

CR 88-140

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CERTIFICATE

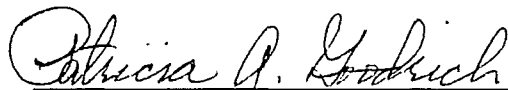
STATE OF WISCONSIN )  
DEPARTMENT OF HEALTH AND SOCIAL SERVICES ) SS

I, Patricia A. Goodrich, Secretary of the Department of Health and Social Services and custodian of the official records of the Department, do hereby certify that the annexed rules relating to the Office of Health Care Information were duly approved and adopted by this Department on May 17, 1989.

I further certify that this copy has been compared by me with the original on file in the Department and that this copy is a true copy of the original, and of the whole of the original.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the Department at the State Office Building, 1 W. Wilson Street, in the city of Madison, this 17th day of May, 1989.

SEAL:



Patricia A. Goodrich, Secretary  
Department of Health and Social Services

7-1-89

**ORDER OF THE  
DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
REPEALING, RENUMBERING, AMENDING AND CREATING RULES**

To repeal HSS 120.09; to renumber HSS 120.03(1), 120.04 to 120.08, and 120.11 and 120.12; to amend HSS 120.01; and to create Subchapter I (title), HSS 120.03(1), (2m), (2r), (10m) and (11m), 120.08, Subchapter II (title) and 120.12 to 120.16, relating to the Wisconsin office of health care information.

Analysis Prepared by the Department of Health and Social Services

The 1988-89 Annual Budget Act, 1987 Wisconsin Act 399, created ch. 153, Stats., which establishes an Office of Health Care Information in the Department to collect and disseminate information about hospital service utilization, charges, revenues, expenses, mortality and morbidity rates, health care coverage and uncompensated health care services.

Section 153.75, Stats., directs and authorizes the Department to promulgate rules for administration of the Office. The rules are to respond to statutory mandates for rules covering specific areas of the Office's work and may provide additional detail in areas where the statutes trace only the outlines of Office activities. Given the scope of ch. 153, Stats., the rules are being promulgated in three or more phases. The first set of rules, stating what inpatient discharge data hospitals are to report and how and by when they are to report it and providing for the confidentiality of reported data, will go into effect on February 1, 1989. This second set of rules requires hospitals to (1) report revenue and expense data by categories specified in the rules, and per unit charges for each of several charge elements specified in the rules and the number of times a charge was made for each charge element in a 12-month period; (2) report actual and anticipated uncompensated health care, including charity care, in a manner prescribed in the rules; and (3) provide notice to the public of any rate increase before that increase takes place, in a manner prescribed in the rules. These second phase rules also provide for the designation of a contractor by the Board on Health Care Information if the Board chooses to designate a contractor to collect, analyze and disseminate health care information on behalf of the Office.

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The Department's authority to create these rules is set forth in ss. 153.05(1)(e)1, 153.35 and 153.75(1)(d), (g), (h), (i) and (j) and (2)(c), Stats., as created by 1987 Wisconsin Act 399. The rules interpret ch. 153, Stats.

SECTION 1. Subchapter I (title) of ch. HSS 120 is created to read:

Subchapter I - General Provisions

SECTION 2. HSS 120.01 is amended to read:

HSS 120.01 AUTHORITY AND PURPOSE. This chapter is promulgated under the authority of s. 153.75, Stats., to implement ch. 153, Stats. Its purpose is to provide definitions and procedures to be used by the department to administer the office of health care information. ~~The office seeks to collect, analyze and disseminate~~ is responsible for collecting, analyzing and disseminating information in language that is understandable to lay persons about hospital service utilization, charges, revenues, expenses, mortality and morbidity rates, health care coverage and ~~care provided to indigent persons~~ uncompensated health care services.

SECTION 3. HSS 120.03(1) is renumbered HSS 120.03(1m).

SECTION 4. HSS 120.03(1), (2m), (2r), (10m) and (11m) are created to read:

HSS 120.03 (1) "Bad debts" means claims arising from rendering patient care services that the hospital, using a sound credit and collection policy, determines are uncollectible, but does not include charity care.

