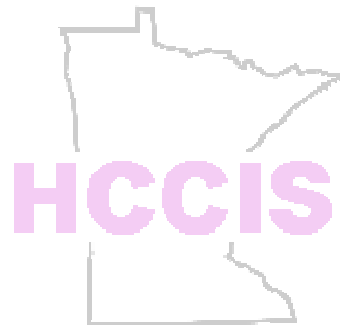# 2017

Hospital Annual Report (HAR) - Instructions

Financial, Utilization, and Services Data

HCCIS

Health Care Cost Information System

m1 DEPARTMENT OF HEALTH

H Minnesota Hospital Association

Completion and submission of this report and of the Audited Financial Statements and Medicare Cost Report are required by Minnesota Statutes, sections 144.695 - 144.703, 144.562, 144.564, 62J.321 and Minnesota Administrative Rules, Chapter 4650.

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GENERAL INFORMATION

Background

According to the Minnesota Health Care Cost Information Act of 1984 (Minnesota Statutes, Sections 144.695 - 703), the Minnesota Department of Health (MDH) is responsible for providing accurate and reliable information about the financial, utilization, and service characteristics of hospitals in Minnesota to public policy makers, purchasers of hospital services, and the general public. Minnesota Rules, chapter 4650, defines the data that are collected. These data provide unique information that is not a part of other data collection requirements.

Minnesota Hospital Association (MHA) serves as a "voluntary nonprofit reporting organization" (VNRO) under an agreement with the Minnesota Department of Health. In this capacity, MHA staff collects and audits financial and statistical information from each hospital on the Hospital Annual Report (HAR) for MDH. In addition to the HAR, MHA collects copies of the Audited Financial Statement (AFS), and Medicare Cost Report (MCR) from hospitals and forwards them to MDH.

Data Uses

The accuracy and reliability of the data reported on the HAR is essential as is evident by its many uses. In addition to facilitating public policy decisions and assisting hospitals in comparing their financial, utilization and services data to individual and aggregated hospital data, the HAR data is used to:

•   Calculate the hospital medical care surcharge

•   Determine eligibility for state rural hospital grant programs

•   Develop estimates of total health care spending and aggregate hospital utilization for the state of Minnesota

•   Demonstrate the impact of health care reform and the cost containment strategies proposed under health reform legislation

•   Assist health care providers to demonstrate to key decision makers particular areas of their costs that may be beyond their control, such as labor costs, malpractice insurance, billing and collections costs, research and education costs, and costs related to uncompensated care and charity care

•   Assist health care providers in identifying trends and variances in costs

Reporting Requirements

All hospitals (excluding federal hospitals), psychiatric hospitals, and specialized hospitals are required to submit data. Hospitals are required to complete *all* "hospital-only" sections of the Hospital Annual Report (HAR), and submit copies of the Audited Financial Statements and Medicare Cost Report.

• Psychiatric and specialized hospitals are required to complete a shorter version of the HAR containing utilization and services information, and total operating revenue and expenses, and are *not* required to submit an Audited Financial Statement or Medicare Cost Report.

Reports and Due Dates

Hospital Annual Report (HAR) for Reporting Year 2017:

Hospitals are required to submit *one* original report within 180 days after the hospital's 2017 fiscal year end. (Minnesota Statutes, Section 144.698, Subd. 1 (6), and Minnesota Rules, part 4650.0130 subparts 1 and 5.)

Note: The *entire* HAR must be submitted at the *same* time. Although different departments within the hospital may participate in data collection efforts, all applicable sections of the report must be complete before it is submitted.

Audited Financial Statements (AFS), Medicare Costs Report (MCR), and reconciliation between the AFS and MCR for 2017:

Submit a **PDF** copy of each report within 180 days after the 2017 fiscal year end of the health facility. (Minnesota Statutes, Section 144.698, subd. 1 (1) and (3), and Minnesota Rules, part 4650.0110, subpart 1, part 4650.011, and part 4650.0130, subpart 5.)

Submit All Reports Through:

> Online Web Submission: https://portal.mnhospitals.org
>
> Please call Jennifer Sanislo (Minnesota Hospital Association) at (651) 659-1440 for your login and password.

Upon receipt:

• MHA staff will make an initial check for completeness and overall accuracy of the HAR. If the report is incomplete, it will be returned to the preparer for revisions. A HAR is accepted only when it is received, revised, and complete.

• The HAR is then audited to verify the figures with the Audited Financial Statement and ensure accuracy and consistency in reporting throughout the report and from year to year. If figures are inaccurate, inconsistent, or cannot be verified, the preparer will be contacted for clarification/correction.

- Upon completion of the audit, the HAR data is considered final and can **only** be changed through a formal amendment process. For information about the amendment process, contact MHA or MDH.

Available upon request:

Minnesota Statutes, sections 144.695 - 144.703
Minnesota Rules, chapter 4650
Statement of Need and Reasonableness (SONAR)

For more information, contact:

Matt Hovila	Financial Analyst, MHA	(651) 641-1121
		(651) 659-1477 FAX
Tracy Johnson	HCCIS Staff, MDH	(651) 201-3572
		(651) 201-5179 FAX

Requests for Extensions

If hospital personnel are unable to complete the HAR by the due date, an extension must be requested **in writing** by the due date of the HAR report, **and** must explain the reason for the extension request. An extension may be granted for a specified period of time if reasonable cause is demonstrated.

- Requests for the initial 21-day extension should be addressed to MHA.
- Additional extensions should be addressed to MDH.

INFORMATION ON COMPLETING THE HAR

Layout
The Financial portion of the report includes data for both the Institution **and** Hospital.
- The Institution page is to be completed by those hospitals with affiliated facilities whose audited financial statements reflect **only** this relationship. Information for the Institution **must tie directly** to the audited financial statement.
- The Hospital segment of the financial portion includes several sections. It is **required** and must reflect information for the **hospital only**.

Many accounts throughout the formset are grayed-out and will be calculated automatically.

The Staffing, Utilization (including separate pages for Swing Bed Care and Subacute/ Transitional Care), and Services sections of the report are to be completed for the **hospital only**, and may require information from other departments of the hospital.

General

The "2017 FYE Reporting Year" column refers to the hospital's 2017 fiscal year end and must reflect **actual** information for 2017.

Whenever reasonably possible, a hospital must report actual numbers in all categories. If it is not reasonably possible to report actual information, the hospital may estimate using reasonable methods. When an entry is an estimate, please identify it as an estimate. Note that, upon request, the hospital must provide a written explanation of the method used for the estimate. (Minnesota Rules, part 4650.0112, subpart 1c.)

Standard methods of allocation are encouraged to insure consistent data across hospitals. Allocations apply to multiple-use hospital systems including Nursing Homes, Stand-Alone Clinics, Home Health Agencies, Hospices and Ambulance Services. Items to be allocated include Natural Expenses, Adjustments and Uncollectibles, Salaries, and FTEs. An example of a standard allocation method is found in the Medicare Cost Report, Worksheet B, Part 1.

In some instances two different accounts will require identical information. When this occurs, it is referenced on each account line (e.g. both Account 0600 and Account 0790 are Total Operating Expense).

Leave accounts *blank* when the account is *not applicable* to your hospital. An exception to this is found with Account 4531, Hospital Licensed Bassinets. Hospitals with no Licensed Bassinets should record -0- for this line. However, if the account *is applicable* and the value happens to be zero, enter -0- for that account.

Please make sure to provide numbers in whole dollar amounts (e.g. $1,234, not $1,234.56) and FTE's to two digits (e.g. 34.45, not 34.56433).

[Bracket] accounts that are negative, such as contractual adjustments and uncollectibles, extraordinary losses, and allowance for uncollectible accounts.

Hospital Annual Report (HAR) Instructions

Hospital Identification HAR p. 1

Please list all identifying information for the facility. Critical Access Hospital (CAH) Status should be recorded.

Enter the National Provider Identifier (NPI) assigned by CMS for the Acute Care hospital.
See http://www.cms.hhs.gov/NationalProvIdentStand/ for more information.

Please report the ***full name*** of the hospital's Emergency Department Physician Director. If you have an Emergency Department, you ***must*** enter the director's name. This is required by Minnesota Rules chapter 4650.0112 subp.2a,C(3).

Certification Statement HAR p. 1

An officer of the hospital such as the Administrator, Chief Executive Officer, Chief Financial Officer, or Controller must sign this certification. A PDF of the signed cover page (e-mailed or uploaded through the HAR upload website https://har.mnhospitals.org) is the preferred method of delivery.

Section 1: Revenue and Expense Summary HAR p. 3

Hospitals affiliated with a nursing home, free-standing clinic, home health agency, hospice agency, ambulance service, senior living facility, or other facility or agency as indicated on the audited financial statement are required to complete this section. Hospitals with audited financial statements specific to the hospital are not required to complete this page, even if the hospital is part of an institution. The primary purpose of this section is to verify revenue and expense accounts with the audited financial statement. If the audited financial statement does not specifically break out hospital revenue and expense from that of the other facilities of an institution, this page is used to verify institution information.

#0201   Gross Hospital Charges from Patient Care (ties to 0740, 0860): The total charges billed by the facility for patient care regardless of whether the facility expects to collect the amount billed.

#0207   Gross Clinic Charges from Patient Care: If the clinic ***is not*** an outpatient department of the hospital, the patients ***are not*** registered outpatients or admitted inpatients of the hospital, you ***do not*** bill for these services on a UB form, and if the clinic ***is listed*** in the hospital's Medicare Cost Report on worksheet S, part II as an entity of the hospital complex, this is considered Institutional revenue and should be reported here.

#0202   Gross Home Health Charges from Patient Care: If your audited financial statement includes revenue for non-hospital services provided by a licensed home health agency that is part of the same institution as the hospital, the Minnesota Department of Health requires that you report such revenue in this account.

#0203   Gross Hospice Charges from Patient Care: If your audited financial statement includes revenue

for non-hospital services provided by a licensed hospice agency that is part of the same institution as the hospital, the Minnesota Department of Health requires that you report such revenue in this account.

#7113 Gross Ambulance Services Charges from Patient Care: If the ambulance service *is not* operated by hospital-employed staff and *is listed* in the hospital's Medicare Cost Report on worksheet S, part II as an entity of the hospital complex, this is considered Institutional revenue and should be reported here.

#0216 Provision for Bad Debts: Due to a change in Financial Accounting Standards Board (FASB) rules, Provision for Bad Debts is now included in Total Adjustments and Uncollectibles. It is no longer included in Total Operating Expense. For further clarification of what should be reported as Provision for Bad Debts please see page 17 (account 8100).

Note: In 2000 MDH revised the rules to pull Ambulance Service charges out of hospital revenue and place it into Institution charges to make hospital revenue more comparative across the state.

