 SONAR Book

Minnesota Department of Health
121 East Seventh Place
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August 16, 1994

Ms. Maryanne V. Hruby, Executive Director
Legislative Commission to Review Administrative Rules
55 State Office Building
100 Constitution Avenue
St. Paul, Minnesota 55155

Re: In the Matter of Proposed Rules of the State Department of Health Relating To Aggregate Data From Hospitals - Chapter 4650

Dear Ms. Hruby:

The Minnesota Department of Health intends to adopt rules relating to aggregate data from hospitals. We plan to publish a Notice Of Intent To Adopt Rules in the August 22, 1994, State Register.

As required by Minnesota Statutes, sections 14.131 and 14.23, the Department has prepared a Statement of Need and Reasonableness which is now available to the public. Also as required, a copy of this Statement is enclosed with this letter.

For your information, we are also enclosing a copy of the proposed Rules and a copy of the Notice Of Intent To Adopt Rules in this matter.

If you have any questions about these rules, please contact me at 282-6310.

Yours very truly,

Dave Orren
Rule Writer

Enclosures: Statement of Need and Reasonableness
Rules
Notice Of Intent To Adopt Rules

STATE OF MINNESOTA
DEPARTMENT OF HEALTH

In the Matter Of Proposed Permanent Amendments To Rules Relating To The Health Care Cost Information System - Aggregate Hospital Data - Chapter 4650

STATEMENT OF NEED AND REASONABLENESS

Statutory Authority

The Commissioner's statutory authority for adopting, amending, and repealing rules under the Health Care Cost Information System (HCCIS) is found in Minnesota Statutes, section 144.703, subdivision 1, which states:

> **"144.703 ADDITIONAL POWERS.**
>
> Subdivision 1. **Rulemaking.** In addition to the other powers granted to the commissioner of health by law, the commissioner of health may:
>
> (a) Adopt, amend, and repeal rules in accordance with chapter 14;
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> (b) Adopt in rule a schedule of fines, ranging from $100 to $1,000, for failure of a hospital or an outpatient surgical center to submit, or to make a timely submission of, information called for by sections 144.695 to 144.703."

The Commissioner's statutory authority for adopting rules under Minnesota Statutes, chapter 62J, is found in Minnesota Statutes, section 62J.35, subdivision 5, which states:

> **"62J.35 DATA COLLECTION.**
>
> Subdivision 5. **Rules.** The commissioner shall adopt permanent rules and may adopt emergency rules to implement the data collection and reporting requirements in this chapter. The commissioner may combine all data reporting and collection requirements into a unified process so as to minimize duplication and administrative costs." (Subdivision 5 was not changed by 1994 Minnesota Laws, chapter 625.)

General Statement Of Need And Reasonableness

The permanent rules and proposed permanent amendments set out the financial and statistical requirements for hospitals and freestanding outpatient surgical centers. This data is collected as part of the Health Care Cost Information System (HCCIS) which has existed since 1984. Recent health care reform initiatives also apply to data collected under these rules.

Health Care Cost Information System - Legal Overview

In 1976, the Minnesota Legislature passed the Minnesota Hospital Administration Act (Minnesota Laws 1976, chapter 296, article 2, codified as Minnesota Statutes, sections

144.695 to 144.703), that established the Minnesota Hospital Rate Review System (MHRRS). MHRRS consisted of hospital reports, and administrative procedures and standards. Hospital Rate Review Panels were appointed by the State Board of Health (the predecessor to the Minnesota Department of Health) to review proposed rate changes and present the Board with recommendations about the proposed hospital rates. The Board was responsible for promulgating rules, publishing the allowable increase limits, and determining the exemption criteria used by MHRRS. The Board was allowed to initiate "investigations as necessary to assure all purchasers of hospital health care services that the total costs of a hospital are reasonably related to the total services offered, that the hospital's aggregate revenues as expressed by rates are reasonably related to the hospital's aggregate costs, and that rates are set equitably." No authority was given to the Board or to the Panels to approval or disapproval of the proposed rate changes.

The Board was also authorized to approve a voluntary non-profit rate review organization to administer the MHRRS, if the organization's rate reporting and rate review procedures were substantially equivalent to those adopted by the Board. This was to be substantially equivalent to a program which might otherwise be run by the Department. The VNRO was responsible for collecting and verifying all licensed hospitals' reporting requirements (annual financial information report, and rate revenue and expense report), and for providing the Panels and the Board with a summary of findings and comments about each individual hospital prior to the effective date of any proposed rate increase. The Minnesota Hospital Association (MHA) was approved as the first Voluntary Non-profit Reporting Organization (VNRO).

In 1981, a provision was added to the Act, Minnesota Statutes, section 144.704, that excluded certain grants, gifts, and income from endowments from non-governmental sources, for the purpose of separating these revenues from the revenues received through the delivery of hospital services. In 1982, a provision was added to the Act, Minnesota Statutes, section 144.705, that encouraged voluntary hospital price reporting for common hospital conditions.

The MHRRS operated until 1984, when the Minnesota Legislature passed the Minnesota Health Care Cost Information Act (Minnesota Laws 1984, chapter 534, which amended Minnesota Statutes, sections 144.695 to 144.703, and repealed Minnesota Statutes, sections 144.704 and 144.705). The Act created the Health Care Cost Information System (HCCIS). Under the Act, the hospital rate review system (MHRRS) was transformed into a data collection and analysis system (HCCIS). The system was expanded to include data collection on freestanding outpatient surgical centers; such centers were provided with an option to comply with the rules under a group variance. HCCIS's main responsibility was to provide accurate and reliable information about the financial and utilization characteristics of hospitals and freestanding outpatient surgical centers in Minnesota to public policy makers, purchasers of hospital services, and the public in general.

Under HCCIS, hospitals were not required to undergo a review of their proposed rate increases. Rate review panels were eliminated in favor of a system of commentaries on

hospital financial and statistical information. The Legislature recommended that the Department encourage price competition within the hospital industry.

In 1985, an amendment was made to Minnesota Statutes, section 144.70, that changed the time and content of the Department's report to the state Legislature. The Department was required to complete studies on uncompensated care, teaching and research costs, hospital financial conditions and utilization characteristics, access to hospital care, and rate disclosure. The Department was also required to complete a biennial report on health care markets in the state.

In 1987, an amendment was made to Minnesota Statutes, section 144.699, subdivision 2, to include home care providers under fostering price competition.

In 1989, amendments were made to three sections of Minnesota Statutes. First, section 144.698, subdivision 1, was extended to require reporting of information on services provided at no cost, teaching and research activities and other charitable activities. Second, section 144.701, subdivision 3, was amended to specify that rate notifications were to be filed on or before their effective date and subdivision 4 was amended to require reporting of termination or non-renewal of the VNRO to the Minnesota Legislature. Third, section 144.702, subdivision 2, was changed to read that the VRNO's procedures must be "consistent" with written operating procedure instead of "substantially equivalent." Subdivision 7 was added to provide staff support for HCCIS at the Minnesota Department of Health. Finally, subdivision 8 was added regarding termination or non-renewal of a reporting organization based upon failure to comply with written operating requirements.

Permanent rules implementing these statutory sections were first adopted in 1977. Permanent amendments to the rules were made in 1979, 1980, and 1984. Emergency amendments to the rules were made in 1993. The status of these emergency rule amendments is discussed later in this SONAR.

A hospital is required to file a copy of its audited financial statement, medicare cost report, and revenue and expense report at the end of its fiscal year, and one copy of a rate notification report each time it plans to implement a new rate schedule. These reports are submitted to a VNRO in charge of administering the system under the supervision of the Minnesota Department of Health. The Minnesota Hospital Association is the designated VNRO for hospital reporting for the 1993-1994 reporting period.

A freestanding outpatient surgical center is required to file a copy of its annual financial information report and annual status report at the end of its fiscal year, and one copy of a rate notification report each time it plans to implement a rate adjustment. Surgical center reports are submitted directly to the Minnesota Department of Health.

Hospital revenue and expense report information and selected indicators from hospital audited financial statements are maintained on the HCCIS computer databases and updated on an ongoing basis. Other reports are compiled through paper files and are archived and maintained on microfilm.

Legislative History: Health Care Reform, MinnesotaCare Act and Data Collection Objectives

Minnesota's health care reform initiative encompasses a wide range of activities. The primary goal is to provide universal coverage for health care while maintaining the quality of the care and reducing the rate of growth in current health care expenditures. Cost containment was clearly a part of the 1992 HealthRight Act and is the vehicle to achieve savings that could be used to expand coverage to the currently uninsured. The 1992 legislation provided a framework for the overall approach to cost containment; the rate of growth in health care spending must be reduced by 10 percent each year beginning in 1993 and the Commissioner of Health was required to establish enforceable statewide and regional limits on the rate of growth of health care spending for Minnesota residents. The 1992 legislation established a 25-member (now 27) commission (The Minnesota Health Care Commission) of providers, payers, and consumers to develop a cost containment strategy and report back to the Legislature in 1993. The Minnesota Health Care Commission met bimonthly for a period of six months to develop and report its cost containment strategy to the Legislature. The Commission's basic proposal, with some modification of the details, was passed by the Legislature as part of the 1993 health reform legislation.

The three key components of Minnesota's cost containment strategy include the following: 1) Integrated Service Networks (ISNs) that agree to provide a defined set of benefits for a fixed price; 2) the Regulated All-Payer Option (RAPO) that sets standardized payment rates for payers and providers who do not participate in ISNs; and 3) overall limits of the rate of growth for health care expenditures for the State.

The framework underlying the strategy of expenditure limits chosen by the state of Minnesota requires the ability to quantify state health care expenditures and monitor the expenditures and their trends over time. There is currently limited data available on health care spending at the state level. The federal Health Care Financing Administration (HCFA) published estimates on health care spending by state; once in 1982 and just recently in 1993. The method used by HCFA actuaries, however, does not provide the detailed information needed to effectively implement and enforce spending limits at the state level. In addition, much of the work done in estimating state-level spending is developed by manually pulling together a diverse set of information from various data sources and this time-consuming compilation of disparate data sources must be re-enacted every year to keep the numbers up to date.

Minnesota's objective was to develop its own method and state infrastructure for collecting information on health care spending for the purposes of quantifying and monitoring health care expenditures and enforcing the limits on the rate of growth of that spending. State-level data would be more accurate, more timely, and could be tied to individual payers and provider groups for accountability purposes. From the data, policy makers could also assess the impact of health care reform.

