PUBLIC GOODS POOL
GENERAL INSTRUCTIONS FOR COMPLETING REPORT OF
PATIENT SERVICES REVENUE RECEIVED AND SURCHARGE OBLIGATIONS

HOSPITAL
INPATIENT AND OUTPATIENT SERVICES

General hospitals issued an operating certificate pursuant to Article 28 of the Public Health Law (PHL) are required to submit reports electronically for reporting periods on and after January 1, 2005 by accessing the WEB at: www.hcrapools.org. Since you are not precluded from submitting reports electronically for periods prior to the date mandated by law, we encourage you to electronically file for reporting periods prior to January 1, 2005.

Providers are required to file the Provider Certification Form and the two most recent service year portions of the Report of Patient Services Revenue for Hospital Inpatient Services and the Report of Patient Services Revenue for Hospital Outpatient Services[1] monthly, even if there is no activity to report. Prior service year portions of the Report of Patient Services Revenue for Hospital Inpatient Services and the Report of Patient Services Revenue for Hospital Outpatient Services are required only when a provider has net patient services revenue and/or prior period adjustments to report which relate to those service years. Revenue received during the month for surchargeable claims for services rendered during a prior service year must be reported in the appropriate service year. Additionally, adjustments to information previously reported for such service years must be reported as prior period adjustments in the appropriate service year.

A designated provider's monthly Public Goods Pool reporting obligation does not cease when the provider has a change of status (i.e., ceased operations, surrendered license, merged with another provider, etc.) The provider's monthly Public Goods Pool reporting obligation, for the service period during which the entity was a designated provider of services under the Health Care Reform Act (HCRA), will continue for a period of one year following the end of the year in which the status change occurred or until all claims for such service period have been adjudicated. Once all claims have been adjudicated, the provider must submit a final monthly report along with a completed DOH 4408 - Provider Status Change form indicating the effective date when all claims were adjudicated. In addition, if you have changed your facility name and/or address, please complete DOH-4407 - Provider Name and Address Change " form. Both forms are located on the HCRA website at:

www.health.state.ny.us/nysdoh/hcra/hcrahome.htm

Pursuant to the New York Health Care Reform Act of 1996, each service period's pool receipts are dedicated to specific purposes and for specific amounts. As a result, monthly reports filed by providers must be segregated into service period portions. For example, providers must report revenue received for services provided in 2006 in the 2006 portion of the report even though the revenue was received in a subsequent service period.

Note that the guidance offered in these instructions is not all-inclusive. Please refer to the New York Health Care Reform Acts and related correspondence previously disseminated by the Department which is available on the WEB.

[1]**Including, but not limited to, hospital based laboratory, clinic, and ambulatory surgery services.**

HOSPITAL INPATIENT SERVICES
REPORT OF PATIENT SERVICES REVENUE RECEIVED
AND SURCHARGE OBLIGATIONS INSTRUCTIONS

COLUMNAR DESCRIPTIONS

Lines 1 through 7

Column A - Description. This column itemizes total net patient services revenue received, including surcharges.

Column B - Current Month. This column is to be used for reporting total net patient services revenue received during the report month, including surcharges. If there are no prior period adjustments to report in Column C, do not complete this column. See Column D instructions.

Column C - Prior Period Adjustment. This column is to be used for reporting adjustments due to a reporting error or omission in a prior month. This may be either a positive or negative adjustment. Denote negative amounts with brackets (). Detailed records must be maintained since all report information is subject to audit.

Column D - Total. Add the individual amounts reported in Column B to the respective amounts reported in Column C and enter the result on the appropriate line in Column D. If there were no prior period adjustments in Column C, total net patient services revenue received during the month may be entered in Column D only.

NET PATIENT SERVICES REVENUE

definition/assessability:

In general, net patient services revenue shall mean all moneys received for or on account of hospital or medical services provided or related to patients whose purpose is the treatment or prevention of human illness, disease, injury or disability. Providers should refer to the Line 1 instructions for a more specific definition for net patient services revenue for inpatient hospital services (PHL Section 2807-j).

Examples of revenue which fall outside this definition include: revenue received for clinical laboratory tests performed in connection with the screening of employees for drug use; revenue received for clinical laboratory tests and/or physical examinations performed in connection with applications for life insurance, health insurance, disability insurance or employment; revenue received for clinical laboratory tests performed for the purpose of establishing paternity; and revenue received for forensic laboratory testing.

