

General Hospital Information (Worksheet A-1)

Submission #:

Facility #:

Reporting Period :

Version:

Identification:

Title V:

Medicare:

Medicaid:

Hospital Name:

Street Address:

City:

County:

Zip Code:

Name of Preparer:

Address of Preparer:

Hospital Contact Person:

Title:

Phone:

Fax:

Email Address:

Components:

Line #	Component	Title V	Medicare	Medicaid
01	Sub Provider			
02	Skilled Nursing Facility			
03	Intermediate Care Facility			
04	Home Health Agency			
05	Special Provider-Controlled Facility			

Control Type:

Type of Control:

Name of Controlling Organization:

Name of Owner:

HospitalType:

Type of Hospital:

Major Organ Transplant

Accreditation:

Statistics:

Code	Description	Total
a	Bone Marrow Transplants	
b	Open-Heart Cases	
c	Heart Transplants	
d	Kidney Transplants	
e	Liver Transplants	
f	Lung Transplants	
g	Neurosurgery Cases	
h	Radiation Therapy Cancer Cases	

General Hospital Information (Worksheet A-1)

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SERVICE INVENTORY AND UNITS OF SERVICE REPORT (Worksheet A-2)

Submission

Facility #:

Reporting Period :

Version:

Line #	Service Name	Account #	Service Code	Description	Amount
01	Psychiatric Acute Care	6210	7	Days	
02	Substance Abuse-Detoxification Unit	6220	7	Days	
03	Medical/Surgical Intensive Care Unit	6310	7	Days	
04	Coronary Care Unit	6330	7	Days	
05	Medical/Surgical/Coronary ICU's (Combined)	6310-6330	7	Days	
06	Neonatal Intensive Care Unit	6370	7	Days	
07	Burn Intensive Care Unit	6380	7	Days	
08	Skilled Nursing Care-Medicare/Medicaid Cert.	6610	7	Days	
09	Residential Care	6660	7	Days	
10	Emergency Services (24-Hour/In-house M.D.)	6710	7	Visits	
11	Emergency Services (24-Hour/M.D. On-call)	6710	7	Visits	
12	Clinic Services	6720	7	Visits	
13	Home Dialysis Services	6820	7	Patient Weeks	
14	Ambulatory Surgery Services	6830	7	Minutes	
15	Ambulance Services	6850	7	Trips	
16	Free Standing Clinic Services	6870	7	Visits	
17	Psychiatric Day Care Program	6890	7	Visits	
18	Home Health Services	6990	7	Visits	
19	Labor and Delivery Services	7010	7	Procedures	
20	Surgical Services (Total Surgery Minutes)	7040	7	Minutes	
21	Neurological Surgery (Included in Line 20)	7040	7	Minutes	
22	Open-Heart Surgery (Included in Line 20)	7040	7	Minutes	
23	Recovery Services	7060	7	Minutes	
24	Anesthesiology	7080	7	Minutes	
25	Laboratory Services	7210	7	Workload Units	
26	Blood/Plasma Collection	7250	7	Workload Units	

SERVICE INVENTORY AND UNITS OF SERVICE REPORT (Worksheet A-2)

Submission

Facility #:

Reporting Period :

Version:

Line #	Service Name	Account #	Service Code	Description	Amount
27	Blood Bank-Processing and Storage	7260	7	Workload Units	
28	Electrocardiography (ECG)	7290	7	Workload Units	
29	Cardiac Catheterization Laboratory	7310	7	Procedures	
30	Radiology/Diagnostic	7320	7	Procedures	
31	Computerized Tomography (CT)	7340	7	Procedures	
32	Magnetic Resonance Imaging (MRI)	7350	7	Procedures	
33	Radiation Therapy	7360	7	Procedures	
34	Nuclear Medicine	7380	7	Procedures	
35	Respiratory Therapy	7420	7	Treatments	
36	Physical Therapy	7510	7	Modalities	
37	Occupational Therapy	7590	7	N/A	
38	Speech Pathology	7590	7	N/A	
39	Rehabilitation Care	7590	7	N/A	
40	Renal Dialysis-Inpatient or Outpatient	7710	7	Treatments	
41	ESW Lithotripsy	7720	7	Procedures	
42	Organ Acquisition and Banking	7730	7	Organs Acquired	
43	Social Work Services (MSW Director)	8350	7	N/A	
44	Pharmacy-Full Time RPh	8470	7	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.