If you completed this portion of the 2016 HAR but are not completing it for 2017, or if you did not complete this portion of the 2016 HAR but will be completing it for 2017, contact MHA at (800) 462-5393 for further information. In addition, if you are proposing to make an alteration to a prior year's format, please contact MHA personnel. *An error in completing this page could necessitate revising the entire financial portion of the report.*

Section 2: Non-Operating Revenue and Expense HAR p. 3

#0333 Extraordinary Items; Gain/(Loss): Material Gains or Losses identified in the institution's Audited Financial Statement as a result of an event that is both unusual in nature and infrequent in occurrence (ex: void of bond debt, highly unusual catastrophic weather conditions).

#0340 Other Changes to Unrestricted Net Assets (FASB's, Changes in Accounting Principles, Transfers, etc.): For this account, report the combined net effect of FASB (Financial Accounting Standards Board) changes or other items that are typically reported below the "Revenue in Excess of Expense" or "Expense in Excess of Revenue" line on the Certified Audit's income statement. Some examples of these items are:
- Cumulative effect of change in accounting principle
- Net assets released from restrictions
- Contributions/donations released for property acquisitions
- Transfers for acquisition of property and equipment
- Donated equipment
- Net transfers to/from other entities

To standardize institutional reporting, report the *net* effect of these changes in Account 0340.

FINANCIAL INFORMATION: HOSPITAL (Hospital Patient Care Services *and* Other Patient Care Services Provided by the Hospital)

All sections identified as **HOSPITAL** must be completed with *hospital-only* information according to

Minnesota Rules, part 4650.0112. If a hospital's audited financial statement shows evidence of affiliation with a free-standing clinic, nursing home, ambulance service, hospice agency, home health agency, or other facility, the hospital information must be reported separately including allocated expenses for general and administrative, medical records, etc. If a hospital's audited financial statement does not show evidence of affiliation with another facility, and the data provided on the HAR does not directly tie to the audited financial statement, please contact MHA staff before proceeding with the formset.

Section 3: Patient Revenue HAR p. 4

#8062 Total Charges from Patient Care: The total *hospital* charges generated from patient care. This account should contain only hospital patient revenue, and exclude any charges generated from any institution that has been broken out in Section 1.

#0739 Provision for Bad Debts: Due to a change in Financial Accounting Standards Board (FASB) rules, Provision for Bad Debts is now included in Total Adjustments and Uncollectibles. It is no longer included in Total Operating Expense. For further clarification of what should be reported as Provision for Bad Debts please see page 17 (account 8100). Account 0739 ties to 8100 on page 7 of the HAR.

#8063 Total Adjustments and Uncollectibles: The total contractuals made to hospital patient charges. Please note that this should include charity care and self-pay discounts and **as of the 2013 HAR,** bad debt should be included.

#0750 Net Patient Revenue: Patient care revenues expected to be collected after accounting for discounts and allowances. HAR net patient revenue should tie to net patient service revenue located on the statement of revenue and expense or combined statement of operations in the hospital's audited financial statements. ***In the absence of hospital specific audited financial statements, an internal hospital specific income statement or audit statement reconciliation should be provided.***

Section 4: Other Operating Revenue HAR p. 4

This section refers to revenue derived from the daily operation of the hospital as a result of non-patient care services. Specific examples include space rental, sale of medical and pharmacy supplies to non-patients, medical record transcription fees, operation of a hospital cafeteria, parking lot/ramp fees, gift shop revenues, auxiliary functions, public phone proceeds, recovery of radiology silver, billing services for other health care entities.

#0775 Donations and Grants for Charity Care: Revenues from an individual, group, foundation, government entity, or corporate donor that are designated by the donor for providing charity care.

#0776 Percentage of Donations/Grants for Charity Care - Public: Report only the **percentage** in the space provided; do not enter revenue amounts in the reporting year column.

#0777 Percentage of Donations/Grants for Charity Care - Private: Report only the **percentage** in the space provided; do not enter revenue amounts in the reporting year column.

#0778 Private Donations and Grants for Operations: Revenues from an individual, group, foundation, or corporate donor that are designated for supporting the continued operation of the facility. Donations and grants for operations do *not* include funding for charity care.

#0772 Public Funding for Operations: Revenues 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 operation does *not* include funding for charity care. For purposes of reporting, public funding for operation is operating revenue. This account includes Medicare EMR incentive payments, hospital grants such as the Sole Community Hospital Financial Assistance Grant, the Rural Hospital Planning and Transition Grant, and Medical Education and Research Costs (MERC) funds (Minnesota Statutes 62J.694)

Section 5: Operating Income HAR p. 4

#0780 Operating Revenue: The sum of net patient revenue and other income received as part of the normal day-to-day operation of the facility.

#0790 Operating Expense: All costs directly associated with providing patient care or other services that are part of the normal day-to-day operation of the facility. Account line 0790 ties to account 0600 on page 8 of the HAR.

Section 6: Non-Operating Revenue HAR p. 4

This section refers to revenue that is not related to patient care activities or daily hospital operations. Examples of non-operating revenue include interest income, non-operating donations and grants, unrestricted donations, and gains from the sale of either assets or investments that are reflected above net income on the hospital's audited financial statement.

#0806 Non-Operating Donations and Grants: Revenues from an individual, group, foundation, or corporate donor 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.

#0819 Non-Operating Public Funding: Revenues 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.

#0820 Non-Operating Revenue: All income received that is not directly related to the normal day-to-day operations of the facility.

Section 7: Non-Operating Expense HAR p. 4

This section refers to expense that is *not* related to patient care activities or daily hospital operations. Examples of non-operating expense include losses from the sale or disposal of either assets or investments that are reflected above net income on the hospital's audited financial statement.

#0830 Non-Operating Expense: All costs not directly associated with the normal day-to-day operations of the facility.

Section 8: Revenue in Excess of Expense HAR p. 4

#0831 Extraordinary Items; Gain/(Loss): Material Gains or Losses identified in the hospital's Audited Financial Statement as a result of an event that is both unusual in nature and infrequent in occurrence (ex: void of bond debt, highly unusual catastrophic weather conditions).

#0840 Other Changes to Unrestricted Net Assets (FASB's, Changes in Accounting Principles, Transfers, etc.): For this account, report the combined net effect of FASB (Financial Accounting Standards Board) changes or other items that are typically reported below the "Revenue in Excess of Expense" or "Expense in Excess of Revenue" line on the Certified Audit's income statement. Some examples of these items are:

- Cumulative effect of change in accounting principle
- Net assets released from restrictions
- Contributions/donations released for property acquisitions
- Transfers for acquisition of property and equipment or donated equipment
- Net transfers to/from other entities

To standardize hospital reporting, report the *net* effect of these changes in Account 0840.

Section 9: Patient Care Charge Summary HAR p. 5

Service line accounts for charges, days, and admissions are located on the "Service Line Data" tab and are in separate sections (sections 58-62). This section (Section 9: Patient Care Charge Summary) is **not** service line (billing) data, and should be completed using your accounting/financial reports.

If your hospital voluntarily reports to the UB data project (Minnesota Health Information Network - MHIN) sponsored by MHA, then MHA can report the service line information (sections 58-62 on the "Service Line Data" tab) for your hospital with your permission. If you want MHA to report this information for your hospital, you must check the box provided in the report. If you check this box, leave Sections 58-62 blank on the "Service Line Data" tab.

If your hospital **does not** report to the UB data project cited above **or** you choose not to have MHA report for you, you must report this information yourself. When you check "no", a blue hyperlink will appear to the right of the check box which will take you to the appropriate area to complete.

#7133 Total Acute Care Charges: The total acute room and board charges should be reported in this account. This should not include any ancillary, physician, or Subacute charges.

#7091 Reference Lab and Reference Radiology Services Charges: Charges for the sale of reference laboratory services or radiology services to non-hospital patients.

#7092 DME and Retail Pharmacy Supplies Charges: Charges for the sale of durable medical equipment and retail pharmacy supplies to non-hospital patients.

#7094 Physician Professional Fees: Charges related to billable professional physician services only (ex: ER phys fees, radiologist, pathologist, anesthesiologist, EKG/EEG physicians).

#7095 Other Billable Professional Fees: Charges related to billable professional (non-physician) services only (ex: CRNA, nurse practitioner).

#0740 Total Charges from Patient Care: The total charges billed by the facility for patient care regardless of whether the facility expects to collect the amount billed. Per Minnesota Rules chapter 4650.0102, subpart20f, "Hospital patient care services charges" means the total charges billed by the 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 revenue regardless of whether the hospital expects to collect the amount billed. Hospital patient care services revenue includes charges for hospital routine inpatient, routine outpatient, and ancillary services.

Section 10: Inpatient/Outpatient/Other Charges Summary HAR p. 5

Reported in this section are Total Patient Charges broken down by either Inpatient or Outpatient, or Other Charges. Total Charges must tie to account 0740.

#0851 Inpatient Charges: All inpatient charges that are included in Hospital Patient Care Services Charges (7090) and Physician Professional Fees (7094) and Other Billable Professional Fees (7095) (professional services codes). These charges are to be broken out further by hospital patient care services and professional patient care services.

#7108 Inpatient Charges - Hospital Patient Care Services: Inpatient charges that are not designated as Physician, CRNA, NP, PA, Midwife, or Chemical Dependency Counselor professional charges.

#7109 Inpatient Charges - Professional Patient Care Services: Inpatient charges that are designated as Physician, CRNA, NP, PA, Midwife, or Chemical Dependency Counselor professional charges.

#0853 Outpatient Charges: All outpatient charges that are included in Hospital Patient Care Services Charges (7090) and Professional Physician Fees (7094) and Other Billable Professional Fees (7095) (professional services codes). These charges are to be broken out further by hospital patient care services and professional patient care services.

#7110 Outpatient Charges - Hospital Patient Care Services: Outpatient charges that are not designated as Physician, CRNA, NP, PA, Midwife, or Chemical Dependency Counselor professional charges.

#7111 Outpatient Charges - Professional Patient Care Services: Outpatient charges that are designated as Physician, CRNA, NP, PA, Midwife, or Chemical Dependency Counselor professional charges.

#7112 Other Patient Charges: Sum of 7091 + 7092 + 7096. All other patient charges that are included in Hospital Patient Care Services (0740) that are designated as either Reference Lab/Reference Radiology (7091), DME/Retail Pharmacy (7092), or Other Patient Care Services Charges (7096).

Section 11: Outpatient Charges Summary HAR p. 5

"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.

The far right column on the formset shows a link labeled "Audit Check." Clicking on this link will take you to another tab in the workbook where you can review your Average Charge per Registration. The average range is also noted for you to compare your hospital with the state average. This is for your information only to aid you in completion of the formset. If your hospital does not fall within the stated ranges, you may be contacted by MHA staff for possible corrections.

#0871 Outpatient Registration Charges: Those charges billed by the hospital for care extended to patients by an outpatient department. Outpatient services may include such services as physical therapy, speech therapy, occupational therapy, CAT scans, MRIs, and dialysis.