(2m) "Charge element" means any service, supply or combination of services or supplies that is specified in the categories for payment under the charge revenue code for the uniform patient billing form.

(2r) "Charity care" means health care a hospital provides to a patient who, after an investigation of the circumstances surrounding the patient's ability to pay, including nonqualification for a public program, is determined by the hospital to be unable to pay all or a portion of the hospital's normal billed charges. "Charity care" does not include any of the following:

(a) Care provided to patients for which a public program or public or private grant funds pay for any of the charges for the care;

(b) Contractual adjustments in the provision of health care services below normal billed charges;

(c) Differences between a hospital's charges and payments received for health care services provided to the hospital's employes, to public employes or to prisoners;

(d) Hospital charges associated with health care services for which a hospital reduces normal billed charges as a courtesy; or

(e) Bad debts.

(3m) "Contractual adjustment" means the difference between a hospital's normal charges for patient services and the discounted charge or payment received by the hospital from the payer.

(10m) "Public program" means any program funded with government funds.

Note: Examples of public programs are general relief under s. 49.01(5m), Stats., primary care under s. 146.93, Stats., medicare under 42 USC 1395 and 42 CFR subchapter B, medical assistance (medicaid) under ss. 49.43 to 49.497, Stats., and chs. HSS 101 to 108, and CHAMPUS under 10 USC 1071 to 1103.

(11m) "Uncompensated health care services" means charity care and bad debts.

SECTION 5. HSS 120.04 is renumbered HSS 120.11.

SECTION 6. HSS 120.05 to HSS 120.08 are renumbered HSS 120.04 to HSS 120.07.

SECTION 7. HSS 120.08 is created to read:

HSS 120.08 SELECTION OF A CONTRACTOR. (1) DEFINITION. In this section, "major purchaser, payer or provider of health care services" means any of the following:

(a) A person as defined in s. HSS 123.03(36), a trust, a multiple employer trust, a multiple employer welfare association, a third party administrator or a labor organization that purchases health benefits, which provides health care benefits or services for more than 500 of its full-time equivalent employes, or members in the case of a labor organization, either through an insurer or by means of a self-funded program of benefits;

(b) An insurer that writes accident and health insurance and is among the 20 leading insurers for either group or individual accident and health insurance, as specified in the market shares table of the most recent annual Wisconsin insurance report of the state commissioner of insurance. "Major purchaser, payer or provider of health care services" does not include an insurer that writes only disability income insurance;

(c) A trust, a multiple employer trust, a multiple employer welfare association or a third party administrator, including an insurer, that administers health benefits for more than 29,000 individuals; or

(d) Any person as defined in s. HSS 123.03(36) that provides health care services and has 100 or more full-time equivalent employes.

(2) ELIGIBLE CONTRACTORS. (a) If the board decides under s. 153.05(6), Stats. to designate a contractor for the provision of data processing services for the office, including the collection, analysis and dissemination of health care information, the contractor shall be a public or private organization that does not have a potential conflict with the purposes of the office as specified under s. 153.05(1), Stats.

(b) A contractor may not be:

1. A major purchaser, payer or provider of health care services in Wisconsin, except as provided in par.(c);

2. A subcontractor of an organization in subd. 1;

3. A subsidiary or affiliate of an organization in subd. 1 in which a controlling interest is held and may be exercised by that organization either independently or in concert with any other organization in subd. 1; or

4. An association of major purchasers, payers or providers of health care services.

(c) The department is exempt from the requirement under par.(b) regarding eligibility to contract and may offer a bid if the board decides to bid the contract for services under s. 153.07(2), Stats., and this section.

(3) CONFIDENTIALITY. The office may grant the contractor authority to examine confidential materials and perform other functions authorized by the office. The contractor shall comply with all confidentiality requirements established under this chapter. The release of confidential information by the contractor without the written consent of the office shall constitute grounds for the office to terminate any agreement between the contractor and the office.

SECTION 8. HSS 120.09 is repealed.

