All information must reflect only the individually licensed hospital 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. This data submission should include hospital-based subunits such as skilled nursing, rehabilitation, psychiatric, long-term, ambulatory surgery, and home health, or any other subunit operating under the hospital’s license. The information should not include the parent organization (with the exception of the balance sheet in certain situations) or a subsidiary, such as physician practices, foundations, separately licensed ambulatory surgery centers or an independent real estate organization.

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 website is divided into five sections with a menu: Financial, Malpractice, Utilization, Payor, and Top Five Third-party Payor.

- Each section will indicate if it is **incomplete and/or contains errors with a red asterisk until all information in that section has been entered correctly.**
- Each section contains a submit button that saves the data entered to our database and reruns validations.
- The system will generate a run time error and log off a user that is inactive for more than ten minutes as a security measure.
- The confirmation button, which signifies that the submission is complete and prints a record for your files, will not appear until all fields are completed correctly.
Financial Section

**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 hospital 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, and include third-party and tobacco settlement receivables. **Patient accounts receivable must be specific to the licensed hospital and correspond to the net patient revenue reported for the hospital.**

**Total Current Assets:**

Total current assets as reported on the audited financial statements.

**Property Plant and Equipment:**

Property plant and equipment (gross), including construction in progress, as reported on the audited financial statements.

**Accumulated Depreciation:**

Accumulated depreciation 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 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 or net equity for 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 payors and others for health care services rendered, including estimated retroactive adjustments. Retroactive adjustments are accrued typically on an estimated basis in the period the services are rendered and adjusted in future periods as adjustments become known. Grants and allowances received for patient care (e.g. disproportionate share and tobacco fund payments) should be recorded as net patient revenue. In the event expenses associated with physician practice groups are embedded in operating expenses, then physician practice group revenue is to be included in other operating revenue.
All Other Operating Revenue:
All non-patient revenue allocated to meet operating expenses. Include physician practice group revenue only if the expenses associated with the practice are embedded in the hospital’s operating expenses. Include interest income only if designated to be used to offset operating expenses.

Total Operating Revenue:
All revenue allocated by the hospital to meet operating expenses.

Total Operating Expenses:
All costs associated with operating the hospital such as salaries, professional fees, supplies, depreciation, interest, and insurance. Hospitals that are part of a multi-unit corporation are to include management fees and other expenses assessed by the parent corporation in total operating expenses. Please do not net interest expense with non-operating interest income. Non-operating interest income should be reported as non-operating income.

Operating Income / Net Pre-tax Income:
The amount by which total operating revenue exceeds total (pre-tax) operating expenses.

All Non-operating Income:
All gains or losses that affect revenue over expenses or net after-tax income that are not allocated to offset operating expenses. Do not include changes to net assets such as transfers to and from affiliates and unrealized gains or losses on investments (except trading securities).

Extraordinary Items:
Commercial Third-party Payers
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Only include extraordinary items as listed on the financial statement that affect operating income and/or revenue over expenses or net after-tax income. Do not include extraordinary items that only affect net assets. Enter “0” if there are no extraordinary items.

**Income Tax Expenses (for-profit hospitals only):**

Hospitals that are part of a for-profit corporation must provide an estimate of the *pro rata* share of income taxes attributable to that hospital. Enter “0” if non-profit.

A hospital that operated at a loss, but whose parent corporation had a positive income with a corresponding tax liability for the fiscal year, must include a tax credit that reflects the amount that the parent’s tax liability was reduced by the net loss of the hospital.

**Revenues Over Expenses / Net After-tax Income:**

The sum of operating income, all non-operating income and extraordinary items, if any, less income taxes, if any.

**Interest Expense:**

Interest expense as reported in the financial statements.

**Depreciation and Amortization Expense:**

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

**Charges:**

**Bad Debt Charges:**

Bad debt charges is the annual bad debt amount reported on the annual income statement (statement of operations) valued at full charges utilizing the hospital’s prevailing schedule of fees (charge master).
Consistent with industry practice, PHC4 relies on Generally Accepted Accounting Principles (GAAP) and the prevailing AICPA Audit and Accounting Guide – Health Care Organizations as guidelines for reporting bad debt and charity care. Bad debt should be derived from the adjustments to accounts receivable for the reporting year.