#0872 Emergency Room Registrations Charges: Charges billed by the hospital for emergency room care extended to patients. Report *only* emergency department charges on this line and report the corresponding ancillary charges in account 0876: All Other Ancillary Outpatient Charges.

#0873 Outpatient Surgery Registrations Charges: Charges billed by the hospital for services rendered by departments such as outpatient surgery (or same day surgery), outpatient anesthesia, and outpatient post anesthesia recovery. Upper and lower GI outpatient diagnostic procedures (colonoscopy, sigmoidoscopy, etc.) should also be included in this account.

#0876 All Other Ancillary Outpatient Charges: This is intended to be an all inclusive or "other" category in which you are to report charges for services that cannot be directly tied to the categories provided in Accounts 0871 - 0873. Examples of services for which charges may be reported in this category are outpatient pharmacy, supplies charged to patients, laboratory, and x-ray. The reason for this category is to ensure that these services are not inappropriately allocated to the other outpatient categories thereby inadvertently inflating the charges.

Section 12: Patient Care Charge Summary by Age HAR p. 6

#7225 Adult Care Charges (18+): Total Hospital Patient Care Services Charges for all patients 18 years of age and older. This includes all Routine (Medical/Surgical Room and Board), Specialty (ICU/CCU, Chemical Dependency, Rehabilitation, Mental Health/Psych, Swing Bed and Transitional Bed Room and Board) and both Inpatient & Outpatient Ancillary Charges. Exclude all Fees for Physicians and Other Billable Professionals in addition to Reference Lab/Reference Radiology Services Charges and DME/Retail Pharmacy Supplies Charges.

#7127 Pediatric and Adolescent Care Charges (including Neonatal): Total Hospital Patient Care Services Charges for all patients less than 18 years of age. This includes all Routine (Medical/Surgical Room and Board), Specialty (ICU/CCU, Neonatal, Chemical Dependency, Rehabilitation, Mental Health/Psych, Nursery, Swing Bed and Transitional Bed Room & Board) and both Inpatient & Outpatient Ancillary Charges. Exclude all Fees for Physicians and Other Billable Professionals in addition to Reference Lab/Reference Radiology Services Charges and DME/Retail Pharmacy Supplies Charges. This is *not* just for Pediatric specialty hospitals only. ***This is to be completed by all hospitals.***

The far right column on the formset shows a link labeled "Audit Check." Clicking on this link will take you to another tab in the workbook where you can review your adjustments to charges ratio. This is for your information only to aid you in completion of the formset. If your hospital does not fall within the stated ranges, you may be contacted by MHA staff for possible corrections.

#7250   Total Medicare Patient Charges: This should be the sum of Medicare Patient Charges (Non-Managed Care) (account 0841) and Medicare Managed Care Patient Charges (account 0842).

#0841   Medicare Charges (Non-Managed Care): Patient Charges billed to Medicare intermediaries such as Noridian Administrative Services for Medicare Patients only.

#0842   Medicare Managed Care Patient Charges: Would include Medicare Advantage plans, Blue Cross Blue Shield – Minnesota Senior Health Options (MSHO).

MDH is frequently asked to provide data on the utilization and financial trends for MA and MinnesotaCare. Eligibility and payment policies related to these programs vary greatly. It is important that these categories be separated, so that we have the ability to analyze trends by program types particularly as eligibility for the programs change. This information is frequently requested by legislators and other state analysts to assist them in policy formation on a program level. With recent budget cuts, these requests have increased in frequency. This information needs to be collected separately, by program, for us to fulfill requests for data and to describe trends for each program.

#7253   Total MA/PMAP Patient Charges: Total Charges billed by the hospital for Medical Assistance and Prepaid Medical Assistance Program patients. This should be the sum of MA Patient Charges (account 7142) and PMAP Managed Care Patient Charges (account 7145).

#7142   MA Patient Charges (Non-Managed Care): Patient Charges billed to the Minnesota Department of Human Services for non-PMAP Medicaid Patients only.

#7145   PMAP Managed Care Patient Charges: Patient Charges billed to third party administrators for PMAP (Prepaid Medical Assistance Program) Medicaid Patients only.

#7256   Total MinnesotaCare Patient Charges: Patient Charges billed to the Minnesota Department of Human Services for non-PMAP MinnesotaCare Patients and Patient Charges billed to third party administrators for PMAP MinnesotaCare Patients. This should be the sum of MinnesotaCare Patient Charges (Non-Managed Care) (account 7144) and Minnesota Care Managed Care Patient Charges (account 7147).

#7259   Total Commercial Insurers, Nonprofit Health Plans, and Private (Non-Public Programs) Patient Charges:
- Commercial insurers include insurers, corporations, or associations providing health insurance such as Allstate, State Farm, etc.
- Nonprofit corporation insurers such as Blue Cross Blue

#0847   Other Payers: Patient Charges: This category is for the payers that are not already identified in the breakouts for Medicare, MA/PMAP, MinnesotaCare, Commercial and Private, and Individual (Self Pay). This would include Champus, Workman's Comp., Auto, etc. for each of the respective sections: Adjustments, Charges, Days, and Admissions. Please note that Commercial and Private payers are *not* reported on the Other Payers lines.

A managed care organization is defined in Minnesota Statutes, Chapter 62Q.01, subd. 5, as **(1)** a health maintenance organization operating under chapter 62D; **(2)** a community integrated service network as defined under section 62N.02, subdivision 4a; or **(3)** an insurance company licensed under chapter 62A, **(4)** a nonprofit health service plan corporation operating under 62C, **(5)** a fraternal benefit society operating under chapter 64B, or **(6)** any other health plan company, to the extent that it covers health care services delivered to Minnesota residents through a preferred provider organization or a network of selected providers.

"Managed Care Organizations Adjustments & Uncollectibles" includes adjustments for such organizations as HMOs and insurance companies delivering care through a PPO or provider network. Below is a partial listing of some of these organizations in Minnesota:
- Blue Plus
- Medica
- First Plan of MN
- Metropolitan Health Plan
- HealthPartners
- Group Health, Inc.
- UCARE MN
- PreferredOne Community Health Plan
- Sanford Health Plan of Minnesota.

The far right column on the formset shows a link labeled "Audit Check." Clicking on this link will take you to another tab in the workbook where you can review your adjustments to charges ratio. This is for your information only to aid you in completion of the formset. If your hospital does not fall within the stated ranges, you may be contacted by MHA staff for possible corrections.

#7260 Total Medicare Adjustments: Summary of two subsequent accounts: Medicare Adjustments (Non-Managed Care) and Medicare Managed Care Adjustments.
#0741 Medicare Adjustments (Non-Managed Care): Difference between Patient Charges billed to and payments received from Medicare intermediaries such as Noridian Administrative Services for Medicare Patients only.

MDH is frequently asked to provide data on the utilization and financial trends for MA and MinnesotaCare. Eligibility and payment policies related to these programs vary greatly. It is important that these categories be separated, so that we have the ability to analyze trends by program types particularly as eligibility for the programs change. This information is frequently requested by legislators and other state analysts to assist them in policy formation on a program level. With recent budget cuts, these requests have increased in frequency. This information needs to be collected separately, by program, for us to fulfill requests for data and to describe trends for each program.

#7263 Total MA/PMAP Adjustments: Total Adjustments for Medical Assistance and Prepaid Medical Assistance Program accounts. This should be the sum of MA Adjustments (Non-Managed Care) (account 7136) and PMAP Managed Care Adjustments (account 7139).
#7136 MA Adjustments (Non-Managed Care): Difference between Patient Charges billed to the

Minnesota Department of Human Services and payments received from DHS for non-PMAP Medicaid Patients only.

#7139 PMAP Adjustments: Difference between Patient Charges billed to and payments received from third party administrators for PMAP (Prepaid Medical Assistance Program) Medicaid Patients only.

#7266 Total MinnesotaCare Adjustments: This should be the sum of MinnesotaCare Adjustments (Non-Managed Care) (account 7138) and MinnesotaCare Managed Care Adjustments (account 7141)

#7138 MinnesotaCare Adjustments (Non-Managed Care): Difference between Patient Charges billed to the Minnesota Department of Human Services and payments received from DHS for non-PMAP MinnesotaCare Patients only.

#7141 MinnesotaCare Managed Care Adjustments: Difference between Patient Charges billed to and payments received from third party administrators for Prepaid MinnesotaCare Patients only.

#7269 Total Commercial Insurers, Nonprofit Health Plans, and Private (Non-Public Programs) Patient Adjustments:
- Commercial insurers include insurers, corporations, or associations providing health insurance such as Allstate, State Farm, etc.
- Nonprofit corporation insurers such as Blue Cross Blue Shield

#7410 Self Pay Discounts: This category *includes* discounts for persons who qualify for partial-bill or sliding scale discounts under a provider's policy that provides discounts to the uninsured. This includes discounts applied to those that qualify for a discount under the Fair Price for the Uninsured agreement with the Minnesota Attorney General's office. *Do not include* prompt pay discounts or staff courtesy discounts; these should be recorded under Other Payers Adjustments and Uncollectibles (#0751).

Self Pay discounts *should be* reported under (#0762) Charity Care Adjustments if the discount is specifically included in your hospital's Charity Care policy. If a self pay discount is included in (#0762) Charity Care, *do not* report the amount in (#7410) Self Pay Discounts.

Example 1: If an uninsured patient is eligible for a self pay discount of 10%, but is not eligible for charity care, record the 10% discount in (#7410) Self Pay Discounts.

Example 2: If an uninsured patient is eligible for a self pay discount of 10% and also eligible for charity care under your hospital's charity care policy for the rest of their bill, include 100% of the charge in (#0762) Charity Care Adjustments. Do not include any part of the bill in (#7410) Self Pay Discounts.

#7570 Self Pay Discount Percentage Applied: *This is a non-public item.* The percentage applied to self pay patient charges based on AG agreement to apply discount of most favored payer.

#0762 Charity Care Adjustments: The total dollar amount that would have been charged by a facility for rendering health care services for which the facility *did not expect payment*. Charity care results from a provider's policy to provide health care services to individuals who meet the providers established criteria of inability to pay.

Self Pay discounts *should be* reported under (#0762) Charity Care Adjustments if the discount is specifically included in your hospital's Charity Care policy. If a self pay discount is included in (#0762) Charity Care, *do not* report the amount in (#7410) Self Pay Discounts.

Please break out Charity Care amounts from insured (#7571) and uninsured patients (#7572). For uninsured patients, also break out the amounts where the hospital has forgiven the *entire bill* (#7573) from where the hospital has applied a *partial discount* (#7574) to the bill. If an uninsured patient is eligible for a self pay discount and full charity care under the hospital's charity care policy, record the entire charge in (#7573) Full Charity Care. If an uninsured patient is eligible for a self pay discount and a partial charity care discount under the hospital's charity care policy, record the total amount of the self pay discount and partial charity care discount in (#7574) Partial Charity Care.