SECTION 9. HSS 120.11 and HSS 120.12 are renumbered HSS 120.09 and HSS 120.095.

SECTION 10. Subchapter II (title) of ch. HSS 120 is created to read:

Subchapter II - Hospital Reporting Requirements

SECTION 11. HSS 120.12 to HSS 120.16 are created to read:

HSS 120.12 REVENUE AND EXPENSE DATA. (1) SUBMITTAL. Each hospital shall annually submit to the office an extract of the information requested by the office from its final audited financial statements. A hospital does not have to alter the way it otherwise records its financial data in order to comply with this section. If a hospital is jointly operated in connection with a nursing home, home health agency or other organization, the hospital shall submit the required information for the hospital unit only.

(2) DEFINITIONS. In this section:

(a) "Health maintenance organization" or "HMO" means a health care plan that makes available to its participants, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers selected by the organization.

(b) "Other alternative health care payment system" means a negotiated health plan other than an HMO or an indemnity health care plan.

(3) REVENUE CATEGORIES. The information reported on each extract shall include the dollar amounts for each of the following revenue categories:

(a) Gross revenue from service to patients. Gross revenue from service to patients, including the following subcategories:

1. Gross revenue from room, board, and medical and nursing services to inpatients, based on full established rates;

2. Gross inpatient ancillary revenue for services other than room, board, and medical and nursing services that are provided to hospital patients in the course of inpatient care;

Note: Examples of these other services provided to inpatients are laboratory, radiology, pharmacy and therapy services.

3. Gross revenue from service to outpatients, based on full established rates; and

4. Total gross revenue from service to patients, obtained by adding the amounts in subds. 1 to 3;

5. Gross revenue from service to patients, by source, which shall be the actual dollar values or a reasonable estimate based on a hospital's internal records. Inpatient and outpatient dollar values shall be listed separately for subpar. a; subpar. b; an aggregation of subpars. c, d, and e; an aggregation of subpars. f, g, h and i; and an aggregation of subpars. j and k.

- a. Medicare;
- b. Medical assistance under ss. 49.43 to 49.497, Stats., excluding medical assistance reimbursement through HMOs under s. 49.45(3)(b), Stats.;
- c. General relief, as defined in s. 49.01(5m), Stats.;
- d. Programs under ss. 51.42 and 51.437, Stats.;
- e. All other public programs;
- f. Group and individual accident and health insurance and self-funded plans;
- g. HMOs, except HMOs under subpar. h, and all other alternative health care payment systems;
- h. HMOs reimbursed by medical assistance under s. 49.45(3)(b), Stats.;
- i. Workers' compensation;
- j. Self pay;
- k. All other nonpublic sources; and
- l. Total gross revenue from service to patients, by source, obtained by adding the total amounts in subpars. a to k. This dollar value shall equal the dollar value in subd. 4;

(b) Deductions from revenue obtained from service to patients. Deductions from revenue obtained from service to patients, which shall be the actual dollar values or a reasonable estimate based on a hospital's internal records, as follows:

1. For contractual adjustments, this includes the difference between billed and paid amounts. Inpatient and outpatient dollar values shall be listed separately for subpar. a; subpar. b; an aggregation of subpars. c, d, and e; an aggregation of subpars. f, g, h and i; and subpar. j.

- a. Medicare;
- b. Medical assistance under ss. 49.43 to 49.497, Stats., excluding medical assistance reimbursement through HMOs under s. 49.45(3)(b), Stats.;
- c. General relief, as defined in s. 49.01(5m), Stats.;
- d. Programs under ss. 51.42 and 51.437, Stats.;
- e. All other public programs;

f. Group and individual accident and health insurance, and self-funded plans;

g. HMOs, except HMOs under subpar. h, and all other alternative health care payment systems;

h. HMOs reimbursed by medical assistance under s. 49.45(3)(b), Stats.;

i. Workers' compensation;

j. All other nonpublic sources; and

k. Total contractual adjustments, obtained by adding the amounts in subpars. a to j;