The Health Care Commission recommended using a two stage strategy for data collection: (1) a short-term initiative to provide immediate information from payers on a significant, but not complete, picture of health care spending that will be used to establish a growth trend for 1991; and (2) a more comprehensive data collection plan to provide more detailed data based

on aggregate surveys of health care providers and payers and encounter-level data that can be used to monitor spending and growth patterns over time. The framework for defining the elements to include in health care spending is based on that used by HCFA National Health Expenditure accounts to estimate national expenditures.

The short-term data collection strategy used to establish the 1991 baseline of health care expenditures clearly did not capture all health care expenditures of interest. The data do not represent all payers nor all types of health care expenditures. Expenditures that were not reviewed as part of the short-term strategy include out-of-pocket expenditures, charity care, bad debt, technology, research and education, and capital expenses. Several provider groups felt strongly that, by relying on payer-level data to set expenditure limits, the Department would miss several important components: namely bad debt, charity care, and out-of-pocket costs. In response, a physician-clinic survey was developed to supplement hospital financial information as part of the long-term data collection strategy.

The goal of the long-term data collection strategy was to collect aggregate data on health care revenues and expenditures by payer type and service category for all public and private payers. The state has several data sources that, while not all-inclusive, are helpful in building the process for data collection for other payers and providers. Minnesota has long-standing data collection requirements for aggregate financial data from hospitals and HMOs and detailed information on its public programs. The largest gaps include the lack of information on physician services and other providers.

The data collection strategy involves collecting: 1) aggregate data on health care revenues and expenditures by payer type and service category for both public and private programs, and 2) unaggregated claims paid and encounter level data provided by payers. This data will be used to track total health care expenditures and revenues in the State of Minnesota. Attention will be given to the data collection and aggregation process to avoid any double counting. The two levels of data will be used to document revenues and expenditures and to cross check the data provided through each method. More detailed information will be needed for both the provider and payer groups including, but not limited to, the identification of Minnesota and non-Minnesota residents and the county of residence. This will establish regional spending and growth targets.

Aggregate data from HMOs (and eventually ISNs and CISNs) will be based on modified versions of annual financial reporting forms. Aggregate data from hospitals will be based on modified versions of the revenue and expense report. New surveys were developed for commercial insurers, Blue Cross/Blue Shield, self-insured plans, and physician clinics.

More state-level data is needed in order to estimate and monitor health care spending in the State of Minnesota for the purposes of accurately establishing spending limits . A primary objective has been to collect uniform and consistent state-level data in a routine and efficient manner on an ongoing basis. The Health Care Commission's report to the Legislature outlined the key assumptions for data collection. These included the following: 1) Health care revenue and spending data will be routinely collected from both payers and providers of health care services. 2) Data will be collected annually based on consistent guidelines and

data definitions. 3) The data set will include as a base, expenditures, revenues, and enrollment for health care services contained in the set of basic benefits generally included in health coverage programs. 4) The expenditure data base will be limited in the initial years but will evolve as additional sources of data are identified, developed, and submitted. 5) Data definitions and data collection techniques will be refined over time to ensure the collection of uniform and accurate data on health care spending and to ensure a balance between the need for accurate data and the costs associated with collecting such data.

Minnesota Statutes, Section 62J.41

Minnesota Statutes, section 62J.41, subdivision 1, governs data to be collected from providers. It states:

> "The commissioner shall require health care providers to collect and provide both patient specific information and descriptive and financial aggregate data on:
>
> (1) the total number of patients served;
>
> (2) the total number of patients served by state of residence and Minnesota county;
>
> (3) the site or sites where the health care provider provides services;
>
> (4) the number of individuals employed, by type of employee, by the health care provider;
>
> (5) the services and their costs for which no payment was received;
>
> (6) total revenue by type of payer, including but not limited to, revenue from Medicare, medical assistance, MinnesotaCare, nonprofit health service plan corporations, commercial insurers, integrated service networks, health maintenance organizations, and individual patients;
>
> (7) revenue from research activities;
>
> (8) revenue from educational activities;
>
> (9) revenue from out-of-pocket payments by patients;
>
> (10) revenue from donations; and
>
> (11) any other data required by the commissioner, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, monitoring actual spending, and monitoring costs and quality."

Data items required by section 62J.41 that are included in the rules are discussed in this SONAR in the Rule-By-Rule Analysis section. Two data items are notable and discussed here because they are not required under these proposed rules. "The total number of patients served by state of residence and Minnesota county" and "revenue from out-of-pocket payments by patients" are data items that have not been included in the rules.
State and county residency is difficult for hospitals to determine because they capture their data by the patient's billing address. Out-of-pocket payment information is currently difficult for hospitals to provide, because hospitals currently do not record payment sources in all instances. For example, hospitals cannot determine when a bill is paid directly out-of-pocket or when an out-of-pocket payment is reimbursed by an insurance company or HMO.

In the short term, the Department plans to work with hospitals to seek voluntary reporting of this information. The Department also plans to reconvene the work group to work on these issues.

Uses of Hospital Data.

The hospital data collected pursuant to these rules will assist analysts with public policy decisions and will also assist hospitals in comparing their expenditures to aggregated data from all hospitals. Ultimately the data collection should provide the information needed to monitor cost savings in the health care system. The financial and statistical data collected by the Department will serve the following purposes:

1) Data will contribute to the development of estimates of total health care spending and aggregate hospital utilization for the state of Minnesota.

The information collected as part of the data requirements for health care providers will be used to help establish baseline information on health care expenditures and track expenditures over time. The Department currently collects detailed revenue and expense data from hospitals. The hospital data set has allowed the Department of Health to monitor hospital revenues, expenditures, utilization, and capacity changes, and evaluate policy options that are being considered by the Minnesota legislature, the federal government, and by other state agencies.

Compiled with other health care spending data, this data will provide information for policy analysts and key decision makers on the total picture of health care spending. Some of the questions that will be addressed include the following:

a) What portion of health care spending is attributed to inpatient hospital services, and what portion is attributed to outpatient hospital services?
b) How does this distribution of health care spending compare with national trends for the same set of services?
c) How have the trends in health care spending changed over time?
d) What proportion of hospital and other provider spending is uncompensated or not reimbursed?

2) The data collected will provide unique information that is not a part of other data collection requirements.

Data collected directly from health care providers on health care revenues and costs will provide additional information that is not a part of the aggregate information submitted by payers. Payers are required to submit aggregate data on health care spending by type of provider. The information submitted, however, is limited to claims paid and does not include any expenditures that are not covered by third-party payers, such as out-of-pocket payments made directly by the patient and care that is provided without remuneration. In addition, the state does not have the authority to require self-insured plans to submit aggregate data. Collecting data directly from the health care providers will provide this additional piece of data.

3) The data collected will be used to refine the methodology currently used to estimate health care spending in the State of Minnesota for setting limits on the rate of growth of health care spending.

The 1993 MinnesotaCare Act established limits on the rate of growth of health care spending for the State of Minnesota. All payers and health care providers are required to comply with the growth limits established under Minnesota Statutes, section 62J.04, subdivision 1. These growth limits were based on estimates of current health care spending in Minnesota and trends in that spending. The information was based on data collected from payers for the years 1990, 1991, and 1992. The 1990 and 1991 information was used to set the baseline on health care spending and to forecast a 1994 trend rate. The estimated baseline figure for 1991 represented approximately 70% of total health care spending in Minnesota.

Additional data from payers and health care providers will provide a more complete picture of health care spending in the state. The data will be used to update the 1990-1992 information and will represent approximately 90% of the health care spending in the state. This information is crucial to accurately estimate health care expenses and enrollment, which in turn is essential to forecasting future trends in spending, refining the growth limit methodology, and making relevant policy decisions on cost containment.

4) Aggregate data will demonstrate the impact of health care reform and the cost containment strategies proposed under health reform legislation.

Health reform legislation has initiated major health care system reform relying on the competitive marketplace and ISNs and CISNs as the major vehicle for service delivery. Providers outside the ISN system will be reimbursed under the RAPO. One of the reasons for collecting comprehensive data on health care spending is to track the impact of major system reform and its ability to contain the growth in health care spending. The information collected through the aggregate surveys from health care providers and payers will be used to monitor trends in health care spending and to report back to the Legislature, the Governor, the Commissioner, the Health Care Commission, and Minnesota citizens on the effects of reforms on the rate of growth in health care spending and costs within the system.

5) The data collected will allow health care providers to demonstrate to policy analysts and key decision makers particular areas of their costs that may be beyond their control.

There are some costs directly related to the provision of health care services that will not be captured by any other source of data collection. Health care providers represented on the Health Care Commission recommended that the state's data collection efforts provide an opportunity for health care providers to submit data to the Department of Health to highlight some of the costs associated with the provision of care. These costs include such items as labor costs, malpractice insurance, billing and collection costs, research and education costs, and costs related to uncompensated care and charity care. Such information can only be obtained from hospital and provider financial and statistical reports.

6) Aggregate data will assist health care providers in identifying trends and variances in costs.

The financial data on their costs will be useful to health care providers in determining how individual health care provider clinic's or group's costs compare to average health care costs

in Minnesota. The data may illustrate variances in the different aspects of health care costs. For example, the data from providers may facilitate understanding of the distribution of costs across specific providers relative to an average.

Four Data Collection Initiatives - Emergency Rules - Input Into The Development Of The Permanent Rules

In response to the data collection and analysis requirements in the 1993 MinnesotaCare Law, the Department embarked on the development of four sets of related data collection rules: 1) aggregate data from hospitals; 2) aggregate data from health care providers; 3) aggregate data from group purchasers; and 4) encounter level (or claims) data from group purchasers.

In January 1993, based on a directive in the 1992 health reform legislation, the Commissioner convened a special work group of the Data Collection Advisory Committee to advise the Department on issues related to the collection of administrative costs data. The Department also communicated with affected parties and received input regarding data collection issues and procedures. Based on the statutory directives and the input from affected parties, the Department developed draft data collection instruments. In June 1993, the Department informed affected parties of what the new reporting requirements would likely be.

The Department proposed four sets of emergency rules on October 4, 1993. For the hospitals, the emergency rules were emergency amendments to the permanent rules. The other three sets of emergency rules were new material. The emergency rules were adopted on November 19, 1993, were approved by the Attorney General on December 7, 1993, and became effective December 14, 1993. The emergency rules are effective through December 8, 1994. The emergency rules governed the 1994 data collection. The proposed permanent rules will replace the emergency rules and will govern data collection beginning in 1995.