Bed and Utilization Statistics (Worksheet B-1)

Submission #:

Facility #:

Reporting Period :

Version:

Cost Centers

Line #	Service Name	Account #	Licensed Beds	Available Beds	Total Available Bed Days	Total Inpatient Days
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	0	0	0	0
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	0	0	0	0
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	0	0	0	0
23	Total DHS/Excluding Newborn (Lines 8, 16, and 22)	B123	0	0	0	0
24	Newborn Nursery	6510				
25	Total Daily Hospital Services (Lines 23 and 24)	B125	0	0	0	0

Bed and Utilization Statistics (Worksheet B-1)

Submission #:

Facility #:

Reporting Period :

Version: 1.01

Acute Patients

Line #	Service Name	Account #	Inpatient Days	Admissions
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	0	0

Subacute Patients

Line #	Service Name	Account #	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	0	0

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.

Psychiatric Hospital Services/Statistics (Worksheet PSY-1)

Submission #:

Facility #:

Reporting Period :

Version:

Unit Statistics

Line #	Service Name	Licensed Beds	Inpatient Days	Patients Treated	ALOS
01	Adult Psychiatric / General				
02	Child / Adolescent Psychiatric				
03	Specialized Child Psychiatric				
04	Geriatric Psychiatric				
05	Intensive Treatment (2)				
06	Adult Substance Abuse - General				
07	Child / Adolescent Substance Abuse				
08	Total Acute and Intensive Care (Lines 1 through 7)	0	0	0	0.00
09	Sub Acute Care				

Hospital Statistics

Line #	Service Name	Patients Treated
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.

MEDICAL STAFF PROFILE AND ALLIED HEALTH EDUCATION PROGRAMS (Worksheet B-4)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Clinical Specialty	Account #	Approved Program	Medical Students (FTEs)	Residents (FTEs)	Active Staff (W#s)
01	Family Practice	4500	No			
02	Psychiatry	4501	No			
03	Psychiatry, Child	4502	No			
04	Public Health / Preventive Medicines	4503	No			
05	Allergy and Immunology	4504	No			
06	Dermatology	4505	No			
07	Internal Medicine	4506	No			
08	Pediatrics	4507	No			
09	Pulmonary Diseases	4508	No			
10	Nuclear Medicine	4509	No			
11	Gastroenterology	4510	No			
12	Emergency Medicine	4511	No			
13	Endocrinology	4512	No			
14	Hematology	4513	No			
15	Infectious Diseases	4514	No			
16	Pediatric Endocrinology	4515	No			
17	Pediatric Hematology	4516	No			
18	Pediatric Nephrology	4517	No			
19	Pediatric Cardiology	4518	No			
20	Rheumatology	4519	No			
21	Nephrology	4520	No			
22	Neurology	4521	No			
23	Neonatal / Perinatal Medicine	4522	No			
24	Oncology, Medicine	4523	No			
25	Cardiovascular Diseases / Cardiology	4524	No			
26	Dental Medicine (DMD)	4560	No			
27	Podiatric Medicine / Surgery (DPM)	4561	No			
28	Otolaryngology (E.N.T.)	4562	No			
29	Ophthalmology	4563	No			
30	Obstetrics and Gynecology	4564	No			