2. For other deductions from revenue, this includes the following uncollectible revenue:

a. Bad debts;

b. Charity care;

c. All other deductions; and

d. Total other deductions from revenue from service to patients, obtained by adding the amounts in subpars. a to c; and

3. Total deductions from revenue, obtained by adding the amounts in subds. 1 k and 2 d;

(c) Total net revenue from service to patients. Total net revenue from service to patients, which is obtained by subtracting total deductions from revenue from service to patients under par.(b)3 from total gross revenue from service to patients under par.(a)4;

(d) Other operating revenue. Other operating revenue, which consists of tax appropriations and revenue from service to patients that are not patient care services, plus sales and activities made available to persons other than patients, which are normally part of the day-to-day operation of a hospital. This shall be reported in the following subcategories:

1. Tax appropriations;

2. All other operating revenue; and

Note: Examples of revenue from hospital operations that are not patient care services are revenue from educational programs, cafeteria sales and gift shop sales.

3. Total other operating revenue. This is obtained by adding the dollar values for subds. 1 and 2;



(e) Nonoperating revenue. Nonoperating revenue, including but not limited to unrestricted gifts, contributions from donors, unrestricted income from endowment funds and income from investments other than income related to borrowed funds; and

(f) Grand total net revenue. Grand total net revenue, which is the total of the sums under pars.(c), (d) and (e).

(4) EXPENSE CATEGORIES. The information reported on each extract shall include the dollar amounts for each of the following expense categories:

(a) Payroll expenses. Payroll expenses, with the following expense subcategories:

1. Physicians and dentists engaged in clinical practice, excluding those physicians and dentists whose clinical work is totally financed by outside research grants or fellowships;
2. Medical and dental residents and interns;
3. Trainees, including medical technology, x-ray therapy, administrative residency and other specialties who have not completed the necessary requirements for certification or qualifications required for full salary under the related title;
4. Registered nurses and licensed practical nurses;
5. All other personnel, including the payroll for physicians and dentists who hold administrative positions; and
6. Total payroll expenses. This is obtained by adding the dollar values for subs. 1 to 5;

(b) Nonpayroll expenses. Nonpayroll expenses, with the following expense subcategories:

1. Employee benefits, including social security, group insurance and retirement benefits;
2. Professional fees, including medical, dental, legal, auditing and consulting fees;
3. Contracted nursing services, including staff from nursing registries and temporary help agencies;
4. Depreciation expense;
5. Interest expense;
6. Amortization of financing expenses;
7. Rents and leases;
8. Capital component of insurance premiums;

9. Nonoperating expenses;

10. All other expenses, including supplies, purchased services, utilities and property taxes; and

11. Total nonpayroll expenses obtained by adding the amounts in subds. 1 to 10;

(c) Total expenses. Total expenses obtained by adding the amounts in pars. (a)6 and (b)11; and

(d) Medical education expenses. The total allowable expenses for medical education activities approved by Medicare under 42 CFR 412 as amended and excerpted from the total expenses in par. (c). These expenses shall be separated into the following expense subcategories:

1. Direct medical education expenses; and
2. Indirect medical education expenses.

HSS 120.13 CHARGES BY CHARGE ELEMENT. The charge elements listed in Table 120.13 shall be reported to the office in accordance with s. HSS 120.14.

TABLE 120.13  
CHARGE ELEMENTS

CHARGE ELEMENT	UB-82 REVENUE CODE
<u>ROOM AND BOARD - PRIVATE</u>	
General classification	110
Medical/surgical/gynecology	111
Obstetrics	112
Pediatric	113
Psychiatric	114
Hospice	115
Detoxification	116
Oncology	117
Other	119
<u>ROOM AND BOARD - SEMI PRIVATE TWO BED</u>	
General classification	120
Medical/surgical/gynecology	121
Obstetrics	122
Pediatric	123
Psychiatric	124
Hospice	125
Detoxification	126
Oncology	127
Other	129
<u>NURSERY</u>	
General classification	170
Newborn	171
Premature	172
Neonatal intensive care unit	175
Other	179
<u>INTENSIVE CARE</u>	
General classification	200
Surgical	201
Medical	202
Pediatric	203
Psychiatric	204
Post intensive care unit	206
Burn care	207
Trauma	208
Other	209

