and deferred revenues
97	Unrestricted fund balances
100	Plant replacement and expansion funds
101	Endowment funds

**Note: Lines 92 and 98 should be equal. However, Combination Facility totals may not balance due to the mixture of hospital-specific and total facility data.**