It should be noted that certain grants and other revenue would be included and may be considered assessable if representing moneys received for the provision of care or other health-related services to individuals. Note however, that government deficit financing grants are never assessable. Such deficit financing grants would be included in Line 1 and then shown as non-assessable on Line 2(h).

LINEAR DESCRIPTIONS

Note: Refer to Hospital Inpatient Report for applicable surcharge percentage.

Line 1 - Total Net Patient Services Revenue Received, including surcharges: Enter total net patient services revenue received during the report month, including surcharges (be sure to include grant revenue on this line). This amount should also include recoveries received from accounts receivable previously written off as uncollectible. Net patient services revenue includes assessable and **non-assessable** patient services revenue. Net patient services revenue must be reported in the month in which it is received.

Pursuant to Section 2807-j(3)(a) of the PHL, net patient services revenue for general hospital inpatient services shall mean all moneys received for or on account of inpatient services, including capitation payments allocable to inpatient services, less refunds, for discharges occurring or for visits made or services performed on or after January 1, 1997, or contracted service obligations for periods on or after January 1, 1997. This section of the Public Health Law applies to all service periods subsequent to 1997.

Line 2 - Non-Assessable Revenue: Report non-assessable net patient services revenue received during the report month according to the following categories. IMPORTANT NOTE: All these amounts must be included on Line 1 - Total Net Patient Services Revenue Received, including surcharges.

Line 2(a) - Report payments related to Medicare eligible beneficiaries on this line. Payments (by Medicare and other payors) to designated providers of services for patient services provided to persons who are eligible for payments as beneficiaries of Title XVIII of the federal Social Security Act (Medicare) are not subject to the HCRA surcharges. This applies whether Medicare is the primary payor or the secondary payor. Also to be included are related co-payment, deductible and coinsurance revenue received. However, revenue received from payors (including patients) making payments to a designated provider where Medicare benefits have exhausted for a particular service or for an uncovered service, shall be subject to all applicable surcharges. The specific surcharge(s) to be applied will be dictated by whether the payor has voluntarily elected to pay the Department's Office of Pool Administration directly.

Line 2(b) - Payments related to patients covered under the Federal Employees Health Benefits Act (FEHBA) and certain federal government payors such as Job Corps, CHAMPUS/TRICARE and VA would be entered on this line. Include related co-payment, deductible and coinsurance revenue received.

Line 2(c) - Report payments received for contracted services performed for other designated providers on this line. Example: An Article 28 general hospital has a contractual agreement with a freestanding Article 28 comprehensive clinic to perform certain x-ray services. The HCRA surcharges do not apply to the amount the Article 28 general hospital bills and receives in payment from the freestanding Article 28 comprehensive clinic.

Line 2(d) - Revenue received from a public hospital pursuant to an affiliation agreement contract would be reported on this line.

Line 2(e) - Report revenue received for residential health care and hospice services on this line. This would include revenue received for swing beds and extended care beds.

Line 2(f) - Physician practice or faculty practice plan revenue based on discrete billings for private practicing physician services would be reported on this line. This refers to situations where a designated provider processes discrete billings for a private practicing physician service or faculty practice plan.

Line 2(g) - Report payments received **directly** from the State or the Pool Administrator on behalf of the State pursuant to PHL Sections 2807-l (Health Care Initiatives) and 2807-v (Tobacco Control and Insurance Initiatives) that are included in Line 1. This would include, but not be limited to grants for the following programs: Health Facility Restructuring, Commissioner's Priority Pool, Health Care Quality and Improvement, Aids Drug Assistance Program, Emergency Medical Services, Children's and Cancer Hospitals, and Health Workforce Retraining.

Line 2(h) - Report government deficit financing grant revenue on this line.
Line 2(i) – Other: Include all other non-assessable patient services revenue received during the report month, which is not reportable on Lines 2(a) through 2(h), on this line. Refer to Section 2807-j(3)(a)(i) through (vii) of

the PHL for a list of non-assessable patient service revenue items. Examples include co-payments received from patients eligible for medical assistance pursuant to Title 11 of Article 5 of the Social Services Law (Medicaid), co-payments received from patients eligible for the Family Health Plus Program pursuant to Title 11-D of Article 5 of the Social Services Law, and Health Care Services Pool, General Hospital Indigent Care Pool, and Professional Education Pool distributions. Additionally, report here certain payments made directly by New York State and its local governmental subdivisions that are non-assessable. Refer to the instructions for Lines 5(a), 5(b) and 5(c) for assessable payments received directly from New York State and its governmental subdivisions.

