

# **INSTRUCTIONS FOR COMPLETING THE 2016 ANNUAL REPORT FOR HOSPITALS AND RELATED FACILITIES**



**STATE HEALTH PLANNING AND DEVELOPMENT  
AGENCY**

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**INSTRUCTIONS FOR COMPLETION OF THE  
2016 ANNUAL REPORT FOR HOSPITALS AND RELATED FACILITIES**  
*Form BHD 134A*

**Both the facility utilization section and patient origin data must be submitted for the entire reporting period before this report can be deemed officially filed and substantially complete. Pursuant to ALA. ADMIN. Code r 410-1-3-.11, this report is deemed a “Mandatory Report” and is due no later than November 30, 2016. ALA. ADMIN. Code r 410-1-3-.09 requires that this report be filed electronically to [data.submit@shpda.alabama.gov](mailto:data.submit@shpda.alabama.gov).**

These instructions for the 2016 Annual Report for Hospitals and Related Facilities are intended to assist in the completion and submission of accurate annual data reports. To ensure data integrity, and determine utilization rates of inpatient and outpatient services provided by hospitals, information reported must be consistent from all hospitals throughout the state. These instructions are intended to assist in the collection of data, and minimize the number of errors experienced in previous years. Should these instructions not address a particular concern, please request additional assistance by contacting the State Health Planning and Development Agency (SHPDA), Bradford L. Williams, Data/Planning Director, at (334) 242-4103 or [bradford.williams@shpda.alabama.gov](mailto:bradford.williams@shpda.alabama.gov).

**Page 1**

The facility identification number is assigned by SHPDA, and **can be obtained from the Contact Implementation form recently filed with the Agency.**

The facility name must match the name on the current license issued by the Alabama Department of Public Health (ADPH).

**Mailing Address:** Provide the complete mailing address to be used by SHPDA for mailing purposes. This address may be different from the physical address of the facility.

**Physical Address:** Provide the complete current physical address of this facility as indicated on the ADPH license.

**County of Location:** Provide the county of physical location of the facility.

**Facility Telephone:** Provide the primary general telephone number of the facility, including area code.

**Facility Fax:** Provide the primary general fax telephone number of the facility, including area code.

Electronic signatures on the form are preferred. If the facility does not have electronic signature capability, the report may be printed, manually signed by both individuals, scanned, and e-mailed as an attachment to [data.submit@shpda.alabama.gov](mailto:data.submit@shpda.alabama.gov).

The signatures and requested identifying information **must** be provided by **two separate individuals**. The primary preparer of the annual report will be contacted first for additional/corrected information. The administration official may be contacted in the event the preparer is unavailable or for informational purposes. Legible e-mail addresses for both the preparer and second verifying administrative individual **must** be provided.

**Page 2**

**Ownership:** Provide the organizational structure of the facility as reported to ADPH.

**Management:** Indicate if this facility is operated by a management firm. If so, check yes and provide the name of the management firm and all contact information requested. If this facility is not

operated under a management contract, go to Section I-A.

### Section I-A - Facilities:

Indicate the type of service(s) provided that best describe this facility based on the primary CON Authorization(s) held.

### Section I-B - Totals:

1. Indicate the number of CON-Authorized beds on the last day of the reporting period.

2. Indicate the number of beds staffed and in operation on the last day of the reporting period. This number may be less than, but not more than, the number of CON-Authorized beds. Staffed beds should be based environmentally, not on personnel. **Example:** a general acute care hospital has CON Authorization for 100 beds; currently has 75 beds set up for immediate admissions, but is staffed according to a 50 inpatient occupancy level. The staffed and operational beds on the last day of the reporting period is 75.

3. Indicate the number of certified Swing Beds authorized by Certificate of Need (CON). If this facility is not certified for Swing Beds, enter %0+.

4. Indicate the total number of admissions during the reporting period of all patients, excluding newborns and NICU patients.

5. Indicate the total number of patient days during the reporting period, excluding newborns and NICU patients.

6. Indicate the total number of discharges during the reporting period, excluding newborns and NICU patients. All deaths, excluding newborns and NICU patients, are to be reported as discharges.

### Page 3

#### Section I-C – Principal Source of Payment:

**Patient Days:** Indicate the breakdown of the total patient days, excluding newborn and NICU patients, by principal source of reimbursement. The total patient days reported in this section

must equal the total number of patient days reported on Page 2, Section I-B-5.

