

THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2017

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2017 ANNUAL REPORT FOR HOSPITALS AND RELATED FACILITIES

SHPDA ID NUMBER FACILITY NAME
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Mailing Address:	_____	_____	_____	_____
	STREET ADDRESS	CITY	STATE	ZIP
Physical Address:	_____	_____	AL	_____
	STREET ADDRESS	CITY		ZIP
County of Location:	_____			
Facility Telephone:	_____	Facility Fax:	_____	
	(AREA CODE) & TELEPHONE NUMBER		(AREA CODE) & TELEPHONE NUMBER	

This reporting period is for October 1, 2016, through September 30, 2017; or for **partial** year of operation beginning _____ and ending _____ a period of _____ days.

MONTH DAY MONTH DAY
*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
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DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS
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A member of administration MUST also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above; and must be separate from the preparer.

PRINTED NAME OF ADMINISTRATION OFFICIAL	SIGNATURE OF ADMINISTRATION OFFICIAL	DATE
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DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS
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FOR OFFICE USE ONLY

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

OWNERSHIP (check one)

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Non-Profit Organization | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Individual | <input type="checkbox"/> Healthcare Authority | <input type="checkbox"/> LLC |
| <input type="checkbox"/> Joint Venture | <input type="checkbox"/> Government | <input type="checkbox"/> Other |

Does this facility operate under a management contract? Yes No

Management Firm:

NAME				
<table style="width: 100%; border: none;"> <tr> <td style="width: 40%;">BASE ADDRESS</td> <td style="width: 20%;">CITY</td> <td style="width: 20%;">STATE</td> <td style="width: 20%;">ZIP</td> </tr> </table>	BASE ADDRESS	CITY	STATE	ZIP
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.

- | | |
|---|---|
| <input type="checkbox"/> General Medical & Surgical (<i>acute care</i>) | <input type="checkbox"/> Pediatric |
| <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Long Term Acute Care (<i>LTACH</i>) | <input type="checkbox"/> Chronic Disease (Long Term Care) |
| <input type="checkbox"/> Critical Access Hospital | <input type="checkbox"/> Other (specify) _____ |

B. Totals

****PLEASE VERIFY ALL TOTALS ON CHECKLIST, PAGE 11, PRIOR TO SUBMISSION****

	TOTALS
1. Total Certificate of Need (CON) approved beds	_____
2. Number of <u>staffed and operational beds</u> on last day of reporting period	_____
3. Number of CON-authorized <u>swing beds</u>	_____
4. Number of admissions for reporting period, excluding <u>all</u> newborns and NICU patients	_____
5. Patients days for reporting period, excluding <u>all</u> newborns and NICU patients	_____
6. Number of discharges for reporting period, excluding all newborns and NICU patients	_____

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C. PRINCIPAL SOURCE OF PAYMENT CATEGORIES. Medicare Supplemental reimbursement should be reported under the actual reimbursement SOURCE, and not reported as a separate (Other) category.

	PATIENT DAYS (exclude <i>all</i> newborns and NICU patients)	DISCHARGES (include deaths, exclude <i>all</i> newborns and NICU patients)
a. Self Pay (Non-Charity Care)		
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. Hospice		
l. Medicare Advantage		
m. Other (specify)		
TOTALS		

* Charity Care is that care provided pursuant to the Hospital's Financial Assistance Policy.

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 (including critical access hospitals, but excluding formal psychiatric, newborn, substance abuse, and rehabilitation units)

	NUMBER OF BEDS BY SERVICE	NUMBER OF DISCHARGES BY SERVICE	PATIENT DAYS BY SERVICE	STAFFED BEDS BY SERVICE (Last Day of Reporting Period Only)
1. Medicine-Surgery				
2. Obstetric (maternity)				
3. Pediatric				

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	NUMBER OF BEDS BY SERVICE	NUMBER OF DISCHARGES BY SERVICE	PATIENT DAYS BY SERVICE	STAFFED BEDS BY SERVICE (Last Day of Reporting Period Only)
4. Orthopedic				
5. Intensive Care Units				
6. Swing Beds	XXXX			XXXXXXX
7. Other (specify)				
TOTALS				