Line 3 - Total Non-assessable Revenue: This line is the sum of Lines 2(a) through 2(i).

Line 4 - Total Assessable Revenue: Line 1 minus Line 3.

Line 5 - Net Assessable Revenue Received from Direct Pay (Electing) Payors: the payors whose names appear on the NYS Department of Health website elector list and the State's fee-for-service Medicaid Program. Net patient services revenue received from direct pay payors must be segregated into the following categories:

Line 5(a) - Medicaid, including HMO/PHSP: Report payments received directly from the Medical Assistance Program as well as from electing Health Maintenance Organizations (HMOs) and Prepaid Health Services Plans (PHSPs), for services provided to patients eligible for medical assistance pursuant to Title 11 of Article 5 of the Social Services Law (Medicaid) and payments received from electing approved organizations for services provided to subscribers eligible for the Family Health Plus Program pursuant to Title 11-D of Article 5 of the Social Services Law.

Line 5(b) - Other Payors: Report payments received directly from electing agencies of the State of New York (e.g., Office of Mental Health payments for services provided to individuals residing in State operated developmental centers) which have as a program component direct reimbursement to hospitals for rendered inpatient services and payments received directly from electing local governments (in New York State) **ONLY** for services provided to correctional facility inmates.

Line 5(c) - All Other Direct Pay Payors: This would include payments from electing local governments (in New York State) for other than correction facility patients and payments by electing self-insured governmental entities in connection with health benefits for their employees (including Workers' Compensation and No-Fault).

Line 6 - Total Net Assessable Revenue Received from Direct Pay Payors: This line is the sum of Lines 5(a) through 5(c).

Line 7 - Total Assessable Revenue Received from Non-Direct Pay Payors, including surcharges: Line 4 minus Line 6. The amount reported in Column D, Line 7 must be segregated into the categories listed in Column A, Lines 8 through 12(b) of the corresponding service period report.

COLUMNAR DESCRIPTIONS

Lines 8 through 12(b)

Column A - Non-Direct Pay Payors: Provides specific line descriptions for non-direct pay payors.

Column B - Total Assessable Revenue, including surcharges: This column is to be used to report total net patient services revenue received from non-direct pay payors during the report month (Column D, Line 7 of the corresponding service period report). However, where a provider erroneously reported non-direct payor payments under the wrong surcharge factor (Column B, Lines 8 through 12b) on a prior month's report, then equivalent positive and negative adjustments should be netted from the affected line totals and adjusted amounts reported on the appropriate line in Column B.

Column C - Surcharge Factor: This column provides the appropriate surcharge factor for each class of non-direct pay payors shown in Column A, Lines 8 through 12(b).

Column D - Assessable Base: Column B divided by Column C.

Column E - Surcharge Payable: Column B minus Column D.

LINEAR DESCRIPTIONS - FOR ASSESSABLE REVENUE

COLUMN B

Note: Refer to Hospital Inpatient Report for applicable surcharge percentage.

Line 8 - Medicaid-HMO/PHSP/Non-Specified Payors: Report payments received from non-electing HMOs or PHSPs, and any payor not specifically listed in Section 2807-j(1) of the PHL (non-specified payor), for services provided to subscribers eligible for medical assistance pursuant to Title 11 of Article 5 of the Social Services Law. See Line 11 for non-specified payor example. Also report payments received from non-electing approved organizations for services provided to subscribers eligible for the Family Health Plus Program pursuant to Title 11-D of Article 5 of the Social Services Law.

Line 9 – Other Payors: Report payments received from non-electing agencies of the State of New York (i.e., Office of Mental Health payments for services provided to individuals residing in State operated developmental centers) which have as a program component direct reimbursement to hospitals for rendered inpatient services and payments received directly from non-electing local governments (in New York State) **ONLY** for services provided to correctional facility inmates.

