QUARTERLY REPORTING REQUIREMENTS

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QUARTERLY REPORTING REQUIREMENTS

PREFACE 8001

Section 128740 of the Health and Safety Code requires hospitals to report specified summary financial and statistical data. Quarterly financial and utilization reports must be submitted by all hospitals for each calendar quarter.

Section 97041, Title 22, of the California Code of Regulations, was amended in October 1993 to require all hospitals to submit the Office's Quarterly Financial and Utilization Report in a standard electronic format, as defined by the Office, rather than using hard-copy report forms. Quarterly reports must be completed and submitted using the Office-developed Internet Hospital Quarterly Reporting System (IHQRS) available on the Office's internet web site at the following address: www.oshpd.state.ca.us/ihqrs. The IHQRS User Guide is also available at that internet web site. The IHQRS application does not support personal computer (PC) diskette reporting. This means that hospitals must have access to an IBM-compatible PC with internet access to submit quarterly reports electronically. Hospitals must have the capability to use the IHQRS application running Microsoft Internet Explorer version 5.0 or higher under Windows 95 or later, or Windows NT operating systems.

Section 97050, Title 22, of the California Code of Regulations allows hospitals to file a request for modification to the Office's electronic quarterly reporting requirements if meeting these requirements is not cost-effective for the hospital. Such requests, if approved, would require the requesting hospital to submit the quarterly reports to the Office on hard-copy report forms.

The quarterly financial and utilization report must be completed and submitted to the Office within 45 days after the end of each calendar quarter. In order to be considered complete, all required items must be completed in accordance with the instructions and shall conform to the uniform description of accounts contained in this Manual. Any hospital which does not file the summary financial and utilization report completed as required is liable for a civil penalty of one hundred dollars ($100) a day for each day the filing of such report with the Office is delayed, considering all extension days granted by the Office.

Adjusted reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal year.

If the hospital has been granted written approval from the Office to submit quarterly financial and utilization reports on hard-copy report forms, reports must be submitted to the:

Office of Statewide Health Planning and Development
Accounting and Reporting Systems Section
400 R Street, Suite 250
Sacramento, CA 95811
FAX No. (916) 323-7675

This chapter contains a copy of the quarterly report form and instructions.

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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. The quarterly report must be completed and submitted using the Internet Hospital Quarterly Reporting System (IHQRS) within 45 days after the close of each calendar quarter. This requirement also applies to hospitals that had a change in licensee, closed, or relocated to a new facility during the quarter. In the event the report is due on a Saturday, Sunday, or Holiday, the report may be submitted on the next business day. Failure of the hospital's internet service to successfully complete and submit a report does not affect the report due date.

   The IHQRS and IHQRS User Guide can be accessed on the Office's internet web site at the following address: www.oshpd.state.ca.us/ihqrs

   The Electronic Quarterly Reporting Certification must be completed and filed with the Office before the initial quarterly report is completed and submitted using IHQRS. The person signing the certification should be aware of the contents of the report and that the certification is being made under penalty of perjury. Additional certifications are not required unless the individual who signed the certification is no longer authorized to accept responsibility for the report.

   The Quarterly Reporting Enrollment Form must be completed and submitted to the Office assigning a user identification and password associated with the hospital before the initial quarterly report can be submitted using IHQRS. Additional enrollment forms are only required to be submitted when the report preparer determines that the current enrollment information is incorrect.

   The forms above are available on the IHQRS web site noted above.

2. The Office's standard report form will not be accepted unless prior written approval has been granted by the Office. If approved, a reproduced copy of the report is acceptable if legible and includes an original signature. For your convenience, the Office will accept approved hard-copy reports transmitted by telecopier (FAX No. 916-323-7675) if the certification is signed. Reports which are not legible will be returned for recopying. The original report will be requested if the faxed report is not legible. The original report is not required if it has already been sent by telecopier.

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3. 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.

4. All amounts shall be reported to the nearest dollar. Rounding amounts to the nearest ten, hundred, or thousand is not acceptable.

5. Any hospital which does not file the report completed as required is liable for a civil penalty of one hundred dollars ($100) a day for each day the filing of such report with the Office is delayed, taking into account any extensions granted as provided in Section 97051, Chapter 10, Title 22, California Code of Regulations.

6. Partial quarter reports must be filed by hospitals which have been in operation for less than one quarter at the end of the first calendar quarter of their operation. The first calendar quarter may be less than three months.