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 and were posted in patient accounts receivable. Other denied payments, such as denied days, is considered to be contractual allowances and is not included in bad debt.

**Charity Care Charges:**

The foregone charges for the care provided to patients that meet the hospital’s charity care policy. Do not include any shortfall between third-party payor (e.g. Medical Assistance, “MA”) reimbursements and the hospital’s charges. For example, charity care charges only include services provided to MA patients if the MA program does not cover such services.

If a patient’s third-party insurance does not provide any reimbursement for specific services, these services are eligible to be included in charity care if the patient meets the hospital’s charity care policy.

Hospitals 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 hospital’s charity care criteria.

Hospitals may only include community service as part of charity care if the patient receiving the care meets the hospital’s charity care criteria and an established charge is imposed on the general patient population for that service.

The accounting guidelines the PHC4 utilizes for bad debt also apply to charity care. These guidelines are outlined in the reporting requirements for bad debt, presented in the previous section.

**Inpatient and Outpatient Charges:**

The amounts billed for patient care at established charges before any adjustments are made for contractual arrangements or other discounts.
Commercial Third-party Payers
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Malpractice Section

Provide the hospital’s annual malpractice expenses incurred during the fiscal year. Expenses should be allocated among the eight lines. Expenses, premiums, claims, accruals, etc. should be reported if they were incurred during the fiscal year; regardless of the time period covered by the insurance, the timing of a malpractice claim, etc.

If there are no expenses in a category, enter “0” (zero).

**Line 1 Commercial Insurance** - Include any premiums paid during the fiscal year for all levels of malpractice exposure that is covered by commercial insurance such as primary, stop loss, tail, excess and reinsurance. Expenses associated with obtaining a commercial malpractice policy, such as a broker’s fees, taxes and finance costs, should be included with the commercial premiums on Line 1.

Do not include in Line 1 premiums for insurance arrangements where the hospital or an affiliate has an ownership interest or ultimately insures the risk. These arrangements are more fully outlined in self-insurance (Line 3) below.

To the extent that all or a portion of risk is ceded to a commercial independent reinsurer, the premiums for that reinsurance should be reported as commercial insurance in Line 1. Commercial premiums paid on behalf of physicians and other clinical staff should be reported on Line 6.

**Line 2 Hospital MCARE Assessment** – Report the hospital’s MCARE assessment for the fiscal year. Assessments paid on behalf of individual physicians should be reported on Line 7. Rebates of prior year assessments should be reflected as an adjustment to the prior year submission are not to be included for this fiscal year.

**Line 3 Risk Portion of Self-Insurance** – Include the hospital’s share of risk-related premiums or payments to any of the broad spectrum of self-insurance arrangements hospitals have created to meet their malpractice exposure including risk retention groups (RRGs) and wholly-owned domestic or captive off-shore insurance companies. Insurance companies that are statutorily separate from the hospital, but all or part of the risk is ultimately reinsured by the hospital or an affiliate, should also be included in self-insurance arrangements. To the extent that all or a portion of risk is ceded to a commercial independent reinsurer, the premiums for that reinsurance should be reported as commercial insurance in Line 1.

Also include the portion of any accruals or reserves (e.g. IBNR) that was posted as an expense during the current reporting year.
Hospitals participating in multi-hospital self-insurance programs or captive insurance companies should only include the individual hospitals *pro rata* share of any accruals, expenses or premiums.

Capital contributions (e.g., initial capitalization) should not be included in the annual malpractice expense beyond any amortizations that were posted as an expense in the current reporting year.

**Line 4 Administrative Expenses of Self-Insurance** - Report the administrative portion of self-insurance expenses (e.g. administrative portion of RRG premiums).

**Line 5 Claims Paid Directly** - Report claims paid directly by the hospital that were not covered by commercial insurance or any self-insurance program (including deductibles). Include only the portion of claims that were posted as an expense during the current reporting year.

**Line 6 Physician Malpractice Premiums** – Report total malpractice premiums paid by the hospital on behalf of individual physicians and other clinical staff during the current reporting year. Report the number of physicians and clinical staff that had all or a portion of the premiums funded by the hospital on **Line 6A**.

