CHAPTER 4650
DEPARTMENT OF HEALTH
HOSPITAL AND SURGICAL CENTER REPORTING

4650.0100 [Repealed, L 1984 c 534 s 11; 9 SR 834]

FINANCIAL, UTILIZATION, AND SERVICES DATA

4650.0102 DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 4650.0102 to 4650.0174, the following terms have the meanings given them.

Subp. 1a. **Accounting and financial reporting expenses.** "Accounting and financial reporting expenses" means all costs related to fiscal services, such as general accounting, budgeting, cost accounting, payroll accounting, accounts payable, and plant, equipment, and inventory accounting.

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

Subp. 2a. **Adjustments and uncollectibles.** "Adjustments and uncollectibles" means the total of charity care and adjustments to charges under reimbursement agreements with payers.

Subp. 2b. **Administrative expenses.** "Administrative expenses" means the sum of the following:

A. admitting, patient billing, and collection expenses;

B. accounting and financial reporting expenses;

C. quality assurance and utilization management program or activity expenses;

D. community and wellness education expenses;

E. promotion and marketing expenses;

F. taxes, fees, and assessments;

G. malpractice expenses; and

H. other administrative expenses.

Subp. 3. [Repealed, 21 SR 1106]

Subp. 3a. **Admitting, patient billing, and collection expenses.** "Admitting, patient billing, and collection expenses" means all costs related to inpatient and outpatient admission or registration, whether scheduled or nonscheduled; the scheduling of admission times;

insurance verification, including coordination of benefits; preparing and submitting claim forms; and cashiering, credit, and collection functions.

Subp. 3b. [Repealed, 21 SR 1106]

Subp. 3c. [Repealed, 21 SR 1106]

Subp. 4. [Repealed, 21 SR 1106]

Subp. 4a. **Available beds.** "Available beds" means the number of beds that can be made available for use within 24 hours, as of the end of a reporting period. Available beds include pediatric bassinets, isolation units, quiet rooms, and all other bed facilities that are set up for use by inpatients who have no other bed facilities assigned to or reserved for them. Available beds do not include newborn bassinets, labor rooms, postanesthesia or postoperative recovery room beds, psychiatric holding beds, beds that are used only as holding facilities for patients prior to their transfer to another hospital, or any other bed facilities for patients receiving special procedures for a portion of their stay and who have other bed facilities assigned to or reserved for them.

Subp. 5. [Repealed, 19 SR 1419]

Subp. 6. [Repealed, 21 SR 1106]

Subp. 7. [Repealed, 19 SR 1419]

Subp. 7a. **Bad debt expense.** "Bad debt expense" means the dollar amount charged for care for which there was an expectation of payment but for which the patient is unwilling to pay.

Subp. 8. [Repealed, 19 SR 1419]

Subp. 8a. **Business day.** "Business day" means Monday through Friday, but does not include those days listed as holidays in Minnesota Statutes, section 645.44, subdivision 5.

Subp. 9. **Charity care adjustments.** "Charity care adjustments" means the dollar amount that would have been charged by a facility for rendering free or discounted care to persons who cannot afford to pay and for which the facility did not expect payment. For purposes of reporting under part 4650.0112, charity care adjustments are included in adjustments and uncollectibles.

Subp. 9a. **Community and wellness education expenses.** "Community and wellness education expenses" means all costs related to wellness programs, health promotion, community education classes, support groups, and other outreach programs and health screening, included in a specific community or wellness education cost center or reclassified from other cost centers. Community and wellness education expenses does not include patient education programs.

Subp. 9b. **Commissioner.** "Commissioner" means the commissioner of health and duly authorized agents of the commissioner of health.

Subp. 10. [Repealed, 21 SR 1106]

Subp. 11. [Repealed, 19 SR 1419]

Subp. 12. [Repealed, 19 SR 1419]

Subp. 12a. [Repealed, 21 SR 1106]

Subp. 12b. **Donations and grants for charity care.** "Donations and grants for charity care" means revenues from an individual, group, foundation, government entity, or corporate donor that are designated by the donor for providing charity care. For purposes of reporting under part 4650.0112, donations and grants for charity care are operating revenue.

Subp. 12c. [Repealed, 26 SR 627]

Subp. 13. [Repealed, 21 SR 1106]

Subp. 14. [Repealed, 21 SR 1106]

Subp. 15. [Repealed, 21 SR 1106]

Subp. 16. [Repealed, 19 SR 1419]

Subp. 17. [Repealed, 21 SR 1106]

Subp. 18. [Repealed, 21 SR 1106]

Subp. 19. [Repealed, 21 SR 1106]

Subp. 19a. **Full-time equivalent employee.** "Full-time equivalent employee" means an employee or any combination of employees that are paid by the facility for 2,080 hours of employment per year.

Subp. 19b. [Repealed, 21 SR 1106]

Subp. 19c. **Full-time equivalent resident.** "Full-time equivalent resident" means a graduate medical resident who is on assigned rotation at the hospital during the full reporting year. Full-time equivalent resident also means any combination of graduate medical residents who are on assigned rotation at the hospital during a portion of the reporting year for a combined amount of time equivalent to one resident for a full year. A graduate medical resident means an individual who is being trained as a physician and is in an accredited residency program at a teaching hospital.

Subp. 20. [Repealed, 19 SR 1419]

Subp. 20a. [Repealed, 21 SR 1106]

Subp. 20b. **Gross surgical center revenue from patient care.** "Gross surgical center revenue from patient care" means the total charges billed by the surgical center for patient care regardless of whether the surgical center expects to collect the amount billed.

