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All information must reflect only the individually licensed surgery center with the exception of the balance sheet in certain situations where the parent organization balance sheet may be used if the facility-specific balance sheet is not prepared.

Please note:

- Not applicable “NA” is not an acceptable value.
- Enter a zero “0” only when the actual value of the data element is zero.
- Use the tab key to move between fields.
- Use a minus sign “-“ for a negative number.
- Do not use commas “,” in numeric fields.
- Do not use text in numeric fields.
- Do not use the escape key “Esc” because it will clear the entire form.
- Round to the nearest whole dollar.

The webpage is divided into three main sections namely Financial, Payer, and Top-Five Third-party Commercial Payer. There is a Save button on the top to save any intermediate changes with your submission. There is also a Submit button on the top to submit when your submission is complete without errors. This signifies to us that your submission is complete and ready for review.

### Financial

**Business Entity**
Select the category that best describes the business organization of the surgery center itself, not a parent organization.

**Majority or Largest Owner**
Select the category that best describes the majority owner(s) or the owner(s) with the largest ownership interest. A physician group should be considered as a single owner. Include the name of the majority owner unless the majority owner is a physician. Do not report individual physician names. In lieu of individual physician name(s) enter the number of physicians with ownership interest (e.g. 5 physicians). A Multi-facility Management Company provides management services for multiple surgery centers with different owners. A Local Management Company provides management services for one or more surgery centers with common local owners.
 Minority Owner #1 and Minority Owner #2
Select the category that best describes the owners with the second and third largest share of ownership in the surgery center, if any.

Balance Sheet
The balance sheet information must match the audited financial statements submitted to the PHC4. Information regarding assets and liabilities may be derived from the balance sheet of a parent organization if the facility-specific balance sheet is not generally prepared with the exception of patient accounts receivable which must be facility specific.

Patient Accounts Receivable
Patient accounts receivable are the portion of accounts receivable that are attributable to net patient revenue, net of allowance for doubtful accounts. Some surgery centers operate on a cash basis and do not have accounts receivable on the balance sheet, but do keep track of the unpaid patient accounts. As an alternative to entering zero, the outstanding patient accounts at the end of the year may be entered. Patient accounts receivable must be specific to the licensed facility.

Total Current Assets
Total current assets as reported on the audited financial statements.

Total Assets
Total assets as reported on the audited financial statements.

Total Current Liabilities
Total current liabilities as reported on the audited financial statements.

Long-term Debt
Long-term debt as reported on the audited financial statements. Long-term debt can include bank loans, bonds, capital leases, lease-to-own arrangements, mortgage notes and payables, and inter-company payables from a parent organization. Do not include other long-term liabilities, such as pension liabilities, deferred compensation, or partner equity. These items should still be reported in total liabilities.

Total Liabilities
Total liabilities as reported on the audited financial statements.

Net Assets / Net Equity
Net assets for non-profit organizations as reported on the audited financial statements. Net equity for the for-profit organizations as reported on the audited financial statements.
Statement of Operations

**Net Patient Revenue**
Net patient revenue includes revenue received (cash basis) or anticipated (accrual basis) from patients, third-party payers and others for patient care rendered by the surgery center. Accordingly, net patient revenue must be net of any contractual allowances or other discounts. In the event physician practice group expenses cannot be separated from the surgery center, then physician practice group revenue must be reported as other operating revenue.

**All Other Operating Revenue**
All non-patient revenue allocated to meet operating expenses. Include interest income only if designated to be used to offset operating expenses.

**Total Operating Revenue**
All revenue allocated by the surgery center to meet operating expenses.

**Total Operating Expenses**
All costs associated with operating the surgery center such as salaries, professional fees, supplies, depreciation, interest, and insurance. In the event physician practice group expenses cannot be separated from the surgery center, then physician practice group revenue must be reported as other operating revenue. Please do not net interest expense with non-operating interest income.

Whenever possible, payment to physicians for clinical services should be reported as an operating expense rather than a distribution of net income. Distributions associated with ownership interest should continue to be reported as net income.

A for-profit surgery center that is part of a multi-unit, for-profit corporation that is subject to income taxes must include an estimate of the *pro rata* share of income taxes attributable to that center in total operating expenses. A surgery center that operated at a loss and the parent corporation had positive income and a corresponding tax liability for the fiscal year, the center must include a tax credit that reflects the amount that the parent’s tax liability was reduced by the net loss of the surgery center.

Centers that operate as a Subchapter S corporation or hybrid corporation (LLP, PC) should not include any income tax expense in the total operating expenses.

**Operating Income**
Operating income is the amount by which total operating revenue exceeds total operating expenses.
All Non-operating Income
All gains or losses that affect net income (revenue over expenses) that are not allocated to offset operating expenses. Do not reduce non-operating income by subtracting interest expenses from any non-operating gains. Interest expenses should be included in operating expenses.

Net Income / Revenues Over Expenses
The sum of operating income and all non-operating income, if any.

Depreciation and Amortization Expense
The combined depreciation and amortization expense amounts from the financial statements.