Line 10 - Self-Pay Uninsured, and Patient/Secondary Payor Co-pay, Deductible and Coinsurance Amounts (where primary payor is a direct pay payor): Self-Pay Uninsured - Report revenue received from patients who do not have any third party health insurance coverage in whole or in part, and also revenue from insured patients who have exhausted their health care benefits or are making payments for an uncovered service.

This line would also include patient and secondary payor co-payment, deductible and coinsurance amounts where the primary payor is a direct pay payor. This amount would be net of the amount reported on Line 17 as co-payment or deductible patient payments for which the patient's third-party payor has submitted related surcharges directly to the Department's Office of Pool Administration.

Line 11 - Non-Specified Payors: Enter total net patient services revenue received from any payor not specifically listed in Section 2807-j(1) of the PHL.

Line 12 - All Other Non-Direct Payors: Report on Lines 12(a) and 12(b) payments from payors subject to the non-direct payor surcharge.

Line 12(a) - Payors having a GME Liability: Report on this line payors subject to the non-direct payor surcharge that also have a GME liability. This would include any of the following payors that have not made an election to remit pool payments directly to the Department's Office of Pool Administration: corporations organized and operating in accordance with Article 43 of the NYS Insurance Law, organizations operating in accordance with the provisions of Article 44 of the NYS PHL (non-Medicaid), effective April 1, 2009, HMOs and insurers licensed outside New York State, authorized to write accident and health insurance and whose policy provides inpatient coverage on an expense incurred basis, and self-insured funds. Note also that this line would include patient and secondary payor co-payment, deductible and coinsurance payments where the primary payor is a non-electing payor having a GME liability.

Line 12(b) - Payors not having a GME Liability: Report on this line payments from payors subject to the non-direct payor surcharge that do not have a GME liability. This line would include all non-electing payors not specified on Line 12(a). Also include patient and secondary payor co-payment, deductible and coinsurance amounts where the primary payor is a non-electing payor with no GME liability.

COLUMN C

Line 12(a), Column C - Surcharge Factor for Payors having a GME Liability: This line is the sum of the non-direct payor surcharge (refer to Hospital Inpatient Report for applicable surcharge percentage) and the GME regional surcharge factor provided in footnote (3) and the chart located on the bottom of the report. Select the appropriate GME regional surcharge factor based on the region in which the hospital is located.

SUMMARY LINES

Line 13 - Total Assessable Revenue, including surcharges: Sum Column B, Lines 8 through 12(b). This amount must equal the amount reported in Column D, Line 7 of the corresponding service period report.

Line 14 - Gross Surcharges Payable: Sum Column E, Lines 8 through 12(b).

Line 15 - Less: Administrative Fee: This line is the product of 2% of the sum of the amounts reported in Column D, Lines 12(a) and 12(b).

Line 16 - Net Surcharges Payable for the Month for Hospital Inpatient Services: Line 14 minus Line 15. This amount must be carried forward to Line 17 of the corresponding service period Hospital Outpatient Services Report.

Line 17 - Co-pay or Deductible Patient Payments: Enter total co-payment and deductible patient payments received during the report month for which the patient's third-party payor had submitted related surcharges directly to the Department's Office of Pool Administration. This amount should have been netted against the gross amount otherwise reportable in Column B, Line 10 and the net amount reported on such line.

Go to the instructions for completing the Hospital Outpatient Services Report.

HOSPITAL OUTPATIENT SERVICES
REPORT OF PATIENT SERVICES REVENUE RECEIVED
AND SURCHARGE OBLIGATIONS INSTRUCTIONS

COLUMNAR DESCRIPTIONS

Column A – Description: This column itemizes total net patient services revenue received, including surcharges.

Column B - Current Month: This column is to be used for reporting total net patient services revenue received during the report month, including surcharges. If there are no prior period adjustments to report in Column C, do not complete this column. See Column D instructions.

Column C - Prior Period Adjustment: This column is to be used for reporting adjustments due to a reporting error or omission in a prior month. This may be either a positive or negative adjustment. Denote negative amounts with brackets (). Detailed records must be maintained since all report information is subject to audit.

Column D - Total. Add the individual amounts reported in Column B to the respective amounts reported in Column C and enter the result on the appropriate line in Column D. If there were no prior period adjustments in Column C, total net patient services revenue received during the month may be entered in Column D only.