Subp. 20c. [Repealed, 21 SR 1106]

Subp. 20d. **Group purchaser.** "Group purchaser" has the meaning given in Minnesota Statutes, section 62J.03, subdivision 6.

Subp. 20e. **Hospital.** "Hospital" means a facility licensed as a hospital under Minnesota Statutes, sections 144.50 to 144.58, to provide to inpatients:

A. diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or

B. rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Subp. 20f. **Hospital patient care services charges.** "Hospital patient care services charges" means the total charges billed by a hospital for care provided to admitted inpatients and registered outpatients by the hospital operating under its Minnesota hospital license. Charges are counted in hospital patient care services charges regardless of whether the hospital expects to collect the amount billed. Hospital patient care services charges include charges for hospital routine inpatient, outpatient, and ancillary services.

Subp. 21. [Repealed, 19 SR 1419]

Subp. 21a. [Repealed, 21 SR 1106]

Subp. 22. [Repealed, 21 SR 1106]

Subp. 23. [Repealed, 19 SR 1419]

Subp. 23a. [Repealed, 21 SR 1106]

Subp. 24. [Repealed, 21 SR 1106]

Subp. 24a. **Malpractice expenses.** "Malpractice expenses" means all costs of malpractice including malpractice insurance, self-insurance expenses including program administration, and malpractice losses not covered by insurance, including deductibles and malpractice attorney fees.

Subp. 24b. **Management information systems expenses.** "Management information systems expenses" means all costs related to maintaining and operating the data processing system of the facility, including such functions as admissions, medical records, patient charges, decision support systems, and fiscal services.

Subp. 24c. **Medical care surcharge.** "Medical care surcharge" means the expenses under Minnesota Statutes, section 256.9657. For purposes of reporting under part 4650.0112, medical care surcharge is an operating expense.

Subp. 24d. [Repealed, 21 SR 1106]

Subp. 24e. **MinnesotaCare tax.** "MinnesotaCare tax" means expenses for the MinnesotaCare tax under Minnesota Statutes, sections 295.52 and 295.582. For purposes of reporting under part 4650.0112, the MinnesotaCare tax is an operating expense.

Subp. 24f. [Repealed, 21 SR 1106]

Subp. 24g. [Repealed, 21 SR 1106]

Subp. 24h. [Repealed, 21 SR 1106]

Subp. 25. [Repealed, 21 SR 1106]

Subp. 25a. [Repealed, 21 SR 1106]

Subp. 26. [Repealed, 21 SR 1106]

Subp. 26a. **Nonoperating donations and grants.** "Nonoperating donations and grants" means revenues from an individual, group, foundation, or corporate donor that are not designated by the donor for a specific purpose or are designated by the donor for a purpose not directly related to the normal day-to-day operations of the facility. For purposes of reporting under part 4650.0112, nonoperating donations and grants are nonoperating revenue.

Subp. 26b. **Nonoperating expenses.** "Nonoperating expenses" means all costs not directly associated with the normal day-to-day operation of the facility.

Subp. 26c. **Nonoperating public funding.** "Nonoperating public funding" means revenue from taxes or other municipal, county, state, or federal government sources, including grants and subsidies, that are not designated for a specific purpose or are designated for a purpose not directly related to the normal day-to-day operations of the facility. For purposes of reporting under part 4650.0112, nonoperating public funding is nonoperating revenue.

Subp. 26d. **Nonoperating revenue.** "Nonoperating revenue" means all income received that is not directly related to the normal day-to-day operations of the facility.

Subp. 26e. **Operating expenses.** "Operating expenses" means all costs directly associated with providing patient care or other services that are part of the normal day-to-day operation of the facility.

Subp. 26f. **Operating revenue.** "Operating revenue" means the sum of hospital patient care services charges, other patient care services charges, total adjustments and uncollectibles, and other operating revenue received as part of the normal day-to-day operation of the facility.

Subp. 27. [Repealed, 19 SR 1419]

Subp. 28. [Repealed, 19 SR 1419]

Subp. 28a. **Other administrative expenses.** "Other administrative expenses" means all costs for the overall operation of the facility associated with management, administration, and legal staff functions, including the costs of governing boards, executive wages and benefits, auxiliary and other volunteer groups, purchasing, telecommunications, printing and duplicating, receiving and storing, and personnel management. Other administrative expenses includes all wages and benefits, donations and support, direct and in-kind, for the purpose of lobbying and influencing policymakers and legislators, including membership dues, and all expenses associated with public policy development, such as response to rulemaking and interaction with government agency personnel including attorney fees for reviewing and analyzing governmental policies. Other administrative expenses does not include the costs of public relations included in promotion and marketing expenses, the costs of legal staff already allocated to other functions, or the costs of medical records, social services, and nursing administration.

Subp. 28b. **Other operating revenue.** "Other operating revenue" means total income received as part of the normal day-to-day operation of a facility that is from services other than patient care and when no hospital medical record is generated. Other operating revenue includes:

A. donations and grants for charity care;

B. private donations and grants for operations;

C. public funding for operations;

D. space rental;

E. medical record transcription fees;

F. operation of a hospital cafeteria;

G. parking lot and ramp fees;

H. gift shop revenues;

I. public phone proceeds;

J. recovery of radiology silver;

K. billing services for other health care entities;

L. weight loss clinics;

M. auxiliary functions; and

N. other income received as part of the normal day-to-day operation of the facility not related to patient care.

Subp. 28c. **Other patient care services charges.** "Other patient care services charges" means the total charges billed by the hospital for patient care services that are provided by the hospital, as described in items A to D.

A. Other patient care services charges include charges billed by the hospital for patient care services provided by hospital components to persons who are not admitted as inpatients or registered as outpatients of the hospital. Charges for the sale of reference laboratory services, reference radiology services, durable medical equipment, and retail pharmacy supplies are included under this item.