7. When the license of the hospital changes during the calendar quarter, a quarterly report must be filed with the Office by the former licensee for the period of their licensure, and a report must be filed by the new licensee for their first and subsequent calendar quarters. Both reports must be submitted within 45 days after the end of the calendar quarter in which the licensure change occurred.

8. Since all quarterly reports are for calendar quarters, changes in fiscal year end dates will not impact quarterly reporting. Facilities using a 13-period accounting cycle must file a modification request and obtain prior approval from the Office before submitting data based on these accounting periods.

9. Revisions to 1997 or later quarterly reports may be completed and submitted using IHQRS. Revisions to pre-1997 quarterly reports may be completed on the Office's standard report form for the calendar year and transmitted to the Office by telecopier (FAX No. 916-323-7675). For example, a revision to the report for the second quarter of 1996 should be submitted on a 1996 quarterly report form.

   Instructions for submitting revisions using the IHQRS application are included in the IHQRS User Guide which can be viewed and printed from the Office's internet reporting web site. If using the Office's standard report form to make revisions, indicate the quarter being revised by checking the appropriate line in column 3 for lines 15 through 20 (1992 and after) or lines 10 through 15 (pre-1992).

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If a prior year report form is not available, you may submit a reproduced copy of the hospital's quarterly report being revised and indicate the changes in red. You may also submit requests for revisions in letter format.

10. Hospitals that receive the preponderance of their revenue from associated comprehensive group-practice prepayment health care service plans and are operated as units of a coordinated group of health facilities under common management may provide financial data for lines 350 through 850 on a group basis. However, such hospitals are encouraged to report line 830, Total Operating Expenses, for each hospital.

DETAILED INSTRUCTIONS FOR COMPLETING QUARTERLY REPORT 8200

To use the Internet Hospital Quarterly Reporting System (IHQRS) , you must use Microsoft Internet Explorer version 5.0 or later, and your personal computer must be connected to the internet. The IHQRS User Guide provides detailed instructions on how to use the IHQRS application and can be viewed and printed from the IHQRS web site at: www.oshpd.state.ca.us/ihqrs .

If the hospital has been granted written approval by the Office to report on the standard hard-copy report form, go to instruction number 7 to begin completing the form.

1. Open the IHQRS home page by entering the web site address listed above in the address bar of Internet Explorer.

2. In the IHQRS Login Page, enter your hospital's nine-digit OSHPD Facility Number, your User ID, and your Password. Each hospital is required to initially create a User ID and Password by submitting an IHQRS Enrollment Form. If you do not know your hospital's OSHPD Facility Number, your User ID, or your Password, please contact the Office (916) 326-3855.

3. Select the year and quarter of the report you want to submit.

4. Mark the report as an original or a revision. IHQRS will not allow you to submit a report marked original if the report for the specified quarter has already been submitted to the Office.

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5. Indicate whether the report is for a standard or non-standard calendar quarter.

   A standard calendar quarter means the report period begins and ends on the standard calendar quarter.

   A non-standard calendar quarter report period does not begin and/or end on a standard calendar quarter. You must complete the report period begin and report period end dates for non-standard calendar quarters.

   A non-standard report period will occur when a partial period report must be submitted due to a change in licensure/ownership, or when a hospital opens or closes during the quarter. Hospitals which use a 13-period accounting cycle should also indicate the calendar quarter as non-standard and indicate that the report is for a 13-period accounting cycle.

6. When the information on the IHQRS Login Page is correct, the next web page produced is the Login Confirmation Page. Please verify the accuracy of the login confirmation information. Note that the Current Enrollee information may be different than the Report Preparer. If the information on this page is correct, go to the next web page.

   If any of the login confirmation information is incorrect, please notify the Office at (916) 326-3855.

7. The IHQRS application will enter the hospital's name from our database. If the hospital has been granted written approval by the Office to report on the standard hard-copy report form, enter in item 1 the name under which the hospital is doing business. This may be the hospital's legal name.

8. The IHQRS application will enter the OSHPD Facility Number in item 2. This nine digit number begins with "106" and is assigned by the Office for reporting purposes. If the hospital has been granted written approval by the Office to report on the standard hard-copy report form, enter the OSHPD Facility Number in item 2.

9. The IHQRS application will enter the hospital's street address, city, and zip code in items 3, 4, and 5 from our database. If the hospital has been granted written approval by the Office to report on the

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standard hard-copy report form, in items 3, 4, and 5, enter the hospital street address, city, and zip code, respectively.

