STATE OF FLORIDA
HOSPITAL UNIFORM REPORTING SYSTEM MANUAL
2010-1, January 2010

Table of Contents

CHAPTER I REPORTING PRINCIPLES AND INSTRUCTIONS

INTRODUCTION

This chapter presents the reporting requirements, principles and instructions for the Florida Hospital Uniform Reporting System. Reporting according to the Florida Hospital Uniform Reporting System requires compliance with three basic principles.

First, hospitals must follow the set of reporting principles specified in this chapter. Items such as methods of capitalization and depreciation of assets and direct assignment of the cost of medical supplies and payroll-related employee benefits to using centers are examples of principles, which must be followed for reporting purposes. When these reporting principles differ from the hospital internal record keeping, reconciliation must be made. Financial data reported by hospitals on worksheets A through C will be reported according to Generally Accepted Accounting Principles (GAAP) as interpreted in the statements of the Financial Accounting Statement Board (FASB) and in the opinions and Hospital Audit guide of the American Institute of Certified Public Accountants (AICPA), except as otherwise provided in this manual.

Secondly, the principles utilized in the preparation of worksheets A through C will be based on a portrayal of the hospital's activities on a functional basis regardless of third party reimbursement policies.

The third principle affecting the preparation of the report is the requirement that costs will be measured at a level where comparability can be obtained and a standard output measurement applied. For purposes of reporting, it was determined that standard units of measurement would be applied to certain cost centers. Therefore, for functional reporting of revenue and expense, there may be a need for reclassification to convert revenue or cost from the responsibility reporting format to a functional reporting format. Responsibility reporting is defined as the reporting of costs according to organizational units such as departments. Functional reporting is defined as the reporting of costs according to type of activity. Total costs are the same with either functional or responsibility reporting. However, because organization structures vary among hospitals, responsibility reporting does not allow the comparability necessary for reasonable evaluation. The Florida Hospital Uniform Reporting System was developed to allow comparable reporting of costs while hospitals maintain responsibility accounting systems, if they so desire.

REPORTING REQUIREMENTS

Hospitals are required to report:

1. Hospital profile data – Data identifying the type of hospital and control, services offered, certification(s), programs, coverage, etc….

2. Assets, liabilities and equity – All balance sheet accounts in the chart of accounts when such assets, liabilities and equity exist.

3. Daily hospital services – All revenue and expense centers when such centers exist and are located in a discrete unit of the facility. A discrete unit is a separately organized, staffed and equipped unit of the facility. (See Section 2410 for reduced reporting option for small hospitals.)

   Where two or more daily hospital services as defined in Chapter III (Description of Accounts) are provided in the same unit, the revenue and expense applicable to that unit must be reported in the functional revenue and cost center which best describes the principle patient service provided in the combined unit. For example, assume that a hospital maintains a combined acute-care unit, which provides medical/surgical and pediatric care. Also assume that the principal care service provided in this unit is medical/surgical acute-care. The hospital in this situation will report the revenue and expense applicable to this unit as being medical/surgical acute-care.

4. All other centers and cost centers – All other revenue centers and cost centers when the service or function exists or is performed in the hospital, irrespective of whether or not it is a discrete unit. (See Section 2410 for reduced option for small hospitals).

5. Units of measure – The required standard unit of measure for all cost centers for which a standard unit of measure has been defined.

All data reported must be presented in accordance with the listing of accounts and definitions, identified in other parts of the manual. No line or column description may be changed on any worksheet.

REPORTING PERIOD

The basic reporting period is 1 year. This period shall consist of (1) 12 consecutive calendar months; (2) 13 four-week periods; or (3) 52 to 53 weeks, at the hospital's option. The 13 period option must begin on the first day of the selected reporting period with an additional day (two in a leap year) added to make it coincide with the end of the calendar year or month. The 52-53 week option will vary because it must always end on the same day of the week. The reporting period must end on the selected day closest to the end of the calendar month.

A beginning operation must select an initial reporting period beginning on the first day of operation through the last month preceding the hospital's selected day fiscal year. For example, a hospital beginning operations August 15, 1980, selecting a fiscal year beginning January 1 and ending December 31 would submit a report for the period August 15, 1980 to December 31, 1980.

When a hospital changes its fiscal year or ownership or both, that information must be reported to AHCA within 30 days, and its audited financial statements and prior year audited actual data report for the period ending with the sale of the previous fiscal year end or the date the new ownership began shall be filed with AHCA within 120 days of the change.

RECLASSIFICATION FOR REPORTING PURPOSES

Reclassifications are necessary to adjust the financial data contained in the hospital's records to the reporting requirements in this manual where they are not recorded on a functional basis. These reclassifications must be completed prior to preparing the required reporting forms and should be maintained as part of the hospital's books and records.

There are two types of reclassifications:

1. Reclassifications to obtain the required level of reporting.
2. Reclassifications to correct accumulation of costs and revenues.

The first type of reclassification may be necessary to reach the required level of reporting because the hospital has combined several cost or revenue centers. For instance, a hospital may be combining the costs of diagnostic radiology with therapeutic radiology. In such cases, it is necessary to reclassify the total direct costs by natural classification of expense incurred for the two different types of services into two specific cost centers relating to these two types of services.

The second type of reclassification, to correct the accumulation of cost and revenues, would be necessary when the expense and/or revenue associated with a particular function is recorded in a cost center different from the functional description specified in this manual. For instance, a reclassification would be required if the Surgery Services cost/revenue center included the costs and revenues associated with the sale of prosthesis and appliances because these cost and revenues must be reported in the Medical Supplies Sold cost/revenue centers rather than the Surgery Services cost/revenue centers.

If expenses and revenues related to the functions and defined by this manual have not been included in the direct costs or revenues of the indicated cost center, a reclassification is required, if significant. In no instance shall an amount be considered insignificant if, in any year for any cost center, the aggregate amount of misplaced costs or revenues within a cost or revenue center is greater than $7500.

These reclassifications may be computed on any one of the following bases:

1. Analysis of direct expense including time and cost studies.
2. Ratio of total standard units of measure to standard units of measure being reclassified in a specific cost center. This basis may be used only for those costs centers with the same standard units of measure (e.g. , radiology)

Activities common to most functional reporting centers such as planning, appraising, analyzing, preparing staffing schedules, meeting legal requirements and sanitary standards, keeping abreast of applicable fields, clerical work incidental to the activities of the functional reporting center, documenting work performed, initiating requisitions, the provision for and receipt of in-service education, educating patients for self-care, maintaining specialized libraries, preparing budgets, evaluating assigned personnel, and attending meetings shall be assigned to the functional reporting center in which the activity is performed. The operation of equipment includes preventative maintenance such as cleaning, oiling and calibration.

Other activities are unique (as herein defined) and their cost must be reported per the cost center functional descriptions. If the costs of these activities are accumulated in a different cost center, they must be reclassified.

REPORTING PRINCIPLES

Accrual Reporting

In order to provide the necessary completeness, accuracy and meaningfulness in reporting data, accrual basis of report should be used. Accrual reporting is the recognizing and reporting of the effects of transactions and other events on the assets and liabilities of the hospital entity in the time periods to which they relate rather than only when cash is received or paid. For example, the reporting as expense each year of 1/3 of the cost of a three-year insurance policy. The requirement is only that the financial reports be prepared on the accrual basis and not that the books be maintained on that basis throughout the period. We recognize that the immediate implementation of this policy may create a hardship for those hospitals currently on a cash basis. Because of this, a waiver of this rule will apply to cash basis hospitals for the first two reporting periods. At the end of this grace period, all reports must be on the accrual basis. Earlier compliance is encouraged.

Matching Of Revenue And Expense

Determination of the net income of an accounting period requires measurements of revenue, revenue deductions, and expenses associated with the period. Hospital revenue must be reported in the period in which it is earned; that is, in the time period during which the services are rendered to patients and a legal claim arises for the value of the services.

Once the revenue determination is made, a measurement must be made of the amount of expense incurred in rendering the services on which the revenue determination was based. Unless there is such a matching of revenue and expense, the reported net income of a period is meaningless.

The requirement that revenue deductions must also be matched properly against the gross revenues of the reporting period is sometimes overlooked. Revenue deductions are reductions in gross revenue arising from bad debts, contractual adjustments, uncompensated/charity care and courtesy, policy and other discounts and adjustments. It is important that these revenue deductions be given recognition in the same period that the related revenue were reported, even though certain of these revenue deductions cannot be precisely determined.

Revenues and expenses are to be matched not only for the hospital as a whole, but also for each cost/revenue center. The cost/revenue center is an accounting device for accumulating items of cost or revenue that have common characteristics. A cost center may or may not be a department within the hospital. A cost center such as depreciation, amortization, lease and rent is an example where the cost center would not be a department of the hospital. The costs or the functions and activities included in each cost center description are to be include in the cost center. Revenue relative to such functions and activities must be included in the matching revenue center. For example, expenses related to the Clinical Laboratory functions (activities) are to be included in the Laboratory Services cost center (Account 7210) and related revenue are to be included in Laboratory Service revenue center (Account 4210).

Some hospitals record revenue on an all-inclusive rate basis (a rate based on type of accommodation regardless of the utilization of ancillary services). Utilization of an inclusive rate system results only in a modification of the patient billing and revenue accounting system. It does not eliminate the need to report expenses in the proper cost center. Those institutions that record charges on an all-inclusive rate basis are required to report revenue as prescribed by the instructions for worksheet C-3.

PROPERTY, PLANT AND EQUIPMENT REPORTING

Classification of Fixed Asset Expenditures

Property, Plant, and Equipment and related liabilities must be reported in the Unrestricted Fund, since segregation in a separate fund would imply the existence of restrictions on the use of the assets. Cost of construction in progress and related liabilities must be reported in the Unrestricted Fund as incurred except for assets and liabilities related to covenant agreements which require formal segregation and/or accountability in a restricted fund.

Basis of Valuation

Property, Plant and Equipment must be reported on the basis of the historical cost incurred by the present owner in acquiring the asset under a bona fide sale. The historical cost shall not exceed the lower of current reproduction cost adjusted for straight-line depreciation. Cost is defined as historical cost or fair market value of the donated property at the date of donation.

Capitalization Policy

For reporting purposes, if a depreciable asset has at the time of its acquisition an estimated useful life of three or more years and the cost of at least $500 or if it is acquired in quantity of at least $1,000, its cost must be capitalized and written off evenly over the estimated useful life of the asset.

If a depreciable asset has a historical cost of less than $500 or if the asset has a useful life of less than three years, its cost is to be reported as an expense in the year it is acquired, subject to the provisions of writing off the cost of minor movable equipment. The hospital may, for reporting purposes, establish a capitalization policy with lower minimum criteria but under no circumstances may the above criteria be exceeded. For reporting purposes, alterations and improvements in excess of $500 which extend the life a minimum of three years or increase the productivity or efficiency of an asset, as opposed to repairs and maintenance which either restore the asset to or maintain it at its normal or expected service life, must be capitalized and depreciated over their expected useful lives not to exceed the lives of the assets to which they are fixed. Normal repair and maintenance costs are to be reported as expense in the current accounting period.

All costs, including personnel costs, prior to a hospital or unit being operational must be capitalized (see matching of revenue and expense).

Minor Equipment

Minor equipment includes such items as wastebaskets, bedpans, silverware, buckets, etc. The general characteristics of this equipment are: (a) in general, no fixed location, and subject to use by various cost centers within a hospital; (b) comparatively small in size and unit cost; (c) subject to inventory control; (d) fairly large quantity in use; and, (e) generally, a useful life of less than three years.

There are two ways in which the cost of minor equipment may be reported:

a. The original cost of this equipment may be capitalized and not depreciated. Any replacements to this base stock would be reported as operating expenses. The amount of the base stock would be adjusted only if there were a significant change in the size of the base stock.

b. All purchases of minor equipment may be capitalized and depreciated over their estimated useful lives.

Once a hospital has applied one of the methods, that method must be used consistently thereafter.

Interest Expense During Period of Construction

Frequently hospitals borrow funds to construct new facilities or modernize and expand existing facilities. Interest cost incurred during the period of construction must be capitalized as part of the cost of the construction. The period of construction is considered to extend to the date the constructed asset is put into use. When proceeds from a construction loan

are invested and income is derived from such investments during the construction period, the amount of interest to be capitalized must be reduced by the amount of such revenue.

Depreciation Policies

Depreciation on plant assets used in the hospital's operations must be reported as an operating expense in the Unrestricted Fund. The straight-line method of depreciation must be used for all assets acquired after July 1970.

The estimated useful life of a depreciable asset is its normal operating or service life in terms of utility to the hospital. Some factors to be considered in determining useful life include normal wear and tear, obsolescence due to normal economic and technological advances, climatic or local conditions and the hospital's policy for repair and replacement. In selecting a proper useful life for computing depreciation, hospitals must utilize the guidelines published by the Internal Revenue Service or the American Hospital Association. However, with the rapid changing technology in hospitals, these recommendations may not be all inclusive; in which case, the expertise of the manufacturer or other reliable sources, may be considered. Any changes in estimated useful lives must be properly documented by the hospital.

For reporting purposes, each hospital must establish and follow consistently from year to year, a policy relative to the amount of depreciation to be taken in the year of acquisition and disposal of depreciable assets. Examples of acceptable policies for all depreciable assets, except buildings are:

- Computing first and last year depreciation based upon the portion of time the asset was in use during the year. That is, if a depreciable asset was received and in use in the hospital for 8 months in the year of acquisition, two-thirds of a full year's depreciation expense would be recognized that year.

- Recording one-half of the yearly depreciation expense in the years of acquisition and disposal, regardless of the date of acquisition or disposal.

- Recording a full year's depreciation expense if the asset was acquired in the first half of the year. If the asset was acquired in the last half of the year, no depreciation expense would be recognized.

Depreciation expense reported on buildings, purchased or constructed, in the year of acquisition or disposal must be based on the actual time that the building was in use for the hospital operations.

SELF INSURANCE

Self insurance by a hospital for potential losses due to unemployment, worker's compensation and malpractice claims, asserted or otherwise, places all or part of the risk of such losses on the hospital rather than insuring against all or part of such losses with an independent insurer. For uniform reporting purposes for self-insurance, hospitals must follow the guidelines of Statement 5 of the Financial Accounting Standards Board.

RELATED ORGANIZATIONS

A hospital itself may be subsidiary to or under the control of a larger organization such as a university, governmental entity or parent corporation. It is typical in such situations for hospitals to receive services from these related organizations. Examples of services received are administration, purchasing, general accounting and menu planning. In addition, related organizations lease property, plant and equipment to hospitals as well as paying for various other items such as insurance. The related organization then usually charges for the service either directly or through a management fee. For uniform reporting purposes, the direct charges must be reported as purchased services in the appropriate functional cost centers as billed, and the management fee must be reported in the functional cost centers in amounts relative to the services received for which the fee is paid.

DIRECT ASSIGNMENT OF COSTS

The direct assignment of costs is the process of identifying and assigning costs directly to the functional cost center generating those costs. Those costs which meet the definitions and guidelines established within this section must be directly assigned.

Salary and Wages and Payroll Related Employee Benefits

The salaries and wages cost must be assigned to the functional cost center to which the employee is assigned. For example, for reporting purposes the salary cost of direct nursing services, including float nurses, must be directly assigned to the patient care cost centers receiving the service. This assignment may be based on each employee's actual nursing services hours performed within each patient care cost center multiplied by that employee's hourly salary rate while performing the direct nursing service, or based on an analysis of salary and wage expense including time and cost studies.

Payroll related employee benefits must be reported in the cost center that the applicable employee's compensation is reported. This assignment can be performed on an actual basis or upon the following basis:

- FICA – actual expense by cost center
- Pension and Retirement and Health Insurance (non-union)
  - gross salaries by cost centers
- Union Health and Welfare – gross salaries by cost center
- All other payroll related benefits – gross salaries by cost center

Non-payroll related employee benefits are to be reported in Account 8830
(Employee Benefits – Non-payroll Related).

Medical Supplies and Durable Medical Equipment

The invoice/inventory cost of all medical and surgical supplies for which a separate charge is made, except home program dialysis supplies, must be reported as a cost of the Medical Supplies Sold cost center (Account 7110). The related revenue must be reflected in the Medical Supplies Sold revenue center (Account 4110). Home Program Dialysis supplies must be reported as a cost of the Home Program Dialysis Center.

Medical and surgical supplies and materials issued by Central Services and Supplies for which a separate charge is not made must be reported at invoice/inventory cost as an expense of the cost center using the supplies and materials.

The invoice/inventory cost and revenue and the depreciation expense associated with durable medical equipment sold, leased, or rented must also be reported in the Medical Supplies Sold cost and revenue centers.

The overhead associated with the issuance of medical and surgical supplies and durable medical equipment must be reported in the Central Services and Supplies cost center (Account 8460). The cost of reusable patient chargeable supplies must remain in the Central Services and Supplies cost center.

Drugs

The Drugs Sold cost center is used for the accumulation of the invoice cost of all pharmaceuticals, blood derivatives and intravenous solutions sold directly to patients and others. The invoice/inventory cost of non-chargeable drugs (pharmaceuticals, blood derivatives and intravenous solutions) issued by the Pharmacy cost center (Account 8470) to other cost centers shall be reported in the using cost center. If drugs are sold in other hospital cost centers, the cost of those items must be reported in this cost center.
The overhead cost of preparing and issuing drugs sold directly to patients and others must be accumulated in the Pharmacy cost center (Account 8470). The applicable portion of such overhead will be allocated to this cost center during the cost allocation process.

Data Processing

All costs, direct or indirect, incurred in operating an electronic data processing center, in purchasing data processing services and/or in obtaining such services from related organizations must be reported in the data processing cost center, Account 8611. No allocation to an individual department is to be performed.

Note that for step down allocation purposes, data processing will be included in Hospital Administration.

Patient Transportation

Because patient transportation costs are relatively minor in most hospitals, direct assignment of this expense is not required. Such expense may be reported where incurred. However, since no patient transportation cost center is provided those hospitals that maintain a central patient transportation department must report such expenses in the appropriate ancillary services cost center. Patient visits or some other valid basis may be used for reclassifying such expenses.

PHYSICIAN REMUNERATION

Due to the numerous types of financial and work arrangements between hospitals and hospital-based physicians, comparability of costs between hospitals may be significantly impaired. This results because all hospitals do not record the professional component as an expense; either because the physician does his own billing, or such amounts are recorded in an agency or clearing account by the hospital. In order to obtain comparability of expenses, the physician cost relative to patient care (professional component) must be isolated.

Included, as part of physician remuneration is the cost of benefits provided to the physicians, e.g., insurance, pensions, etc. paid by the hospital on behalf of physicians.

In addition to direct patient care, hospital-based physicians also provide the following types of services:

1. Education – Teaching and supervising student activity in educational programs.
2. Research – Working on research projects.
3. Medical Care Review – Serving on the hospital's Medical Care Review Committee
4. Hospital Administration – Administering overall hospital activities (including hospital committees).
5. Cost Center Supervision – Supervision and other activities of the cost center.

When physicians are involved in more than one of the above functional activities, their remuneration (including professional fees, salaries and employee benefits) if any, must be reported in the functional cost center related to the services rendered. This is necessary to obtain functional comparability.

As an example, if a hospital-based physician is paid and spends 40 percent of his time in direct care of patients, 10 percent educational activities, 15 percent in research, 5 percent in medical care review activities, 10 percent administrative duties outside the department, and 20 percent in supervision of the department, the reclassification of his remuneration would be as follows:

40 percent Physician's Professional Component (this amount must be reported in the Medical Staff Services cost center Account 8730)
10 percent Education Costs (To Accounts 8220 – 8260)
15 percent Research Projects (To Account 8010)
5 percent Medical Care Review (To Account 8740)
10 percent Hospital Administration (To Account 8610)
20 percent Cost Center Supervision (Remains in the cost center)

NOTE: Compensation paid to residents is not to be included in the revenue producing cost centers, but must be reported in the Post Graduate Medical Education cost centers, Accounts 8240 and 8250, as appropriate.

INSERVICE EDUCATION – NURSING

Nursing inservice education activities are defined as educational activities conducted by the hospital for hospital nursing personnel. The cost of time spent by nursing personnel as students in such classes and activities must be reported in the cost center in which their normal salary and wage costs are reported (i.e., the cost centers in which they work). However, the cost (defined as salary, wages, and payroll related employee benefits) of time spent in such classes and activities by those instructing and administering the programs must be included in the Nursing Administration cost center (Account 8750).

INSERVICE EDUCATION – NON-NURSING

All expenses, including student and instructor salaries, associated with non-nursing inservice education activities, must be included in the functional cost center to which the participating employees' salaries and wages are assigned, as such inservice educational activities will rarely apply to more than one functional activity.

CHAPTER II REPORTING FORMS AND INSTRUCTIONS

WORKSHEET A – TRANSMITTAL AND CERTIFICATION

PURPOSE: This is a representation from hospital management that the reporting package is complete and accurate. The letter to AHCA documents management's responsibility for the propriety of data submitted and serves as a reminder to management of the importance of complete and accurate information.

INSTRUCTIONS: ENTER THE HOSPITAL NAME, HRS LICENSE NUMBER, (AHCA) NUMBER, ADDRESS, AND TELEPHONE NUMBER.

ENTER THE BEGINNING AND ENDING DATES FOR THE PERIOD COVERED IN THIS REPORT FOR EXAMPLE: 10/01/1999 TO 09/30/2000.

OBTAIN THE SIGNATURES OF THE HOSPITAL'S CHIEF EXECUTIVE OFFICER AND THE CHIEF FINANCIAL OFFICER AND THE DATE OF THE SIGNATURES.

WORKSHEET A
ACTUAL /_____/

_____
(SUBMISSION NUMBER)

TRANSMITTAL AND CERTIFICATION
OF PRIOR YEAR ACTUAL REPORT
TO

AGENCY FOR HEALTH CARE ADMINISTRATION
2727 Mahan Drive
Fort Knox, Building 1 MS #28
Tallahassee, Florida 32308

FROM

_____ _____
(NAME OF HOSPITAL) (LICENSE NO.)

_____ _____
(STREET ADDRESS) (AHCA NUMBER)

_____ _____ _____
(CITY AND ZIP CODE) (TELEPHONE)

PERIOD FROM: _____ TO: _____

I HEREBY CERTIFY THAT I HAVE EXAMINED THE ACCOMPANYING WORKSHEETS AS PART OF THE STATE OF FLORIDA UNIFORM REPORT AND SUCH OTHER WORKSHEETS AND FORMS INCLUDED FOR YOUR INFORMATION FOR THE ABOVE PERIOD, IN ACCORDANCE WITH AND SUBJECT TO THE PROVISIONS OF SECTION *408.061(4)*, F.S. TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION CONTAINED IN THE REPORT SUBMITTED IS TRUE, ACCURATE, AND COMPLETE AND HAS BEEN PREPARED FROM THE HOSPITAL'S BOOKS AND RECORDS, EXCEPT AS NOTED.

CHIEF EXECUTIVE OFFICER: _____
(TYPE OR PRINT)

_____
(SIGNATURE)

_____
(DATE)

CHIEF FINANCIAL OFFICER: _____
(TYPE OR PRINT)

_____
(SIGNATURE)

_____
(DATE)

WORKSHEET – A-1: GENERAL HOSPITAL INFORMATION

PROVIDER NUMBERS:

a) Enter the hospital's assigned Title V number.
b) Enter the hospital's assigned MEDICARE number.*
c) Enter the hospital's assigned MEDICAID number.

SECTION 2

d) Enter the name of the hospital. REPORT THE NAME OF THE HOSPITAL AS IT IS KNOWN IN THE COMMUNITY, DO NOT REPORT THE CORPORATE NAME OF THE CONTROLLING ENTITY. (Report Controlling organization and owner in Section 3)
e) Enter the street address of the hospital.
Report only the hospital's address; do not use the address of a corporate or hospital office that is not on the hospital premises.
f) Enter the city name.
g) Enter the county name.
h) Enter the zip code.
i) Enter the name of the person who prepared the report.
j) Enter the address of the person who prepared the report, if different from the hospital's.
k) Enter the name of the person at the hospital (or the preparer's, if report preparation is contracted out) to be contacted in the event that there are questions related to the report.
l) Enter the contact person's title.
m) Enter the contact person's telephone number and extension.

SECTION 2 – HOSPITAL COMPONENTS AND SUBPROVIDERS:

Items (a) – (o):

For each of the hospital components – Subprovider, Skilled Nursing Facility, Intermediate Care Facility, Home Health Agency, and Special Provider – Controlled Facility:

Enter the corresponding PROVIDER NUMBER in the appropriate column(s) –
Title V, MEDICARE, or MEDICAID.

SECTION 3 – TYPE OF CONTROL:

Items (a) – (l):

Based on the type of ownership of the hospital, check the appropriate TYPE OF CONTROL indicator in the associated column.

For hospitals which are VOLUNTARY, NOT-FOR-PROFIT or INVESTOR OWNED, enter the name of the CONTROLLING ORGANIZATION and the name of the OWNER, (IF DIFFERENT FROM THE CONTROLLING ORGANIZATION) in the space provided.

See Chapter IV, A, GLOSSARY OF HEALTHCARE TERMINOLOGY, for a definition of CONTROLLING ORGANIZATION and OWNER.

WORKSHEET – A-1 GENERAL HOSPITAL INFORMATION CONTINUED-

SECTION 4 – TYPE OF HOSPITAL:

Items (a) – (j):

Check, in the appropriate column – SHORT-TERM or LONG-TERM, the category which best describes the type of hospital for which this report is submitted (Note 1).

For hospitals with a short-term OSTEOPATHIC, PEDIATRIC, etc., specialty, check ITEM (e) – OTHER and enter "OSTEOPATHIC", etc., in the space provided; if LONG-TERM, check ITEM (j) and enter "OSTEOPATHIC", etc.

Items (k) – (l):

Check the appropriate box (Yes or No) to indicate whether the hospital is a MAJOR ORGAN TRANSPLANTATION hospital. A major organ is considered to be Heart, Kidney, Liver or Lung.

Items (m) – (n):

Enter a check mark in the CONDITIONAL or UNCONDITIONAL boxes to indicate whether the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JAHCO) or by the American Osteopathic Hospital Association.

If the hospital is not accredited, leave both boxes blank.

NOTE (1): See Chapter IV, GLOSSARY OF HEALTHCARE TERMINOLOGY for definitions of GENERAL HOSPITAL, SPECIALTY HOSPITAL, SHORT-TERM HOSPITAL and LONG-TERM HOSPITAL.

SECTION 5 – CHANGES IN OWNERSHIP AND MANAGEMENT STATUS:

Items (a) – (e):

a. Hospitals which have not had a change in either ownership or ownership status within the reporting period, need only report "NO" in answer to both questions.