B. SPECIALTY HOSPITALS (excluding psychiatric)

- | | |
|--|---|
| <input type="checkbox"/> Rehabilitation Hospital | <input type="checkbox"/> Long-Term Acute Care Hospital |
| <input type="checkbox"/> Pediatric Hospital | <input type="checkbox"/> Pediatric and Obstetric Hospital |

	NUMBER OF BEDS BY SERVICE	NUMBER OF DISCHARGES BY SERVICE	PATIENT DAYS BY SERVICE	STAFFED BEDS BY SERVICE (Last Day of Reporting Period Only)
1. Obstetric (maternity)				
2. Pediatric				
3. Intensive Care Units				
4. Rehabilitation				
5. LTACH				
6. Other (specify)				
TOTALS				

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C. PSYCHIATRIC UNITS/PSYCHIATRIC HOSPITALS (for formal CON-authorized psychiatric beds). Acute Care Hospitals not having formal, CON-authorized, psychiatric beds should report psychiatric days above under "General Hospital" information.

STAFFED BEDS BY TYPE (on the last day of reporting period)**

Adolescent (patients 17 and under)		Adult and Geriatric	
Adult			
Geriatric		Unclassified	

**Currently law allows for bed types to change and this reporting only reflects type of bed as of last day of reporting

	TOTAL NUMBER CON AUTHORIZED BEDS	TOTAL NUMBER OF ADMISSIONS	TOTAL NUMBER OF DISCHARGES	TOTAL PATIENT DAYS	TOTAL STAFFED BEDS BY SERVICE (Last Day of Reporting Period Only)
Inpatient Unit					

D. SPECIALTY UNITS (do not duplicate data reported in other sections; for CON-authorized services only except Burn Units, which may not hold CON-authorization).

	TOTAL NUMBER CON AUTHORIZED BEDS	TOTAL NUMBER OF ADMISSIONS	TOTAL NUMBER OF DISCHARGES	TOTAL PATIENT DAYS	TOTAL STAFFED BEDS BY SERVICE (Last Day of Reporting Period Only)
1. Substance Abuse					
2. Medical Rehabilitation Inpatient Unit – PPS-EXCLUDED					
3. Burn Unit					

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E. OBSTETRICS & NURSERY (do not include newborn data in other sections)

	Number of Rooms	Total Number of Live Births	Total Number of Fetal Deaths
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)			
<i>Level</i> _____	_____	_____	_____
Other (specify) _____	_____	_____	_____

F. SURGERY

1. General Surgery

	Rooms	
a. Total number of inpatient operating rooms only	_____	
b. Total number of outpatient operating rooms only	_____	
c. Total number of "mixed-use" (inpatient and outpatient) operating rooms	_____	
Total number of operating rooms available for general surgeries (exclude specialized surgeries)	_____	
	Number of Persons (cases)	Number of Procedures
d. Inpatient	_____	_____
e. Outpatient	_____	_____
f. Does this facility have a designated separate/organized outpatient surgical unit? (Operating rooms used only for outpatient surgery, do not include separately licensed ASC's)	_____	_____
	YES	NO

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2. Specialized Surgery (Do not count general operating rooms)

a. Open Heart

Open heart (defined as surgery in which thoracic cavity is opened to expose the heart and the blood is re-circulated and oxygenated by a heart-lung machine).

Number of Rooms	Number of Cases	Number of Procedures
_____	_____	_____

b. Transplants

Number of Rooms	Number of Cases	Number of Procedures
_____	_____	_____

c. Other Specialized Surgery

Number of Rooms	Number of Cases	Number of Procedures
_____	_____	_____

Please specify the type of Other Specialized Surgery :

3. Total Inpatient and Outpatient Operating Rooms Available for all Surgeries

Total number of operating rooms: _____

(Include all general AND specialized surgery operating rooms).

