STATE OF FLORIDA
HOSPITAL UNIFORM REPORTING SYSTEM MANUAL
2017-1 June 2017

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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

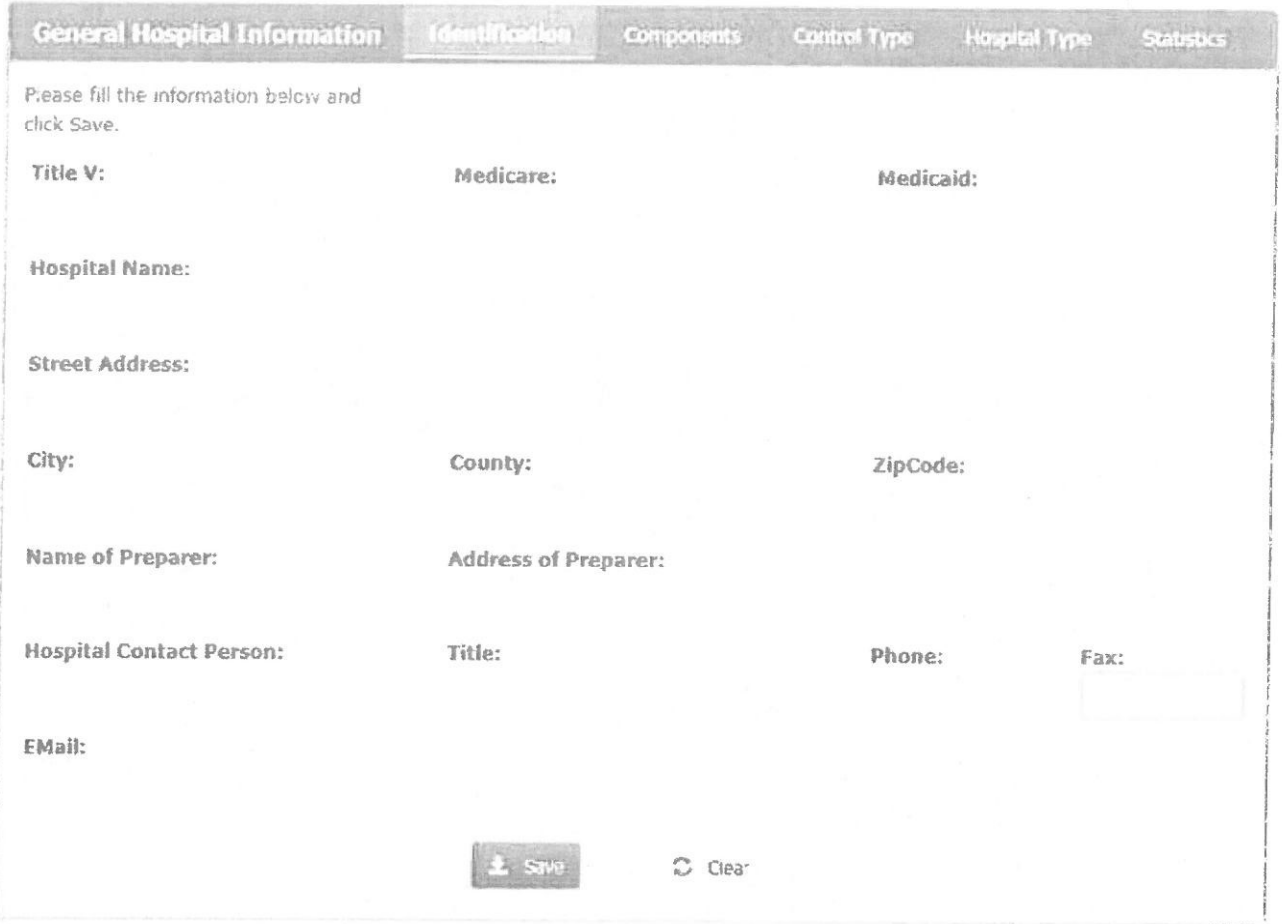
PURPOSE: This is a representation from hospital management that the reporting package is complete and accurate. The letter to AHCA documents management's responsibility for the propriety of data submitted and serves as a reminder to management of the importance of complete and accurate information.

INSTRUCTIONS:

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

WORKSHEET – A-1: GENERAL HOSPITAL INFORMATION

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.
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 fax number and e-mail address.

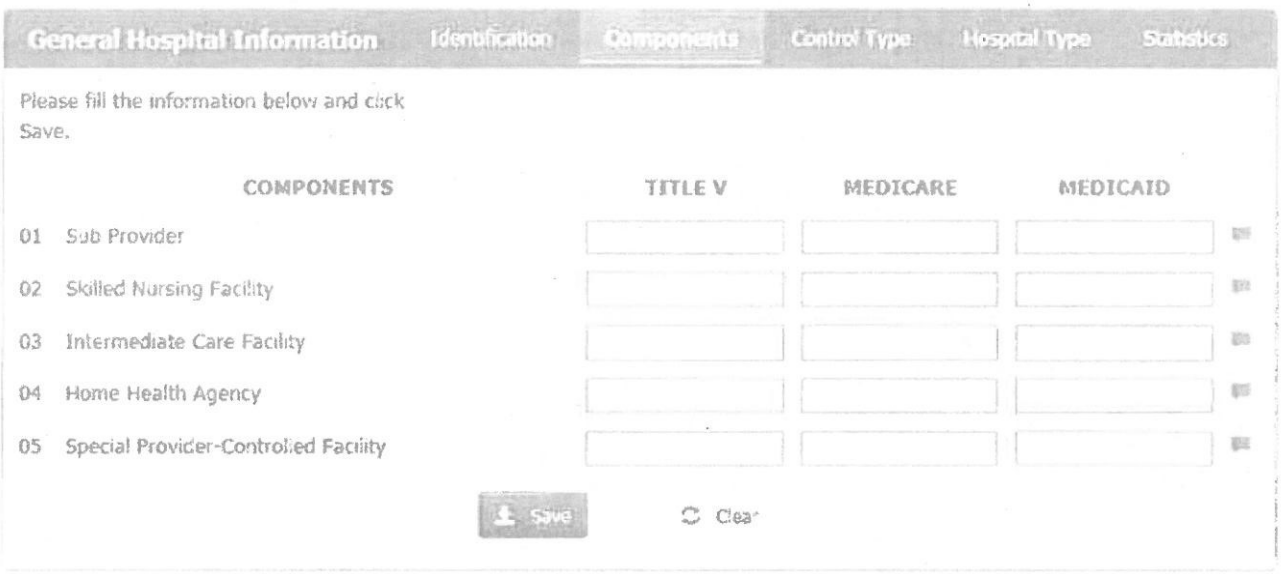


WORKSHEET – A-1 GENERAL HOSPITAL INFORMATION CONTINUED-

SECTION ~~2~~ – HOSPITAL COMPONENTS

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~~ – CONTROL TYPE

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 – HOSPITAL TYPE:

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.

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.

Enter a check mark in the 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, click N/A.

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


General Hospital Information
Identification
Components
Control Type
Hospital Type
Statistics
Please fill the information below and click Save.
Type of Hospital:
-- Select --
Major Organ Transplant:
Yes
No
Accreditation:
Yes
No
N/A
Save
Clear

WORKSHEET – A-1 GENERAL HOSPITAL INFORMATION CONTINUED-

SECTION

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 neurosurgery cases performed during the reporting period.
h. 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.

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:

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.