B. Other patient care services charges include charges billed by the hospital for the professional component of patient care services provided by physicians and by billable midlevel practitioners whose scope of practice allows them to practice independent of direct physician supervision. This applies to physicians and billable midlevel practitioners, whether they are employed by the hospital or under contract with the hospital, when the charges are billed and received by the hospital, unless the hospital acts merely as a billing agent.

C. Charges for patient care services that are hospital patient care services charges as defined in subpart 20f are not included as other patient care services charges.

D. Charges are included as other patient care services charges regardless of whether the hospital expects to collect the amount billed.

Subp. 29. [Repealed, 21 SR 1106]

Subp. 30. **Outpatient registration.** "Outpatient registration" means a documented acceptance of a patient by a facility for the purpose of providing outpatient services in an outpatient or ancillary department, including documented acceptance for the provision of emergency and outpatient surgery services. An outpatient registration may involve the provision of more than one outpatient service, and a patient may have more than one outpatient registration per day. Outpatient registration does not include failed appointments or telephone contacts.

Subp. 30a. [Repealed, 21 SR 1106]

Subp. 30b. [Repealed, 21 SR 1106]

Subp. 30c. [Repealed, 21 SR 1106]

Subp. 30d. **Outpatient surgical center.** "Outpatient surgical center" means a free-standing facility licensed under Minnesota Statutes, sections 144.50 to 144.58, and organized for the specific purpose of providing elective outpatient surgery for preexamined, prediagnosed, low-risk patients.

Subp. 31. [Repealed, 21 SR 1106]

Subp. 31a. **Plant, equipment, and occupancy expenses.** "Plant, equipment, and occupancy expenses" means all costs related to plant, equipment, and occupancy expenses, including maintenance, repairs, and engineering expenses, building rent and leases, equipment rent and leases, and utilities. Plant, equipment, and occupancy expenses includes interest expenses and depreciation.

Subp. 31b. **Private donations and grants for operations.** "Private donations and grants for operations" means revenues from an individual, group, foundation, or corporate donor that are designated for supporting the continued operation of the facility. Private donations and grants for operations do not include donations and grants for charity care. For purposes of reporting under part 4650.0112, private donations and grants for operations are operating revenue.

Subp. 32. [Repealed, 19 SR 1419]

Subp. 32a. **Promotion and marketing expenses.** "Promotion and marketing expenses" means all costs related to marketing, promotion, and advertising activities such as billboards, yellow page listings, cost of materials, advertising agency fees, marketing representative wages and fringe benefits, travel, and other expenses allocated to the promotion and marketing activities. Promotion and marketing expenses does not include costs charged to other departments within the hospital.

Subp. 32b. **Psychiatric hospital.** "Psychiatric hospital" means a facility licensed as a psychiatric hospital under Minnesota Statutes, sections 144.50 to 144.58, to provide psychiatric services to inpatients for the diagnosis and treatment of mental illness.

Subp. 32c. **Public funding for operations.** "Public funding for operations" means revenue from taxes or other municipal, county, state, or federal government sources, including grants and subsidies, that are designated for supporting the continued operation of a facility. Public funding for operations does not include donations and grants for charity care. For purposes of reporting under part 4650.0112, public funding for operations is operating revenue.

Subp. 32d. **Quality assurance and utilization management program or activity expenses.** "Quality assurance and utilization management program or activity expenses" means all costs associated with any activities or programs established for the purpose of quality of care evaluation and utilization management. Activities include quality assurance, development of practice protocols, utilization review, peer review, provider credentialing, and all other medical care evaluation activities.

Subp. 33. [Repealed, 19 SR 1419]

Subp. 34. [Repealed, 19 SR 1419]

Subp. 34a. **Regulatory and compliance reporting expenses.** "Regulatory and compliance reporting expenses" means all costs of the facility associated with, or directly incurred in the preparation and submission of financial, statistical, or other utilization, satisfaction, or quality reports, or summary plan descriptions that are required by federal, state, and local agencies.

Subp. 34b. **Reporting organization.** "Reporting organization" has the meaning given in Minnesota Statutes, section 144.702, subdivision 6.

Subp. 35. **Research expenses.** "Research expenses" means the costs incurred by a facility for research purposes. Research means a systematic, intensive study directed toward a better scientific knowledge of the science and art of diagnosing, treating, curing, and preventing mental or physical disease, injury, or deformity; relieving pain; and improving or

preserving health. Research may be conducted at a laboratory bench without the use of patients or it may involve patients. Furthermore, there may be research projects that involve both laboratory bench research and patient care research.

Subp. 35a. **Resident salaries and benefits.** "Resident salaries and benefits" means the total salaries or stipends paid to graduate medical residents, as well as costs for job-related benefits provided for residents, including health or disability insurance. Resident salaries and benefits include those salaries and benefits for the proportion of time on assigned rotation at the hospital, regardless of whether the salaries and benefits are paid by the hospital or another entity. A graduate medical resident means an individual who is being trained as a physician and is in an accredited residency program at a teaching hospital.

Subp. 35b. **Rural hospital planning and transition grant.** "Rural hospital planning and transition grant" means a grant awarded under Minnesota Statutes, section 144.147. For purposes of reporting under part 4650.0112, a rural hospital planning and transition grant is public funding for operations.

Subp. 35c. MR 2001 [Removed, L 2003 1Sp14 art 7 s 88]

Subp. 35d. **Specialized hospital.** "Specialized hospital" means a state-operated facility licensed as a specialized hospital under Minnesota Statutes, sections 144.50 to 144.58, to provide services to inpatients for the diagnosis and treatment of mental illness.