Immediately after the adoption and approval of the emergency rules, the Department began work on the development of the permanent rules. It was the Department's plan to have four work groups to advise the Department on the development of the permanent rules, one for each set of rules. The Department then approached the Minnesota Health Data Institute, an organization created under Minnesota Statutes, section 62J.45, as a public-private partnership between the Commissioner of Health and a Board of Directors representing health carriers and other group purchasers, health care providers, and consumers, to determine the role the Data Institute wanted to play in advising on the development of the rules. Following the suggestion of the Data Institute, the Department formed an advisory task force in addition to the four advisory work groups. The task force monitored the work on all four sets of rules and coordinated the work on issues common to more than one set of rules. The task force consisted of 12 members, half from the Data Institute and half appointed by the Department. The work groups were made up of persons technically qualified to advise on data collection issues. The Department's goal was to accommodate all persons who wished to participate on the work groups.

On January 18, 1994, the Department published in the State Register a Notice Of Solicitation Of Outside Information Or Opinions notifying the public of the Department's plans to

develop rules and to form a task force and four work groups to advise on the development of the rules. The Solicitation invited all interested persons to contact the Department. The Solicitation was also mailed to persons on the Department's rulemaking mailing list, to persons who had commented on the proposed emergency rules, and to other persons identified by the Department as likely to be interested in the permanent rules.

The first meeting of the task force and work group members was held on March 3, 1994. The task force met four times from March through July 1994. The hospital work group members met ten times from March through June 1994.

The hospital work group did not endorse the collection of administrative costs data, but, given the requirement, felt the support services categories developed under the permanent rules would be an improvement over the administrative costs categories under the emergency rules.

Persons who participated in one or more hospital work group meeting were:

Andrew Calkins, Minnesota Nurses Association
Mitchell Davis, Jr., Minnesota Hospital Association
David Doth, Metropolitan Healthcare Council
Mike Nass, HealthEast
Trisha Schirmers, HealthSpan
Mark Skubic, HealthSystems Minnesota

Updating Existing Rules

The hospital work group began by reviewing its charge and the timeline for its process. Two products were expected from the process, new draft language for chapter 4650 and a statement of need and reasonableness for any proposed amendments. In planning general strategy for the changes to the permanent rules, the work group approached the review in three groups: 1) scope; 2) data elements and definitions; and 3) administrative procedures for filing. These three groupings parallel the overall structure of the existing permanent rules.

During the review process, the work group received copies of Minnesota Statutes, sections 144.695 to 144.703, the revenue and expense report and its instructions, a list of HCCIS data uses and users, the freestanding surgical center formset and its instructions, along with numerous drafts of chapter 4650.

The work group also reviewed other hospital data collection systems, most specifically the Colorado hospitals data bank. The advantage of the HCCIS system was that it collected audited financial data. The disadvantage of the HCCIS system was the time lag between collection and availability of the data. The work group recommended not to consider a new system of reporting at this time and therefore, began to strategically improve the HCCIS system.

The work group recommended that no changes to the first paragraph of the scope were needed. The exemption in the second paragraph was determined to be unnecessary and so

the paragraph was deleted. The third paragraph of the scope was changed to automatically reflect current federal law and regulations instead of those in effect on April 1, 1976.

In reviewing the data elements and definitions, the work group recommended updating the names of the current reports from "rate revenue and expense report" and "interim increase report" to "revenue and expense report" and "rate notification report" respectively. This change was necessary to remove the reference to rate review, which was eliminated in 1984. The new report names are those currently used by HCCIS, even though they had not been consistent with the rules.

The work group focused on the language referring to the Medicare cost report under parts 4650.0110 and 4650.0132, entitled "Annual Financial Statement." The work group agreed that the Medicare cost report was a separate report and should be moved into two new sections (4650.0111 and 4650.0133) specifically created for this report.

The work group considered citing generally accepted accounting principles or standards for financial reporting instead of listing the detailed requirements in the annual financial statement. After some discussion, the detailed requirements were updated instead. Subpart 1 was updated to specifically include references to standard parts of an audited financial report. Specific changes include moving "bad debts" from a reduction in gross revenue to an expense category and deleting part 4650.0110, subpart 2, item F, because it was not currently being collected by HCCIS. Three items under subpart 3, "Income and expenses" were changed to subparts because they are not part of the income and expenses, but are each components of the annual financial report.

The work group recommended clarifying the estimation of current year information in the revenue and expense report in part 4650.0112, subpart 1, item B such that three months of the estimate must be based upon actual data and the remaining months be estimated on budget information. Next, the work group recognized that "budget year" reporting was a relic from rate review (eliminated in 1984) and so all references in the revenue and expense report to "budget year" were recommended to be repealed. Finally, the work group identified several areas where data collected by the current revenue and expense report formset was not specifically required in the rules. Language was added in part 4650.0112 for the collection of statistical and financial data items on the current revenue and expense report formset. Some of these additional items, part 4650.0112, subpart 3, items B and C, are covered in more detail under the Administrative Costs discussion later in this SONAR.

The work group continued its revision of part 4650.0112 Revenue and Expense Report through additions and modifications to the definitions. In part 4650.0112, subpart 2, items B and D, references to revenue and service centers were clarified with more exact definitions. The daily patient services were specifically listed as the categories on the revenue and expense report formset. The language on full-time equivalent employee was removed from item C and inserted in part 4650.0102, subpart 19a. In item E, "clinic visits" was replaced with "outpatient visits" and a definition for "outpatient visit" was added in part 4650.0102, subpart 30. This definition removed the ambiguity of this previously undefined term.

Part 4650.0112, subpart 4, item A was moved to 4650.0114, subpart 2, item C because the language pertained to the rate notification report. Part 4650.112, item B was repealed because the language referred to the certificate of need law, which was repealed in 1982.

The work group discussed repealing part 4650.0114 in its entirety, since it was believed that the rates would be evaluated and adjusted by both the growth limits and the all payer system. The work group agreed to delay repealing 4650.0114 until the Department could evaluate how effective these rate controls were.

1989 Form Set

Minnesota Statutes, section 144.698, sets out reporting requirements under HCCIS. Subdivision 1, which governs yearly reports, states in pertinent part:

> "Each hospital and each outpatient surgical center, which has not filed the financial information required by this section with a voluntary, nonprofit reporting organization pursuant to section 144.702, shall file annually with the commissioner of health after the close of the fiscal year:
>
> . . .
>
> (6) information required on the revenue and expense report form set in effect on July 1, 1989, or as amended by the commissioner in rule . . . ."

A number of data elements in the current form set are not required by the existing permanent rules, but instead are required under section 144.698, subdivision 1, clause (6), since they were on the 1989 form set. In this rulemaking, the Department is now proposing to amend the rules to incorporate many of these 1989 form set data elements. In the Rule-By-Rule Analysis section of this SONAR where amendments are proposed based on incorporating 1989 form set data elements, only a reference to this fact will be given.

It is important for the Department to continue collecting these data elements because they have provided useful information. It is workable for hospitals to provide these data elements since they have now been submitting them for at least five years. The Department will rely on this to show the need for and reasonableness of these data elements.

A copy of the 1989 form set is attached to this SONAR as an appendix.

Administrative Costs

The purpose of the administrative costs page of the revenue and expense report formset is to identify and measure key functional categories of health care provider costs. The information required by the emergency rules, from which data was collected from hospitals in 1994, contained a detailed breakdown of costs incurred in 1991 and 1992.

The 1993 MinnesotaCare Act required the Commissioner of Health to study administrative costs in the health care system in the interest of identifying and recommending cost savings and efficiencies related to administrative costs. Minnesota Laws 1993, chapter 345, article 3, section 17, titled "Study Of Administrative Costs" states:

"The data analysis unit shall study costs and requirements incurred by health carriers, group purchasers, and health care providers that are related to the collection and submission of information to the state and federal government, insurers, and other third parties. The data analysis unit shall also evaluate and make recommendations related to cost-savings and efficiencies that may be achieved through streamlining and consolidating health care administrative, payment, and data collection systems. The unit shall recommend to the commissioner of health and the Minnesota health care commission by January 1, 1994, any reforms that may produce cost-savings and efficiencies without compromising the purposes for which the information is collected."

Additionally, Minnesota Statutes, section 62J.41, subdivision 1, clause (11), requires providers to submit "any other data required by the commissioner . . . for the purposes of . . . monitoring actual spending, and monitoring costs and quality."

Administrative costs has been a topic of continued and intense interest both for persons interested in health care reform and specifically for the Minnesota Legislature. Because of this interest, the Department decided to include administrative cost data as part of its annual aggregate data collection effort. The starting point for data collection under the permanent rules was the revenue and expense report page developed under the emergency rules. To understand the development of and rationale for the permanent rules related to administrative costs, it is instructive to look at the development of and rationale for the emergency rules related to administrative costs.

In developing the original administrative costs page of the revenue and expense report and the emergency rules, the Department worked with a work group formed from the Data Collection Advisory Committee (DCAC). In their preliminary research, the group and the Department found that published estimates of administrative costs were not comparable due to differences in operational definitions, data sources, measurement techniques, and theoretical assumptions. Cost accounting is a complex exercise, the principles of which vary among the various components of the health care system. It should also be noted that the definition, identification, measurement, and analysis of administrative costs is likely to become even more difficult with a further integration of the various components of the health care delivery system. Managed care and capitation further challenge traditional accounting procedures and cost-finding. Thus the concept of administrative costs will become more ambiguous, less precise, increasingly controversial and, consequently, of little analytic value, unless a consistent conceptual framework and uniform accounting procedures are applied.

Despite the inherent difficulties with the issue of administrative costs, the Department felt that measuring these costs as well as the costs directly related to patient care was important to providing a total picture of health care spending. It will be important to collect and maintain data to chart the trend in all sectors of health care spending in order to make informed policy decisions and to adequately assess the impact of health care reform legislation. However, in order to meaningfully and accurately measure these costs, the Department needed to develop a framework to consistently identify these costs. For the administrative costs data collected under the emergency rules, the Department, in conjunction

with the Data Collection Advisory Committee, looked to Kenneth Thorpe's framework for identifying administrative costs as a model.

Thorpe's model for categorizing and analyzing administrative costs was presented in the Summer 1992 volume of Health Affairs. Thorpe begins by explaining that administrative costs should be identified as "inputs" into the "function" of health care providers and payers. He notes that "investments in administrative spending produce or support several outputs, including patient care, clinical and health services research, and education," (Thorpe, 1992). Importantly, Thorpe's conceptualization of administrative costs includes a framework which may help distinguish which costs "are amenable to change and those where reductions could increase total (health care) spending." There are administrative functions that, if eliminated, would actually increase health care spending. For example, a study of industry data reveals that every dollar spent on utilization management reduces claim costs from one to nine dollars, (Sheils, et al., 1992). In addition, Thorpe's research and article clearly acknowledge the difficulty in comparing administrative costs across payers and providers.