   Only hospitals which have had a change in ownership or ownership status within the reporting period must complete items (b) and (c).

b. Enter the effective date of the change in ownership or reorganization.

c. Enter the name of the previous controlling organization. This should not be the same as the name entered in Section 3 above, TYPE OF CONTROL.

d. Indicate whether the organization is managed under a contractual agreement by an outside organization.

e. If the answer to (d) is YES, enter the name of the management organization.

WORKSHEET – A-1 GENERAL HOSPITAL INFORMATION CONTINUED-

SECTION 6 – STATISTICS:

Items (a) – (g):

This section should be completed only after the previous sections have been completed, the form has been copied, and the type of report designation has been made. For budget reports, complete only the total column; interim reports must complete both the actual and projected columns, as well as the total column.

a. Enter the total number of bone marrow transplants performed during the period.
b. Enter the total number of open-heart surgery procedures performed during the period.
c. Enter the number of heart transplants performed during the reporting period.
d. Enter the number of kidney transplants performed during the reporting period.
e. Enter the number of liver transplants performed during the reporting period.
f. Enter the number of lung transplants performed during the reporting period.
g. Enter the number of cancer patients who received radiation therapy during the reporting period. Count each patient only once regardless of the number of treatments received during the visit.

GENERAL HOSPITAL INFORMATION

SUBMISSION NUMBER:	REPORTING PERIOD FROM: TO:	FACILITY NUMBER	WORKSHEET A-1

1. IDENTIFYING INFORMATION

HOSPITAL PROVIDER NUMBERS
a. TITLE V: b. MEDICARE: c. MEDICAID:

d. HOSPITAL NAME:

e. STREET ADDRESS:

f. CITY:	g. COUNTY:	h. ZIPCODE:
i. NAME OF PREPARER:	j. ADDRESS OF PREPARER:	
k. HOSPITAL CONTACT PERSON:	l. TITLE: m. PHONE NO: n. FAX NO: o. E-MAIL:	

2. FEDERAL COMPONENTS

HOSPITAL COMPONENTS	PROVIDER NUMBER		
	TITLE V	MEDICARE	MEDICAID
SUBPROVIDER	a.	f.	k.
SKILLED NURSING FACILITY	b.	g.	l.
INTERMEDIATE CARE FACILITY	c.	h.	m.
HOME HEALTH AGENCY	d.	i.	n.
SPECIAL PROVIDER-CONTROLLED FACILITY	e.	j.	o.

3. TYPE OF CONTROL

NOT-FOR-PROFIT	INVESTOR-OWNED	GOVERNMENT
a. ____ RELIGIOUS b. ____ OTHER	c. ____ INDIVIDUAL d. ____ PARTNERSHIP e. ____ CORPORATION	f. ____ CITY g. ____ CITY/COUNTY h. ____ COUNTY i. ____ HOSPITAL AUTH. j. ____ HOSPITAL DISTRICT k. ____ STATE l. ____ OTHER:
NAME OF CONTROLLING ORGANIZATION	NAME OF CONTROLLING ORGANIZATION	
OWNER:	OWNER:	

4. TYPE OF HOSPITAL

SHORT TERM	LONG TERM	TRANSPLANT HOSPITAL
a. ____ GENERAL b. ____ PSYCHIATRIC c. ____ SUBSTANCE ABUSE d. ____ TEACHING e. ____ OTHER SPECIALTY:	f. ____ GENERAL g. ____ PSYCHIATRIC h. ____ SUBSTANCE ABUSE i. ____ REHABILITATION j. ____ OTHER SPECIALTY:	MAJOR ORGAN TRANSPLANT: k. YES ____ l. NO ____ ACCREDITED UNCONDITIONAL m. ____ CONDITIONAL n. ____

5. OWNERSHIP AND MANAGEMENT

a. DURING THE REPORTING PERIOD, HAS THE HOSPITAL EXPERIENCED A CHANGE IN EITHER OF THE FOLLOWING? TYPE OF CONTROL: YES ____ NO ____ OWNERSHIP STATUS: YES ____ NO ____

b. DATE OF CHANGE: _____

c. NAME OF PREVIOUS CONTROLLING ORGANIZATION: _____

d. DOES THE HOSPITAL HAVE A MANAGEMENT CONTRACT? YES ____ NO ____

e. NAME OF CONTRACTOR:

6. STATISTICS

STATISTICS	ACTUAL 1	PROJECTED 2	TOTAL 3
a. BONE MARROW TRANSPLANTS			0
b. OPEN-HEART CASES			0
c. HEART TRANSPLANTS			0
d. KIDNEY TRANSPLANTS			0
e. LIVER TRANSPLANTS			0
f. LUNG TRANSPLANTS			0
g. NEUROSURGERY CASES			0
h. RADIATION THERAPY CANCER CASES			0

WORKSHEET A-2: SERVICES INVENTORY AND UNITS OF SERVICE REPORT

PURPOSE: These worksheets provide an inventory of services offered by the hospital, as well as report the units of service of the departments of the hospital not covered in the services inventory.

INSTRUCTIONS:

FACILITY NO: Enter the hospital's assigned AHCA number.

PERIOD: Enter the beginning and ending date for the period covered in this report. For example: 10/01/1999-9/30/2000.

COLUMN DEFINITIONS:

ACCOUNT NO.: The standardized account number assigned to this service. See Chapter III of this manual, "DESCRIPTION OF ACCOUNTS" for more detail.

COLUMN (1): Code each service line with the appropriate code, (1-7). Services coded 1, 2, or 3, must report revenue and expense in order to receive credit for those cost centers in the index of services.

CODE: See the CODE TABLE below.

For all services coded "1", the STANDARD UNIT OF SERVICE should correspond to the units entered on WORKSHEETS B-1. For example, the NUMBER OF DAYS entered on WORKSHEET A-2, LINE 6 – NEONATAL INTENSIVE CARE should agree to the number of days entered on WORKSHEET B-1, LINE 11 – NEONATAL INTENSIVE CARE under COLUMN 4 – Total Inpatient Days.

LINE 3 – MEDICAL/SURGICAL INTENSIVE CARE UNIT; LINE 4 – CORONARY CARE UNIT; LINE 5 – MEDICAL/SURGICAL INTENSIVE CARE UNIT-CORONARY CARE UNIT (COMBINED): If both services are provided in a combined setting, code both LINES 3 & 4 as a "2" and code LINE 5 as a "1". If these two services are provided in a separate setting, non-combined, code both LINE 3 & LINE 4 as a "1" and code LINE 5 as a "7". At no time should LINES 3, 4, & 5 be simultaneously coded as a "1".

LINE 10 – 24 HOUR EMERGENCY SERVICES/M.D. IN-HOUSE & line 11 – 24 HOUR EMERGENCY SERVICES/M.D. ON-CALL: The two emergency service categories are considered to be mutually exclusive. If LINE 10 is coded "1", then LINE 11 should be coded "7", and vice versa.

LINE 21 – NEUROLOGICAL SURGERY: Neurological surgery involves procedures on a patient's brain, spinal cord, or central nervous system by a Board Certified neurosurgeon. As a benchmark for this service, at least 1,200 minutes must be reported to obtain credit in the service index. Hospitals reporting less than 1,200 minutes for this service must provide an explanation on WORKSHEET X-4. Also, please note that since the number of minutes reported for neurosurgery are used as a benchmark, these minutes must be included in total surgery service minutes on LINE 20. If LINE 21 is coded a "1" or a "2", then the number of neurosurgeons should be reported on WORKSHEET B-4, LINE 43, COLUMN 4, ACTIVE STAFF.

LINE 22 – OPEN-HEART SURGERY: Open-Heart surgery involves procedures on a patient's heart, aorta, and cardiac arteries by a Board Certified cardiovascular surgeon.

As a benchmark for this service, at least 1,200 minutes must be reported to obtain credit in the service index. Hospitals reporting less than 1,200 minutes for this service must provide an explanation on WORKSHEET X-4. Also, please note since the number of minutes reported for neurosurgery are used as a benchmark, these minutes must be included in total surgery service minutes on LINE 20. If LINE 22 is coded a "1" or a "2", then the number of cardiovascular surgeons should be reported on WORKSHEET B-4, LINE 41 COLUMN 4, ACTIVE STAFF.

LINES 37, 38, and 39 – OCCUPATIONAL THERAPY, SPEECH PATHOLOGY, AND REHABILITATION CARE are included for service coding purposes only. No UNIT OF SERVICE statistics are assigned to these services.

See Chapter IV GLOSSARY OF HEALTHCARE TERMINOLOGY, for further definition of each term.

WORKSHEET A-2 SERVICES INVENTORY AND UNITS OF SERVICE REPORT CONTINUED

COLUMN (2): Enter the appropriate number of services as measured by the designated STANDARD UNIT OF SERVICE (SUS). For example, for Line 31 – CT SCANNERS, enter the number of CT Scan procedures performed during the reporting period. See the ACCOUNT NUMBER/SUS TABLE on pages 2.11 through 2.13.

See Chapter V, "STANDARD UNITS OF SERVICE" for more detail on units of service used in this manual.

CODE TABLE

CODE	DESCRIPTION
1.	Separately organized, staffed and equipped unit of the hospital (discrete).
2.	Services maintained in hospital but not in separate unit (nondiscrete).
3.	Services contracted but hospital-based.
4.	Services not maintained in hospital but available from outside contractor
5.	Services shared under agreement.
6.	Clinic services commonly provided in emergency suite to non-emergency outpatients by hospital-based physicians or residents
7.	Services not available.

WORKSHEET A-2 SERVICES INVENTORY AND UNITS OF SERVICE REPORT CONTINUED

ACCOUNT NUMBER TABLE
STANDARD UNITS OF SERVICES (SUS)

Service	Account No.	Standard Unit of Service
Psychiatric Acute Care	6210	Patient Days
Substance Abuse Acute-Detoxification Unit	6220	Patient Days
Medical/Surgical Intensive Care Unit	6310	Patient Days
Coronary Care Unit	6330	Patient Days
Combined ICU/CCU	6310/6330	Patient Days
Neonatal Intensive Care Unit	6370	Patient Days
Burn Intensive Care Unit	6380	Patient Days
Skilled Nursing Care-Certified Medicare/Medicaid	6610	Patient Days
Residential Care	6660	Resident Days
Emergency Services (24-hour Physician Coverage In-House)	6710	Number of Visits
Emergency Service (24-hour Coverage with On-Call Physicians Only)	6710	Number of Visits
Clinic Services	6720	Number of Visits
Home Dialysis Services	6820	Patient Weeks
Ambulatory Surgery Services	6830	Number of Surgery Minutes
Ambulance Services	6850	Number of Trips
Free Standing Clinic	6870	Number of Visits
Psychiatric Day Care Program	6890	Number of Visits
Home Health Services	6990	Number of Visits
Labor & Delivery Services	7010	Number of Procedures
Surgical Services	7040	Number of Surgery Minutes
Neurological Surgery	7040	Number of Surgery Minutes
Open-Heart Surgery	7040	Number of Surgery Minutes
Recovery Services	7060	Number of Recovery Room Minutes
Anesthesiology	7080	Number of Anesthesia Minutes
Laboratory Services	7210	Workload Units
Blood/Plasma Collection	7250	Workload Units
Blood Bank-Processing & Storage	7260	Workload Units
Electrocardiography (ECG)	7290	Workload Units
Cardiac Catheterization Laboratory	7310	Number of Procedures
Radiology/Diagnostic	7320	Number of Procedures
Computerized Tomography (CT Scanner)	7340	Number of Procedures
Magnetic Resonance Imaging	7350	Number of Procedures
Radiation Therapy	7360	Number of Procedures
Nuclear Medicine	7380	Number of Procedures
Respiratory Therapy	7420	Number of Treatments
Physical Therapy	7510	Number of Modalities
Renal Dialysis- Inpatient or Outpatient	7710	Number of Treatments
Lithotripsy	7720	Number of Procedures
Organ Acquisition & Banking	7730	Organs Acquired

SERVICES INVENTORY AND UNITS OF SERVICE REPORT

SUBMISSION NUMBER:	REPORTING PERIOD FROM: TO:	FACILITY	**WORKSHEET A-2**

	Services	ACCT. NUMB.	SERV. CODE	STANDARD UNITS OF SERVICE (S.U.S)	
				DESCRIPTION	AMOUNT
			(1)		(2)
01	Psychiatric Acute Care	6210		Days	
02	Substance Abuse-Detoxification Unit	6220		Days	
03	Medical/Surgical Intensive Care Unit	6310		Days	
04	Coronary Care Unit	6330		Days	
05	Medical/Surgical/Coronary ICU's (Combined)	6310-6330		Days	
06	Neonatal Intensive Care Unit	6370		Days	
07	Burn Intensive Care Unit	6380		Days	
08	Skilled Nursing Care-Medicare/Medicaid Cert.	6610		Days	
09	Residential Care	6660		Days	
10	Emergency Services (24-Hour/Inhouse M.D.)	6710		Visits	
11	Emergency Services (24-Hour/M.D. On-call)	6710		Visits	
12	Clinic Services	6720		Visits	
13	Home Dialysis Services	6820		Patient Weeks	
14	Ambulatory Surgery Services	6830		Minutes	
15	Ambulance Services	6850		Trips	
16	Free Standing Clinic Services	6870		Visits	
17	Psychiatric Day Care Program	6890		Visits	
18	Home Health Services	6990		Visits	
19	Labor and Delivery Services	7010		Procedures	
20	Surgical Services (Total Surgery Minutes)	7040		Minutes	
21	Neurological Surgery (Included in Line 20)	7040		Minutes	
22	Open-Heart Surgery (Included in Line 20)	7040		Minutes	
23	Recovery Services	7060		Minutes	
24	Anesthesiology	7080		Minutes	
25	Laboratory Services	7210		Workload Units	
26	Blood/Plasma Collection	7250		Workload Units	
27	Blood Bank-Processing and Storage	7260		Workload Units	
28	Electrocardiography (ECG)	7290		Workload Units	
29	Cardiac Catheterization Laboratory	7310		Procedures	
30	Radiology/Diagnostic	7320		Procedures	
31	Computerized Tomography (CT)	7340		Procedures	
32	Magnetic Resonance Imaging (MRI)	7350		Procedures	
33	Radiation Therapy	7360		Procedures	
34	Nuclear Medicine	7380		Procedures	
35	Respiratory Therapy	7420		Treatments	
36	Physical Therapy	7510		Modalities	
37	Occupational Therapy	7590		N/A	
38	Speech Pathology	7590		N/A	
39	Rehabilitation Care	7590		N/A	
40	Renal Dialysis-Inpatient or Outpatient	7710		Treatments	
41	ESW Lithotripsy	7720		Procedures	
42	Organ Acquisition and Banking	7730		Organs Acquired	
43	Social Work Services (MSW Director)	8350		N/A	
44	Pharmacy-Full Time RPh	8470		N/A	

SERVICE CODE DESCRIPTION

1. SEPARATELY ORGANIZED, STAFFED, AND EQUIPPED UNIT OF HOSPITAL (DISCRETE)
2. SERVICES MAINTAINED IN HOSPITAL BUT NOT IN SEPARATE UNIT (NONDISCRETE)
3. SERVICES CONTRACTED OUT BUT HOSPITAL-BASED
4. SERVICES NOT MAINTAINED IN HOSPITAL, BUT AVAILABLE FROM OUTSIDE CONTRACTOR
5. SERVICES SHARED UNDER AGREEMENT
6. CLINIC SERVICES COMMONLY PROVIDED IN EMERGENCY SUITE TO NON-EMERGENCY OUTPATIENTS BY HOSPITAL-BASED PHYSICIANS OR RESIDENTS
7. SERVICES NOT AVAILABLE

NOTE: IF A SERVICE IS CODED ONE, TWO, OR THREE, SEE INSTRUCTIONS FOR REPORTING OF REVENUE AND EXPENSE.

WORKSHEET B-1: DAILY HOSPITAL SERVICES STATISTICS

PURPOSE: To collect statistical data which are used to perform comparative analysis and used for other relevant statistical functions.

INSTRUCTIONS:

FACILITY NO: Enter the hospital's assigned AHCA number.

PERIOD: Enter the beginning and ending dates for the period covered in this report. For example: 10/1/1999 to 9/30/2000.

GENERAL: Complete columns (1) through (4) for each of the respective services offered by the hospital.

COLUMN DEFINITIONS:

COST CENTER: A description of each of the cost centers/services provided by the hospitals.

ACCOUNT NUMBER: The standardized account number assigned to this cost center. See Chapter III, DESCRIPTION OF ACCOUNTS for more detailed information.

COLUMN 1 – LICENSED BEDS END OF PERIOD: Enter the number of beds licensed and/or registered in the hospital facility as of the last day of the hospital's reporting period.

Enter the number of licensed beds for an Intermediate Care Facility Mentally Retarded in the "INTERMEDIATE CARE" cost center, LINE 18.

COLUMN 2 – BEDS AVAILABLE END OF PERIOD: Enter the number of beds available for use by patients at the end of the reporting period.

See Chapter IV, GLOSSARY OF HEALTHCARE TERMINOLOGY, for a definition of BEDS AVAILABLE.

COLUMN 3 – TOTAL BED DAYS AVAILABLE: Enter the total bed days available. TOTAL BED DAYS AVAILABLE is computed multiplying the number of beds available throughout the period by the number of days in the period.

If the number of beds available has fluctuated throughout the report period, the WEIGHTED AVERAGE TOTAL BED DAYS AVAILABLE should be reported. This is computed by multiplying the available beds for a segment of the report period by the number of days in that segment. Each segment in which the number of beds has changes should be computed separately. The TOTAL BED DAYS AVAILABLE reported is the summation of all segments' total bed days available. For example, if the hospital had a unit of 24 beds open for only six months during the year, the computation would be 24 x 180 = 4,320 and NOT 24 X 365 = 8,760.

COLUMN 4 – TOTAL INPATIENT DAYS: Enter the total number of INPATIENT DAYS for each of the services.

CLASSIFICATION OF ACUTE AND INTENSIVE CARE PATIENTS SERVED

LINE 26 – SELF-PAY PATIENTS: Enter the total of self-pay acute and intensive care patient days in COLUMN 1 – INPATIENT DAYS. Enter the total of self-pay admissions in COLUMN 2 – ADMISSIONS.

LINE 27 – MEDICARE: Enter the total of MEDICARE reimbursed acute and intensive care patient days in COLUMN 1 – INPATIENT DAYS. Enter the total of MEDICARE reimbursed acute and intensive care admissions in COLUMN 2 – ADMISSIONS.

LINE 27a – MEDICARE – HMO: Enter the total of acute and intensive patient days attributable to patients of a qualified MEDICARE HMO in COLUMN 1 – INPATIENT DAYS. Enter the total of acute and intensive admissions attributable to patients of a qualified MEDICARE HMO in COLUMN 2 – ADMISSIONS.

WORKSHEET B-1 DAILY HOSPITAL SERVICES STATISTICS CONTINUED-

LINE 28 – MEDICAID: Enter the total of MEDICAID reimbursed acute and intensive care patient days in COLUMN 1 – INPATIENT DAYS. Enter the total of MEDICAID reimbursed acute and intensive care admissions in COLUMN 2 – ADMISSIONS.

LINE 28a – MEDICAID – HMO: Enter the total of acute and intensive patient days attributable to patients of a qualified MEDICAID – HMO in COLUMN 1 – INPATIENT DAYS. Enter the total acute and intensive admissions attributable to patients of a qualified MEDICAID – HMO in COLUMN 2 – ADMISSION.

LINE 29 THROUGH 33 – OTHER PATIENT CLASSIFICATIONS: Enter the total of all OTHER PATIENT CLASSIFICATIONS listed, acute and intensive care patient days in the COLUMN 1 – INPATIENT DAYS of each classification line. Enter the total of all OTHER PATIENT CLASSIFICATIONS listed, acute and intensive care admissions in COLUMN 2 – ADMISSIONS of that classification line.

LINE 34 – TOTAL ACUTE AND INTENSIVE CARE: Enter the total of LINES 26-33 for each column. The total on LINE 34, COLUMN 1, should agree with the sum of LINE 6 & LINE 16, COLUMN 4, of this worksheet.

CLASSIFICATION OF SUBACUTE CARE PATIENTS SERVED:

Follow the above instructions for LINES 26-33, entering the corresponding statistics of SUBACUTE patients. The total on LINE 43, COLUMN 1, should agree with the total on LINE 22, COLUMN 4 of this worksheet.

DAILY HOSPITAL SERVICES/STATISTICS

SUBMISSION NUMBER:	REPORTING PERIOD FROM: TO:	FACILITY NUMBER	**WORKSHEET B-1**

	COST CENTER	ACCT. NUMB	LICENSED BEDS (END OF PERIOD)	AVAILABLE BEDS (END OF PERIOD)	TOTAL AVAILABLE BED DAYS	TOTAL INPATIENT DAYS
	DAILY HOSPITAL SERVICES (DHS)		(1)	(2)	(3)	(4)
01	Medical/Surgical Acute	6010				
02	Pediatric Acute	6170				
03	Psychiatric Acute	6210				
04	Substance Abuse Acute-DTU	6220				
05	Obstetrics Acute	6250				
06	Definitive Observations	6280				
07	Other Acute Care *	6290				
08	Total Acute Care (Lines 01 through 07)	B107	-	-	-	-
09	Medical/Surgical ICU	6310				
10	Coronary Care	6330				
11	Pediatric Intensive Care	6350				
12	Neonatal Intensive Care	6370				
13	Burn Care	6380				
14	Psychiatric Intensive Care	6390				
15	Other Intensive Care *	6410				
16	Total Intensive Care (Lines 09 through 15)	B115	-	-	-	-
17	Skilled Nursing Facility	6610				
18	Psychiatric Long-Term Care	6630				
19	Intermediate Care	6650				
20	Residential Care	6660				
21	Other Subacute Care *	6690				
22	Total Subacute Care (Lines 17 through 21)	B122	-	-	-	-
23	Total DHS/Excluding New born (Lines 8, 16, and 22)	B123	-	-	-	-
24	New born Nursery	6510				
25	Total Daily Hospital Services (Lines 23 and 24)	B125	-	-	-	-

	CLASSIFICATION OF ACUTE AND INTENSIVE CARE PATIENTS SERVED		INPATIENT DAYS (1)	ADMISSIONS (2)
26	Self-Pay	S105		
27	Medicare	B127		
27a	Medicare-HMO	H110		
28	Medicaid	B128		
28a	Medicaid-HMO	H115		
29	Champus	G104		
29a	Other Government *	G105		
30	Insurance Charge-Based	B130		
31	Other Charge-Based *	N105		
32	Commercial HMO/PPO	N110		
33	Other Discounted *	B129		
34	Total Acute Intensive Care	B131	-	-

	CLASSIFICATION OF SUBACUTE PATIENTS SERVED		INPATIENT DAYS	ADMISSIONS
35	Self-Pay	S110		
36	Medicare	B132		
36a	Medicare-HMO	H120		
37	Medicaid	B133		
37a	Medicaid-HMO	H125		
38	Champus	G109		
38a	Other Government *	G110		
39	Insurance Charge-Based	B135		
40	Other Charge-Based*	N115		
41	Commercial HMO/PPO	N120		
42	Other Discounted *	B134		
43	Total Subacute	B136	-	-

NOTE: TOTAL ON LINE 34(1) IS EQUAL TO THE SUM OF LINES 8(4) AND 16(4).
TOTAL ON LINE 43(1) IS EQUAL TO THAT OF LINE 22(4).
*DETAIL THESE ACCOUNTS ON WORKSHEET X-4.

WORKSHEET B-4: MEDICAL STAFF PROFILE

PURPOSE: To provide data useful in evaluating residency programs to determine whether teaching hospital requirements are met. To provide for assessment of services provided by physician specialty.

INSTRUCTIONS:

FACILITY NO: Enter the hospital's assigned AHCA number.

PERIOD: Enter the beginning and ending date for the period covered in this report. For example: 10/01/1999-9/30/2000.

WORKSHEET B-4 MEDICAL STAFF PROFILE

COLUMN DEFINITIONS:

COLUMN 1 – APPROVED PROGRAM: Enter in this column either YES or NO with regard to the hospital's participation in each residency program listed. Total the number of affirmative responses on LINE 50 of the Worksheet.

COLUMN 2 – MEDICAL STUDENTS: Enter in this column, after the appropriate specialty, the number of medical students who are completing their clinical practicum at the hospital. Medical students are to be shown as FTE's, rather than as whole numbers.

COLUMN 3 – RESIDENTS: For each CLINICAL SPECIALTY listed, enter the ACTUAL number of RESIDENTS (FTE's) enrolled in teaching programs at the close of the reporting period (teaching program year). Residents at hospitals providing only clinical experience for an approved teaching program are not to be reported.

COLUMN 4 – ACTIVE STAFF: For each CLINICAL SPECIALTY listed, enter the number of physicians who were members of the active medical staff at the end of the period. Report under the appropriate clinical specialty only physicians who are Board Certified.

Do not include courtesy staff in the reported totals.

NOTE: See Chapter IV, GLOSSARY OF HEALTHCARE TERMINOLOGY, for a definition of ACTIVE MEDICAL STAFF.

MEDICAL STAFF PROFILE AND ALLIED HEALTH EDUCATION PROGRAMS

SUBMISSION NUMBER:	REPORTING PERIOD FROM: TO:	FACILITY NUMBER	**WORKSHEET B-4**

PART I - MEDICAL STAFF PROFILE

	CLINICAL SPECIALITY	ACCT. NUMB.	APPROVED PROGRAM (Y/N)	MEDICAL STUDENTS (FTE's)	RESIDENTS (FTE's)	ACTIVE STAFF (W#'s)
			1	(2)	(3)	(4)
01	Family Practice	4500	n			
02	Psychiatry	4501	n			
03	Psychiatry, Child	4502	n			
04	Public Health / Preventive Medicines	4503	n			
05	Allergy and Immunology	4504	n			
06	Dermatology	4505	n			
07	Internal Medicine	4506	n			
08	Pediatrics	4507	n			
09	Pulmonary Diseases	4508	n			
10	Nuclear Medicine	4509	n			
11	Gastroenterology	4510	n			
12	Emergency Medicine	4511	n			
13	Endocrinology	4512	n			
14	Hematology	4513	n			
15	Infectious Diseases	4514	n			
16	Pediatric Endocrinology	4515	n			
17	Pediatric Hematology	4516	n			
18	Pediatric Nephrology	4517	n			
19	Pediatric Cardiology	4518	n			
20	Rhuematology	4519	n			
21	Nephrology	4520	n			
22	Neurology	4521	n			
23	Neonatal / Perinatal Medicine	4522	n			
24	Oncology, Medicine	4523	n			
25	Cardiovascular Diseases / Cardiology	4524	n			
26	Dental Medicine (DMD)	4560	n			
27	Podiatric Medicine / Surgery (DPM)	4561	n			
28	Otolaryngology (E.N.T.)	4562	n			
29	Opthalmology	4563	n			
30	Obstetric and Gynecology	4564	n			
31	Urological, Medicine / Surgery	4565	n			
32	Radiology	4570	n			
33	Radiology, Diagnostic	4571	n			
34	Radiology, Diagnostic / Nuclear	4572	n			
35	Radiology, Therapeutic	4573	n			
36	Pathology	4580	n			
37	Pathology, Dermatopathology	4581	n			
38	Pathology, Bloodbanking	4582	n			
39	Pathology, Forensic	4583	n			
40	Pathology, Neuropathology	4584	n			
41	Anesthesiology	4592	n			
42	Surgery, General	4600	n			
43	Surgery, Oral & Maxillofacial (DDS, MD)	4601	n			
44	Surgery, Plastic	4602	n			
45	Surgery, Orthopedic	4603	n			
46	Surgery, Thoracic	4604	n			
47	Surgery, Neurological	4605	n			
48	Surgery, Cardiovascular	4606	n			
49	Other Clinical Specialties *	4998	n			
50	Totals (Lines 1 through 49)	4999	**0**	**0.0**	**0.0**	**-**

NOTES: ON LINE 50 OF COLUMN (1) ENTER THE TOTAL OF AFFIRMATIVE (Y) RESPONSES.
IN COLUMN (4), ENTER THE NUMBER OF PHYSICIANS WHO ARE MEMBERS OF THE ACTIVE MEDICAL STAFF (AS DEFINED IN APPENDIX A OF THE FHURS MANUAL) AT THE CLOSE OF THE REPORTING PERIOD AND WHO ARE BOARDCERTIFIED IN THE INDICATED SPECIALTY.
REPORT ACTIVE MEDICAL STAFF AS WHOLE NUMBERS, BUT REPORT MEDICAL STUDENTS AND RESIDENTS AS FTE'S TO THE NEAREST SINGLE DECIMAL PLACE (I.E. 99.9).

