CHAPTER 4650
DEPARTMENT OF HEALTH
MINNESOTA HOSPITAL RATE REVIEW SYSTEM

NOTE: Under Minnesota Statutes, section 144.011, the State Board of Health was abolished and all of its duties transferred to the commissioner of health.

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4650.0100 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 4650.0100 to 4650.5300, the following terms have the meanings given them.

Subp. 2. **Accounting period.** "Accounting period" means the fiscal year of a hospital which is a period of 12 consecutive months established by the governing authority of a hospital for purposes of accounting.

Subp. 3. **Admissions.** "Admissions" means the number of patients accepted for inpatient services in beds licensed for inpatient hospital care exclusive of newborn admissions.

Subp. 4. **Applicant.** "Applicant" means a voluntary nonprofit rate review organization which has applied to the commissioner of health for approval or renewed approval of its reporting and review procedures.

Subp. 5. **Auxiliary enterprises.** "Auxiliary enterprises" means significant continuing revenue-producing activities which, while not related directly to the care of patients, are businesslike activities commonly found in health care institutions for the convenience of employees, physicians, patients, and/or visitors. An activity is significant if either its revenues or direct costs exceed 20

cents per inpatient day. An activity is businesslike if it has related direct costs equal to at least 25 percent of its revenues. Irrespective of the above criteria, all parking lots, private physicians' offices, and retail operations are considered to be auxiliary enterprises.

Subp. 6. **Beds.** "Beds" means the number of acute care beds licensed by the Minnesota Department of Health, pursuant to Minnesota Statutes, sections 144.50 to 144.58.

Subp. 7. **Burden of proof.** "Burden of proof" means the burden of persuasion by the preponderance of the evidence.

Subp. 8. **Charges.** "Charges" means the regular amounts charged less expected bad debts, contracted allowances, and discounts to patients and/or insurers, prepayment plans, and self-insured groups on the patient's behalf. The terms "charges" and "rates" are synonymous for the purposes of these rules. "Gross charges" means charges irrespective of any discounts, deductions, or other reductions which by contract or other agreement, may be applicable. The terms "gross charges," "gross acute care charges," and "gross rate" are synonymous for the purpose of these rules.

Subp. 9. **Cost.** "Cost" means the amount, measured in money, of cash expended or other property transferred, services performed, or liability incurred, in consideration of goods or services received or to be received.

Subp. 10. **Emergency services.** "Emergency services" are those inpatient or outpatient hospital services that are necessary to prevent immediate loss of life or function due to the sudden onset of a severe medical condition.

Subp. 11. **Emergency visit.** "Emergency visit" means an acceptance of a patient by a hospital for the purpose of providing emergency services in a distinct emergency service center.

Subp. 12. **Expanded facility.** "Expanded facility" means any expansion or alteration in the scope of service of an institution subject to the provisions of the Minnesota Certificate of Need Law, Minnesota Statutes, sections 145.71 to 145.84, or section 1122 of the Social Security Amendments of 1972, Public Law 92-603, according to the definitions contained in these laws and the current rules sanctioned by them.

Subp. 13. **Expense(s).** "Expense(s)" means costs that have been incurred in carrying on some activity and from which no benefit will extend beyond the period for which the expense is recorded.

Subp. 14. **Fiscal year.** "Fiscal year" means that period of 12 consecutive months established by the state for the conduct of its business.

Subp. 15. **Inpatient hospital services.** "Inpatient hospital services" means the following items and services furnished by a hospital to an inpatient of such a hospital:

A. bed and board;

B. nursing services and other related services;

C. use of hospital facilities;

D. medical social services;

E. drugs, biologicals, supplies, appliances, and equipment;

F. certain other diagnostic or therapeutic items or services; and

G. medical or surgical services provided by certain residents-in-training.

Subp. 16. **Loss.** "Loss" means the excess of all expenses over revenues for an accounting period or the excess of all or the appropriate portion of the net book value of assets over related proceeds, if any, when items are sold, abandoned, or either wholly or partially destroyed by casualty or otherwise written off.

Subp. 17. **Nonrevenue center.** "Nonrevenue center" means a service center which incurs direct operating expenses but which does not generate revenue directly from charges to patients for services. These centers, which rely on revenue from revenue centers to meet their expenses, may include such service centers of a hospital as:

A. general services, including: dietary services, plant operation and maintenance services, housekeeping services, laundry services, and other services;

B. fiscal services;

C. administrative services; and

D. medical care evaluation services.

Subp. 18. **Outpatient services.** "Outpatient services" mean those services offered by a hospital which are furnished to ambulatory patients not requiring emergency care and which are not inpatient services.

Subp. 19. **Outpatient visit.** "Outpatient visit" means an acceptance of a patient by a hospital for the purpose of providing outpatient services.

Subp. 20. **Program.** "Program" means the reporting and review procedures proposed by an applicant.

Subp. 21. **Quarter.** "Quarter" means that period of the fiscal year corresponding to a three-month period of time for which the state regularly gathers information for the conduct of its business. For purposes of parts 4650.0100 to 4650.5300, a fiscal year is composed of four quarters corresponding to the following groupings of months: a quarter is defined by the time period represented by the months of July, August, and September; a quarter is defined by the time period represented by the months of October, November, and December; a quarter is defined by the time period represented by the months of January, February, and March; and, a quarter is defined by the time period represented by the months of April, May, and June.

Subp. 22. **Rate.** "Rate" means "gross charges" as defined in subpart 8. "Aggregate rate" means the average gross revenue per adjusted admission for a full accounting period determined by dividing total gross revenue by the number of adjusted admissions:

$$\frac{\text{Total Gross Revenue}}{\text{Number of Adjusted Inpatient Admissions}}$$

Adjusted admissions are determined by:

$$\text{Outpatient \& Emergency Visits} \times \frac{\text{Total Outpatient \& Emergency Gross Revenue}}{\text{Number of Outpatients \& Emergency Visits}}$$

$$\times \frac{1}{\text{Inpatient Gross Revenue Per Admission}} \text{ PLUS } \text{The Number of Inpatient Admissions}$$

The aggregate rate for the budget year shall always be based upon annually projected admissions as stated in the rate revenue and expense report.

Subp. 23. **Restricted funds.** "Restricted funds" mean funds donated to the hospital which are restricted for a specific purpose by the donor.

Subp. 24. **Revenue(s) or income(s).** "Revenue(s)" or "income(s)" means the value of a hospital's established charges for all hospital services rendered to patients less expected and/or incurred bad debts, contracted allowances, and discounts granted to patients and/or insurers, prepayment plans, and self-insured groups. "Gross revenue(s)" or "gross income(s)" means "revenue(s)" or

"income(s)" regardless of the amounts actually paid to or received by the hospital.

Subp. 25. **Revenue center.** "Revenue center" means a service center which incurs direct operating expenses and which generates revenue from patients on the basis of charges customarily made for services that center offers directly to patients. Revenue centers may include such service centers of a hospital as:

A. Daily patient services (routine services) including: medical services, surgical services, pediatric services, intensive care services, psychiatric services, obstetric-gynecological services, newborn nursery services, premature nursery services, and other routine services.

B. Other nursing services (ancillary services), including: operating room services, recovery room services, delivery and labor room services, central services and supply services, intravenous therapy services, emergency services, and other ancillary services.

C. Other professional services (ancillary services), including: laboratories, blood bank, electrocardiology, radiology, pharmacy, anesthesia, physical therapy, and other special services.

Subp. 26. **Service center.** "Service center" means an organizational unit of a hospital for which historical and projected statistical and financial information relating to revenues and expenses are accounted. A service center may be a routine, special, or ancillary service center. A service center may also be a revenue center or a nonrevenue center.

Subp. 27. **System.** "System" means the Minnesota hospital rate review system and any applicant approved to operate it or the commissioner of health.

Subp. 28. **Third party payors.** "Third party payors" mean insurers, health maintenance organizations licensed pursuant to Minnesota Statutes, chapter 62D, nonprofit service plan corporations, self-insured or self-funded plans, and governmental insurance programs, including the health insurance programs authorized by the United States Social Security Act, title V, title XVIII, and title XIX (Medicare and Medicaid).

Subp. 29. **Unrestricted funds.** "Unrestricted funds" mean funds not restricted by the donor and funds designated by the governing authority of the hospital, not including revenues in excess of expenses.

Statutory Authority: *MS s 144.703*

4650.0200 SCOPE.

All acute care hospitals licensed pursuant to Minnesota Statutes, sections 144.50 to 144.58 are subject to the requirements of the Minnesota hospital rate review system established by parts 4650.0100 to 4650.5300.

Beds located in these hospitals, which are not licensed as acute care beds pursuant to Minnesota Statutes, sections 144.50 to 144.58, are not subject to the requirements of the Minnesota hospital rate review system. Where costs incurred through the operation of these beds are commingled with the costs of operation of acute care beds in a hospital subject to the system, associated revenue and expenses and other related data shall be separated in a manner consistent with the normal requirements for allocation of costs as stated by Code of Federal Regulations, title 20, section 405.453 (Medicare).

Citations of federal law or federal regulations incorporated in parts 4650.0100 to 4650.5300 are for those laws and regulations then in effect on April 1, 1976.

Statutory Authority: *MS s 144.703*

4650.0300 THE MINNESOTA HOSPITAL RATE REVIEW SYSTEM.

The Minnesota hospital rate review system is established. This system shall be operated by the commissioner of health and any voluntary nonprofit rate review organization whose reporting and review procedures have been approved by the commissioner pursuant to parts 4650.3500 to 4650.4000. The system shall consist of reports, administrative procedures, and standards.

Statutory Authority: *MS s 144.703*

4650.0400 REPORT REQUIREMENTS.

The system shall require annual financial information and rate revenue and expense, and interim increase reports.

Statutory Authority: *MS s 144.703*

4650.0500 ANNUAL FINANCIAL INFORMATION REPORT.

Each hospital shall submit an annual financial information report to the system. This report shall include:

A. A balance sheet detailing the assets, liabilities, and net worth of the hospital. This balance sheet should include information on:

(1) Current assets, including: cash; marketable securities; accounts and notes receivable; allowances for uncollectable receivables and third party contractuals; receivables from third party payors; pledges and other receivables; due from other funds; inventory; and prepaid expenses.

(2) Plant capital allowances, including historical cost of, price level increments related to, and accumulated depreciation related to: land; land improvements; buildings; leasehold improvements; building equipment; movable equipment; and construction in progress.

