

Department of Health Care Access and Information
ACCOUNTING AND REPORTING MANUAL FOR CALIFORNIA HOSPITALS

QUARTERLY REPORTING REQUIREMENTS

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GENERAL INSTRUCTIONS FOR COMPLETING QUARTERLY REPORT **8100**
(Rev. 12/31/2023)

The following rules apply to completing and submitting the quarterly financial and utilization report:

1. In order to be considered complete, the report must be correctly filled out in accordance with the instructions herein and in conformance with the definitions of the account descriptions contained in this Manual.
2. All amounts shall be reported to the nearest dollar. Rounding amounts to the nearest ten, hundred, or thousand is not acceptable.
3. A hospital that receives the preponderance of its revenue from associated comprehensive group practice prepayment health care service plans and that is operated as a unit of a coordinated group of health facilities under common management may provide financial data for lines 1000 through 1170 on a group basis.

DETAILED INSTRUCTIONS FOR COMPLETING QUARTERLY REPORT **8200**
(Rev. 12/31/2023)

1. SIERA will enter the name of the person completing the report, that person's phone number, fax number and e-mail address in items 6 and 7 based on the information submitted to the Office in SIERA. This person will be contacted by the Office if there are any questions about the report. If data in items 6, or 7 are incorrect, enter the correct information.
2. SIERA will enter the name of the chief executive officer (administrator) and the hospital's main business phone number in items 8 and 9. If the data in these items are incorrect, enter the correct information.
3. SIERA will enter the complete phone number of the hospital's disaster coordinator in item 10. If the data in item 10 is incorrect, enter the correct phone number. This individual is responsible for coordinating the hospital's disaster preparedness programs.
4. For lines 25 through 1170, enter the appropriate financial and utilization data pertaining to the quarter being reported.

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NOTE: If you have been granted permission to file a quarterly report based on your 13-period accounting cycle, be sure that utilization data are also provided for the same reporting period.

5. Enter on line 25 the number of licensed beds (excluding bassinets) stated on the facility license as of the last day of the reporting period. Do not include licensed beds placed in suspense.
6. Enter on line 30 the average number of available beds (excluding bassinets) during the reporting period. Available beds are defined as the daily average complement of beds physically existing and actually available for overnight use, regardless of staffing levels. Do not include beds placed in suspense or in nursing units converted to uses other than inpatient overnight accommodations which cannot be placed back into service within 24 hours.

The number of available beds may be and often is less than the number licensed. On occasion, such as pending license application for a new inpatient service or when placing licensed beds into suspense, the average number of available beds for the reporting period may exceed the number of licensed beds at the end of the reporting period.

7. Enter on line 35 the daily average complement of beds fully staffed (excluding bassinets) during the quarter. Staffed beds are those beds set up, staffed, equipped and in all respects ready for use by patients remaining in the hospital overnight. The number of staffed beds is usually less than the number of available beds, since hospitals typically staff for those beds currently occupied by inpatients, plus an increment for unanticipated admissions.
8. Enter on lines 50 through 95 by payor (Medicare - Traditional, Medicare - Managed Care, Medi-Cal - Traditional, Medi-Cal - Managed Care, County Indigent Programs - Traditional, County Indigent Programs - Managed Care, Other Third Parties - Traditional, Other Third Parties - Managed Care, Other Indigent, and Other Payors) the number of hospital discharges from all Daily Hospital Services cost centers, including Long-Term Care (LTC) patients discharged during the reporting period. SIERA will enter on line 100 the sum of lines 50 through 95. These are the total number of discharges as defined in Section 4120 of the Manual. Do not include nursery patients discharged from the nursery.

Discharges are to be reported by primary payor, or that payor who is responsible for the predominant portion of the patient's bill. The primary payor may be different than the expected source of payment at the time of discharge. Do not allocate discharges by payor based on the ratio of patient (census) days or gross inpatient revenue.

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See Section 4120 of the Manual for more information on the definition of a hospital discharge.

NOTE: Managed care patients are patients enrolled in a managed care plan to receive health care from providers on a pre-negotiated or per diem basis, usually involving utilization review (includes Health Maintenance Organizations, Health Maintenance Organizations with Point-of-Service option (POS), Preferred Provider Organizations, Exclusive Provider Organizations, Exclusive Provider Organizations with Point-of-Service option, etc.).

