FORM BHD 134A
REVISED 8/2010

THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2010

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4109
www.shpda.alabama.gov

STREET ADDRESS (Commercial Carrier)
100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104
FAX: (334) 242-4113
bradford.williams@shpda.alabama.gov

2010 ANNUAL REPORT FOR HOSPITALS AND RELATED FACILITIES

TYPE FACILITY ID # HERE

TYPE FACILITY NAME HERE

Mailing Address: _____ (STREET ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Physical Address: _____ (STREET ADDRESS) _____ (CITY) **AL** _____ (ZIP)

County of Location: _____

Facility Telephone: _____ (AREA CODE) & TELEPHONE NUMBER **Facility Fax:** _____ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for October 1, 2009, through September 30, 2010*; or for **partial** year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

*Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. ***If there was a change in ownership during the reporting period, data for the full year should be reported by the current owner.***

We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this facility.

PRINTED NAME OF PREPARER	SIGNATURE OF PREPARER	DATE
DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS

A member of administration <u>MUST</u> also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above.

PRINTED NAME OF ADMINISTRATION OFFICIAL	SIGNATURE OF ADMINISTRATION OFFICIAL	DATE
DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS

FOR OFFICE USE ONLY

Facility Verified:		Initial Scan:		Completed:	
Entered:		Final Scan:		Audited:	

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OWNERSHIP (check one)

◯ Corporation	◯ Non-Profit Organization	◯ Partnership
◯ Individual	◯ Healthcare Authority	◯ LLC
◯ Joint Venture	◯ Government	◯ Other

Does this facility operate under a management contract? ◯ Yes ◯ No

Management Firm: _____

NAME

_____

BASE ADDRESS CITY STATE ZIP

I. FACILITIES

A. Check the ONE category that best describes the type of service provided to the majority of admissions.

◯ General Medical & Surgical ***(acute care)***	◯ Pediatric
◯ Psychiatric	◯ Rehabilitation
◯ Long Term Acute Care ***(LTACH)***	◯ Chronic Disease (Long Term Care)
◯ Critical Access Hospital	◯ Other (specify) _____

B. Totals

	TOTALS
1. Number of **licensed beds** on last day of reporting period	
2. Number of **staffed and operational beds** on last day of reporting period	
3. Number of CON-authorized, certified **swing beds**	
4. Number of admissions for reporting period, excluding **all** newborns and NICU patients	
5. Patients days for reporting period, excluding **all** newborns and NICU patients	
6. Number of discharges for reporting period, excluding all newborns and NICU patients	
7. Outpatient visits	

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C. Information provided should be for the reporting period for each of the following PRINCIPAL source of payment categories.

		PATIENT DAYS (exclude *all* newborns and NICU patients)	DISCHARGES (include deaths, exclude *all* newborns and NICU patients)
a.	Self Pay		
b.	Worker's Compensation		
c.	Medicare		
d.	Medicaid		
e.	Tricare		
f.	Blue Cross		
g.	Other Insurance Companies		
h.	No Charge (charity & other free care)		
i.	Health Maintenance Organization (HMO)		
j.	All Kids		
k.	Other (specify) _____		
TOTALS		0	0

II. SERVICES OFFERED

Indicate below the services actually available and staffed within this facility, and quantitative data for those applicable services for this reporting period. **Provide information only if the hospital has a specified area and beds staffed and assigned for the listed services**. This information should be provided for inpatient clinical services, unless otherwise noted.