Subp. 36. [Repealed, 21 SR 1106]

Subp. 37. [Repealed, 21 SR 1106]

Subp. 38. [Repealed, 21 SR 1106]

Subp. 39. [Repealed, 21 SR 1106]

Subp. 39a. **Taxes, fees, and assessments.** "Taxes, fees, and assessments" means the direct payments made to government agencies including property taxes; medical care surcharge; MinnesotaCare tax; unrelated business income taxes; any assessments imposed by local, state, or federal jurisdiction; all fees associated with the facility's new or renewal certification with state or federal regulatory agencies, including fees associated with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation; and any fees or fines paid to government agencies for examinations related to regulation.

Subp. 40. [Repealed, 21 SR 1106]

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

History: *L 1984 c 534 s 11; 9 SR 834; 19 SR 1419; 21 SR 1106; 26 SR 627; L 2003 1Sp14 art 7 s 88*

4650.0104 SCOPE; REPORT REQUIREMENTS.

Subpart 1. **Scope.** All hospitals, psychiatric hospitals, specialized hospitals, and outpatient surgical centers licensed under Minnesota Statutes, sections 144.50 to 144.58, are subject to this chapter.

Subp. 2. **Report requirements.** A hospital, psychiatric hospital, or specialized hospital shall submit a financial, utilization, and services report as described in part 4650.0112. An outpatient surgical center shall submit a financial, utilization, and services report as described in part 4650.0113. A hospital or outpatient surgical center shall submit an audited annual financial statement as described in part 4650.0110 and a Medicare cost report as described in part 4650.0111.

Subp. 3. **Citations.** Citations of federal law or federal regulations incorporated in parts 4650.0102 to 4650.0174 are for those laws and regulations as amended.

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

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

4650.0106 [Repealed, 21 SR 1106]

4650.0108 [Repealed, 21 SR 1106]

4650.0110 AUDITED ANNUAL FINANCIAL STATEMENT.

Subpart 1. **Reporting requirements.** A hospital or outpatient surgical center shall submit an audited annual financial statement, including all notes, footnotes, and auditor's opinion, to the commissioner or the voluntary, nonprofit reporting organization approved by the commissioner.

Subp. 2. [Repealed, 21 SR 1106]

Subp. 3. [Repealed, 21 SR 1106]

Subp. 4. [Repealed, 21 SR 1106]

Subp. 5. [Repealed, 21 SR 1106]

Subp. 6. [Repealed, 21 SR 1106]

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

History: *L 1984 c 534 s 11; 9 SR 834; 19 SR 1419; L 1994 c 488 s 8; 21 SR 1106*

4650.0111 MEDICARE COST REPORT.

A hospital or outpatient surgical center shall submit to the commissioner or the voluntary, nonprofit reporting organization approved by the commissioner a copy of the facility's cost report as filed under United States Social Security Act, title XVIII, stated in Code of Federal Regulations, title 42, section 413.20, and the uniform cost report required under United States Code, title 42, section 1320a. The hospital or outpatient surgical center shall also submit a copy of any supplemental reconciliation schedules tying the financial statement to the cost report.

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

History: *19 SR 1419; 21 SR 1106; 26 SR 627*

4650.0112 FINANCIAL, UTILIZATION, AND SERVICES REPORT; HOSPITALS.

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

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

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

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

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

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

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

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

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

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

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

G. the total number of births;

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

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

J. the number of physicians with admitting privileges; and

K. the average length of stay.

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

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

(1) inpatient and outpatient abortion services;

(2) cardiac catheterization services;

(3) outpatient chemical dependency treatment and detoxification services;

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

(5) electroencephalography services;

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

(7) geriatric day care services;

(8) home health care services;

(9) hospice services;

(10) mammography services;

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

(12) outpatient psychiatric services;

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

(14) diagnostic and therapeutic radioisotope services;

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

(16) inpatient and outpatient renal dialysis services;

(17) reproductive health services-genetic counseling;

(18) social services;

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

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

(21) volunteer services;

(22) diagnostic X-ray services;

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

(24) diagnostic ultrasound services; and

(25) laboratory services;

B. provide the following measures of utilization:

(1) the total number of catheterizations;

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

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

(4) the number of home health care visits;

(5) the number of hospice visits;

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

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

(8) the number of outpatient registrations;

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

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

(11) the number of diagnostic ultrasounds;

(12) the number of outpatient surgical registrations;

(13) the number of inpatient surgical admissions;

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

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

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

C. provide the following measures of staffing:

(1) the number of volunteers;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. total operating expenses and total operating revenue;

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

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

D. regulatory and compliance reporting expenses;

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

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

(1) by type of payer;

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

(3) by outpatient services categories;

(4) for services provided in swing beds;

(5) for subacute or transitional care services;

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

(7) by designated care unit or revenue center;

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

(1) for hospital patient care services; and

(2) for other patient care services;

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

I. income or loss from hospital operations;

J. gross receivables by payer and net receivables;

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

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

M. the medical care surcharge and MinnesotaCare tax paid;

N. provision for bad debts:

(1) for hospital patient care services; and

(2) for other patient care services;

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

P. nonoperating revenue and nonoperating expenses;

Q. nonoperating donations and grants and nonoperating public funding;

R. salaries and wages by employee classification; and

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

Subp. 4. [Repealed, 19 SR 1419]

Subp. 5. [Repealed, 21 SR 1106]

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

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

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

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

C. the number of registrations by clinic location;

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

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

F. malpractice expenses, if separate from the hospital;

G. addresses of each clinic location;

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

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

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

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

4650.0113 FINANCIAL, UTILIZATION, AND SERVICES REPORT; OUTPATIENT SURGICAL CENTERS.

Subpart 1. **Reporting requirements.** An outpatient surgical center shall submit a report, including the financial, utilization, and services information described in subpart 4,

for the outpatient surgical center's last full accounting period prior to the accounting period during which it submits the report. This period is called the reporting year. Information must be reported according to subpart 3.