Charges

Bad Debt Charges
Bad debt is to be valued and reported at the surgery center’s full established charges.

Bad debt occurs when a bill is rendered, payment is expected, and the surgery center has made a determination that none of the amount billed will be paid, or that a portion of the amount billed will not be paid.

For surgery centers that use accrual accounting, bad debt must originate from adjustments to accounts receivable.

Reimbursements denied by third-party insurers may only be included in bad debt if the services provided were beyond the scope of services covered by the insurer. Other denied payments, such as care determined to be medically unnecessary by the insurer, are not included in the bad debt reported to the PHC4.

Charity Care Charges
The foregone charges for the care provided, consistent with the surgery center’s charity care policy. Do not include any shortfall between third-party payer (e.g. Medical Assistance, “MA”) reimbursements and the surgery center’s charges. Charity care charges only include services provided to MA patients if the MA program does not cover such services.

Facilities may uniformly waive co-payments and deductibles for participants in certain health insurance programs such as Medicare. Do not include waived co-payments as part of charity care unless an individual patient meets the surgery center’s charity care criteria.
Surgery centers may only include community service as part of charity care if the patient receiving the service meets the surgery center’s charity care criteria, and an established charge is imposed on the center’s general patient population for the service.

**Total Patient Charges**
Total amounts billed for patient care at established rates before any adjustments are made for contractual arrangements or other discounts. Charges are reported on a cash basis when using a cash accounting method.

<table>
<thead>
<tr>
<th>Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Visits</strong></td>
</tr>
<tr>
<td>All visits (encounters) during the fiscal year by primary payer. The primary payer is the source of more than 50% of the reimbursement for the patient’s care. The total of all payer categories must equal the total visits for the fiscal year.</td>
</tr>
<tr>
<td><strong>Total Net Patient Revenue</strong></td>
</tr>
<tr>
<td>Distribute the net patient revenue by the patients’ primary payer. For example, for Medicare Indemnity patients, reimbursements from Medicare supplement insurance and patient payments should be included in the Medicare Indemnity category.</td>
</tr>
<tr>
<td>The sum of the net patient revenue reported for the payer categories must equal the total net patient revenue reported in the Financial section.</td>
</tr>
<tr>
<td><strong>Medicare Indemnity</strong></td>
</tr>
<tr>
<td>All care rendered and patient revenue received from the Medicare fee for service program. Revenue received from Medicare supplement insurance provided by commercial insurers should be included in either the Medicare indemnity or managed care category.</td>
</tr>
<tr>
<td><strong>Medicare Managed Care</strong></td>
</tr>
<tr>
<td>All care rendered and patient revenue received on behalf of Medicare managed care participants. Reimbursements for this category are administered by a commercial managed care organization.</td>
</tr>
<tr>
<td><strong>Medicaid (Medical Assistance) Indemnity</strong></td>
</tr>
<tr>
<td>All care rendered and patient revenue received from the Medicaid fee for service program.</td>
</tr>
</tbody>
</table>
Medicaid (Medical Assistance) Managed Care
All care rendered and patient revenue received on behalf of Medicaid managed care participants. Reimbursements for this category are administered by a commercial managed care organization.

Commercial Indemnity
All care rendered and patient revenue received by all commercial indemnity (fee for service) health insurance plans including Blue Cross and Blue Shield.

Commercial Managed Care
All care rendered and patient revenue received by all commercial managed care plans including hospital/health care system plans and plans offered by Blue Cross and Blue Shield organizations. Managed care includes licensed HMO, PPO and POS plans that may either require some form of preauthorization or utilize a provider network. Do not include visits or reimbursements for Medicare or Medicaid participants even though reimbursements are administered by commercial managed care organizations.

Other Third-party
All care rendered and patient revenue received by third-party payers other than health insurance companies and managed care organizations, such as direct payments by employers or associations, auto insurance, workers’ compensation, and government programs (other than Medicare and Medical Assistance).

Self-pay
All care rendered and patient revenue received on behalf of uninsured patients and/or where the patient is the primary payer and bills for service have been rendered to the patient. Patient co-payments, deductibles, and co-insurance are included with the revenue from the primary payer (e.g. Medicare).

Charity Care
Visits that were provided to patients that qualified for free care according to the surgery center’s charity care policy.

Top Five Third-party Commercial Payer
The five largest third-party payers are reported in terms of net patient revenue received by the surgery center during the fiscal year. Do not list Medicare or MA indemnity programs. For this section (and not the Payer section), revenue received from Medicare and Medicaid funded managed care programs should be included with the revenue from the organization administering the reimbursements for the patients.
Select the NAIC code, along with the provider name, from the third-party payer list and provide the percent of the total net patient revenue received by that payer.

All products offered by one company should be aggregated under the NAIC code within the product types the payer offers. To assist you in identifying these products, a list of the health insurance companies, along with their product names and NAIC codes, is displayed on our website. If for some reason an insurer is not on the list, please enter “12345” and “Not on List.”