

HOSPITAL FISCAL SURVEY FISCAL YEAR 2011

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 2011*.

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

Round all amounts to the nearest dollar.

Complete 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
--

I. HOSPITAL INFORMATION

Type or print in black ink.

Hospital Name and Address «NAME»
 «ADDRESS»
 «CITY», «STATE» «ZIP»

FY 2011 Beginning Date «FYBEG»

FY 2011 Ending Date «FYEND»

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 2011*). 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.

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

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

For definitions and instructions, see the *Hospital Fiscal Survey Manual, Fiscal Year 2011*.

STATEMENT OF REVENUE AND EXPENSES

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

_____ \$ _____

Other Revenue

4 Tax appropriations _____ \$ _____

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

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

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

Payroll Expenses

8 Physicians and dentists _____ \$ _____

9 Medical and dental residents and interns _____ \$ _____

10 Trainees _____ \$ _____

11 Registered nurses and licensed practical nurses _____ \$ _____

12 All other personnel _____ \$ _____

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

Nonpayroll Expenses

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

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

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

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

18 Interest expense _____ \$ _____

19 Bad debt expense (must equal line 124) _____ \$ _____

20 Medical malpractice insurance premiums _____ \$ _____

21 Amortization of financing expenses _____ \$ _____

22 Rents and leases _____ \$ _____

23 Capital component of insurance premium _____ \$ _____

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

25 TOTAL Nonpayroll Expenses (add lines 14 through 24) _____ \$ _____

26 TOTAL EXPENSES (add lines 13 and 25) _____ \$ _____

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

Nonoperating Gains / Losses

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

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

Gross Patient Service Revenue and Its Sources

34	Gross revenue from room, board, and medical and nursing services to INPATIENTS	_____	\$	_____] (sum of lines 34 and 35 must equal sum of inpatient breakouts, lines 38-51)
35	Gross INPATIENT ancillary revenue =	_____	\$	_____	
36	Gross revenue from service to OUTPATIENTS	_____	\$	_____	(must equal sum of outpatient breakouts, lines 38-51)
37	TOTAL GROSS revenue from service to patients	_____	\$	_____	(add lines 34-36)

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
38	Medicare	\$ _____	\$ _____	\$ _____
39	HMOs reimbursed by Medicare under 42 CFR pt. 417	\$ _____	\$ _____	\$ _____
40	Medical Assistance (Including BadgerCare)	\$ _____	\$ _____	\$ _____
41	HMOs reimbursed by Medical Assistance under s. 49.45 (3) (b), Wis. Stats	\$ _____	\$ _____	\$ _____
42	County General Relief (Should include pre-capitated GAMP revenue)	\$ _____	\$ _____	\$ _____
43	County 51.42 / 51.437 programs	\$ _____	\$ _____	\$ _____
44	All other public programs	\$ _____	\$ _____	\$ _____
Commercial Sources (GAMP)				
45	Group and individual accident and health insurance, self-funded plans	\$ _____	\$ _____	\$ _____
46	Worker's compensation	\$ _____	\$ _____	\$ _____
47	HMOs and all other alternative health care payment systems (exclude lines 39 and 41)	\$ _____	\$ _____	\$ _____
48	Self-pay	\$ _____	\$ _____	\$ _____

49	_____	\$ _____	\$ _____	\$ _____
50	_____	\$ _____	\$ _____	\$ _____
51	Milwaukee Hospitals Report Post-Capitated GAMP (see instructions)	\$ _____	\$ _____	\$ _____
52	Total Gross revenue from service to patients, by source (add lines 38-51, should equal value on line 37)	\$ _____	\$ _____	\$ _____