Subp. 2. **Changes in accounting period.** If an outpatient surgical center changes its audited accounting period, reports must include financial, utilization, and services information for all time periods. Required information for a period of up to 13 months may be included in one report.

Subp. 3. **Estimating.** Whenever reasonably possible, an outpatient surgical center must report actual numbers in all categories. If it is not reasonably possible for the facility to report actual numbers, the facility may estimate using reasonable methods. Upon request from the commissioner, the outpatient surgical center must provide a written explanation of the method used for the estimate.

Subp. 4. **Financial, utilization, and services information.** Financial, utilization, and services information must include:

A. the number of surgical cases;

B. the number of operating rooms;

C. the average weekly hours open;

D. the type of nonsurgical procedures or services provided, including radiology, laboratory, and medical procedures and services;

E. the average number of full-time equivalent employees by employee classification;

F. the number of physicians with staff privileges;

G. the ten surgical procedures performed most frequently during the reporting year, including the procedure name, the current procedural terminology code number, and the number of procedures. Current procedural terminology code numbers are contained in "Physician's Current Procedural Terminology" (CPT manual) (4th edition 1996 and subsequent editions), published by the American Medical Association. The CPT manual is incorporated by reference, is subject to frequent change, and is available through the Minitex interlibrary loan system;

H. gross surgical center revenue from patient care;

I. charges by type of payer;

J. adjustments and uncollectibles by type of payer, and for charity care;

K. bad debt and total operating expenses;

L. total administrative expenses;

M. an estimate of regulatory and compliance reporting expenses;

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

O. a description of ownership, including corporations that the outpatient surgical center is owned by or owns;

P. a description of contracts or formal affiliations with hospitals, providers of radiology services, providers of laboratory services, other outpatient surgical centers, or third-party payers, including the name of the entity, the purpose of the contract, and whether the contract or affiliation includes price discounts, quality or practice patterns, performance incentives, volume of business guarantees, or exclusivity arrangements;

Q. the availability of price information, including whether:

(1) prices are posted at the surgical center;

(2) a written price list is available on request;

(3) specific service prices are available on request;

(4) prices are included in advertising and other literature; or

(5) it is the surgical center's policy not to disclose price information;

R. the number of inquiries concerning the price of services the surgical center receives in an average business week;

S. a description of charity care policies, including income guidelines, asset guidelines, medical assistance status impact, and sliding fee schedules;

T. a general description of the change in the demand for charity care to be provided in the budget year; and

U. a general estimate of the change in the amount of charity care the surgical center expects to provide in the budget year.

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

History: *21 SR 1106; 26 SR 627*

4650.0114 [Repealed, 21 SR 1106]

4650.0115 CHARITY CARE REPORTING.

Subpart 1. **Facility requirements.** For a facility to report amounts as charity care adjustments, the facility must:

A. generate and record a charge;

B. have a policy on the provision of charity care that contains specific eligibility criteria and is communicated or made available to patients;

C. have made a reasonable effort to identify a third-party payer, encourage the patient to enroll in public programs, and, to the extent possible, aid the patient in the enrollment process; and

D. ensure that the patient meets the charity care criteria of this part.

Subp. 2. **Classification as charity care adjustments.** In determining whether to classify care as charity care, the facility must consider the following:

A. charity care may include services that the provider is obligated to render independently of the ability to collect;

B. charity care may include care provided to patients who meet the facility's charity care guidelines and have partial coverage, but who are unable to pay the remainder of their medical bills. This does not apply to that portion of the bill that has been determined to be the patient's responsibility after a partial charity care classification by the facility;

C. charity care may include care provided to low-income patients who may qualify for a public health insurance program and meet the facility's eligibility criteria for charity care, but who do not complete the application process for public insurance despite the facility's reasonable efforts;

D. charity care may include care to individuals whose eligibility for charity care was determined through third-party services employed by the facility for information-gathering purposes only;

E. charity care does not include contractual allowances, which is the difference between gross charges and payments received under contractual arrangements with insurance companies and payers;

F. charity care does not include bad debt;

G. charity care does not include what may be perceived as underpayments for operating public programs;

H. charity care does not include unreimbursed costs of basic or clinical research or professional education and training;

I. charity care does not include professional courtesy discounts;

J. charity care does not include community service or outreach activities; and

K. charity care does not include services for patients against whom collection actions were taken that resulted in a financial obligation documented on a patient's credit report with credit bureaus.

Subp. 3. **Reporting categories.** When reporting charity care adjustments, the facility must report total dollar amounts and the number of contacts between a patient and a health care provider during which a service is provided for the following categories:

A. care to patients with family incomes at or below 275 percent of the federal poverty guideline;

B. care to patients with family incomes above 275 percent of the federal poverty guideline; and

C. care to patients when the facility, with reasonable effort, is unable to determine family incomes.

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

History: *26 SR 627*

4650.0116 [Repealed, 19 SR 1419]

4650.0117 BAD DEBT REPORTING.

In determining whether to classify care as a bad debt expense, a facility must:

A. presume that a patient is able and willing to pay until and unless the facility has reason to consider the care as a charity care case under its charity care policy and the facility classifies the care as a charity care case; and

B. include as a bad debt expense any unpaid deductibles, coinsurance, copayments, noncovered services, and other unpaid patient responsibilities.