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G. CARDIAC PROCEDURES

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. 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 CATHETERIZATION LAB		PERFORMED IN ELECTROPHYSIOLOGY LAB		OTHER LOCATION (specify)	
	Inpatient Procedures	Outpatient Procedures	Inpatient Procedures	Outpatient Procedures	Inpatient Procedures	Outpatient Procedures
Heart Catheterization Diagnostic						
Heart Catheterization Therapeutic/ Interventional <small>(Including PTCA, directional coronary atherectomy, rotational atherectomy and similar complex therapeutic procedures)</small>						
Pediatric Catheterization						
Electrophysiology Diagnostic						
Electrophysiology Therapeutic						
Pacemaker Implants (permanent)						
Other (specify below)						
TOTAL PROCEDURES						
TOTAL PATIENTS (cases)						
	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT

TOTAL NUMBER OF CON AUTHORIZED CATH LABS: _____

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H. THERAPEUTIC SERVICES

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

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 this 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	Number of Free Standing Emergency Exam Rooms	Number of Free Standing Emergency Room Visits
_____	_____	_____	_____

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B. PERSONS (CASES) BY AGE AND GENDER – Only report outpatient surgery cases in this section for the entire reporting period

	MALE	FEMALE	TOTAL
18 & under			
19 – 34 years of age			
35 – 54 years of age			
55 – 64 years of age			
65 – 74 years of age			
75 – 84 years of age			
85 years and older			
TOTALS			*

** This total should equal the total reported in Section IV-A.*

C. PERSONS (CASES) BY RACE – Only report outpatient surgery cases in this section for the entire reporting period

	TOTAL
White/Caucasian	
Black/African American/Negro	
Hispanic/Spanish/Latino	
Asian	
American Indian/Alaskan Native	
Pacific Islander	
India	
Middle Eastern	
Other (please specify other race category):	
TOTALS	*

** This total should equal the total reported in Section IV-A and IV-B.*

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V. HOSPICE SERVICES

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 beds **dedicated only** for use by hospice providers for the provision of respite and/or inpatient hospice services, but for which the facility still maintains bed licensure?
_____ YES _____ NO

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

***Keep a copy of the completed report for the provider's records before submitting to SHPDA.

***This report should be submitted to SHPDA only one time.
The preferred method is electronic submission to data.submit@shpda.alabama.gov.
If submitted electronically please do not also submit via hard copy unless specifically requested to do so by SHPDA staff.

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Hospital Annual Report Checklist

	Totals
CON Authorized Beds	
Page 2, Section I-B-1.	_____
Page 4, Section II-A	_____
Page 4, Section II-B	_____
Page 5, Section II-C	_____
Page 5, Section II-D	_____
<i>CON Authorized Beds in Sections II-A+II-B+II-C+IID must equal CON Authorized Beds reported in Section I-B</i>	
TOTAL CON AUTHORIZED BEDS SECTION II	_____
Staffed and Operational Beds by Service	
Page 2, Section I-B-2.	_____
Page 4, Section II-A	_____
Page 4, Section II-B	_____
Page 5, Section II-C	_____
Page 5, Section II-D	_____
<i>Staffed and Operational Beds in Sections II-A+II-B+II-C+IID must equal Staffed and Operational Beds reported in Section I-B</i>	
TOTAL STAFFED AND OPERATIONAL BEDS SECTION II	_____
Patient Days	
Page 2, Section I-B-5.	_____
Page 3, Section I-C	_____
<i>Patient Days in Section I-C must equal Patient Days reported in Section I-B</i>	
Page 4, Section II-A	_____
Page 4, Section II-B	_____
Page 5, Section II-C	_____
Page 5, Section II-D	_____
<i>Patient Days in Sections II-A+II-B+II-C+II-D must equal Patient Days reported in Section I-B</i>	
TOTAL PATIENT DAYS SECTION II	_____
Discharges	
Page 2, Section I-B-6.	_____
Page 3, Section I-C	_____
<i>Discharges in Section I-C must equal Discharges reported in Section I-B</i>	
Page 4, Section II-A	_____
Page 4, Section II-B	_____
Page 5, Section II-C	_____
Page 5, Section II-D	_____
<i>Discharges in Sections II-A+II-B+II-C+II-D must equal Discharges reported in Section I-B</i>	
TOTAL DISCHARGES SECTION II	_____