**Discharges:** Indicate the breakdown of the total number of discharges, including the total number of deaths, but excluding newborn and NICU patients, by principal source of reimbursement. The total discharges reported in this section must equal the total number of discharges reported on Page 2, Section I-B-6.

Reimbursements from hospice providers are to be reported separately where indicated.

All reimbursement categories in this section are verified by dividing the number of patient days by the total number of discharges for each reimbursement source. This provides an average length of stay for each reimbursement category. For hospitals providing general acute care services only, any average length of stay over 5 days (over 7 days for Medicare and Medicaid reimbursements) should be verified by the facility for accuracy before submitting the report. For hospitals providing specialty services, it is understood that the average length of stay will be greater than that of general acute care hospitals.

### Pages 3 and 4

#### Section II-A – Services Offered- GENERAL HOSPITALS:

**IMPORTANT NOTE:** Due to changes in the annual reporting form, **Rehabilitation Hospitals, Pediatric Hospitals, Long-Term Acute Care Hospitals, and Pediatric and Obstetric Hospitals** are to report utilization in Section I-B. **Psychiatric Hospitals** are to report utilization in Section I-C.

Inpatient general acute care services only should be reported in this section. For services listed which are not offered in a specified area, data should be reported under Medicine-Surgery as applicable. For services listed which are provided in a specified area, applicable information should be reported for each service. **All CON-Authorized substance abuse, inpatient rehabilitation, and burn unit services are to be reported in Section II-D only.**

**Number of CON-Authorized Beds by Service:**  
Enter the maximum number of CON-Authorized

beds to be utilized in a dedicated area for each inpatient service offered.

**Number of Discharges by Service:** Enter the total number of discharges for each listed inpatient service offered in a dedicated area. Deaths should also be included as discharges. Transfer of patients from one service to another service should not be listed as discharges. Discharges for transfer patients should be provided for the last service offered at the time of discharge.

**Patient Days by Service:** Enter the total number of patient days for each listed inpatient service offered in dedicated areas.

**Staffed Beds by Service:** Enter the number of beds staffed (not to exceed authorized bed capacity) on the last day of the reporting period for each inpatient service offered in dedicated areas. Refer to Section I-B-2 instructions for definition of %Staffed Beds+.

Occupancy rates in this section are verified by dividing the number of patient days by the number of days in the reporting period, divided by the number of **CON-Authorized** beds for the service(s) provided, multiplied by 100. The occupancy rate for specified service(s) cannot be over 100%.

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**Section II-B – Specialty Hospitals (excluding psychiatric hospitals)**

All hospitals classified as Rehabilitation, Pediatric, Long-Term Acute Care, or Pediatric and Obstetric should complete this section. Services only should be reported in this section. **All CON-Authorized inpatient rehabilitation units of general acute care hospitals are to report in Section II-D only.**

**Number of CON-Authorized Beds by Service:** Enter the maximum number of CON-Authorized beds for this facility.

**Number of Discharges by Service:** Enter the total number of discharges for each applicable listed inpatient service. Deaths should also be included as discharges.

**Patient Days by Service:** Enter the total number of patient days for each listed inpatient service offered for each applicable service.

**Staffed Beds by Service:** Enter the number of beds staffed (not to exceed authorized bed capacity) on the last day of the reporting period for each applicable inpatient service offered. Refer to Section I-B-2 instructions for definition of %Staffed Beds+.

Occupancy rates in this section are verified by dividing the number of patient days by the number of days in the reporting period, divided by the number of **CON-Authorized** beds for the service(s) provided, multiplied by 100. The occupancy rate for applicable service(s) cannot be over 100%.

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**Section II-C – Psychiatric Units/Psychiatric Hospitals**

**Staffed Beds by Type:** Refer to Section I-B-2 instructions for definition of %Staffed Beds+. It is acknowledged that not all CON Authorizations to provide psychiatric services are limited to specific age group(s). In an effort to determine utilization of psychiatric services offered throughout the state, please provide a breakdown of the number of CON-Authorized psychiatric beds on the last day of the reporting period, both by non-classification and by classification according to population demographics outlined.

Psychiatric services which may be provided, but are not provided through CON authorization or exemption provided through Department of Mental Health contracts should be reported under the General Acute Care section on Page 3, Section II-A, as (1.) Medicine-Surgery.