In his paper, Thorpe groups administrative costs by function into four categories: 1) transaction-related, 2) benefits management, 3) selling and marketing, and 4) regulatory/compliance. Within these functions are various administrative activities or inputs. The administrative costs work group of the DCAC began with the Thorpe system for categorizing administrative costs. The work group expanded some of the expense categories described by Thorpe and these were the categories used in collecting the 1991-92 hospital revenue and expense report data that was reported in 1994.

After the hospitals submitted the 1994 report of 1991-92 revenue and expense report data, it was clear that one of the difficulties in using the Thorpe model of administrative cost functions was that the cost data required for the page on administrative costs was different from the cost accounting of a typical hospital. Thorpe's methodology for determining functional costs does not follow traditional general ledger accounting. A typical financial statement does not reflect the cost of the functions defined by Thorpe or those used in the original administrative cost page. Many hospitals expressed problems in completing the administrative costs page because they did not know what expenses to include in each category. The original administrative costs page and emergency rules did not adequately define what costs to include or how to calculate these costs from typical hospital financial data.

In order to transform standard financial data into the Thorpe functional categories, the hospitals needed to allocate costs from traditional categories from the chart of accounts. For example, the Thorpe-defined transaction-related function includes billing and collection costs. Billing and collection costs are not a unique item in a typical chart of accounts. However, items such as postage, service bureau fees, wages, and rent, which contribute to the process of billing and collection as well as many other functions are included within the chart of accounts. In order to determine the billing and collection functional cost, the hospitals had to allocate and sum up the costs of the various inputs that comprise billing and collection costs.

It is necessary for the permanent rule amendments to define both the categories and the method for making these administrative expense allocations. The proposed rules do not prescribe one precise method for making expense allocations. It was determined, with the work group's recommendation, that it was important to have a flexible approach for making these allocations. The instructions, however, do provide examples of allocation methods. Based upon these examples, the expense allocations will be made in a similar manner. Because of the variety in hospital sizes and their administrative and organizational schemes, one rigid approach for allocating expenses was deemed to be unworkable.

The work group members who had completed the 1991-92 revenue and expense report page on administrative costs data also voiced their concerns and problems with the labeling of particular functional cost categories. Work group members said that some of the categories did not reflect the nature of their business. They indicated that many of the classifications or labels were artificial. Finally, there were concerns about labeling costs as "administrative" because they might be interpreted as "unnecessary paper shuffling" or perceived as "bad costs" by some policy makers.

The work group recommended combining some of the categories, expanding some of the categories, and deleting some of the categories in an effort to provide efficient, consistent and understandable categories of reporting hospital expenses. In addition, each definition was extensively rewritten in language familiar to those who will complete the revenue and expense report.

The initial categories and the work group's final proposed categories are as follows:

Initial categories	Final proposed categories
Admitting	Admitting
Billing and Data Processing	Patient Billing and Collection
Quality Assurance	Quality Assurance
Selling and Promotion	Promotion and Marketing
Taxes and Assessments	Taxes, Fees and Assessments
General Administration	Other Support Services
Total Administrative Costs	Total Support Services
Regulatory and Compliance Reporting	Estimated Cost of Regulatory and Compliance Reporting
Government Relations	
Fees	
Research/Education	Research
	Education
	Accounting and Financial Reporting
	Community and Wellness Education
	Malpractice
	Management Information Systems
	Plant, Equipment and Occupancy

The task force directed the hospital work group to parallel the work of the provider work group wherever possible. In this effort, the hospital work group identified two groups of

expenses that other providers were allocating to functional categories of expenses: management information systems expenses and plant, equipment and occupancy expenses. Allocating these expenses posed some concern to the hospital work group since the sheer magnitude of these hospital expenses might outweigh or overshadow the magnitude of the category by itself. As a result, the work group decided to provide a category for each of these two expenses and to allocate a percentage (which would not sum to 100%) of each expense to each category of administrative costs.

The research and expense categories of administrative costs would be those expenses reported on the Medicare cost report and already reported on the revenue and expense report. Consequently, the category definitions were improved to better reflect the Medicare cost report definition and the revenue and expense report will collect information on these expenses in both its public and non-public sections.

The work group considered whether the Medicare cost report categories could be reorganized to provide the administrative costs information. It was believed that the information could be obtained from the Medicare cost report, but a unique mapping of accounts for each hospital would be needed to categorize the information into administrative costs categories. The work group agreed to postpone discussion of the Medicare cost report method until after the administrative cost categories were finalized in the permanent rules. The Medicare cost report might then be used as one method for collecting this administrative cost information.

Finally, the work group recommended that the page title, "administrative costs", be changed. Several alternatives were considered before the work group agreed to "support services expenses". This title was believed to reflect the content of the page and not to have the negative connotations of "administrative costs".

Small Business Considerations

Minnesota Statutes, section 14.115, requires the Department of Health to consider the effect on small businesses when it adopts rules. For purposes of this section, "small business" means a business entity, including farming and other agricultural operations and its affiliates, that (a) is independently owned and operated; (b) is not dominant in its field; and (c) employs fewer than 50 full-time employees or has gross annual sales of less than $4,000,000. For purposes of a specific rule, an agency may define small business to include more employees if necessary to adapt the rule to the needs and problems of small businesses. The rules will have a direct effect on small businesses that operate hospitals and freestanding surgical centers.

Section 14.115, subdivision 2, states in relevant part:

"When an agency proposes a new rule, or an amendment to an existing rule, which may affect small businesses ..., the agency shall consider each of the following methods for reducing the impact of the rule on small businesses:

(a) the establishment of less stringent compliance or reporting requirements for small businesses;

(b) the establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses;

(c) the consolidation or simplification of compliance or reporting requirements for small businesses;

(d) the establishment of performance standards for small businesses to replace design or operational standards required in the rule; and

(e) the exemption of small businesses from any or all requirements of the rule."

Specific methods for reducing the impact of the rules on small businesses have been considered. In general, the rules are drafted to impose as small a burden as possible on all businesses, including small businesses. The impact of the rules on small businesses has been reduced as follows:

a) Less stringent requirements. The work group process was designed to get input from the hospital industry in an effort to make these rules more workable for the industry and to get the data needed by the Department without undue burden. Some requirements amended include that the estimate of budget year data being based on three months instead of nine months of actual data and that certain data fields were combined into one.

b) Less stringent schedules. This area is governed statutorily. It was not appropriate to change schedules.

c) Consolidation or simplification of requirements. The work group process achieved significant clarification of definitions. This will simplify the process of completing the report for all businesses. The report collects some data elements directly from the Medicare cost report so that hospitals can use data that is already compiled.

d) Performance standards. This is not applicable because there are no design or operational standards.

e) Exemption. This is not appropriate because the data from all hospitals is deemed important to the Health Care Cost Information System.

Departmental Charges Imposed By The Rules

Minnesota Statutes, section 16A.1285, does not apply because the rules do not establish or adjust charges for goods and services, licenses, or regulation.

Fiscal Impact On Local Public Bodies

Minnesota Statutes, section 14.11, subdivision 1, does not apply because adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption of the rules.

Agricultural Land Impact

Minnesota Statutes, section 14.11, subdivision 2, does not apply because adoption of these rules will not have an impact on agricultural land.

Other Specific Statutory Requirements

Minnesota Statutes, section 62J.07, subdivision 3, requires the commissioners of health, commerce, and human services to provide periodic reports to the legislative commission on health care access on the progress of rulemaking that is authorized or required under chapter 62J and to notify members of the commission when a draft of proposed rules has been completed and scheduled for publication in the State Register. This will be done concurrently with submitting the rules and the Notice of Intent to Adopt to the State Register for publication.

Witnesses

If these rules go to a public hearing, the witnesses listed below may testify on behalf of the Department in support of the need for and reasonableness of the rules. The witnesses will be available to answer questions about the development and the content of the rules.

Barbara Nerness, Department of Health, Assistant Commissioner.
Mary Kennedy, Department of Health, Director of the Health Care Delivery Policy Division.
Lynn Blewett, Department of Health.
Grace Sheely, Department of Health.
JoMarie Williamson, Department of Health.
Dave Orren, Department of Health.
Mary Sarazin Timmons, Department of Health.
Other employees of the Minnesota Department of Health, as deemed necessary or appropriate.

Rule-By-Rule Analysis

4650.0102 DEFINITIONS. This part is amended in many subparts to make existing definitions more precise and to add definitions for terms mandated by relevant statutes.

Subpart 1a. Accounting and financial reporting expenses. This definition is needed because the term is used to capture a functional component of total support services expenses and is not defined. The hospital work group process developed this definition, from which the hospitals' accounting systems could reasonably and consistently determine these expenses, either through direct costs or allocations.

Subpart 3. Admissions or adjusted admissions. In this definition, the word "normal" is inserted before "newborn admissions" to distinguish neonatal admissions from normal newborn admissions. Adjusted admissions is used in the calculation of aggregate rate and is defined as it is used by the hospital industry for clarification.

Subpart 3a. Admitting expenses. This definition is need because the term is used to capture a functional component of total support service expenses and is not defined. The hospital work group process developed this definition, from which the hospitals' accounting

systems could reasonably and consistently determine these expenses, either through direct costs or allocations.

Subpart 3b. Aggregate rate. This definition is clarified to include aggregate rate in its heading. The written formula is modified to reflect current accounting terminology. The mathematical formula is deleted as it is redundant and confusing.

Subpart 3c. Ambulatory surgical procedures. This definition is needed because the term is used to capture the number of outpatient surgical procedures and is not defined. The term is reasonable because it is consistent with the common usage of this term by hospitals.

Subpart 5. Auxiliary enterprises. This definition is repealed because it is obsolete; it applied to rate review, which was eliminated in 1984.

Subpart 6. Bad debts. This definition is modified to reflect generally accepted accounting principles, whereby bad debts are reported as expenses.

Subpart 7. Beds. This definition is repealed because it was overly broad. Subpart 23a, "Licensed beds or setup beds" is added and provides more specific definitions for beds.

Subpart 8. Charges. This definition is repealed because it is obsolete; it applied to rate review, which was eliminated in 1984.

Subpart 9. Charity care services. This definition is modified to reflect generally accepted accounting principles, whereby charity care services are never expected to result in cash flows. The language referencing the Hill Burton Act is removed because Hill Burton Act obligations for free patient care are reported separately from charity care services. Also, the collection of services and their cost for which no payment was received was mandated by Minnesota Statutes, section 62J.41, subdivision 1.