The Medicare - Traditional category includes patients covered under the Social Security Amendments of 1965. These patients are primarily the aged and needy.

The Medicare - Managed Care category includes patients covered by a managed care plan funded by Medicare.

The Medi-Cal - Traditional category includes patients who are qualified as needy under state laws.

The Medi-Cal - Managed Care category includes patients covered by a managed care plan funded by Medi-Cal.

The County Indigent Programs - Traditional category includes indigent patients covered under Welfare and Institution Code Section 17000. Also included are patients paid for in whole or in part by the County Medical Services Program (CMSP), California Health Care for Indigent Program (CHIP or tobacco tax funds), and other funding sources whether or not a bill is rendered. This category also includes indigent patients who are provided care in county hospitals, or in certain non-county hospitals where no county-operated hospital exists, whether or not a bill is rendered.

The County Indigent Programs - Managed Care category includes indigent patients covered under Welfare and Institution Code Section 17000 and are covered by a managed care plan funded by a county.

The Other Third Parties - Traditional category includes all other forms of health coverage excluding managed care plans. Examples include Short-Doyle, Tricare (CHAMPUS), IRCA/SLIAG, Children's Medical Services, indemnity plans, fee-for-service plans, and Workers' Compensation. Children's Medical Services includes the following state programs: California Children's Services (CCS), Child Health Disability Prevention (CHDP), Genetically Handicapped Persons Program (GHPP), Newborn Hearing Screening Program, and Medically Vulnerable Infant Program (MVIP).

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The Other Third Parties - Managed Care category includes patients covered by managed care plans other than those funded by Medicare, Medi-Cal, or a county. Include patients covered by the Healthy Families Program.

The Other Indigent category includes indigent patients, excluding those who are recorded in the County Indigent Programs category and including those who are being provided charity care by the hospital and U.C. teaching hospital patients who are provided care with Support for Clinical Teaching funds.

The Other Payors category includes all patients who do not belong in the categories listed above, such as those designated as self-pay.

9. Enter LTC Discharges for the reporting period on line 105. This is an optional item. Hospitals which provide skilled nursing care, intermediate care, transitional inpatient care (SNF Beds), sub-acute care, and other long-term care services are encouraged to report LTC Discharges so that comparable average lengths of stay can be calculated. LTC also includes skilled nursing care provided in swing beds.
10. Enter on lines 150 through 195 the number of census patient days by payor for all Daily Hospital Services cost centers, including LTC patient (census) days, for the reporting period. Count the day of formal admission, but not the day of discharge as a patient (census) day. Count as one day, each patient formally admitted and discharged on the same day. Do not include nursery days or purchased inpatient days. Do not allocate patient (census) days by payor based on the ratio of discharges or gross inpatient revenue. On line 200, SIERA will enter the sum of lines 150 through 195.
11. Enter LTC Patient (Census) Days for the reporting period on line 205. This is an optional item. Hospitals which provide long-term care services, as defined in step 13, and reported LTC Discharges on line 105, are encouraged to report this item.
12. Enter on lines 250 through 295 the number of outpatient visits by payor for the reporting period. Section 4130 of the Manual provides detailed definitions for all outpatient visits. Do not include purchased outpatient visits. Please refer to Section 4130 to assure that all outpatient visit information is being properly recorded and reported.
13. Enter Gross Inpatient Revenue by payor on lines 350 through 395. These amounts are the total inpatient charges, including PPC charges, at the hospital's full established rates for services rendered and goods sold to inpatients during the reporting period. It includes daily hospital services, inpatient ambulatory services, and

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inpatient ancillary services. The amounts reported by payor are to be from either the general ledger or payor logs, whichever provides the most accurate data related to the primary payor. SIERA will enter the sum of lines 350 through 395 on line 400.