A. GENERAL HOSPITALS (excluding formal psychiatric, newborn, substance and rehabilitation units)

		NUMBER OF LICENSED BEDS BY SERVICE	NUMBER OF DISCHARGES BY SERVICE	PATIENT DAYS BY SERVICE	STAFFED BEDS BY SERVICE (Last day of reporting period only)
1.	Medicine				
2.	Surgery				
3.	Medicine-Surgery				
4.	Obstetric (maternity)				
5.	Pediatric				
6.	Orthopedic				

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	NUMBER OF LICENSED BEDS BY SERVICE	NUMBER OF DISCHARGES BY SERVICE	PATIENT DAYS BY SERVICE	STAFFED BEDS BY SERVICE (Last day of reporting period only)
7. Intensive Care Unit (cardiac only)				
8. Intensive Care Unit				
9. Cardiac & Intensive Care Units (mixed)				
10. Swing Beds	XXXXX			XXXXX
11. Other (specify) _____				
TOTALS	0	0	0	0

B. <u>PSYCHIATRIC UNITS/PSYCHIATRIC HOSPITALS</u> (for formal psychiatric units). Hospitals not having formal, CON-authorized, psychiatric units should report psychiatric days above under "General Hospital" information.

	NUMBER LICENSED BEDS	NUMBER OF ADMISSIONS	NUMBER OF DISCHARGES	PATIENT DAYS	STAFFED BEDS BY SERVICE (LAST DAY OF REPORTING PERIOD ONLY)
Inpatient Unit					

C. <u>SPECIALTY UNITS</u> (do not duplicate data reported in other sections)

	NUMBER LICENSED BEDS	NUMBER OF ADMISSIONS	NUMBER OF DISCHARGES	PATIENT DAYS	STAFFED BEDS BY SERVICE (LAST DAY OF REPORTING PERIOD ONLY)
1. Substance Abuse					
2. Long-Term Care Unit of Hospital (DO NOT include if this is licensed as a nursing home)					
3. Long-Term Acute Care Hospital (LTACH)					
4. Medical Rehabilitation Inpatient Unit					
5. Burn Unit					

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D. OBSTETRICS & NURSERY (do not include newborn data in more than one place)

	Number of Rooms	Total Number of Live Births	Total Number of Fetal Deaths	Total Number of Other Procedures/ Cases
Delivery Rooms/ LDR/Obstetrical Recovery				
C-Section Rooms				

Well Newborn Unit	Number of Bassinets	Number of Infants	Newborn Days
Newborn (Well Baby) Unit (DO NOT include any newborns shown in separately designated special-care units)			
Newborn ICU and NICU			
Intermediate Care Unit (ICU) (include newborns in separate special-monitoring units that are not NICU level care)			
Neonatal Intensive Care Unit (NICU)			
Level _____			
Other (specify) _____			

E. SURGERY

1. General Surgery

	Rooms
a. Total number of inpatient surgery rooms only	
b. Total number of outpatient surgery rooms only	
c. Total number of "mixed-use" (inpatient and outpatient) surgery rooms	
Total number of operating rooms available for general surgeries (exclude specialized surgeries)	0

	Number of Persons (cases)	Number of Procedures
d. Inpatient		
e. Outpatient		

	YES	NO
f. Does this facility have a designated separate/organized outpatient surgical unit? (OR rooms used only for outpatient surgery, **do not** include separately licensed ASC's)	◯	◯

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2. Specialized Surgery
(Do not count normal OR procedures.)

	Rooms
a. Total number of open heart rooms	
b. Total number of transplant rooms	
c. Total number of rooms used for specialized surgeries not listed above.	
Total number of operating rooms available for specialized surgeries	0

	Number of Persons (cases)	**Number of Procedures**
d. Open heart (defined as surgery in which thoracic cavity is opened to expose the heart and the blood is recirculated and oxygenated by a heart-lung machine)		
e. Transplants		
f. Other		

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F. Classify the total invasive cardiac procedures into one of the following inpatient or outpatient categories. Do not count Swan/Ganz insertions performed in other areas of your facility under right heart catheterization.