* DETAIL ON WORKSHEET X-4

WORKSHEET C-1: BALANCE SHEET

PURPOSE: This form was primarily designed to standardize the various methods of reporting used by hospitals throughout the state. The primary purpose for requesting such information is to obtain a general level of comparability as well as to provide AHCA with a complete picture of a particular hospital's range of operations and resources. In addition, this information is used to compute various cost relationships (e.g., interest expense to average loan balance) that will allow AHCA to perform an analysis of significant fluctuations and trends internally and among hospitals of similar nature.

INSTRUCTIONS: NOTE: THIS WORKSHEET IS NOT REQUIRED FOR FACILITIES THAT ARE OPERATED BY THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES OR THE DEPARTMENT OF CORRECTIONS.

FACILITY NO: Enter the hospital's assigned AHCA number.

PERIOD: Enter the beginning and ending date for the period covered in this report. For example: 10/01/1999-9/30/2000.

COLUMN DEFINITIONS: NOTE: Investor owned hospital, not utilizing fund accounting need only complete COLUMN 1 – OPERATING FUNDS.

COLUMN 1 – OPERATING FUNDS: For each line, enter the corresponding amounts from the hospital's balance sheet accounts, which are recorded in the OPERATING FUND.

COLUMN 2 – (Hospital to Supply the Appropriate Fund Title): For each line, enter the corresponding amounts from the hospital's balance sheet accounts, which are recorded in that fund.

COLUMN 3 – (Hospital to Supply the Appropriate Fund Title): For each line, enter the corresponding amounts from the hospital's balance sheet accounts, which are recorded in that fund.

COLUMN 4 – TOTAL/ALL FUNDS: Enter the total of COLUMNS 1, 2 and 3 for each account. These totals should reconcile to the AUDITED COMBINED BALANCE SHEET.

LINE 23 – OTHER CURRENT LIABILITIES: Enter the portion of this reported amount, which represents the current portion of long-term debt on LINE 44.

LINE 33 – INTERCOMPANY INDEBTEDNESS – NONCURRENT: Enter the amount, which represents loans from related parties for which interest or other costs are paid as operating costs. If the intercompany indebtedness account shows a debit balance, the amount should be reported in this account as a negative amount.

LINE 38 – ADDITIONAL PAID-IN CAPITAL: The amount entered should include money loaned by related parties, which has no other associated cost or interest.

NOTE: See Chapter III, DESCRIPTION OF ACCOUNTS, for more detailed definitions of the accounts listed above.

BALANCE SHEET

SUBMISSION NUMBER:	REPORTING PERIOD FROM: TO:	FACILITY NUMBER	**WORKSHEET C-1**

LN NO	ACCOUNT DESCRIPTIONS	ACCT. NUMB.	OPERATING FUNDS	OTHER FUNDS		TOTAL ALL FUNDS
			(1)	(2)	(3)	(4)
	CURRENT ASSETS					
01	Cash and Investments	1010				-
02	Current Portion Assets Whose Use Is Limited	1020				-
03	Accounts & Notes Receivable-Net	1030				-
04	Inventories	1080				-
05	Other Current Assets *	1090				-
06	Total Current Assets (Lines 1 through 5)	1099	-	-	-	-
07	Board Designated Assets	1110				-
08	Donor Restricted Assets	1130				-
09	Trustee Held Funds	1140				-
10	Total Assets Whose Use Limited (Lines 7 through 9)	1199	-	-	-	-
11	Plant, Property, & Equipment	1297	-			-
12	Less: Accumulated Depreciation	1298	-			-
13	Net Plant, Property, & Equipment	1299	-	-	-	-
14	Other Tangible Assets *	1350				-
15	Deferred Financing Costs	1355				-
16	Deferred 3rd-Party Receivables	1360				-
17	Deferred Income Taxes	1365				-
18	Goodwill	1380				-
19	Other Intangible Assets *	1390				-
20	Total Assets (Lines 6, 10 and Lines 13 through 19)	1999	-	-	-	-
	CURRENT LIABILITIES					
21	Accounts, Notes & Loans Pay	2010				-
22	Other Current Liabilities (1)*	2080				-
23	Current Liabilities for Assets Whose Use Is Limited (WUIL	2110				-
24	Total Current Liabilities (Lines 21 through 23)	2199	-	-	-	-
25	Deferred Credits and Other Liabilities*	2140				-
	LONG-TERM DEBT (EXCLUDING CURRENT MATURITY)					
26	Mortgages Payable / FHA	2210				-
27	Mortgages Payable / Other	2220				-
28	Construction Loans	2230				-
29	Notes-Revolving Credit	2240				-
30	Capitalized Lease Obligation	2250				-
31	Bonds Payable-Taxable	2260				-
32	Bonds Payable-Tax-Exempt	2270				-
33	Intercompany Debt-Noncurrent	2280				-
34	Other Noncurrent Debt*	2290				-
35	Total Long-Term Debt (Lines 26 through 34)	2299	-	-	-	-
36	Total Liabilities (Lines 24, 25 and 35)	2998	-	-	-	-
37	Stockholders Equity	2350				-
38	Additional Paid-In Capital	2360				-
39	Retained Earnings	2370				-
40	Capital-Partner / Sole Proprieter	2380				-
41	Fund Balances (Non Profit)	2390				-
42	Total Equities and Capital (Lines 37 through 41)	2399	-	-	-	-
43	Total Liabilities and Equities (Lines 36 & 42)	2999	-	-	-	-
44	Current Maturities on Long-Term Debt:					

* IF THIS ACCOUNT EXCEEDS 1.25% OF NET PLANT, PROPERTY, AND EQUIPMENT, DETAIL ON WORKSHEET X-4, (ACTUAL REPORTS ONLY) LINES 02 AND 23 WUIL = WHOSE USE IS LIMITED.

WORKSHEET C-2: INCOME STATEMENT

PURPOSE: The information presented on this form will primarily be used to compute various ratios and relationships (e.g., salaries to total revenues) that will allow AHCA to perform an analysis of significant fluctuations and trends within and among hospitals of similar nature. By requesting such information to be presented using common classifications, AHCA will ultimately have information that will compliment the departmental analysis of revenues and expenses, as presented in other forms, which will permit certain critical cost comparisons, such as food cost per patient day.

INSTRUCTIONS: NOTE: Since this worksheet utilizes information reported on other related worksheets the preparer must complete the following worksheets prior to completion of this worksheet: C-3, C-3a, C-4, C-5, and C-6.

FACILITY NO: Enter the hospital's assigned (AHCA) number.

PERIOD: Enter the beginning and ending date for the period covered in this report. For example: 10/01/1999-9/30/2000.

LINE 1 – INPATIENT SERVICES REVENUE: Enter the amount reported on WORKSHEET C-3, COLUMN 1, LINE 54.

LINE 2 – OUTPATIENT SERVICES REVENUE: Enter the amount reported on WORKSHEET C-3, COLUMN 2, LINE 54.

LINE 3 – TOTAL PATIENT SERVICE REVENUE: Enter the total of LINES 1 & 2 of this worksheet.

LINE 4 – TOTAL DEDUCTIONS FROM REVENUE: Enter the total from COLUMN 4, ACCT. COO3, WORKSHEET C-3a.

LINE 5 – NET PATIENT CARE REVENUE: Subtract LINE 4 from LINE 3 and enter the result.

LINE 6 – OTHER OPERATING REVENUE: Enter the amount reported on WORKSHEET C-4, COLUMN 1, LINE 20.

LINE 7 – TOTAL OPERATING REVENUE: Enter the total of LINES 5 & 6.

LINE 8 – SALARIES AND WAGES – PATIENT CARE: Enter the amount reported on WORKSHEET C-5, COLUMN 1, LINE 54.

LINE 9 – OTHER EXPENSE – PATIENT CARE: Enter the amount reported on WORKSHEET C-5, COLUMN 2, LINE 54.

LINE 10 – SALARIES AND WAGES – GENERAL & ADMINISTRATIVE: Enter the amount reported on WORKSHEET C-6, COLUMN 1, LINE 37.

LINE 11 – OTHER EXPENSE – GENERAL & ADMINISTRATIVE: Enter the amount reported on WORKSHEET C-6, COLUMN 2, LINE 37.

LINE 12 – TOTAL OPERATING EXPENSE: Enter the total of LINE 8 through LINE 11.

LINE 13 – OPERATING MARGIN: Subtract LINE 12 from LINE 7 and enter the result.

LINE 14 – NONOPERATING REVENUE: Enter the amount reported on WORKSHEET C-4, COLUMN 1, LINE 33.

LINE 15 – NONOPERATING EXPENSES: Enter the amount reported on WORKSHEET C-6, COLUMN 3, LINE 40.

LINE 16 – EXCESS/DEFICIENCY OF NONOPERATING REVENUES OVER NONOPERTING EXPENSES: Subtract LINE 17 from LINE 16 and enter the result.

LINE 17 – TOTAL MARGIN B/F INCOME TAXES & EXTRAORDINARY ITEMS: Enter the total of LINES 13 PLUS OR MINUS 16.

WORKSHEET C-2 INCOME STATEMENT
CONTINUED-

LINE 18 – PROVISION FOR INCOME TAXES: In budgets, taxable entities should report the estimated provision for both state and federal income taxes on the amount of either profit or loss that has been budgeted, even if this results in a negative amount. For proprietary entities, if the provision for income taxes is negative or zero then a detailed explanation of the reason must be provided on WORKSHEET X-4. In Actual reports, hospitals will report the actual amount of taxes paid or allocated, if part of a chain operation.

LINE 19 – 24 – EXTRAORDINARY ITEMS: Report specific extraordinary items in the space allowed. Do not include these amounts on WORKSHEET C-6, COLUMN 3, LINES 1-41. Report only those amounts classified as "EXTRAORDINARY" in accordance with generally accepted accounting principles. Final settlements for the prior year Medicare cost report should be reported as "CONVENTIONAL – MEDICARE" in ACCT 5910 of WORKSHEET C-3a.

Extraordinary gains are bracketed, due to data processing requirements. If these signs are changed the report will show an incorrect total margin and will be returned to the hospital for correction.

LINE 25 – TOTAL MARGIN: Enter the total on LINE 17 plus or minus the amounts on LINES 18 and 24.

INCOME STATEMENT

SUBMISSION NUMBER:	REPORTING PERIOD FROM: TO:	FACILITY NUMBER	**WORKSHEET C-2**

	OPERATING REVENUE:	
01	Inpatient Services Revenue (Worksheet C-3, Col(1), Line 54)	-
02	Outpatient Services Revenue (Worksheet C-3, Col(2), Line 54)	-
03	Total Patient Service Revenue (Line 1 + Line 2)	-
	DEDUCTIONS FROM REVENUE AND NET REVENUE:	
04	Total Deductions from Revenue (Worksheet C-3a, ACCT, C003, Col(6))	-
05	Net Patient Care Revenue (Line 3 - Line 4)	-
06	Other Operating Revenue (Worksheet C-4, Col(1), Line 20)	-
07	Total Operating Revenue (Line 5 + Line 6)	-
	OPERATING EXPENSE:	
08	Salaries and Wages-Patient Care (Worksheet C-5, Col(1), Line 54)	-
09	Other Expense-Patient Care (Worksheet C-5 Col(2), Line 54)	-
10	Salaries and Wages-Administrative & General (Worksheet C-6 Col(1), Line 37)	-
11	Other Expense-Administrative & General (Worksheet C-6 Col(2), Line 37)	-
12	Total Operating Expense (Lines 8 through Line 11)	-
13	Operating Margin (Line 7 - Line 12)	-
	NONOPERATING REVENUE AND EXPENSE:	
14	Nonoperating Revenue (Worksheet C-4, Col(1), Line 34)	-
15	Nonoperating Expense (Worksheet C-6, Col(3), Line 40)	-
16	Excess (Deficiency) of Nonoperating Revenues Over Nonoperating Expenses (Line 14 - Line 15)	-
17	Total Margin B/F Income Taxes & Extraordinary Items (Line 13 + Line 16)	-
18	Provision for Incomes Taxes	
	EXTRAORDINARY ITEMS (DETAIL BELOW):	
19	Extraordinary Gains *	
21	Extraordinary Losses *	
24	Total Extraordinary Items (Lines 19 + 21)	-
25	Total Margin (Line 17 + 18 + 24)	-

* DETAIL ON WORKSHEET X-4

WORKSHEET C-3: STATEMENT OF PATIENT CARE SERVICES REVENUE

PURPOSE: This worksheet summaries inpatient and outpatient revenue by revenue category for all Patient Care Services.

INSTRUCTIONS:

FACILITY NO: Enter the hospital's assigned AHCA number.

PERIOD: Enter the beginning and ending date for the period covered in this report. For example: 10/01/1999-9/30/2000.

COLUMN DEFINTIONS:

NOTE: The amounts to be reported for each Patient Care Service listed are the gross revenues (charges), regardless of the method used to charge for that service.

ACCOUNT NUMBER: The standardized account number assigned to this revenue category.

NOTE: Account numbers are standardized for data processing purposes. No changes or substitutions can be made to these account numbers.

COLUMN 1 – INPATIENT REVENUE: Enter the gross revenue amount associated with services provided in an inpatient setting during the reporting period.

COLUMN 2 – OUTPATIENT REVENUE: Enter the gross revenue amount associated with services provided in an outpatient setting during the reporting period.

COLUMN 3 – TOTAL REVENUE: Enter the summation of COLUMN 1 and COLUMN 2.

LINE 17 – INTERMEDIATE CARE: Include revenue from INTERMEDIATE CARE – MENTALLY RETARDED with revenue reported in this account.

LINE 23 – HOME DIALYSIS PROGRAM: Report all revenue from HOME DIALYSIS programs, including equipment rentals, and supplies sold.

LINE 26 – OTHER AMBULATORY SERVICES: Include revenue from PSYCHIATRIC DAY CARE SERVICES.

LINE 31 – SURGERY SERVICES: Report revenue from OPEN HEART AND NEUROLOGICAL SURGERY SERVICES in this account.

LINE 34 – MEDICAL SUPPLIES SOLD: Include revenue from the sale, lease and/or rental of DURABLE MEDICAL EQUIPMENT.

LINE 35 – DRUGS SOLD: Include revenues from INTRAVENOUS SOLUTIONS and ADMIXTURE SERVICE in this account.

LINE 36 – LABORATORY SERVICES: Include PATHOLOGY revenue within laboratory services. However, DO NOT include the pathologist fees unless the hospital bills for the service and collects the payments, and the physician is paid by the hospital under a separate contractual agreement or salary arrangement.

LINE 39 – ELECTROCARDIOGRAPHY: Include CARDIOVASCULAR TREADMILL STRESS TESTING, ECHOCARDIOGRAM, PHONOCARDIOGRAM, NEUROLOGICAL FUNCTION TESTING, AND TELEMETRY revenue with electrocardiographpy.

LINE 46 – RESPIRATORY THERAPY SERVICES: Include PULMONARY FUNCTION TESTING within respiratory services.

LINE 47 – PHYSICAL THERAPY: Include ELECTROMYOGRAPHY revenue within physical therapy.

WORKSHEET C-3 STATEMENT OF PATIENT CARE SERVICES REVENUE CONTINUED-

LINE 48 – OTHER REHABILITATIVE SERVICES: Include revenue from OCCUPATIONAL THERAPY, SPEECH THERAPY, RECREATIONAL THERAPY, AND AUDIOLOGY.

LINE 52 – OTHER ANCILLARY SERVICES: Include revenue from GASTROENTEROLOGY, DENTAL SERVICES. (NOTE: Gastroenterology includes all endoscopic procedures).

NOTE: Report the totals on LINE 54 for inpatient, outpatient, and total patient revenue on the appropriate lines on WORKSHEET C-2.

STATEMENT OF PATIENT CARE SERVICES REVENUE

SUBMISSION NUMBER:	REPORTING PERIOD FROM: TO:	FACILITY NUMBER	**WORKSHEET C-3**

	REVENUE CENTER	ACCT. NUMB.	INPATIENT REVENUE (1)	OUTPATIENT REVENUE (2)	TOTAL REVENUE (3)
	DAILY HOSPITAL SERVICES				
01	Medical / Surgical Acute	3010			-
02	Pediatric Acute	3170			-
03	Psychiatric Acute	3210			-
03a	Substance Abuse Acute-DTU	3220			-
04	Obstetrics Acute	3250			-
05	Definitive Observation	3280			-
06	Other Acute Care *	3290			-
07	Medical / Surgical ICU	3310			-
08	Coronary Care Unit	3330			-
09	Pediatric ICU	3350			-
10	Neonatal ICU	3370			-
11	Burn Care Unit	3380			-
12	Psychiatric Unit	3390			-
13	Other Intensive Care *	3410			-
14	New born Nursery	3510			-
15	Skilled Nursing Facility	3610			-
16	Psychiatric Long-Term Care	3630			-
17	Intermediate Care	3650			-
18	Residential Care	3660			-
19	Other Subacute Care *	3690			-
20	Total Daily Hospital Services (Lines 1 through 19)	C322	-	-	-
	AMBULATORY SERVICES				
21	Emergency Services	3710			-
22	Clinic Services	3720			-
23	Home Dialysis Program	3820			-
24	Ambulatory Surgery Services	3830			-
25	Ambulance Services	3850			-
26	Other Ambulatory Services *	3860			-
27	Free Standing Clinic	3870			-
28	Home Health Services	3990			-
29	Total Ambulatory Services	C337	-	-	-
	ANCILLARY SERVICES				
30	Labor and Delivery Services	4010			-
31	Surgery Services	4040			-
32	Recovery Services	4060			-
33	Anesthesiology	4080			-
34	Medical Supplies Sold	4110			-
35	Drugs Sold	4150			-
36	Laboratory Services	4210			-
37	Blood / Plasma Collection	4250			-
38	Blood Bank-Processing & Storage	4260			-
39	Electrocardiography (ECG)	4290			-
40	Cardiac Catheterization	4310			-
41	Radiology / Diagnostic	4320			-
42	Computerized Tomography (CT)	4340			-
43	Magnetic Resonance Imaging (MRI)	4350			-
44	Radiology / Therapeutic	4360			-
45	Nuclear Medicine	4380			-
46	Respiratory Therapy	4420			-
47	Physical Therapy	4510			-
48	Other Rehabilitative Services *	4590			-
49	Renal Dialysis	4710			-
50	ESW Lithotripsy	4720			-
51	Organ Acquisition & Banking	4730			-
52	Other Ancillary Services *	4910			-
53	Total Ancillary Services (Lines 30 through 52)	C369	-	-	-
54	Total Patient Care Services (Lines 20, 29, & 53)	C370	-	-	-

* IF THIS ACCOUNT IS EQUAL TO OR EXCEEDS .25% OF NET PATIENT REVENUE, DETAIL ON WORKSHEET X-4.

WORKSHEET C-3a: STATEMENT OF PATIENT CARE REVENUE AND DEDUCTIONS FROM REVENUE BY PAYER CLASS FOR INPATIENT AND OUTPATIENT SERVICES

PURPOSE: This worksheet summarizes inpatient and outpatient revenues, deductions from revenue, and net revenue by payer class for all Patient Care Services. This categorization is necessary to properly calculate the assessment for the Patient Medical Assistance Trust Fund (PMATF)

INSTRUCTIONS:

FACILITY NO: Enter the hospital's assigned AHCA number.

PERIOD: Enter the beginning and ending date for the period covered in this report. For example: 10/01/1999-9/30/2000.

COLUMN DEFINITIONS:

NOTE: The inpatient and outpatient revenue amounts to be reported for each payer class listed are the gross patient service revenues (charges) regardless of the method used to charge for that service.

ACCOUNT NUMBER: The AHCA standardized account number assigned to this payer category.

NOTE: Account numbers are standardized for data processing purposes. No changes or substitutions can be made to these account numbers.

COLUMN 1 – INPATIENT REVENUE: Enter the inpatient revenue amounts associated with each class of payer, for which services were provided during the reporting period. The total reported in COLUMN 1, Account COO3, must equal the revenue reported in account C370 on LINE 54, COLUMN 1 on WORKSHEET C-3.

COLUMN 2 – OUTPATIENT REVENUE: Enter the outpatient revenue amounts associated with each class of payer, for which services were provided during the reporting period. The total reported in COLUMN 2, Account COO3, must equal the revenue reported in account C370 on LINE 54, COLUMN 2 on WORKSHEET C-3.

COLUMN 3 – TOTAL PATIENT REVENUE: Enter the summation of COLUMN 1 and COLUMN 2. The total reported in COLUMN 3, Account COO3, must equal the revenue reported in account C370 on LINE 54, COLUMN 3 on WORKSHEET C-3.

COLUMN 4 – TOTAL INPATIENT DEDUCTIONS FROM REVENUE: Enter the amount of inpatient deductions from revenue associated with each class of payer during the reporting period.

COLUMN 5 – TOTAL OUTPATIENT DEDUCTIONS FROM REVENUE: Enter the amount of outpatient deductions from revenue associated with each class of payer during the reporting period.

COLUMN 6 – TOTAL DEDUCTIONS FROM REVENUE: Enter the summation of COLUMN 4 and COLUMN 5. Amounts reported in this column represent the total revenue deduction for the indicated account. The total in COLUMN 6, Line 19 will also be reported on WORKSHEET C-2, Line 4.

COLUMN 7 – NET INPATIENT REVENUE: Subtract amount of inpatient deductions from revenue in COLUMN 4 from the amount of inpatient revenue reported in COLUMN 1 and enter the result.

COLUMN 8 – NET OUTPATIENT REVENUE: Subtract amount of outpatient deductions from revenue in COLUMN 5 from the amount of outpatient revenue reported in COLUMN 2 and enter the result.

COLUMN 9 – TOTAL NET PATIENT REVENUE: Enter the summation of COLUMN 7 and COLUMN 8. Amounts reported in this column represents the total net patient services revenue for the indicated account. The total in COLUMN 9, Line 19 will also be reported on WORKSHEET C-2, Line 5.

WORKSHEET C-3a– STATEMENT OF PATIENT CARE REVENUE AND DEDUCTIONS FROM REVENUE BY PAYER CLASS FOR INPATIENT AND OUTPATIENT SERVICES (CONTINUED)

ACCOUNT 5980 – ADMINISTRATIVE, COURTESY, AND POLICY DISCOUNT CARE: This account is used to report the discounting by the hospital of care provided to members of its Governing Board, staff physicians and their families, and members of the clergy. These discounts may range from 10% to 100% of the hospital's bill. If the hospital discounts 100% of the bill, the gross charges should be reported in COLUMNS 1, 2, and 3, ACCOUNT 5905 and a deduction equal to those charges should be reported in COLUMNS 4, 5, and 6, ACCOUNT 5980. If the hospital discounts only a portion of the bill, the gross charges must be reported in the primary classification, e.g., commercial insurance, self pay, etc., and the amount discounted should be reported in account 5980, COLUMNS 4, 5, and 6.

ACCOUNT 5981 – EMPLOYEE DISCOUNTED CARE: Discounts for employees will generally be a secondary deduction of the commercial insurance classification. The hospital's discount portion will be reported in account 5981, COLUMNS 4,5, and 6. However, the uncollectible amounts of employee deductibles and coinsurance should be reported in account 5900, COLUMNS 4,5, and 6.

ACCOUNT 5995 – RESTRICTED FUNDS FOR INDIGENT CARE: This account is the amount received from donors and government agencies to off set the cost of indigent care provided by the hospital. This account was formerly listed on worksheet C-2 as "RESTRICTED GRANTS AND DONATIONS FOR INDIGENT CARE". The amount reported herein represents an offset to total deductions from revenue.

ACCOUNT 4900 – RADIATION THERAPY REVENUE AND DEDUCTIONS: Enter the amount of radiation therapy revenue for both inpatient and outpatient services on line 20 in COLUMNS 1, 2, and total in COLUMN 3. The amount in COLUMN 3 should equal ACCOUNT 4360, COLUMN 3, line 44, on worksheet C-3. Enter radiation therapy deductions from revenue on line 20 in COLUMNS 4, 5, and 6. Subtract the amounts on line 20 in COLUMNS 4, 5, and 6 from those on line 20 in COLUMNS 1, 2, and 3 and enter the result on line 20 in COLUMNS 7, 8, AND 9.

ACCOUNT C035 – ADJUSTED REVENUE AND DEDUCTIONS: Subtract the amounts on LINE 20 from those on LINE 19 and enter the result on LINE 21. This represents the adjustment for radiation therapy net revenues from total net patient service revenues.

ACCOUNT C004 – TOTAL HMO/PPO PAYMENTS: Enter the amount of HMO/PPO payment for inpatient and outpatient services on COLUMNS 7 and 8, then sum the two figures and enter the total in COLUMN 9.