(3) Deferred charges and other assets, including: other assets; investments in nonoperating property, plant, and equipment; accumulated depreciation on investments in nonoperating plant and equipment; and other intangible assets (e.g., good will, unamortized borrowing costs).

(4) Current liabilities, including: notes and loans payable; accounts payable; accrued compensation and related liabilities; other accrued expenses; advances from third party payors; payable to third party payors; due to other funds; income taxes payable; and other current liabilities.

(5) Deferred credits and other liabilities, including: deferred income taxes; deferred third party revenue; long-term debt; and fund balances (identifying donor restricted and unrestricted funds).

(6) In the case of hospitals owned by, operated by, affiliated with, or associated with an organization, corporation, or other hospital(s), a statement of the flow of funds between the hospitals and that organization, corporation, or other hospital(s). This statement shall detail all transactions between the hospital and the organization, corporation, or other hospital(s).

(7) In the event that a hospital maintains a balance sheet which includes information which differs from the information required by the balance sheet recommended by item A, the hospital may substitute its balance sheet. This balance sheet shall include a narrative description of the scope and type of differences between its balance sheet and that balance sheet recommended by item A.

B. A detailed statement of income and expenses, including:

(1) gross revenues from and expenses directly attributable to revenue centers;

(2) all operating revenues and expenses other than those directly associated with patient care;

(3) reductions in gross revenues that result from charity care, contractual adjustments, administrative and policy adjustments, provision for bad debts, and other factors;

(4) direct expenses incurred by the research and educational, general, fiscal, and administrative service centers;

(5) direct gross revenue and gross expense received or incurred from nonhospital operations; and

(6) a statement of expenses by a natural classification of expenses for the hospital as a whole. The natural classification of expenses may include such factors as:

(a) salaries and wages, including: management and supervision; technicians and specialists; registered nurses; licensed practical nurses; aides and orderlies; clerical and other administrative employees; environment and food service employees; physicians; nonphysician medical practitioners; vacation, holiday, sick pay, and other non-worked compensation.

(b) employee benefits, including: F.I.C.A.; state unemployment insurance and federal unemployment insurance; group health insurance; pension and retirement; workmen's compensation insurance; and group life insurance.

(c) professional fees, medical, including: physician's remuneration; and therapists and other nonphysicians.

(d) other professional fees, including: consulting and management services; legal services; auditing services; and collection services.

(e) special departmental supplies and materials.

(f) general supplies, including: office and administrative supplies; employee wearing apparel; instruments and minor medical equipment which are nondepreciable; minor equipment which is nondepreciable; and other supplies and materials.

(g) purchased services, including: medical-purchased services; repairs and maintenance-purchased services; medical school contracts-purchased services; and other purchased services.

(h) other direct expenses, including: depreciation, amortization, and rental or lease expenses necessary to maintain an adequate plant capital fund, pursuant to part 4650.2400; utilities-electricity; utilities-gas; utilities-water; utilities-oil; other utilities; insurance-professional liability; insurance-other; licenses and taxes other than income taxes; telephone and telegraph; dues and subscriptions; outside training sessions; travel; and other direct expenses.

(7) In the event that a hospital maintains accounts which include information resulting in detailed statements of income and expense which differ from the information required by the statement of income and expense recommended by item B, the hospital may substitute its statement of income and expenses. This statement shall include a narrative description of the scope and type of differences between its statement of income and expenses and that statement recommended by item B.

C. An unaudited copy of the hospital's cost report filed pursuant to requirements of the United States Social Security Act, title XVIII stated in Code of Federal Regulations, title 20, section 405.406(b) and the uniform cost report required under Public Law Number 95-142, section 19. These cost reports shall correspond to the same accounting period as that used in the compilation of data for other requirements for the report of annual financial information.

D. Attestation by the governing authority of the hospital or its designee that the contents of the report are true.

E. Attestation by a qualified, independent public accountant that the contents of the balance sheet and statement of income and expense have been audited.

F. A statement of changes in financial position showing the source and application of all funds.

G. A statement(s) of all fund balance(s).

H. All notes and footnotes to the balance sheet, statement of income and expense, statement of changes in financial position, and statement(s) of fund balance(s).

I. Each hospital claiming exempt status pursuant to Minnesota Statutes, section 144.7021 and parts 4650.4200 to 4650.4600 shall include or append a clearly identifiable statement(s) of annual gross acute care charges.

Statutory Authority: *MS s 144.703*

4650.0600 RATE REVENUE AND EXPENSE REPORT.

Subpart 1. **Statistical and financial information.** Each hospital shall submit a report of rate revenue and expense to the system on an annual basis. This report shall include statistical and financial information for:

A. The hospital's last full and audited accounting period prior to the accounting period during which a hospital files this report with the system. This period shall be known as the prior year. Information for the prior year shall be actual.

B. The hospital's full accounting period during which a hospital files this report with the system. This period shall be known as the current year. Information for the current year shall be actual and estimated according to the following: information for at least the first six months shall be actual; information for the remaining months may be estimated.

C. The hospital's next subsequent full accounting period following the accounting period during which the report is filed with the system. This period shall be known as the budget year. Information for the budget year shall be projected.

Subp. 2. **Statistical information.** Statistical information for the rate revenue and expense report shall include:

A. The number of inpatient days excluding nursery days for the hospital, and each appropriate service center.

B. The number of admissions for the hospital and for each appropriate service center.

C. The average number of full-time-equivalent employees during each accounting period for the hospital and for each of its service centers. An employee or any combination of employees which are reimbursed by the hospital for 2080 hours of employment per year is a full-time-equivalent employee.

D. The number of beds (licensed), the number (the statistical mean) of beds physically present, and the number (the statistical mean) of beds actually staffed and set up for the hospital and each appropriate service center, excluding nursery bassinets.

E. The number of outpatient clinic visits for the hospital.

F. The number of emergency visits for the hospital.

G. The number of units of service provided by each of the hospital's other service centers. The hospital shall select the statistic that best measures the level of activity for a particular function or service center and that, in addition, is compiled on a routine basis by the hospital to serve as the appropriate unit of service for each of its service centers.

For example, although patient days might be used as the unit of service for daily patient services, treatments, procedures, visits, hours, or other statistics would be the applicable measure of activity in other service centers.

Subp. 3. **Financial information.** Financial information for the rate revenue and expense report shall include:

A. An interim financial statement of the hospital which shall include an interim balance sheet and an interim income and expense statement for the current year only. The balance sheet and income and expense statement shall conform to the requirements of parts 4650.0500, items A and B. This financial statement shall contain a minimum of six months of actual information for the current year.

B. A statement of expenses for the hospital and for each of its service centers and a statement according to natural classifications of expenses as provided by part 4650.0500, item B, subitem (6).

C. A statement detailing the accounting method used to allocate expenses from among the nonrevenue centers to revenue centers, which shall detail compliance with the offsets to costs and allocation of costs specified by the bases for judging stated by parts 4650.2300 to 4650.2700.

D. A statement of total direct and indirect costs for the hospital and for each of its service centers before and after the allocation of expenses.

E. A statement of the accounts receivable by type of purchaser of services and a statement of the average aggregate number of day's charges outstanding at the end of each period.

F. A statement of the capital budget of the hospital.

Subp. 4. **Additional information.** The report of rate revenue and expense shall also contain the following information:

A. The pricing policy of the hospital which incorporates the overall pricing policy and financial objectives of the institution. This will be supplemented by a statement of budgeted increases in charges, revenue, and aggregate rates for the budget year including these items:

(1) date(s) on which gross charges, and gross revenue will be adjusted;

(2) for each such date, the resulting aggregate dollar amount and weighted average percent of increase in budget year aggregate rates and gross charges for each revenue center;

(3) for each such date, the resulting aggregate dollar and weighted average percent of increase in budget year total hospital gross revenues;

(4) for each date, the resulting aggregate dollar amount and percent of increase in the budget year aggregate rate.

B. Attestation by the hospital's governing authority or its designee that the rates are set equitably and without discrimination among insurers.

C. In the case of a hospital with expanded facilities, a copy of the hospital's report used to obtain a certificate of need for the expanded facility which projects the patient and service activity levels of the expanded facility for its first five years of operation.

Subp. 5. **Accounts as substitute for rate revenue and expense report.** If a hospital maintains its accounts in a way which necessarily results in detailed statements of income, expense, and statistics differing in form and content from those recommended by parts 4650.0400 to 4650.0700 and part 4650.1400, subpart 1, the hospital may substitute the information it has available. However, in all such cases the hospital shall submit a detailed reconciliation of the differences between the two sets of information and presentations in conjunction with the rate revenue and expense report.

Statutory Authority: *MS s 144.703*

4650.0700 INTERIM INCREASE REPORTS.

Subpart 1. **To amend or modify the aggregate rates.** Each hospital desiring to amend or modify the aggregate rates for the budget year stated in the rate revenue and expense report then on file with the system to an extent exceeding the allowable increase limit prescribed according to part 4650.4100, shall submit an interim increase report. In instances where changes in rates during the budget year are the result of legislative policy and appropriations to hospitals subject to these rules which are operated by the commissioner of public welfare, this report is not required.

Subp. 2. **Content of report.** The interim increase report shall include statistical and financial information for:

A. The period of the budget year immediately preceding the effective date of amendments or modifications to the rates for the budget year which are stated in the rate revenue and expense report then on file with the system. Data for this period shall be actual for all expired months of the budget year, excepting the 60-day period immediately preceding the filing of this report for which data may be projected.

B. The period immediately subsequent to and including the effective date of these amendments or modifications which terminates at the end of the last day of the budget year. Information for this period shall be projected on the basis of these rate amendments or modifications.

Subp. 3. **Statistical information on the report.** Statistical information for each period established by subpart 2 for the interim increase report shall include that required of a hospital for the rate revenue and expense report, pursuant to part 4650.0600, subparts 2 and 5, which shall be recorded for each period stated by subpart 2. This information shall indicate any change in the budget year from the projected information then on file with the system.

Subp. 4. **Financial information on the report.** Financial information for each period established by subpart 2 for the interim increase report shall include that required of a hospital for the rate revenue and expense report, pursuant to part 4650.0600, subparts 3 and 5, which shall be recorded for each period stated by subpart 3. This information shall indicate any change in the budget year from the projected information then on file with the system.