Subpart 9a. Community and wellness education expenses. This definition is needed because the term is used to capture a functional component of total support services expenses and is not defined. The hospital work group process developed this definition, from which the hospitals' accounting systems could reasonably and consistently determine these expenses, either through direct costs or allocations.

Subpart 10. Cost. This definition is modified to reflect current accounting terminology, which includes in-kind transactions.

Subpart 11. Direct patient care expenses. This definition is repealed because it was overly broad. Also, it applied to rate review, which was eliminated in 1984.

Subpart 12. Discount or price differentials. This definition is repealed because it is obsolete; it applied to rate review, which was eliminated in 1984. Discount or price differentials are both obsolete and illegal.

Subpart 12a. Donations. This definition is needed because the term is used to capture revenue from donation and is not defined. Also, the collection of data on this revenue from donations was mandated by Minnesota Statutes, section 62J.41, subdivision 1.

Subpart 13. Education expenses. This definition is needed because the term is used to capture a functional component of total support services expenses and is not defined. The hospital work group process developed this definition, from which the hospitals' accounting systems could reasonably and consistently determine these expenses, either through direct costs or allocations. Also, the collection of data on these expenses was mandated by Minnesota Statutes, section 62J.41, subdivision 1.

Subpart 16. Expanded facility. This definition is repealed because the Minnesota Certificate of Need Law, Minnesota Statutes, section 145.832 to 145.845 was repealed in 1982.

Subpart 17. Expenses. This definition has a grammatical change to make all references to expenses be consistent as plural.

Subpart 19a. Full-time equivalent employee. This definition is needed because the term is used to capture the number of individuals employed by a facility and is not defined. Also, the collection of data on the number of employees was mandated by Minnesota Statutes, section 62J.41, subdivision 1.

Subpart 19b. Government subsidies. This definition is needed because the term is used to capture public funding of hospital operating revenue and is not defined.

Subpart 20. Governmental contractual allowances. This definition is repealed because contractual adjustments are now provided by type of payer. Data on governmental contractual allowances is no longer collected or required in the rule.

Subpart 20a. Grants. This definition is needed because the term is used to capture public and private funding of hospital operating revenue and is not defined.

Subpart 20b. Gross patient revenue. This definition is modified to reflect current accounting terminology.

Subpart 20c. Health maintenance organization. This definition is needed because the term is used to capture revenue by this payer type and is not defined. Also, the collection of revenue by this payer type was mandated by Minnesota Statutes, section 62J.41, subdivision 1.

Subpart 21. Inpatient hospital services. This definition is repealed because it is obsolete; it applied to rate review, which was eliminated in 1984.

Subpart 21a. Insurance company. This definition is needed because the term is used to capture revenue by this payer type and is not defined. Also, the collection of revenue by this payer type was mandated by Minnesota Statutes, section 62J.41, subdivision 1.

Subpart 22. Interest expenses. This definition has a grammatical change to make all references to expenses be consistent as plural.

Subpart 23. Inventories. This definition is repealed because it is obsolete; it applied to rate review, which was eliminated in 1984.

Subpart 23a. Licensed beds or setup beds. This definition replaces the overly broad definition of "beds" and is more specific in clarifying and defining setup beds as a smaller subcategory of licensed beds.

Subpart 24a. Malpractice expenses. This definition is needed because the term is used to capture a functional component of total support services expenses and is not defined. The hospital work group process developed this definition, from which the hospitals' accounting systems could reasonably and consistently determine these expenses, either through direct costs or allocations.

Subpart 24b. Management information systems expenses. This definition is needed because the term is used to capture an allocated component of total support services expenses and is not defined. The hospital work group process developed this definition, from which the hospitals' accounting systems could reasonably and consistently determine these expenses, either through direct costs or allocations. These MIS expenses will be allocated to the other functional components, but the percentage allocations will not total 100%.

Subpart 24c. Medical care surcharge. This definition is needed because the term is used in the rules and is not defined elsewhere. The definition refers to the statutory section under which the surcharge is established.

Subpart 24d. MinnesotaCare. This definition is needed because the term is used to capture revenue by this payer type and is not defined. Also, the collection of revenue by this payer type was mandated by Minnesota Statutes, section 62J.41, subdivision 1.

Subpart 24e. MinnesotaCare tax. This definition is needed because the term is used in the rules and is not defined elsewhere. The definition refers to the statutory section under which the tax is established.

Subpart 24f. Net inpatient revenue. This definition is needed to capture revenue data related to inpatients for the hospital growth limit calculations.

Subpart 24g. Net outpatient revenue. This definition is needed to capture revenue data related to outpatients for the hospital growth limit calculations.

Subpart 24h. Net patient revenue. This definition is modified to reflect current accounting terminology. "Contracted" is change to "contractual" for clarity and consistency.

Subpart 25. Net receivables. This definition is modified to reflect current accounting terminology.

Subpart 25a. Nonprofit health service plans. This definition is needed because the term is used to capture revenue by this payer type and is not defined. Minnesota Statutes, section 62J.41, subdivision 1, clause (6), requires the collection of revenue by type of payer and lists nonprofit health service plan corporations as one category of payer. The term is defined in statute under the name "service plan corporations". The definition in the rules is reasonable because it reconciles the use of the two terms by defining the term that is more commonly used by hospitals.

Subpart 27. Orientation costs and on-the-job training costs. This definition is repealed because it is obsolete; it applied to rate review, which was eliminated in 1984.

Subpart 28. Other net payables. This definition is repealed because it is obsolete; it applied to rate review, which was eliminated in 1984.

Subpart 28a. Other support services expenses. This definition is needed because the term is used to capture a functional component of total support services expenses and is not defined. The hospital work group process developed this definition, from which the hospitals' accounting systems could reasonably and consistently determine these expenses, either through direct costs or allocations.

Subpart 30. Outpatient visit. This definition has been expanded to clarify visits as being a distinct episodes of care. The definition also clarifies the areas of the facility that are considered outpatient.

Subpart 30a. Patient. This definition is needed because the term is used to capture the number of patients served and is not defined. Also, the collection of data on the number of patients served was mandated by Minnesota Statutes, section 62J.41, subdivision 1.

Subpart 30b. Patient billing and collection expenses. This definition is needed because the term is used to capture a functional component of total support services expenses and is not defined. The hospital work group process developed this definition, from which the hospitals' accounting systems could reasonably and consistently determine these expenses, either through direct costs or allocations.

Subpart 30c. Patient days. This definition is needed because the term is used for the purposes of cost containment in calculating inpatient revenue per patient day as was previously undefined.

Subpart 31. Plant capital needs. This definition is expanded to include land improvements, fixtures, building improvements, and fixed equipment, which are currently being reported.

Subpart 31a. Plant, equipment, and occupancy expenses. This definition is needed because the term is used to capture an allocated component of total support services expenses and is not defined. The hospital work group process developed this definition, from which the hospitals' accounting systems could reasonably and consistently determine these expenses, either through direct costs or allocations. These plant, equipment, and occupancy expenses will be allocated to the other functional components, but the percentage allocations will not total 100%.

Subpart 32. Program. This definition is repealed because it is obsolete; it applied to rate review, which was eliminated in 1984.

Subpart 32a. Promotion and marketing expenses. This definition is needed because the term is used to capture a functional component of total support services expenses and is not defined. The hospital work group process developed this definition, from which the hospitals' accounting systems could reasonably and consistently determine these expenses, either through direct costs or allocations.

Subpart 32b. Quality assurance expenses. This definition is needed because the term is used to capture a functional component of total support services expenses and is not defined. The hospital work group process developed this definition, from which the hospitals' accounting systems could reasonably and consistently determine these expenses, either through direct costs or allocations.

Subpart 33. Quarter. This definition is repealed because it is obsolete; it applied to rate review, which was eliminated in 1984

Subpart 34. Rate. This is vague definition is repealed because it is obsolete; it applied to rate review, which was eliminated in 1984.

Subpart 34a. Regulatory and compliance reporting expenses. This definition is added to capture the cost of regulatory and compliance reporting. The hospital work group process developed this definition, from which the hospitals' accounting systems could estimate these expenses, either through direct costs or allocations.

Subpart 35. Research expenses. This definition is needed because the term is used to capture a functional component of total support services expenses and is not defined. The hospital work group process developed this definition, from which the hospitals' accounting systems could reasonably and consistently determine these expenses, either through direct costs or allocations. Also, the collection of data on these expenses was mandated by Minnesota Statutes, section 62J.41, subdivision 1.

Subpart 36. Revenue or income. This definition is modified to reflect current accounting terminology. "Contracted" is change to "contractual" for clarity and consistency. In accordance with generally accepted accounting principles, bad debts are reported as expenses and therefore is removed from this definition of revenue.

Subpart 37. Revenue center. This definition is modified to delineates the specific categories of daily patient services that are currently being reported.

Subpart 38. Service center. This definition is modified for clarification.

Subpart 39a. Taxes, fees, and assessments. This definition is needed because the term is used to capture a functional component of total support services expenses and is not defined. The hospital work group process developed this definition, from which the hospitals' accounting systems could reasonably and consistently determine these expenses, either through direct costs or allocations.

Subpart 40. Third party payers. This definition is modified to correctly refer to the defined term "nonprofit health service plans".

4650.0104 SCOPE. The only change to the scope clarifies that updates in federal laws or regulations will be incorporated as updated instead of those in effect on April 1, 1976.

4650.0108 REPORT REQUIREMENTS. The system has always required four separate documents: an annual financial statement, a Medicare cost report, a revenue and expense report, and rate notification reports. This language modification now specifically cites each of the four reports by name. The Medicare cost report language has been moved from the annual financial statement language into its own part, 4650.0133.

4650.0110 ANNUAL FINANCIAL STATEMENT. This part is renamed, changing the words "Information Report" to "Statement" to reflect the current accounting terminology.

Subpart 1. Reporting requirements. The words "Information Report" is replaced by "Statement" in the title of the report as previously explained under part 4650.0110. This subpart is modified to reflect the annual financial statement's contents that are currently being filed with HCCIS.

Subpart 2. Balance sheet. Items A and D. These items were modified to correct the spelling of "payor" to "payer" for consistency with the definition in subpart 40.

Item F. This item is repealed because it is obsolete and is not currently being filed.

Item G. This item is redesignated because item F was repealed. This item now refers to the information within this subpart, and so the subpart numbering is corrected to reflect subpart 2.

Subpart 3. Income and Expenses.

Item C. This item is modified to reflect generally accepted accounting principles, which report "bad debts" as expenses and not as a reduction in gross revenue.

Item F. This item has punctuation added for ease in separating each group of factors. In (8), language is added to reflect generally accepted accounting principles, which report "bad debts" as expenses.