STATEMENT OF PATIENT CARE REVENUES AND DEDUCTIONS FROM REVENUE BY PAYOR OR CLASS FOR INPATIENT AND OUTPATIENT SERVICES				REPORTING PERIOD FROM: TO:		AHCA No.						WORKSHEET C-3a(rev.)
LN NO	REVENUE BY PAYOR CLASSIFICATION	ACCT. NUMB.	TOTAL INPATIENT REVENUE	TOTAL OUTPATIENT REVENUE	TOTAL PATIENT REVENUE	TOTAL INPATIENT DEDUCTIONS FROM REVENUE	TOTAL OUTPATIENT DEDUCTIONS FROM REVENUE	TOTAL DEDUCTIONS FROM REVENUE	NET INPATIENT REVENUE	NET OUTPATIENT REVENUE	TOTAL NET PATIENT REVENUE	
			(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	
01	Bad Debts	5900						-	-	-	-	
02	Self-Pay Patients	5905			-				-	-	-	
03	Charity Care-Hill Burton	5950						-	-	-	-	
04	Charity Care-Other	5960						-	-	-	-	
05	Conventional-Medicare	5910			-			-	-	-	-	
06	Conventional-Medicaid	5920			-			-	-	-	-	
07	Other Government Fixed-Price Payors	5930			-			-	-	-	-	
08	Insurance Charge-Based	5935			-				-	-	-	
09	Other Charge Based Payors	5936			-				-	-	-	
10	Medicare-HMO	5911			-			-	-	-	-	
11	Medicaid-HMO	5921			-			-	-	-	-	
12	Commercial-HMO	5940			-			-	-	-	-	
13	Commercial-PPO	5941			-			-	-	-	-	
14	Other Commercial Discounted Payors	5945			-			-	-	-	-	
15	Admin. Courtesy and Policy Discounts	5980						-	-	-	-	
16	Employee Discounts	5981						-	-	-	-	
17	Other Deductions from Revenue	5990						-	-	-	-	
18	Restricted Funds for Indigent Care	5995						-	-	-	-	
19	Total Revenue and Deductions	C003	-	-	-	-	-	-	-	-	-	
20	Radiation Therapy Revenue	4900	-	-	-			-	-	-	-	
21	Adjusted Revenue And Deductions	C035	-	-	-	-	-	-	-	-	-	
22	Total HMO/PPO Payment	C004										

NOTE: THE AMOUNT ON LINE 19, COLUMN 3 SHOULD EQUAL ACCOUNT C370(3), ON WORKSHEET C-3

THE REVENUE AMOUNTS FOR ACCOUNT 4900 SHOULD EQUAL ACCOUNT 4360(1),(2),(3) ON WORKSHEET C-3

NOTES: ACCOUNT 5995 IS "RESTRICTED GRANTS AND DONATIONS FOR INDIGENT CARE" WHICH FORMERLY APPEARED ON WORKSHEET C-2.

WORKSHEET C-4: STATEMENT OF OTHER OPERATING AND NONOPERATING REVENUE

PURPOSE: This form will gather the various types of operating and non-operating revenue generated by the hospital into a schedule that can be used to analyze each class of revenue.

INSTRUCTIONS:

FACILITY NO: Enter the hospital's assigned AHCA number.

PERIOD: Enter the beginning and ending date for the period covered in this report. For example: 10/01/1999-9/30/2000.

COLUMN DEFINITIONS:

ACCOUNT NUMBER: Enter the preprinted standardized account numbers for these revenue categories.

NOTE: Account numbers are standardized for data processing purposes. No changes or substitutions can be made to these account numbers.

COLUMN 1 – AMOUNT: Enter the corresponding revenue amounts in either the OPERATING REVENUE or NONOPERATING REVENUE sections.

LINE 15 – TELEVISION RENTAL SERVICE: Report all revenue from the operation of a television rental service, either by the hospital or by an auxiliary organization. If the service is operated by an auxiliary organization, report the commissions paid to the hospital by the organization here. If operated directly by the hospital, report all revenue generated by the service. Report salaries, wages, and other expenses related to the operation of the television rental service in HOSPITAL ADMINISTRATION, LINE 21 of WORKSHEET C-6.

LINE 16 – GIFT SHOP: Report all revenue from the operation of a gift shop, either by the hospital or by an auxiliary organization. If the shop is operated by an auxiliary organization, report the commissions paid to the hospital by the organization here. If operated directly by the hospital, report all revenues from the shop NET of purchases. Report salaries, wages, and other expenses related to the operation of the gift shop in HOSPITAL ADMINISTRATION, LINE 21 of WORKSHEET C-6.

LINE 18 & 32 – OTHER OPERATING REVENUE and OTHER NONOPERATING REVENUE: Include revenue from seminars, conferences, and silver recovery in Account 5870 – OTHER OPERATING REVENUES.

If the individual revenue amounts reported in accounts 5870 or 9150 equal or exceed .25% of NET PATIENT SERVICE REVENUE, each amount should be detailed on WORKSHEET X-4, EXPLANATIONS AND COMMENTS.

STATEMENT OF OTHER OPERATING AND NONOPERATING REVENUE

SUBMISSION NUMBER:	REPORTING PERIOD FROM: TO:	FACILITY NUMBER	**WORKSHEET C-4**

	REVENUE CENTER	ACCT. NUMB.	REVENUE AMOUNT (1)
	OTHER OPERATING REVENUE		
01	Transfers from Restricted Funds for Research Expenses	5020	
02	Nursing Education	5220	
03	Approved Post Graduate Medical Education	5240	
04	Nonapproved Post Graduate Medical Education	5250	
05	Other Allied Health Programs *	5260	
06	Transfers from Restricted Funds for Education Expenses	5280	
07	Cafeteria Revenue/Non-Patient	5320	
08	Laundry and Linen Revenue	5330	
09	Social Services Revenue	5350	
10	Housing Revenue	5360	
11	Parking Revenue	5440	
12	Housekeeping Revenue	5450	
13	Telephone Service Revenue	5610	
14	Data Processing Service Revenue	5620	
15	Television Rental Revenue	5630	
16	Gift Shop	5640	
17	Purchasing Services Revenue	5690	
18	Other Operating Revenue *	5870	
19	Transfers from Restricted Funds for Operating Expenses	5880	
20	Total Other Operating Revenue (Lines 1 through 19)	C430	-
	NONOPERATING REVENUE		
21	Gain/(Loss) on Sale of Assets	9010	
22	Unrestricted Contributions	9020	
23	Donated Services	9030	
24	Income and/or Gain/(Loss) from Unresticted Investments	9040	
25	Unrestricted Income/Endowment Funds	9050	
26	Unrestricted Income/Other Restricted Funds	9060	
27	Term Endowment Funds Becoming Unrestricted	9070	
28	Nursing Challenge Scholarship Revenue	9075	
29	Transfers from Restricted Funds for Nonoperating Expenses	9080	
30	Physician Private Office Rental Revenue	9110	
31	Unrestricted Tax Revenue & Appropriated Funds - State/Federal	9130	
32	Unrestricted Tax Revenue & Appropriated Funds - Local Govt.	9132	
33	Other Nonoperating Revenue *	9150	
34	Total Nonoperating Revenue (Lines 21through 33)	C441	-

* IF THIS ACCOUNT IS EQUAL TO OR EXCEEDS .25% OF NET PATIENT REVENUE, DETAIL ON WORKSHEET X-4

WORKSHEET C-5: STATEMENT OF PATIENT CARE SERVICES EXPENSE

PURPOSE: This schedule is used to report expenses by category. It is setup in the same format as WORKSHEET C-3. Salaries are disclosed separately due to their significance in proportion to total hospital expenses. This schedule, when analyzed in conjunction with the statistical section, will provide important information as to the operational efficiency of the hospital.

INSTRUCTIONS:

FACILITY NO: Enter the hospital's assigned AHCA number.

PERIOD: Enter the beginning and ending date for the period covered in this report. For example: 10/01/1999-9/30/2000.

COLUMN DEFINITIONS:

ACCOUNT NUMBER: Enter the standardized account number for this expense category. See Chapter III, DESCRIPTION OF ACCOUNTS, for further detail.

> NOTE: Account numbers are standardized for data processing purposes. No changes or substitutions can be made to these account numbers.

COLUMN 1 – SALARIES AND WAGES: Enter the amount of salaries and wages attributable to the related PATIENT CARE SERVICES cost center. The amount reported should not include the cost of the FRINGE BENEFITS related to the salaries and wages reported. FRINGE BENEFITS such as: FICA, pension expense, health insurance, and other payroll related fringe benefits are to be reported in COLUMN "2" – OTHER EXPENSES. DO NOT report as salaries and wages amounts paid to the agency personnel through the accounts payable system; only personnel who are paid through the hospital's payroll system should be reported in this classification.

COLUMN 2 – OTHER EXPENSES: Enter the amount of other expenses, including employee fringe benefit, for the specific cost center.

COLUMN 3 – TOTAL EXPENSE: Enter the total of the expenses reported in COLUMNS 1 and 2.

COLUMN 4 – FTE'S: Enter the number of FULL-TIME EQUIVALENT (FTE) employees. DO NOT include as FTE's, agency or contracted personnel who are not on the hospital's payroll. Round the total to the nearest tenth of a point, (e.g., 99.9).

STATEMENT OF PATIENT CARE SERVICES EXPENSE

SUBMISSION NUMBER:	REPORTING PERIOD FROM: TO:	FACILITY NUMBER	**WORKSHEET C-5**

LN NO	COST CENTER	ACCT. NUMB.	SALARIES AND WAGES (1)	OTHER EXPENSE (2)	TOTAL EXPENSE (3)	FTE'S (4)
	DAILY HOSPITAL SERVICES					
01	Medical / Surgical Acute	6010			-	
02	Pediatric Acute	6170			-	
03	Psychiatric Acute	6210			-	
03a	Substance Abuse Acute-DTU	6220			-	
04	Obstetrics Acute	6250			-	
05	Definitive Observation	6280			-	
06	Other Acute Care *	6290			-	
07	Medical / Surgical ICU	6310			-	
08	Coronary Care Unit	6330			-	
09	Pediatric ICU	6350			-	
10	Neonatal ICU	6370			-	
11	Burn Care Unit	6380			-	
12	Psychiatric ICU	6390			-	
13	Other Intensive Care *	6410			-	
14	New born Nusery	6510			-	
15	Skilled Nursing Facility	6610			-	
16	Psychiatric Long-Term Care	6630			-	
17	Intermediate Care	6650			-	
18	Residential Care	6660			-	
19	Other Sub-Acute Care *	6690			-	
20	Total Daily Hospital Services (Lines 1 through 19)	C522	-	-	-	**0.0**
	AMBULATORY SERVICES					
21	Emergency Services	6710			-	
22	Clinic Services	6720			-	
23	Home Dialysis Program	6820			-	
24	Ambulatory Surgery Services	6830			-	
25	Ambulance Services	6850			-	
26	Other Ambulatory Services *	6860			-	
27	Free Standing Clinic	6870			-	
28	Home Health Services	6990			-	
29	Total Ambulatory Services (Lines 21 through 28)	C537	-	-	-	**0.0**
	ANCILLARY SERVICES					
30	Labor and Delivery Services	7010			-	
31	Surgery Services	7040			-	
32	Recovery Services	7060			-	
33	Anesthesiology	7080			-	
34	Medical Supplies Sold	7110			-	
35	Drugs Sold	7150			-	
36	Laboratory Services	7210			-	
37	Blood / Plasma Collection	7250			-	
38	Blood Bank - Processing & Storage	7260			-	
39	Electrocardiography (ECG)	7290			-	
40	Cardiac Catheterization	7310			-	
41	Radiology / Diagnostic	7320			-	
42	Computerized Tomography (CT)	7340			-	
43	Magnetic Resonance Imaging (MRI)	7350			-	
44	Radiology / Therapeutic	7360			-	
45	Nuclear Medicine	7380			-	
46	Respiratory Therapy	7420			-	
47	Physical Therapy	7510			-	
48	Other Rehabilitative Services *	7590			-	
49	Renal Dialysis	7710			-	
50	ESW Lithotripsy	7720			-	
51	Organ Acquisition & Banking	7730			-	
52	Other Ancillary Services *	7910			-	
53	Total Ancillary Services (Lines 30 through 52)	C569	-	-	-	**0.0**
54	Total Patient Care Services (Lines 20, 29 & 53)	C570	-	-	-	**0.0**

NOTES: *IF THIS ACCOUNT IS EQUAL TO OR EXCEEDS 1.25% OF PATIENT CARE EXPENSE, DETAIL ON WORKSHEET X-4.
*FTE'S MUST BE TO THE NEAREST TENTH.

WORKSHEET C-6: STATEMENT OF OTHER OPERATING AND NONOPERATING EXPENSE

INSTRUCTIONS:

FACILITY NO: Enter the hospital's assigned AHCA number.

PERIOD: Enter the beginning and ending date for the period covered in this report. For example: 10/01/1999-9/30/2000.

COLUMN DEFINITIONS: NOTE: SMALL HOSPITALS have the option of reporting expenses on a more summarized level: A "Small Hospital" is defined as a hospital or hospital health services complex that has had, for three (3) accounting periods preceding the reporting period, average annual hospital admissions of less than 4,000 patients. The following classifications apply to small hospitals:

Expenses for Plant Operation and Maintenance, Utilities – Energy and Other, Security and Protection, and Parking, LINES 11-15, may be summarized and the total amount reported on LINE 11, Plant Operation and Maintenance.

Expenses for Patient Accounting/Admitting, Hospital Administration, Data Processing, Purchasing and Stores, and Medical Staff Administration, LINES 20-23 and LINE 25, may be summarized and the total amount reported on LINE 21, Hospital Administration.

ACCOUNT NUMBER: Use the AHCA standardized account number for this expense category. See Chapter III, DESCRIPTION OF ACCOUNTS for further detail.

NOTE: Account numbers are standardized for data processing purposes. No changes or substitutions can be made to these account numbers.

COLUMN 1 – SALARIES AND WAGES: Enter the amount of salaries and wages attributable to the related expense category. The amount reported should not include the cost of the FRINGE BENEFITS related to the salaries and wages reported. FRINGE BENEFITS such as FICA, pension expense, health insurance, and other payroll related fringe benefits should be reported as part of "OTHER EXPENSE".

DO NOT report as salaries and wages amounts paid to agency personnel through the accounts payable system; only personnel who are paid through the hospital's payroll system should be reported in this classification.

COLUMN 2 – OTHER EXPENSE: Report in this column all expenses other than salaries and wages that are normally charged to the specific cost center. Fringe benefits and administrative professional fees should be reported here.

LINE 2 – NURSING EDUCATION: Enter the total expenses associated with a formally organized nursing educational program that leads to either a degree or diploma. DO NOT report the expenses of inservice nursing educational programs.

LINE 9 – SOCIAL SERVICES: Include in this cost center the total expenses associated with providing social services to patients and families. Those expenses should include, but are not limited to patient aftercare and health education, placement of patient in a skilled nursing or other facility, and assisting families in securing public assistance.

LINE 28 – NURSING ADMINSTRATION: Report in this cost center all expenses related to the administration of the hospital's nursing service. Include the salaries of the Director of Nursing, the Assistant Director of Nursing, and Hospital Shift Supervisors, as well as those of the nursing office personnel. Expenses associated with inservice educational programs should be reported here.

LINE 30 – DEPRECIATION EXPENSE: Enter here the total amount of depreciation expense on all of the hospital's plant, property, and equipment. Regardless of the method the hospital uses to compute depreciation, for AHCA reporting purposes, only the straight line method may be used. A reconciliation between the AHCA report and the hospital's financial statements will be provided on WORKSHEET B-3.

LINE 30a – AMORTIZATION EXPENSE: This account is to report all amortization expense on the hospital's intangible assets. Include amortization on goodwill, start-up costs, and bond issue costs in this account.

WORKSHEET C-6 – STATEMENT OF OTHER OPERATING AND NONOPERATING EXPENSE CONTINUED-

LINE 30b – LEASE AND RENTAL EXPENSE: Report all leases, including lease of the hospital building, and equipment rental expense.

LINE 32 – INSURANCE – MALPRACTICE: Report here all expenses associated with providing the hospital professional and liability (malpractice) insurance. This should include all premium expenses for purchased commercial insurance as well as payments made into a self-insurance fund. This line should also contain any assessments made by the Florida Patient's Compensation Fund. Amounts related to the Florida Patient's Compensation Fund should be detailed on WORKSHEET X-4, EXPLANATION AND COMMENTS.

LINE 34 – TAXES AND LICENSES (OTHER THAN INCOME TAXES): This account should be used to report the expenses of all sales, ad valorem, and personal property taxes, as well as the cost of all hospital licenses. Include all assessments related to the HEALTHCARE COST CONTAINMENT TRUST FUND and the BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION TRUST FUND.

LINE 34a – PUBLIC MEDICAL ASSISTANCE TRUST FUND ASSESSMENT: Include all assessments related to the PUBLIC MEDICAL ASSISTANCE TRUST FUND (PMATF).

LINE 41 – TOTAL HOSPITAL EXPENSE: Total the amount of LINE 54 from WORKSHEET C-5, with the amounts on LINES 37 and 40 on WORKSHEET C-6 and enter the result on LINE 41.

COLUMN 4 – FTE'S: Enter the number of FULL-TIME EQUIVALENT (FTE) employees. DO NOT include as FTE's, agency or contracted personnel who are not on the hospital's payroll. Round the total to the nearest tenth of a point. (e.g., 99.9).

STATEMENT OF OTHER OPERATING AND NONOPERATING EXPENSE

SUBMISSION NUMBER:	REPORTING PERIOD FROM: TO:	FACILITY NUMBER	**WORKSHEET C-6**

LN NO	COST CENTER	ACCT. NUMB.	SALARIES AND WAGES (1)	OTHER EXPENSE (2)	TOTAL EXPENSE (3)	FTE'S (4)
	OTHER OPERATING EXPENSE GENERAL AND ADMINISTRATIVE					
01	Research Expense	8010			-	
02	Nursing Education	8220			-	
03	Approved Graduate Medical Education Program	8240			-	
04	Nonapproved Graduate Medical Education Program	8250			-	
05	Allied Health Education Program	8260			-	
06	Dietary Services / Patients	8310			-	
07	Cafeteria / Nonpatient	8320			-	
08	Laundry and Linen	8330			-	
09	Social Services	8350			-	
10	Housing	8360			-	
11	Plant Operation & Maintenance	8410			-	
12	Utilities-Energy	8411			-	
13	Utilities-Other	8412			-	
14	Security and Protection	8430			-	
15	Parking	8440			-	
16	Housekeeping Services	8450			-	
17	Central Supply-Administratioon	8460			-	
18	Pharmacy-Administration	8470			-	
19	General Accounting	8510			-	
20	Patient Accounting / Admitting	8520			-	
21	Hospital Administration	8610			-	
22	Data Processing Services	8611			-	
23	Purchasing / Storage	8690			-	
24	Medical Records Services	8710			-	
25	Medical Staff Administration	8720			-	
26	Medical Staff Services	8730			-	
27	Medical Care Review	8740			-	
28	Nursing Administration	8750			-	
29	Fund Raising Expense	8780			-	
30	Depreciation	8810			-	
30a	Amortization	8820			-	
30b	Lease and Rental	8825			-	
31	Employee Benefits / Nonpayroll	8830			-	
32	Insurance-Malpractice	8840			-	
33	Insurance-Other *	8850			-	
34	Taxes and Licenses (Excluding Income Taxes)	8860			-	
34a	PMATF Assessment	8865			-	
35	Interest Short-Term	8870			-	
36	Interest Long-Term	8880			-	
37	Total Other Operating Expense (Lines 1 through 36)	C637	-	-	-	**0.0**
	NONOPERATING EXPENSE					
38	Professional Office Building Expense	9210			-	
39	Other Nonoperating Expense *	9250			-	
40	Total Nonoperating Expense (Lines 38 and 39)	C641	-	-	-	**0.0**
41	Total Hospital Expense (Lines 37, 40, & 54, C5)	C642	-	-	-	**0.0**

NOTES: *IF THIS ACCOUNT IS EQUAL TO OR EXCEEDS .125% OF PATIENT CARE EXPENSE, DETAIL ON WORKSHEET X-4.

REPORT EXPENSES APPLICABLE TO THE NURSING CHALLENGE SCHOLARSHIP PROGRAM ON LINE 05, WITH DETAILED EXPLANATION ON WORKSHEET X-4.

WORKSHEET X-1: ANALYSIS OF EMPLOYEE BENEFITS

PURPOSE: Generally, salaries and the related fringe benefits comprise a significant portion of a hospital's operating expenses. (See the Revenue and Expense section for data gathering techniques to analyze salaries). The information on this form will primarily be used to compute various significant cost relationships (e.g., group health insurance per FTE) which will provide the Board with a greater understanding of fluctuations and trends within and among hospitals of similar nature.

INSTRUCTIONS:

FACILITY NO: Enter the hospital's assigned AHCA number.

PERIOD: Enter the beginning and ending date for the period covered in this report. For example: 10/01/1999-9/30/2000.

AMOUNT OF BENEFITS:

For each benefit category listed, enter the appropriate total amount of benefit costs for the reporting period.

LINE 11 – EMPLOYEE BENEFITS – NONPAYROLL RELATED

The total entered for this line should equal the amount reported on WORKSHEET C-6, COLUMN (3), LINE 31.

ANALYSIS OF EMPLOYEE BENEFITS

SUBMISSION NUMBER:	REPORTING PERIOD FROM: TO:	FACILITY	**WORKSHEET X-1**

	DETAIL OF EMPLOYEE BENEFITS	DOLLAR AMOUNT
02	FICA - Employer's Portion	
03	FICA - Employee's Portion (Paid by Employer)	
04	State and Federal Unemployment Insurance	
05	Group Health Insurance	
06	Group Life Insurance	
07	Pension and Retirement	
08	Worker's Compensation Insurance	
09	Union Health and Welfare	
10	Other Payroll Related Employee Benefits *	
11	Employee Benefits - Nonpayroll Related (1)	-
12	Total Employee Benefits	-

NOTES: (1) NONPAYROLL RELATED EMPLOYEE BENEFITS SHOWN ON THIS LINE SHOULD EQUAL LINE 31, COL(3) ON WORKSHEET C-6.

* DETAIL THIS ACCOUNT ON WORKSHEET X-4.

WORKSHEET X-4: EXPLANATIONS AND COMMENTS

PURPOSE: This worksheet should be used by the preparer for the following purposes:

1) To provide an explanation of any amount or transaction reported which may appear unusual when compared against other hospitals. Data that appears abnormal may be questioned by the AHCA. By providing an explanation on this worksheet, the preparer may avoid requests for further explanations.

2) To detail the composition of all amounts entered throughout the worksheets in "OTHER" categories. Only significant amounts, those exceeding the specified percentage threshold for each worksheet, need be detailed on this worksheet. See the TABLE OF OTHER CATEGORIES on the next page for specified line references to "OTHER" categories.

3) To explain why a certificate of need has not been obtained for any of the expenditures listed on LINES 1-40 on WORKSHEET X-3, LISTING OF CAPITAL EXPENDITURES.

INSTRUCTIONS:

FACILITY NO: Enter the hospital's assigned AHCA number.

PERIOD: Enter the beginning and ending date for the period covered in this report. For example: 10/01/1999-9/30/2000.

COLUMN DEFINITIONS:

WORKSHEET: Enter the worksheet number on which the amount listed is reported. (For example: C-6).

LINE NUMBER: Enter the worksheet line number on which the amount listed is reported.

DOLLAR AMOUNT: Enter the amount of the item being explained. This amount should correlate to the amount reported on the previously referenced worksheet and line number.

EXPLANATIONS AND COMMENTS: Enter any explanation or comments applicable to the item referenced.

TABLE OF OTHER CATEGORIES

Worksheet	"OTHER" Line No.	Worksheet	"OTHER" Line No.
B-1	06	C-4	05
B-1	14	C-4	18
B-1	20	C-4	32
B-4	49	C-5	06
C-1	05	C-5	13
C-1	14	C-5	19
C-1	19	C-5	26
C-1	25	C-5	48
C-1	27	C-5	52
C-1	34	C-6	33
C-2	21-25	C-6	39
C-3	06	X-1	10
C-3	13		
C-3	19		
C-3	26		
C-3	48		
C-3	52		

EXPLANATIONS AND COMMENTS			
SUBMISSION NUMBER: 1	REPORTING PERIOD FROM: TO:	FACILITY NUMBER	**WORKSHEET X-4** ACTUAL **X** BUDGET __

W/S NUMB.	LINE NUMB.	DOLLAR AMOUNT	EXPLANATION AND COMMENT

WORKSHEET PSY-1: PSYCHIATRIC HOSPITAL STATISTICS

PURPOSE: To collect relevant statistics from all short-term psychiatric hospitals and community mental health centers with an average length of stay less than or equal to 60 days. These statistics are necessary to perform the grouping of short-term psychiatric hospitals.

INSTRUCTIONS:

WHO MUST REPORT: All short-term psychiatric hospitals and community mental health centers with an average length of stay (ALOS) equal to or less than sixty (60) days must submit WORKSHEET PSY-1 as part of its prior year actual report, no later than 120 days following the close of its fiscal year.

FACILITY NO: Enter the hospital's assigned AHCA number.

PERIOD: Enter the beginning and ending dates for the reporting period. For example 10/01/1999 to 09/30/2000.

SECTION A – UNIT STATISTICS

COLUMN DEFINITIONS: NOTE: ALL SUBACUTE data should be segregated and reported on LINE 9 of this worksheet. LINES 1-8 should include statistics for acute and intensive care only. A unit is defined as a service with dedicated space and dedicated staffing including a separate nursing station. Report statistics for each line item for which the hospital has the unit specified. Report zeros for each line item for which the hospital does not have the unit specified. For example, if the hospital has a substance abuse unit serving both adults and adolescents, report the appropriate statistics on line 6 and enter zero on line 7. If the hospital has both a substance abuse unit for adults and a separate substance abuse unit for children and adolescents, report the appropriate statistics on line 6 and line 7.

COLUMN 1 – LICENSED BEDS (END PERIOD): For each LINE 1-9, enter the number of LICENSED BEDS as of the end of the reporting period.

LINE 8 –TOTAL ACUTE AND INTENSIVE CARE: This line should equal the sum of LINE 7 plus LINE 15, COLUMN 1 of WORKSHEET B-1.

LINE 9 – SUBACUTE CARE: This line should equal the number entered on LINE 21, COLUMN 1 of WORKSHEET B-1.

COLUMN 2 – TOTAL INPATIENT DAYS: For each LINE 1-9, enter the TOTAL INPATIENT DAYS for the report period.

LINE 8 – TOTAL ACUTE AND INTENSIVE CARE: This total should equal the total on LINE 29, COLUMN 1 of WORKSHEET B-1.

LINE 9 – SUBACUTE CARE: This line should equal the number entered on LINE 29, COLUMN 4 of WORKSHEET B-1.

COLUMN 3 – NUMBER OF PATIENTS TREATED: Number of patients treated is a count of all patients served by the unit during the fiscal year including those transferred from other units within the hospital. If a patient is transferred out of a unit and later returned to the unit, the patient would be counted twice in that unit.