Subp. 5. **Rationale for increase.** This report shall also include a narrative statement describing the reason for admendments or modifications to the hospital's aggregate rates.

Statutory Authority: *MS s 144.703*

4650.0800 EXPERIMENTAL ALTERNATIVE REPORTING REQUIREMENTS.

Each hospital meeting the criteria specified in part 4650.0900 may file annual rate revenue and expense reports and interim increase reports according to part 4650.1000, in lieu of information required under part 4650.0600, subparts 2 and 3.

Statutory Authority: *MS s 144.703*

4650.0900 SELECTION CRITERIA.

Nonstate, nonfederal acute care hospitals licensed in the state of Minnesota are eligible if they belong to the set of hospitals comprising 15 percent of the total gross acute (inpatient plus outpatient) charges for all nonstate, nonfederal acute care hospitals in the state. Determination of the hospitals to be included in the set of hospitals comprising 15 percent of total state gross acute charges shall be made as follows:

A. The total gross acute charges used shall be for the hospital's 1977 fiscal year, pursuant to part 4650.0600, item A.

B. The hospital with the lowest total gross acute charges shall be selected first. The hospital with the second lowest total gross acute charges shall be selected second and its gross acute charges shall be added to the first selected hospital's. The hospital with the third lowest gross acute charges shall be selected third and its total gross acute charges shall be added to the sum of the gross acute charges of the hospitals selected first and second. The procedure shall continue in direct ascending order so as to maximize the number of hospitals included, but the sum of gross patient charges included shall not exceed 15 percent of the total gross acute charges for all nonstate and nonfederal acute care hospitals.

Statutory Authority: *MS s 144.703*

4650.1000 RATE REVENUE AND EXPENSE REPORT.

Subpart 1. **Submission of the report.** Each hospital shall submit a report of rate, revenue, and expense pursuant to part 4650.1600. This report shall include statistical and financial information for: the prior year as provided by part 4650.0600, subpart 1, item A; the current year as provided by part 4650.0600, subpart 1, item B; the budget year as provided by part 4650.0600, subpart 1, item C.

Subp. 2. **Statistical information on the report.** Statistical information submitted in the rate revenue and expense report shall include:

A. The number of inpatient days for the hospital.

B. The number of admissions for the hospital.

C. The average number of full-time-equivalent employees during each accounting period for the hospital and each service center. An employee or any combination of employees which is reimbursed by the hospital for 2,080 hours of employment per year is a full-time-equivalent employee.

D. The number of beds licensed, the number (the statistical mean) of beds physically present, and the number (the statistical mean) of beds actually staffed and set up for the hospital.

E. The number of outpatient and emergency visits for the hospital.

Subp. 3. **Financial information of the report.** Financial information submitted in the rate revenue and expense report shall include:

A. an interim financial statement as provided by part 4650.0600, subpart 3, item A;

B. a statement of expenses for the hospital according to natural classifications of expenses as provided by part 4650.0500, item B, subitem (6);

C. a statement indicating the accounting method used to allocate expenses from among the "nonrevenue producing centers" to "revenue producing centers" as provided by part 4650.0600, subpart 3, item C;

D. a statement of total "direct" and "indirect" costs and revenues where applicable for the hospital and for each of the following, both before and after allocation of indirect expenses: daily services, ancillary services (enumerating inpatient, outpatient, and emergency), and nonrevenue producing services;

E. a statement of the accounts receivable in total and of gross revenue by type of payer;

F. a statement of the capital budget of the hospital; and

G. all information as provided by part 4650.0600, subparts 4 and 5.

Statutory Authority: *MS s 144.703*

4650.1100 INTERIM INCREASE REPORTS.

Interim increase reports shall be filed as required under part 4650.0700, subpart 1. Statistical and financial information shall be filed as required under part 4650.0700, subparts 2 to 5, except when in conflict with information required in the rate revenue and expense report as provided by part 4650.1000. In such circumstances, the information required by part 4650.1000 shall be the required information.

Statutory Authority: *MS s 144.703*

4650.1200 REVIEW AND COMMENT.

The review and comment upon all experimental reports reviewed pursuant to parts 4650.1000 and 4650.1100 shall be conducted and made as stated in part 4650.3100, with the exceptions of part 4650.3100, subpart 2, item A, subitem (3) and part 4650.3100, subpart 2, item B, subitem (6). The following shall substitute for part 4650.3100, subpart 2, item A, subitem (3) and part 4650.3100, subpart 2, item B, subitem (6):

A. Aggregate rates and costs and components of aggregate rates and costs have been demonstrated by the hospital to be consistent or inconsistent with the reasonable operating expenses found in part 4650.2400, subpart 2, items A to F, subpart 3, item A, subitem (1), and items B to G; 4650.2500; 4650.2600; and 4650.2700. In addition, a maximum of five percent of part 4650.2400, subpart 2, items A, B, C, D; and subpart 3, item A, subitem (1) shall serve in lieu of: (1) part 4650.2400, subpart 3, item A, subitem (2), (2) part 4650.2400, subpart 3, items B, C, and D; or (3) part 4650.3000 or 4650.3100.

B. Sixty-six percent of the five percent plus factor provided in item A shall be placed in an identifiable depreciation fund and may be used in the manner prescribed in part 4650.2400, subpart 3.

Statutory Authority: *MS s 144.703*

4650.1300 ASPECTS OF THE EXPERIMENT.

The alternative experimental reporting requirements shall remain in force for a period of four years (four complete reporting cycles) commencing with the effective date of parts 4650.0100 to 4650.5300. At the close of the third year of the experiment an evaluation of the alternative reporting requirements shall be made by the Department of Health in conjunction with all approved voluntary, nonprofit rate review organizations. The evaluation shall address the following, at a minimum: the adequacy of the data, impact of the reduced data set on the quality of rate reviews, the appropriateness of the set of hospitals chosen to participate in the experiment, and the appropriateness of adopting the requirements permanently.

Statutory Authority: *MS s 144.703*

ADMINISTRATIVE PROCEDURES

4650.1400 GENERAL PROVISIONS FOR FILING OF REPORTS.

Subpart 1. **Forms to be specified.** The system shall design and issue forms as necessary for meeting the requirements of reports established by parts 4650.0100 to 4650.5300. These forms shall contain clear instructions for their completion.

Subp. 2. **Filed personally.** All documents may be filed personally or by the United States Postal Service with the system at the system's official offices during normal business hours.

Subp. 3. **Recordkeeping system.** The system shall establish a method of recordkeeping which shall ensure that reports and other documents are ordered, stored, designated, and dated in such a manner that facilitates easy public access

to the contents of those reports, documents, and other information as required by parts 4650.0100 to 4650.5300. These records shall be open to the public inspection during normal business hours.

Subp. 4. **Record complete.** No report required by these rules shall be deemed to be filed until the system has ascertained the completeness of the report in accordance with the provisions of part 4650.3000.

Statutory Authority: *MS s 144.703*

4650.1500 FILING OF REPORT OF ANNUAL FINANCIAL INFORMATION.

Subpart 1. **Filing of report.** Each year, each hospital shall file a report of annual financial information as required by part 4650.0500 with the system within 120 days after the close of that hospital's full accounting period. The cost report of the hospital filed pursuant to the requirements of the United States Social Security Act, Code of Federal Regulations, title 20, section 405.406(b), title XVIII, may be filed separately from the other requirements for the report of annual financial information, provided:

A. It is filed no later than the time it is required to be filed with the Medicare Fiscal Intermediary as identified according to Code of Federal Regulations, title 20, section 405.651, et. seq. (Medicare). The hospital shall inform the system of this date when filing other information required by this report.

B. The report of annual financial information is considered incomplete until the receipt of the unaudited cost report, but the hospital is not considered in violation of rules until the date required by the Medicare fiscal intermediary for the submission of the unaudited Medicare cost report.

C. The audited Medicare cost report is submitted as soon as is practicable to substitute for the unaudited Medicare cost report. The submission of an audited Medicare cost report shall not affect the official filing date of a report of annual financial information.

Subp. 2. **Failure to file.** Any hospital which fails to file the annual financial information report, and which has not requested an extension of time pursuant to part 4650.2100, to file that report shall be considered to be in violation of rules. The system shall notify the commissioner, the appropriate health systems agency and professional standards review organization to this effect.

Statutory Authority: *MS s 144.703*

4650.1600 FILING OF REPORT OF RATE REVENUE AND EXPENSE.

Subpart 1. **Filing the report.** Each year, each hospital shall file a report of rate revenue and expense up to 60 days prior to the commencement of any accounting period of the hospital. No change in rates shall be made until 60 days have elapsed from the date of filing.

Subp. 2. **Failure to file.** Any hospital which fails to file a report of rate revenue and expense, and which has not requested an extension of time, pursuant to part 4650.2100, to file that report shall be considered to be in violation of rules. The system shall notify the commissioner of health, the appropriate health systems agency, and professional standards review organization to this effect.

A hospital which fails to file a report of rate revenue and expense, and which has requested an extension of time, pursuant to part 4650.2100, to file that report may be charged an additional late fee as authorized by part 4650.5000. A hospital which fails to file a report of rate revenue and expense, and which has not requested an extension of time, pursuant to part 4650.2100, to file that report shall not amend or modify its rates until 60 days after that hospital files that report with the system.

Statutory Authority: *MS s 144.703*

4650.1700 FILING OF INTERIM INCREASE REPORTS.

Subpart 1. **Filing the report.** A hospital shall file an interim increase report 60 days prior to the effective date of any amendments or modifications to aggregate rates then on file with the system for the budget year if:

A. the proposed aggregate rate change exceeds the allowable increase limit established according to part 4650.4100; or

B. amendments or modifications to aggregate rates which are to become effective after the first day of the budget year and prior to the end of the last day of the budget year were not included in the report of rate revenue and expense then on file with the system.

Subp. 2. **Limitations.** An interim increase report may not be filed within 90 days of any other interim increase or rate revenue and expense report filed by that hospital or when there are any reports, fees, or other documents due to the system from that hospital. This provision may be waived by the system if the hospital can show cause therefor.