10. The IHQRS application 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 on the Quarterly Reporting Enrollment Form. The report preparer must correct these items using IHQRS if they are incorrect. If the hospital has been granted written approval by the Office to report on the standard hard-copy report form, enter in items 6 and 7 the name and complete phone number of the person who completed the report. This person will be contacted by the Office if there are any questions about the report.

11. The IHQRS application 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, notify the Office to correct the data by calling (916) 326-3855. If the hospital has been granted written approval by the Office to report on the standard hard-copy report form, enter in items 8 and 9 the name of the chief executive officer (administrator) and the hospital's main business phone number.

12. The IHQRS application will enter the complete phone number of the hospital's disaster coordinator in item 10. If the data in item 10 is incorrect, notify the Office to correct the data by calling (916) 323-0875. If the hospital has been granted written approval by the Office to report on the standard hard-copy report form, enter in item 10 the complete phone number of the hospital's disaster coordinator. This individual is responsible for coordinating the hospital's disaster preparedness programs.

13. If you have been pre-approved to submit the Office's standard report form, and if the report is for a full calendar quarter, check the appropriate line in column 2 or column 3 for the quarter being reported. Check column 2 if the report is an original report or column 3 if the report is a revised report. Revised reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal year.

    If the report period is for more or less than an actual calendar quarter, enter the beginning date of the reporting period on line 19, column 1, and the ending date of the reporting period on line 20, column 1, and check column 2 or column 3 as appropriate.

14. 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.

15. 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.

16. 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.

17. 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.

18. 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. The IHQRS application 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), Genetically Handicapped Persons Program (GHPP), Newborn

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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.

19. 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.

20. 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, the IHQRS application will enter the sum of lines 150 through 195.

21. 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.

22. Enter on lines 250 through 295 the number of outpatient visits by 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.

23. 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

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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. The IHQRS application will enter the sum of lines 350 through 395 on line 400.

24. 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, the IHQRS application will enter the sum of lines 450 through 495.

25. 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 IHQRS 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 850 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 850, 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 575, 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.

The IHQRS application 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.

26. Enter Capitation Premium Revenue by payor on lines 650 through 680. The IHQRS application will enter the sum of lines 650 through 680 on line 700.

27. 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

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care to that payor category. The IHQRS application 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.

28. 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.

29. 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.

30. 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.

31. 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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32. 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.

33. 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.

34. 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.

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

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36. 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.

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

    Please note that the IHQRS application classifies potential data errors as either Fatal, or Warning; and that Fatal errors must be resolved before a report can be successfully transmitted. We strongly recommend that you print a Validation Report and review any error messages before officially submitting your report.

38. If you have been granted written permission to file a hard-copy report mail the completed report to:

    Office of Statewide Health Planning and Development
    Accounting and Reporting Systems Section
    400 R Street, Suite 250
    Sacramento, CA 95811

    For your convenience, you may submit your completed and signed quarterly financial and utilization report by telecopier (FAX No. 916-323-7675). You are not required to submit the original report if it has already been sent by telecopier.

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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: 2009___ 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)
15.	January 1 - March 31, 2009	May 15, 2009		
16.	April 1 - June 30, 2009	August 14, 2009		
17.	July 1 - September 30, 2009	November 14, 2009		
18.	October 1 - December 31, 2009	February 14, 2010		
19. 20.	Other (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	2009 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)	
50.	Hospital Discharges (excluding nursery discharges) 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)**	
150.	Patient (Census) Days (excluding nursery patient (census) days) 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)**	

Continued on Next Page

** The reporting of this item is optional.

HOSPITAL QUARTERLY FINANCIAL AND UTILIZATION REPORT (Cont'd)

Facility DBA Name:	2009 Quarter Ending:	OSHPD Facility No.:

Line No.	UTILIZATION DATA ITEMS (Cont'd)	2009 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	
	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)	$

Continued on Next Page

HOSPITAL QUARTERLY FINANCIAL AND UTILIZATION REPORT (Cont'd)

Facility DBA Name:	2009 Quarter Ending:	OSHPD Facility No.:

Line No.	FINANCIAL DATA ITEMS (Cont'd)	2009 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)	$
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, or FAX number:

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Office of Statewide Health Planning and Development
Accounting and Reporting Systems Section
400 R Street, Suite 250
Sacramento, CA 95811
Phone: (916) 326-3855 FAX No: (916) 323-7675

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: _____