For LINES 1-7 and LINE 9, enter the NUMBER OF PATIENTS TREATED for the reporting period.

LINE 8 – TOTAL ACUTE AND INTENSIVE CARE: Enter the total of LINES 1-7. MUST be equal to, or greater than LINE 4, Section B of this worksheet.

COLUMN 4 – AVERAGE LENGTH OF STAY (ALOS): For each LINE 1-7 and LINE 9, compute and enter the AVERAGE LENGTH OF STAY (ALOS) for the reporting period. The AVERAGE LENGTH OF STAY is computed as follows: COLUMN 2 divided by COLUMN 3.

WORKSHEET PSY-1 – PSYCHIATRIC HOSPITAL STATISTICS CONTINUED-

SECTION B – HOSPITAL STATISTICS

COLUMN DEFINITIONS: NOTE: ALL SUBACUTE data should be excluded from the data reported on this worksheet. Report data for acute and intensive patients only.

LINE 1 – NUMBER OF ADMISSIONS BILLED TO BAKER ACT: Enter the number of admissions that were billed to the BAKER ACT during the reporting period. Include only ACUTE and INTENSIVE CARE ADMISSIONS.

LINE 2 – PATIENT CENSUS, BEGINNING OF PERIOD: Enter the total number of acute and intensive patients at the beginning of the report period.

LINE 3 – ACUTE AND INTENSIVE ADMISSIONS: Enter the total number of admissions for both ACUTE and INTENSIVE CARE that occurred during the reporting period.

LINE 4 – TOTAL PATIENTS TREATED: Enter the total of LINE 2 and LINE 3.

PSYCHIATRIC HOSPITAL STATISTICS

SUBMISSION NUMBER:	REPORTING PERIOD FROM: TO:	FACILITY NUMBER	**WORKSHEET PSY-1**

SECTION A: UNIT STATISTICS

	HOSPITAL UNIT(1)	LICENSED BEDS (END OF PERIOD)	TOTAL INPATIENT DAYS	NUMBER OF PATIENTS TREATED	ALOS [COL.(2)/COL.(3)]
		(1)	(2)	(3)	(4)
01	Adult Psychiatric / General				**0**
02	Child / Adolescent Psychiatric				**0**
03	Specialized Child Psychiatric				**0**
04	Geriatric Psychiatric				**0**
05	Intensive Treatment (2)				**0**
06	Adult Substance Abuse - General				**0**
07	Child / Adolescent Substance Abuse				**0**
08	Total Acute and Intensive Care (Lines 1 through 7)	0	**0**	**0**	**0**
09	Subacute Care				

SECTION B: HOSPITAL STATISTICS

01	Number of Admissions Billed to Baker Act	
02	Patient Census, Beginning of Period (Acute & Intensive Patients)	
03	Acute and Intensive Admissions	
04	Total Patients Treated (Line 2 plus Line 3)	**0**

NOTES: (1) ALL UNIT DESIGNATIONS REFER TO INDIVIDUAL UNITS IN YOUR HOSPITAL, NOT SIMPLY TO AN INPATIENT SERVICE. AN INDIVIDUAL UNIT IS IDENTIFIED AS HAVING SPECIFIC SPACE AND STAFF ALLOCATED TO IT, AND HAVING A DEFINED AND UNIQUE TREATMENT PROGRAM AND/OR BEING DIRECTED TOWARD A SPECIFIC SUBSET OF THE PATIENT POPULATION.

(2) A UNIT PROVIDING INTENSIVE LOCK-WARD INPATIENT TREATMENT, IF YOU SOMETIMES ALLOCATE BEDS TO INTENSIVE TREATMENT, BUT DO NOT HAVE A DESIGNATED ITS, DO NOT REPORT THE ALLOCATED BEDS AS ITU BEDS, BUT INCLUDE THEM IN THE UNIT THEY ARE CUSTOMARILY ASSIGNED TO.

CHAPTER III DESCRIPTION OF ACCOUNTS

INTRODUCTION

This chapter provides a detailed description for each account referenced in the uniform reporting system.

The majority of the account descriptions have been adopted from the American Hospital Association's Chart of Accounts for Hospitals. Report preparers should reference the account descriptions in this manual as some of the AHA account descriptions have been modified for FHURS reporting purposes.

The Standard Units of Service, required on Worksheets A-1, A-2, and C-5, are identified separately for each account. A table of all accounts and their related Standard Unit of Service can be found in Chapter V.

BALANCE SHEET ACCOUNTS

ASSETS

CURRENT ASSETS - 1010-1090

1010	CASH AND INVESTMENTS - This account represents the amount of cash on deposit in banks and that which is immediately available for use in financing Operating Fund activities, amounts on hand for minor disbursements, amounts invested in savings accounts and certificates of deposit and current securities and investments evidenced by certificates of ownership or indebtedness. This amount is exclusive of Assets Whose Use Is Limited, (Account 1110-1190) as described below.
1020	CURRENT PORTION OF ASSETS WHOSE USE IS LIMITED - This account is used to report funds that are needed to pay those liabilities that have been obligated by Assets Whose Use Is Limited.
1030	ACCOUNTS AND NOTES RECEIVABLE - This account must reflect the amounts due from hospital patients and their third party sponsors, not of allowances for uncollectible receivables and third-party contractual adjustments. This account also reflects the amounts due from third-party reimbursement programs based upon cost reports submitted and/or audited and all notes receivable.
1080	INVENTORY - This balance reflects the cost of unused hospital supplies. The balance in this account consists of: medical and surgical supplies, drugs and medicines, linens, uniforms and garments, food, housekeeping supplies, office supplies, maintenance supplies and stationary forms.
1090	OTHER CURRENT ASSETS - This account includes current assets not included in other accounts. Pledges receivables should be reported in this account.

ASSETS WHOSE USE IS LIMITED - 1110-1190

1110	BOARD DESIGNATED ASSETS - Unrestricted resources may be appropriated or designated by the governing board for specific use. If the governing board appropriates resources in this manner, they should be reported in this account.
1130	DONOR RESTRICTED ASSETS
1140	TRUSTEE HELD FUNDS

PROPERTY, PLANT AND EQUIPMENT - 1200-1260

1200	LAND - The balance of this account reflects the cost of land used in hospital operations. Included here is the cost of off-site sewer and water public utility charges for servicing the land, governmental assessments for street paving and sewers, the cost of permanent roadways and of grading of a non-depreciable nature, the cost of curbs and of sidewalks whose replacement is not the responsibility of the hospital, as well as other land expenditures of a non-depreciable nature.
1210	LAND IMPROVEMENTS - All land expenditures of a depreciable nature that are used in hospital operations are charged to this account. This would include the cost of on-site sewer and water lines; paving of roadways, parking lots, curbs and sidewalks (if replacement is the responsibility of the hospital) as well as the cost of shrubbery, fences and walls.
1220	BUILDINGS - The cost of all buildings and subsequent additions used in hospital operations must be reported in this account. Included are all architectural, consulting and legal fees related to the acquisition or construction of buildings. Interest paid during construction is a cost of the building and is included in this account.
1230	FIXED EQUIPMENT - The cost of all fixed equipment used in hospital operations must be reported in this account. Fixed equipment has the following general characteristics: 1) Affixed to the building, not subject to transfer or removal. 2) Used in hospital operations. Fixed equipment includes such items as boilers, generators, elevators, engines, pumps and refrigeration machinery, including the plumbing, wiring, etc., necessary for equipment operations.
1240	LEASEHOLD IMPROVEMENTS - All expenditures for depreciable improvement of a leasehold used in hospital operations must be reported in this account.
1250	MOVABLE EQUIPMENT (Major and Minor) Major movable equipment to be reported in this account has the following general characteristics: 1) Ability to be moved, as distinguished from fixed equipment. 2) Usually assigned to a department or specific area. 3) A unit cost large enough to justify control by means of an equipment ledger. 4) Sufficient individuality and size to make control feasible by means of identification tags. 5) Used in hospital operations. Major movable equipment includes such items as automobiles and trucks, desks, beds, desktop computers, sterilizers, operating tables, oxygen tents, and X-ray apparatus. Minor movable equipment to be reported in this account has the following general characteristics: 1) Location generally not fixed; subject to requisition or use by various cost centers of the hospital. 2) Relatively small in size and unit cost. 3) Fairly large number in use. 4) Used in hospital operations.

	Minor movable equipment include such items as wastebaskets, bed pans, basins, glassware, silverware, pots and pans, sheets, blankets, ladders, and instruments. Source: AHCA Chart of Accounts.
1260	CONSTRUCTION IN PROGRESS - Cost of construction that will be in progress for more than one month and will be used for hospital operations must be reported in this account. Upon completion of the construction program, all costs associated with the particular project must be reported in the appropriate asset account(s). Interest paid during construction is a cost of the asset and is included in the asset account upon completion of construction.
1215	ACCUMILATED DEPRECIATION – LAND IMPROVEMENTS
1225	ACCUMULATED DEPRECIATION – BUILDINGS
1235	ACCUMULATED DEPRECIATION – FIXED EQUIPMENT
1245	ACCUMULATED DEPRECIATION – LEASHOLD IMPROVEMENTS
1255	ACCUMULATED DEPRECIATION – MOVABLE EQUIPMENT

The balance in these accounts reflects the depreciation accumulated on the above – mentioned assets used in hospital operations.

OTHER ASSETS - 1350-1370

These accounts include the cost (or fair market value at date of donation) of property, plant and equipment not used in hospital operations and related accumulated depreciation. Other tangible assets, such as certain deferred items, not included elsewhere are also contained in these accounts.

1350	OTHER TANGIBLE ASSETS
1355	DEFERRED FINANCING COSTS
1360	DEFERRED THIRD-PARTY RECEIVABLES
1365	DEFERRED INCOME TAXES
1390	INTANGBILE ASSETS - This account is used to report intangible assets, net of accumulated amortization, including goodwill and organization costs.

LIABILITIES

CURRENT LIABILITIES - 2010-2080

2010	ACCOUNTS, NOTES, AND LOANS PAYABLE - This account will be used to report liabilities of the hospital due and payable within one year to vendors, banks, trade creditors, or others for purchased supplies and services. This account will also include promissory notes, drafts, or other credit instruments that are due and payable within one year.
2080	OTHER CURRENT LIABILITIES - This account will be used to report any other liabilities due and payable within one year, including accrued payroll expenses that are not included in account 2010, advances and reimbursement settlements due to third party PAYERs, amounts due to other funds, and deferred income to be received within the next accounting period.

2110	CURRENT LIABILITIES – ASSETS WHOSE USE IS LIMITED - This account contains the current installments on long-term debt and those liabilities (amounts due to creditors or other funds) which are to be paid by Assets Whose Use is Limited.
2140	DEFERRED CREDITS AND OTHER LIABILITIES - This account reflects the effects of timing differences that occur between the "book" and the tax or cost reporting accounting for deferred income taxes and third party revenue. This account also reflects all deferred credits not specifically identified elsewhere.

LONG-TERM DEBT - 2210-2290

In the following accounts, report the indebtedness of the entity with maturity dates extending more than one year beyond the current year-end.

2210	MORTGAGES PAYABLE – FHA
2220	MORTGAGES PAYABLE – OTHER LENDERS
2230	CONSTRUCTION LOANS
2240	NOTES PAYABLE – REVOLVING CREDIT LINE
2250	CAPITALIZED LEASE OBLIGATIONS
2260	BONDS PAYABLE – TAXABLE
2270	BONDS PAYABLE – TAX EXEMPT
2280	INTERCOMPANY DEBT, NONCURRENT
2290	OTHER NONCURRENT DEBT

EQUITIES

TAXABLE ENTITIES - 2350-2380
(Corporations, Partnerships, and Sole Proprietorships)

2350	STOCKHOLDER'S EQUITY
2360	ADDITIONAL PAID-IN CAPITAL
2370	RETAINED EARNINGS - This account is used to report the earnings retained in the entity after the distribution of all dividends and payment of taxes. This account should also be used to report the Fund Balance of those corporations that are organized as Not-For-Profit, but whose income is taxable.
2380	CAPITAL PARTNERSHIP OR SOLE PROPRIETOR - The total of these equity accounts reflects the difference between the total assets and the total liabilities of the Taxable Entity.

TAX EXEMPT ENTITIES - 2390-2395
(Voluntary Not-For-Profits)

2390	FUND BALANCE – TAX EXEMPT - The balance of this account represents the difference between the total of Unrestricted Fund Assets and Unrestricted Fund Liabilities, e.g., the net assets in the Unrestricted

	Fund of the tax-exempt entity.

INCOME STATEMENTACCOUNTS

REVENUE ACCOUNTS

PATIENT REVENUE ACCOUNT DESCRIPTIONS- 3000-4990

Detailed descriptions of the functions or types of activities to be included in each patient care revenue center are included in the cost center activities that must be reported in the revenue account matching the cost center for which the expenses are reported. For example, charges for Emergency Services are reported in Emergency Services (Account 3710) and the cost of the services are reported in Emergency Services (Account 6710). Thus a matching of revenue and expenses is achieved within each cost center.

3010-3690	DAILY HOSPITAL SERVICES - This group of accounts is used to report the gross revenue measured in terms of the hospital's full established rates, earned from daily hospital services rendered to inpatients. This revenue must be reported at the hospital's full established rates, regardless of the amounts actually collected. Daily hospital services generally are those services included by the provider in a daily service charge sometimes referred to as the "room and board" charge. Included in daily hospital services revenue are the regular room, dietary and nursing services, minor medical and surgical supplies, social services, and the use of certain equipment and facilities for which the hospital does not customarily make a separate charge. This includes patient education that provides for the teaching and counseling of the patient and his family. Daily hospital services are further categorized into the following areas: (a) acute care, (b) intensive care, (c) nursery, and (d) subacute care.
3710-3990	AMBULATORY SERVICES - This group of accounts is used to report the gross revenue measured in terms of the hospital's full established rates earned from services provided to ambulatory patients who are outpatients and to other patients who do not require admission to the hospital as inpatients. For reporting purposes ambulatory services also include ambulance, outpatient clinic, and home health services.
4010-4990	ANCILLARY SERVICES - The group of accounts is used to report the gross revenues measured in terms of the hospital's full established rates earned from ancillary services. Ancillary services generally are those special services other than room, board, medical and nursing services such as: laboratory, radiology, surgery services, etc. Ancillary services are usually billed as separate items when the patient receives these services.

DEDUCTIONS FROM REVENUE- 5900-5990

This group of accounts is used to report reductions from gross revenue arising from bad debts, contractual adjustments, uncompensated care, administrative, courtesy, and policy discounts, and other revenue deductions.

In many instances, the hospital receives less than its full established charges for the services it renders. It is essential that reported data reflect both the gross revenue and related revenue "adjustments" resulting from the inability to collect established charges for services provided. These revenue "adjustments" are referred to as "Deductions from Revenue" and consist of the following primary categories:

1) Provision for Bad Debts.

2) Contractual Adjustments (Medicare, Medicaid, HMO, PPO, etc.).

3) Charity Care.

4) Administrative, Courtesy, and Policy Discounts

5900	PROVISION FOR BAD DEBTS - This account shall contain the hospital's periodic estimates of the amounts in accounts and notes receivable that are likely to be credit losses. The estimated amount of bad debts may be based on an experience percentage applied to the balance of accounts receivable or the amount of charges to patients' accounts during the period, or it may be based on a detailed aging and analysis of patients' accounts. These losses will occur despite collection efforts of the hospital. This account should not be used to report amounts for charity care.
5910	CONTRACTUAL ADJUSTMENTS – MEDICARE
5911	CONTRACTUAL ADJUSTMENTS – MEDICARE/HMO
5920	CONTRACTUAL ADJUSTMENTS – MEDICAID
5921	CONTRACTUAL ADJUSTMENTS – MEDICAID/HMO
5940	CONTRACTUAL ADJUSTMENTS – OTHER (PPO's and HMO's other than Medicare/Medicaid) These contractual accounts must be used to report the differential (more or less) between the amount, based on the hospital's full established rates, of contractual patients' charges for hospital services which are rendered during the reporting period and are covered by the contract, and the amount received and due from third-party agencies in payment of such charges, including adjustments made at year end, based upon cost reports submitted. When reporting the contractual adjustments for Medicare and Medicaid programs, these adjustments will be separated into two categories: (1) Conventional Medicare and Medicaid, (2) Medicare and Medicaid HMOs. These adjustments will also be entered on the appropriate lines on worksheet C-2. Prior period contractual revenue adjustments, as appropriate will also be reported in these accounts rather than in the Fund Balance or Retained Earnings accounts. When the difference between the amount of a patient's bill and the payment received by the hospital from a third-party agency is recoverable from the patient, any resulting uncollected amount should be reported in the appropriate bad debt or uncompensated care category and should not be reported in contractual adjustments.
5950	CHARITY CARE – HILL BURTON - Account 5950 shall be used to report the charges applicable to any charity services that are being used to comply with the requirements of the Hill-Burton Hospital and Medical Facilities Construction Plan.
5960	CHARITY CARE – OTHER - Account 5960 shall be used to report "Charity care" or "uncompensated charity care" which means that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment, for care provided to a patient whose family income for the twelve months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four (4) times the federal poverty level for a family of four be considered charity. Each hospital will determine which patients are charity care patients by a verifiable process subject to the following provisions:

	Documentation shall include one of the following forms: 1) W-2 withholding forms 2) Paycheck stubs 3) Income tax returns 4) Forms approving or denying unemployment compensation or worker's compensation. 5) Written verification of wages from employer 6) Written verification from public welfare agencies or any governmental agency which can attest to the patient's income status for the past twelve (12) months 7) A witnessed statement signed by the patient or responsible party, as provided for in public law 770-725, as amended, known as the Hill-Burton Act, except that such statement need not be obtained within the 48 hours of the patients' admission to the hospital as required by the Hill-Burton Act. The statement shall include an acknowledgement that, in accordance with Section 817.50 F.S., providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second (2^{nd}) degree. 8) A Medicaid remittance voucher which reflects that the patient's Medicaid benefits for that Medicaid fiscal year have been exhausted. Charges applicable to account 5950 should not be reported in this account. Contractual adjustments should not be reported in this account. When the hospital receives lump-sum grants or subsidies (rather than specific payments for an individual patient's bill) from governmental or voluntary agencies for the care of medically indigent patients, the amount of the lump-sum grant or subsidy must be reported under "Restricted Donations and Grants for Indigent Care" (Account 5970).
5980	ADMINISTRATIVE, COURTESY AND POLICY DISCOUNTS - This account shall be used to report write-offs of debit or credit balances in patient's accounts in which the cost of billings or refunding exceeds the amount of the account balance. In addition, reductions in the nature of courtesy allowances must be reported in this account.
5981	EMPLOYEE DISCOUNTS - This account shall be used to report employee discounts from the hospital's full established rates for services rendered.
5990	OTHER DEDUCTIONS FROM REVENUE - Other deductions from revenue which are not included elsewhere must be reported in this account.
5995	RESTRICTED DONATIONS AND GRANTS FOR INDIGENT CARE - This account is used to report voluntary and governmental agency grants or subsidies for the care of nonspecified medically indigent patients during the current reporting period.

OTHER OPERATING REVENUE - 5010-5890

This group of accounts is used to report all operating revenues other than those that are directly associated with patient care.

5020	TRANSFERS FROM RESTRICTED FUNDS FOR RESEARCH EXPENSES - This account reflects the amount of transfers from restricted funds to the Operating Fund to match expenses incurred in the current period by the Operating Fund for restricted fund research activities.
5220	NURSING EDUCATION
5240	POSTGRADUATE MEDICAL EDUCATION – APPROVED TEACHING PROGRAMS
5250	POSTGRADUATE MEDICAL EDUCATION – NON APPROVED TEACHING PROGRAMS
5260	OTHER HEALTH PROFESSION EDUCATION - These accounts (5220-5260) are used to report the revenue from the schools of nursing, postgraduate medical education, paramedical education, and other professional education activities.

5280	TRANSFERS FROM RESTRICTED FUNDS FOR EDUCATION EXPENSES - This account reflects the amount of transfers from restricted funds to the Operating Fund to match expenses incurred in the current period by the Operating Fund for restricted fund educational activities.
5320	NON-PATIENT FOOD SALES - This account is used to report the revenue earned in the hospital cafeteria from meals sold to employees and others. Also report revenues from food sales through vending machines when the hospital does not operate a formal cafeteria.
5330	LAUNDRY AND SERVICES REVENUE - This account is used to report revenue earned by providing laundry services to other organizations (both related and nonrelated) and to employees and students housed on hospital property.
5350	SOCIAL WORK SERVICE REVENUE - This account is used to report revenue earned by providing social work services to patients and others.
5360	HOUSING REVENUE - This account is used to report revenue from room (or cot) rentals provided to employees and students.
5440	PARKING REVENUE - This account is used to report revenues received from visitors, employees, and others in payment for parking privileges.
5450	HOUSEKEEPING SERVICES REVENUE - This account is used to report revenue earned by providing housekeeping services to other organizations (both related and nonrelated).
5610	TELEPHONE REVENUE - This account is used to report revenue received from patients, employees, and others in payment of hospital telephone and telegraph services.
5620	DATA PROCESSING SERVICES REVENUE - This account is used to report revenue earned by providing data processing services to other organizations (both related and nonrelated).
5630	TELEVISION RENTAL REVENUE – HOSPITAL OPERATED SERVICE - This account will be used to report revenue from the rental of television service to patients in the hospital. Report here only if the service is provided directly by the hospital and not by an auxiliary or other organization which retains the revenue and pays the hospital a fee for allowing it to provide the service.
5640	GIFT SHOP REVENUE – HOSPITAL OPERATED - This account will be used to report revenue from the operation of a gift shop in the hospital. Report here only if the shop is operated directly by the hospital and not an auxiliary or other organization which retains the revenue and pays the hospital a fee for allowing it to operate the shop.
5690	PURCHASING SERVICE REVENUE - This account is used to report revenue earned by providing purchasing services to other organizations (both related and nonrelated).
5870	OTHER OPERATING REVENUE - This account is used to report operating revenue not included elsewhere, including, but not limited to the following: Donated commodities, donated blood, cash discounts, rebates and refunds, vending machine and other commissions, non-patient room rentals, management services revenue, professional fee revenue, gift shop, non-patient snack bar, sale of scrap, health fitness center, training programs for employees and community, and employee childcare center.
5880	TRANSFERS FROM RESTRICTED FUNDS FOR OTHER OPERATING EXPENSES - This account reflects the amounts of transfers from restricted funds to the Operating Fund to match expenses incurred by the Operating Fund for restricted fund activities. This account does not include funds reported in Account 5020 (Transfers from Restricted Funds for Research Expenses) and Account 5280 (Transfers from Restricted Funds for Education Expenses).

NONOPERATING REVENUE - 9010-9150

Nonoperating revenue includes revenue not directly related to patient care, related patient services, or the sale of related goods. The following accounts are required to be reported.

9010	GAINS OR LOSSES ON SALE OF HOSPITAL PROPERTY - This account is used to report net gains and losses from the disposal of hospital property.
9020	UNRESTRICTED CONTRIBUTIONS - This account is used to report all contributions, donations, legacies, and bequests that are made to the hospital without restriction by the donors.
9030	DONATED SERVICES - Many hospitals receive donated services from individuals and organizations. Fair value of donated services must be reported when an employer/employee relationship exists and there is an objective basis for valuing such services. The value of services donated by organizations may be evidenced by a contractual relationship that may provide the basis for valuation. Donated Services are most likely to be reported by a hospital operated by a religious group. If members of the religious group are not paid (or paid less than the fair value of their services rendered), then the lay equivalent value of services (or the difference between lay equivalent value of services rendered and compensation paid) must be reported as an expense in the cost center in which the service was rendered with an offsetting amount in this account.
9040	INCOME, GAINS AND LOSSES FROM UNRESTRICTED INVESTMENTS - Income, gains and losses from investments of unrestricted funds must be reported in this account.
9050	UNRESTRICTED INCOME FROM ENDOWMENT FUNDS - This account is used to report the unrestricted revenue and net realized gains on investments of endowment funds.
9060	UNRESTRICTED INCOME FROM OTHER RESTRICTED FUNDS - This account contains the revenue and net realized gains on investments of restricted funds (other than endowment funds) if the income is available for unrestricted purposes.
9070	TERM ENDOWMENT FUNDS BECOMING UNRESTRICTED - Restricted endowment funds that become available during the reporting period for unrestricted purposes must be reported in this account.
9080	TRANSFERS FROM RESTRICTED FUNDS FOR NONOPERATING EXPENSES - This account reflects the amounts of transfers from restricted funds to match nonoperating expenses in the current period for restricted fund activities.
9110	PHYSICIANS PRIVATE OFFICE RENTAL REVENUE - This account contains the revenue earned from rental of office space and equipment to physicians and other medical professionals for use in their private practice.
9130	UNRESTRICTED TAX REVENUE AND APPROPRIATED FUNDS – STATE/FEDERAL - This account contains the revenue obtained from assignment of unrestricted tax revenue and funds appropriated by state and federal governmental entities.
9132	UNRESTRICTED TAX REVENUE AND APPROPRIATED FUNDS – LOCAL GOVERNMENTS - This account contains the revenue obtained from assignment of unrestricted tax revenue and funds appropriated by local governmental entities, e.g., city, county, special tax district, or hospital authority.
9150	OTHER NONOPERATING REVENUE - This account contains nonoperating revenue not specifically required to be reported in the above accounts.

PATIENT CARE AND OPERATING EXPENSE ACCOUNTS

PATIENT SERVICE EXPENSE - 6010-7990

This group of accounts is used to report the direct expenses incurred in providing nursing and other professional services (daily hospital services, ambulatory services and ancillary services) rendered to patients. For each nursing and other professional service revenue center, a corresponding cost center is provided.

DAILY HOSPITAL SERVICES EXPENSE - 6010-6990

Activities in each of the following Daily Hospital Services cost centers include but are not limited to, the following:

Giving routine patient care; monitoring vital life signs; assisting physicians during patient examinations and treatment; changing dressings and cleansing wounds and incisions; administering specified medication; infusing fluids, including IVs and blood.

These cost centers contain the direct expenses incurred in providing daily bedside care to patients. Included as direct expenses are; salaries and wages, employee benefits, administrative professional fees, supplies, contracted labor, purchased services, and other direct expenses.