Statutory Authority: *MS s 144.703*

4650.1800 FAILURE TO FILE.

A hospital which fails to file an interim increase report with the system when it is required to file such a report pursuant to part 4650.0700 shall be considered in violation of these rules. If this violation is discovered by the system during the budget year, the system may require a hospital so violating these rules to adjust its aggregate rate to be consistent with the allowable increase limits until 60 days after the hospital properly files an interim increase report. If this violation is discovered by the system subsequent to the expiration of the budget year during which the violation occurred, the system may investigate this violation, pursuant to parts 4650.2800 and 4650.2900, in order to determine the effect of this violation upon the aggregate rate of the hospital. The system may recommend a reduction in the rates of the hospital and require that the hospital submit interim increase reports for every increase in aggregate rate, irrespective of the allowable increase limits, for the next two subsequent full accounting periods following the discovery of the violation.

In making any retrospective assessment of a hospital's compliance with requirements to file interim increase reports, the system shall recognize that the actual aggregate rate for the budget year may exceed the projected aggregate rate for that budget year by a reasonable amount due to slight variations from projected information contained in the rate revenue and expense report then on file with the system. A reasonable amount may vary with the financial and statistical composition of each hospital but, it should never exceed one and one-tenth times the allowable increase limit for the accounting period in question.

Statutory Authority: *MS s 144.703*

4650.1900 ALLOWABLE INCREASE LIMITS: HOSPITAL CALCULATION.

In order for a hospital to determine the extent to which it may increase its aggregate rate during the budget year before it is required to submit an interim increase report, the hospital shall:

A. Add the four quarterly allowable increase limits established by the commissioner of health, pursuant to 4650.4100, which are appropriate for the budget year of the rate revenue and expense report then on file with the system. This calculation provides the hospital with an allowable increase limit for the budget year stated in percentage terms.

B. Then subtract from the allowable increase limit for the budget year the percentage of the aggregate rate increase for the hospital, if any, from the current year to the budget year, as stated in the rate revenue and expense report then on file with the system. To the extent that the remainder from this

calculation is positive, the hospital may increase its aggregate rate for the hospital by this amount at any time during the budget year. Cumulative increases in the aggregate rate of the hospital over the budget year up to this amount do not require the submission of an interim increase report. The system should be advised by the hospital at the time that rates are being so increased, stating the reason for and general scope of such an increase. The next subsequent rate revenue and expense report of the hospital should detail these increases.

C. Amendments or modifications which do not exceed the allowable increase limit or provide for aggregate rate decreases may take effect immediately upon determination by the hospital's governing authority or its designee. Notice of the amendments or modifications at the time they become effective shall be given to the commissioner of health. These amendments or modifications shall also be noted in the hospital's next subsequent rate revenue and expense report.

Statutory Authority: *MS s 144.703*

4650.2000 FILING OF REPORTS IN MULTI-HOSPITAL CORPORATIONS AND OTHER ORGANIZATIONS OPERATING MORE THAN ONE HOSPITAL.

The system requires the filing of all reports for each individually licensed acute care hospital, as provided by parts 4650.0400 to 4650.0700. A multi-hospital corporation or organization operating more than one hospital may act as the reporting organization for the hospital to the system. This reporting organization shall provide all information separately for each hospital it operates. The reporting organization shall also provide with this information a statement detailing the financial relationship between each hospital it operates and the reporting organization, as required by part 4650.0500, item A, subitem (1), unit (f) for the annual financial information report.

Statutory Authority: *MS s 144.703*

4650.2100 FILING OF REPORTS: EXTENSIONS.

Upon reasonable cause being shown by a hospital, the system may extend any period of time established for the submittal of any report or other information, or any period of time established for the performance of any other act permitted or prescribed by these rules, for an additional and specified period of time.

Statutory Authority: *MS s 144.703*

4650.2200 INVESTIGATIONS, ANALYSIS, AND REVIEW STANDARDS.

The system shall investigate, analyze, and review all reports and other information it receives relating to hospital rates according to the following standards.

Statutory Authority: *MS s 144.703*

4650.2300 BASES FOR JUDGING THE REASONABLE USE OF FINANCES IN A HOSPITAL.

In all investigations, analyses, and reviews conducted pursuant to Minnesota Statutes, sections 144.695 to 144.703, and parts 4650.0100 to 4650.5300, the system shall recognize that rates must supply the financial resources necessary to meet the financial requirements of a hospital. In meeting the reporting requirements of parts 4650.0100 to 4650.5300, hospitals shall address the contents of their reports to and indicate their compliance with these financial requirements and to the other stated bases for judging the reasonable use of finances in a hospital. The system shall then conduct investigations, analyses, and reviews following these established bases.

Statutory Authority: *MS s 144.703*

4650.2400 FINANCIAL REQUIREMENTS OF HOSPITALS.

Subpart 1. **Rates.** The gross rates charged to patients or their insurers by a hospital must be adequate to maintain the solvency of the hospital. Rates should provide adequate money to meet expenses incurred in the following specific categories.

Subp. 2. **Current operating needs related to patient care.** In meeting the needs of a hospital to provide health care services, rates should provide finances necessary to meet expenses incurred by:

A. Direct patient care. Rates should provide finances to meet expenses in this category which may include salaries, wages, employee fringe benefits, services, supplies, normal maintenance, minor building modification, and any applicable taxes.

The monetary value of services provided by members of religious orders, other organized religious or social service groups or organizations, or by a unit of government, such as a county, may be included in rates, provided:

(1) that value does not exceed the amount that would have been paid to regular salaried hospital employees for the provision of the same services;

(2) the maximum value for nongovernmental services is the cash payment to the order, group, or organization from the hospital; and

(3) that value is reduced by the expense incurred by the hospital for the provision of any room and/or board without charge to members of those orders, groups, or organizations.

B. Interest expense. Rates should provide the finances necessary to recover costs incurred by the hospital due to necessary and proper interest on funds borrowed for operating and plant capital needs. Interest on funds borrowed for operating needs is the cost incurred for funds borrowed for a relatively short term. This interest is usually attributable to funds borrowed for such purposes as working capital for normal operating expenses. Interest on funds borrowed for plant capital needs is the cost incurred for funds borrowed for plant capital purposes, such as the acquisition of facilities and equipment, and capital improvements. These borrowed funds are usually long-term loans.

Interest is necessary if it is:

(1) Incurred on a loan made to satisfy a financial need of the hospital. Loans which result in excess funds or investments should not be considered necessary.

(2) Incurred on a loan made for a purpose reasonably related to patient care. Loans made for the following are not to be considered to be for a purpose reasonably related to patient care: to expand facilities that have been determined to have excess capacity, pursuant to part 4650.2700.

Interest is proper if it is incurred at a rate not in excess of what a prudent borrower would have to pay in the money market existing at the time the loan was made.

C. Educational program expenses. Rates should provide the finances necessary to recover the net cost to the hospital of providing educational activities which:

(1) are approved educational activities and can be demonstrated to directly contribute to the care of patients who are in hospitals during the time the cost is incurred; or

(2) can be demonstrated to contribute to the preventive health education of the population of areas of patient origin which the hospital serves.

"Approved educational activities" means formally organized or planned programs of study usually engaged in by hospitals in order to enhance the quality of patient care in a hospital. These activities shall be licensed where required by state law. Where licensing is not required, the hospital shall be able to demonstrate that it has received approval for its activity from a recognized

national professional organization for the particular activity. Approved educational activities include those programs defined as approved by Code of Federal Regulations, title 20, section 405.116(f) (Medicare) and Code of Federal Regulations, title 20, section 405.421(e) (Medicare).

"Net cost" means the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs), less any reimbursement from grants, tuition, and specific donations. Non-inpatient revenue sources, including fees from those receiving educational benefits, should be investigated and utilized prior to the inclusion of the cost of community preventive health education in financial requirements.

"Orientation" and "on-the-job training" costs are recognized as normal operating costs of hospitals for employees of the hospital.

The extent of costs incurred for the provision of educational activities contributing to the preventive health education of the population of the hospital's areas of patient origin should not exceed that amount necessary to provide activities recommended appropriate for hospitals by the state health planning and development agency, and appropriate health systems agency, pursuant to Public Law Number 93-641, sections 1523 and 1513, respectively.

D. Research program expenses. Rates should provide finances necessary to meet costs incurred by a hospital due to research programs which directly relate to daily patient care to the extent that nonpatient revenue of the hospital is unavailable to offset these research costs. Rates should not provide finances necessary to meet costs incurred by a hospital due to research purposes, over and above usual patient care.

E. Bad debt, charity allowances, and contractual allowances. Gross rates should provide finances necessary to recover losses in gross revenue due to bad debts, charity allowances, and governmental contractual allowances:

(1) "Bad debts" mean amounts considered to be uncollectable from accounts and notes receivable which were created or acquired in providing services. Accounts receivable and notes receivable are designations for claims arising from the rendering of services, and are collectable in money in the near future. These amounts should not include any amount attributable to a reclassification of any expenses incurred due to the provision of charity care. Income reductions due to charity allowances, and contractual allowances should be recorded as such in the records of a hospital and not as bad debts.

(2) "Charity allowances" means the provision of care at no charge to patients determined to be qualified for care according to Code of Federal Regulations, title 42, section 53.111(f) and (g), in hospitals required to provide free care, pursuant to United States Code, title 49, section 291, et. seq. (the Hill-Burton Act). The annual amount of charity care shall be no greater than the amount of the Hill-Burton grant or Hill-Burton guaranteed loan amortized in equal installments over the life of the hospital's Hill-Burton free care obligation.

(3) "Governmental contractual allowances" are those discounts from the established gross charges required due to governmental reimbursement practices established pursuant to regulations authorized by such governmental programs as those created by United States Social Security Act, title V, title XVIII, and title XIX.

The losses in revenues due to bad debts, charity allowances, and governmental contractual allowances should be offset by available and applicable income from sources other than patients, as identified by part 4650.2500, before these losses are included in rates. Such offsets should never result in a condition where charges are lower than the actual cost of providing care for purposes of reimbursement by third party payers or by governmental programs.

F. "Discounts" and/or "price differentials" are those discounts and/or prices granted and/or charged to certain payers (patients, groups of patients, or third party payers), which result in receipts by a hospital of something less than

the average expected dollar amount received for services rendered of comparable type, kind, and quality in the absence of such discounts and/or prices. These discounts and/or price differentials shall be classified as either cost-justified or non-cost-justified.

