4650.0112 FINANCIAL, UTILIZATION, AND SERVICES REPORT; HOSPITALS.

Subpart 1. **Reporting requirements.** A hospital, psychiatric hospital, or specialized hospital shall submit a report including financial, utilization, and services information for the facility's last full and audited accounting period prior to the accounting period during which it submits this report. This period is called the reporting year. A hospital must include the information described in subparts 2, 2a, and 3. A psychiatric hospital or a specialized hospital must include the information described in subparts 2, 2a, and 3, item A, but is not required to report the detailed financial data described in subpart 3, items B to R. Information must be reported according to subpart 1c.

Subp. 1a. **Changes in accounting period.** If a hospital, psychiatric hospital, or specialized hospital changes its audited accounting period, reports must include financial, utilization, and services information for all time periods. Required information for a period of up to 13 months may be included in one report.

Subp. 1b. **Clinic data reporting.** If a hospital is not part of a multihospital system, but is affiliated with a clinic as evidenced on the audited annual financial statement, the hospital must separately report the hospital and affiliated clinic information. Reporting affiliated clinic information as specified in subpart 7 fulfills the requirements of chapter 4651 for physicians whose information is included in the clinic reporting.

Subp. 1c. **Estimating.** Whenever reasonably possible, a hospital, psychiatric hospital, or specialized hospital must report actual numbers in all categories. If it is not reasonably possible for the facility to report actual numbers, the facility may estimate using reasonable methods. Upon request from the commissioner, the facility must provide a written explanation of the method used for the estimate.

Subp. 2. **Utilization information.** Utilization information must include:

A. the number of patient days, excluding swing bed and subacute or transitional care patient days, categorized by type of payer and by designated care unit or revenue center;

B. the number of admissions, excluding swing bed and subacute or transitional care admissions, categorized by type of payer and by designated care unit or revenue center;

C. the number of swing bed patient days, subacute or transitional care patient days, and nursery days;

D. by employee classification, the average number of vacant full-time equivalent positions and the average number of full-time equivalent employees categorized by consulting or contracting, full-time, part-time, and total;

E. the number of swing bed admissions and subacute or transitional care admissions categorized by origin, and the number of patients readmitted to a swing bed within 60 days of a patient's discharge from the facility;

F. the number of licensed beds, the number of licensed bassinets, the number of available beds, the maximum daily census and the minimum daily census for the reporting period, and the average number of beds used by the facility for swing beds and subacute or transitional care;

G. the total number of births;

H. the number of swing bed and subacute or transitional care discharges categorized by destination;

I. any changes in the number of licensed beds during the reporting year and the effective dates of the changes;

J. the number of physicians with admitting privileges; and

K. the average length of stay.

Subp. 2a. **Services information.** Services information must:

A. specify whether the following services are provided on or off site, and whether the services are provided by facility staff or by contractual arrangement:

(1) inpatient and outpatient abortion services;

(2) cardiac catheterization services;

(3) outpatient chemical dependency treatment and detoxification services;

(4) computerized tomography scanning services, including mobile unit services;

(5) electroencephalography services;

(6) extracorporeal shock wave lithotripter (ESWL) services;

(7) geriatric day care services;

(8) home health care services;

(9) hospice services;

(10) mammography services;

(11) nuclear magnetic resonance imaging (MRI) services;

(12) outpatient psychiatric services;

(13) radiation therapy services, including cobalt-60 devices, linear accelerators, and other devices greater than one megaelectron volt;

(14) diagnostic and therapeutic radioisotope services;

(15) radium, cesium, or iridium therapy services;

(16) inpatient and outpatient renal dialysis services;

(17) reproductive health services-genetic counseling;

(18) social services;

(19) surgical services, including outpatient surgery services, inpatient surgery services, open-heart surgery services, and organ transplant services;

(20) therapy services, including inhalation therapy, outpatient medical rehabilitation, occupational therapy, physical therapy, and speech therapy;

(21) volunteer services;

(22) diagnostic X-ray services;

(23) emergency department or emergency room services, including radio, paging, and telemedicine capabilities; level of trauma care; and the number of hours per week that the emergency department or emergency room is staffed with contracted physicians rather than hospital-employed physicians;

(24) diagnostic ultrasound services; and

(25) laboratory services;

B. provide the following measures of utilization:

(1) the total number of catheterizations;

(2) the number of computerized tomography (CT) scanners and the number of inpatient, outpatient, total, and mobile unit procedures;

(3) the number of inpatient, outpatient, and total extracorporeal shock wave lithotripter (ESWL) treatments;

(4) the number of home health care visits;

(5) the number of hospice visits;

(6) the number of inpatient, outpatient, and total mammography X-rays;

(7) the number of inpatient, outpatient, and total nuclear magnetic resonance imaging (MRI) scans;

(8) the number of outpatient registrations;

(9) the number of devices, the number of cancer cases treated, and the total number of treatments for cobalt-60 devices, linear accelerators, and other devices greater than one megaelectron volt;

(10) the number of inpatient and outpatient renal dialysis treatments;

(11) the number of diagnostic ultrasounds;

(12) the number of outpatient surgical registrations;

(13) the number of inpatient surgical admissions;

(14) the number of open-heart surgical procedures;

(15) the number of kidney, bone marrow, heart, and other transplants, and the total number of organic transplants; and

(16) the number of emergency department or emergency room registrations, and the number of admissions through the emergency department or emergency room; and

C. provide the following measures of staffing:

(1) the number of volunteers;

(2) the level and type of emergency department or emergency room staffing; and

(3) the name of the emergency department or emergency room physician director.