**Line 7 Physician MCARE Assessments** - Report total MCARE assessments (net of any abatements) paid by the hospital on behalf of individual physicians and other clinical staff during the fiscal year. Report the number of physicians and clinical staff that had all or a portion of the MCARE assessments funded by the hospital on revenue may include settlements received during the current fiscal year for care provided in prior fiscal years. Revenue received as third-party settlements, grants or allowances (e.g. disproportionate share allowances) must be appropriately allocated to inpatient, outpatient, and home health, as well as indemnity and managed care categories. **Line 7A** Rebates of prior year assessments should be reflected as an adjustment to the prior year submission are not to be included for this fiscal year.

**Line 8 Other Expenses** – Report malpractice expenses not reported in Lines 1 through 7 and a brief description of those expenses.

**Utilization Section**

**Staffed Beds:**
Report the number of beds that were set up and staffed in the reporting year. The number of “staffed beds” may be different than the number of licensed or available beds.

**Bed Days Available:**

Report the actual bed days available for the year. If beds were added or taken out of service during the year, bed days available should only reflect the portion of the year that the beds were set up and staffed.

**Medical-Surgical:**

Medical and surgical acute care services to patients. This includes, but is not limited to, intensive care, obstetrics, cardiac intensive care, neonatal intensive/intermediate care, burn care and long-term acute care.

The total number of swing beds and total bed days available for swing beds are to be included in the medical-surgical category. The number of patient days and discharges for swing bed patients receiving acute care is to be included in the medical-surgical category. The number of patient days and discharges for swing bed patients receiving non-acute (e.g. skilled nursing care) is to be included in the “other” category.

Do not include care to a routine newborn as a separate patient under the medical-surgical category; the mother and routine newborn are to be reported as a single patient. Report routine newborn care separately in the “routine newborn” category (below the total line).

**Psychiatric:**

Psychiatric care services encompass both short and long-term acute psychiatric care for patients with mental or emotional disorders, including patients admitted for diagnosis and those admitted for treatment of psychiatric conditions. (Applies to freestanding psychiatric hospitals and psychiatric subunits of all other hospitals.) Report post-acute psychiatric care in the “other” category.
Rehabilitation:

Rehabilitation care services encompass a comprehensive array of restoration and all support services necessary to help patients attain their maximum functional capacity. (Applies to freestanding rehabilitation hospitals and rehabilitation subunits of all other hospitals.)

Skilled Nursing Subunit:

Skilled nursing and non-acute medical care services, therapy and social services.

Long-term Care:

Long-term (non-acute) care other than skilled nursing care. This can include residential care services for those who do not require daily medical or nursing services, but may require some assistance in the activities of daily living, or sheltered care facilities for the developmentally disabled. Report long-term acute care services in the medical-surgical category.

Other:

Please indicate the type of service.

Drug and Alcohol: provides diagnosis and therapeutic services to patients with alcoholism or other drug dependencies. Includes inpatient/residential treatment for patients whose course of treatment involves more intensive care than provided in an outpatient setting or where the patient requires supervised withdrawal.

Hospice: provides palliative care, chiefly medical relief of pain and supportive services, addressing the emotional, social, financial, and legal needs of terminally ill patients and their families. Includes inpatient care only.

Residential Treatment: post-acute residential programs.

Swing Bed Care: provides skilled nursing and non-acute medical care services, as well as therapy and social services to patients that occupy a swing bed. Only report the non-acute days and discharges here. The beds and bed days available are to be included in the medical-surgical category.
**Total:**
The sum of medical-surgical, psychiatric, rehabilitation, skilled nursing, long-term acute care and other subunits. This must equal the total days and discharges reported in the Payor Section.

**Routine Newborn:**
Routine newborn care. Non-routine newborn care and beds are included in medical-surgical.

**Home Health Discharges:**
The total number of home health discharges. A home health care patient may receive one or more visits prior to being discharged from home health care. Psychiatric home care discharges are included in the home health discharges.

**Outpatient Episodes:**
The total number of outpatient episodes. One episode includes all outpatient visits for a patient for the same medical condition. For example, a patient being treated for a single medical condition (one episode) may have a visit to radiology, a visit to the lab, and the surgical unit (three visits).