**Number of CON-Authorized Beds:** Enter the maximum number of CON-Authorized beds for this facility.

**Number of Discharges:** Enter the total number of discharges during the reporting period. Deaths should also be included as discharges.

**Patient Days:** Enter the total number of patient days during the reporting period.

**Staffed Beds:** Enter the number of beds staffed (not to exceed authorized bed capacity) on the last day of the reporting period. Refer to Section I-B-2 instructions for definition of %Staffed Beds+. The Staffed Beds reported should equal the number of Staff Beds reported above.

The occupancy rate in this section is verified by dividing the number of patient days by the number of days in the reporting period, divided by the number of **CON-Authorized** beds, multiplied by 100. The occupancy rate cannot be over 100%.

### Section II-D – Specialty Units

This section is to be completed by facilities providing CON-Authorized substance abuse and inpatient rehabilitation services within a facility primarily providing additional inpatient services. Burn units should also report in this section although the burn unit may not hold CON-Authorization.

**Number of CON-Authorized Beds:** Enter the total number of CON-Authorized beds providing specified service(s). (See above for burn units).

**Number of Admissions:** Enter the total number of patients admitted to CON-Authorized beds providing the specified service(s). (See above for burn units).

**Number of Discharges:** Enter the total number of patients discharged from CON-Authorized beds providing specified service(s). Deaths must also be included as discharges for the service(s). (See above for burn units).

**Patient Days:** Enter the total number of patient days for CON-Authorized beds providing specified service(s). (See above for burn units).

**Staffed Beds by Service:** Enter the number of beds staffed on the last day of the reporting period for each inpatient service offered. Refer to Section I-B-2 instructions for definition of %Staffed Beds+.

Occupancy rates in this section are verified by dividing the number of patient days by the number of days in the reporting period, divided by the number of **CON-Authorized** beds, multiplied by 100 (see above for burn units). The

occupancy rate for specified service(s) cannot be over 100%.

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### Section II-E – Obstetrics & Nursery

This section is to be completed by facilities providing obstetrical services. If obstetrical services are not provided, continue to Section II-F.

**Number of Rooms:** Enter the maximum number of rooms available at one time, broken down by vaginal and c-section deliveries.

**Total Number of Live Births:** Enter the total number of live births for the reporting period, broken down by vaginal and c-section deliveries.

**Total Number of Fetal Deaths:** Enter the total number of fetal deaths for the reporting period, broken down by vaginal and c-section deliveries.

**Number of Bassinets:** Enter the maximum number of bassinets that can be placed in the newborn unit at one time, including the number of bassinets available for rooming-in with mothers. Report the maximum number of bassinets available at one time in the intermediate care and neonatal intensive care units; and any other newborn units not included above. NOTE: The maximum number of bassinets reported should not exceed the total number of bassinets available for use in the facility.

**Number of Infants:** Enter the total number of infants for the reporting period placed in the newborn unit or rooming-in with mothers, not requiring special monitoring; requiring special monitoring but not requiring neonatal intensive care; requiring neonatal intensive care; and the total number of infants requiring additional level of care not specified.

**Newborn Days:** Enter the total number of newborn days for the reporting period for infants in the newborn unit or rooming-in with mothers not requiring special monitoring; newborn days for infants requiring special monitoring but not requiring neonatal intensive care; newborn days for infants requiring neonatal intensive care; and the total number of newborn days for infants requiring additional level of care not specified.

## Section II-F-1 - Surgery

**General Surgery Rooms:** Enter the total number of operating rooms designated for general inpatient surgery only; the total number of operating rooms designated for general outpatient surgery only; and the total number of operating rooms utilized for both inpatient and outpatient general surgeries.

**General Surgery Persons (cases):** Enter the number of persons receiving surgical procedures, broken down by inpatient and outpatient persons.

**General Surgery Procedures:** Enter the number of general surgical procedures performed, broken down by inpatient and outpatient persons. NOTE: the number of procedures reported is generally greater than the number of persons, as multiple procedures are often performed during surgery, i.e., tonsillectomy and adenoidectomy are considered two separate procedures.

All general surgeries are verified by dividing the number of procedures performed by the number of inpatients and outpatients. Any average over three (3) procedures per patient should be verified by the facility before submitting the report to SHPDA.