ACUTE CARE SERVICES - 6010-6290

6010	MEDICAL/SURGICAL ACUTE - A Medical/Surgical Acute Care unit provides acute care to patients on the basis of physicians' orders and approved nursing care plans.
6170	PEDIATRIC ACUTE - A Pediatric Acute Care unit provides acute care to pediatric patients in pediatric nursing units on the basis of physicians' orders and approved nursing care plans.
6210	PSYCHIATRIC ACUTE - A Psychiatric Acute Care unit provides care to patients admitted for diagnosis as well as treatment on the basis of physicians' orders and approved nursing care plans. The unit is staffed with nursing personnel specially trained to care for the mentally ill, mentally disordered, or other mentally incompetent persons.
6220	SUBSTANCE ABUSE/DETOXIFICATION ACUTE - Substance abuse-chemical dependency detoxification care which provide care related to the treatment of alcoholism and/or drug abuse which involves misuse or abnormal use of both controlled and noncontrolled substances. Detoxification Services are provided in an acute inpatient setting in a 7, 14, 21, or 28-day program.
6250	OBSTETRICS ACUTE - An Obstetrics Acute Care unit provides both pre- and postpartum care to the mother on the basis of physicians' orders and approved nursing care plans.
6280	DEFINITIVE OBSERVATION - A Definitive Observation unit provides care to patients requiring care more intensive than that provided in other acute care areas yet not sufficiently intensive to require admission to an intensive care area. Patients admitted to this cost center are generally transferred here from an intensive care unit after their condition has improved.
6920	OTHER ACUTE CARE - Other Acute Care units provide acute care to patients on the basis of physicians' orders and approved nursing care plans. Included are those units not required to be included in other specific Acute Care cost centers.

INTENSIVE CARE SERVICES - 6310-6410

6310	MEDICAL/SURGICAL INTENSIVE CARE - A Medical/Surgical Intensive Care unit provides patient care of a more intensive nature than that provided to the Medical and Surgical Acute patients. The unit is staffed with specially trained nursing personnel and contains monitoring and specialized support equipment for patients who, because of shock, trauma, or life threatening conditions, require intensified, comprehensive

	observation and care.
6330	CORONARY CARE - The delivery of care of a more specialized nature than that provided to the usual Medical, Surgical, and Pediatric patient is provided in the Coronary Care unit. The unit is staffed with specially trained nursing personnel and contains monitoring and specialized support or treatment equipment for patients who, because of heart seizure, open heart surgery or life threatening conditions require intensified, comprehensive observation and care.
6350	PEDIATRIC INTENSIVE CARE - A Pediatric Intensive Care unit provides care to Pediatric patients of a more intensive nature than the usual Pediatric Acute level. The units are staffed with specially trained personnel and contain monitoring and specialized support equipment for patients who because of shock, trauma, or life threatening conditions, require intensified, comprehensive observation and care. The unit must be specifically designed to solely treat pediatric patients.
6370	NEONATAL INTENSIVE CARE - A Neonatal Intensive Care unit provides care to newborn infants that are of a more intensive nature than care provided in a newborn nursery unit. Care is provided on the basis of physicians' orders and approved nursing care plans. The units are staffed with specially trained nursing personnel and contain specialized support equipment for treatment of newborn infants who require intensified comprehensive observation and care. To be considered as a neonatal intensive care unit, standards set forth by the Department of Health and Rehabilitation Services for Regional Perinatal Intensive Care Centers (RPICC) must be met.
6380	BURN CARE - A Burn Care unit provides care to severely burned patients that is of a more intensive nature than the usual acute nursing care provided in medical and surgical units or more than normal intensive care units. Burn units are staffed with specially trained nursing personnel and contain specialized support equipment capable of treating such patients.
6390	PSYCHIATRIC INTENSIVE CARE - A Psychiatric Intensive Care unit provides care to psychiatric patients which is of a more intensive nature than the usual nursing care provided to Psychiatric Acute patients. The units are staffed with specially trained nursing personnel and contain monitoring and specialized support equipment for patients who, because of shock, trauma, or threatening conditions, require intensified, comprehensive observation and care.
6410	OTHER INTENSIVE CARE - Other Intensive Care units provide patient care of a more intensive nature than that provided to the Medical and Surgical Acute patients. The unit is staffed with specially trained nursing personnel and contains monitoring and specialized support equipment for patients who require intensified, comprehensive observation and care. Included are those units not required to be included in other specific intensive care cost centers.

NEWBORN NURSERY CARE SERVICE - 6510

6510	NEWBORN NURSERY - Daily care for newborn infants (including "boarder babies") is provided in these nursery units on the basis of physicians' orders and approved nursing care plans. Activities, in addition to those above, include but are not limited to feeding and bathing infants.

SUBACUTE CARE SERVICES - 6610-6690

6610	SKILLED NURSING CARE – MEDICARE/MEDICAID CERTIFIED - Skilled Nursing Care is provided to patients on the basis of physicians' orders and approved nursing care plans and consists of care in which the patients require convalescent and/or restorative services at a level less intensive than normal acute care requirements. This unit is sometimes referred to as Extended Care.
6630	PSYCHIATRIC LONG-TERM CARE - Medical care, nursing services, and intensive supervision of chronically mentally ill, mentally disordered, or other mentally incompetent persons are rendered in the Psychiatric Long-term Care unit of a general hospital or a facility licensed as a specialty psychiatric

	hospital. Such care requires an average length of stay of 60 days or more.
6650	INTERMEDIATE CARE - Intermediate Care is the provision of supportive, restorative, and preventive health services in conjunction with a socially oriented program for patients, and the maintenance and operation of 24-hour services including room, personal care, and continuous nursing service under the direction of a professional nurse. This cost center includes programs for patients with psychiatric or developmental impairment.
6660	RESIDENTIAL CARE - Residential Care is the provision of safe, hygienic, sheltered living for residents not capable of fully independent living. Regular and frequent, but not continuous, medical and nursing services are provided. Also included is self-care. Self-care units provide supportive, restorative, and preventive healthcare for ambulatory patients who are capable of caring for themselves under the supervision of a professional nurse. The unit is used by recovering patients who are making the transition to discharge or by patients who are undergoing tests and medical evaluation who require a minimal amount of nursing supervision. These patients generally eat in a central dining facility and do not require bedside nursing care.
6690	OTHER SUBACUTE CARE SERVICES - This cost center contains the direct expenses incurred in maintaining subacute care, daily hospital service units not specifically required to be included in other subacute care cost centers.

AMBULATORY SERVICES EXPENSE - 6710-6990

The essential characteristic of ambulatory services is that the patients come to or are brought to the health care facility for the purpose of receiving outpatient diagnostic or therapeutic services. Examples of this type of service are: emergency room service, clinic service, and outpatient surgery.

These cost centers contain the direct expenses incurred in providing ambulatory services to patients. Included as direct expenses are: salaries and wages, employee benefits, administrative professional fees, supplies, purchased services, and other direct expenses.

6710	EMERGENCY SERVICES - Emergency Services provides emergency treatment to the ill and injured who require immediate medical or surgical care on an unscheduled basis. Additional activities include, but are not limited to, the following: Maintaining aseptic conditions; assisting physicians in performance of emergency care; monitoring of vital life signs; applying or assisting physicians in applying bandages; coordinating the scheduling of patients through required professional service functions; administering specified medications; and infusing fluid, including IV's and blood. Standard Unit of Service: Number of Visits A visit is measured by each registration of a patient in the emergency services unit of the hospital. Multiple services performed in the emergency services unit during a single registration, e.g., encounters with two or more physicians, two or more types of service, or any combination of the above, are recorded as one visit. Services provided to emergency patients in or by ancillary cost centers are not included here, but are included in the applicable ancillary cost center.
6720	CLINIC SERVICES - Clinics provide organized diagnostic, preventive, curative, rehabilitative, and educational services on a scheduled basis to ambulatory patients. Additional activities include, but are not limited to, the following: Administration of physical examinations, diagnosis and treatment of ambulatory patients having illnesses which respond quickly to treatment; referring patients who require prolonged or specialized care to other

	appropriate services; assigning patients to doctors in accordance with clinic rules; assisting and guiding volunteers in their duties; making patient appointments through required professional service functions. Standard Unit of Service: Number of Visits A visit is measured by each registration of a patient in a formally organized clinic of the hospital. Multiple services performed in each formally organized clinical unit during a single registration; e.g., encounters with two or more physicians, two or more types of service, any combination of one or more encounters and types of service, are recorded as one visit. Visits made by clinic patients to ancillary cost centers are not included here but are accumulated in the appropriate ancillary cost center.
6820	HOME PROGRAM DIALYSIS - The Home Program Dialysis cost center provides home dialysis support services for dialysis patients capable of administering their own treatment in their home. This program obtains or arranges for the provision of: a) Medically necessary dialysis equipment as prescribed by the attending physician such as artificial kidney and automated peritoneal dialysis machines, including supportive equipment such as blood pumps, heparin pumps, bubble detectors, and other alarm systems. (Supportive equipment does not include items not directly used with delivery systems such as scales, blood pressure apparatus, and other diagnostic devices.); b) Dialysis equipment installation, maintenance and repair; c) Dialysis equipment reconditioning for subsequent use; d) All necessary medical supplies; and e) The services of trained home dialysis aides, when necessary. Additional activities include, but are not limited to, the following: Periodic monitoring of patient's home adaptation of self-dialysis in accordance with patient care plans; home visits by qualified provider personnel; water testing; making minor plumbing and electrical changes to accommodate the equipment; delivering the equipment; replacing water filters on reverse osmosis devices; providing minor parts to the patient for patient performed maintenance; transporting equipment for installation and reconditioning. Note: All dialysis equipment maintenance expense and all home program dialysis patient chargeable supplies are to be included in this cost center rather than in the general cost centers for maintenance and supplies. Standard Unit of Service: Number of Patient Weeks Each week, or major portion thereof, that each home dialysis patient is in the home dialysis program should be counted as one patient week.
6830	AMBULATORY SURGERY SERVICES - Ambulatory Surgery Services are those surgical services provided to outpatients in a discrete outpatient suite by specially trained nursing personnel to assist physicians in the performance of surgical and related procedures both during and immediately following surgery. Additional activities include, but are not limited to the following: Maintaining aseptic techniques; scheduling operations in conjunction with surgeons; assisting surgeons during operations; preparing for operations; cleaning up after operations to the extent of preparation for pickup and disposal of used linen, gloves, instruments, utensils, equipment, and waste; arranging sterile setup for operations; assisting and preparing patients for surgery; inspecting, testing, and maintaining special equipment related to this function; preparing patients for transportation to recovery room; counting sponges, needles and instruments used during operations; enforcing safety rules and standards; monitoring patients while recovering from anesthesia. This cost center contains the direct expenses associated with a separately identifiable outpatient surgery

	room. When a common operating room is used for both inpatients and outpatients, the direct costs for both must be reported in the Surgery Services cost center (Account 7040). Standard Unit of Service: Number of Surgery Minutes Surgery minutes are measured by the difference between the starting time and ending time defined as follows: Starting time begins when anesthesia is administered in the room in which the procedure is to be performed (or when surgery begins if anesthesia is not administered or if anesthesia is administered in other than the operating room). Ending time occurs at the completion of surgery. (When the last suture is made by the physician). Additional time that the anesthesiologist spends with the patient in the recovery room is not to be counted.
6850	AMBULANCE SERVICES - This cost center provides ambulance service to the ill and injured who require medical attention on a scheduled and an unscheduled basis. Additional activities include, but are not limited to, the following: Lifting and placing patients into and out of an ambulance; transporting patients to and from the hospital; first aid treatment administered by a physician, paramedic, or other medical staff prior to arrival at the hospital. Standard Unit of Service: Number of Trips Ambulance service provided to a patient from the point of pickup to the delivery of the patient to the facility is counted as one trip.
6860	OTHER AMBULATORY SERVICES - This cost center contains the direct expenses incurred in maintaining ambulatory services not specifically required to be included in Emergency Services, Clinic Services, Home Program Dialysis, Ambulatory Surgery Services, Free Standing Clinic Services or Home Health Services cost centers. Note: Psychiatric day care service expenses should be reported in this cost center using Number of Visits as the standard unit of service. Standard Unit of Service: Number of Visits (Psychiatric Day Care) A visit is each registration of a patient in a formally organized psychiatric day care program of the hospital. Multiple services performed in each formally organized clinical unit during a single registration, e.g., encounters with two or more physicians, two or more occasions of service, and combination of one or more encounters and occasions of service, are recorded as one visit.
6870	FREE STANDING CLINIC SERVICES - Free Standing Clinics provide organized diagnostic, preventive, curative, rehabilitative, and educational services on a scheduled basis to ambulatory patients at locations other than on the hospital grounds. Additional activities include, but are not limited to, the following: Participating in community neighborhood activities designed to promote health education; the Administration of physical examinations and the diagnosis and treatment of ambulatory patients having illnesses which respond quickly to treatment; referring patients who require prolonged or specialized care to other appropriate services; assigning patients to doctors in accordance with clinic rules; assisting and guiding volunteers in their duties; making patient appointments through required professional service functions. Standard Unit of Service: Number of Visits A visit is measured by each registration of a patient in a formally organized freestanding clinic of the hospital. Multiple services performed in each formally organized clinical unit during a single registration, e.g., encounters with two or more physicians, two or more occasions of service, and combination of one or more encounters and occasions of service, are recorded as one visit.
6990	HOME HEALTH SERVICES - This cost center is used to report home health patient care which includes the following: • Home Health Skilled Nursing Care – The part-time or intermittent nursing care provided by or under the direct supervision of a licensed nurse (R.N. or L.P.N.) to patients in their residence on the basis

	of physicians' orders and an approved plan of care established and periodically reviewed by the physician. It consists of care in which the patients require convalescent and/or major retroactive services at a level less intensive than institutional requirements. Activities include, but are not limited to the following: administration of parenteral medication (e.g., intravenous and intramuscular injections or insertion of a catheter); changing of dressings and cleansing of wounds; irrigations; enema; colostomy care; urethral catheter care; administration of oxygen and certain drugs through inhalation of positive pressure; vital signs; observing and recording psychiatric symptoms. • Home Health Medical Social Services – The provision of counseling and assessment activities that contribute meaningfully to the treatment of a patient's condition. These services must be under the direction of a physician and must be given by or under the supervision of a qualified medical or psychiatric social worker. Such services include, but are not limited to the following: assessment of the social and emotional factors related to the patient's illness, his need for care, his response to treatment, and his adjustment to care; appropriate action to obtain case work services to assist in resolving problems in these areas; assessment of the patient's medical and nursing requirements as they relate to his home situation, his financial resources, and the community resources available to him. • Home Health Aides Services – The provision of personal care services under the supervision of a registered professional nurse, and if appropriate a physical, speech or occupational therapist, or other qualified person. This function is performed by specially trained personnel who assist individuals in carrying out physicians' instructions and established plans of care. Additional services include, but are not limited to the following: assisting the patient with activities of daily living (helping to bathe, to get in and out of bed, to care for hair and teeth, to exercise, to take medications specially ordered by a physician which are ordinarily self-administered); assisting the patient with necessary self help skills. Also included in this cost center are such services as nutritional services, homemaker services, and private duty nursing. The cost of therapy services such as physical therapy, speech/language therapy, occupational therapy and respiratory therapy must be reported in the appropriate ancillary cost centers. Standard Unit of Service: Number of Home Visits A home visit is a personal contact in the place of residence of a patient made for the purpose of providing a service by a member of the staff of the home health agency or by others under contract or arrangements with the home health agency. Visits by therapists are not included here, but in the appropriated ancillary cost center. If a visit is made simultaneously by two or more persons from the home agency to provide a single service which one person supervises or instructs the other, it is counted as one visit. If one person visits the patient's home more than once during a day to provide services, each visit is recorded as a separate visit. If a visit is made by two or more persons from the home health agency for the purpose of providing separate and distinct types of services each service constitutes a separate visit.

ANCILLARY SERVICES EXPENSE – 7010-7910

Ancillary service cost centers provide services for therapeutic or diagnostic purposes. Ancillary services are generally specific services for which separate charges are customarily made, in addition to routine charges. These cost centers include laboratory, radiology, respiratory therapy, surgical and other special services.

These cost centers contain the direct expenses incurred in providing ancillary services to patients. Included as direct expenses are: Salaries and wages, employee benefits, administrative professional fees, supplies, purchased services, and other direct expenses.

7010	LABOR AND DELIVERY SERVICES - Labor and delivery services are provided by specially trained personnel to patients in Labor and Delivery, including prenatal care in labor, assistance in delivery, postnatal care in recovery, abortion procedures, and minor gynecological procedures, if performed in the delivery suite. Additional activities include, but are not limited to the following: Comforting maternity patients in the labor, delivery and postnatal recovery rooms; maintaining aseptic techniques; preparing for

	deliveries and surgery; cleaning up after deliveries to the extent of preparation for pickup and disposal of used linen, gloves, instruments, utensils, equipment, and waste; arranging sterile setup for deliveries and surgery; preparing patients for transportation to delivery room and recovery room; enforcing safety rules and standards; monitoring patients while in recovery. Standard Unit of Service: Number of Procedures Report multiple births as one procedure. Include Cesarean sections only when they are performed in the delivery room. Cesarean sections performed in the surgical suite shall be included in the Surgery Services statistics. Stillbirths are counted as procedures. Infants born outside of the hospital buildings are not to be classified as a procedure unless care was rendered in Labor and Delivery. Whenever obstetrical and gynecological procedures such as abortions, D & C's, etc., are performed in Labor and Delivery, each procedure performed is counted as one.
7040	SURGERY SERVICES - Surgery services are provided to inpatients and outpatients, if the hospital uses a common operating room for both inpatients and outpatients, by physicians and specially trained nursing personnel who assist physicians in the performance of surgical and related procedures during and immediately following surgery. Additional activities include, but are not limited to the following: Maintaining aseptic techniques, scheduling operations in conjunction with surgeons, assisting surgeons during operations, preparing for operations, cleaning up after operations to the extent of preparation for pickup and disposal of used linen, gloves, instruments, utensils, equipment and waste; assisting in preparing patients for surgery; inspecting and testing special equipment related to this function; preparing patients for transportation to recovery room; counting of sponges, needles, and instruments used during operations; enforcing safety rules and standards. Included as part of Surgery Services are the specialized services of: 1) Neurological Surgery that involves procedures performed by a board certified or board eligible neurosurgeon. 2) Open heart surgery involving procedures that use a heart-lung machine to perform the function of circulation during surgery. Standard Unit of Service: Number of Surgery Minutes Surgery minutes are measured by the difference between the starting time and ending time defined as follows: Starting time begins when anesthesia is administered in the room in which the procedure is to be performed (or when surgery begins, if anesthesia is not administered or if anesthesia is not administered in the operating room). Ending time occurs at the completion of surgery (when the last suture is made by the physician).
7060	RECOVERY SERVICES - Recovery Services are provided by specially trained personnel immediately following a surgery for monitoring of patients while recovering from anesthesia. Services include, but are not limited to the following: Caring for patients in the recovery room, maintaining aseptic techniques, monitoring vital life signs, operating specialized equipment related to this function; administering specific medication; observing patient's condition until major effects of the anesthesia have passed; preparing patients for transportation to acute care or intensive care units. Standard Unit of Service: Number of Recovery Room Minutes Recovery Room minutes are measured by the time elapsed between admission to the recovery room and the time of discharge from the unit.
7080	ANESTHESIOLOGY - Anesthesia services are rendered in the hospital by or under the direction of either an Anesthesiologist or a Nurse Anesthetist under the direction of the operating surgeon. Additional activities include, but are not limited to the following: Recording amount and type of anesthetic administered; conducting physical examination of patients; observing patient's condition until major effects of the anesthesia have passed; obtaining laboratory findings before anesthetic is administered; administering treatment to patients having symptoms of post anesthetic complication; accompanying patients to recovery

	room or to intensive care units; prescribing pre- and post-anesthesia medication; establishing and carrying out safeguards for administration of anesthetics. Standard Unit of Service: Number of Anesthesia Minutes Anesthesia minutes are defined as the difference between starting time and ending time defined as follows: Anesthesia time begins when the anesthesiologist or nurse anesthetist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area, and ends when he/she is no longer in personal attendance and the patient may be placed under postoperative supervision.
7110	MEDICAL SUPPLIES SOLD - The Medical Supplies Sold cost center is used for the accumulation of the invoice costs of all medical and surgical supplies sold directly to patients. The invoice/inventory costs of non-chargeable supplies and equipment issued by the Central Services and Supplies cost center (Account 8460) to other cost centers shall be reported in the user cost centers. If medical and surgical supplies are sold in other hospital cost centers, the cost of those items must be reported in this cost center. The overhead cost of preparing and issuing medical and surgical supplies and equipment sold directly to patients must be reported in the Central Services and Supplies cost center (Account 8460). The application portion of such overhead will be allocated to this cost center during the cost allocation process. The cost of reusable patient chargeable supplies must be reported in the Central Services and Supplies Cost Center. Also report in this cost center the cost of durable medical equipment sold, leased or rented. Revenue related to durable medical equipment should be reported in the Medical Supplies Sold revenue center (Account 4110).
7150	DRUGS SOLD - The Drugs Sold cost center is used for the accumulation of the invoice/inventory cost of all pharmaceuticals, blood derivatives, and intravenous solutions sold directly to patients and others. The invoice or inventory cost of all non-chargeable drugs, whether pharmaceuticals, blood derivatives, or intravenous solutions issued by the Pharmacy cost center (Account 8470) to other cost centers shall be reported in the using cost center. If drugs are sold in other hospital cost centers, the cost of those items must be reported in this cost center. The overhead cost of preparing and issuing drugs sold directly to patients and others must be accumulated in the Pharmacy cost center (Account 8470). The applicable portion of such overhead will be allocated to this cost center during the cost allocation process.
7210	LABORATORY SERVICES - This cost center performs diagnostic and routine clinical and pathological tests necessary for the diagnosis and treatment of hospital patients. Additional activities include, but are not limited to the following: Transporting specimens from nursing floors and operating rooms; drawing of blood samples; mortuary operation, autopsy; caring for laboratory animals; maintenance of quality control standards; preparation of samples for testing. Standard Unit of Service: Workload Measurement Units Laboratory Workload Recording Method published by the College of American Pathologists, (use the latest edition). In reporting Workload Measurement Units, workload units related to quality control standards, calibration standards, specimen collection, and duplicates and repeats for which a patient is not charged are not to be reported. Workload units for unlisted procedures should be reasonably estimated based upon work units for other comparable procedures, or estimated by qualified personnel. Workload measurement units shall also be reported for laboratory services obtained from outside laboratories.
7250	BLOOD PLASMA COLLECTION - This cost center procures and collects whole blood and packed red cells. Also included is the recruitment of donors. This cost center contains the direct expenses incurred in procuring whole blood and packed red cells, drawing blood, and recruiting and paying donors. Do not include in this cost center the expenses incurred in performing tests on blood (e.g., typing, crossmatching, etc.). These expenses must be reported in Laboratory Services (Account 7210). This cost of blood derivatives sold to patients and others must be reported in the Drugs Sold Cost Center (Account 7150). The cost of blood derivatives issued by the Pharmacy cost center to other cost centers must be reported in the using cost centers.

	The cost of blood (amount paid or fair market value) is reported in this cost center, or an inventory account if applicable, rather than netted against revenue or cleared through an agency account. When blood is purchased, cost is the amount paid. The service fee charged by the outside blood sources is not reported here but reported in Blood Processing and Storage (Account 7260). When blood is donated, cost is its fair market value at the date of donation reported in Other Operating Revenue (Account 5870). If replacement blood is received by the hospital blood bank, the original amount charged to the patient is reported in this cost center and removed from the patient's account (Accounts and Notes Receivable – Account 1030). Standard Unit of Service: Workload Measurement Units Laboratory Workload Recording Method published by College of American Pathologists, (use the latest edition).
7260	BLOOD PROCESSING AND STORAGE - This cost center processes, preserves, stores, and issues whole blood and packed red cells after they have been procured. Additional activities include, but are not limited to the following: Plasma fractionation; freezing and thawing blood; maintaining inventory control. This cost center contains the direct expenses incurred in processing, storing and issuing whole blood and packed red cells after it has been procured. Include in this cost center the cost of spoiled or defective blood and the service fee charged by outside blood sources, whether or not the blood is replaced. Do not include in this cost center the expense incurred in performing tests on blood (e.g., typing, crossmatching, etc.). These expenses must be reported in Laboratory Services cost center (Account 7210). The cost of blood and packed red cells must be reported in the Whole Blood and Packed Red Cells cost center (Account 7250). The cost of blood derivatives sold to patients and others must be reported in the Drugs Sold cost center (Account 7150). The cost of blood derivatives issued by the Pharmacy cost center to other cost centers must be reported in the using cost center. Standard Unit of Service: Workload Measurement Units Laboratory Workload Recording Method published by the College of American Pathologists, (use the latest edition).
7290	ELECTROCARDIOGRAPHY - This cost center operates specialized equipment to record graphically: (1) electromotive variation in actions of the heart muscle: (2) the direction and magnitude of the electrical forces of the heart's action; (3) the sound of the heart for diagnostic purposes; and (4) the electromotive variations in brain waves. Additional activities include, but are not limited to the following: Wheeling portable equipment to patient's bedside; explaining test procedures to the patient; operating specialized equipment; inspecting, testing and maintaining special equipment; attaching and removing electrodes from the patient. Standard Unit of Service: Workload Measurement Units Laboratory Workload Recording Method published by the College of American Pathologists, (use the latest edition). Workload units for unlisted procedures should be reasonably estimated based upon work units for other comparable procedures or estimates by qualified personnel.
7310	CARDIAC CATHETERIZATION LABORATORY - The Cardiac Catheterization Laboratory provides specialized diagnostic procedures such as right or left cardiac catheterization required for the assessment of patients with cardiac conditions. Therapeutic procedures such as balloon angioplasty are also performed in the catheterization laboratory. Standard Unit of Service: Number of Procedures