NET PATIENT SERVICES REVENUE

definition/assessability:

In general, net patient services revenue shall mean all moneys received for or on account of hospital or medical services provided or related to patients whose purpose is the treatment or prevention of human illness, disease, injury or disability. Providers should refer to the Line 1 instructions for a more specific definition for net patient services revenue for outpatient hospital services (PHL Section 2807-j).

Examples of revenue which fall outside this definition include: revenue received for clinical laboratory tests performed in connection with the screening of employees for drug use; revenue received for clinical laboratory tests and/or physical examinations performed in connection with applications for life insurance, health insurance, disability insurance or employment; revenue received for clinical laboratory tests performed for the purpose of establishing paternity; and revenue received for forensic laboratory testing.

It should be noted that certain grants and other revenue would be included and may be considered assessable if representing moneys received for the provision of care or other health-related services to individuals. An example would be a grant to perform tuberculosis testing of individuals within a specific geographic region. Note however, that government deficit financing grants are never assessable. Such deficit financing grants would be included in Line 1 and then shown as non-assessable on Line 2(i).

LINEAR DESCRIPTIONS

Note: Refer to Hospital Outpatient Report for applicable surcharge percentage.

Line 1 - Total Net Patient Services Revenue Received, including surcharges: Enter total net patient services revenue received during the report month, including surcharges (be sure to include grant revenue on this line). This amount should also include recoveries received from accounts receivable previously written off as uncollectible. Net patient services revenue includes assessable and **non-assessable** patient services revenue. Net patient services revenue must be reported in the month in which it is received.

Pursuant to Section 2807-j(3)(a) of the Public Health Law, net patient services revenue for general hospital outpatient services shall mean all moneys received for or on account of outpatient services (including referred ambulatory services), emergency services, ambulatory surgical services, hospital based clinical laboratory services, and other hospital or health-related services, including capitation payments allocable to outpatient services (including referred ambulatory services), emergency services, ambulatory surgical services, hospital based clinical laboratory services, and other hospital or health-related services, less refunds, for visits made or services performed on or after January 1, 1997, or contracted service obligations for periods on or after January 1, 1997. This section of the Public Health Law applies to all service periods subsequent to 1997.

Line 2 - Non-Assessable Revenue: Report non-assessable net patient services revenue received during the report month according to the following categories. IMPORTANT NOTE: All these amounts must be included on Line 1 - Total Net Patient Services Revenue Received, including surcharges.

Line 2(a) - Report payments related to Medicare eligible beneficiaries on this line. Payments (by Medicare and other payors) to designated providers of services for patient services provided to persons who are eligible for payments as beneficiaries of Title XVIII of the federal Social Security Act (Medicare) are not subject to the HCRA surcharges. This applies whether Medicare is the primary payor or the secondary payor. Also to be included are related co-payment, deductible and coinsurance revenue received. However, revenue received from payors (including patients) making payments to a designated provider where Medicare benefits have exhausted for a particular service or for an uncovered service, shall be subject to all applicable surcharges. The specific surcharge(s) to be applied will be dictated by whether the payor has voluntarily elected to pay the Department's Office of Pool Administration directly.

Line 2(b) - Payments related to patients covered under the Federal Employees Health Benefits Act (FEHBA) and certain federal government payors such as Job Corps, CHAMPUS/TRICARE and VA would be entered on this line. Include related co-payment, deductible and coinsurance revenue received.

Line 2(c) - Report payments received for contracted services performed for other designated providers on this line. Example: An Article 28 general hospital has a contractual agreement with a freestanding Article 28 comprehensive clinic to perform certain x-ray services. The HCRA surcharges do not apply to the amount the Article 28 general hospital bills and receives in payment from the freestanding Article 28 comprehensive clinic.

Line 2(d) - Revenue received from a public hospital pursuant to an affiliation agreement contract would be reported on this line.

Line 2(e) - Report revenue received for hospice, adult day care and home care services on this line.

Line 2(f) - Physician practice or faculty practice plan revenue based on discrete billings for private practicing physician services would be reported on this line. This refers to situations where a designated provider processes discrete billings for a private practicing physician service or faculty practice plan.

Line 2(g) - Report revenue from laboratory specimens drawn or collected outside New York State on this line.