Item G. This item refers to information within this subpart, and so the subpart numbering is corrected to reflect subpart 3.

Item H. This item is renumbered as part 4650.0111.

Item I. This item is renumbered as subpart 6.

Item J. This item is renumbered as subpart 5.

Items K. and L. These items are incorporated into subpart 1.

Item M. This item is renumbered as subpart 4.

Subpart 4. Notes and footnotes. This subpart is modified to reflect current accounting terminology.

Subpart 5. Attestation by public accountant. This subpart is modified into a full sentence from an item J. Also, all references to expenses are made consistent as plural.

Subpart 6. Attestation by governing authority. This subpart is modified into a full sentence from an item I.

4650.0111 MEDICARE COST REPORT. This part is composed from part 4650.0110, subpart 3, items H and I. It has been modified to clarify that this report is annually submitted as mandated by Minnesota Statutes, section 144.698, subdivision 1(3). The words "Information Report" is replaced by "Statement" in the title of the report as previously explained under part 4650.0110.

4650.0112 REVENUE AND EXPENSE REPORT. This part is renamed, deleting the word "Rate". Rate review was eliminated in 1984.

Subpart 1. Reporting Requirements. This subpart's heading is changed to better reflect its contents.

Item B. This item is modified to clarify how current year information shall be estimated. To be consistent, a hospital must use the same basis as another hospital for estimating current year.

Item C. This item is repealed because budget year is no longer reported on the revenue and expense report; it applied to rate review, which was eliminated in 1984.

Subpart 2. Statistical information.

Items A to G. The amendments to these items are to make them consistent with 1989 form set data elements.

Item H. Ambulatory surgical procedures was added to this item to make it consistent with the 1989 form set data elements. The total number of major surgical procedures was added because it is the hospital counterpart of surgical center ambulatory procedures.

Item I. The amendment to this item is to make it consistent with the 1989 form set data elements. Note that it is renumbered due to the inclusion of other statistical information items. It was formerly designated item E. For the purposes of cost containment, outpatient visits are used in calculating outpatient revenue per visit.

Item J. This item is renumbered due to the inclusion of other statistical information items. It was formerly designated item G.

Subpart 3. Financial information. The word "Rate" is removed from the title of the report as previously explained under part 4650.0112.

Former Item A. This requirement of an interim financial statement is no longer needed because it relates to rate review which was eliminated in 1984.

Item A. This item was formerly item B and is renumbered due to the repeal of former item A. This item has been amended to include expenses for the medical care surcharge and the MinnesotaCare tax. The reference to MinnesotaCare tax is made to financially measure the total MinnesotaCare tax that is being paid to the Department of Revenue. This measure serves as a validation for the Department of Revenue, where the tax is forecasted and received. The reference to the medical care surcharge is made to financially measure the total surcharge that is being paid to the Department of Human Services. This measure serves both as a validation for the Department of Health where the surcharge is calculated and for the Department of Human Services where the surcharge is received.

Items B to D. These items are used to capture data on support services expenses, formerly called administrative costs. Please refer to the discussion on this issue earlier in this SONAR.

Items E to M. These items have been amended to make them consistent with 1989 form set data elements. Note that items E, G, and K have additional data elements that were not found in the 1989 form set. Item E requires information required by Minnesota Statutes, section 62J.41, subdivision 1, clause (6). Item G requires information needed for growth limit calculations. Item K requires costs by type of payer because it is parallel to the revenue information by type of payer. Items J and M are renumbered from former items D and F, respectively.

Item N. Item N requires information required by Minnesota Statutes, section 62J.41, subdivision 1, clause (5).

Subpart 4. Additional Information. This item is repealed because it is no longer reported on the revenue and expense report; it applied to rate review, which was eliminated in 1984. The language is relevant to the rate notification report and has been inserted as part 4650.0114, subpart 2, item C.

Subpart 5. Accounts as substitute for revenue and expense report. The word "Rate" is removed from the title of the report as previously explained under part 4650.0112. This subpart has a grammatical change to make all references to expenses be consistent as plural.

4650.0114 RATE NOTIFICATION REPORTS. The name of the interim increase report is changed because this report is used to amend or modify a facility's aggregate rate. Rate

could be decreased as well as increased. The report currently submitted to the system is named "rate notification report".

Subpart 1. Reporting requirements. This subpart's heading is changed to better reflect its contents and the name of the interim increase report is changed as explained in part 4650.0114.

Subpart 2. Content of report. The name of the interim increase report is changed as explained in part 4650.0114.

Items A and B. In these items, rate(s) has been clarified to mean aggregate rate(s).

Item C. This item is inserted from part 4650.0112, subpart 4, because it no longer applies to the revenue and expense report, but it does apply to the rate notification reports.

Subpart 3. Statistical information on report. The name of the interim increase report is changed as explained in part 4650.0114.

Subpart 4. Financial information on report. The name of the interim increase report is changed as explained in part 4650.0114.

4650.0116 ALTERNATIVE REPORTING REQUIREMENTS. This is repealed because alterative reporting is no longer used and the language is obsolete.

4650.0118 SELECTION CRITERIA. This is repealed because it refers to alterative reporting, which is no longer used. The language is obsolete.

4650.0120 RATE REVENUE AND EXPENSE REPORT. This is repealed because it refers to alterative reporting, which is no longer used. The language is obsolete.

4650.0122 INTERIM INCREASE REPORTS. This is repealed because it refers to alterative reporting, which is no longer used. The language is obsolete.

ADMINISTRATIVE PROCEDURES

4650.0130 PROVISIONS FOR FILING REPORTS.

Subpart 2. Filing reports. This subpart provides that the address for the official offices be provided on the reporting forms instead of being documented in this rule. This is reasonable since it is more adaptable to change and the reporting forms are more "user-friendly".

4650.0132 FILING REPORT OF ANNUAL FINANCIAL STATEMENT.

Subpart 1. Filing report. The words "Information Report" is replaced by "Statement" in the title of the report as previously explained under part 4650.0110. This subpart is also modified to clarify which facilities must file this report, and language referring to the Medicare cost report has been moved to part 4650.0133.

Subpart 2. Failure to file. The words "Information Report" is replaced by "Statement" in the title of the report as previously explained under part 4650.0110. This subpart is also

modified to specifically notify facilities of the possibility of being fined for failing to file the annual financial statement as authorized under 4650.0172. Notification of failure to file is removed; the procedures for notification are specified in the Department's reporting and review procedures.

4650.0133 FILING OF MEDICARE COST REPORT.

Subpart 1. Filing report. This subpart reflects the change in the name of the report which must be filed with the State. The addition of the word "Medicare" before "cost report" clarifies which report is being discussed.

Item A. This item is the language from part 4650.0132, subpart 1, item A.

Item B. This item is the language from part 4650.0132, subpart 1, item C.

Subpart 2. Failure to file. This subpart is added because this part was previously under part 4650.0132 and its subpart 2. on failure to file also applied to the Medicare cost report.

4650.0134 FILING OF REVENUE AND EXPENSE REPORT. The word "Rate" is removed from the title of the report as previously explained under part 4650.0112.

Subpart 1. Filing report. The word "Rate" is removed from the title of the report as previously explained under part 4650.0112. This subpart is clarifies the time frame for filing of the revenue and expense report. Some language is repealed because it is obsolete; it applied to rate review, which was eliminated in 1984.

Subpart 2. Failure to file. This subpart is also modified to specifically notify facilities of the possibility of being fined for failing to file the revenue and expense report as authorized under 4650.0172. Notification of failure to file is removed; the procedures for notification are specified in the Department's reporting and review procedures. Some language is repealed because it is obsolete; it applied to rate review, which was eliminated in 1984.

4650.0136 FILING OF RATE NOTIFICATION REPORTS. The name of the interim increase report is changed as explained in part 4650.0114.

4650.0150 COMPLETENESS.

Subpart 1. Review by system. The numbering of the parts in this subpart is changed to reflect the repeal of 4650.0176.

Subpart 4. Reports filed prior to October 29, 1984. This subpart is repealed because it is obsolete and relates to changes made when the rules were last amended in 1984.

Subpart 5. Amending reports. The subpart heading is incorrect; "rules" is changed to "reports" to more correctly title this subpart.

4650.0152 REVIEW OF RATE REVENUE AND EXPENSE REPORTS AND INTERIM INCREASE REPORTS. This part is repealed because it is obsolete; it applied to rate review, which was eliminated in 1984.

4650.0156 OPEN APPLICATION PERIOD. This part was modified to remove a date in 1985, which is now obsolete.

4650.0158 CONTENTS OF APPLICATION.
Item A. This item was added to reflect the current application practices.
Item B. This item is renumbered to item B from item A, due to the addition of language.
Item C. This item is renumbered to item C from item B, due to the addition of language.
Item C. This item is repealed to remove a date in 1985, which is now obsolete.

4650.0160 REVIEW OF APPLICATION.
Subpart 1. Commissioner's decision. This subpart has changed the time frame for a decision from the commissioner to a specific date, May 15 of each year. This change was made to reflect the current voluntary nonprofit reporting organization's open application period, as authorized under 4650.0156. Consequently, May 15 is 45 days after the latest application period date, March 31. This subpart is also modified to clarify that decision refers to and application from a voluntary, nonprofit reporting organization.

4650.0166 FEES. This part is changed to reflect the name changes of both reports. The word "Rate" is removed from the title of the report as previously explained under part 4650.0112. The name of the interim increase report is changed as explained in part 4650.0114. Since rate review was eliminated in 1984, "rates" has been changed to "reports" reviewed by the commissioner.

4650.0168 REVENUE AND EXPENSE REPORT FEE. The word "Rate" is removed from the title of the report as previously explained under part 4650.0112.

4650.0170 RATE NOTIFICATION REPORT FEE. This part is changed to reflect the name changes of both reports. The word "Rate" is removed from the title of the report as previously explained under part 4650.0112. The name of the interim increase report is changed as explained in part 4650.0114.

4650.0172 TIMELY REPORT.
Subpart 1. Late fee schedule. This subpart has been modified to reflect the times prescribed in the four separate parts: 4650.0132 Annual Financial Statement, 4650.0133 Medicare Cost Report, 4650.134 Revenue and Expense Report, and 4650.0136 Rate Notification Reports.

4650.0174 SUSPENSION OF FEES. In this part, rates has been clarified to mean aggregate rates.

4650.0176. OFFICIAL OFFICES. This part is repealed because the address of the official offices is included in part 4650.0130, subpart 2. The system shall indicate on the report forms the address or addresses for filing reports.

Conclusion

Based on the foregoing, the Department's proposed rules are both necessary and reasonable.