(1) "Cost-justified discounts" and/or "cost- justified price differentials" are discounts and/or price differentials, as measured in dollars, for the services and/or other benefits given to a hospital by a payer during an accounting period. Cost reducing benefits and services that shall be considered in a determination of whether a discount is cost justified include: hospital administration, payer admitting requirements, payer accounting and audit requirements, payer billing costs, hospital working capital requirements, cash and prepayment, the length of time taken to pay bills, and other cost reducing activities undertaken by specific payers that do not simply and inequitably shift costs from one payer to another.

(2) "Non-cost-justified discounts" and/or "non-cost-justified price differentials" are all other discounts and/or price differentials that are not cost justified in a manner consistent with subitem (1).

(3) "Cost-justified discounts" and/or "price differentials" shall be granted to payers for hospital services and shall be included in a hospital's financial requirements if: the amount of the discounts or price differentials as measured in dollars is equal to or less than the value of services or other benefits given to a hospital by a payer during an accounting period; and the dollar value, per adjusted admission, of the services or other benefits offered to a hospital by a payer is first subtracted from the average cost (which includes the cost saving associated with the service or the benefit given) per adjusted admission for all patients.

(4) "Non-cost-justified discounts" and/or "non-cost-justified price differentials" shall not be included in a hospital's financial requirements.

Subp. 3. **Plant capital needs.** Rates should provide the finances necessary for various plant capital needs. In order to include plant capital needs in rates, the hospital must fund the plant capital requirement and be in receipt of a certificate of need as required by Minnesota Statutes, sections 145.71 to 145.84. "Funding of depreciation" shall mean the actual placement of the cash in the fund or meeting the capital obligations and depositing the net amount to the fund.

A. Finances which relate to land, land improvement, building and building equipment, and movable equipment shall be placed in an identifiable fund. The use of the fund shall be restricted to debt principle retirement, new plant and equipment (with certificate of need approval if necessary), major repairs (that are capitalized), replacement of capital equipment (with certificate of need approval if necessary), Hill-Burton free-care expenses in excess of those accounted for by subpart 2, item E, subitem (1), and all other free-care (not to exceed three percent of operating expenses net of medicare and medicaid expenses). The annual increment to this fund should be:

(1) The annual straight-line depreciation expense on land improvements, buildings, building equipment, and movable equipment.

(2) Plus an amount annually determined (for each hospital) to be consistent with the established useful lives of land improvements, buildings, building equipment, and movable equipment. This amount shall be determined as follows:

(a) an index or cumulative index determined by the system and recognized by independent public appraisers as expressing the annual effects of inflation upon historical cost from the year of purchase of hospital land improvements, buildings, hospital building equipment, and movable equipment and shall be multiplied by an asset(s) annual depreciation expense;

(b) the index for the budget year's expected annual depreciation expense shall not exceed 1.04.

(3) The system shall derive these indices from any of the most current indices then available to the system which give specific recognition to the following factors:

(a) the effect of inflation upon the replacement cost of existing land improvements, buildings, building equipment, and movable equipment, based upon their historical cost; and

(b) the effect of inflation upon funds necessary for the modification of or addition to hospital buildings, land improvements, building equipment, and movable equipment.

B. One hundred percent of the inflation factors should be included by the hospital as the annual inflation factor unless the hospital has been determined to have excess capacity, as provided by part 4650.2700, or by the appropriate health systems agency, professional standards review organization, and state health planning and development agency. In instances where excess capacity exists, the annual inflation factor and the level of debt principal payment in excess of the depreciation allowance permitted by item A should be reduced by the proportion of facilities determined to be in excess.

C. The fund may not be sufficient to retire existing debt.

D. The annual interest income earned from an investment of this fund annually should be used to reduce the inflation factor requirements for plant capital needs which are included in rates. In addition, the annual increment to the plant capital fund, when projected over the lives of the depreciable assets of the hospital using the current year's experience, should be evaluated with regard to the individual hospital's capital needs in relationship to the appropriate health systems agency's areawide health' plan and the state health planning and development agency's state health plan.

E. In the event that sufficient financial resources are not available in this fund to meet plant capital needs (including the need for the replacement of existing facilities and the need for expansion of the scope of services to accommodate advances in medical technology, where either or both of these needs have received certificate of need approval when required), the additional financial resources should be acquired from:

(1) income from appropriate sources other than patients;

(2) borrowed funds or leases to the extent income from sources other than patients can be demonstrated to be inadequate; or

(3) approved inclusion in rates to the extent it can demonstrate that insufficient resources exist from (1) and (2) above, and that inclusion in rates will result in a lower cost to current patients than would result from the borrowing of funds or leasing of plant capital assets. Approval of inclusion in rates shall be by the system upon demonstration by the hospital of both of the conditions herein stated. Once approved, the inclusion in rates of these additional financial requirements may be considered reasonable. Any portion of the annual equal amortized historical cost of any plant capital needs, as determined over the useful life of those plant capital needs, so included in rates should not be depreciated.

F. If a hospital can demonstrate that an emergency exists, then the hospital may, with certificate of need approval, include the cost of the emergency plant capital needs directly in its rates in a manner consistent with the previous financial practices of that hospital.

G. If a hospital can demonstrate that the assumption of any specific capital debt will result in a greater cost to current patients than depreciation or retirement of that debt under consistent financial practices of that hospital which differ from the determination of plant capital needs as stated by these rules, then a hospital may choose an alternative method of meeting its plant capital needs.

In this instance, the hospital should provide complete information to the system regarding the precise method which will be used to meet such a plant capital need. Direct inclusion of plant capital needs in rates requires approval by the system as provided by subpart 3, above.

Subp. 4. **Incremental operating cash needs.** Rates should provide finances to maintain a reasonable working capital allowance.

A. The working capital allowance which may be included in rates is determined by the annual incremental difference between (net accounts receivable and inventories and prepaid expenses) and (salaries payable and other net payables) at the end of an accounting period. Any increases in working capital over the prior year, as stated in the first report of annual financial information submitted to the system by a hospital shall form the initial basis for the system's assessment of the reasonableness of the working capital allowance.

B. The amount of working capital is dependent upon the number of days charges in accounts receivable for the hospital. These days charges should be stated in aggregate for an accounting period. A statement of accounts receivable by payer must also be provided.

(1) Payers may include:

(a) third party payers, including: Medicare; Medicaid; Blue Cross; health maintenance organizations; other insurers; and

(b) paying patients.

(2) the number of days charges in accounts receivable for the hospital is determined by:

$$\frac{\text{Total Net Accounts Receivable At the End of An Accounting Period}}{\text{Total Patient Charges For The Same Accounting Period}}$$

$$\frac{\text{Total Patient Charges For The Same Accounting Period}}{\text{Actual Number of Calender Days In That Same Accounting Period}}$$

C. "Net accounts receivable" means the dollar amount accounts receivable at the end of an accounting period less estimated discounts and differentials and reserve for uncollectables. To the extent that the number of days charges in accounts receivable for a hospital increases from one accounting period to another subsequent accounting period, the hospital may increase rates to maintain its working capital allowance. To the extent that the number of days charges in accounts receivable for a hospital which is attributable to a particular payer or category of payers decreases, the working capital allowance should be reduced by that amount.

D. "Inventories" means the dollar amount in inventories at the end of an accounting period. The dollar amount in inventories should not increase from one accounting period to another subsequent accounting period unless the hospital can justify such an increase as due to inflation, alterations in scope or volume of services offered.

E. "Other net payables" means total payables at the end of an accounting period less all liabilities owed to third party payers and less the current portion of plant capital expenditure from the plant capital fund.

F. The reasonableness of the working capital allowance depends upon factors including:

(1) the number of days charges in accounts receivable for a hospital compared with the number of days charges in accounts receivable for other hospitals determined by the system to share common characteristics (this number may be compared for hospitals in total);

(2) the amount of bad debts accrued by a hospital during an accounting period; and

(3) the amount of finances a hospital may hold in reserve funds.

Statutory Authority: *MS s 144.703*

4650.2500 RESTRICTED AND UNRESTRICTED FUNDS FROM SOURCES OTHER THAN PATIENTS.

In all investigations, analyses, and reviews conducted pursuant to parts 4650.0100 to 4650.5300, the system shall recognize that hospitals have sources of funds other than patients which are intended to be or may be used for the reduction of rates. In meeting the reporting requirements of parts 4650.0100 to 4650.5300, hospitals shall disclose the extent of which these funds are used to offset costs and to provide service in such a manner as to reduce gross rates charged patients. This income includes:

A. Restricted endowment funds, specific purpose funds, tax funds (tax receipts or appropriations received), and gifts. Moneys from endowment funds, and/or gifts restricted by donors, or moneys generated by taxes to provide for services for designated patients should be used to reduce the payment for those services. Moneys from endowment funds, and/or gifts restricted by donors or moneys generated by taxes to provide for buildings and movable equipment should be used to reduce the designated building and movable equipment capital needs, (this may include debt principal retirement) as appropriate.

If a hospital has restricted funds which could be used for a building or equipment purchase but chooses instead to use borrowed money, all costs associated with paying off the incurred debt should not be considered reasonable unless the hospital demonstrates that the financing method used was to the economic benefit of patients then utilizing that building or equipment. If funds are restricted to a particular type of plant capital project, which is not a replacement of a previous or existing project, these funds should not be used until the hospital has obtained a certificate of need, if required, for that type of plant capital project. Funds restricted to research should be used if needed and available to offset any research costs. Patient revenues from revenue cost centers should not be used to provide matching monies for nonpatient-care related research.

Moneys from endowment funds, and/or gifts restricted by donors or monies generated by taxes to provide for operating expenses should be used to reduce payments for operating expenses.

B. Unrestricted funds from nonpatient sources. Unrestricted funds from nonpatient sources should be used to reduce the total financial requirements of a hospital. Exceptions to this rule may be granted if the hospital can show that alternative uses of these funds are to the economic benefit of current patients and/or are in the best interests of the community served.

C. Auxiliary enterprises. Profits from such enterprises operated by hospitals should be used primarily to offset the financial requirements of a hospital. Such enterprises should be self-sufficient and profitable. Any losses incurred by the hospital due to such an enterprise which can be demonstrated to be a fringe benefit to hospital employees or of direct economic benefit to patients receiving care during the period of incurred loss may be included in rates.

D. Special projects income. Income received to finance special projects or salaries paid to special project employees should be deducted from financial requirements before determining the amount of payment to be made for patient services. Income to the hospital from the special projects in excess of

the projects' financial requirements should be used to offset the hospital's financial requirements.

