GENERAL HOSPITAL INFORMATION

SUBMISSION NUMBER:

REPORTING PERIOD
FROM:
TO:
(Use MM/DD/YYYY format)

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. FEDERALLY CERTIFIED 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
a. RELIGIOUS
b. OTHER
NAME OF CONTROLLING ORGANIZATION
OWNER:

INVESTOR-OWNED
c. INDIVIDUAL
d. PARTNERSHIP
e. CORPORATION
NAME OF CONTROLLING ORGANIZATION
OWNER:

GOVERNMENT
f. CITY
g. CITY/COUNTY
h. COUNTY
i. HOSPITAL AUTH.
j. HOSPITAL DISTRICT
k. STATE
l. OTHER:

4. TYPE OF HOSPITAL

SHORT TERM
a. GENERAL
b. PSYCHIATRIC
c. SUBSTANCE ABUSE
d. TEACHING
e. OTHER SPECIALTY:

LONG TERM
f. GENERAL
g. PSYCHIATRIC
h. SUBSTANCE ABUSE
i. REHABILITATION
j. OTHER SPECIALTY:

TRANSPLANT HOSPITAL
MAJOR ORGAN TRANSPLANT:
k. YES
l. NO

ACCREDITED (select one)
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

SERVICES INVENTORY AND UNITS OF SERVICE REPORT

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

	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/In-house 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.

DAILY HOSPITAL SERVICES/STATISTICS

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

	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 Sub Acute Care *	6690				
22	Total Sub Acute Care (Lines 17 through 21)	B122	-	-	-	-
23	Total DHS/Excluding Newborn (Lines 8, 16, and 22)	B123	-	-	-	-
24	Newborn 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 Sub Acute	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.

MEDICAL STAFF PROFILE AND ALLIED HEALTH EDUCATION PROGRAMS

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

PART I - MEDICAL STAFF PROFILE

	CLINICAL SPECIALITY	ACCT. NUMB.	APPROVED PROGRAM	MEDICAL STUDENTS	RESIDENTS	ACTIVE STAFF
			(Y/N)	(FTE's)	(FTE's)	(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	Rheumatology	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	Ophthalmology	4563	n			
30	Obstetrics 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, Blood banking	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

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 Proprietor	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.

INCOME STATEMENT

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

Line	Description	Amount
	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	Non-operating Revenue (Worksheet C-4, Col(1), Line 34)	-
15	Non-operating Expense (Worksheet C-6, Col(3), Line 40)	-
16	Excess (Deficiency) of Non-operating Revenues Over Non-operating 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

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	Newborn Nursery	3510			-
15	Skilled Nursing Facility	3610			-
16	Psychiatric Long-Term Care	3630			-
17	Intermediate Care	3650			-
18	Residential Care	3660			-
19	Other Sub Acute 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.

STATEMENT OF PATIENT CARE REVENUES AND DEDUCTIONS FROM REVENUE BY PAYOR OR CLASS FOR INPATIENT AND OUTPATIENT SERVICES	REPORTING PERIOD FROM: TO:	AHCA #	SUBMISSION NUMBER:	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.

STATEMENT OF OTHER OPERATING AND NONOPERATING REVENUE

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

	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	Non-approved 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 Unrestricted 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 Non-operating 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 Non-operating Revenue *	9150	
34	Total Non-operating Revenue (Lines 21through 33)	C441	-

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

STATEMENT OF PATIENT CARE SERVICES EXPENSE

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

LN NO	COST CENTER	ACCT. NUMB.	SALARIES AND WAGES	OTHER EXPENSE	TOTAL EXPENSE	FTE'S
			(1)	(2)	(3)	(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	Newborn Nursery	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.

STATEMENT OF OTHER OPERATING AND NONOPERATING EXPENSE

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

LN NO	COST CENTER	ACCT. NUMB.	SALARIES AND WAGES	OTHER EXPENSE	TOTAL EXPENSE	FTE'S
			(1)	(2)	(3)	(4)
	OTHER OPERATING EXPENSE GENERAL AND ADMINISTRATIVE					
01	Research Expense	8010			-	
02	Nursing Education	8220			-	
03	Approved Graduate Medical Education Program	8240			-	
04	Non-approved Graduate Medical Education Program	8250			-	
05	Allied Health Education Program	8260			-	
06	Dietary Services / Patients	8310			-	
07	Cafeteria / Non-patient	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-Administration	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 / Non-payroll	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 Non-operating Expense *	9250			-	
40	Total Non-operating 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.

ANALYSIS OF EMPLOYEE BENEFITS

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

	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 - Non-payroll 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.

EXPLANATIONS AND COMMENTS

SUBMISSION NUMBER:	REPORTING PERIOD		FACILITY NUMBER	WORKSHEET X-4
	FROM:			
	TO:			

W/S NUMB.	LINE NUMB.	VALUE	EXPLANATION AND COMMENT

PSYCHIATRIC HOSPITAL STATISTICS

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

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	Sub Acute 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.

FLORIDA HOSPITAL UNIFORM REPORTING SYSTEM
PRIOR YEAR ACTUAL REPORT
LIST OF DETECTED EXCEPTION CONDITIONS

Provider Name:
D/B/A:
Provider No.:

Reporting Period
From To

Name	Section	Field Description / Condition Detected
FATAL	WS: reportingperiodfrom	MISSING REPORTING PERIOD FROM DATE
FATAL	WS: reportingperiodto Ref:	MISSING REPORTING PERIOD TO DATE
FATAL	WS: facilitynumber Ref:	MISSING FACILITY NUMBER
WARNING	WS: A1 Ref: 04 I	MAJOR ORGAN TRANSPLANT QUESTION NOT ANSWERED
CRITICAL	WS: A2 Ref: 01 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 02 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 03 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 04 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 05 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 06 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 07 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 08 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 09 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 10 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 11 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 12 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 13 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 14 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 15 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 16 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 17 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 18 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 19 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 20 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 21 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 22 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 23 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 24 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 25 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 26 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 27 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 28 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 29 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 30 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 31 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 32 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 33 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 34 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 35 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 36 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 37 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 38 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 39 01	SERVICE CODE INVALID
CRITICAL	WS: A2 Ref: 40 01	SERVICE CODE INVALID

(SUBMISSION NUMBER)

WORKSHEET A

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)