14. Enter Gross Outpatient Revenue by payor on lines 450 through 495. These amounts are the total outpatient charges, including PPC charges, at the hospital's full established rates for services rendered and goods sold to outpatients during the reporting period. It includes outpatient ambulatory services and outpatient ancillary services. The amounts reported by payor are to be from either the general ledger or payor logs, whichever provides the most accurate data related to the primary payor. On line 500, SIERA will enter the sum of lines 450 through 495.
15. Enter the various component amounts of the hospital's Deductions from Revenue for the reporting period on lines 545 through 615. Enter components of deductions from revenue with credit balances as negative amounts. Briefly explain in the Comments feature provided by SIERA why a credit balance appears. Complete lines 545 through 615 as follows:
 - a. Enter Provision for Bad Debts, net of bad debt recoveries, on line 545.
 - b. Enter Medicare - Traditional contractual adjustments on line 550.
 - c. Enter Medicare - Managed Care contractual adjustments on line 555.
 - d. Enter Medi-Cal - Traditional contractual adjustments on line 560.
 - e. Enter Medi-Cal - Managed Care contractual adjustments on line 565.
 - f. Enter Disproportionate Share payment adjustments related to Medi-Cal inpatients on line 566. Retroactive Disproportionate Share payments related to prior payment years are to be reported on line 840 as non-operating revenue.
 - g. Enter County Indigent Programs - Traditional contractual adjustments on line 570.
 - h. Enter County Indigent Programs - Managed Care contractual adjustments on line 575.
 - i. Enter Other Third Parties - Traditional contractual adjustments on line 580.
 - j. Enter Other Third Parties - Managed Care contractual adjustments on line 585. Report capitation premium revenue separately on lines 650 through 680.
 - k. Enter Charity - Hill-Burton amounts on line 590.
 - l. Enter Charity - Other amounts on line 595.
 - m. Enter Restricted Donations and Subsidies for Indigent Care on line 600.

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County hospitals are to report Realignment Funds that do not relate directly to patient care on line 840, Non-Operating Revenue Net of Non-Operating Expenses. Realignment Funds used for specific patients are to be credited against their accounts receivable. Realignment Funds that are used for direct patient care, but not for specific patients, are to be reported on line 570, County Indigent Programs - Traditional contractual adjustments. In essence, these last two entries reduce the County Indigent Programs - Traditional contractual adjustments account.

- n. U.C. teaching hospitals are to enter Teaching Allowances and Support for Clinical Teaching on lines 605 and 610.
- o. Enter on line 615 policy discounts, administrative adjustments, and other adjustments and allowances, not specified above.

SIERA will enter the sum of lines 545 through 615 on line 620. This is the sum of all deductions from revenue, net of Disproportionate Share Payments, line 566; Restricted Donations and Subsidies for Indigent Care, line 600; and Support for Clinical Teaching, line 610.

Deductions from revenue must be matched against related gross patient revenue within each quarterly reporting period. Most contractual arrangements with purchasers of health care services allow for the reasonable estimation and recording of deductions from revenue when the contractual purchaser is billed. To record deductions from revenue when claims are paid results in a mismatching of deductions from revenue and gross patient revenue, unless payments for such claims are received within the same reporting period. Prior period cost settlements are to be recorded and reported in the reporting period in which they are paid or received.

Refer to Sections 1400 and 2410.5 of the Manual for more information regarding Charity Care and definitions of the components of deductions from revenue.

- 16. Enter Capitation Premium Revenue by payor on lines 650 through 680. SIERA will enter the sum of lines 650 through 680 on line 700.
- 17. Enter Net Patient Revenue by payor on lines 750 through 795. Net patient revenue by payor is defined as gross inpatient revenue plus gross outpatient revenue plus capitation premium revenue minus related deductions from revenue. When entering Net Patient Revenue by payor, be sure to apply related bad debts and charity care to that payor category. SIERA will enter on line 800 the sum of lines 750 through 795. Total Net Patient Revenue on line 800 must also equal line 400 plus line 500 plus line 700 minus line 620.

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18. Enter Other Operating Revenue on line 810. This amount represents revenue related to health care operations, but not from patient care services. Examples include non-patient food sales, rebates and refunds, purchase discounts, supplies and drugs sold to non-patients, Medical Records abstract sales, and Reinsurance Recoveries. Section 2410.4 of the Manual provides a detailed list and descriptions of Other Operating Revenue accounts.
19. Enter Total Operating Expenses on line 830. This amount consists of all operating expenses incurred by the hospital for the reporting period accrued to the end of the reporting period. This includes daily hospital services, ambulatory services, ancillary services, purchased inpatient services, purchased outpatient services, research, education, general services, fiscal services, administrative service, and other unassigned costs. If the physicians' professional component (all amounts paid to hospital-based physicians and residents for patient care) is recorded as an expense, it must be included in this amount. Non-operating expenses and provisions for income taxes are excluded. Do not reduce operating expenses by Other Operating Revenue.
20. Enter Depreciation and Amortization Expense from Operations on line 833. This should be the total for subclassifications .71, .72, .73, and .74 for Operating Expense Accounts.