Line 2(h) - Report payments received **directly** from the State or the Pool Administrator on behalf of the State pursuant to PHL Sections 2807-l (Health Care Initiatives) and 2807-v (Tobacco Control and Insurance Initiatives) that are included in Line 1. This would include, but not be limited to grants for the following programs: Health Facility Restructuring, Commissioner's Priority Pool, Health Care Quality and Improvement, Aids Drug Assistance Program, Emergency Medical Services, Children's and Cancer Hospitals, and Health Workforce Retraining.

Additionally, report here certain payments made directly by New York State and its local governmental subdivisions that are non-assessable. Refer to the instructions for Lines 5(a), 5(b) and 5(c) for assessable payments received directly from New York State and its governmental subdivisions.

Line 2(i) - Report government deficit financing grant revenue on this line.

Line 2(j) - Other - Include all other non-assessable patient services revenue received during the report month, which is not reportable on Lines 2(a) through 2(i), on this line. Refer to Section 2807-j(3)(a)(i) through (vii) of the PHL for a list of non-assessable patient service revenue items. Examples include co-payments received from patients eligible for medical assistance pursuant to Title 11 of Article 5 of the Social Services Law (Medicaid), co-payments received from patients eligible for the Family Health Plus Program pursuant to Title 11-D of Article 5 of the Social Services Law, and Health Care Services Pool, General Hospital Indigent Care Pool, and Professional Education Pool distributions.

Line 2(k) - Revenue received for or on account of referred ambulatory clinical laboratory hospital visits made or services performed on or after October 1, 2000, is reported on this line.

Referred (ordered) ambulatory care laboratory hospital services are defined as clinical laboratory services provided to non-registered patients upon the order and referral of a qualified physician, physician's assistant, dentist, or podiatrist to test or diagnose a specimen taken from a patient. For purposes of the specific service being ordered for a specific patient, the specified provider ordering the service may not be employed by or under contract to provide direct patient care for the facility.

Referred (ordered) ambulatory care laboratory services do not include clinical laboratory services provided to a patient admitted to any of such hospital’s inpatient units; an emergency outpatient defined as one who is admitted to the emergency, accident or equivalent service of a hospital (Title 10, Sect. 441.104); nor clinical laboratory services provided to a clinic outpatient defined as one who is registered with a formally organized hospital service unit known as a clinic (Title 10, Sect. 441.65).

Line 3 - Total Non-assessable Revenue: Enter the sum of the individual amounts reported in the Line 2 subcategories.

Line 4 - Total Assessable Revenue: Line 1 minus Line 3.

Line 5 - Net Assessable Revenue Received from Direct Pay (Electing) Payors: the payors whose names appear on the NYS Department of Health website elector list and the State's fee-for-service Medicaid Program.

Net patient services revenue received from direct pay payors must be segregated into the following categories:

Line 5(a) - Medicaid, including HMO/PHSP: Report payments received directly from the Medical Assistance Program as well as from electing HMOs and PHSPs for services provided to patients eligible for medical assistance pursuant to Title 11 of Article 5 of the Social Services Law (Medicaid) and payments received from electing approved organizations for services provided to subscribers eligible for the Family Health Plus Program pursuant to Title 11-D of Article 5 of the Social Services Law.

Line 5(b) - Other Payors: Report payments received directly from electing agencies of the State of New York (e.g., Office of Mental Health payments for services provided to individuals residing in State operated developmental centers) which have as a program component direct reimbursement to hospitals for rendered inpatient services and payments received directly from electing local governments (in New York State) **ONLY**

for services provided to correctional facility inmates.

Line 5(c) - All Other Direct Pay Payors: This would include payments from electing local governments (in New York State) for other than correction facility patients and payments by electing self-insured governmental entities in connection with health benefits for their employees (including Workers' Compensation and No-Fault).

Line 6 - Total Net Assessable Revenue Received from Direct Pay Payors: This line is the sum of Lines 5(a) through 5(c).

Line 7 - Total Assessable Revenue Received from Non-Direct Pay Payors, including surcharges: Line 4 minus Line 6. The amount reported in Column D, Line 7 must be segregated into the categories listed in Column A, Lines 8 through 12 of the corresponding service period.