Charity care is a *required* field in the HAR and *cannot* be reported in 8100 Bad Debt Expense.

Example 1: If an **uninsured** patient is determined to be eligible for charity care and is not asked to pay *any* portion of the bill, record the full amount in Charity Care Adjustments (#0762). Be sure to *also record* in Full Charity Care (#7573). If the uninsured patient is eligible for full charity care and a self pay discount, record the full amount of the charge in (#0762) Charity Care Adjustments and in (#7573) Full Charity Care; *do not record* any amount of the charge in Self Pay Discounts (#7410).

Example 2: If an **uninsured** patient is determined to be eligible for a charity care discount of 60% and is asked to pay the remaining 40%, record the 60% discount in charity care adjustments (#0762). Be sure to *also record* in Partial Charity Care (#7574).

Example 3: If an **uninsured** patient is determined to be eligible for a self pay discount of 10%, a charity care discount of 50%, and is asked to pay the remaining 40% of the charge, record the 60% discount in Charity Care Adjustments (#0762). Be sure to *also record* the 60% discount in Partial Charity Care (#7574). *Do not record* any part of the discount in Self Pay Discounts (#7410) if the uninsured patient is eligible for charity care under your hospital's Charity Care policy.

Example 4: If an **insured** patient is unable to pay their portion of the bill (deductible, co-insurance, co-payment) and is eligible for charity care and not asked to pay *any* part of *their portion* of the bill, record the *full patient portion* of the bill under Charity Care Adjustments (#0762). Be sure to *also record* in Insured Patients Charity Care (#7571).

Example 5: If an **insured** patient is unable to pay their portion of the bill and is eligible for a 30% charity care discount on *their portion* of the bill, record the 30% discount on the patient portion of the bill in Charity Care Adjustments (#0762). Be sure to *also record* in Insured Patients Charity Care (#7571).

#7575 Average Partial Charity Care Discount Applied: What is the average partial discount applied to Uninsured Patients who qualify for a partial charity care discount under your hospital's Charity Care Policy. Include self pay discounts in this calculation that are included in your hospital's Charity Care Policy.

#8100 Provision for Bad Debts: The provision for actual or expected doubtful accounts resulting from the extension of credit. This includes the total dollar amount charged for health care services that were provided for which there was an expectation of payment. *Do not include* charity care or self pay discounts in this category; only include the portion of the charge for which there was

an expectation of payment.

In determining whether to classify charity care as bad debt expense, the facility must consider the following points:

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

B. The facility may include as bad debt expense unpaid deductibles, co-insurance, co-payments, and charges for non-covered services and any other unpaid patient responsibilities.

Example 1: If an **uninsured** patient receives a self pay discount of 10% and is expected to pay 90% of the charge, record the 10% as a Self Pay Discount (#7410). If the patient ***does not pay*** the remaining 90% of the bill for which there was an expectation of payment, record that amount in Provision for Bad Debts (#8100). Be sure to ***also record*** in (#7567) Bad Debt Write Offs and in (#7569) Bad Debt Write Offs for Uninsured Patients, the amount that was actually written off as bad debt during the fiscal year. ***Do not reclassify*** the 10% self pay discount as bad debt.

Example 2: If an **insured** patient receives a charity care discount of 20% off of their deductible amount of $5,000 and they are expected to pay the remaining 80%, record the 20% or $1,000 discount in charity care adjustments (#0762). If the insured patient ***does not pay*** the remaining 80% or $4,000, record $4,000 in provision for bad debts (#8100). Be sure to ***also record*** in (#7567) Bad Debt Write Offs and in (#7568) Bad Debt Write Offs for Insured Patients, the amount that was actually written off as bad debt during the fiscal year. ***Do not reclassify*** the $1,000 charity care adjustment as bad debt.

#0751 Other Payers Adjustments and Uncollectibles: This category is for the payers that are ***not already identified*** in the breakouts for Non-Managed Care, Managed Care, and Individual (Self Pay). This would ***include*** Champus, Workman's Comp., Auto, etc. for each of the respective sections: Adjustments, Charges, Days, and Admissions. Please note that Commercial and Private payers are ***not*** reported on the Other Payers lines. This category also ***includes*** small balance write offs, staff courtesy discounts, and prompt pay discounts.

Section 15: Inpatient/Outpatient Adjustment Summary HAR p. 7

#0752 Inpatient Adjustments & Uncollectibles: Calculation of the Adjustment & Uncollectible percentage of the hospital Inpatient Charges. This is automatically calculated. Calculation: (0851/0860)*0760.

#0754 Outpatient Adjustments & Uncollectibles: Calculation of the Adjustment & Uncollectible percentage of the hospital Outpatient Charges. This is automatically calculated. Calculation: (0853/0860)*0760.

Section 16: Natural Expense Summary HAR p. 8

#0601 Salaries and Wages: Salaries and wages should include only actual W-2 earnings. These salaries should reflect only the hospital portion of staff allocations between the hospital and affiliated organizations such as a nursing home or clinic.

#0625 Malpractice Expenses: 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.

#0622 Medical Care Surcharge: The expenses incurred under Minnesota Statute, section 256.9657, subdivision 2. For purposes of reporting, medical care surcharge is an operating expense.

#0623 MinnesotaCare Tax: Expenses for the MinnesotaCare tax under Minnesota Statutes, section 295.52 and 295.582.

#0619 Other Expenses: Other expenses should encompass any residual hospital specific expenses not included in the other distinct natural expense classifications. A lump sum allocation of all expenses to an affiliated entity may not be netted into this line but must be properly designated to their correct expense categories. This figure *cannot* be negative.

Section 17: Bad Debt Write Offs HAR p. 8

#7567 Bad Debt Write Offs: The amount of actual write offs for bad debt. Please break out actual bad debt write offs from insured (#7568) and uninsured (#7569) patients. Amounts in these categories will be used to estimate the insured and uninsured portions of (#8100) Provision for Bad Debts.

Section 18: Administrative Expenses (Hospital Only) HAR p. 9

NOTE: The information reported in this section is classified as *non-public* data according to Minnesota Statutes, section 62J.321. This means it is not available to the public unless in aggregate form.

The requirement for reporting administrative expenses differs depending on a hospital's number of licensed beds.
- Hospitals with fewer than 50 beds are required to report Total Administrative Expenses (Account 0630) only.
- Hospitals with 50 beds or greater are required to report Total Administrative Expenses (Account 0630) *and* expenses by functional categories (Accounts 0632-0641).

Report *hospital only* information. Record all direct and indirect expenses related to the line items listed below. Include Cost of Regulatory and Compliance Reporting, MIS, and Plant, Equipment and Occupancy Expenses as appropriate in Administrative Expenses.

The far right column on the formset shows a link labeled "Audit Check." Clicking on this link will take you to another tab in the workbook where you can review your Administrative Costs as a Percentage of Total Expense. This is for your information only to aid you in completion of the formset. If your hospital does not fall within the stated ranges, you may be contacted by MHA staff for possible corrections.

#0632 Admitting, Patient Billing and Collection Expenses: All of the costs related to inpatient and

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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 collections functions. Expenses allocated back to the hospital relating to Medical Records, Coding, and/or Billing that are performed for a specific hospital through a Home Office or other similar entity should be reported in account 0632. Report all direct and indirect expenses **and** allocated amounts of 0637, 0650, and 0655 (if applicable).

#0634   Accounting and Financial Reporting Expenses: All costs related to fiscal services, such as general accounting, budgeting, cost accounting, payroll accounting, accounts payable, fixed asset accounting, and inventory accounting. Report all direct and indirect expenses **and** allocated amounts of 0637, 0650, and 0655 (if applicable).

#0635   Quality Assurance and Utilization Management Program/Activity Expenses: 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 credential review, and all other medical care evaluation activities. Report all direct and indirect expenses **and** allocated amounts of 0637, 0650, and 0655 (if applicable).

#0636   Community Wellness and Education Expenses: All the 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 do not include patient education programs. Report all direct and indirect expenses **and** allocated amounts of 0637, 0650, and 0655 (if applicable).

#0639   Promotion and Marketing Expenses: All cost related to marketing, promotion, and advertising activities such as billboards, yellow page listing, 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. Report all direct and indirect expenses **and** allocated amounts of 0637, 0650, and 0655 (if applicable).

#0647   Taxes, Fees, and Assessments: 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. Report all direct and indirect expenses **and** allocated amounts of 0637, 0650, and 0655 (if applicable).

#0648   Malpractice Expenses: 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. Report all direct and indirect expenses **and** allocated amounts of 0637, 0650, and 0655 (if applicable).

#0641   Other Administrative Expenses: 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, donation and support, direct and in-kind, for the purpose of lobbying and influencing policy makers 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 analyzing governmental policies. Other administrative expenses *does not* include the costs of public relations included in promotion and marketing expenses, the cost of legal staff already allocated to other functions, or the costs of medical records, social services, and nursing administration. Report all direct and indirect expenses *and* allocated amounts of 0637, 0650, and 0655 (if applicable).

#0630 Total Administrative Expenses: The sum of the following expenses:
- Admitting, patient billing, and collections (Account 0632)
- Accounting and financial reporting (Account 0634)
- Quality assurance and utilization management program or activity (Account 0635)
- Community and wellness education (Account 0636)
- Promotion and marketing (Account 0639)
- Taxes, fees, and assessments (Account 0647)
- Malpractice (Account 0648)
- Other administrative expenses (Account 0641)

Section 19: Cost of Regulatory and Compliance Reporting HAR p. 9

The information reported in this section is classified as *nonpublic* data according to Minnesota Statutes, section 62J.321. This means it is not available to the public unless in aggregate form.

Note: Whenever reasonably possible, you are required to report *actual* numbers. If it is not reasonably possible, you may estimate using reasonable methods. Upon request, you must provide a written explanation of the method used for the estimate.

#0637 Total Cost of Regulatory and Compliance Reporting Expenses: 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. The portion of Account 0637 that is administrative expenses is to be reported in the breakouts of Account 0630 *and* included in the total of Account 0637.

Section 20: MIS and Occupancy Expenses HAR p. 9

The information reported in this section is classified as *nonpublic* data according to Minnesota Statutes, section 62J.321. This means it is not available to the public unless in aggregate form.

This section establishes the costs related to maintaining and operating a data processing system and the costs associated with plant, equipment and occupancy. The amounts reported for these accounts include the total estimated costs for *hospital only* expenses.

#0650 Total Management Information System Expenses: 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. The portion of Account 0650 that is administrative expenses is to be reported in the breakouts of Account 0630 *and*

included in the total of Account 0650.

#0655 Total Plant, Equipment, and Occupancy Expenses: 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 include interest expenses and depreciation. The portion of Account 0655 that is administrative expenses is to be reported in the breakouts of Account 0630 **and** included in the total of Account 0655.