See Section 2420.4 through 2420.9 of the Manual for a detailed description of Operating Expense Accounts, and Section 2440.6 for a list of Depreciation and Amortization Expense Classifications.
21. Line 835, Physicians' Professional Component Expenses, is an optional reporting item. However, hospitals are encouraged to report this amount as it will allow a better indication of the change in Total Operating Expenses. Enter on line 835 the physicians' professional component (PPC) expenses included in the physicians' total compensation. This includes all amounts paid or to be paid to hospital-based physicians and residents for patient care and recorded as an expense of the hospital for the reporting period.
22. Enter Non-operating Revenue Net of Non-operating Expenses on line 840. If non-operating expenses are greater than non-operating revenue, enter the amount as a negative number (with brackets). Non-operating items are those revenue and expenses that do not relate directly to the provision of health care services. Examples include gains and losses on the disposal of assets; income, gains and losses from unrestricted investments; revenue and expenses associated with Medical Office Buildings; and various governmental assessments, taxes (excluding income taxes), and appropriations.

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See Section 2420.10 of the Manual for a detailed list and descriptions of Non-Operating Revenue and Expense accounts.

23. On lines 850 through 860, enter the discharges, patient (census) days, and expenses associated with Purchased Inpatient Services. These are optional data items. Purchased Inpatient Services expenses are incurred by the purchasing hospital when inpatient services, including ancillary services, are provided by another hospital for patients who are the responsibility of the purchasing hospital. The patients are not formally admitted as inpatients to the purchasing hospital, but are admitted to the hospital providing the inpatient services. This situation may arise due to managed care contract requirements or the lack of appropriate medical technology at the facility purchasing the services. See Section 1250 of the Manual for additional information.
24. On line 870, enter the outpatient expenses associated with Purchased Outpatient Services. This is an optional item. Purchased Outpatient Services expenses are incurred by the purchasing hospital when outpatient services are provided by another hospital for patients who are the responsibility of the purchasing hospital. The patients are not registered as outpatients of the purchasing hospital, but are registered outpatients of the hospital providing the outpatient services. This situation may arise due to managed care contract requirements or the lack of appropriate medical technology at the facility purchasing the services. See Section 1250 of the Manual for additional information.
25. Line 900, Disproportionate Share Funds transferred to Related Public Entity, relate to county, University of California, and district hospitals only and is an optional reporting item. For applicable hospitals, enter on line 900 the amount of disproportionate share funds transferred or to be transferred to the related public entity for the current quarterly period.

NOTE: The following are unrestricted fund balance sheet items. Do not include restricted fund items in these balances.

26. On line 1000, enter unrestricted Cash (Accounts 1000-1009). Remember that negative cash balances must be reported as other current liabilities.
27. On line 1005, enter Marketable Securities (Accounts 1010-1019).
28. On line 1010, enter the sum of all Other Current Assets (Accounts 1020-1109). Allowance for Uncollectible Receivables and Third-Party Contractual Withholds (Accounts 1040-1049) must be offset against the rest of other current assets.

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SIERA will enter the Total Current Assets (sum of lines 1000 through line 1010) on line 1020.

29. On line 1030, enter board designated (or appropriated) unrestricted Limited Use Cash (Accounts 1110-1119).
30. On line 1035, enter board designated (or appropriated) unrestricted Limited Use Investments (Accounts 1120-1129).
31. On line 1040, enter board designated (or appropriated) unrestricted Limited Use Other Assets (Accounts 1130-1139).

SIERA will enter the Total Assets Whose Use is Limited (sum of lines 1030 through 1040) on line 1045.

32. On line 1050, enter the historical cost of Property, Plant, and Equipment (Accounts 1200-1249). Amounts must be the historical cost of the assets as appropriate under Generally Accepted Accounting Principles.
33. On line 1055, enter the Accumulated Depreciation and Amortization (based on historical cost) for all Property, Plant, and Equipment assets (Accounts 1260-1299). Enter the amount as a positive number.

SIERA will enter Net Total Property, Plant, and Equipment (line 1050 minus line 1055) on line 1060.