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

History: *26 SR 627*

4650.0118 [Repealed, 19 SR 1419]

4650.0120 [Repealed, 19 SR 1419]

4650.0122 [Repealed, 19 SR 1419]

ADMINISTRATIVE PROCEDURES

4650.0130 PROVISIONS FOR SUBMITTING REPORTS.

Subpart 1. **Forms to be specified.** The commissioner or the voluntary, nonprofit reporting organization approved by the commissioner shall provide a data collection form or electronic application and instructions for reporting the financial, utilization, and services data. A hospital, psychiatric hospital, specialized hospital, or outpatient surgical center shall submit its financial, utilization, and services data on the form or electronic application provided by the commissioner or the approved voluntary, nonprofit reporting organization.

Subp. 2. [Repealed, 21 SR 1106]

Subp. 3. [Repealed, 21 SR 1106]

Subp. 4. [Repealed, 21 SR 1106]

Subp. 5. **Due date.** A licensed hospital, psychiatric hospital, specialized hospital, or outpatient surgical center shall annually submit all reports required by this chapter within 180 days of the close of the facility's accounting period, and shall base all reports required by this chapter on the same accounting period.

Subp. 6. **Extensions.** If a hospital, psychiatric hospital, specialized hospital, or outpatient surgical center requests an extension in writing by the due date specified in subpart 5 and shows reasonable cause, the commissioner shall grant an extension of the due date of a report for a specified period of time. The commissioner shall respond to the facility's request for an extension within five business days of receipt of the request. The response must

include approval, disapproval, or a request for more information. In determining whether a facility has met the burden of showing reasonable cause, the commissioner shall consider:

A. delays in the availability of the forms described in subpart 1;

B. additional reporting requirements of the facility;

C. emergency conditions of the facility, including natural disasters;

D. the absence of a key administrative employee; or

E. other factors which impact the economic or administrative condition of a facility.

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

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

4650.0132 [Repealed, 21 SR 1106]

4650.0133 [Repealed, 21 SR 1106]

4650.0134 [Repealed, 21 SR 1106]

4650.0136 [Repealed, 21 SR 1106]

4650.0138 REPORTING; OTHER SITUATIONS.

Subpart 1. **Organizations operating more than one facility.** Except as allowed under part 4650.0139, subpart 2, reports required by this chapter are required for each individually licensed hospital, psychiatric hospital, specialized hospital, and outpatient surgical center. If an organization operating more than one facility submits reports for more than one facility, the organization shall provide all information separately for each individually licensed hospital, psychiatric hospital, specialized hospital, or outpatient surgical center covered by the reports.

Subp. 2. **Institutional information.** This subpart applies when a hospital is affiliated with an institution that includes a nursing home, clinic, home health agency, hospice agency, or other facility or agency and the audited financial statement does not specifically break out the hospital's individual revenue and expense from that of the other facilities or agencies of the institution. The hospital must include the following institutional information in its report to tie the hospital-specific information to the institution's audited financial statement:

A. gross nursing home charges from patient care;

B. gross clinic charges from patient care;

C. gross home health charges from patient care;

D. gross hospice charges from patient care;

E. gross ambulance services charges from patient care;

F. other institution charges from patient care;

G. total adjustments and uncollectibles;

H. total other operating revenue;

I. total operating revenue;

J. total operating expenses;

K. total nonoperating revenue;

L. total nonoperating expenses;

M. extraordinary items resulting in a gain or loss; and

N. other changes to unrestricted net assets.

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

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

4650.0139 VARIANCES.

Subpart 1. **Data from other sources.** Upon a written request from a hospital, psychiatric hospital, specialized hospital, or outpatient surgical center, or upon the commissioner's own initiative, the commissioner shall determine whether to use data from other sources instead of collecting data required by this chapter. To make this determination, the commissioner shall consider whether:

A. data from other sources are duplicative of data required under this chapter;

B. data from other sources are available at a reasonable cost;

C. the commissioner has the resources readily available to use the data from other sources;

D. data from other sources is in an acceptable form; and

E. the commissioner will be able to use the data from other sources to meet all statutory data collection, analysis, verification, and privacy requirements.

Subp. 2. **Aggregate reporting for systems.** An organization operating a hospital, psychiatric hospital, specialized hospital, or outpatient surgical center which is part of a system of hospitals, psychiatric hospitals, specialized hospitals, outpatient surgical centers, clinics, or group purchasers may make a written request for permission to report to the commissioner for all components of the system as an aggregate. If the commissioner determines that the commissioner will be able to use the data from the system as an aggregate to meet all statutory data collection, analysis, verification, and privacy requirements, the commissioner shall grant the request. The commissioner may accept some system data reported in aggregate and may require some data to be reported for each individually licensed hospital, psychiatric hospital, specialized hospital, outpatient surgical center, clinic, or group purchaser.

Subp. 3. **Additional variances.** Upon written application or upon the commissioner's own initiative, the commissioner shall grant a variance to this chapter when the commissioner determines that:

A. enforcing a rule would impose an excessive burden on the applicant or others affected by the rule;

B. granting the variance would not adversely affect the public interest; and

C. granting the variance would not conflict with standards imposed by law.

Subp. 4. **Burden.** When a facility makes a request under this part, the facility has the burden of showing that the required criteria under subpart 1, 2, 3, or 5 are met.

Subp. 5. **Alternative practices.** A variance granted under this part may be conditioned upon alternative practices proposed by the applicant or by the commissioner and adapted to the circumstances and facts justifying approval of the variance. The commissioner must determine that the variance will not significantly increase the cost of data collection required under this chapter and that the commissioner will be able to use the data collected under the variance to meet statutory data collection, analysis, verification, and privacy requirements.