**Payor Section**
Distribute revenue and utilization by primary payor into the payor categories.

**Patient Days:**
All patient days, except routine newborn, by primary payor. The mother and routine newborn are captured as a single patient. The total number of patient days must equal the total patient days reported in the Utilization Section.

**Discharges:**
All discharges, except routine newborn, by primary payor. The mother and routine newborn are captured as a single patient. The total number of discharges must equal the total discharges reported in the Utilization Section.
Commercial Third-party Payers
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Outpatient Visits:
All outpatient visits (encounters) by primary payor. Outpatient visits include all emergency room care and clinic visits if costs to operate the clinic are included as operating expenses in the audited financial statement. An outpatient visit is an individual visit to a single outpatient unit of a hospital. There may be more than one visit for each episode of care.

Home Health Visits:
The total number of home health visits by primary payor. Psychiatric home care visits are to be included in the home health visits.

Net Inpatient, Outpatient, Home Health Total Net Patient Revenue:
Revenue may include settlements received during the fiscal year for care provided in prior fiscal years. Revenue received as third-party settlements, grants or allowances (e.g. disproportionate share allowances) must be appropriately allocated to inpatient, outpatient, and home health, as well as indemnity and managed care categories.

The sum of the total net patient revenue reported for the payor categories must equal the total net patient revenue reported in the Financial Section.

Allocate all special payments, grants and allowances distributed by the Pennsylvania Department of Public Welfare among the indemnity and managed care, as well as inpatient and outpatient categories even though the funds were transmitted in conjunction with the fee for service payments. Distribute the special funding into the categories based on the overall distribution of MA reimbursements. For example, if 20% of the hospital’s total MA revenue came from inpatient care for patients covered by the indemnity (fee for service) program, then 20% of the special funds received are to be allocated to MA indemnity inpatient care. However, if these funds are designated for a specific group of patients (e.g. outpatient prenatal), they should be allocated to the appropriate MA category(s).

Medicare Indemnity:
All care rendered and patient revenue received from the Medicare program. Revenue received from Medicare supplement insurance provided by commercial insurers should be included with the primary payor in either the Medicare indemnity or managed care category.
Commercial Third-party Payers
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Medicare Managed Care:
All care rendered and patient revenue received on behalf of Medicare managed care participants. This includes all Medicare HMO, PPO, POS, etc. plans often referred to as Medicare Advantage plans. Reimbursements for this category are administered by commercial managed care or health insurance organizations.

Medicaid (Medical Assistance) Indemnity:
All care rendered and patient revenue received on behalf of Medicaid indemnity (fee for service) patients.

Medicaid (Medical Assistance) Managed Care:
All care rendered and patient revenue received on behalf of Medicaid managed care participants. Reimbursements for this category are usually administered by a commercial managed care organization.

Commercial Indemnity:
All care rendered and patient revenue received on behalf of commercial indemnity patients. Commercial indemnity includes patients covered by Blue Cross and Blue Shield indemnity plans.

Commercial Managed Care:
All care rendered and patient revenue received on behalf of commercial managed care patients. Plans include hospital/health care system plans and managed care plans offered by Blue Cross and Blue Shield organizations. Managed care includes licensed HMO, PPO and POS insurance plans that may either require some form of pre-authorization or utilize a provider network. This category does not include care and reimbursements for Medicare or Medicaid managed care participants even though reimbursements are administered by commercial managed care organizations.

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

Self-pay:

All care rendered and patient revenue received on behalf of uninsured patients and/or where the patient is the primary payor 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 payor (e.g. Medicare).

Charity Care:

Days, discharges and visits that were provided where the fees were waived because the patient qualified for free care according to the hospital's charity care policy. The days, discharges and visits for charity care patients that had their care reimbursed by a third-party payor (e.g. Medicare or MA) should be included with the third-party payor.

Top Five Commercial Third-party Payor Section

The five largest third-party payors are reported in terms of net patient revenue received by the hospital during the fiscal year. Do not list Medicare or MA indemnity programs. For this section (and not the Payor section), revenue received from Medicare and MA 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 payor list and provide the percent of the total net patient revenue received by that payor.

All products offered by one company should be aggregated under the NAIC code within the product types the payor 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.”