Section 21: Community Benefit Summary HAR p. 10

General Guidelines

- For hospital systems, report community benefits at the facility level, using reasonable methods to allocate costs and associated offsets across facilities;
- Follow generally accepted accounting practices (see publications by the Health Care Financial Management Association) and industry standards for the accounting of community benefits (CHA/VHA);
- With the exception of "community care" and "underpayments for services provided under State Health Care Programs," always report the actual costs of services, activities and programs;
- For facilities that do not operate cost accounting systems, use reasonable, consistent methods to arrive at the actual cost of services, activities, and programs;
- Report any offsetting revenues to assure that the difference between reported cost and offsets accurately represents internal resources made available by the facility for supporting community benefits;
- Avoid double-counting of community benefit cost.

Cost-to-Charge Ratio
In section 21, the cost-to-charge ratio (CCR) is used to adjust charge data reported elsewhere in this report by hospitals. The CCR is the quotient of total operating expenses (0600) and the sum of total revenue from patient care services (total charges, 0740) and other operating revenue (0740).

#7310 Community Care: The cost for medical care that a hospital has determined is charity care as defined under Minnesota Rules, part 4650.0115, or for which the hospital determines after billing for the services that there is a demonstrated inability to pay. Any costs forgiven under a hospital's community care or charity care plan or under Minnesota Statutes, section 62J.83 may be counted in the hospital's calculation of "community care." "Community care" does not include bad debt expenses and discounted charges available to the uninsured.

For the purposes of reporting under section 21, "community care" will be charity care (0762) adjusted by a cost to charge ratio. *This field is a calculated field, no user input is necessary.*

#7577 Underpayments for Services Provided under State Health Care Programs: Estimates of payment shortfalls for services provided under the following State Health Care Programs, where state government directly sets payment rates: Medicaid, PMAP and MinnesotaCare.

For the purposes of reporting under section 21, "underpayments for services provided under State Health Care Programs" are calculated by subtracting payments for State Health Care Programs (the sum of patient charges and contractual adjustments) from the product of patient charges for State Health Care Programs and the cost-to-charge ratio. *This field is a calculated field, no user input is necessary.*

#7578   Cost of Operating Subsidized Services: The cost associated with providing hospital patient services that are operated at a significant financial loss. Only include such services that meet all of the following criteria: a) exhibit negative margins even after the effects of charity or community care (7310) and Medicaid shortfalls (7557) have been removed; b) represent an actual community benefit; c) if discontinued at the facility, would be unavailable in the area or fall to the responsibility of other providers or government agencies. Do not include potential payment shortfalls associated with care for Medicare patients.

#7579   Education Cost: The cost of operating professional education and training programs and providing financial assistance to physicians, medical students, nurses, nursing students, and other health professionals. Only include Medicare Indirect Medical Education (IME) payments if the Medicare IME reimbursements are included as offsets. Do not include costs associated with providing continuing medical education (CME), financial assistance or tuition reimbursements that are offered as employee benefits, or the as cost of required education or employee orientation programs.

#7580   Research Cost: The cost of conducting research that is intended for the public domain and falls in one of the following three areas: clinical research, community health research, and research on innovative health care delivery.

#7581   Community Health Services Cost: The total cost of activities to improve community health in the following areas:
   1)   Providing community health education, including classes, support groups and self-help programs.
   2)   Offering community-based clinic services and mobile units that are outside of the primary business activities of the facility.
   3)   Providing health care support services in the form of enrollment assistance, information and referral.

   Do not include the cost of activities whose primary purpose are marketing or directly associated with hospital patient care or discharge planning.

#7582   Financial and In-Kind Contributions: The total of value of cash and in-kind contributions made by the facility to health care organization and community groups to improve the health of the community. In-kind contributions include goods and services donated or provided for an activity without compensation. Do not count volunteer contributions by employees or emergency funds provided to employees. Also, do not include the cost of promotional and marketing activities.

#7583   Cost of Community Building Activities: The value of programs and activities that, while not directly related to health care, are designed to address root causes of health problems in the community. Programs and activities may include physical improvements to the neighborhood and housing

stock, investments in economic development, support of the operational structure of communities and community networks, environmental improvements, and advocacy for health improvements. Do not include the value of activities that are undertaken primarily for marketing purposes. Also, do not include investments in facility construction and improvement and the cost of routine financial investments.

#7584 Cost of Community Benefit Operations: The overhead cost associated with operating a community benefit program. This may include the cost associated with maintaining dedicated community benefit staff, conducting community benefit and community asset assessments, and designing a community benefit strategy. Do not count the cost of staff to coordinate in-house volunteer programs, including outpatient volunteer programs. Do not count the cost of conducting market share and marketing analyses.

#7586 - **#7592** Offsets for the Cost of Community Benefit Activities: All revenue that is received by the facility to support community benefit programs and activities, including, but not limited to, the value of grants and donations that are restricted for support of these activities, and revenue that is received as cost offset from foundations and unrelated entities. Also, include revenue that hospitals receive through fees from conducting community benefit activities.

Section 22: Charity Care Summary HAR p. 10

Enter the number of charity care contacts and the corresponding amount of charity care provided by the breakouts of the family income of the patient in relation to the Federal Poverty Guideline (FPG).

Charity Care Contacts should be counted as 1 contact per Outpatient visit and 1 contact per Inpatient stay.

Note: The amount entered in #7057 should be the absolute value of the amount reported in account #0762. Charity care #7057 should be reported as a *positive* number.

Section 23: Physician Services Schedule HAR p. 11

This supplemental information will be provided to the Department of Human Services (DHS), the agency that is responsible for administration of the Medical Care Surcharge, for their consideration. It is the responsibility of DHS and the legislature to determine criteria for taxation and which data items will be used in the calculation of the Medical Care Surcharge.

This section provides a schedule for reporting Physician Services revenues, which are revenues received by the hospital for services performed by physicians who are employees of the hospital, and/or revenues for physician services billed and received by the hospital when contractual agreements or arrangements stipulate payment to physicians by the hospital through a set fee or other compensation (ex: ER phys fees, radiologist, pathologist, anesthesiologist, EKG/EEG physicians). Administrative agreements in which the hospital processed physician bills, which are paid to the physician, *do not* constitute physician services revenue nor should it be included in total hospital revenue.

In order to report in this schedule, physician charges, discounts, uncollectibles and bad debt must be included in the following accounts: charges (accounts #0740 and #0841), discounts and uncollectibles (accounts #0760 and #0741), and bad debt (account #8100). In addition, if there are Managed Care Organization patient charges (account #0842), there **must** be corresponding Managed Care Organization patient adjustments (account #0742).

#7117 Inpatient Gross Physician Charges: includes all Physician patient service charges provided to admitted inpatients of the hospital.
#7118 Outpatient Gross Physician Charges: includes all Physician patient service charges provided to registered outpatients of the hospital.
#7087 Physician Expense: includes direct expenses (i.e., Salaries, Benefits and Purchased Services) incurred through the contractual agreement with physicians providing professional services for hospital patients. Only expenses for physicians who bill for their services under accounts 5501 and 0740 can be considered in this line (ex: ER Physicians). Estimates of expenses based on hospital revenue percentages may be substituted if actual expenses are unavailable.

Section 24: Other Billable Professional Services Schedule HAR p. 11

This supplemental information will be provided to the Department of Human Services (DHS), the agency that is responsible for administration of the Medical Care Surcharge, for their consideration. It is the responsibility of DHS and the legislature to determine criteria for taxation and which data items will be used in the calculation of the Medical Care Surcharge.

This section provides a schedule for reporting Other Billable Professional Services revenues, which are revenues received by the hospital for services performed by other billable professionals who are employees of the hospital, and/or revenues for other billable professional services billed and received by the hospital when contractual agreements or arrangements stipulate payment to other billable professionals by the hospital through a set fee or other compensation. (Administrative agreements in which the hospital processed other billable professionals bills, which are paid to the other billable professional, do not constitute other billable professionals services revenue nor should it be included in total hospital revenue.)

Other Billable professional services include revenues from billable mid-level practitioners whose scope of practice allows them to practice independent of direct physician supervision (ex: CRNA, nurse practitioner). This applies to billable mid-level practitioners, whether they are employed by the hospital or under contract with the hospital, where the charges are billed and received by the hospital, unless the hospital acts merely as a billing agent.
In order to report in this schedule, other billable professional charges, discounts, uncollectibles and bad debt must be included in the following accounts: charges (accounts #0740 and #0841), discounts and uncollectibles (accounts #0760 and #0741), and bad debt (account #8100). In addition, if there are Managed Care Organization patient charges (account #0842), there **must** be corresponding Managed Care Organization patient adjustments (account #0742).

#7119 Inpatient Gross Other Billable Professional Charges: includes all Other Billable Professional patient service charges provided to admitted inpatients of the hospital.

#7120 Outpatient Gross Other Billable Professional Charges: includes all Other Billable Professional patient service charges provided to registered outpatients of the hospital.

#7088 Other Billable Professional Expense: includes direct expenses (i.e., Salaries, Benefits and Purchased Services) incurred through the contractual agreement with CRNAs, PAs, NPs or Midwives providing services for hospital patients. Only expenses for other professionals who bill for their services under accounts 7061 and 0740 can be considered in this line. Estimates of expenses based on hospital revenue percentages may be substituted if actual expenses are unavailable.

Section 25: Reference Lab/Reference Radiology Services Schedule HAR p. 12

This supplemental information will be provided to the Department of Human Services (DHS), the agency that is responsible for administration of the Medical Care Surcharge, for their consideration. It is the responsibility of DHS and the legislature to determine criteria for taxation and which data items will be used in the calculation of the Medical Care Surcharge.

This section provides a schedule for reporting Reference Lab/Reference Radiology revenues, which are revenues received by the hospital for services performed by the hospital's lab or radiology department for patients that are neither admitted inpatients nor registered outpatients of the hospital.

In order to report in this schedule, Reference Lab/Reference Radiology charges, discounts, uncollectibles and bad debt must be included in the following accounts: charges (accounts #0740 and #0841), discounts and uncollectibles (accounts #0760 and #0741), and bad debt (account #8100). In addition, if there are Managed Care Organization patient charges (account #0842), there **must** be corresponding Managed Care Organization patient adjustments (account #0742).

#7085 Reference Lab/Reference Radiology Expense: includes direct expenses incurred by the hospital in providing outside Lab/Radiology services for non-hospital patients. These services are usually provided under a contractual basis with other organizations such as clinics, nursing homes, neighboring hospitals and other health care providers. Types of expenses include direct costs such as salaries, benefits, supplies, purchased services, etc. Calculations of expenses based on the Lab Cost to Charge Ratio found in the Medicare Cost Report, Worksheet C, Part I applied to Gross Reference Lab/Reference Radiology Charges may be used. Estimates of expenses based on hospital revenue percentages may be substituted if actual expenses are unavailable.