CORONARY CARE

General classification	210
Myocardial infarction	211

INCREMENTAL NURSING CHARGE RATE

General classification	230
Nursery	231
Intensive Care	233
Coronary Care	234

OTHER IMAGING SERVICES

Mammography, excluding physician fees	401
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EMERGENCY ROOM

General classification - based on highest volume, excluding physician fees	450
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LABOR ROOM/DELIVERY

General classification	720
Labor	721
Delivery	722
Circumcision	723
Birthing center	724
Other	729

PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS

General classification	900
Electroshock treatment	901
Milieu therapy	902
Play therapy	903
Other	909

PSYCHIATRIC/PSYCHOLOGICAL SERVICES

General classification	910
Rehabilitation	911
Day care	912
Night care	913
Individual therapy	914
Group therapy	915
Family therapy	916
Biofeedback	917
Testing	918
Other	919

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HSS 120.14 TIMING, FORMAT AND REVIEW OF FISCAL DATA REPORTS.

(1) CHARGES BY CHARGE ELEMENT. (a) By July 1, 1989, each hospital shall submit to the office:

1. The amount of the per unit charge for each of the charge elements under s. HSS 120.13 as of that date and the amount one year previous to that date. The outpatient per unit charge shall be listed separately if it differs from the inpatient per unit charge; and

2. The number of times a charge occurred for each of the charge elements under s. HSS 120.13 in the 12-month period of the hospital's most recently completed fiscal year and in the 12-month period previous to the most recently completed fiscal year. A hospital may estimate the volume of charges for each charge element, rounded to the nearest 100, except that if a charge occurred less than 50 times in a 12-month period, the hospital shall count the exact number of times that the charge occurred.

(b) By July 1, 1990 and annually thereafter, each hospital shall submit to the office:

1. The amount of the per unit charge for each of the charge elements under s. HSS 120.13 as of that date. The outpatient per unit charge shall be listed separately if it differs from the inpatient per unit charge; and

2. The number of times a charge occurred for each of the charge elements under s. HSS 120.13 for the 12-month period of the hospital's most recently completed fiscal year. A hospital may estimate the volume of charges for each charge element, rounded to the nearest 100, except that if a charge occurred less than 50 times in a 12-month period, the hospital shall count the exact number of times that the charge occurred.

(2) REVENUE AND EXPENSE DATA. (a) Except as provided in par.(b), by July 1, 1989, each hospital shall submit to the office the dollar amounts of the revenue and expense data included in its audited financial statements, as specified under s. HSS 120.12, for the hospital's fiscal years 1987, 1988 and 1989.

(b) If a hospital's 1989 fiscal year ends after March 1, 1989, the hospital shall submit the 1989 fiscal data to the office no later than 120 calendar days following the close of its 1989 fiscal year.

(c) For each subsequent fiscal year, the hospital shall annually submit to the office the dollar amounts of the revenue and expense data included in its audited financial statements, as specified under s. HSS 120.12, no later than 120 calendar days following the close of that fiscal year.

(d) If the exact audited financial data required for pars. (a), (b) and (c) are available from the department's Wisconsin annual survey of hospitals, a hospital may use the data from that source to submit the required audited revenue and expense data to the office.

(e) Except as provided in par. (b), by July 1, 1989, each hospital shall report to the office the total gross and net revenue figures required under s. HSS 120.12(3)(a)4 and (c) for its fiscal years 1987, 1988 and 1989; the dollar difference between the revenue figures for each of these fiscal years; and an explanation of the amount of the dollar difference that was due to a price change and the amount of the dollar difference that was due to a utilization change.