	Each cardiac catheterization procedure for which a charge is made should be counted as one procedure.
7320	RADIOLOGY – DIAGNOSTIC - This cost center provides diagnostic radiology services as required for the examination and care of patients under the direction of a qualified radiologist. Diagnostic radiology services include the taking, processing, examining and interpreting of radiographs, ultrasonograms, and fluorographs. Additional activities include, but are not limited to, the following: Consultation with patients and attending physicians; radioactive waste disposal; storage of radioactive materials. Standard Unit of Service: Number of Procedures Count each diagnostic radiology procedure as one procedure. Count only those procedures for which a charge is made. Patient procedure is defined as the initial film and any additional films of the same anatomical area during a single visit.
7340	COMPUTERIZED TOMOGRAPHIC (CT) SCANNER - The Computerized Tomographic (CT) Scanner function provides computed tomographic scans or cross-sectional images of the head and other parts of the body. Standard Unit of Service: Number of Procedures Count each computerized tomographic scan procedure as one procedure. Count only those procedures for which a charge is made. A patient procedure is defined as the initial scan and any additional scans of the same anatomical area during a single visit.
7350	MAGNETIC RESONANCE IMAGING (MRI) - Magnetic Resonance Imaging provides computer-generated scans that produce axial, lateral, or frontal images of the head or other parts of the body. Standard Unit of Service: Number of Procedures Each magnetic resonance imaging procedure counts as one procedure. Count only those procedures for which a charge is made. A patient procedure is defined as the initial scan. Any additional areas scanned are counted as separate procedures, even if preformed during a single visit.
7360	RADIOLOGY – THERAPEUTIC - This cost center provides therapeutic radiology services as required for the care and treatment of patients under the direction of a qualified radiologist. Therapeutic radiology services include therapy by radium and other radioactive substances. Additional activities include, but are not limited to the following: Consultation with patients and attending physician; radioactive waste disposal; storage of radioactive materials. Standard Unit of Service: Number of Procedures Count each therapeutic radiology procedure as one procedure. Count only those procedures for which a charge is made. A patient procedure is defined as the initial radiation treatment and any additional treatments of the same anatomical area during a single visit.
7380	NUCLEAR MEDICINE - This cost center provides diagnostic, therapeutic, and investigative use of injectable or ingestible radioactive isotopes as required for the care and treatment of patients under the direction of a qualified physician. Additional activities include, but are not limited to the following: Consultation with patients and attending physicians; radioactive waste disposal; storage of radioactive materials. Standard Unit of Service: Number of Procedures Each nuclear medicine procedure should be counted as one procedure. Count only those procedures for which a charge is made. A patient procedure is defined as the initial nuclear medicine treatment and any additional treatment of the same anatomical area during a single visit.
7420	RESPIRATORY THERAPY - Respiratory therapy is the administration of oxygen and certain potent drugs

	through inhalation of positive pressure and other forms of rehabilitative therapy as prescribed by physicians. This cost center also includes pulmonary function testing, the testing of patients through measurement of inhaled and exhaled gases and analysis of blood, and evaluation of the patient's ability to exchange oxygen and other gases. This function is performed by specially trained personnel who initiate, monitor, and evaluate patient performance, cooperation, and ability during testing procedures. Additional activities include, but are not limited to the following: Assisting physician in performance of emergency care; reviving and maintaining patient's vital life signs; maintaining open airways, breathing, and blood circulation; maintaining aseptic conditions; transporting equipment to patient's bedside; observing and instructing patient's during therapy; visiting all assigned patients to ensure that physicians' orders are being carried out; inspecting and testing equipment; enforcing safety rules; and calculating test results. This cost center contains the direct expenses incurred in the administration of oxygen and other forms of therapy through inhalation and those incurred in the performance of patient and laboratory testing necessary for diagnosis and treatment of pulmonary disorders. Standard Unit of Service: Number of Treatments Each procedure for which a charge is made should count as one treatment. Oxygen charges would be reported as one per day regardless of service time.
7510	PHYSICAL THERAPY - The physical therapy cost center provides patient evaluation and therapeutic activities, patient education, and home visits. In addition, it provides the diagnostic neurology service of electromyography. The cost center provides patient evaluation by performing and interpreting tests and measurements of cardiovascular, neuromuscular, and musculoskeletal functions and establishes treatment programs. Treatment is administered through the use of therapeutic exercise, massage, mechanical devices and therapeutic agents which employ the physical, chemical, and other properties of air, water, electricity, sound, and light. Specialized equipment is used to record electromotive variations in brain waves and to record electrical potential variation for diagnosis or muscular or nervous disorders. Specific evaluation and therapeutic activities provided by this cost center include, but are not limited to the following: Application of manual and electrical muscle and range of motion measurement; evaluation and fitting of prosthetic, orthotic, and other assistive devices; functional testing and training; perceptual and sensory evaluations; planning and executing therapeutic exercise programs for increasing strength, endurance, coordination, and range of motion, gait analysis and training; instruction and counseling patients and families. Standard Unit of Service: Number of Modalities The standard unit of measure will be the modality or the method of application of any therapeutic agent. A modality is defined as a single encounter with a physical therapist, such as gait training, whirlpool, or paraffin bath. One or more modalities will constitute a patient visit. In addition to modalities, the number of physical therapy patient visits will be reported on Worksheet A-1. A patient visit is one appearance of a patient regardless of the number of evaluation, therapeutic, and patient educational activities performed during that appearance. Also included as patient visits are the home visits made by physical therapists. See Account 6990 for a definition of home visits.
7590	OTHER REHABILITATIVE SERVICES - Other Rehabilitative Services include educational and therapeutic activities related to the treatment, habilitation and rehabilitation of patients with neuromuscular and musculoskeletal impairments. Include milieu therapy in this cost center. This cost center includes, but is not limited to the following: • Occupational Therapy – The application of purposeful, goal oriented activity in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health. • Speech Pathology – Providing and coordinating services to persons with impaired functional communication skills. This includes the evaluation and management of any existing disorders of the communicative process, centering entirely or in part on the reception and production of speech and language related to organic and/or inorganic factors.

	• Audiology – Providing and coordinating services to persons with impaired peripheral and/or central auditory function. This includes the detection and management of any existing communication handicaps centering in whole or in part on the hearing function. • Recreational Therapy Services – The employment of sports, dramatics, arts, and other recreational programs to stimulate a patient's recovery rate. This cost center contains the direct expenses incurred in providing the activities described above and in providing any other physical medical services not specifically required to be included in another cost center. Standard Unit of Service Not applicable.
7710	RENAL DIALYSIS - Renal Dialysis is the process of cleansing the blood by use of an artificial kidney machine or other method. Additional activities include but are not limited to the following: Transporting portable equipment to patient's bedside; explaining procedures to the patient; operating dialysis equipment, inspecting, testing and maintaining special equipment. Report all Home Program Dialysis expenses in Account 6820. Standard Unit of Service: Number of Treatments Each treatment for which a charge is made is counted as one treatment regardless of the length of the treatment.
7720	EXTRACORPOREAL SHOCKWAVE LITHOTRIPSY (ESWL) - ESW Lithotripsy is a noninvasive procedure by which renal and ureteral calculi (kidney stones) are pulverized using electro-hydraulic shock waves. This cost center contains the direct expenses incurred in the treatment of kidney stones through the use of lithotripsy. Standard Unit of Service: Number of Procedures Each lithotripsy procedure for which a charge is made is counted as one procedure.
7730	ORGAN ACQUISITION - This cost center is used to record the acquisition, storage and preservation of all human organs for the eventual transplantation. Unlike other ancillary services, the total cost of organ acquisition is not accumulated in any one patient care cost center. Therefore, include only the costs that are not properly includable in another cost center. Standard Unit of Service: Number of Organs Acquired Each organ acquired should be counted as one.
7910	OTHER ANCILLARY SERVICES - This cost center contains the direct expenses incurred in providing ancillary services other than those required to be included in other specific cost centers. Included are expenses incurred in providing psychiatric and psychological services such as individual, group, and family therapy to adults, adolescents and families; biofeedback training; psychological testing; and shock therapy. Related revenue must be included in the Other Ancillary Services revenue center (Account 4910). Standard Unit of Service Not applicable.

OTHER OPERATING EXPENSE

OTHER OPERATING EXPENSE-DEPARTMENTAL - 8010-8780

This group of accounts is used to report the direct expenses incurred by the research, education, general, fiscal, and administrative cost centers, and various unassigned cost centers. When cost allocation procedures are performed, the expenses reported in these centers are allocated to the various patient service cost centers to determine the full cost of providing each revenue producing service.

Included as direct expenses in these cost centers are: Salaries and wages, employee benefits, administrative professional fees, supplies, purchased services, and other direct expenses.

8010	RESEARCH EXPENSE - This cost center administers research projects funded by outside donations, grants, and/or the hospital. Additional activities include: Maintenance of animal houses; administration of specific research projects; cost of laboratory chemicals and reagents; glassware and lab supplies.
8220	NURSING EDUCATION/DEGREE PROGRAMS - Hospitals may either operate a school of nursing or provide the clinical training activities and facilities for student nurses when the degree is issued by a college or university. This cost center is to regard expenses associated with educational programs which result in either an Associate or Bachelor's degree, and which allows graduates to be eligible for licensure examinations as Registered or Practical Nurses. Activities include, but are not limited to the following: Selecting qualified nursing students; providing education in theory and practice conforming to approved standards; maintaining student personnel records; counseling students regarding professional, personal and educational problems; selecting faculty personnel; assigning and supervising students in providing nursing care to selected patients; and administering aptitude and other tests for counseling and selection purposes.
8240	POST GRADUATE MEDICAL EDUCATION – APPROVED TEACHING PROGRAM - A post graduate medical education teaching program provides an organized program of post graduate medical clinical education to residents. To be approved, a medical residency training program must be approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. Residency programs in the field of dentistry in a hospital or osteopathic hospital must have the approval of the Council on Dental Education of the American Dental Association. Activities include, but are not limited to the following: Selecting qualified students; providing education in theory and practice conforming to approved standards; maintaining student personnel records; counseling students regarding professional, personal and educational problems; and assigning and supervising students. All salaries and stipends paid to residents in approved teaching programs must be reported in this cost center in the "Salaries and Wages" natural expense classification.
8250	POST GRADUATE MEDICAL EDUCATION – NON-APPROVED TEACHING PROGRAM - A post graduate medical education program provides an organized program of post graduate medical clinical education to residents. A non-approved medical residency training program is not approved by the Council on Medical Education of the American Medical Association, or in the case of an osteopathic hospital, is not approved by Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. Residency programs in the field of dentistry in a hospital or osteopathic hospital are considered non-approved unless approval has been granted by the Council on Dental Education of the American Dental Association. Activities include, but are not limited to the following: Selecting qualified students; providing education in theory and practice conforming to approved standards; maintaining student personnel records; counseling students regarding professional, personal and educational problems; and assigning and supervising students. All salaries or stipends paid to residents in non-approved teaching programs must be reported in this cost center in the "Salaries and Wages" natural expense classification.

8260	ALLIED HEALTH EDUCATION PROGRAMS - Allied Health Education Programs provide organized medical clinical education for administrative interns and externs, medical record librarians, medical technologists, and other health professionals, excluding nurses (RNs and LPNs) and physicians. Activities include, but are not limited to the following: Selecting qualified students; providing education in theory and practice conforming to approved standards; maintaining student personnel records; counseling of students regarding professional, personal and educational problems; selecting faculty personnel; assigning and supervising students in providing medical care to selected patients and administering aptitude and other tests for counseling and selection purposes. This cost center contains the direct expenses relative to operating health education programs, other than nursing and postgraduate medical programs, such as School of Medical Technology, School of X-Ray Technology, School of Respiratory Therapy, Occupational Therapy Field Work Experience, and other similar educational programs. Inservice educational programs are not reported in this cost center, rather in the department responsible for the program.

GENERAL SERVICES EXPENSE

8310	DIETARY SERVICES - Dietary Services includes the procurement, storage, processing and delivery of food and nourishment for patients in compliance with Public Health Regulations and physicians' orders. Additional activities include, but are not limited to the following: Educating patients and their families in nutritional and modified dietary requirements; determining patient food preferences; preparing selective menus for various specific dietary requirements; preparing or recommending a diet manual approved by the medical staff for use by physicians and nurses; delivering and collecting patient food trays; and other incidental related activities. Also included is Dietary Service's share of common costs of the Non-Patient Food Service and Dietary Services cost centers. Examples of common costs would include salaries of cooks who prepare food for both cost centers, common food costs, common minor equipment costs, if expensed, common administrative costs, etc. These common costs must be allocated to the Dietary Services and Non-Patient Food Service cost centers based upon the ratio of the number of meals served in each cost center. To obtain an equivalent meal in a pay cafeteria, divide total cafeteria revenue by the average selling price of a full meal. The average full meal should include meat, potato/starch vegetable, green vegetable, salad, beverage and dessert. When there is a selection of entrees, desserts and so forth, that are available at different prices, use an average in calculating the selling price of a full meal. Count a free meal served as a full meal.
8320	NON-PATIENT FOOD SERVICE (Cafeteria/Snack bar) - Non-patient Food Service includes all directly identifiable expenses incurred for the procurement, storage, processing, and delivery of food to employees and other non-patients in compliance with Public Health Regulations. Also included is the Non-Patient Food Service's share of the common costs to both the Non-Patient Food Service and the Dietary Services cost centers. The cost of edible supplies for vending machines serviced by the health facility must be included in this cost center. Vending Machine revenue is to be included in Other Operating Revenue (Account 5870 – Vending Machine Commissions).
8330	LAUNDRY AND LINEN - Laundry and Linen Services include pickup, storage, issuance, distribution, mending, washing, and processing of inservice linens. The services include uniforms, special linens, and disposable linen substitutes.
8350	SOCIAL SERVICES - The Social Services cost center obtains, analyzes and interprets psychosocial, environmental and economic information to assist in diagnosis, treatment, rehabilitation, and placement of patients. These services include counseling of patients and families in individual and group units; collaboration with health care staff; organizing on behalf of patients both within a given hospital and in various agencies outside the hospital; and participation in the development of social and health programs in the community. Other tasks involve collecting and revising information on community health and welfare resources, departmental management and accountability to responsible external organizations. Major activities include, but are not limited to the following:

	1) SCREENING: The process whereby a determination is made concerning the necessity for further professional assessment and services. 2) ASSESSMENT: (Including family members or significant others). The explication of a patient's problem(s) and the initial determination of a course of action for resolving the problem(s). 3) THE PROVISION OF PROBLEM FOCUSED SERVICES: Services directed toward the resolution of identified problems (such as dealing with psychosocial problems as they relate to a patient's health and/or hospitalization, and arranging for post discharge care of patients). This cost center contains the direct expenses incurred in providing social work services to patients with the exception of those incurred within the context of Home Health Care as defined in the Home Health – Medical Social Services cost center (Account 6990, Home Health Medical Social Services).
8360	HOUSING - Housing includes the cost and maintenance of living quarters provided to hospital employees, non-paid workers and students, including interns and residents participating in educational programs conducted by the hospital. Expenses of "on call" rooms should be included in this cost center only when they are not directly identifiable to another cost center.
8410	PLANT SERVICE AND MAINTENANCE - Plant Service and Maintenance includes the service and maintenance of utility systems such as heat, light, water, air conditioning, and air treatment. This cost center does not include: the expenses of electricity, natural gas, liquid propane or butane gas, oil, coal, purchased steam and hot water, and water and sewage charges; the maintenance and repair of buildings, parking facilities, and equipment; painting; elevator maintenance, vehicle maintenance; performance of minor renovation of buildings and equipment; and maintenance of grounds, such as landscaped and paved areas, streets on the property, sidewalks, fenced areas and fencing, external recreation areas, and parking facilities. Additional costs include, but are not restricted to the following: Waste management and disposal; boiler operating and maintenance; service and maintenance of water treatment facilities, drainage systems and utility transmission systems, including all maintenance performed under contract; technical assistance on equipment purchases and installation; coordinating construction; establishing priorities for repairs and utility projects. The costs of maintenance, repair and renovation of renal dialysis equipment used for Home Dialysis for which the hospital has been 100% reimbursed by Medicare must be reported in the Home Program Dialysis cost center (Account 6820). Note: Utility costs are not included in this cost center. These costs are included in Utilities.
8411	UTILITIES – ENERGY - Utilities – Energy includes costs of all utilities used in the production of energy for the hospital such as electricity, fuel, and purchased steam. (Note: for step-down allocation purposes, utilities accounts 8411 and 8412, will be included in Plant Service and Maintenance – Account 8410).
8412	UTILITIES – OTHER - Utilities – Other include all non-energy utility cost, such as water, and disposal service. (Note: for step-down allocation purposes, utilities accounts 8411 and 8412, will be included in Plant Services and Maintenance – Account 8410).
8430	SECURITY SERVICES - The Security Services cost center includes the costs associated with ensuring the safety and well-being of hospital patients, personnel, and visitors, as well as the protection of the hospital facility.
8440	PARKING - Parking includes the costs of providing parking facilities to patients, physicians, employees and visitors.
8450	HOUSEKEEPING - This cost center is responsible for the care and cleaning of the interior physical plant,

	including the care (washing, waxing, and stripping) of floors, walls, ceilings, partitions, windows (inside and outside), furniture (stripping, disinfecting and making beds upon discharge), fixtures (excluding equipment) and furnishings, and emptying of room trash containers, as well as the costs of similar services purchased from outside organizations.
8460	CENTRAL SERVICES AND SUPPLIES - Central Services and Supplies prepares and issues medical and surgical supplies and equipment to patients and to other cost centers. Additional activities include, but are not limited to the following: Requisitioning and issuing of appropriate supply items required for patient care; preparing sterile irrigation solutions; collecting, assembling, sterilizing, and redistributing reusable items; cleaning, assembling, maintaining, and issuing portable apparatuses. The invoice/inventory cost of non-chargeable supplies and equipment issued to other cost centers must be reported in the using cost center. The invoice/inventory cost of chargeable medical and surgical supplies must be reported in the Medical Supplies Sold cost center (Account 7110). The invoice/inventory cost of durable medical equipment leased and rented must also be reported in the Medical Supplies Sold cost center (Account 7110). For further discussion see Chapter I, of this manual.
8470	PHARMACY - The Pharmacy procures, preserves, stores, compounds, manufactures, packages, controls, assays, dispenses, and distributes medications (including I.V. solutions and blood derivatives, except packed red cells) for inpatients and outpatients under the direction of a licensed pharmacist. Pharmacy services include maintaining separate stocks of commonly used items in designated areas. Additional activities include, but are not limited to the following: Development and maintenance of the hospital's formulary established by the medical staff; consultation and advice to medical and nursing staff on drug therapy; I.V. add-mixture service; determining incompatibility of drug combinations; stocking floor drugs and dispensing machines; preparing patient medication histories; monitoring drug therapy; counseling patients; making patient rounds. The invoice/inventory cost of chargeable pharmaceuticals, I.V. solutions, and blood derivatives issued to other cost centers shall be reported in the Drugs Sold cost center (Account 7150). For further discussion, see Chapter I of this manual.

ADMINISTRATIVE EXPENSE

8510	GENERAL ACCOUNTING - This cost center performs general accounting (e.g., non-patient billing and accounting) activities of the hospital such as the preparation of ledgers, budgets and financial reports, payroll accounting, accounts payable accounting, plant and equipment accounting, inventory accounting, non-patient accounts receivable accounting (tuition, sales to other institutions), etc.
8520	PATIENT ACCOUNTS, ADMITTING, AND REGISTRATION - The processing of patient charges, including posting charges to patient accounts, preparing claims, extending credit, collecting accounts receivable, cashiering, and other patient related billing and accounting activities, are handled by this cost center. Additional activities include interviewing patients and others relative to the extension of credit, checking references and utilizing outside collection agencies. The admitting of inpatients for hospital services including completing admission forms, scheduling admission times, accompanying patients to room or service areas after admission, and arrangement of admission details are performed by this cost center. All outpatient registration services are also included here, including emergency, clinic, and referred patients.

8610	HOSPITAL ADMINISTRATION - Hospital Administration provides overall management and administration of the institution. This function includes the following areas of administration: Governing Board, public relations, spiritual care, communications, personnel, management engineering, patient and health sciences libraries, and auxiliary groups. Communications is responsible for the operation of the communications systems within and outside of the hospital including, the telephone system, radio and telemetry communications systems, public address systems, closed circuit television, messenger services, internal information systems, and mail services. Personnel provides staffing of hospital departments and works to maintain employee satisfaction and morale. Activities include recruitment, employee selection, salary and wage administration, employee health services, employee benefit program administration, employment and procurement of temporary help (including fees paid to temporary agencies). Management engineering is an administrative service which assists hospital administrators in performing their managerial functions by providing specialized knowledge and skill in the mathematical, physical and social sciences, combined with the principles and methods of engineering analysis, and development and implementation. Management Engineering performs a wide variety of services including, but not limited to the following: productivity analysis and improvement; cost containment; planning and control procedures; systems analysis and design; facilities layout; and operations research. Data processing expenses should be included separately in the Data Processing cost center (Account 8611). (See description of Account 8611 for further explanation). However, for step-down allocation purposes, data processing will be included in this cost center. Expenses, which are not assignable to a particular administrative services functional cost center, must be included here. Care should be taken to ascertain that all costs included in this cost center do not properly belong in a different cost center. For example, expenses chargeable to hospital administration do not include legal fees incurred in connection with the purchase of property (which should be capitalized), nor fund raising costs, which should be included in Fund Raising (Account 8780).
8611	DATA PROCESSING - Data Processing performs systems design, analysis and programming, operates the hospital electronic data processing systems, including encoding input, storing and safeguarding data, operating data processing equipment, scheduling data processing jobs, distributing output, and identifying and solving hardware and software problems. All hospital related data processing expenses are to be reported in this cost center including the expense related to data processing service provided to outside organizations. The related revenue is to be reported in Account 5620, Data Processing Services Revenue. (Note: Data processing expenses should not be reported in the using cost centers. For step-down allocation purposes, Data Processing should be included in Hospital Administration – Account 8610).
8690	PURCHASING AND STORES - Purchasing and Stores includes the procurement of supplies, equipment, and services necessary to hospital operations, the receipt of supplies and materials from vendors and their routing and distribution to specific using areas, and the receipt and central storage of all non-pharmaceutical and non-dietary supplies and materials prior to their issuance to using cost centers. Additional activities include, but are not limited to the following: Receipt and processing of requisitions; monitoring perpetual supply items; obtaining quotes from selected vendors; and monitoring receipt of supplies.
8710	MEDICAL RECORDS - Medical Records includes the maintenance of a records system for the use, transportation, retrieval, storage, and disposal of patient medical records; the production of indexes, abstracts, and statistics for hospital management and medical staff use. This function also includes tumor registry activities.
8720	MEDICAL STAFF ADMINISTRATION - This cost center is used to report certain general expenses associated with medical staff administration, such as the salaries and related expenses of the Chief of the Medical Staff and assigned non-physician employees. The direct expenses incurred in providing medical photography and illustration services are also included in this cost center.

	Residents' salaries (or stipends) must not be included here, but rather in the Post Graduate Medical Education – Approved Teaching Program (Account 8240) or Post Graduate Medical Education – Non-approved Teaching Program (Account 8250) cost centers, as appropriate. Compensation paid to physicians (other than Chief of the Medical Staff) must not be included here. Physicians' professional component expenses must be reported in the Medical Staff Services cost center (Account 8730). Other physician compensation must be reported in the functional cost center related to the service rendered. See Chapter I, for further discussion.
8730	MEDICAL STAFF SERVICES - This cost center is used to report the professional component expenses associated with services provided by hospital based physicians to hospital patients. Professional component expenses include the applicable percentage of professional fees and of salaries and employee benefits. Residents salaries (or stipends) must not be included here but rather in the Post Graduate Medical Education – Approved Teaching Program (Account 8240) or Post Graduate Medical Education – Non-approved Teaching Program (Account 8250), as appropriate.
8740	MEDICAL CARE REVIEW - This cost center conducts ongoing evaluation of the quality of care given and includes periodic review of the utilization of bed facilities, diagnostic nursing, and therapeutic resources of the hospital with respect to both the availability of these resources to all patients in accordance with their medical needs and the recognition of the medical practitioner's responsibility for the cost of health care. This review should cover necessity of admission, length of stay, level of care, quality of care, utilization of ancillary services, professional services furnished, effectiveness of discharge planning, and the availability and alternate use of out of hospital facilities and services. The Medical Care Review cost center includes three review programs: pre-admission screening, concurrent review (including admission certification and continued stay review), and retrospective medical care evaluation studies. The review committee should include medical staff, hospital administration, nurses, and home health planners. This cost center should contain the costs incurred in providing peer review, quality assurance, utilization review, professional standards review, and medical care evaluation functions.
8750	NURSING ADMINISTRATION - Nursing Administration is responsible for the management of the nursing function in the hospital including scheduling and transfer of nurses among the services and units, nursing staff supervision, evaluation and discipline. This cost center also includes continuing education of hospital employed nursing personnel, (e.g., RNs, LPNs, Nursing technicians, aides, and orderlies) including regularly scheduled classes, in-service educational seminars, workshops, and special training sessions. This cost center should contain the direct expenses associated with nursing administration and with conducting a nursing in-service educational program. Costs related to in-service student time must not be included, rather, these costs must remain in the cost center in which the student works. If hospital employees work part-time in the in-service educational program and part-time in other nursing activities, their salaries, wages, and employee benefits must be allocated based upon the number of hours spent in each activity and reported in the appropriate cost centers. Scheduling and other administrative functions relative to float nursing personnel are considered costs of Nursing Administration. The salaries, wages, and employee benefits paid to float personnel shall be reported in the cost center in which they work. Any idle time would be added to the actual hours worked. The salaries, wages, and employee benefits of supervisors assigned to specific cost centers must be reported in those cost centers.
8780	FUND RAISING - Fund Raising includes activities such as special luncheons and meetings and special mailings for the purpose of raising funds.

OTHER OPERATING EXPENSES – NON-DEPARTMENTAL - 8810-8880

8810	DEPRECIATION – PLANT, PROPERTY, & EQUIPMENT - Depreciation – plant, property, & equipment is a cost center for reporting depreciation on land improvements, buildings and building improvements,

	leasehold improvements, and fixed and movable equipment. All such expenses must be reported in this cost center.
8820	AMORTIZATION EXPENSE - Amortization of bond issue costs, goodwill, start-up costs or other intangible assets should be reported in this cost center.
8825	LEASE AND RENTAL EXPENSE - The Lease and Rental Expense cost center should be used for recording lease and rental expenses on plant, property, and equipment.
8830	EMPLOYEE BENEFITS – NON-PAYROLL RELATED - This cost center should be used to report all non-payroll related employee benefits. Included in non-payroll related employee benefits are such costs as personal education, recreational and cultural activities, day care, subsidized housing, and executive benefits. Amounts in this account must also be reported on Worksheet X-1, line 11.
8840	INSURANCE – HOSPITAL AND PROFESSIONAL MALPRACTICE - This cost center is used to report all hospital and professional malpractice insurance expenses incurred in maintaining hospital and professional liability insurance policies. Also included is the self-insurance expense related to malpractice claims. Itemize special assessments on Worksheet X-4.
8850	INSURANCE OTHER - This cost center is used to record insurance expenses incurred in maintaining all insurance policies except professional and hospital malpractice insurance and employee benefit insurance. For example, fire, theft, employee fidelity bonds, liability (non-professional), property damage, auto, boiler, and business interruption insurance expenses would be included here. Also included is the expense associated with self-insurance of such losses.
8860	LICENSES AND TAXES (OTHER THAN INCOME TAXES) - This cost center is used to report all business license expenses incidental to the operation of the hospital, all other license expenses, and all taxes (other than on income tax). Fees paid to a city and/or county (or other governmental units, except the State Tax Board) for doing business in the city and/or county must be reported in this cost center. .
8865	PUBLIC MEDICAL ASSISTANCE TRUST FUND (PMATF) ASSESSMENT - The Medical Assistance Trust Fund assessment under Section 154.35 F.S., must be included in this account.
8870	INTEREST SHORT TERM - This cost center is used to report all interest incurred on borrowings obtained for working capital purposes for hospital operations. Interest incurred on mortgage notes and other borrowings for the acquisition of equipment must not be included in this cost center.
8880	INTEREST – LONG TERM - This cost center contains all interest incurred on capital, mortgages, and other loans for the acquisition of property, plant and equipment. This includes the interest on the current portion of long-term debt. NOTE: Capitalized interest costs that are being amortized as start-up costs should be reported in Account 8820, Amortization Expense. DETERMINATION OF ALLOWABLE INTEREST EXPENSE Interest expense paid to or accrued for sources other than unrelated entities which do not meet the following criteria may not be included in the Board's computation of a hospital's operating and total margins or setting its operating expenses in either the hospital's budget or prior year report. A) Interest is attributable to a debt of the reporting hospital and is supported by a written debt instrument. B) The hospital has provided adequate documentation supporting the reasonableness of all interest. If the debt and its corresponding interest are shown on a related entity's books, and the interest is allocated to the hospital by formula, then a copy of the methodology of allocation must be provided to the Board's staff. The basis of the methodology shall be the hospital's most recently completed fiscal year data. C) Interest expense that is based on capital market conditions at the time that the debt is incurred

	shall be deemed reasonable.