34. On line 1065, enter the Construction in Progress (Accounts 1250-1259).
35. On line 1070, enter Total Investments and Other Assets (Accounts 1310-1359). Accumulated Depreciation on Investment in Plant and Equipment (Account 1320-1329) must be offset against the asset balance.
36. On line 1080, enter the Total Intangible Assets (Accounts 1360-1399). This amount should be reported net of any accumulated amortization of the assets.

SIERA will enter the Total Assets (sum of lines 1020, 1045, 1060, 1065, 1070, and 1080). This amount must match the amount reported on line 1170.

37. Enter the amount of Total Capital Expenditures made during the reporting period on line 1095. Capital expenditures are defined as all additions to property, plant and equipment, including amounts which have the effect of increasing the capacity, efficiency, lifespan, or economy of operation of an existing capital asset.

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These are the expenditures recorded under the property, plant and equipment accounts of the balance sheet, and are subject to depreciation or amortization. (Amounts used for acquiring land for hospital operations must be included here although land does not depreciate.)

Be sure to include all capitalized leases and construction-in-progress in addition to purchased property, plant and equipment. Do not reduce capital expenditures to reflect accrued depreciation expense or the disposal of capital assets; or include capital expenditures associated with Medical Office Buildings.

38. On line 1100, enter the Current Liabilities (Accounts 2010-2109).
39. Current maturities of long-term debt are entered on line 1105. This amount must match the amount reported on line 1135.

SIERA will enter the Total Current Liabilities (line 1100 plus line 1105) on line 1110.

40. On line 1120, enter the Total Deferred Credits (Accounts 2110-2139).
41. Enter the unpaid principal (including current maturity amounts) for Total Long-Term Debt (Accounts 2210-2279) on line 1130.
42. Enter the current maturities (principal amounts due within one year of the end of the reporting period) of long-term debt on line 1135 as a positive amount. This amount must match the amount reported on line 1105.

SIERA will enter Net Long-Term Debt (line 1130 minus line 1135) on line 1140.

SIERA will enter Total Liabilities (sum of lines 1110, 1120, and 1140) on line 1150.

43. On line 1160, enter Total Equity (Accounts 2310-2750).

SIERA will enter Total Liabilities and Equities (line 1150 plus 1160) on line 1170. This amount must match the amount reported on line 1090.

44. Enter any comments you may have using the comments feature provided by SIERA, especially if SIERA has flagged potential data errors during the validation process, or if there has been a significant change in patient care services since the previously filed report.

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REPORTING FORM

8300

(Rev. 12/31/2023)

The following is a reproduction of the Quarterly Financial and Utilization Report.

HOSPITAL QUARTERLY FINANCIAL AND UTILIZATION REPORT				HCAI Use Only: 106 _____	
				Filed Date: _____ PM ___ FAX ___	
1. Facility DBA (Doing Business As) Name:			2. HCAI Facility No.:		
3. Street Address:		4. City:		5. Zip Code:	
6. Report Prepared By:			7. Preparer's Phone: () Ext:		
8. Chief Executive Officer (Administrator):		9. Main Hospital Phone: ()		10. Disaster Coordinator's Phone: () Ext:	
Line No.	(1) Report Period	Report Due Date	(2) Original	(3) Revised (Check One)	
19.	(Specify: Month/Day/Year) Begin Date: ____/____/____	Within 45 days of the end of the corresponding calendar quarter.			
20.	End Date: ____/____/____				
21.	Is this report based on a 13-period accounting cycle?				[] Yes [] No
UTILIZATION DATA ITEMS					QUARTER
25.	Licensed Beds (end of report period - excluding bassinets and beds in suspense)				
30.	Available Beds (average for report period - excluding bassinets and beds in suspense)				
35.	Staffed Beds (average for report period - excluding bassinets and beds in suspense)				
Hospital Discharges (excluding nursery discharges)					
50.	Medicare - Traditional				
55.	Medicare - Managed Care				
60.	Medi-Cal - Traditional				
65.	Medi-Cal - Managed Care				
70.	County Indigent Programs - Traditional				
75.	County Indigent Programs - Managed Care				
80.	Other Third Parties - Traditional				
85.	Other Third Parties - Managed Care				
90.	Other Indigent				
95.	Other Payors				
100.	Total Hospital Discharges (sum of lines 50 thru 95)				
105.	Long-term Care (LTC) Discharges (included in lines 50 thru 100) (Optional)**				
Patient (Census) Days (excluding nursery patient (census) days)					
150.	Medicare - Traditional				
155.	Medicare - Managed Care				
160.	Medi-Cal - Traditional				
165.	Medi-Cal - Managed Care				
170.	County Indigent Programs - Traditional				
175.	County Indigent Programs - Managed Care				
180.	Other Third Parties - Traditional				
185.	Other Third Parties - Managed Care				
190.	Other Indigent				
195.	Other Payors				
200.	Total Patient (Census) Days (sum of lines 150 thru 195)				
205.	Long-term Care (LTC) Patient (Census) Days (included in lines 150 thru 200) (Optional)**				

