QUARTERLY REPORTING REQUIREMENTS

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GENERAL INSTRUCTIONS FOR COMPLETING QUARTERLY REPORT 8100

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.

DETAILED INSTRUCTIONS FOR COMPLETING QUARTERLY REPORT 8200

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 900, 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

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payor based on the ratio of patient (census) days or gross inpatient revenue.

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),

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Genetically Handicapped Persons Program (GHPP), Newborn Hearing Screening Program, and Medically Vulnerable Infant Program (MVIP).

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 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.

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m. Enter Restricted Donations and Subsidies for Indigent Care on line 600.

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

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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.

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. 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.

21. 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.

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

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22. 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.

23. 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.

24. Enter the amount of Total Capital Expenditures made during the reporting period on line 880. 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. 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.

25. Enter the amount of Fixed Assets Net of Accumulated Depreciation at the end of the reporting period on line 885. Net fixed assets include land, land improvements, buildings and improvements, leasehold improvements, and equipment, less accumulated depreciation and amortization thereon, plus

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construction-in-progress. Do not include Medical Office Buildings.

26. 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.

27. 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

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

HOSPITAL QUARTERLY FINANCIAL AND UTILIZATION REPORT

OSHPD Use Only: 106_____
Filed Date:_____ PM___ FAX___

1. Facility DBA (Doing Business As) Name:		2. OSHPD 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 (Check One)	(3) [ ] Revised (Check One)
19. 20.	(Specify: Month/Day/Year) Begin Date: _____/_____/_____ End Date: _____/_____/_____	Within 45 days of the end of the corresponding calendar quarter.		
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)**			
	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)			

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** The reporting of this item is optional.

HOSPITAL QUARTERLY FINANCIAL AND UTILIZATION REPORT (Cont'd)

Facility DBA Name:	Quarter Ending:	OSHPD Facility No.:

Line No.	FINANCIAL DATA ITEMS	QUARTER
	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)	$
	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)	$

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HOSPITAL QUARTERLY FINANCIAL AND UTILIZATION REPORT (Cont'd)

Facility DBA Name:	Quarter Ending:	OSHPD Facility No.:

Line No.	FINANCIAL DATA ITEMS (Cont'd)	QUARTER
	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)	$
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)**	$
880.	Total Capital Expenditures (excluding disposal of assets)	$
885.	Fixed Assets Net of Accumulated Depreciation (including construction-in-progress)	$
900.	Disproportionate Share Funds Transferred to Related Public Entity**	$

** The reporting of this item is optional.

QUESTIONS

Please contact us at the following address, phone number:

Office of Statewide Health Planning and Development
Accounting and Reporting Systems Section
2020 West El Camino Avenue, Suite 1100
Sacramento, CA 95833

Phone: (916) 326-3854

CERTIFICATION

I, _____, certify under penalty of perjury that to the best of my knowledge and information, the information reported is true and correct.

By: _____

Title: _____ Date: _____