NONOPERATING EXPENSE - 9210-9500

Nonoperating expense including expenses not directly related to patient care, related patient services, or the sale of related goods. The following accounts are required to be reported:

9210	DOCTORS PRIVATE OFFICE RENTAL EXPENSES - This account contains the expenses incurred in connection with the rental of office space and equipment to physicians and other medical professionals for use in their private practice.
9250	OTHER NONOPERATING EXPENSES - This cost center contains nonoperating expenses not specifically required to be reported in Account 9210.
9410	PROVISION FOR INCOME TAXES - This cost center contains income tax expense and related deferred taxes.
9500	EXTRAORDINARY ITEMS - This cost center is used to report extraordinary items in accordance with "Generally Accepted Accounting Principles" (GAAP) to determine when items are to be considered extraordinary, unless required to report an item or amount in these accounts by AHCA interpretive ruling, which may not be in accordance with GAAP.

EMPLOYEE BENEFITS

SOCIAL SECURITY TAXES

FICA – Employer's Portion
FICA – Employee's Portion

These accounts are used to report all payments to the Federal Government for Social Security taxes. Employee portion should be completed for those institutions which have adopted a policy of paying their employees' Social Security taxes.

STATE AND FEDERAL UNEMPLOYMENT INSURANCE - This account is used to report payments for unemployment insurance.

GROUP HEALTH INSURANCE &GROUP LIFE INSURANCE - These accounts are used to report the employer's contribution toward health/life insurance for their employees.

PENSION AND RETIREMENT - This account is used to report the employer's contribution to a retirement plan for employees of the institution.

WORKER'S COMPENSATION INSURANCE - This account is used to report the employer's payments for worker's compensation insurance.

UNION AND WELFARE - This account is used to report payments to a union administrated health and welfare plan.

OTHER PAYROLL RELATED BENEFITS - This account is used to report all employee benefits not included in the accounts described above.

CHAPTER IV GLOSSARY OF HEALTHCARE TERMINOLOGY

Accrual Reporting - The recognition and reporting of the effects of transactions and other events on the assets and liabilities of the hospital entity in the time period to which they relate rather than only when cash is received or paid, in accordance with generally accepted accounting principles.

Active Medical Staff - Physicians, other than residents, who have been accepted as members of the medical staff organization of the hospital, and who are also voting members of the medical staff, holding positions which will entitle them to voting staff privileges.

Actual Audited Data - "Audited Actual Experience", "Audited Actual Data", or "Audited Financial Statements" means data contained within financial statements examined by an independent, Florida-licensed, certified public accountant in accordance with generally accepted auditing standards and including an opinion on the audited financial statements. However, for the purposes of the Medicaid program, "Actual Audited Data" or "Actual Audited Experience" means data reported to the Agency for Health Care Administration which has been audited in accordance with generally accepted auditing standards by the Agency for Health Care Administration or representatives under contract with the agency.

Acute Care - Inpatient general routine care provided to patients who are in an acute phase of illness but not to the degree, which requires the concentrated and continuous observation and care provided in the intensive care units of an institution.

Adjusted Admissions - Adjusted admissions are the sum of acute admissions and the intensive care admissions divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory and ancillary patient services to gross revenues, as defined in 408.07(22), F.S. The formula for computation of adjusted admissions is as follows:

The Total of Acute & Intensive
Care Admissions

Divided by
the Quotient of

(Total Inpatient Revenue – Sub Acute Inpatient Revenue) / Gross Revenue

Adjusted Patient Days - Adjusted patient days are the sum of acute patient days and the intensive care patient days divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory and ancillary patient services to gross revenues, as defined in 408.07(22), F.S. The formula for computation of adjusted patient days is as follows:

The Total of Acute & Intensive
Care Patient Days

Divided by
the quotient of

(Total Inpatient Revenue – Sub Acute Inpatient Revenue) / Gross Revenue

Admission, Inpatient - A person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. An inpatient is a patient that is defined in Rule 59E-7.011(4), Agency For Health Care Administration.

Ambulatory Care Services - Health services rendered to persons who are not confined overnight in a health care institution. The essential characteristic of "Ambulatory Services" is that the patients come or are brought to a facility of the hospital for a purpose other than admission as an inpatient. Ambulatory services include emergency services, clinical services, ambulance services, and home health services. Ancillary services, such as laboratory, physical therapy, and radiology are also provided in an ambulatory setting. Ambulatory care services are often referred to as "outpatient" services.

Ancillary Services - Diagnostic or therapeutic services performed by specific facility departments as distinguished from general or routine patient care such as room and board charges. Ancillary services generally are those specific services for

which charges are customarily made in addition to routine charges and include such services as surgery, laboratory, radiology, pharmacy, and therapy.

Assets Whose Use is Limited - Assets Whose Use is Limited includes the following:

Proceeds of debt issuances and funds of the health care entity deposited with a trustee and limited to use in accordance with the requirements of an indenture or similar document.

Other assets limited to use for identified purposes by an agreement between the healthcare entity and an outside party other than a donor or grantor. Examples include assets set aside under agreements with third-party payers to meet depreciation funding arrangements and assets set aside under self-insurance funding arrangements.

See Board Designated Assets

Available Beds - Licensed hospital beds that are staffed and ready for use with necessary supporting services. Beds in labor rooms, post anesthesia / postoperative recovery rooms, outpatient surgery centers, observation beds and other such areas, which are regularly maintained and utilized for only a portion of the stay of patients, primarily for special procedures and not for inpatient lodging, would not be deemed a "bed" for these purposes.

Average Daily Inpatient Census - The total number of inpatient days divided by the number of days in the period. For example: A hospital with 109,500 inpatient days during a given year of 365 days has an average daily inpatient census of 300. (109,500 / 365 = 300). If the reporting period is more or less than 365 days, inpatient days would be divided by the number of days in that reporting period.

Average Length of Stay - The number of days of that the average inpatient remains in the hospital. For example: A hospital with 25,000 inpatient admissions and 125,000 inpatient days during a given year or other reporting period has an average length of stay of 5.0 days. (125,000 / 25,000 = 5.0)

Base Medicaid Per Diem - The hospital's Medicaid per diem rate initially established by the Agency for Health Care Administration on January 1, 1999. The base Medicaid per diem rate shall not include any additional per diem increases received as a result of the disproportionate share distribution. (Applicable only to the Medicaid Disproportionate Share program).

Board Certified - This term refers to a physician who has met all educational and residency requirements of a medical specialty governing authority (i.e. The American College of Cardiology, The American College of Surgeons, etc.) and who has passed the required national examination.

Board Designated Assets - Assets set aside by the governing Board for identified purposes and over which the Board retains control and at its discretion subsequently may use for other purposes. (Also see: Assets Whose Use Is Limited)

Board Eligible - This term refers to a physician who has met all educational and residency requirements of a medical specialty governing authority (i.e. The American College of Cardiology, The American College of Surgeons, etc.) and is or has been eligible to take the national examination but has not passed it.

Boarder Baby - A newborn infant is retained in the nursery while the mother is not an inpatient of the hospital.

Case-Mix - A calculated index for each hospital, based on financial accounting and patient data collection as defined in s. [408.07(10) F.S].

Charity Care or Uncompensated Charity Care - Medical care provided by a healthcare entity to a person who has insufficient resources or assets to pay for needed medical care without utilizing his resources, which are required to meet his basic need for shelter, food, or clothing.

"Charity care" or uncompensated charity care": means that portion of hospital charges reported to the Agency for Health Care Administration for which there is no compensation, other than restricted or unrestricted revenues provided to a hospital by local governments or tax districts regardless of the method of payment; for care provided to a patient whose family income for the twelve months preceding the determination is less than or equal to 200 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no

case shall the hospital charges for a patient whose family income exceeds four (4) times the federal poverty level for a family of four be considered charity

Computerized Tomography (CT) - Diagnosis of disease through visualization of the transverse plane of internal body structure by means of a pinpoint radiographic beam resulting in the production of a precise reconstruction image of the area through a computerized analysis of the variance in tissue absorption rates.

Contract Services - Services performed in whole or in part by an outside individual or organization on a contractual basis.

Contractual Adjustments (Allowances) - Difference between revenue at full, established rates and amounts realized from third-party payers under contractual agreements.

Controlling Organization - The organization, which operates a hospital and has control of the plant, property, and equipment, but does not have legal title to the aforementioned assets.

Daily Inpatient Census - The number of inpatients present at the census taking time each day, plus any inpatients who were both admitted and discharged after the census taking time the previous day. Generally the inpatient census is taken each midnight. However, a facility may designate and consistently use any other specified hour for census taking.

Deductions from Revenue - Reductions in gross revenue arising from bad debts, contractual adjustments, charity care, administrative, courtesy, and policy discounts, and other deductions.

Diagnosis Related Groups (DRG) - A method of patient classification that categorizes patients who are medically related with respect to diagnoses and treatment and are statistically similar in their length of stay.

Direct Expense - The cost of any goods or services that contributes to, and is readily ascribable to, the output of a product or service. Direct expenses include salaries and wages, employee benefits, professional fees, supplies, purchased services, and other direct expenses.

Direct Assignment of Cost - The process of identifying and assigning costs directly to the functional cost center generating those costs.

Discharge - The termination of lodging and the formal release of an inpatient by the institution. Since deaths are a termination of lodging, they are also inpatient discharges.

Discrete Unit - A separately organized, staffed, and equipped unit of the institution.

Disproportionate Share Percentage - Means a rate of increase in the Medicaid per diem rate as calculated under Chapter 409.911, F.S.

Donated Commodities - Gifts of supplies and other materials such as medicines, blood, linen, and office supplies which are normally purchased by the institution, and are reported at their fair market value at the time of donation, regardless of when actual receipt takes place.

Donated Services - The services performed by personnel who receive no compensation or partial compensation for their services. The equivalent of an employer-employee relationship must exist between the institution and the individual donating the services. The term is usually applied to services rendered by members of religious orders, societies, or groups to an institution operated by or affiliated with such an order, society, or group.

Employee - As distinguished from an independent contractor, an employee is a person who performs services subject to the will and control of an employer with respect to what he does and how he does it and is on the payroll of the institution.

Employee Benefits - A pension provision, retirement allowance, insurance coverage, or other cost representing a present or future value to an employee, which is paid for by the employer.

Encounter - A face-to-face contact between a patient and a provider who has primary responsibility for assessing and treating the condition of the patient at a given contact and who exercises independent judgment in the care of the patient.

Expense - Expired cost; any item or class of cost of (or loss from) carrying on an activity; a present or past experience defraying a present operating cost or representing an unrecoverable cost or loss.

Fringe Benefit - See employee benefit.

Full Time Equivalent (FTE) Employees - An objective measurement of the personnel employment of an institution in terms of full labor capability. To calculate the number of full time equivalent employees, sum all hours for which employees were paid (whether worked or not) during the year and divide by 2080 (in leap years divide by 2088).

Function - A collection of activities having related purposes.

Functional Reporting - Reporting of revenue and expense according to type of activity performed.

Generally Accepted Accounting Principles - "Generally accepted accounting principles" (GAAP) means the term as defined in Rule 61H1-20.007 F.A.C., Department Of Business And Professional Regulation, Board of Accountancy.

Generally Accepted Auditing Standards - "Generally accepted auditing standards" (GAAS) means the term as defined in Rule 61H1-20-008 F.A.C., Department of Business and Professional Regulation, Board of Accountancy.

Gross Revenue - The sum of daily hospital service charges, ambulatory service charges, ancillary service charges and other operating revenue. Gross revenue does not include contributions, donations, legacies, or bequests made to a hospital without restriction by the donors. [s. 408.07(22), F.S.]

Gross Revenue Per Adjusted Patient Day (GRAPD) - Gross revenue divided by total adjusted patient days.

Health Care Facility - Means a hospital, long-term care hospital, skilled nursing facility, or intermediate care facility for the developmentally disabled. A facility relying solely on spiritual means through prayer for healing is not included as a health care facility. [s. 408.032(8), F.S.]

Health Related Care - Care, other than medical that is performed by qualified personnel and pertains to protective, preventive, personal and social services.

Hill-Burton Program - Federal program of financial assistance created by the Hospital Survey and Construction Act of 1946 for the construction and modernization of health care facilities.

Home Health Agency - A public or private organization that provides, either directly or through arrangements with other org., health services such as nursing, therapy, health related homemaker, or social services in the patient's home.

Hospital:

General, Short – Term Acute Care - Any establishment, licensed under chapter 395, that offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy; and regularly makes available at least clinical laboratory services, diagnostic radiology services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent. [s. 395.002(12)(a)(b), F.S.]

Specialty - Any facility which meets the provisions of section (1), and which regularly makes available either: the range of medical services offered by a general hospital, but restricted to a defined age or gender group of the population; or a restricted range of services appropriate to the diagnosis, care, treatment of patients with specific categories of medical or psychiatric illnesses or disorders, or Intensive residential treatment programs for children and adolescents as defined in subsection 395.002 (15).

Long Term - A facility, which treats patients requiring less intense treatment than those, defined in section (1), and in which the majority of those patients will have lengths of stay greater than sixty (60) days.

Rural - An acute care hospital licensed under Chapter 395, having 100 licensed beds or less and an emergency room that meets the criteria established in Section 408.07 (43)(a)(b)(c)(d)(e), F.S.

Teaching - Any hospital formally affiliated with an accredited medical school that exhibits activity in the area of medical education as reflected by at least seven different resident physician specialties and the presence of 100 or more resident physicians. [s. 408.07(45), F.S.]

Hospital–Based Physician - A physician who spends the predominant part of his practice time within one or more hospitals rather than in an office setting. Such a physician has either a special financial arrangement with the hospital (salary or a percentage of fees collected) or bills patients separately for his/her services. Such physicians include directors of medical education, pathologists, anesthesiologists and radiologists, as well as physicians who staff hospital emergency rooms and outpatient departments or clinics.

Inpatient - "Inpatient" means a patient who has an admission order given by a licensed physician or other individual who has been granted admitting privileges by the hospital. Observation patients are excluded unless they are admitted.

Intangible Assets - A nonphysical, noncurrent asset such as goodwill, a trademark, or capitalized interest cost. It is amortized over a period not to exceed forty (40) years.

Intensive Care - Services provided in an inpatient care unit to patients, who require extraordinary observation and care on a concentrated, exhaustive and continuous basis.

Intermediate Care Facility - An institution, other than an intermediate care facility for the developmentally disabled (ICF/DD), which has six beds or less and provides health – related care and services on a regular basis to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but because of their mental or physical condition, require health – related care and services above the level of room and board.

Invoice Cost - Cost incurred by a buyer and reflected on an invoice, which unless otherwise specified, is net after deducting trade discounts.

Length of Stay - The number of calendar days that elapse between an inpatient's admission and discharge; counting the day of admission and not counting the day of discharge. An admission and discharge on the same day is counted as a single day.

Lithotripsy - Extra corporeal Shockwave Lithotripsy (ESWL) is a noninvasive procedure by which renal and urethral calculi are pulverized using electro hydraulic shock waves.

Long–Term Psychiatric Care - Psychiatric care rendered in a licensed unit of a general hospital or a psychiatric facility with an average length of stay of 60 days of more.

Maintenance - Effort expended to keep assets in proper condition to serve their intended purpose. This effort is ordinary and recurring and does not improve the asset or add to its useful life.

Magnetic Resonance Imaging (MRI) - Refers to a noninvasive method of graphically representing the distribution of water and other hydrogen rich molecules in the human body.

Major Organ Transplantation - A major organ transplant is generally considered to be the acquisition of a healthy heart, kidney, liver, or lung either from a living donor or a cadaver, which is used to replace a diseased organ of a patient. The transplantation of a major organ system is highly resource intensive, due to the extremely complex and sophisticated surgical techniques involved.

Medicaid Days - For the purpose of the Medicaid program, means the number of actual Medicaid days attributable to Medicaid patients as determined by the Agency for Health Care Administration.
For the purpose of prior year reports, Medicaid days are the number of days attributable to Medicaid patients reported by a hospital.

Multi-hospital Organization - A healthcare or other organization consisting of a group of two or more facilities, which are owned, leased, or through any other arrangement, is controlled by one business entity.

Net Operating Revenue - Net operating revenue means gross revenue minus deductions from revenue. [395.701(1)(d) F.S.]

Net Revenue per Adjusted Patient Day (NRAPD) - Net operating revenue divided by total adjusted patient days

Non-operating Expense - The expenses of a hospital, which are not directly related to patient care, patient services, or the sale of related goods. For example, non-operating expenses include losses on the sale of hospital property and expenses for retail operations.

Non-operating Revenue - Revenue not directly related to the entity's ongoing or principal operations is classified as non-operating and may include unrestricted gifts, unrestricted income from endowment funds, gain on sale of hospital properties, and income and gains from investments of general funds.

Non-revenue Producing Cost Centers - These are overhead units, such as dietary and plant operations and maintenance that provide necessary support services to revenue producing centers.

Occasion of Service - Any examination, consultation, treatment, or procedure performed in any of the service facilities of a hospital.

On – Call Pay - Compensation paid to an employee for being available to work.

Operating Expenses - Operating expenses include all necessary and proper costs that are appropriate in developing and maintaining the operation of the patient care facilities and activities. Necessary and proper costs related to patient care are those costs which are common and accepted occurrences in the hospital operation.

Operating Revenue - Operating revenue is that revenue resulting form the entity's ongoing central operations. For example, revenue for the care of patients or residents of a hospital or nursing home would be considered operating revenue.

Other Operating Revenue - Other operating revenue normally includes revenue from the services other than healthcare provided to patients and residents, as well as sales and services to persons other than patients. Such revenue arises from the normal day-to-day operations of most healthcare entities and is accounted for separately from health care service revenue.

Outpatient - A hospital patient who received services in one or more of the facilities of the hospital that is not an inpatient of the hospital at the time services were rendered.

Owner - The person or organization having legal title to the plant, property, and equipment of a hospital.

Patient Care Services Revenue - The hospital's full-established charges for services rendered to patients regardless of amounts actually paid to the hospital by or on behalf of patients.

Patient Day - A unit of measure denoting lodging facilities provided and services rendered to one inpatient between the census-taking hour on two successive days. The day of admission, but not the day of discharge or death, is counted as a patient day. If both admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one patient day.

Pediatric Patient - Any patient of a hospital who is less than 15 years of age.

Periodic Interim Payment (PIP) - A plan under which the hospital receives cash payments from third-party payers (usually Medicare) in constant amounts each period.

Procedure - A unit of activity for a cost center. For example, a procedure in a radiology cost center may include a series of pictures that constitute an exam.

Professional Component - The professional services provided to patients by hospital-based physicians, as opposed to the education, research, and administrative duties performed by the hospital-based physicians.

Reclassification - The process of recasting a hospital's revenue and expense accounts into a new structure e.g. moving from a responsibility to a functional arrangement. For purposes of the Florida Hospital Uniform Reporting System (FHURS), the process of converting the hospital's accounts so as to comply with the prescribed reporting principles, definitions, listing of accounts and formats found in this manual. A record of the conversion process must be maintained.

Reporting Manual - The Florida Hospital Uniform Reporting System Manual is a handbook of accounting policies, principles, and concepts, including a chart of accounts with definitions and standard units of service. The Manual establishes guidelines and specific requirements based on statutory regulations for Florida hospitals reporting to the Florida Agency for Health Care Administration.

Registration - The process of formally entering a patient's name on the institution's records for service in an outpatient care service area.

Related Party - A provider which to a significant extent is associated or affiliated with, or has control of, or is controlled by the organization furnishing the services, facilities, or supplies.

Relative Value Unit - An index number assigned to various procedures based upon the relative amount of labor, supplies, and capital needed to perform the procedure. The unit value represents the cost of performing a service relative to some other service that is used as a base; i.e., the base has a unit value of one.

Resident - A recent graduate physician/dentist employed by a hospital that is serving an advanced period of postgraduate training. This may represent the first year of training or any year thereafter.

Restricted Funds - Funds restricted by donors or grantors for specific purposes. Restricted funds generally fall into three categories: Plant Replacement and Expansion Fund, Specific Purpose Fund, and Endowment Fund. The accounts within each restricted fund are self-balancing, as each fund constitutes a separate accounting entity.

Revenue Center - An account for accumulating revenue consistent with the functional definition of the matching cost center.

Revenue Producing Cost Centers - Health facility activities providing direct services to patients (such as nursing, physical therapy, and laboratory) and thereby generating revenue.

Self-Insurance - The assumption by a hospital of risks arising out of the ownership of property or from other causes.

Skilled Nursing Facility (SNF) / Skilled Nursing Unit (SNU) - An institution, or distinct part of an institution, which is primarily engaged in providing to inpatients, skilled nursing and related services to patients who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons. [s. 408.032(16), F.S.]

Standard Unit of Measure - A uniform statistic for measuring and comparing hospital costs and productive output as defined in this manual. (See Chapter V)

Subacute Care Services - Services provided to patients, who require a level of hospital care less than that defined as acute care, including for example, residential care, and chemical dependency that does not require detoxification.

Subprovider - A portion of a general hospital that has been issued subprovider identification number because it offers a clearly different type of service from the remainder of the facility, for example: Long-term psychiatric care unit, substance abuse unit, or rehabilitation unit.

Teaching Program (Approved) - A medical residency training program approved by the Council on Medical Education of the American Medical Association, or in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. Residency programs in the field of dentistry must have the approval of the Council on Dental Education of the American Dental Association.

Teaching Program (Non-approved) - A medical internship or residency training program is not approved unless it has been recognized by the Council on Medical Education of the American Medical Association, or in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. A residency program in the field of dentistry is not approved unless approval has been received from the Council on Dental Education of the American Dental Association.

Tertiary Health Services - A health service which due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be confined to a limited number of hospitals to ensure the quality, availability, and cost effectiveness of such service. Examples of such services include, but are not limited to, organ transplantation, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or

developmental in nature, to the extent that the provision of such services are not yet considered within the commonly accepted course of diagnosis or treatment for the condition. [s. 408.032(17), F.S.]

Third-Party Payer - Any agency that contracts with either hospitals or patients to pay for the health care services provided to covered patients. Examples of third party payers are: the Medicare and Medicaid Programs, health maintenance organizations (HMO's), or commercial insurers.

Unrestricted Funds - Funds which bear no external restrictions as to use or purpose; i.e., funds which can be used for any legitimate purpose designed by the Governing Board as distinguished from funds restricted externally for specific operating purposes, for plant replacement and expansion, and for endowment.

CHAPTER V STANDARD UNITS OF SERVICE

The Standard Unit of Service is required to provide a uniform statistic for measuring costs. The Standard Unit of Service for revenue producing cost centers (Daily Hospital, Ambulatory, and Ancillary Services) attempts to measure the volume (productive output) of services rendered to patients for which a charge is made. All-inclusive rate and No charge hospitals should count Standard Units of Service as if a change were being made. The Standard Unit of Service provides a method of determining unit cost, revenue to unit cost and revenue to unit cost and revenue comparisons among peer group health facilities.

Table of Standard Units of Service

This table of Standard Units of Service has been developed as a quick reference source. If a cost center is not listed, then a Standard Unit of Service has not been prescribed. For a detailed description of particular Standard Units of Service, refer to the appropriate cost center description.

ACCOUNT NUMBER	COST CENTER	STANDARD UNIT OF SERVICE
Daily Hospital Services		
6010	Medical/Surgical Acute	Number of patient days
6170	Pediatric Acute	Number of patient days
6210	Psychiatric Acute	Number of patient days
6220	Substance Abuse Acute –DTU	Number of patient days
6250	Obstetrics Acute	Number of patient days
6280	Definitive Observation	Number of patient days
6290	Other Acute Care	Number of patient days
6310	Medical/Surgical Intensive Care	Number of patient days
6330	Coronary Care	Number of patient days
6350	Pediatric Intensive Care	Number of patient days
6370	Neonatal Intensive Care	Number of patient days
6380	Burn Care	Number of patient days
6390	Psychiatric Intensive Care	Number of patient days
6410	Other Intensive Care	Number of patient days
6510	Newborn Nursery	Number of newborn days
6610	Skilled Nursing Care- Medicare/Medicaid Certified	Number of patient days
6630	Psychiatric Long-Term Care	Number of patient days
6650	Intermediate Care	Number of patient days
6660	Residential Care	Number of patient days
6690	Other Subacute Care Services	Number of patient days
Ambulatory Services		
6710	Emergency Services	Number of Visits
6720	Clinic Services	Number of Visits
6820	Home Program Dialysis	Number of Patient Weeks
6830	Ambulatory Surgery Services	Number of Surgery Minutes
6850	Ambulance Services	Number of Runs
6870	Free Standing Clinic Services	Number of Visits
6990	Home Health Services	Number of Home Visits

ACCOUNT NUMBER	COST CENTER	STANDARD UNIT OF SERVICE
Ancillary Services		
7010	Labor and Delivery Services	Number of Procedures
7040	Surgery Services	Number of Surgery Minutes
7060	Recovery Services	Number of Recovery Room Minutes
7080	Anesthesiology	Number of Anesthesia Minutes
7210	Laboratory Services	Workload Measurement Units
7250	Whole Blood and Packed Red Cells	Workload Measurement Units
7260	Blood Processing and Storage	Workload Measurement Units
7290	Electrocardiography	Workload Measurement Units
7310	Cardiac Catheterization Laboratory	Number of Procedures
7320	Radiology – Diagnostic	Number of Procedures
7340	CT Scanner	Number of Procedures
7350	Magnetic Resonance Imaging	Number of Procedures
7360	Radiology – Therapeutic	Number of Procedures
7380	Nuclear Medicine	Number of Procedures
7420	Respiratory Therapy	Number of Treatments
7510	Physical Therapy	Number of Modalities
7710	Renal Dialysis	Number of Treatments
7720	ESW Lithotripsy	Number of Procedures
7730	Organ Acquisition	Number of Organs Acquired