MEDICAL STAFF PROFILE AND ALLIED HEALTH EDUCATION PROGRAMS (Worksheet B-4)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Clinical Specialty	Account #	Approved Program	Medical Students (FTEs)	Residents (FTEs)	Active Staff (W#s)
31	Urological, Medicine / Surgery	4565	No			
32	Radiology	4570	No			
33	Radiology, Diagnostic	4571	No			
34	Radiology, Diagnostic / Nuclear	4572	No			
35	Radiology, Therapeutic	4573	No			
36	Pathology	4580	No			
37	Pathology, Dermatopathology	4581	No			
38	Pathology, Blood banking	4582	No			
39	Pathology, Forensic	4583	No			
40	Pathology, Neuropathology	4584	No			
41	Anesthesiology	4592	No			
42	Surgery, General	4600	No			
43	Surgery, Oral & Maxillofacial (DDS, MD)	4601	No			
44	Surgery, Plastic	4602	No			
45	Surgery, Orthopedic	4603	No			
46	Surgery, Thoracic	4604	No			
47	Surgery, Neurological	4605	No			
48	Surgery, Cardiovascular	4606	No			
49	Other Clinical Specialties *	4998	No			
50	Totals (Lines 1 through 49)	4999	0	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 (Worksheet C-1)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Account Description	Account #	Operating Funds	Other Funds (1)	Other Funds (2)	Total Funds
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	0	0	0	0
07	Board Designated Assets	1110				
08	Donor Restricted Assets	1130				
09	Trustee Held Funds	1140				
10	Total Assets Whose Use Is Limited (Lines 7 through 9)	1199	0	0	0	0
11	Plant, Property, & Equipment	1297				
12	Less: Accumulated Depreciation	1298				
13	Net Plant, Property, & Equipment	1299	0	0	0	0
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	0	0	0	0
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	0	0	0	0
25	Deferred Credits and Other Liabilities*	2140				
26	Mortgages Payable / FHA	2210				

BALANCE SHEET (Worksheet C-1)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Account Description	Account #	Operating Funds	Other Funds (1)	Other Funds (2)	Total Funds
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	0	0	0	0
36	Total Liabilities (Lines 24, 25 and 35)	2998	0	0	0	0
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	0	0	0	0
43	Total Liabilities and Net Assets (Lines 36 & 42)	2999	0	0	0	0
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.

STATEMENT OF PATIENT CARE SERVICES REVENUE (Worksheet C-3)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Account Description	Account #	Inpatient Revenue	Outpatient Revenue	Total Revenue
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	0	0	0
21	Emergency Services	3710			
22	Clinic Services	3720			
23	Home Dialysis Program	3820			
24	Ambulatory Surgery Services	3830			
25	Ambulance Services	3850			

STATEMENT OF PATIENT CARE SERVICES REVENUE (Worksheet C-3)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Account Description	Account #	Inpatient Revenue	Outpatient Revenue	Total Revenue
26	Other Ambulatory Services *	3860			
27	Free Standing Clinic	3870			
28	Home Health Services	3990			
29	Total Ambulatory Services	C337	0	0	0
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			

STATEMENT OF PATIENT CARE SERVICES REVENUE (Worksheet C-3)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Account Description	Account #	Inpatient Revenue	Outpatient Revenue	Total Revenue
52	Other Ancillary Services *	4910			
53	Total Ancillary Services (Lines 30 through 52)	C369	0	0	0
54	Total Patient Care Services (Lines 20, 29, & 53)	C370	0	0	0

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

REVENUE BY PAYOR CLASSIFICATION (Worksheet C-3a)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Account Description	Acct #	Inpatient Revenue	Outpatient Revenue	Total Patient Revenue	Inpatient Deductions	Outpatient Deductions	Total Deductions	Net Inpatient Revenue	Net Outpatient Revenue	Total Net Patient Revenue
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									

REVENUE BY PAYOR CLASSIFICATION (Worksheet C-3a)

Submission #: _____

Facility #: _____

Reporting Period: _____

Version: _____

Line #	Account Description	Acct #	Inpatient Revenue	Outpatient Revenue	Total Patient Revenue	Inpatient Deductions	Outpatient Deductions	Total Deductions	Net Inpatient Revenue	Net Outpatient Revenue	Total Net Patient Revenue
18	Restricted Funds for Indigent Care	5995									
19	Total Revenue and Deductions	C003	0	0	0	0	0	0	0	0	0
20	Radiation Therapy Revenue	4900									
21	Adjusted Revenue And Deductions	C035	0	0	0	0	0	0	0	0	0
22	Total HMO/PPO Payment	C004			0			0			0

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

STATEMENT OF OTHER OPERATING AND NON-OPERATING REVENUE (Worksheet C-4)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Description	Account #	Revenue Amount
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	0
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	

STATEMENT OF OTHER OPERATING AND NON-OPERATING REVENUE (Worksheet C-4)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Description	Account #	Revenue Amount
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 21 through 33)	C441	0

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

STATEMENT OF PATIENT CARE SERVICES EXPENSE (Worksheet C-5)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Description	Account #	Salaries and Wages	Other Expense	Total Expense	FTEs
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	0	0.0
21	Emergency Services	6710				
22	Clinic Services	6720				
23	Home Dialysis Program	6820				
24	Ambulatory Surgery Services	6830				
25	Ambulance Services	6850				