Subp. 2b. **Additions in required services information.** When medical or technological advances introduce a new health care service or when information about an existing health care service is important for policy analysis purposes, the commissioner shall determine if information about the health care service will be requested under this chapter. To make this determination, the commissioner shall consider:

A. whether the service is likely to be provided in a significant number of hospitals, psychiatric hospitals, specialized hospitals, or outpatient surgical centers;

B. whether the geographic location of the service is important to monitoring access to the service;

C. whether information about the service is important consumer, industry, or policy analysis information;

D. whether reporting information about the service is an administrative burden for the hospital, psychiatric hospital, specialized hospital, or outpatient surgical center; and

E. other factors which relate to the anticipated utilization of the health care service.

Subp. 2c. **Elimination of required services information.** The commissioner shall eliminate requests for information about obsolete health care services. To determine if a health care service is obsolete, the commissioner shall consider whether:

A. there has been a significant reduction in the number of hospitals, psychiatric hospitals, or specialized hospitals that provide the service;

B. there has been a significant overall reduction in the statewide utilization of the service;

C. the elimination of information about the service would adversely affect the public interest; and

D. the elimination of information about the service would conflict with standards imposed by law.

Subp. 3. **Financial information.** Financial information must include:

A. total operating expenses and total operating revenue;

B. management information systems expenses and plant, equipment, and occupancy expenses;

C. total administrative expenses. A hospital licensed for 50 or more beds shall report expenses for each of the following functions: admitting, patient billing, and collection; accounting and financial reporting; quality assurance and utilization management program or activity; community and wellness education; promotion and marketing; taxes, fees, and assessments; malpractice; and other administrative expenses;

D. regulatory and compliance reporting expenses;

E. hospital patient care services charges and other patient care services charges;

F. the sum of hospital patient care services charges and other patient care services charges:

(1) by type of payer;

(2) by inpatient, outpatient, and other patient category;

(3) by outpatient services categories;

(4) for services provided in swing beds;

(5) for subacute or transitional care services;

(6) by the top ten diagnosis related groups, as those groups are maintained under Code of Federal Regulations, title 42, part 412; and

(7) by designated care unit or revenue center;

G. a statement of adjustments and uncollectibles by type of payer, for charity care, and by inpatient or outpatient category:

(1) for hospital patient care services; and

(2) for other patient care services;

H. public funding for operations and donations and grants for charity care with estimates of the percentage received from private and public sources;

I. income or loss from hospital operations;

J. gross receivables by payer and net receivables;

K. a copy of charity care policies, including a description of, if applicable, income guidelines, asset guidelines, medical assistance status impact on charity care eligibility, and sliding fee schedules; charity care services provided; other benefits provided to the community; costs in excess of public program payments; and other community services costs;

L. a description of the care provided in swing beds;

M. the medical care surcharge and MinnesotaCare tax paid;

N. provision for bad debts:

(1) for hospital patient care services; and

(2) for other patient care services;

O. all other operating expenses by a natural classification of expense;

P. nonoperating revenue and nonoperating expenses;

Q. nonoperating donations and grants and nonoperating public funding;

R. salaries and wages by employee classification; and

S. the number of full-time equivalent residents, resident salaries and benefits, and research expenses.

Subp. 4. [Repealed, 19 SR 1419]

Subp. 5. [Repealed, 21 SR 1106]

Subp. 6. **Budget year reporting.** A hospital shall report budgeted information or reasonable estimates of total operating expenses, the sum of hospital patient care services charges and other patient care services charges, total adjustments and uncollectibles, total salaries and wages, total patient days, total admissions, and total outpatient registrations for the hospital's full accounting period during which it submits the report. This period is called the budget year.

Subp. 7. **Affiliated clinic data reporting.** If affiliated clinic data is reported according to subpart 1b, the clinic data must include the following:

A. gross patient revenue, adjustments and uncollectibles, net patient revenue by type of payer, and charity care as defined in part 4651.0100, subpart 4;

B. operating revenue categorized by education revenue as defined in part 4651.0100, subpart 8, research revenue as defined in part 4651.0100, subpart 22, and donations for charity care as defined in part 4651.0100, subpart 4;

C. the number of registrations by clinic location;

D. other patient care costs as defined in part 4651.0100, subpart 16, bad debt as defined in part 4651.0100, subpart 2, education-degree program costs as defined in part 4651.0100, subpart 9, and research costs as defined in part 4651.0100, subpart 21;

E. the total number of full-time equivalent employees for the clinic by employee classification;

F. malpractice expenses, if separate from the hospital;

G. addresses of each clinic location;

H. names and provider identifiers of physicians by clinic location; and

I. a description of how the clinic is defined and how it is distinguished from other outpatient services of the hospital.

Statutory Authority: *MS s 62J.321; 62J.35; 144.56; 144.703*

History: *L 1984 c 534 s 11; 9 SR 834; 19 SR 1419; 21 SR 1106; 26 SR 627*

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