E. Income from sources other than patients used as offsets to rates should never result in a condition where charges are lower than the actual cost of providing care for purposes of reimbursement by third party payers or by governmental programs. If such a condition should result, the offsets should be adjusted to that portion which would not cause this condition.

Statutory Authority: *MS s 144.703*

4650.2600 VARIATIONS FROM BUDGETED REVENUE AND EXPENSE.

Subpart 1. **Variations from budgeted revenue and expense.** Changes in aggregate rates may be necessary due to variations from budgeted volume and mix of services, and assumptions about future input prices. The financial requirements of a hospital for a budget year should reflect variations from budgeted revenue and expense as depicted by actual experience in the current and prior years.

Subp. 2. **Financial requirements in excess of revenues.** If actual reasonable financial requirements pursuant to part 4650.3100, subpart 2, as reconciled to an audit, are in excess of actual reasonable revenues, as reconciled to an audit, pursuant to part 4650.3100, subpart 2, by a greater margin than was previously budgeted in the year in question, then the excess may be included in the forthcoming budget year's reasonable financial requirements pursuant to part 4650.3100, subpart 2.

Subp. 3. **Revenues in excess of requirements.** If actual reasonable revenues pursuant to part 4650.3100, subpart 2, as reconciled to an audit, are in excess of actual reasonable financial requirements, as reconciled to an audit, pursuant to part 4650.3100, subpart 2, for the year in question, then the excess may be used to offset the forthcoming budget year's reasonable financial requirements pursuant to part 4650.3100, subpart 2.

Subp. 4. **Adjustment of budget.** When adjusting the forthcoming year's budgeted reasonable financial requirements pursuant to part 4650.3100, subpart 2 for the conditions described in subparts 2 and 3:

A. Hospitals should not benefit from unanticipated gains resulting from underestimates of projected reasonable revenues, and/or volume, and/or overestimates of the costs of services delivered pursuant to part 4650.3100, subpart 2, however, hospitals should benefit from productivity increases that reduce the reasonable cost of delivered and/or offered services pursuant to part 4650.3100, subpart 2.

B. Hospitals should not be penalized for incurring unanticipated losses resulting from overestimates of reasonable volume, and/or revenue, and/or underestimates of the reasonable costs of services delivered (when compared to the allowable increase limit adjusted for actual inflation for the relevant period), however, hospitals shall not carry forward losses that result from conditions that should have been averted and/or decreases in productivity.

C. If current year estimates of unanticipated losses exceed .005 times the hospital's operating budget, then that amount in excess of the loss estimated in the budget year may be carried forward to the forthcoming budget year. The estimated loss carried forward to the budget year must be reconciled to an audit in a subsequent filing (when the budget year becomes the prior year).

Statutory Authority: *MS s 144.703*

4650.2700 EXCESS CAPACITY.

For hospitals with occupancy rates, based upon staffed and set up beds, below the average occupancy rate of other hospitals determined by the system to share common characteristics, the aggregate rate set on the basis of costs may produce unreasonable charges to patients. The system may assess the aggregate rate of such hospitals where the criteria of need for beds shall be consistent with the demand for beds as indicated on a hospital or a service center level by occupancy rates. In cases where low occupancy appears to affect the aggregate hospital rate, the hospital shall be considered to have excess capacity.

Prior to any determination by the system that excess capacity exists in a hospital, the system shall submit its preliminary determination to the appropriate health systems agency and to the state health planning and development agency, both of which are identified according to Public Law Number 93-641, sections 1515 and 1521, as well as the appropriate professional standards review organization. These agencies may comment to the system regarding the consistency of this preliminary determination with health care standards regarding occupancy rates in their areas of expertise. If these agencies comment that this preliminary determination is consistent with health planning standards and, if applicable, the declarations of an appropriateness review, then the system may determine a hospital to have excess capacity. This determination shall state in quantitative terms the extent of any determination of excess capacity and the basis for the determination.

In hospitals where excess capacity exists, the annual inflation factor and any debt principle payment to the plant capital fund which relates to beds, in excess of the depreciation allowance permitted by part 4650.2400, subpart 3, item A, should be reduced by the proportion of excess beds to total beds available.

Statutory Authority: *MS s 144.703*

4650.2800 INVESTIGATIONS.

The system may investigate any or all hospital rates, rate components, or rate structures established by a hospital or common to more than one hospital. Such investigations shall be supplemental to and not in place of review of reports of rate revenue and expense or interim increase reports as authorized by part 4650.3100. The system shall investigate the basis of existing rates as contained in the rate revenue and expense reports of hospitals in an effort to assess whether or not current rates are reasonable, equitable, and nondiscriminatory among insurers. The system shall notify any hospital or hospitals whose rates, rate components, or rate structures are to be investigated, as provided by this part, and shall state the objective of such an investigation.

Investigations and subsequent reports shall analyze rates, rate components, and rate structures in accordance with the bases for judging established by parts 4650.2300 to 4650.2700.

Statutory Authority: *MS s 144.703*

4650.2900 INVESTIGATIVE REPORT.

Subsequent to an investigation, the system shall issue an investigative report which shall detail its findings. The findings of an investigative report shall be considered in the review of any interim increase or rate revenue and expense report subsequently submitted by an investigated hospital.

Statutory Authority: *MS s 144.703*

REVIEW OF REPORTS

4650.3000 COMPLETENESS.

Subpart 1. **Review by system.** Each report required by these rules shall be reviewed by the system in order to ascertain that the report is complete. A report shall be deemed to be filed when the system has ascertained that the report is complete. Complete means that the report contains adequate data for the system to commence its review in a form determined to be acceptable by the system pursuant to parts 4650.0500 to 4650.0700, as appropriate.

Subp. 2. **Timely reply that report is incomplete.** If the system has not responded to the hospital within ten working days after the receipt of a report by the system, the report is deemed to be complete and filed as of the initial day of receipt by the system. The system may stipulate any additional time it may need to ascertain a report's completeness in which case, the ten working day period does not apply. Such stipulated additional time shall not exceed 30 days after the day of the initial receipt of a report by the system. If a report is not found to be incomplete during such additional period, it shall be deemed to be complete and filed as of the initial day of receipt by the system.

Subp. 3. **Incomplete report.** A report determined by the system to be incomplete shall be returned immediately by the system to the hospital with a statement describing the report's deficiencies. The hospital shall resubmit an amended report to the system. Such a return and resubmittal shall be recorded in that hospital's file as maintained by the system. If the resubmitted report is determined to be complete by the system, then it shall be deemed to be filed on the date the resubmitted report is received by the system.

Subp. 4. **Reports filed prior to effective date.** Reports filed with the system by hospitals prior to the effective date of parts 4650.0100 to 4650.5300 shall be deemed to be temporarily complete. Subsequent to the effective date of parts 4650.0100 to 4650.5300, the system may require hospitals to amend these reports to conform with the requirements of parts 4650.0100 to 4650.5300.

Subp. 5. **Amending rules.** If a hospital discovers any error in its statements or calculations in any of its submitted reports ascertained by the system to be complete, it shall inform the system of the error and submit an amendment to a report. In the case of an interim increase report or a rate revenue and expense report, the submittal of an amended report by a hospital to the system shall not affect the date of filing or the 60 day period required, providing: the hospital informs the system of any errors prior to the system's public comments on the reasonableness of the hospital's aggregate rate; and the errors are not of such great magnitude as to affect the system's ability to make a fair comment. An amended rate revenue and expense report or interim increase report not meeting the conditions established by this part shall be refiled as if it were a new report.

Subp. 6. **Error in the reports.** If the system discovers an error in the statements or calculations in a report filed with it which the system determines will have a noticeable impact upon its ability to render a fair comment on the report, it may require the hospital to amend and resubmit the report by a date determined by the system to be reasonable. The initial filing date is not affected if the hospital resubmits the report by the determined date. If the hospital fails to resubmit the amended report by that date, the date of filing shall be the date the system receives the resubmission.

Statutory Authority: *MS s 144.703*

4650.3100 REVIEW OF RATE REVENUE AND EXPENSE REPORTS AND INTERIM INCREASE REPORTS.

Subpart 1. **Review of reports.** These reports shall be reviewed on a basis of the rate and cost history of each hospital on an institutional and a service center basis. Statistical and financial information available for a hospital as a whole institution may be compared with the same type of information for other

peer hospitals which share common characteristics. In instances where service centers among hospitals sharing common characteristics themselves share common characteristics, hospitals may be compared on a service center basis. Common characteristics may include:

A. similarity in available number of beds and related occupancy rates;

B. similarity in composition of areas of patient origin;

C. similarity in composition of patient services;

D. the status of a hospital as a teaching or nonteaching institution;

E. similarity in size and composition of full-time-equivalent staff of the hospital and ratios of that staff to patient admissions; and

F. other data determined by the system to be appropriate which may be available pursuant to annual licensing report requirements as established pursuant to part 4640.1300, subpart 1.

Subp. 2. **Comment.** The system shall comment upon interim increase reports and rate revenue and expense reports to the hospital, the board, and the public prior to the implementation of proposed budgets or aggregate rates. The comment shall state that a hospital's existing and proposed aggregate rates are reasonable or are in question.

A. Bases which may be used to comment that a hospital's existing and prospective rates are reasonable, include:

(1) aggregate rates and components of aggregate rates are similar to the average of the aggregate rates and components of aggregate rates in effect in the prior year for other hospitals in a peer group;

(2) prospective aggregate rates and components of prospective aggregate rates represent a minimal increase which is consistent with the allowable increase limit established by part 4650.4100;

(3) aggregate rates and components of aggregate rates have been demonstrated by the hospital to be necessary and consistent with the principles of the bases of judging established by parts 4650.2300 to 4650.2700;

(4) aggregate costs and components of aggregate costs are similar to the average of the aggregate costs and components of aggregate costs incurred by other hospitals in a peer group during the prior year;

(5) prospective aggregate costs and components of prospective aggregate costs represent a minimal increase which is consistent with the allowable increase limit established in part 4650.4100 and components of the allowable increase limit that corresponds to natural expense categories presented in part 4650.0500, item B, subitem (6);

(6) aggregate costs and components of aggregate costs have been demonstrated by the hospital to be necessary and consistent with the principles for judging established by parts 4650.2300 to 4650.2700;

(7) total prior and current year's actual aggregate rates and costs are similar to prior and current year's budgeted aggregate rates and costs;

(8) actual and budgeted costs and revenues for each service center are similar.