8/9/11
Date

Mary Jo O'Brien, Commissioner
Department of Health

Appendix

This Appendix item is included as part of the official rulemaking record. A copy is available upon request from Grace Sheely, Minnesota Department of Health, Health Care Delivery Systems Policy Division, P.O. Box 64975, 121 East Seventh Place, Suite 400, St. Paul, Minnesota 55164-0975, 612/282-5645. TDD users may call the Minnesota Department of Health at 612/623-5522.

A. The 1989 Revenue and Expense Report Form Set.

(See Re ...e side)

HEALTH INFORMATION RESOURCES OF MINNESOTA

MINNESOTA HOSPITAL ASSOCIATION

REVENUE & EXPENSE REPORT
HEALTH INFORMATION RESOURCES OF MINNESOTA
MINNESOTA HOSPITAL ASSOCIATION

Appendix A

FACILITY NAME
ADDRESS
PRIOR YEAR END INTERIM REPORT y ____ n ____

1989 Prior Year Edition

RETURN THIS ORIGINAL TO HEALTH INFORMATION RESOURCES OF MINNESOTA UPON ITS COMPLETION.
DO NOT SEND A PHOTOCOPY.

TABLE OF CONTENTS

In preparing this formset, it is preferred that you use PICA type. If it is not available, use black ink.

GENERAL INFORMATION

Completion of this report and submission of other materials are required by Minnesota Statute 144.695 - 144.703.

Institution _____

Address _____

_____

_____

County _____

Chief Executive Officer _____

Phone _____

Person Completing Form _____

Title _____

Phone _____

(0001) Date Filed _____

(0002) Revised _____

DATE OF FACILITY'S PRIOR YEAR END

(0007) _____ / _____ / 89
month day

CERTIFICATION STATEMENT

I hereby certify that I have examined the accompanying Health Information Resources Revenue and Expense Report and to the best of my knowledge the information contained herein is accurate.

Signed _____

Position _____

OTHER MATERIALS REQUIRED WITH SUBMISSION OF FORMSET:

_____ A current copy of the Articles of Incorporation or Bylaws is required to be on file. If either have been amended since the last filing, submit a copy of the Articles of Incorporation or Bylaws.

INSTITUTION
NATURAL EXPENSE SUMMARY

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	NATURAL EXPENSE SUMMARY — INSTITUTION			
0101	Salaries and Wages			
0102	Employee Benefits			
0103	Fees			
0106	Raw Food			
0107	Drugs			
0108	Supplies			
0111	Utilities			
0112	Repairs and Maintenance			
0113	Rental Expense			
0114	Insurance			
0115	Interest			
0116	Depreciation			
0118	Property Taxes			
0119	Other Expense			
0100	TOTAL INST. OPERATING EXP.	260		

INSTITUTION
REVENUE SUMMARY

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	REVENUE SUMMARY — INSTITUTION (Revenue from patient care)			
0201	Gross Hospital Revenue	0740		
0204	Gross Nursing Home Revenue			
0207	Other (specify)			
0208	Other (specify)			
0209	Other (specify)			
0210	GROSS PATIENT REVENUES			
	ADJUSTMENTS & UNCOLLECTABLE ACCOUNTS			
0211	Hospital*	0760		
0214	Other*			
0220	TOTAL ADJUSTMENTS & UNCOLLECTABLE ACCOUNTS*			

* Traditionally adjustments & uncollectable allowances have been deductions from Revenues. However with the pospective payment system, adjustments & uncollectables have also become additional sources of revenue. For consistent and accurate measurement throughout this report PLEASE BRACKET IF they are [deductions] from revenue.

	OTHER OPERATING REVENUE			
0221	Consulting & Management Fees			
0224	Transfers From Specific Purpose Funds For Operation			
0227	Education Programs (approved)			
0229	Research			
0232	Public Donations & Grants for Charity Care			
0235	Private Donations & Grants for Charity Care			
0237	County/Municipal Funding for Operations**			
0239	Other (specify)			
0240	TOTAL OTHER OPERATING REVENUE			

**Do not include funding for Charity Care in this Account.

INSTITUTION
OPERATING INCOME

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	OPERATING INCOME — INSTITUTION			
0250	TOTAL OPERATING REVENUES*			
0260	TOTAL OPERATING EXPENSES	0100		
0200	OPERATING INCOME (LOSS) FROM INSTITUTION'S OPERATIONS			

*Account Number 0250 = (0240 + 0210) ± 0220

INSTITUTION
NON-OPERATING INCOME

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	NON-OPERATING REVENUE			
0301	Interest Income			
0307	Unrestricted Donations			
0313	Gain on Disposal of Assets			
0316	Gain on Sale of Investments			
0319	Other			
0320	TOTAL NON-OPERATING REVENUE			
	NON-OPERATING EXPENSE			
0321	Loss on Disposal of Assets			
0324	Loss on Sale of Investments			
0327	Other (Specify)			
0330	TOTAL NON-OPERATING EXPENSE			
0333	Extraordinary Items, Gains/(Losses)			
0336	Net Income Before Income Tax			
0339	Income Tax			
0300	REVENUE IN EXCESS OF EXPENSES			

INSTITUTION
SALARIES SUMMARY

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	SALARIES SUMMARY — INSTITUTION			
0401	Total Hospital Salaries	2010		
0404	Total Nursing Home Salaries			
0407	Total Other Salaries			
0410	Total Institution Salaries			
	FTEs SUMMARY — INSTITUTION			
0421	Total Hospital FTEs	2020		
0424	Total Nursing Home FTEs			
0427	Total Other FTEs			
0430	Total Institution FTEs			
0441	Total Annual Hours Per FTE (usually 2080)			

HOSPITAL
NATURAL EXPENSE SUMMARY

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	NATURAL EXPENSE SUMMARY — HOSPITAL			
0601	Salaries and Wages	2010		
0602	Employee Benefits			
0603	Fees			
0606	Raw Food			
0607	Drugs			
0608	Supplies			
0611	Utilities			
0612	Repairs and Maintenance			
0613	Rental Expense			
0614	Insurance			
0615	Interest			
0616	Depreciation			
0618	Property Taxes			
0619	Other Expense			
0600	TOTAL HOSPITAL OPERATING EXPENSE	0790		

HOSPITAL
REVENUE SUMMARY

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	REVENUE SUMMARY — HOSPITAL (Revenue from patient care)			
0701	Adults and Pediatrics			
0704	Intensive Care			
0707	Coronary			
0711	Nursery (routine)			
0714	Neonatal			
0717	Swing Bed			
0721	Chemical Dependency			
0724	Rehab			
0727	Mental Health (Psych)			
0731	Other			
0730	TOTAL ROUTINE CARE			
0733	Other Professional Services (ancillary)			
0740	GROSS HOSPITAL REVENUES FROM PATIENT CARE	0201		
	ADJUSTMENTS & UNCOLLECTABLE ACCOUNTS (Please Bracket Deductions from Revenue)			
0741	Medicare			
0744	Medicaid			
0747	HMO			
0762	Charity Care*			
0757	Hill Burton			
0759	Bad Debt			
0754	Courtesy Discounts			
0751	Other Discounts			
0760	TOTAL ADJUSTMENTS & UNCOLLECTABLE ALLOWANCES	0211		

* "CHARITY CARE" is provided to patients who are unable to pay, whereas "BAD DEBT" results from failure to pay by those who are able to pay (HFMA Principles & Practice Board Statement No. 2). Please answer questions on page 21 before proceeding.

HOSPITAL
OPERATING REVENUE

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	OTHER OPERATING REVENUE			
0761	Consulting & Management Fees			
0763	Transfers from Specific Purpose Funds*			
0765	Education Programs (approved)			
0768	Research			
0774	Public Donations & Grants for Charity Care			
0771	Private Donations & Grants for Charity Care			
0772	County/Municipal Funding for Operations**			
0773	Other (specify)			
0770	TOTAL OTHER OPERATING REVENUE			
0780	TOTAL OPERATING REVENUES			
0790	TOTAL OPERATING EXPENSES	0600		
0700	OPERATING INCOME (LOSS) FROM HOSPITAL'S OPERATIONS			

*For Operations
**Do not include funding for Charity Care in this Account

HOSPITAL
NON-OPERATING REVENUE

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	NON-OPERATING REVENUE			
0801	Interest Income			
0806	Unrestricted Donations			
0811	Gain on Disposal of Assets			
0813	Gain on Sale of Investments			
0815	Other			
0820	TOTAL NON-OPERATING REVENUE			
	NON-OPERATING EXPENSE			
0821	Loss on Disposal of Assets			
0823	Loss on Sale of Investments			
0825	Other (specify)			
0830	TOTAL NON-OPERATING EXPENSE			
0831	Extraordinary Items, Gains/(Losses)			
0834	Net Income Before Income Tax			
0837	Income Tax			
0800	REVENUE IN EXCESS OF EXPENSES			

HOSPITAL PAYER
CHARGE SUMMARY

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	PATIENT CHARGE SUMMARY — HOSPITAL			
0841	Medicare Patient Charges			
0843	Medicaid Patient Charges			
0845	HMO Patient Charges			
0847	Other Payor Patient Charges			
0850	TOTAL PATIENT CHARGES	0740		
0851	Hospital Inpatient Charges			
0853	Hospital Outpatient Charges *			
0860	TOTAL PATIENT CHARGES	0740		

* Is specific breakdown of Account 0853 available? Yes _____ No _____ (if yes, please list below)

0871	Outpatient Charges			
0872	Emergency Room Charges			
0873	Same Day Surgery Charges			

HOSPITAL
PATIENT COST SUMMARY

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	DIRECT & INDIRECT COST SUMMARY — HOSPITAL			
0901	Medicare Patient Costs			
0902	Other Payer Patient Costs			
0910	TOTAL PATIENT COSTS	0600		
	ROUTINE HOSPITAL SERVICE COSTS - (DIRECT & INDIRECT)			
0911	Adults & Pediatrics			
0912	Intensive Care			
0913	Coronary			
0914	Nursery (routine)			
0915	Neonatal			
0916	Chemical Dependency			
0917	Rehab			
0919	Mental Health (Psych)			
0921	Other			
0930	TOTAL DIRECT & INDIRECT ROUTINE HOSPITAL SERVICE COSTS			