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
<i>Public Source Contractual Adjustments</i>				
53	Medicare _____	\$ _____	\$ _____	\$ _____
54	HMOs reimbursed by Medicare under 42 CFR pt. 417 _____	\$ _____	\$ _____	\$ _____
55	Medical Assistance (include effect of enhanced Medical Assistance payments) _____	\$ _____	\$ _____	\$ _____
56	HMOs reimbursed by Medical Assistance under s. 49.45 (3) (b), Wis Stats. (include effect of enhanced Medical Assistance payments) _____	\$ _____	\$ _____	\$ _____
57	County General Relief (Should include pre-capitated GAMP allowances)(Line 64 – report any post-cap GAMP, do not report in Line 63) _____	\$ _____	\$ _____	\$ _____
58	County 51.42 / 51.437 programs _____	\$ _____	\$ _____	\$ _____
59	All other public programs _____	\$ _____	\$ _____	\$ _____
<i>Commercial Source Contractual Adjustments</i>				
60	Group and individual accident and health insurance, self-funded plans _____	\$ _____	\$ _____	\$ _____
61	Worker’s compensation _____	\$ _____	\$ _____	\$ _____
62	HMOs and all other alternative health care payment systems (exclude lines 54 and 56) _____	\$ _____	\$ _____	\$ _____
<i>Other Source Contractual Adjustments</i> All other sources (specify below)				
63	_____	\$ _____	\$ _____	\$ _____
64	_____	\$ _____	\$ _____	\$ _____
65	_____	\$ _____	\$ _____	\$ _____

66	Charity care (revenue foregone at full established rates) (must equal line 122) ... (Should include post-capitated GAMP allowances)	\$ _____	\$ _____	\$ _____
67	All other noncontractual deductions	\$ _____	\$ _____	\$ _____
68	TOTAL DEDUCTIONS FROM REVENUE	\$ _____	\$ _____	\$ _____

(add lines 53-67) (total, not breakouts)

Medicare-Approved Medical Education Activities

NOTE: Of TOTAL expenses in line 26, the reimbursable expenses for Medicare-approved medical education activities separated into the following categories:

69	Direct medical education expenses	\$ _____		
70	Indirect medical education expenses	\$ _____		
71	TOTAL reimbursable expenses for Medicare-approved medical education activities (add lines 69 and 70)	\$ _____		\$ _____

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 2011*.

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

Current Assets

72	Cash and cash equivalents	\$ _____		
73	Inter-corporate account(s)	\$ _____		
	Net patient accounts receivable			
74	Medicare (T18) -Including HMOs reimbursed by T-18 *	\$ _____		
75	Medical Assistance (T-19)- Including HMOs reimbursed by T-19 *	\$ _____		
76	Self-Pay*	\$ _____		
77	All other pay sources*	\$ _____		
78	Total Net patient accounts receivable (add lines 74 thru 77)	\$ _____		
79	Other accounts receivable	\$ _____		
80	Other current assets	\$ _____		
81	TOTAL current assets (add lines 72 through 80)	\$ _____		\$ _____
82	Noncurrent assets whose use is limited	\$ _____		\$ _____

Property, Plant and Equipment

Gross Plant Assets

83	Land	\$ _____		
84	Land improvements	\$ _____		
85	Buildings and building improvements	\$ _____		
86	Construction in progress	\$ _____		
87	Fixed equipment	\$ _____		
88	Moveable equipment	\$ _____		
89	TOTAL gross plant assets (add lines 83 through 88)	\$ _____		\$ _____

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

90	Land improvements	\$ _____
91	Buildings and building improvements	\$ _____
92	Fixed equipment	\$ _____
93	Moveable equipment	\$ _____
94	TOTAL accumulated depreciation (add lines 90 through 93)	\$ _____
95	NET property, plant, and equipment assets (subtract line 94 from line 89)	\$ _____
96	Long-term investments	\$ _____
97	Other unrestricted assets	\$ _____
98	TOTAL unrestricted assets (add lines 81, 82, 95, 96 and 97)	\$ _____