**Outpatient Surgical Unit:** Indicate if this facility has a separate designated unit (day surgery) utilized for outpatient surgery only, not licensed by ADPH separately as an ambulatory surgical center. All ambulatory surgical centers licensed holding separate CON-Authorization for outpatient surgery MUST report those services on the Annual Report for Ambulatory Surgical Center form.

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## Section II-F-2 – Specialized Surgery

### a. Open Heart

**Number of Rooms:** Enter the total number of operating rooms available for open heart surgery.

**Number of Cases:** Enter the total number of cases (patients) receiving open heart surgical services.

**Number of Procedures:** Enter the total number of open heart surgical procedures performed.

### b. Transplants

**Number of Rooms:** Enter the total number of operating rooms available for organ transplantation surgery.

**Number of Cases:** Enter the total number of cases (patients) receiving organ transplant services.

**Number of Procedures:** Enter the total number of organ transplant procedures performed.

### c. Other Specialized Surgery

**Number of Rooms:** Enter the total number of operating rooms, not reported in open heart and transplant rooms, available for other non-general surgeries.

**Number of Cases:** Enter the total number of cases (patients) receiving non-general surgical services not classified as open heart or organ transplant.

**Number of Procedures:** Enter the total number of non-general surgical procedures performed, not classified as open heart or organ transplant.

Other Specialized Surgeries performed must be specified where requested.

NOTE: The number of procedures reported may be greater than the number of persons reported if multiple procedures are performed on the same case (patient) during surgery.

**Total Number of Surgery Rooms:** The total number of rooms available for surgical procedures in the facility for inpatients and outpatients, general and specialized surgeries.

NOTE: The total reported may be less than the sum of indicated open heart rooms, transplant rooms, and other specialized rooms if any operating rooms are not dedicated for sole use of specified procedures.

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**Section II-G Cardiac Procedures:** Enter the total number of cardiac procedures for inpatients and outpatients, separated by type of procedure(s) performed and location of procedure(s). Report the total number of physical procedures performed by the lab(s); NOT the number of procedures billed by the hospital (billing code numbers).

**Performed in CON-Authorized CATH Lab:** Enter the number of cardiac procedures, separated by inpatient and outpatient, and by type of procedure performed, in a CON-Authorized catheterization laboratory.

**Total Procedures:** Enter the total sum of cardiac procedures performed in the CON-Authorized catheterization lab(s), separated by inpatient and outpatient.

**Total Patients:** Enter the total number of patients (cases) separated by inpatient and outpatient, receiving cardiac procedures performed in CON-Authorized catheterization lab(s).

**Performed in Electrophysiology Lab:** Enter the number of cardiac procedures, separated by inpatient and outpatient and by type of procedure, performed in an electrophysiology lab.

**Total Procedures:** Enter the total sum of cardiac procedures performed in an electrophysiology lab, separated by inpatient and outpatient.

**Total Patients:** Enter the total number of patients (cases) separated by inpatient and outpatient, receiving cardiac procedures performed in an electrophysiology lab.

**Other Location:** Enter the number of cardiac procedures, separated by inpatient and outpatient and by type of procedure, performed in a location other than a CON-Authorized catheterization lab or an electrophysiology lab. The *other* location must be specified where requested.

**Total Procedures:** Enter the total sum of cardiac procedures performed in the other location, separated by inpatient and outpatient.

**Total Patients:** Enter the total number of patients (cases), separated by inpatient and outpatient, receiving cardiac procedures in the %Other+location.

NOTE: the number of procedures reported should generally be greater than the number of persons, as multiple procedures are often performed on a single patient.

**Total Number of CON-Authorized Cath. Labs:** Enter the total number of CON-Authorized catheterization laboratories located in this facility on the last day of the reporting period.

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**Section II-H – Therapeutic Services**

Count only the units and patients if the equipment is physically located in or at the facility, and performed and billed directly by the facility.

**Number of Units:** Provide the total number of units located in this facility for Gamma Knife and Linear Accelerator (Megavoltage Therapy) services.

**Inpatient Persons:** Provide the total number of inpatients receiving Gamma Knife and Linear Accelerator (Megavoltage Therapy) services.

**Outpatient Persons:** Provide the total number of outpatients receiving Gamma Knife and Linear Accelerator (Megavoltage Therapy) services.

**Section III-A – Outpatient Services**

Review each level of emergency outpatient care carefully and indicate the highest level of emergency outpatient care that was available on a daily basis throughout the entire reporting period.