B. Bases which may be used to comment that a hospital's existing and prospective rates are in question include:

(1) aggregate rates and components of aggregate rates deviate from the average of the aggregate rates and components of aggregate rates in effect in the prior year for other hospitals in a peer group;

(2) prospective aggregate rates and components of prospective aggregate rates do not represent a minimal increase which is consistent with the allowable increase limit established in part 4650.4100;

(3) rates provide revenue which is in excess of expenses which deviate from the past financial practices of that hospital, of hospitals sharing common characteristics, or which deviate from the principles of the bases for judging established by parts 4650.2200 to 4650.2700;

(4) aggregate costs and components of aggregate costs are not similar to the average of the aggregate costs incurred for other hospitals in a peer group during the prior year;

(5) prospective aggregate costs and components of prospective aggregate costs do not represent a minimal increase which is consistent with the allowable increase limit established in part 4650.4100 and components of the allowable increase limit that corresponds to natural expense categories presented in parts 4650.0500, item B, subitem (6);

(6) aggregate costs and components of aggregate costs have not been demonstrated by the hospital to be necessary and consistent with the principles for judging established by parts 4650.2300 to 4650.2700;

(7) total prior and current year's actual aggregate rates and costs are not similar to prior and current year's budgeted aggregate rates and costs; and

(8) actual and budgeted costs and revenues for each service center are not similar.

Statutory Authority: *MS s 144.703*

4650.3200 PUBLIC MEETINGS.

All official meetings of the system, including executive sessions, which occur for any purpose related to completion of an investigation, release of results of an analysis, or issuance of comment upon review of reports pursuant to these rules shall be open to the public. Public notice shall be given one week in advance of any official meetings of the system where the results of investigations, analyses, or reviews are to be discussed or acted upon.

Statutory Authority: *MS s 144.703*

4650.3300 BURDEN OF PROOF.

In all matters relating to the review of interim increase reports or rate revenue and expense reports or other analyses or investigations, the burden of proof of the reasonableness, equity, and lack of discrimination of established or proposed rates under review shall rest with the hospital.

Statutory Authority: *MS s 144.703*

4650.3400 CONSOLIDATION.

When two or more investigations, analyses, or reviews involve common questions of fact, the system may address the common questions of fact and make comments applicable to all hospitals under consideration.

Statutory Authority: *MS s 144.703*

4650.3500 APPROVAL FOR OPERATION OF THE SYSTEM.

The commissioner of health may approve the operation of the system by any voluntary, nonprofit rate review organization. Such an organization desiring this approval may apply for approval by the procedure in parts 4650.3600 to 4650.4000.

Statutory Authority: *MS s 144.703*

4650.3600 OPEN APPLICATION PERIOD.

A voluntary, nonprofit rate review organization may apply for approval of its reporting and review procedures after January 1 and before March 31 of a fiscal year, or within 90 days after the effective date of parts 4650.0100 to 4650.5300, for operation of the Minnesota hospital rate review system during the next subsequent fiscal year.

Statutory Authority: *MS s 144.703*

4650.3700 CONTENTS OF APPLICATION.

An application for approval shall include:

A. A detailed statement of the type of reports and administrative procedures proposed by the applicant which shall demonstrate that, in all instances, the reports and procedures are substantially equivalent to those established by the system, pursuant to parts 4650.0400 to 4650.0700, and 4650.1400 to 4650.3400.

B. A statement that all reports determined to be complete and information filed with the applicant from its participating hospitals shall be available for inspection by the commissioner of health and the public within five working days after completeness of reports is proposed to be determined and at least prior to the proposed date of issuance of any findings and comments.

C. Provisions establishing a proposed enrollment period for hospitals which shall not extend beyond March 31 of any fiscal year, or beyond 90 days after the effective date of parts 4650.0100 to 4650.5300 in the first instance, for any eligible hospital that wishes to participate in the proposed program of the applicant for the next three subsequent fiscal years.

D. Provisions establishing any proposed criteria whereby a hospital may be judged by the applicant to be eligible for participation in its proposed program.

E. Any additional statements or information which is necessary to insure that the proposed reporting and review procedures of the applicant are substantially equivalent to all the rules established for the system, pursuant to parts 4650.0400 to 4650.0700, and 4650.1400 to 4650.3400.

Statutory Authority: *MS s 144.703*

4650.3800 REVIEW OF APPLICATION.

Subpart 1. **Commissioner's decision.** Within 45 calendar days of the receipt of an application for approval by a voluntary, nonprofit rate review organization, the commissioner of health shall issue its decision that the procedures for reporting and review proposed by the applicant are approved or disapproved. Approval by the commissioner shall take effect immediately.

Subp. 2. **Disapproval.** The commissioner of health may disapprove any application on demonstration that the reporting and review procedures of any voluntary, nonprofit rate review organization are not substantially equivalent to those established by the commissioner.

Subp. 3. **Reapplication.** An organization whose application has been disapproved by the commissioner of health may submit a new or amended application to the commissioner within 15 calendar days after disapproval of the initial application. An organization may only reapply for approval on one occasion during any fiscal year.

Statutory Authority: *MS s 144.703*

4650.3900 ANNUAL REVIEW OF APPLICANT.

Subpart 1. **Annual review statement.** By March 31 of each year, any voluntary, nonprofit rate review organization whose reporting and review procedures have been approved by the commissioner of health for the fiscal year then in progress which desires to continue operation of the system shall submit an annual review statement of its reporting and review procedures. The annual review statement shall include: attestation by the applicant that no amendments or modifications of practice contrary to the initially approved application have occurred; or, details of any amendments or modifications to the initially approved application, which shall include justifications for those amendments or modifications.

Subp. 2. **Additional information.** The commissioner of health may require additional information from the applicant supporting that the applicant's reports and procedures are substantially equivalent to those established for the system.

Subp. 3. **Decision on renewal.** Forty-five days from the receipt of the annual review statement, the commissioner of health shall issue a decision that the applicant has renewed approval or that the applicant has been denied renewed approval. Renewed approval shall be immediately effective.

Subp. 4. **Denial of renewed approval.** The commissioner of health may deny renewed approval on the demonstration that the reporting and review procedures of any applicant are no longer substantially equivalent to those established for the system.

Subp. 5. **Reapplication.** An applicant whose renewed approval has been denied by the commissioner of health may submit a new or an amended annual review statement to the commissioner within 15 calendar days after denial of the initial statement. An applicant may only reapply on one occasion during the fiscal year.

Subp. 6. **Review for subsequent fiscal years.** A hospital enrolled with an applicant whose renewed approval has been denied and which has not enrolled with any other applicant whose reporting and review procedures have been approved by the commissioner of health shall become subject to the system as operated by the commissioner for the next three subsequent fiscal years.

Statutory Authority: *MS s 144.703*

4650.4000 REVOCATION OF APPROVAL.

The commissioner of health may revoke its approval of any applicant's reporting and review procedures at any time upon demonstration that the reporting and review procedures of that organization are not longer substantially equivalent to those required by the system.

Statutory Authority: *MS s 144.703*

4650.4100 COMMISSIONER OF HEALTH DETERMINATION OF ALLOWABLE INCREASE LIMIT.

Subpart 1. **Commissioner authority.** The commissioner of health maintains the authority to establish allowable increase limits. Increases in rates which have minimal impact upon the average charges per patient admission for the hospital are allowed to meet expenses incurred by a hospital due to inflation. Increases are determined to have minimal impact if they do not exceed, for any projected accounting period or portion thereof, a cumulative total of the appropriate quarterly allowable increase limits established by the commissioner.

Subp. 2. **Quarterly allowable increase limit.** During the quarter of the first fiscal year that parts 4650.0100 to 4650.5300 are effective, the commissioner of health shall establish a quarterly allowable increase limit: for each of the full quarter(s) of its current fiscal year which remain unexpired at the time rules are promulgated; and for each quarter of its next subsequent fiscal years necessary to result in a total of six quarterly allowable increase limits corresponding to the

next six quarters of the current and next subsequent fiscal years occurring immediately after the implementation of parts 4650.0100 to 4650.5300.

Subp. 3. **Quarterly allowable increase limit for the sixth subsequent quarter.** At the beginning of each quarter subsequent to the effective date of parts 4650.0100 to 4650.5300, the commissioner of health shall establish a quarterly allowable increase limit for the sixth subsequent quarter.

Subp. 4. **Information provided by the commissioner.** The commissioner of health shall provide each hospital and each approved applicant with information concerning the quarterly allowable increase limits on each occasion that the commissioner does establish such a limit.

Subp. 5. **Form.** The quarterly allowable increase limit is a single percentage figure which is applicable to the average aggregate rate and average aggregate cost for the hospital.

Subp. 6. **Basis.** This single percentage figure is based upon the average quarterly consumer and/or wholesale price indices, and/or relevant components of the consumer, wholesale price, or other appropriate economic indices as published by the Division of Labor Statistics, U.S. Department of Commerce. The single percentage figure shall be so constructed so that it will contain the proportionate contribution of each of the natural expense categories presented in part 4650.0500, subpart 1, item B, subitem (6).

Subp. 7. **Compensation.** Should quarterly allowable increase limits prospectively established by the commissioner according to these rules allow increases in aggregate rates in excess or less than any actual increases in the consumer and/or wholesale price indices, or relevant components of these indices the commissioner may compensate for this excess by: measuring the difference between the prospective quarterly allowable increase limits and the actual changes in the consumer price index for expired quarters; and adding or reducing by a reasonable proportion of that difference the next set of quarterly allowable increase limits to be established by the commissioner.

Statutory Authority: *MS s 144.703*

4650.4200 ACCEPTABLE INCREASES IN HOSPITAL GROSS ACUTE CARE CHARGES: EXEMPTIONS FROM HOSPITAL RATE REVIEW.

Each hospital that anticipates an increase in budget year gross acute care charges which is less than the acceptable increase determined by the commissioner of health may claim and shall be granted, an exemption from the filing of a rate revenue and expense report as required by part 4650.1600 and as described in part 4650.0600 and the review and comment provisions of part 4650.3100, upon filing an abbreviated projected operating statement as described in part 4650.4600, subpart 2.