COLUMNAR DESCRIPTIONS

Lines 8 through 12

Column A - Non-Direct Pay Payors: Provides specific line descriptions of non-direct pay payors.

Column B - Total Assessable Revenue, including surcharges: This column is to be used to report total net patient services revenue received from non-direct pay payors during the report month (Column D, Line 7 of the corresponding service period report). However, where a provider erroneously reported non-direct payor payments under the wrong surcharge factor on (Column B, Lines 8 through 12) a prior month's report, then equivalent positive and negative adjustments should be netted from the affected line totals and adjusted amounts reported on the appropriate line in Column B.

Column C - Surcharge Factor: This column provides the appropriate surcharge factor for each class of non-direct pay payors shown in Column A, Lines 8 through 12.

Column D - Assessable Base: Column B divided by Column C.

Column E - Surcharge Payable: Column B minus Column D.

LINEAR DESCRIPTIONS - FOR ASSESSABLE REVENUE

COLUMN B

Note: Refer to Hospital Outpatient Report for applicable surcharge percentage.

Line 8 - Medicaid-HMO/PHSP/Non-Specified Payors: Report payments received from non-electing HMOs or PHSPs, and any payor not specifically listed in PHL Section 2807-j(1) (non-specified payor), for services provided to subscribers eligible for medical assistance pursuant to Title 11 of Article 5 of the Social Services Law. See Line 11 for non-specified payor example. Also report payments received from non-electing approved organizations for services provided to subscribers eligible for the Family Health Plus Program pursuant to Title 11-D of Article 5 of the Social Services Law.

Line 9 – Other Payors: Report payments received from non-electing agencies of the State of New York (i.e., Office of Mental Health payments for services provided to individuals residing in State operated developmental centers) which have as a program component direct reimbursement to hospitals for rendered inpatient services and payments received directly from non-electing local governments (in New York State) **ONLY** for services provided to correctional facility inmates.

Line 10 - Self-Pay Uninsured, and Patient/Secondary Payor Co-pay, Deductible and Coinsurance Amounts (where primary payor is a direct pay payor): Self-Pay Uninsured - Report revenue received from patients who do not have any third party health insurance coverage in whole or in part, and also revenue from insured patients who have exhausted their health care benefits or are making payments for an uncovered service.

This line would also include patient and secondary payor co-payment, deductible and coinsurance amounts where the primary payor is a direct pay payor. This amount would be net of the amount reported on Line 19 as co-payment or deductible patient payments for which the patient's third-party payor has submitted related surcharges directly to the Department's Office of Pool Administration**.**

Line 11 - Non-Specified Payors: Enter total net patient services revenue received from any payor not specifically listed in PHL Section 2807-j(1).

Line 12 - All Other Non-Direct Payors: Report on this line payors subject to the non-direct payor surcharge. This would include any payor specified under PHL as being allowed to remit pool payments directly which has not made such election. Note also that this would include patient and secondary payor co-payment, deductible and coinsurance amounts where the primary payor is a non-electing payor.

SUMMARY LINES

Line 13 - Total Assessable Revenue, including surcharges: Sum Column B, Lines 8 through 12. This amount must equal the amount reported in Column D, Line 7 of the corresponding service period report.

Line 14 - Gross Surcharges Payable: Sum Column E, Lines 8 through 12.

Line 15 - Less: Administrative Fee: This line is the product of 2% of the amount reported in Column D, Line 12.

Line 16 - Net Surcharges Payable for the Month for Hospital Outpatient Services: Line 14 minus Line 15.

Line 17 - Net Surcharges Payable for the Month for Hospital Inpatient Services: The amount reported on this line is carried forward from Line 16 of the corresponding service period Hospital Inpatient Report. If the provider entered an "X" in the appropriate box at the top of the corresponding service period Hospital Inpatient Report to indicate that there were no net patient services revenue received during the report month and no applicable prior period adjustments to report, enter "0" on this line.

Line 18 - Total Public Goods Liability: Line 16 plus Line 17.

Line 19 - Co-pay or Deductible Patient Payments: Enter total co-payment and deductible patient payments received during the report month for which the patient's third-party payor had voluntarily submitted related surcharges to the Department's Office of Pool Administration. This amount should have been netted against the gross amount otherwise reportable in Column B, Line 10 and the net amount reportable on such line.