Subp. 6. **Notice.** Within 30 calendar days after receiving an application, the commissioner shall notify the applicant in writing that the variance is granted or denied and shall specify the reasons for the decision. The commissioner may extend the review period, provided the applicant is notified in writing of the reasons for the extended review period.

Subp. 7. **Duration; revocation.** A variance may be of limited duration. The commissioner shall revoke a variance if a material change occurs in the circumstances that justified the variance under this part, or if the applicant fails to comply with the conditions of the variance.

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

History: *21 SR 1106*

4650.0140 [Repealed, 21 SR 1106]

4650.0141 SUBMITTING AMENDED REPORTS.

Subpart 1. **Reports amended by facility.** A hospital, psychiatric hospital, specialized hospital, or outpatient surgical center may submit an amended financial, utilization, and services report at any time within 18 months of the required submission date specified in part 4650.0130, subpart 5, and must include justification for the amended report. The commissioner must review and approve the amended report before it replaces the previously submitted report.

Subp. 2. **Reports amended by commissioner.** The commissioner may amend a report of a hospital, psychiatric hospital, specialized hospital, or outpatient surgical center at any time if the commissioner finds that the data submitted were not accurate.

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

History: *21 SR 1106*

REVIEW OF REPORTS

4650.0150 COMPLETE REPORTS.

Subpart 1. **Review of each report.** The commissioner or the voluntary, nonprofit reporting organization approved by the commissioner shall review each report submitted under this chapter to determine if the report is complete. "Complete" means that the report contains adequate data in a form that will allow further review and verification of the accuracy of the report. A report is considered submitted when the commissioner or the approved voluntary, nonprofit organization has determined that the report is complete.

Subp. 2. **Timely reply that report is incomplete.** If the commissioner or the voluntary, nonprofit reporting organization approved by the commissioner does not respond to the facility within 30 calendar days after receiving a report, the report is considered complete and submitted on the day the commissioner or approved voluntary, nonprofit reporting organization received the report.

Subp. 3. **Incomplete report.** A report that the commissioner or the voluntary, nonprofit reporting organization approved by the commissioner determines to be incomplete must be returned within three business days of the determination to the hospital, psychiatric hospital, specialized hospital, or outpatient surgical center with a statement describing the report's deficiencies. The facility shall correct the deficiencies and resubmit the report within ten business days or request an extension according to part 4650.0130, subpart 6. If the resubmitted report is determined to be complete, it is considered complete and submitted on the date the resubmitted report was received.

Subp. 4. [Repealed, 19 SR 1419]

Subp. 5. [Repealed, 21 SR 1106]

Subp. 6. **Error in reports.** If the commissioner discovers a significant error in a submitted report, the commissioner shall require the hospital, psychiatric hospital, specialized hospital, or outpatient surgical center to provide corrections by a date agreed upon by the commissioner and the facility.

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

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

4650.0152 [Repealed, 19 SR 1419]

VOLUNTARY, NONPROFIT REPORTING ORGANIZATION

4650.0154 APPROVAL OF VOLUNTARY, NONPROFIT REPORTING ORGANIZATION.

Subpart 1. **Voluntary, nonprofit reporting organization approval.** The commissioner may approve a voluntary, nonprofit reporting organization to collect and process the data and prepare reports required by this chapter. The approval shall extend for a period specified by the commissioner not to exceed two years. If the approval extends for

a period of more than one year, the voluntary, nonprofit reporting organization's reporting procedures must be consistent with the written operating requirements established annually by the commissioner. An organization desiring approval may apply for approval by the procedure in parts 4650.0156 to 4650.0160.

Subp. 2. **Termination of approved voluntary, nonprofit reporting organization.** The commissioner may withdraw approval of the approved voluntary, nonprofit reporting organization according to Minnesota Statutes, section 144.702, subdivision 8.

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

History: *L 1984 c 534 s 11; 9 SR 834; 21 SR 1106*

4650.0156 OPEN APPLICATION PERIOD.

A voluntary, nonprofit reporting organization may apply for approval of its reporting and review procedures after January 1 and before March 31 of a state fiscal year, for the next subsequent state fiscal year. The commissioner may at any time issue a request for applicants to be a voluntary, nonprofit reporting organization to collect and process the data and prepare reports required by this chapter during the subsequent state fiscal year or to replace a voluntary, nonprofit reporting organization that has been terminated according to Minnesota Statutes, section 144.702, subdivision 8.

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

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

4650.0158 CONTENTS OF APPLICATION.

An application for approval must include:

A. general information about the applicant organization, including: organization's name, address, telephone number, contact person, proposed staff, and a detailed description of its computing facilities;

B. a detailed description of the proposed reports and administrative procedures related to the collection and analysis of aggregate hospital data;

C. a statement that all reports submitted by the facilities determined to be complete according to part 4650.0150 will be available for inspection by the commissioner within five business days of the determination;

D. a description of the primary activities of the applicant that qualify the applicant as a reporting organization as defined under Minnesota Statutes, section 144.702, subdivision 6;

E. adequate documentation to demonstrate that the proposed reporting and review procedures meet or exceed the requirements of this chapter and Minnesota Statutes, sections 144.695 to 144.703;

F. a detailed description of the procedures used to receive and verify the accuracy of reports, including data processing procedures and the capability to receive and transmit report data electronically;

G. a statement guaranteeing that all data from submitted financial, utilization, and services reports will be transmitted electronically to the commissioner by a date specified by the commissioner;

H. a detailed fee schedule showing the fees for submission of the reports required by this chapter, the method used to determine the fee schedule, the estimated costs of processing the aggregate data required by this chapter, and a statement that, to the extent possible, the fees will not exceed the costs of reviewing the reports and processing the aggregate data required by this chapter;