Section 26: DME/Retail Pharmacy Supplies Services Schedule HAR p. 12

This supplemental information will be provided to the Department of Human Services (DHS), the agency that is responsible for administration of the Medical Care Surcharge, for their consideration. It is the responsibility of DHS and the legislature to determine criteria for taxation and which data items will be used in the calculation of the Medical Care Surcharge.

This section provides a schedule for reporting DME (Durable Medical Equipment) and/or Retail Pharmacy Supplies revenues, which are revenues received by the hospital for services provided by the

hospital for patients that are neither admitted inpatients or registered outpatients of the hospital.

In order to report in this schedule, DME and/or Retail Pharmacy Supplies charges, discounts, uncollectibles, and bad debt must be included in the following accounts: charges (accounts #0740 and #0841), discounts and uncollectibles (accounts #0760 and #0741), and bad debt (account #8100). In addition, if there are Managed Care Organization patient charges (account #0842), there *must* be corresponding Managed Care Organization patient adjustments (account #0742).

#7086 Durable Medical Equipment (DME)/Retail Pharmacy Expense: includes direct expenses incurred by the hospital in providing DME/Retail Pharmacy services for non-hospital patients. These services are provided to non-hospital patients usually on a cash basis. Types of expenses include direct costs such as salaries, benefits, supplies, pharmaceutical drugs, purchased services, etc. Calculations of expenses based on the DME or Pharmacy Cost to Charge Ratio found in the Medicare Cost Report, Worksheet C, Part I applied to Gross DME/Retail Pharmacy Charges may be used. Estimates of expenses based on hospital revenue percentages may be substituted if actual expenses are unavailable.

Section 27: Hospital Employed Staffing by Employee Classification HAR p. 13

This section requires you to report W-2 salaries, FTEs, and FTE vacancies by designated employee classifications.

Note: Report *only* the number of FTEs in the corresponding employee classifications for which salaries and wages are reported.

In many cases, an institution shares staff between the hospital and another facility such as a nursing home. The salaries & wages and corresponding FTEs reported in this section should reflect only the average percentage of time devoted *to the hospital* for those shared staff members employed by the institution. For example, a physical therapist that is employed by the institution as a full-time employee, but devotes 50% time to the hospital and 50% time to the nursing home, should be reported in this section as .5 FTE and 50% of the physical therapist's salary & wages should be allocated to the hospital.

Full-Time Equivalent Employee (FTE): An employee or any combination of employees that are paid by the facility for 2,080 hours of employment per year.

FTE Vacancies: Any *budgeted* position (based on 2,080 hours or a percentage of 2,080 hours) that was unused during the fiscal year.

The far right column on the formset shows a link labeled "Audit Check." Clicking on this link will take you to another tab in the workbook where you can review your average salary per FTE. The average range is also noted for you to compare your hospital with the state average. This is for your information only to aid you in completion of the formset. If your hospital does not fall within the stated ranges, you may be contacted by MHA staff for possible corrections.

Employee Classifications:

Nurse Anesthetist (Accounts 2121/2131/2171): The qualifications generally required for a nurse anesthetist include graduation from an accredited school of nursing, graduation from an accredited program in nurse anesthesia, current licensure by the Minnesota Board of Nursing as a registered nurse, and certification as a CRNA by the American Association of Nurse Anesthetists.

Nurse Practitioner (Accounts 2026/2036/2076): The qualifications generally required for a nurse practitioner include graduation from an accredited school of nursing, current licensure by the Minnesota Board of Nursing as a registered nurse, and certification as a nurse practitioner.

Nursing Assistant/Aide (Accounts 2023/2033/2073): The qualifications generally required for a nursing assistant/aide include completion of an accredited nursing assistant training program and registered as a nursing assistant.

Pharmacist (Accounts 2027/2037/2077): The qualification generally required for a pharmacist is graduation from an accredited 5-year program in pharmacy. This classification includes pharmacists only. Pharmacy technicians and other pharmacy personnel should be included in the All Other Personnel classification (accounts 2128/2138/2177).

Physician (Accounts 2024/2034/2074): Includes medical interns, medical residents, and all other physicians (Doctors of Medicine or Doctors of Osteopathic Medicine) in all physician specialties. Any "mid-level" physicians (podiatrist, optometrist, psychologist and social worker) should be reported in the All Other Personnel accounts.

Physician Assistant (Accounts 2028/2038/2078): The qualifications generally required for a physician assistant include Minnesota registration to practice as a physician assistant and national certification by the National Commission of Physician Assistants.

Occupational Therapists (Accounts 2122/2132/2172): The qualifications generally required for an occupational therapist include a bachelor's degree, registration as an occupational therapist with the American Occupational Therapy Association, and registered with the State of Minnesota as an occupational therapist.

Physical Therapist (Accounts 2123/2133/2173): The qualifications generally required for a physical therapist include being registered with the Minnesota State Board of Medical Examiners as a physical therapist.

Imaging Technician (Accounts 2125/2135/2175): Includes all imaging technicians, including x-ray, CT, MRI, PET, etc.

Laboratory Technologist/Technician (Accounts 2125/2135/2175): This classification includes both laboratory technologists and technicians.

All Other Patient Specialists (Accounts 2104/2114/2194): This classification includes all direct patient care related specialists. This includes technicians and technologists, care coordinators, specialists and patient care assistants that are not represented in other employee classification categories. Some examples of technicians in this classification include: Surgery Tech, Emergency Room/Department Tech,

Pharmacy Tech, Cardio Tech, etc. This category should not include Lab Techs and Imaging Techs, which should be represented in specifically identified categories.

Administrator (Account 2176): Record any budgeted position that has been unfilled during the fiscal year. Please only report the Administrator/CEO. The Chief Medical Officer, Chief Information Officer, etc. should be reported in the All Other Personnel accounts.

All Other Personnel (Accounts 2128/2138/2177): This classification includes salaries & wages and FTEs for employees not specifically designated by the other employee classifications such as hospital administrative staff, dietary staff, housekeeping, etc.

Section 28: Hospital Employed Staffing by Employee Classification HAR p. 13

This section asks for actual *employees* rather than FTEs. The total number of employed staff on this page will *not* tie to the total number of FTEs on page 13. The employed staff figure will be a larger number.

- List the total number of active employees in their appropriate categories as of the last pay period of the fiscal year.
- In some cases, an institution shares staff between the hospital and another facility such as the nursing home. This probably does not affect the total number of hospital employees.
- For definitions of the Employee Classifications, please reference Section 27, starting on page 28 of the Instructions.

Section 29: Consultant/Contract Staffing by Employee Classification HAR p. 14

This section asks for amounts of contract dollars and the associated FTEs covered by that contract.

- List the total contract dollars and the number of Contract FTEs in their appropriate categories as of the last pay period of the fiscal year.
- For definitions of the Employee Classifications, please reference Section 27, starting on page 28 of the Instructions.

Section 30: Physicians with Admitting Privileges HAR p. 14

#4530 Physicians with Admitting Privileges: List only licensed physicians who have applied and been granted admitting privileges by the hospital's Board of Directors.

Section 31: Teaching Hospital Medical Education Expenses HAR p. 14

Questions concerning Medical Education Expenses should be directed to MERC, Health Policy Division at the Minnesota Department of Health at (651) 201-3566 or diane.reger@state.mn.us.

#5101 Full-Time Equivalent Resident: 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.

#5102 Resident Salaries and Benefits: 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.***

Section 32: Research Hospital Research Expenses HAR p. 14

#5200 Research Expenses: 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.

Section 33: Emergency Services/Department HAR p. 15

This section requires you to report information about your hospital's emergency services department.

Section 34: Summary of Outpatient Registrations HAR p. 15

Outpatient registrations represent the number of outpatient registrations as tabulated according to your hospital's established system. If modifications have been made to your hospital's registration system that result in a new method of counting, the modification should be documented and explained in the report.

The far right column on the formset shows a link labeled "Audit Check." Clicking on this link will take you to another tab in the workbook where you can review your Average Charge per Registration. The average charge is compared against last year's average charge for your hospital. This is for your information only to aid you in completion of the formset. If your hospital does not fall within a variance of 25% from prior year, you may be contacted by MHA staff for possible corrections.

#4503 Total Number of Emergency Room Registrations (does not include those patients that leave before seeing a physician): This should represent the total number of ER visits ***including*** those admitted to the hospital. This ***does not*** include any patients that have been triaged and leave before seeing a physician.

#4505 Outpatient Surgery Registrations: Gastric Scopes should be included in 4505 Outpatient Surgery

Registrations.

#4502 All Other Outpatient Registrations: Exclude the number of home health care and hospice visits.

#4501 Total Outpatient Registrations: An 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, observation 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. (Minnesota rules, part 4650.0102, subp. 30) Upper and lower GI outpatient diagnostic procedures (colonoscopy, sigmoidoscopy, etc.) should **not** be included in this account but in Outpatient Surgery Registrations (account 4505). Exclude the numbers of home health care and hospice visits.

#7044 Total Number of Patients Admitted to the Hospital through the Emergency Department: This is a subcategory of account 4503 and is *required when applicable*.

#7311 Total Number of Emergency Room Registrations that leave before seeing a physician (these are not included in 4503): This should represent the total number of ER visits that have registered, been triaged, and leave prior to being seen by a physician. Reporting this is OPTIONAL.

Section 35: Total Admissions by Hospital Service HAR p. 16

Enter the admissions by category including admissions for swing bed care, Subacute/transitional care and births.

If you report admissions, you must also report corresponding patient days and patient charges.

Please note that if you checked "no" in Section 9: "Patient Care Charge Summary" to the question "Do you want MHA to report your hospital's service line details from the UB Data Project?," you will need to complete sections 58-62 on the "Service Line Data" tab. If you checked "yes", charges, days, and admissions service line information will be supplied by MHA through the UB Data project.

Section 36: Top Ten Hospital DRGs by Total Discharges HAR p. 16

The detail reporting for this section has been moved to the "Service Line Data" tab in the HAR Formset. This section requires you to report the top ten DRGs for your hospital. The top ten DRGs are to be determined according to the *total number of discharges per DRG*. The DRG with the largest number of discharges is to be reported as number one, the DRG with the next largest number of discharges as number two, etc. in descending order. You are also required to report the associated total gross charges for each of the top ten DRGs reported.

Reporting this information is *mandatory*.

If your hospital voluntarily reports to the UB data project (Minnesota Health Information Network - MHIN) sponsored by MHA, then MHA can report the DRG information (section 64 on the "Service Line

Data" tab) for your hospital with your permission. If you want MHA to report this information for your hospital, you must check the box provided in the report. If you check this box, leave section 64 blank on the "Service Line Data" tab.

If your hospital **does not** report to the UB data project cited above **or** you choose not to have MHA report for you, you must report this information yourself. When you check "no", a blue hyperlink will appear to the right of the check box which will take you to the appropriate area to complete.