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** The reporting of this item is optional.

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HOSPITAL QUARTERLY FINANCIAL AND UTILIZATION REPORT (Cont'd)

Facility DBA Name:		Quarter Ending:	HCAI Facility No.:
Line No.	UTILIZATION DATA ITEMS (Cont'd)	QUARTER	
	Outpatient Visits (including ER, Clinic, Referred, Home Health Visits, and Day Care Days)		
250.	Medicare - Traditional		
255.	Medicare - Managed Care		
260.	Medi-Cal - Traditional		
265.	Medi-Cal - Managed Care		
270.	County Indigent Programs - Traditional		
275.	County Indigent Programs - Managed Care		
280.	Other Third Parties - Traditional		
285.	Other Third Parties - Managed Care		
290.	Other Indigent		
295.	Other Payors		
300.	Total Outpatient Visits (sum of lines 250 thru 295)		
FINANCIAL DATA ITEMS - INCOME STATEMENT			
	Gross Inpatient Revenue (including PPC charges)		
350.	Medicare - Traditional		\$
355.	Medicare - Managed Care		
360.	Medi-Cal - Traditional		
365.	Medi-Cal - Managed Care		
370.	County Indigent Programs - Traditional		
375.	County Indigent Programs - Managed Care		
380.	Other Third Parties - Traditional		
385.	Other Third Parties - Managed Care		
390.	Other Indigent		
395.	Other Payors		
400.	Total Gross Inpatient Revenue (sum of lines 350 thru 395)		\$
	Gross Outpatient Revenue (including PPC charges)		
450.	Medicare - Traditional		\$
455.	Medicare - Managed Care		
460.	Medi-Cal - Traditional		
465.	Medi-Cal - Managed Care		
470.	County Indigent Programs - Traditional		
475.	County Indigent Programs - Managed Care		
480.	Other Third Parties - Traditional		
485.	Other Third Parties - Managed Care		
490.	Other Indigent		
495.	Other Payors		
500.	Total Gross Outpatient Revenue (sum of lines 450 thru 495)		\$
	Deductions from Revenue		
545.	Provision for Bad Debts (including bad debt recoveries)		\$
550.	Medicare - Traditional Contractual Adjustments		
555.	Medicare - Managed Care Contractual Adjustments		
560.	Medi-Cal - Traditional Contractual Adjustments		
565.	Medi-Cal - Managed Care Contractual Adjustments		
566.	Disproportionate Share Payments for Medi-Cal Patient Days (SB 855)		()
570.	County Indigent Programs - Traditional Contractual Adjustments		
575.	County Indigent Programs - Managed Care Contractual Adjustments		
580.	Other Third Parties - Traditional Contractual Adjustments		
585.	Other Third Parties - Managed Care Contractual Adjustments		
590.	Charity - Hill-Burton		
595.	Charity - Other		
600.	Restricted Donations and Subsidies for Indigent Care		()
605.	Teaching Allowance (for U.C. teaching hospitals only)		
610.	Clinical Teaching Support (for U.C. teaching hospitals only)		()
615.	Other Adjustments and Allowances		
620.	Total Deductions from Revenue (sum of lines 545 thru 615)		\$

HOSPITAL QUARTERLY FINANCIAL AND UTILIZATION REPORT (Cont'd)