CARDIAC PROCEDURES

	PERFORMED IN CON-AUTHORIZED CATHETERIZATION LAB		PERFORMED IN ELECTRO-PHYSIOLOGY LAB		OTHER LOCATION (specify)	
	Inpatient Procedures	Outpatient Procedures	Inpatient Procedures	Outpatient Procedures	Inpatient Procedures	Outpatient Procedures
Left Heart Catheterization (to include coronary cine angiograms)						
Right Heart Catheterization (to include endocardial biopsy, Swan/Ganz insertions, right heart and pulmonary angiograms)						
Right & Left Heart Catheterization (to include coronary cine angiograms)						
P.T.C.A.						
Pacemaker Implants (permanent)						
Other (specify)						
TOTAL PROCEDURES	0	0	0	0	0	0
TOTAL PATIENTS (cases)						
	INPATIENT	OUTPATIENT				

TOTAL NUMBER OF CON AUTHORIZED CATH LABS: _____

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G. DIAGNOSTIC EQUIPMENT

	Number of Fixed Units	Number of Mobile Units	Total Number of Patients
Magnetic Resonance Imaging (MRI)			
Lithotripsy			
Positron Emission Tomography (PET)			

H. THERAPEUTIC SERVICES

	Number of Units (pieces of equipment)	Number of Inpatient Persons	Number of Outpatient Persons
Gamma Knife			
Linear Accelerator			
Megavoltage Therapy			
Renal Dialysis (number of stations)			

I. CLINICAL EQUIPMENT

	Number of Adult Ventilators	Number of Pediatric/Neonatal Ventilators
Mechanical Ventilators (Do not include manual resuscitators or therapeutic IPPB)		

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III. OUTPATIENT SERVICES

A. Emergency Outpatient Unit

1. The hospital's emergency facilities and services (usually called the "emergency department" or "emergency room") intended primarily for care of outpatients whose conditions require medical attention. Indicate below the emergency medical care provided that best describes your facility.

◯ Comprehensive 24 hours a day, including in-hospital physician coverage for medical, surgical, obstetric, and anesthesiology services by members of the medical staff or senior level trainees.

◯ Limited by the lack of immediate coverage in some major specialties, but a physician is always present in the emergency area, a surgeon is immediately available for consultation, and other clinical specialists are on call within 15 to 30 minutes. Following assessment by a physician, a few patients may be transferred to another facility

◯ Essentially prompt emergency care available at all times. Basic medical and surgical service is usually supplied within 30 minutes or less. Certain well-defined clinical problems are always immediately transferred to another facility, while others may require specific assessment before transfer.

◯ Little or none beyond first aid given by a nurse. There is a written plan relative to handling individuals who inadvertently appear for treatment.

◯ Non-existent. There is no emergency service or plan offered at this hospital.

Number of Exam Treatment Rooms/Cubicles	Number of Outpatient Visits to Emergency Unit

IV. EXPENSES & REVENUES

NOTE: These amounts **DO NOT** have to be **AUDITED** prior to reporting.

	INPATIENT	OUTPATIENT
TOTAL EXPENSES	$ .00	$ .00
TOTAL REVENUES	$ .00	$ .00
TOTAL BAD DEBT	$ .00	$ .00
TOTAL CHARITY	$ .00	$ .00

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FACILITY ID: _____

FACILITY NAME: _____

On May 13, 2009, Alabama Act 2009-492 was signed into law to include hospice service providers within the definition of a healthcare facility. As a result of this Act, all hospice providers are required to have Certificate of Need (CON) authorization to provide hospice services. To determine the current availability and utilization of hospice services in Alabama, the following information is needed on behalf of hospice services provided by this facility.

1. Are in-home hospice services provided by this facility or by a separate entity under common ownership with this facility? ○ YES ○ NO

2. Has a Letter of Non-Reviewability been issued by SHPDA to this facility to provide inpatient hospice services through rural exemption? ○ YES ○ NO

3. Does this facility have **contracts** with hospice providers to provide respite and/or inpatient hospice services as needed? ○ YES ○ NO

4. If yes, how many providers have **current contracts** with this facility? _____

5. Does this facility have any licensed beds **dedicated** for use by hospice providers **only** for the provision of respite and/or inpatient hospice services? ○ YES ○ NO

6. If yes, how many beds are **dedicated** for this service? _____

7. How many respite and/or inpatient hospice days were provided (billed) during the reporting period? _____