**Number of Exam Treatment Rooms/Cubicles:** Indicate the total number of rooms/cubicles available in the facility on the last day of the reporting period for treatment of emergency cases. If multiple emergency patients can be treated in the same room, count the total number of emergency patients that can be treated at the same time.

**Number of Outpatient Visits to Emergency Unit:** Indicate the total number of outpatient visits to the facility emergency room during the reporting period.

**Number of Free Standing Emergency Exam Rooms:** Report the number of exam rooms operated at a CON-Authorized Freestanding Emergency Department under common ownership, but operated off-campus by the facility.

**Number of Free Standing Emergency Rooms Visits:** Report the number of emergency room visits to a CON-Authorized Free Standing Emergency Department, under common ownership, but operated off-campus by the facility.

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**Section IV – Outpatient Surgery**

**Section A – Patient Origin by Zip Code**

Enter the unique residence zip code for all patients (cases) receiving outpatient surgery reported in Section I-F-1-e, and the number of patients (cases) for each unique residence zip code. Attach additional pages as necessary utilizing the same format as this section. The total persons (cases) MUST equal the total number of persons (cases) reported in Section I-F-1-e.

**Section B – Persons (Cases) by Age and Gender**

Report the persons (cases) reported in Section I-F-1-e by specified age and gender demographics. The total persons (cases) MUST equal the total number of persons (cases) reported in Section I-F-1-e.

NOTE: If this information is not collected on individuals receiving outpatient surgeries, a statement to that effect must be provided on facility letterhead, signed and currently dated by the administrator or a corporate official.

**Section C – Persons (Cases) by Race**

Report the persons (cases) reported in Section I-F-1-e by specified racial demographics. The total persons (cases) MUST equal the total number of persons (cases) reported in Section I-F-1-e.

NOTE: If this information is not collected on individuals receiving outpatient surgeries, a statement to that effect must be provided on facility letterhead, signed and currently dated by the administrator or a corporate official.

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**Section V – Hospice Services**

**1:** Indicate if in-home hospice services were offered directly or by a separate entity under common ownership with this facility during the reporting period.

**2:** Indicate if this facility has been granted a Letter of Reviewability from SHPDA, based on rural exemption, to provide inpatient hospice services on site.

**3:** Indicate if in-home hospice providers had contracts to provide palliative care/respice care to any patients at this facility during the reporting period.

**4:** Indicate the total number of contracts held with hospice providers during the reporting period to provide palliative care/respice care at the facility.

**5:** Indicate if this facility provided beds during the reporting period which were **dedicated** solely for the use of hospice patients to the exclusion of any other type of service, but for which licensure as an Inpatient Hospice provider has not been obtained.

**6:** Indicate the total number of beds **dedicated** to hospice care on the last day of the reporting period, but for which licensure as an Inpatient Hospice bed has not been obtained.

**Hospital Annual Report Checklist**

In addition to the report verification procedures outlined throughout these instructions, the checklist must be completed to verify the following data reported equals in all applicable sections of the report: licensed beds, staffed beds, patient days, and discharges. Failure for each category to equal throughout the report results in an incorrect submission. If interactive



completion of the report is utilized, this checklist will be completed automatically based on information provided in Sections I-B, II-A, II-B, II-C, and II-D.

### **Pages 14 – 18**

Patient Origin data must be submitted for the entire reporting period as part of the mandatory reporting requirements for hospitals. Pages 14 . 18 provide the needed instructions and formats for accurate reporting, which must be submitted separately from the utilization portion of the report. Patient Origin data is to be submitted only in Microsoft Excel (v. 2003 or later) or CSV formats.

#### **\*\*\*REMINDERS\*\*\***

- The annual report MUST be signed by both the preparer and a separate administrative official. If the report is completed by an administrative official, the signature of a second administrative or corporate official must be provided. Electronic signatures are preferred.
- Keep a copy of the completed report for your records prior to submitting to SHPDA.
- The report MUST be submitted to [data.submit@shpda.alabama.gov](mailto:data.submit@shpda.alabama.gov) to be deemed officially filed. Hard and faxed copies of the report cannot be accepted. If the facility is unable to submit the completed report to this e-mail address, please contact the Agency for alternative .pdf submission (utilization portion only). Patient origin data is not to be submitted in .pdf format.