I. a detailed description of the procedures the applicant will use to process data and the associated completed reports in accordance with Minnesota Statutes, chapter 13; and

J. any other documentation or information considered necessary by the commissioner to satisfy a law or rule.

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

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

4650.0160 REVIEW OF APPLICATION.

Subpart 1. **Commissioner's decision.** By May 15 of each year, the commissioner shall issue a decision regarding an unsolicited application from a voluntary, nonprofit reporting organization that the procedures for reporting and review proposed by the applicant are approved or disapproved. Within 45 days of the close of the application period specified in a request for applicants, the commissioner shall issue a decision regarding applications received in response to the request that the applicant and the applicant's proposed procedures for reporting and review are approved or disapproved. Approval by the commissioner is effective immediately.

Subp. 2. **Disapproval.** The commissioner may disapprove any application on demonstration that the reporting and review procedures of a voluntary, nonprofit reporting organization are not substantially equivalent to those established by the commissioner or if the commissioner reasonably believes that the reporting and review procedures of a voluntary, nonprofit reporting organization are not likely to meet the deliverable dates established in the written operating requirements or specified in the request for proposals.

Subp. 3. **Reapplication.** An organization whose application has been disapproved by the commissioner may submit a new or amended application to the commissioner within 15 calendar days after disapproval of the initial application.

Subp. 4. **Oral presentation.** The commissioner may request an oral presentation from a voluntary, nonprofit reporting organization that has submitted an application under parts 4650.0154 to 4650.0158. The oral presentation must include the items in the application as described in part 4650.0158 and must address any questions the commissioner has about the application.

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

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

4650.0162 [Repealed, L 1989 c 282 art 2 s 219 subd 1]

4650.0164 [Repealed, L 1989 c 282 art 2 s 219 subd 1]

FEES AND FINES

4650.0166 FEES; HOSPITALS.

Subpart 1. **Fee required.** A hospital whose reports are reviewed by the commissioner rather than the voluntary, nonprofit reporting organization shall submit a fee to the commissioner with the reports. The base for calculating the fee is the sum of the nonoperating revenue plus the operating revenue reported by the hospital under part 4650.0112 for the accounting period immediately preceding the reporting year for which the fee is due.

Subp. 2. **Fee determination.** The fee shall be determined as follows:

A. for a hospital with a base less than or equal to $12,000,000, the fee is $1,200;

B. for a hospital with a base greater than $12,000,000 but less than or equal to $40,000,000, the fee is equal to the base multiplied by 0.0001;

C. for a hospital with a base greater than $40,000,000 but less than or equal to $80,000,000, the fee is equal to $4,000 plus the amount of the base exceeding $40,000,000 multiplied by 0.00009;

D. for a hospital with a base greater than $80,000,000, the fee is equal to $7,600 plus the amount of the base exceeding $80,000,000 multiplied by 0.00008. The maximum fee shall not exceed $8,300;

E. for a hospital that was not in operation and did not file a report for the accounting period immediately preceding the reporting year for which the fee is due, the fee is $1,200; or

F. for a hospital that was in operation, but failed to file the report required under this chapter for the accounting period immediately preceding the reporting year for which the fee is due, the commissioner shall determine the amount of the fee after considering some or all of the following factors:

(1) data submitted by the hospital in a previous year;

(2) data submitted by the hospital on its Medicare cost report;

(3) data submitted by the hospital on its audited financial statement; or

(4) fees paid by similar hospitals.

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

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

4650.0167 FEES; OUTPATIENT SURGICAL CENTERS.

An outpatient surgical center whose reports are reviewed by the commissioner rather than the voluntary, nonprofit reporting organization shall submit a fee of $200 to the commissioner with the reports.

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

History: *21 SR 1106*

4650.0168 [Repealed, 21 SR 1106]

4650.0170 [Repealed, 21 SR 1106]

4650.0172 [Repealed, 21 SR 1106]

4650.0173 FINES.

If a hospital, psychiatric hospital, specialized hospital, or outpatient surgical center does not comply with the requirements of this chapter and does not respond to requests from the commissioner and the voluntary, nonprofit reporting organization approved by the commissioner to comply with the requirements of this chapter, the commissioner shall charge the facility a fine in addition to the original submission fees. The fine is a base of $100 plus $10 per day until the facility complies with the requirements of this chapter. The fine shall not exceed $1,000.

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

History: *21 SR 1106*

4650.0174 SUSPENSION OF FEES AND FINES.

The commissioner may suspend all or any portion of the submission fees and fines if a facility shows cause. In determining whether a facility has shown cause, the commissioner shall consider:

A. the inability of a facility to pay the fees or fines without directly affecting the rates charged to patients;

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

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

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

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

4650.0176 [Repealed, 19 SR 1419]

4650.0200 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.0300 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.0400 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.0500 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.0600 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.0700 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.0800 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.0900 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.1000 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.1100 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.1200 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.1300 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.1400 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.1500 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.1600 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.1700 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.1800 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.1900 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.2000 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.2100 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.2200 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.2300 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.2400 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.2500 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.2600 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.2700 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.2800 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.2900 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.3000 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.3100 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.3200 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.3300 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.3400 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.3500 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.3600 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.3700 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.3800 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.3900 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.4000 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.4100 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.4200 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.4300 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.4400 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.4500 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.4600 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.4700 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.4800 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.4900 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.5000 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.5100 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.5200 [Repealed, L 1984 c 534 s 11; 9 SR 834]

4650.5300 [Repealed, L 1984 c 534 s 11; 9 SR 834]