If you are unable to determine the actual total gross charges associated with each DRG, you may estimate using a reasonable method. One methodology is to determine an average charge per discharge for each DRG by taking a sample of bills for each DRG, totaling the charges and dividing by the number of bills. Multiply the average charge you calculated for the DRG by the total number of discharges for that DRG and the product is an estimated gross charge for the DRG. Other methods of estimation are acceptable if based on reasonable methods. Upon request, your facility must provide a written explanation of the method used for the estimate(s).

Section 37: Patient Days by Hospital Service HAR p. 16

Enter the patient days by category including patient days for nursery, swing bed care and subacute/transitional care.

If you report patient days, you must also report corresponding charges and admissions.

Please note that if you checked "no" in Section 9: "Patient Care Charge Summary" to the question "Do you want MHA to report your hospital's service line details from the UB Data Project?", you will need to complete sections 58-62 on the "Service Line Data" tab. If you checked "yes", charges, days, and admissions service line information will be supplied by MHA through the UB Data project.

Section 38: Acute Admissions by Primary Payer HAR p. 17

Enter the admissions by category excluding admissions for swing bed care, Subacute/transitional care and births.

#4370 Total Medicare Admissions: Summary of two subsequent accounts: Medicare
Admissions (Non-Managed Care) and Medicare Managed Care Admissions.
#7184 Medicare Managed Care Admissions: Admissions for Medicare Managed Care programs such as Medicare Plus Choice.

MDH is frequently asked to provide data on the utilization and financial trends for MA and MinnesotaCare. Eligibility and payment policies related to these programs vary greatly. It is important that these categories be separated, so that we have the ability to analyze trends by program types particularly as eligibility for the programs change. This information is frequently requested by legislators and other state analysts to assist them in policy formation on a program level. With recent budget cuts, these requests have increased in frequency. This information needs to be collected separately, by program, for us to fulfill requests for data and to describe trends for each program.

#4373 Total MA/PMAP: Total Admissions for Medical Assistance and Prepaid Medical Assistance Care Program patients. This should be the sum of MA Patient Admissions (account 7181) and PMAP Managed Care Patient Admissions (account 7186).

#7181 MA Admissions (Non-Managed Care): Admissions for non-PMAP Medicaid Patients only.

#7186 PMAP Managed Care Admissions: Admissions for Prepaid Medical Assistance Program Patients only.

#4376 Total MinnesotaCare Patient Admissions: Admissions for non-Prepaid MinnesotaCare Patients and Admissions for Prepaid MinnesotaCare Patients. This is the sum of MinnesotaCare Admissions (Non-Managed Care) and MinnesotaCare Managed Care Admissions.

#4344 Other Payers Admissions: This category is for the payers that are not already identified in the breakouts for Non-Managed Care, Managed Care, and Individual (Self Pay). This would include Champus, Workman's Comp., Auto, etc. for each of the respective sections: Adjustments, Charges, Days, and Admissions. Please note that Commercial and Private payers are *not* reported on the Other Payers lines.

Section 39: Calculations based on Acute Care Admissions HAR p. 17

#4360 Acute Adjusted Patient Admissions: This figure is a calculation that is used as an industry accepted way to standardize the per unit measure between hospitals allowing for the outpatient book of business. The adjustment factor is calculated by dividing Total Charges by Inpatient Charges. When this factor is multiplied by acute admissions, it provides a common denominator of units of service in terms of inpatient activity. This is automatically calculated. Calculation: (0860/0851)*4340.

#4351 Average Length of Stay: This is automatically calculated. Calculation: (4030/4320).

Section 40: Acute Patient Days by Primary Payer HAR p. 18
Exclude Swing Bed, Subacute/Transitional Care and Routine Nursery Days.

Enter the patient days by primary payer excluding patient days for nursery, swing bed care and Subacute/transitional care.

If you report patient days, you must also report corresponding charges, admissions and adjustments.

MDH is frequently asked to provide data on the utilization and financial trends for MA and MinnesotaCare. Eligibility and payment policies related to these programs vary greatly. It is important that these categories be separated, so that we have the ability to analyze trends by program types particularly as eligibility for the programs changes. This information is frequently requested by legislators and other state analysts to assist them in policy formation on a program level. With recent budget cuts, these requests have increased in frequency. This information needs to be collected separately, by program, for us to fulfill requests for data and to describe trends for each program.

#4380 Total Medicare Patient Days: Summary of two subsequent accounts: Medicare Patient Days (Non-Managed Care) and Medicare Managed Care Patient Days.

#7162 Medicare Managed Care Patient Days: Patient Days for Medicare Managed Care programs such as Medicare Plus Choice.

#4383 Total MA/PMAP: Total Patient Days for Medical Assistance and Prepaid Medical Assistance Care Program patients. This should be the sum of MA Patient Patient Days (account 7181) and PMAP Managed Care Patient Patient Days (account 7186).

#7159 MA Patient Days (Non-Managed Care): Patient Days for non-PMAP Medicaid Patients only.

#7164 PMAP Managed Care Patient Days: Patient Days for Prepaid Medical Assistance Program Patients only.

#4386 Total MinnesotaCare Days: Patient Days for non-Prepaid MinnesotaCare Patients and Patient Days for Prepaid MinnesotaCare Patients. This is the sum of MinnesotaCare Patient Days (Non-Managed Care) and MinnesotaCare Managed Care Patient Days.

#4026 Other Payers Patient Days: This category is for the payers that are not already identified in the breakouts for Non-Managed Care, Managed Care, and Individual (Self Pay). This would include Champus, Workman's Comp., Auto, etc. for each of the respective sections: Adjustments, Charges, Days, and Patient Days. Please note that Commercial and Private payers are *not* reported on the Other Payers lines.

Section 41: Calculations based on Acute Patient Days HAR p. 18

#4060 Acute Adjusted Patient Days: This figure is a calculation that is used as an industry accepted way to standardize the per unit measure between hospitals allowing for the outpatient book of business. The adjustment factor is calculated by dividing Total Charges by Inpatient Charges. When this factor is multiplied by acute patient days, it provides a common denominator of units of service in terms of inpatient activity. This is automatically calculated. Calculation: (0860/0851)*4030.

Section 42: Daily Census HAR p. 18

In order to capture the capacity of a hospital, report on the daily census of your hospital. Exclude patient days for nursery, swing bed care and subacute/transitional care.
Report the minimum and maximum census.

#7058 Report the maximum daily census recorded in FY 2017.

#7059 Report the minimum daily census recorded in FY 2017.

SWING BED INFORMATION: HOSPITAL HAR p. 19

These sections pertain to the utilization of swing beds and are required by Minnesota Statutes, section 144.562, subdivision 3. Complete these sections *only* if services were provided in *Medicare approved* swing beds.
At the top of HAR page 19, a brief description of the types of services provided to patients in swing beds is listed. Edit this description if your hospital varies from this service. Minnesota Statutes, section 144.562, subdivision 3(e)(2) requires this information.

Section 43: Number of Swing Beds HAR p. 19

#4550 Number of Swing Beds: A swing bed means a hospital bed licensed under Minnesota Statutes, sections 144.50 to 144.56 that has been granted a license condition under Minnesota Statutes, section 144.562 and which has been certified to participate in the federal Medicare program under United States Code, title 42, section 1395. Admission to a swing bed is limited to patients who have been hospitalized and not yet discharged from the hospital or patients who are transferred directly from an acute care hospital. Eligible hospitals are allowed a total of 1,460 days of swing bed use per year or an average of 4 beds, provided that no more than ten hospital beds are used for swing beds at any one time. Under new CMS rules, Critical Access Hospitals (CAH) may count up to 10 swing beds as part of their total licensed beds.

Section 44: Swing Bed Patient Days HAR p. 19

Do **not** include patient days for Subacute or transitional care services not provided in a swing bed (see the next section for Subacute/Transitional Care Information). If the patient was covered by Medicare FFS or Medicare Advantage, Medicaid or PMAP (managed Medicaid), report it under the Swing bed accounts (either Medicare or Medicaid respectively). If it was not paid under a Medicare or Medicaid program (managed or otherwise) and was paid by commercial, reports as transitional/subacute care.

#4033 Medicare Reimbursed Swing Bed Days: Swing bed patient days *reimbursed by Medicare for Medicare patients*.

#4035 Medicaid Reimbursed Swing Bed Days: Swing bed patient days that are *approved and reimbursed by Medicaid (Medical Assistance) for Medicaid (Medical Assistance) patients*. (Please note that only hospitals approved as *Sole Community Providers* are permitted to use swing beds for Medicaid patients.)

Section 45: Swing Bed Admissions by Origin HAR p. 19

#4326 Swing Bed Readmission: Readmission to a swing bed *within 60 days* of a patient's discharge from the facility.

Section 46: Swing Bed Discharges by Destination HAR p. 19

Swing Bed Discharges should approximate Swing Bed Admissions.

SUBACUTE/TRANSITIONAL CARE: HOSPITAL HAR p. 19

These sections pertain to the provision of Subacute/transitional care and are required by Minnesota Statutes, section 144.564. These sections should be used to record all **non-acute** patient days that are **not** included as Swing Bed Days. All data in these sections must comply with the definition provided below.

Subacute/Transitional Care means care provided in a hospital bed to patients who have been hospitalized and no longer meet established acute care criteria. Subacute/transitional care also includes

care provided to patients who are admitted for respite care. Do *not* include information about care provided in Medicare or Medicaid approved swing beds.

Section 47: Total Subacute/Transitional Care Patient Days (Exclude care provided in an approved swing bed.) HAR p. 19

Enter the patient days.

Section 48: Subacute/Transitional Care Beds HAR p. 19

#4540 Average Number of Subacute/Transitional Care Beds: This is automatically calculated. Calculation: (4037/365 days).

Section 49: Subacute/Transitional Care Admissions by Origin HAR p. 19

Enter the admissions by category.

Section 50: Subacute/Transitional Care Discharges by Destination HAR p. 19

Subacute/Transitional Care Discharges should approximate Subacute/Transitional Care Admissions.

Section 51: Licensed Beds and Bassinets HAR p. 20

#4504 Total Number of Hospital Licensed Beds: The number of beds licensed by the Department of Health, pursuant to Minnesota Statutes, sections 144.50 to 144.58.
#4531 Total Number of Licensed Bassinets: The number of bassinets licensed by the Department of Health, pursuant to Minnesota Statutes, sections 144.50 to 144.58. If you have no licensed bassinets, enter -0-. Do **not** leave this blank.

Section 52: Change in Licensed Beds or Bassinets HAR p. 20

Report any *permanent* change in the number of licensed beds or bassinets during the reporting period. The requirement to report the change in licensed bassinets was added in 2001 due to the changes in Minnesota Rules, chapter 4650.

Section 53: Available Beds in Dedicated Specialty Units HAR p. 20

This section is for *Available* Beds only. Identify the number of available beds in each category where your facility has a *dedicated specialty unit*.

Neonatal are *bassinets* and should be counted in the total available *bassinets* count.