Facility DBA Name:		Quarter Ending:	HCAI Facility No.:
Line No.	FINANCIAL DATA ITEMS - INCOME STATEMENT (Cont'd)		QUARTER
	Capitation Premium Revenue		
650.	Capitation Premium Revenue - Medicare		\$
660.	Capitation Premium Revenue - Medi-Cal		
670.	Capitation Premium Revenue - County Indigent Programs		
680.	Capitation Premium Revenue - Other Third Parties		
700.	Total Capitation Premium Revenue (sum of lines 650 thru 680)		\$
	Net Patient Revenue (Gross Patient Revenue less Deductions from Revenue plus Capitation Revenue)		
750.	Medicare - Traditional		\$
755.	Medicare - Managed Care		
760.	Medi-Cal - Traditional		
765.	Medi-Cal - Managed Care		
770.	County Indigent Programs - Traditional		
775.	County Indigent Programs - Managed Care		
780.	Other Third Parties - Traditional		
785.	Other Third Parties - Managed Care		
790.	Other Indigent		
795.	Other Payors		
800.	Total Net Patient Revenue (sum of lines 750 thru 795) (Line 400 + line 500 - line 620 + line 700)		\$
810.	Other Operating Revenue		\$
830.	Total Operating Expenses (including PPC expenses reported in line 835)		\$
833.	Depreciation and Amortization Expense from Operations (included in line 830)		\$
835.	Physician Professional Component Expenses (PPC)**		\$
840.	Nonoperating Revenue Net of Nonoperating Expenses		\$
	Purchased Inpatient Services		
850.	Discharges (Not included in lines 50 thru 100)**		
855.	Patient Days (Not included in lines 150 thru 200)**		
860.	Expenses (included in line 830)**		\$
	Purchased Outpatient Services		
870.	Expenses (included in line 830)**		\$
900.	Disproportionate Share Funds Transferred to Related Public Entity**		\$
	FINANCIAL DATA ITEMS - UNRESTRICTED BALANCE SHEET		
	Current Assets		
1000.	Cash		\$
1005.	Marketable Securities		
1010.	Other Current Assets		
1020.	Total Current Assets (sum of lines 1000 thru 1010)		\$
	Assets Whose Use is Limited		
1030.	Limited Use Cash		\$
1035.	Limited Use Investments		
1040.	Limited use other assets		
1045.	Total Assets Whose Use is Limited (sum of lines 1030 thru 1040)		\$
	Property, Plant, and Equipment - At Cost		
1050.	Total Property, Plant, and Equipment		\$
1055.	Less Accumulated Depreciation and Amortization		
1060.	Net Total Property, Plant, and Equipment (line 1050 minus line 1055)		\$
1065.	Construction In Progress		\$
	Investments and Other Assets		
1070.	Total Investments and Other Assets		\$
	Intangible Assets		
1080.	Total Intangible Assets		\$
1090.	Total Assets (sum of Lines 1020, 1045, 1060, 1065, 1070, and 1080)		\$
	Other Information		
1095.	Total Capital Expenditures (excluding disposal of assets)		\$

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** The reporting of this item is optional.

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HOSPITAL QUARTERLY FINANCIAL AND UTILIZATION REPORT (Cont'd)

Facility DBA Name:		Quarter Ending:	HCAI Facility No.:
Line No.	FINANCIAL DATA ITEMS - UNRESTRICTED BALANCE SHEET (Cont'd)	QUARTER	
	Current Liabilities		
1100.	Current Liabilities		\$
1105.	Current maturities of long-term debt (must agree with line 1135)		
1110.	Total Current Liabilities (sum of lines 1100 through 1105)		
	Deferred Credits		
1120.	Total Deferred Credits		\$
	Long-Term Debt Unpaid Principle		
1130.	Total Long-Term Debt		\$
1135.	Less amount shown as current maturities		
1140.	Net Total Long-Term Debt (line 1130 minus 1135)		\$
1150.	Total Liabilities (sum of lines 1110, 1120, and 1140)		\$
	Equities		
1160.	Total Equity		\$
1170.	Total Liabilities and Equities (sum of lines 1150 and 1160)		\$

<p style="text-align: center;">QUESTIONS</p> <p>Please contact us at the following address, phone number, or Email:</p> <p>Department of Health Care Access and Information Accounting and Reporting Systems Section 2020 West El Camino Avenue, Suite 1100 Sacramento, CA 95833 Phone: (916) 326-3240 Email: financial@hcai.ca.gov</p>	<p style="text-align: center;">CERTIFICATION</p> <p>I, _____, certify under penalty of perjury that to the best of my knowledge and information, the information reported is true and correct.</p> <p>By: _____</p> <p>Title: _____ Date: _____</p>
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