(f) For each subsequent fiscal year, each hospital shall annually submit to the office, no later than 120 calendar days following the close of the hospital's fiscal year, the following information for the fiscal year and the previous fiscal year:

1. The total gross revenue figure required under s. HSS 120.12(3)(a)4;

2. The dollar difference between the revenue figures for each of these fiscal years; and

3. The amount in subd. 2 attributable to a price change and the amount attributable to a utilization change.

(3) EXTENSION OF SUBMITTAL DEADLINES. (a) Except as provided in par. (b) the office may grant an extension of a deadline specified in this section for submission of a report only when need for additional time is adequately justified by the hospital. Adequate justification may include, but is not limited to, a strike, fire, natural disaster or delay due to data system conversion. A request for an extension shall be submitted in writing to the office at least 10 calendar days prior to the date that the data are due. An extension for adequate justification may be granted for up to 30 calendar days.

(b) An extension of a deadline specified in this section for submission of a report by a department operated state mental health institute may be granted for up to 90 calendar days.

(4) FORMAT FOR DATA SUBMISSION. Each hospital shall submit the charge element and revenue and expense data to the office in a paper medium format provided by the office. The revenue and expense data submitted under s. HSS 120.12 shall be subscribed under oath or affirmation by the chief executive officer before a notary public.

(5) REVIEW OF DATA BY OFFICE AND HOSPITALS AFTER DATA SUBMISSION. The office shall check the accuracy and completeness of submitted charge element and revenue and expense data. Unacceptable data shall be returned to the hospital with a paper copy of the information for revision and resubmission if the office has contacted the hospital and has determined that the data cannot be corrected via the telephone. Data returned to the hospital shall be resubmitted to the office within 10 working days after a hospital's receipt of the unacceptable data.

HSS 120.15 PUBLICATION OF A RATE INCREASE NOTICE. (1) USE. The procedures set out in this section shall be used by a hospital to provide notice to the public of a rate increase.

(2) DEFINITIONS. In this section:

(a) "Affidavit of publication" means a sworn statement in writing affirming the publication of the notice issued by the editor, publisher, printer or proprietor of any newspaper, or by the printer or proprietor's lead worker or principal clerk.

(b) "Class 1 notice" has the meaning specified in s. 985.07(1), Stats., namely, a notice requiring at least one insertion.

(c) "Rate increase" means an increase that raises a hospital's total gross revenue from continuing services to patients, as determined under s. HSS 120.12(3)(a)4, not less than one-half percent within the hospital's fiscal year.

(3) TYPE OF NOTICE. A hospital shall publish a class 1 notice at least 10 days prior to instituting a rate increase to inform interested persons of the increase. The notice shall be published in one or more newspapers of general circulation likely to give notice to the hospital's patients and payers.

(4) PUBLICATION OF NOTICE. If at any time during a hospital's fiscal year cumulative rate increases meet the definition of a rate increase in sub.(2)(c), the hospital shall publish a notice of that rate increase.

(5) CONTENTS OF NOTICE. A hospital shall include in a notice of rate increase at least the following elements:

(a) A bold heading entitled, "NOTICE OF HOSPITAL RATE INCREASE FOR (name of hospital)" printed in capital letters of not less than 18 point type size. The text of the notice shall be printed in not less than 10 point type size. Any numbers printed in the notice shall be expressed as numerals;

(b) The address of the hospital;

(c) Beginning and ending dates of a hospital's fiscal year;

(d) An increase in the rate for any charge element under s. HSS 120.13. If a rate for a charge element will not increase, the hospital is not required to list that charge element in the notice. The information about the increase shall be formatted as follows:

1. Name of the charge element;
2. Previous per unit dollar value of the charge element;
3. New per unit dollar value of the charge element;
4. Dollar increase between subds. 2 and 3; and
5. Percentage increase between subds. 2 and 3;

(e) The anticipated overall increase in a hospital's total gross revenue under s. HSS 120.12(3)(a)4 that will result from rate changes in all reportable and unreportable charge elements for the following 12-month period, expressed as an annualized percentage;

(f) The date the rate increase will go into effect;

(g) The date and annualized percentage of each rate increase within the 12 months prior to this rate increase; and

(h) The date of the last rate increase if there was no increase specified under par. (g).