HOSPITAL
ANCILLARY SERVICE COSTS SUMMARY

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	ANCILLARY SERVICE COSTS - (DIRECT & INDIRECT)			
0925	Operating Room			
0926	Recovery Room			
0927	Delivery Room & Labor Room			
0928	Anesthesiology			
0929	Radiology — Diagnostic & Therapeutic			
0931	Radioisotope			
0932	Laboratory			
0934	Blood			
0936	Intravenous Therapy			
0937	Respiratory Therapy			
0938	Physical Therapy			
0939	Occupational Therapy			
0941	Speech Pathology			
0942	Electrocardiology			
0943	Electroencephalography			
0944	Medical Supplies Charged to Patients			
0945	Drugs Charged to Patients			
0946	Renal Dialysis			
0947	Emergency Room			
0948	Ambulance Services			
0952	Other			
0960	TOTAL DIRECT & INDIRECT ANCILLARY SERVICE COSTS			
0961	Hospital Non-Reimbursable Costs			
0900	TOTAL DIRECT & INDIRECT HOSPITAL COST	0600		

HOSPITAL
RECEIVABLES SUMMARY

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	RECEIVABLES SUMMARY — HOSPITAL			
1001	Medicare Gross Receivables			
1002	Medicaid Gross Receivables			
1003	HMO Gross Receivables			
1004	Other Payer Gross Receivables			
1010	TOTAL GROSS RECEIVABLES			
1011	Allowance for Uncollectables & Contractual Adjustments		[ ]	[ ]
1020	TOTAL HOSPITAL NET RECEIVABLES			

HOSPITAL
SALARIES SUMMARY

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	SALARIES SUMMARY — HOSPITAL			
2001	Routine Hospital Service (salaries)			
2002	Ancillary Service (salaries)			
2003	Hospital Non-revenue Producing Center (salaries)*			
2010	TOTAL HOSPITAL SALARIES	~~600~~ 601		
	FTE SUMMARY — HOSPITAL			
2011	Routine Hospital Service (FTEs)			
2012	Ancillary Service (FTEs)			
2013	Hospital Non-revenue Producing Centers (FTEs)*			
2020	TOTAL HOSPITAL FTEs	0421		

* Include in this account only the portion of shared services applicable to the hospital's non-revenue producing center. Some common examples of shared services are dietary, laundry, and housekeeping.

HOSPITAL
EMPLOYEE CLASSIFICATION

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	EMPLOYEE CLASSIFICATION OF SALARIES			
2021	Total RNs (salaries)			
2022	Total LPNs (salaries)			
2121	Total Nurse Anesthetists (salaries)			
2023	Total Aides & Orderlies (salaries)			
2024	Total Physicians (salaries)			
2122	Total Occupational Therapists (salaries)			
2123	Total Physical Therapists (salaries)			
2124	Total X-Ray Technicians (salaries)			
2125	Total Laboratory Technicians (salaries)			
2126	Total Administration Personnel (salaries) (Management, Marketing, Planning, Finance, Accounting)			
2025	All Others (salaries)			
2030	TOTAL HOSPITAL SALARIES	~~600~~ 661		

HOSPITAL
EMPLOYEE CLASSIFICATION

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	EMPLOYEE CLASSIFICATION OF FTEs			
2031	Total RNs (FTEs)			
2032	Total LPNs (FTEs)			
2131	Total Nurse Anesthetists (FTEs)			
2033	Total Aides & Orderlies (FTEs)			
2034	Total Physicians (FTEs)			
2132	Total Occupational Therapists (FTEs)			
2133	Total Physical Therapists (FTEs)			
2134	Total X-Ray Technicians (FTEs)			
2135	Total Laboratory Technicians (FTEs)			
2136	Total Administration Personnel (FTEs) (Management, Marketing, Planning, Finance, Accounting)			
2035	All Others (FTEs)			
2040	TOTAL HOSPITAL FTES	2020		

HOSPITAL
CAPITAL EXPENDITURES

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	CAPITAL EXPENDITURES — HOSPITAL			
3001	Land			
3002	Land Improvements			
3003	Building and Fixtures			
3004	Building Improvements			
3005	Fixed Equipment			
3006	Movable Equipment			
3000	TOTAL HOSPITAL CAPITAL EXPENDITURES			
3007	County/Municipal Funding Related to Hospital Nonoperating Budget (Capital Assets, Unrestricted Funds, Debt Retirement, Other (specify))			

INSTITUTION AND HOSPITAL
PATIENT DAY SUMMARY

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
4001	Adults & Pediatrics Days			
4004	Intensive Care Days			
4007	Coronary Care Days			
4011	Chemical Dependency Days			
4014	Mental Health Days (Psych)			
4017	Rehab Days			
4019	Other			
4044	Neonatal Days			
4030	TOTAL HOSPITAL ACUTE PATIENT DAYS (exclude swing bed and nursery days)	4020		
4025	Medicare Days			
4022	Medicaid Days			
4023	HMO Days			
4026	Other Payer Days			
4020	TOTAL HOSPITAL ACUTE PATIENT DAYS (exclude swing bed and nursery days)	4030		
4034	Swing Bed Days (Medicare)			
4037	Other Non-Acute Days (exclude Nursing Home Days)			
4040	TOTAL NON-ACUTE HOSPITAL DAYS			
4041	NURSERY DAYS			
4031	NURSING HOME DAYS			
4060	(For Staff Use Only)			

INSTITUTION AND HOSPITAL ADMISSIONS SUMMARY

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
4301	Adults & Pediatrics Admissions			
4304	Chemical Dependency Admissions			
4307	Mental Health Admissions (Psych)			
4309	Rehab Admissions			
4311	Other			
4334	Neonatal			
4320	TOTAL HOSPITAL ACUTE PATIENT ADMISSIONS (exclude swing bed & newborn admissions)	4340		
4341	Medicare Admissions			
4342	Medicaid Admissions			
4343	HMO Admissions			
4344	Other Payer Admissions			
4340	TOTAL HOSPITAL ACUTE PATIENT ADMISSIONS (exclude swing bed and newborn admissions)	4320		
4324	Swing Bed Admissions (Medicare)			
4327	Other Non-Acute Admissions (exclude Nursing Home Days)			
4330	TOTAL NON-ACUTE ADMISSIONS			
4331	BIRTHS			
4321	NURSING HOME ADMISSIONS			
4360	(For Staff Use Only	)		

INSTITUTION AND HOSPITAL MISCELLANEOUS SUMMARY

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
4501	Total Outpatient Visits*			
	Is specific breakdown of Total Outpatient Visits available? Yes _____ No _____ (if yes, please list below)			
4502	Outpatient Department Visits			
4503	Emergency Room Visits			
4505	Same Day Surgery Visits			
4504	Hospital Licensed Beds			
4507	Hospital Beds Set Up			
	Is specific breakdown of **Hospital Licensed Beds** available? Yes _____ No _____ (If yes, please list below)			
4511	Chemical Dependency Beds**			
4514	Mental Health Beds (Psych)**			
4517	Rehab Beds**			
4519	Other			
4529	LICENSED NURSING HOME BEDS			

* Report number of patient visits to hospital on an outpatient basis. Include visits to the outpatient department, emergency room, and same day surgeries. (Only count each patient visit once even if several departments, such as x-ray and lab, provide service.)

** Report number of beds designated for the service listed.

ADDITIONAL INFORMATION ON HARITY CARE ACCOUNT (0762)

	YES	NO
I. Do you classify **CHARITY CARE** under **BAD DEBT?**	_____	_____
If yes, please estimate the percentage of **BAD DEBT** that is **CHARITY CARE.**	_____	

II. Please identify your hospital's criteria, if any, for determining patient eligibility for charity care (check all that apply).

CHECK IF APPLY

A. No policies or procedures established. Eligibility determined on a CASE-BY-CASE Basis. _____

B. Policies and/or procedures established. Please attach a copy of your hospital's policies and procedures established for determining patient eligibility for charity care. _____

Eligibility determined by one or several of the following guidelines:

1. INCOME GUIDELINES:
   a. Federal Poverty Income Guidelines _____
      If Yes, please mark one:
      (1) 100% ____.
      (2) 200% ____.
      (3) Other _____. _____
      Please specify: ____%.

2. ASSET GUIDELINES:
   a. Specify: _____ _____
      _____
      _____

3. MUST HAVE APPLIED AND HAVE BEEN TURNED DOWN FOR:
   a. Medical Assistance (MA) _____
   b. General Assistance Medical Care (GAMC) _____

4. OTHER GUIDELINES: _____
   If yes, please specify: _____
   _____
   _____
   _____

III. SLIDING FEE SCHEDULE USED _____
If yes, please attach a copy and/or specify: _____
_____
_____

INSTITUTION AND HOSPITAL EDUCATION COSTS

ACCOUNT	DESCRIPTION	REF	1989 PRIOR YEAR	1990 CURRENT YEAR
	EDUCATION COSTS (approved)			
5111	Education Costs (Direct & Indirect)			
5122	Other (specify)			
5133	Other (specify)			
	RESEARCH COSTS			
5211	Research (Direct & Indirect)			
5222	Other (specify)			
5233	Other (specify)			
	NON-ALLOWABLE RESEARCH — MEDICARE			
5311	Non-Allowable Research — Medicare (Direct & Indirect)			
5322	Other (specify)			
5333	Other (specify)			

Upon completion of the formset, please check your figures for internal consistency. The accounts that are grouped should tie to the others in that group. They should also reconcile to the Audited Financial Statements (A.F.S.). For example, accounts 600, 790, 910, & 900 should tie and also reconcile to the A.F.S.

Place marks in the blanks of the corresponding accounts on this checklist that tie and reconcile.

* Starred accounts below refer to the hospital-only portion of an institution's revenue and expenses. Hospitals that don't use pages 1-5 need not check-off on the starred accounts.

HOSPITAL SELF-AUDIT CHECKLIST

		____790	____ A.F.S
600 ____	Total Hosp. Operating Exp.	____900	or reconciled
		____910	
		____740	
201____*	Gross Hosp. Operating Rev.	____850	____ A.F.S
		____860	
760 ____	Adjustments & Uncollectibles	* ___211	___ A.F.S.
770 ____	Total Other Operating Revenue		___ A.F.S.
780 ____	Total Operating Revenue		___ A.F.S.
700 ____	Revenue over Expenses (Operating)		___ A.F.S.
820 ____	Total Non-Operating Revenue		___ A.F.S.
830 ____	Total Non-Operating Expenses		___ A.F.S.
800 ____	Net Revenue over Expenses		___ A.F.S.
1020____	Hospital Net Receivables		___ A.F.S.
1011____	Allowance for Uncollectibles/Contracts		___ A.F.S.
		___601	
401____*	Total Hopital Salaries	___2010	
		___2030	
		___2020	
421____*	Total Hospital FTEs	___2040	
4030____	Total Hospital Acute Days (Excluding nursery & swing bed)		__ MCR, S-3 or reconciled

Signed _____