#7082 Total Available Beds (as of the last day of the FY 2017): The number of acute care beds that are

immediately available for use or could be brought online within a short period of time. Available beds should not include: labor rooms, bassinets, post-anesthesia beds, post-operative beds, or other non-routine beds. Do not leave this blank. Note: If your hospital is Critical Access, your total Available Beds may not exceed 25 (you may also have 10 beds for mental health and 10 beds for rehab which do not count towards the 25).

Section 54: Available Bassinets HAR p. 20

Enter the total number of Neonatal Acute Care Available Bassinets and Routine Nursery Non-Acute Care Available Bassinets. Neonatal are classified as bassinets according to Minnesota licensing.

Section 55: Facilities and Services Within the Hospital HAR pp. 21-24

Much attention has been focused in recent years on the proliferation of imaging technology and equipment around the state. The Minnesota Legislature has shown a keen interest in this topic, particularly around the issue of free-standing versus hospital based services. To provide timely and accurate information to policymakers and to properly analyze the situation, MDH needs more detailed information on the number of scanners at hospitals, the type of scanners (fixed vs. mobile), and the number of procedures being performed, therefore, some additional accounts have been added to the formset.

In this section you are to report the types of services the hospital offers by responding with the applicable number:

1 = The service is available *on site* at the hospital *and* provided by hospital staff.
2 = The service is *not available*.
3 = The service is available *on site* through contracted services.
4 = The service is available *off site* through shared services agreement.

For some services, you are only required to report whether the service is available. For other services, however, you are required to provide the utilization of that service as well as its availability.

#6030 and 6034 Cardiac Catheterization Services: Includes the following ICD9-CM procedure codes: 00.66, 35.41, 35.96, 36.06, 36.07, 36.09, 37.21, 37.22, 37.23. 37.26, 37.27, 37.34 and also the following radiology codes: 88.52, 88.53, 88.54, 88.55, 88.56, 88.57, 88.58.
#6334 Number of Volunteers: Please report the collective amount of volunteers throughout the reporting year.
#7206 Obstetrics Services: Any services involving the medical treatment of pregnant women or mothers following delivery.
#7207 Gynecology Services: Any therapeutic or diagnostic services to women with diseases or disorders of reproductive organs.
#6270 Organ Transplant Services: When reporting these services, count transplants, not surgeries. If the transplant surgery involved more than 1 transplant, report 1 for EACH applicable category.
#7210 Transportation Services (non-ambulance): A support service designed to assist the mobility of the patients to/from the hospital's facilities. It may include programs offering

subsidies/vouchers for public transit use or separate vans or mini buses, financed and operated by the hospital or an affiliate for exclusive use by patients. This does *not* include Ambulance services.

#6290 Outpatient Medical Rehabilitation Services: Any rehabilitation service other than PT, OT, Speech, CD, or Psych.

Diagnostic Imaging Services

Combination (SPECT/CT and PET/CT) scanners and procedures should be reported on the specific combination line and *not* counted in the single (SPECT, CT, or PET) machine lines.

A heart study consisting of the stress test and resting non-stress test is counted as 2 procedures.

Sections 56 and 57: Capital Expenditure Commitment Summary and Detail HAR p. 25

Minnesota Statutes, Section 62J.17 requires that health care providers report all major capital spending commitments of $1 million or more to the Minnesota Department of Health.

Hospitals are required to report major capital expenditures on an annual basis. The law previously required providers to report within 60 days after the date of the spending commitment.

Please report the *Hospital only* portion of any major capital expenditure commitments in sections 56 and 57.

The Minnesota Department of Health (MDH) will continue retrospective reviews of major capital spending commitments, as required by Minnesota Statutes, section 62J.17, subd. 5a, and prospective reviews under certain circumstances, as specified by Minnesota Statutes, section 62J.17, subd. 6a.

Retrospective reviews of major capital spending commitments are done for all providers and are to be submitted with the existing data collections. *Institution level* major capital spending commitments documentation is to be *submitted along with the HAR* report. This information will be forwarded to MDH for completion of the retrospective review.

The following information is needed to allow MDH to complete a retrospective review of each major capital spending commitment, including:

- A description of the project, its purpose, the street address of the facility, and the total cost of the project;
- The date of the spending commitment, such as the date of board authorization;
- The expected impact of the project on clinical effectiveness or the quality of care received by the patients that the provider serves;
- The extent to which equivalent services or technology are already available to the patient population within a service area of at least 30 miles;
- The distance in miles to the location of the nearest equivalent services or technology that are available to the provider's actual and potential patient population;
- Whether or not any of the improvements in quality or clinical effectiveness are supported by

evidence.
- A statement describing the pursuit of or existence of any lawful collaborative arrangements, and the names of parties and a description of their involvement.

In order to complete the retrospective review on a particular project, MDH may request additional information about the project. Providers that fail retrospective review may become subject to prospective review of major capital spending commitments.

"Major spending commitment" means an expenditure in excess of $1,000,000 for:
    (1) acquisition of a unit of medical equipment;
    (2) a capital expenditure for a single project for the purposes of providing health care services, other than for the acquisition of medical equipment;
    (3) offering a new specialized service not offered before;
    (4) planning for an activity that would qualify as a major spending commitment under this paragraph; or
    (5) a project involving a combination of two or more of the activities in clauses (1) to (4).
    The cost of acquisition of medical equipment, and the amount of a capital expenditure, is the total cost to the provider regardless of whether the cost is distributed over time through a lease arrangement or other financing or payment mechanism.

If you have any questions while completing these sections or preparing the documents for the retrospective review process, please contact the Minnesota Department of Health at 651-201-3572.

SERVICE LINE INFORMATION: HOSPITAL HAR "Service Line Data" Tab

The "Service Line Data" tab contains those sections of the HAR which should be completed using your UB billing data.

If your hospital voluntarily reports to the UB data project (Minnesota Health Information Network - MHIN) sponsored by MHA, then MHA can report the service line information (sections 58-62 on the "Service Line Data" tab) for your hospital with your permission. If you want MHA to report this information for your hospital, you must check the box provided in the report on the "2017 HAR" tab in section 9. If you check this box, leave sections 58-62 blank on the "Service Line Data" tab. To have MHA also supply your hospital's Top Ten DRG's , check "yes" in section 36 on the "2017 HAR" tab in the report. This information will be provided for you when the HAR is audited.

If your hospital **does not** report to the UB data project cited above **or** you choose not to have MHA report for you, you must report this information yourself. If you are choosing to report this information yourself, please first contact MHA for help in determining the proper methodology for completing these sections. Not doing so may result in these sections being completed inaccurately, and result in additional questions and revisions during the audit process.

Section 58: Charges by Hospital Service HAR "Service Line Data" p. 1

This section should be completed using your hospital's billing data utilizing DRG and revenue codes to arrive at the charges for each category. If you want MHA to report this information for your hospital,

you must check the box provided in the report on the "2017 HAR" tab in section 9. Both MDH and MHA *highly* recommend your facility have MHA complete this section for you. If you choose to complete it yourself, please contact Matt Hovila (651-603-3536, mhovila@mnhospitals.org) before beginning this section.

Section 59: Admissions by Hospital Service HAR "Service Line Data" p. 2

This section should be completed using your hospital's billing data utilizing DRG and revenue codes to arrive at the admissions for each category. If you want MHA to report this information for your hospital, you must check the box provided in the report on the "2017 HAR" tab in section 9. Both MDH and MHA *highly* recommend your facility have MHA complete this section for you. If you choose to complete it yourself, please contact Matt Hovila (651-603-3536, mhovila@mnhospitals.org) before beginning this section.

Section 60: Admissions by Age HAR "Service Line Data" p. 2

#7261 Adult Care Admissions (18+): Total Hospital Admissions for all patients 18 years of age and older. This includes all Med/Surg, ICU/CCU, Chemical Dependency, Rehabilitation, Mental Health/Psych, Swing Bed and Transitional Admissions.

#7264 Pediatric and Adolescent Admissions (including Neonatal): Total Hospital Admissions for all patients less than 18 years of age. This includes all Med/Surg, ICU/CCU, Nursery, Neonatal, Chemical Dependency, Rehabilitation, Mental Health/Psych, Swing and Transitional Bed Admissions.

Section 61: Total Patient Days by Hospital Service HAR "Service Line Data" p. 3

This section should be completed using your hospital's billing data utilizing DRG and revenue codes to arrive at the patient days for each category. If you want MHA to report this information for your hospital, you must check the box provided in the report on the "2017 HAR" tab in section 9. Both MDH and MHA *highly* recommend your facility have MHA complete this section for you. If you choose to complete it yourself, please contact Matt Hovila (651-603-3536, mhovila@mnhospitals.org) before beginning this section.

Section 62: Patient Days by Age HAR "Service Line Data" p. 3

#7245 Adult Care Patient Days (18+): Total Hospital Patient Days for all patients 18 years of age and older. This includes all Med/Surg, ICU/CCU, Chemical Dependency, Rehabilitation, Mental Health/Psych, Swing Bed and Transitional patient days.

#7248 Pediatric and Adolescent Patient Days (including Neonatal): Total Hospital Patient Days for all patients less than 18 years of age. This includes all Med/Surg, ICU/CCU, Nursery, Neonatal, Chemical Dependency, Rehabilitation, Mental Health/Psych, Swing and Transitional Bed patient

days.

This section requires you to report the top ten DRGs for your hospital. The top ten DRGs are to be determined according to the **total number of discharges per DRG**. The DRG with the largest number of discharges is to be reported as number one, the DRG with the next largest number of discharges as number two, etc. in descending order. You are also required to report the associated total gross charges for each of the top ten DRGs reported.

Reporting this information is **mandatory**.

If your hospital voluntarily reports to the UB data project (Minnesota Health Information Network - MHIN) sponsored by MHA, then MHA can report the DRG information for your hospital with your permission. If you want MHA to report this information for your hospital, you must check the box provided in the report in section 36 on page 16 in the "2017 HAR" tab.

If your hospital **does not** report to the UB data project cited above **or** you choose not to have MHA report for you, you must report this information yourself.

If you are unable to determine the actual total gross charges associated with each DRG, you may estimate using a reasonable method. One methodology is to determine an average charge per discharge for each DRG by taking a sample of bills for each DRG, totaling the charges and dividing by the number of bills. Multiply the average charge you calculated for the DRG by the total number of discharges for that DRG and the product is an estimated gross charge for the DRG. Other methods of estimation are acceptable if based on reasonable methods. Upon request, your facility must provide a written explanation of the method used for the estimate(s).

Provide the names and addresses of all outpatient departments, clinics, and components not located on the hospital's premise. Please indicate which locations are billed under the hospital's Medicare and Medicaid provider numbers. Please not that all revenues and expenses for services billed under the hospital's Medicare and Medicaid provider numbers are required to be included with the hospital reporting in the HAR report.

In addition, please provide a short description of the services provided at the offsite component, i.e. physical therapy, speech therapy, occupational therapy, ambulatory surgery, outpatient medical services, etc.