(6) AFFIDAVIT OF PUBLICATION. Within 2 weeks after the date on which a rate increase notice is published, the hospital shall submit to the office an affidavit of the publication annexed to a copy of the notice, clipped from the paper in which it was published, that specifies the date of insertion and the name of the newspaper.

HSS 120.16 UNCOMPENSATED HEALTH CARE SERVICES. (1) PLAN. Every hospital shall submit to the office a written plan for providing uncompensated health care services as required under sub.(2). The plan shall include at least the following elements:

(a) A set of definitions describing terms used throughout the plan;

(b) The procedures used to determine a patient's ability to pay for health care services received and to verify financial information from the patient;

(c) The number of patients who received uncompensated health care services provided by the hospital in its preceding fiscal year, and the total charges for those services, as determined by:

1. The number of patients who received charity care from the hospital in that fiscal year;



2. The total charges for charity care, obtained from the hospital's final audited financial statements, that was provided to patients by the hospital in that fiscal year;

3. The number of patients whose charges were determined to be bad debts in that fiscal year; and

4. The total charges determined to be bad debts, as obtained from the hospital's final audited financial statements in that fiscal year;

(d) The projected number of patients who will receive uncompensated health care services from the hospital in its ensuing fiscal year, and the projected total charges for those services, as determined by:

1. The hospital's projected number of patients to whom charity care will be provided by the hospital for that fiscal year;

2. The hospital's projected total charges for charity care to be provided by the hospital for that fiscal year;

3. The hospital's projected number of patients whose charges will be bad debts for that fiscal year;

4. The hospital's projected total charges for bad debts for that fiscal year; and

5. A rationale for the hospital's projections under subds. 1 to 4, considering the hospital's total patients and audited total charges for the preceding fiscal year; and

(e) The hospital's procedure to inform the public about charity care available at that hospital.

(2) SUBMISSION DATES. (a) By July 1, 1989 and annually thereafter, each hospital shall submit its uncompensated health care services plan to the office for its most recently completed fiscal year.

(b) If a hospital's 1989 fiscal year ends after March 1, 1989, the hospital does not have to submit the 1989 plan to the office until 120 calendar days following the close of its 1989 fiscal year.

(c) For all subsequent uncompensated health care services plan submissions, each hospital shall annually submit to the office the plan for its most recently completed fiscal year no later than 120 calendar days following the close of that fiscal year.

(3) HILL-BURTON UNCOMPENSATED SERVICES PROGRAM REQUIREMENTS. Any hospital that has a current obligation under 42 CFR. pt. 124 shall annually report to the office on the same date as provided in sub.(2) the date the obligation went into effect and the date the obligation will be satisfied.

The repeals and rules contained in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register as provided in s. 227.22(2), Stats.

Approved by the Board on Health  
Care Information

Date: May 17, 1989

By: Ronald Dix  
Ronald Dix, Chairperson

Wisconsin Department of Health and  
Social Services

Date: May 17, 1989

By: Patricia A. Goodrich  
Patricia A. Goodrich  
Secretary

Seal:



State of Wisconsin \

DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
1 West Wilson Street, Madison, Wisconsin 53702

Tommy G. Thompson  
Governor

Patricia A. Goodrich  
Secretary

Mailing Address:  
Post Office Box 7850  
Madison, WI 53707

May 17, 1989

Mr. Orlan Prestegard  
Revisor of Statutes  
7th Floor - 30 on the Square  
Madison, Wisconsin 53702

Dear Mr. Prestegard:

As provided in s. 227.20, Stats., there is hereby submitted a certified copy of HSS 120, administrative rules relating to the Office of Health Care Information.

These rules are also being submitted to the Secretary of State as required by s. 227.20, Stats.

These rules will not have a significant economic impact on a substantial number of small businesses as defined in s. 227.114(1)(a), Stats.

Sincerely,

A handwritten signature in cursive script that reads 'Patricia A. Goodrich'.

Patricia A. Goodrich  
SECRETARY

Enclosure