STATEMENT OF PATIENT CARE SERVICES EXPENSE (Worksheet C-5)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Description	Account #	Salaries and Wages	Other Expense	Total Expense	FTEs
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	0	0.0
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				

STATEMENT OF PATIENT CARE SERVICES EXPENSE (Worksheet C-5)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Description	Account #	Salaries and Wages	Other Expense	Total Expense	FTEs
52	Other Ancillary Services *	7910				
53	Total Ancillary Services (Lines 30 through 52)	C569	0	0	0	0.0
54	Total Patient Care Services (Lines 20, 29 & 53)	C570	0	0	0	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 NON-OPERATING EXPENSE (Worksheet C-6)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Description	Account #	Salaries	Other Expense	Total Expense	FTEs
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				

STATEMENT OF OTHER OPERATING AND NON-OPERATING EXPENSE (Worksheet C-6)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Description	Account #	Salaries	Other Expense	Total Expense	FTEs
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	0	0.0
38	Professional Office Building Expense	9210				
39	Other Non-operating Expense *	9250				
40	Total Non-operating Expense (Lines 38 and 39)	C641	0	0	0	0.0
41	Total Hospital Expense (Lines 37, 40, & 54, C5)	C642	0	0	0	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 (Worksheet X-1)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Description	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	0

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 (Worksheet X-4)

Submission #: Facility #:

Reporting Period : - Version:

Line #	Worksheet	Error Message	Explanation
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INCOME AND EXPENSE STATEMENT (Worksheet C-2)

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Description	Amount
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)	
04	Total Deductions from Revenue (Worksheet C-3a, ACCT, C003, Col(6))	
05	Net Patient Care Revenue (Line 3 - Line 4)	0
06	Other Operating Revenue (Worksheet C-4, Col(1), Line 20)	
07	Total Operating Revenue (Line 5 + Line 6)	0
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)	0
13	Operating Margin (Line 7 - Line 12)	0
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)	0
17	Total Margin B/F Income Taxes & Extraordinary Items (Line 13 + Line 16)	0
18	Provision for Incomes Taxes	
19	Extraordinary Gains *	
20	Extraordinary Losses *	
21	Total Extraordinary Items (Lines 19 + 20)	0
22	Total Margin (Line 17 + 18 + 21)	0

* DETAIL ON WORKSHEET X-4

FINANCIAL STATEMENT AUDIT

Submission #:

Facility #:

Reporting Period :

Version:

Line #	Description	Calculated Amount	Audited Amount	Difference	Unreconciled Amount
01	Current Assets (Worksheet C-1, Col(4), Line 06)		0	0	0
02	Net PP&E (Worksheet C-1, Col(4), Line 13)	0	0	0	0
03	Total Assets (Worksheet C-1, Col(4), Line 20)	0	0	0	0
04	Current Maturities on Long-Term Debt Reported (Worksheet C-1, Col(1), Line 44)		0	0	0
05	Current Liabilities (Worksheet C-1, Col(4), Line 24)		0	0	0
06	Total Liabilities (Worksheet C-1, Col(4), Line 36)		0	0	0
07	Total Liabilities and Net Assets (Worksheet C-1, Col(4), Line 43)		0	0	0
08	Net Patient Care Revenue (Worksheet C-2, Line 5)	0	0	0	0
09	Total Operating Expense (Worksheet C-2, Line 12)	0	0	0	0
10	Total Margin (Worksheet C-2, Line 22)	0	0	0	0
11	Provision of Bad Debt (Worksheet C-3a, Col(6), Line 01)		0	0	0
12	Charity Care (Worksheet C-3a, Col(6), Line 03 and 04)		0	0	0
13	Depreciation and Amortization (Worksheet C-6, Col(3), Line 30 and 30a)		0	0	0
14	Interest (Worksheet C-6, Col(3), Line 35 and 36)		0	0	0
15	Salaries and Benefits (Worksheet C-5, Col(1), Line 54 + C-6, Col(1), Line 37 + X-1, Line 12)	0	0	0	0

ERRORS IN SUBMISSION

Submission #: Facility #:

Reporting Period : - Version:

Line #	Worksheet	Error Message
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