Statutory Authority: *MS s 144.701 subd 5*

4650.4300 COMMISSIONER OF HEALTH ESTABLISHMENT.

Subpart 1. **Establishment of percentage figure.** The commissioner of health shall establish at the beginning of each quarter of the fiscal year (July 1, October 1, January 1, April 1), a percentage figure representing an acceptable increase in gross acute care charges for the succeeding six quarters (18 months).

Each hospital being reviewed by the commissioner of health pursuant to Minnesota Statutes, section 144.701 shall be notified of each quarterly established acceptable increase in and adjustments to the acceptable increase in gross acute care charges pursuant to part 4650.4500. Each voluntary nonprofit rate review organization approved pursuant to parts 4650.3500 to 4650.4000 shall be notified of each quarterly established acceptable increase in and adjustments to the acceptable increase in gross acute care charges and shall in turn notify each of the hospitals electing to be reviewed by said organization.

Subp. 2. **Basis.** The single percentage figure established by the commissioner of health shall be the algebraic sum of the following percentages:

A. An estimate of the forthcoming annual rate of change in the average total cost of all goods and services to hospitals. This estimate shall be determined by summing the weighted change in price of each of the natural expense classifications described in part 4650.0500, item B, subitem (6). The weights shall be the proportionate contributions of each of these natural expense classifications to hospitals' total cost. The estimate shall explicitly recognize the expected overall level of price change in the state's economy and shall be derived from expected annual changes in the consumer and/or producer price indices and/or relevant components of the consumer and/or producer price and/or other similar economic indices published by an agency of the federal or state government.

B. An estimate of the rate of change in the dollar value of the forthcoming annual statewide change in: the average mix of patients utilizing hospitals, and the average intensity of services received by patients during hospital stays or visits as is consistent with the delivery of medical care which is of generally accepted quality and efficiency. The estimate shall not be less than zero nor more than .036. For the purposes of this section:

(1) "Mix" means the types of illnesses, injuries, and conditions treated in hospitals.

(2) "Intensity of services" means the styles and methods of treating illness, injuries, and conditions in hospitals.

C. An estimate of the forthcoming annual rate of change in the statewide number of hospital adjusted admissions per 1,000 population as is consistent with the delivery of medical care which is of generally accepted quality and efficiency.

Statutory Authority: *MS s 144.701 subd 5*

4650.4400 CONFORMITY.

Subpart 1. **Assessment.** Each exempted hospital, by the close of the third quarter of its fiscal year, shall assess its likely conformity with its most recently filed abbreviated projected operating statement. If the anticipated actual increase in gross acute care charges, to be reported pursuant to part 4650.0500, item I, for an exempt hospital is in excess of the acceptable increase in gross acute care charges under which exemption was claimed pursuant to part 4650.4200, as adjusted pursuant to part 4650.4500, then that hospital shall file a rate revenue and expense report for the coming budget year pursuant to part 4650.0600 and part 4650.1600.

Subp. 2. **Increase in gross acute care charges.** If an exempt hospital estimates that it is likely to conform with its most recently filed abbreviated projected operating statement and does not file a rate revenue and expense report pursuant to subpart 1 and it is subsequently found that the actual increase in gross acute care charges was more than .00125 in excess of the acceptable increase in gross acute care charges under which exemption was claimed pursuant to part 4650.4200, as adjusted pursuant to part 4650.4500, then that hospital shall file a rate revenue and expense report pursuant to part 4650.1600 no later than 150 days after the close of the fiscal year in question.

Statutory Authority: *MS s 144.701 subd 5*

4650.4500 ADJUSTMENTS TO THE ACCEPTABLE CHANGE.

Each figure in part 4650.4300 shall be adjusted and updated at the close of the third quarter after its establishment according to the criteria specified in part 4650.4300, subpart 2, item A and shall reflect actual changes in the overall price

change level throughout the state's economy. The updated figure shall be used when judging conformity to part 4650.4400, subpart 1.

Statutory Authority: *MS s 144.701 subd 5*

4650.4600 ABBREVIATED PROJECTED OPERATING STATEMENT.

Subpart 1. **Filing.** Each hospital claiming exempt status shall file an abbreviated projected operating statement no later than the commencement of its fiscal year or up to 60 days prior to the commencement of its fiscal year. Pursuant to Minnesota Statutes, section 144.701, subdivision 5, no change in rates may be made until 60 days have elapsed from the date of filing.

Subp. 2. **Content.** An abbreviated projected operating statement shall include the following data for the prior, current, and budget years:

A. total acute care hospital operating expense;

B. total institutional patient charges;

C. total acute care hospital patient charges;

D. total acute care hospital inpatient charges;

E. total acute care hospital outpatient charges;

F. an expense analysis consisting of acute care:

(1) direct costs for: daily hospital services, ancillary service, nonrevenue producing centers;

(2) costs after allocation of nonrevenue producing centers costs to: daily hospital services, ancillary service;

G. an acute care hospital statistical summary consisting of:

(1) number of patient days (excluding nursery);

(2) number of nursery days;

(3) number of total patient days;

(4) number of admissions;

(5) average length of stay;

(6) occupancy - licensed beds;

(7) occupancy - staffed and set-up beds;

(8) number of outpatient and emergency room visits;

H. an acute care hospital full-time equivalent summary consisting of salary and numbers of full-time equivalent personnel for:

(1) daily hospital services;

(2) ancillary services;

(3) nonrevenue producing centers;

(4) total hospital;

(5) total institution;

I. an acute care bed summary consisting of: number of licensed beds, number of physically present beds, number of staffed and set-up beds; and

J. depreciation fund, beginning balance, ending balance.

Subp. 3. **Purpose.** The information provided on the abbreviated projected operating statement shall support the hospital's claim that it will achieve an increase in gross acute care charges less than that established by the commissioner of health pursuant to part 4650.4300.

Statutory Authority: *MS s 144.701 subd 5*

4650.4700 FEES.

Hospitals whose rates are reviewed by the commissioner of health as distinct from a voluntary, nonprofit rate review organization shall submit filing fees with rate revenue and expense reports and interim increase reports which are submitted to the commissioner. These fees are based on the cost of reviews and

the number of beds licensed as acute care beds in a hospital, pursuant to Minnesota Statutes, sections 144.50 to 144.58.

Statutory Authority: *MS s 144.701 subd 6*

4650.4800 RATE REVENUE AND EXPENSE REPORT FEE.

On each occasion which a hospital submits a rate revenue and expense report to the commissioner of health as distinct from a voluntary, nonprofit rate review organization, it shall accompany this report with a filing fee based upon the following schedules which shall be annually adjusted to reflect the impact of inflation upon these fees, providing the report is timely:

A. If the hospital gross revenue is under $2,500,000, the filing fee is .0005 times gross revenue or $200 (whichever is less) to a maximum of $800.

B. If the hospital gross revenue is at least $2,500,000 but not more than $19,999,999, the filing fee is .004 times gross revenue to a maximum of $5,500.

C. If the hospital gross revenue is $20,000,000 or more, the filing fee is .003 times gross revenue to a maximum of $7,500.

Statutory Authority: *MS s 144.701 subd 6*

4650.4900 INTERIM INCREASE REPORT FEE.

On each occasion which a hospital submits an interim increase report to the commissioner of health as distinct from the voluntary, nonprofit rate review organization, it shall accompany this report with a filing fee. This fee shall be one-half of the rate revenue and expense report fee, as established by part 4650.4800, providing the report is timely.

Statutory Authority: *MS s 144.70 subd 6*

4650.5000 TIMELY REPORT.

Subpart 1. **Late fee schedule.** "Timely" means that each report has been submitted within the time prescribed by part 4650.1600, subpart 1 or part 4650.1700, subpart 1, as appropriate, that an extension of these reporting times, as permitted by part 4650.2100, has not been necessary, and that the report has been determined to be complete, pursuant to part 4650.3000. If a report does not meet these standards, the commissioner may require the submission of an additional late fee according to the following late fee schedule.

Subp. 2. **Late report due to submission after reporting times.** A report submitted after the reporting times established by part 4650.1600, subpart 1 or part 4650.1700, subpart 1, as appropriate, for which an extension in time has been permitted, pursuant to part 4650.2100, shall be liable for a late fee in addition to the filing fee established by part 4650.4800 or 4650.4900, above, as appropriate. This late fee shall be ten percent of the filing fee established by part 4650.4800 or 4650.4900, and as appropriate for that hospital.

Subp. 3. **Late report due to incomplete report.** A report submitted by a hospital which is determined not to be complete, pursuant to part 4650.3000, shall be liable for a late fee for each occasion on which a resubmission as provided by part 4650.3000 occurs. This late fee shall be, for each such occasion of resubmission, five percent of the filing fee paid on submission of the initial report to the commissioner of health by the hospital as established by part 4650.4800 or 4650.4900.

Subp. 4. **Reports not filed.** Reports not submitted or submitted after the reporting times established by part 4650.1600, subpart 1 or part 4650.1700, subpart 1, as appropriate, for which an extension has not been requested or permitted, pursuant to part 4650.2100, shall be liable for the cost of a full audit by an independent public accountant, as necessary for the completion of the

report in addition to the filing fee established by part 4650.4800 or 4650.4900, as appropriate.

Statutory Authority: *MS s 144.701 subd 6*

4650.5100 SUSPENSION OF FEES.

The commissioner of health may suspend all or any portion of the filing fees and late fees herein established upon cause being shown by a hospital. Such cause may consider such factors as:

A. the inability of a hospital to pay the fees without directly affecting the rates;

B. the occurrence of any emergency financial condition of a hospital, including natural disasters or difficulties associated with completion of reports related to sickness or other absences of related hospital employees or other administrative complications resulting in delay in the completion of reports; and

C. other factors which relate to the economic condition or administrative condition of a hospital.

Statutory Authority: *MS s 144.701 subd 6*

4650.5200 OFFICIAL OFFICES.

For purposes of parts 4650.0100 to 4650.5300, the official offices of the commissioner of health are: Minnesota Department of Health, 717 Delaware Street Southeast, Minneapolis, Minnesota 55440.

Statutory Authority: *MS s 144.703*

4650.5300 SEVERABILITY.

If any section or provision of parts 4650.0100 to 4650.5300 is declared unconstitutional or void by any court of competent jurisdiction, or its applicability to any person or circumstances is held invalid, the constitutionality or validity of the remainder of the rules and the applicability to other persons and circumstances are not affected, and to this end, the sections and provisions of these rules are declared to be severable.

Statutory Authority: *MS s 144.703*