Unrestricted Liabilities, Deferred Revenues, and Fund Balances

99	Current liabilities	\$ _____
100	Inter-corporate account(s)	\$ _____
101	Long-term debt	\$ _____
102	Other noncurrent liabilities and deferred revenues	\$ _____
103	Unrestricted fund balances	\$ _____
104	TOTAL unrestricted liabilities, deferred revenues, and fund balances (add lines 99 through 103). (NOTE: lines 98 and 104 should be equal. Combination facilities, see manual instructions)	\$ _____

Restricted Hospital Funds (report fund balances only)

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

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

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

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

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

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

VI. SUMMARY AND EXPLANATION OF REVENUE DOLLAR DIFFERENCES BETWEEN FY 2010 AND FY 2011

	GROSS REVENUE	NET REVENUE
118 Fiscal Year 2011 [line 37 (gross) and line 3 (net)]	\$ _____	\$ _____
119 Fiscal Year 2010 [FY 2010 Fiscal Survey - line 35 (gross) and line 1 (net)]	\$ _____	\$ _____
120 Increase / Decrease 2011 v. 2010 (subtract line 119 from line 118) [indicate + or -]	\$ _____	\$ _____

121 **Explain** in a short narrative the relative importance of various causes for the dollar differences (lines 118 and 119) 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 2011	FY 2012 (Projected)
122 Charges for charity care provided for the fiscal year	\$ _____ (from line 66)	\$ _____
123 Charity care cost (using hospital cost to charge ratio)	\$ _____	\$ _____
124 Charges determined to be a bad debt expense for the fiscal year	\$ _____ (from line 19)	\$ _____
125 Bad debt cost (using hospital cost to charge ratio)	\$ _____	\$ _____
126 TOTAL charges for uncompensated health care for the fiscal year	\$ _____ (add lines 122 and 124)	\$ _____ (add lines 122 and 124)

- 127 Total cost (using hospital cost to charge ratio) \$ _____ \$ _____
- 128 Hospital cost-to-charge ratio (used for calculations of lines 123, 125 and 127) (e.g. .458) _____

Number of “Patients” Receiving Uncompensated Health Care

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

- | | FY 2011 | FY 2012 (Projected) |
|--|---------|---------------------|
| 129 Number of individual patient visit ledgers that received charity care for the fiscal year | _____ | _____ |
| 130 Number of individual patient visit ledgers whose charges were determined to be bad debt for the fiscal year | _____ | _____ |
| 131 Provide a rationale for the hospital’s fiscal year 2012 projections in the space below. Explain how the projections used “patients” and total charges for fiscal year 2011, if at all. It could also include a description of the socioeconomic climate of your hospital’s market and how that affects your hospital’s Uncompensated Health Care Plan. Attach additional page(s) if necessary. (Using cost to charge ratio) | | |

Hill-Burton Uncompensated Health Care Information

- 132 Does the hospital have current obligations under this program?
Enter Yes, No, or C (for conditional) on this line. _____
- 133 If YES, enter date(s) the obligation(s) went into effect and date(s) the obligation(s) will be satisfied.

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

- 134 If YES, enter the amount of total federal assistance believed to remain under obligation. \$ _____

WISCONSIN HOSPITAL MEDICAL ASSISTANCE (MA) ASSESSMENT PROGRAM

TOTAL

135 Medicaid Assistance assessments paid to State of Wisconsin \$ _____

PAY SOURCE	TOTAL	INPATIENT	OUTPATIENT
-------------------	--------------	------------------	-------------------

136 Enhanced MA fee-for-service payments (<i>estimates</i>)	<u>\$ _____</u>	<u>\$ _____</u>	<u>\$ _____</u>
--	-----------------	-----------------	-----------------

137 Actual access payments received through HMOs Reimbursed by Medical Assistance under Ch. 49, Wis. Stats.	<u>\$ _____</u>	<u>\$ _____</u>	<u>\$ _____</u>
--	-----------------	-----------------	-----------------

138 TOTAL MA reimbursement enhancements	<u>\$ _____</u>	<u>\$ _____</u>	<u>\$ _____</u>
--	-----------------	-----------------	-----------------