FORM BHD 134A
REVISED 05/2016

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

**Save**

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SHPDA ID NUMBER

FACILITY NAME

**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, 2016, through September 30, 2017; 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; and <u>must be separate from the preparer</u>.***

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

| | TOTALS |
|---|---|
| 1. Total Certificate of Need (CON) approved beds | 0 |
| 2. Number of **staffed and operational beds** on last day of reporting period | 0 |
| 3. Number of CON-authorized **swing beds** | 0 |
| 4. Number of admissions for reporting period, excluding **all** newborns and NICU patients | 0 |
| 5. Patients days for reporting period, excluding **all** newborns and NICU patients | 0 |
| 6. Number of discharges for reporting period, excluding all newborns and NICU patients | 0 |

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

* 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** | 0 | 0 | 0 | 0 |
| 2. | **Obstetric (maternity)** | 0 | 0 | 0 | 0 |
| 3. | **Pediatric** | 0 | 0 | 0 | 0 |

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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 | 0 | 0 | 0 | 0 |
| 5. | Intensive Care Units | 0 | 0 | 0 | 0 |
| 6. | Swing Beds | XXXX | 0 | 0 | XXXXXX |
| 7. | Other (specify) | 0 | 0 | 0 | 0 |
| | TOTALS | 0 | 0 | 0 | 0 |

**B. SPECIALTY HOSPITALS (excluding psychiatric)**

- ◯ Rehabilitation Hospital
- ◯ Long-Term Acute Care Hospital
- ◯ Pediatric Hospital
- ◯ 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) | 0 | 0 | 0 | 0 |
| 2. | Pediatric | 0 | 0 | 0 | 0 |
| 3. | Intensive Care Units | 0 | 0 | 0 | 0 |
| 4. | Rehabilitation | 0 | 0 | 0 | 0 |
| 5. | LTACH | 0 | 0 | 0 | 0 |
| 6. | Other (specify) | 0 | 0 | 0 | 0 |
| | TOTALS | 0 | 0 | 0 | 0 |

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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 only)****

| | | | |
|---|---|---|---|
| **Adolescent (patients 17 and under)** | 0 | **Adult and Geriatric** | 0 |
| **Adult** | 0 | | |
| **Geriatric** | 0 | **Unclassified** | 0 |

****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** | 0 | 0 | 0 | 0 | 0 |

**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** | 0 | 0 | 0 | 0 | 0 |
| **2.** | **Medical Rehabilitation Inpatient Unit – *PPS-EXCLUDED*** | 0 | 0 | 0 | 0 | 0 |
| **3.** | **Burn Unit** | 0 | 0 | 0 | 0 | 0 |

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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** | 0 | 0 | 0 |
| **C-Section Rooms** | 0 | 0 | 0 |
| ***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) | 0 | 0 | 0 |
| ***Newborn ICU and NICU*** | | | |
| **Intermediate Care Unit (ICU)** (include newborns in separate special-monitoring units that are not NICU level care) | 0 | 0 | 0 |
| **Neonatal Intensive Care Unit (NICU)** ***Level*** _____ | 0 | 0 | 0 |
| **Other** (specify) _____ | 0 | 0 | 0 |

## F. SURGERY

### 1. General Surgery

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

| | | Number of **Persons** (cases) | Number of **Procedures** |
|---|---|---|---|
| d. | Inpatient | 0 | 0 |
| e. | Outpatient | 0 | 0 |
| 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 |
|---|---|---|
| 0 | 0 | 0 |

b. Transplants

| Number of Rooms | Number of Cases | Number of Procedures |
|---|---|---|
| 0 | 0 | 0 |

c. Other Specialized Surgery

| Number of Rooms | Number of Cases | Number of Procedures |
|---|---|---|
| 0 | 0 | 0 |

**Please specify the type of Other Specialized Surgery :**

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

**Total number of operating rooms:** 0

(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** | 0 | 0 | | | | |
| **Heart Catheterization Therapeutic/ Interventional** (Including PTCA, directional coronary atherectomy, rotational atherectomy and similar complex therapeutic procedures) | 0 | 0 | | | | |
| **Pediatric Catheterization** | 0 | 0 | | | | |
| **Electrophysiology Diagnostic** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Electrophysiology Therapeutic** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Pacemaker Implants (permanent)** | 0 | 0 | 0 | 0 | 0 | 0 |
| **Other (specify below)** | 0 | 0 | 0 | 0 | 0 | 0 |
| **TOTAL PROCEDURES** | 0 | 0 | 0 | 0 | 0 | 0 |
| **TOTAL PATIENTS** (cases) | 0 | 0 | 0 | 0 | 0 | 0 |
| | INPATIENT | OUTPATIENT | INPATIENT | OUTPATIENT | INPATIENT | OUTPATIENT |

**TOTAL NUMBER OF CON AUTHORIZED CATH LABS:** 0

### H. THERAPEUTIC SERVICES

| | Number of Units (pieces of equipment) | Number of Inpatient Persons | Number of Outpatient Persons |
|---|---|---|---|
| **Gamma Knife** | 0 | 0 | 0 |
| **Linear Accelerator (Megavoltage Therapy)** | 0 | 0 | 0 |

## 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 |
|---|---|---|---|
| 0 | 0 | 0 | 0 |

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# IV. OUTPATIENT SURGERY

## A. PATIENT ORIGIN BY ZIP CODE

**Please report, by zip code of residence, the total number of outpatient surgery persons (cases) treated by this provider during the reporting period. (This total should equal the totals reported in Section II-F-1-e on page 6) (Make additional copies of this page and attach as required)**

| ZIP CODE OF RESIDENCE | TOTAL NUMBER OF PERSONS (CASES) |
|---|---|
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |
| 0 | 0 |

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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 | 0 | 0 | 0 |
| 19 – 34 years of age | 0 | 0 | 0 |
| 35 – 54 years of age | 0 | 0 | 0 |
| 55 – 64 years of age | 0 | 0 | 0 |
| 65 – 74 years of age | 0 | 0 | 0 |
| 75 – 84 years of age | 0 | 0 | 0 |
| 85 years and older | 0 | 0 | 0 |
| **TOTALS** | 0 | 0 | * 0 |

**** 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 | 0 |
| Black/African American/Negro | 0 |
| Hispanic/Spanish/Latino | 0 |
| Asian | 0 |
| American Indian/Alaskan Native | 0 |
| Pacific Islander | 0 |
| India | 0 |
| Middle Eastern | 0 |
| Other (please specify other race category): | 0 |
| **TOTALS** | * 0 |

**** 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? 0

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? 0

***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. | 0 |
| Page 4, Section II-A | 0 |
| Page 4, Section II-B | 0 |
| Page 5, Section II-C | 0 |
| Page 5, Section II-D | 0 |
| *CON Authorized Beds in Sections II-A+II-B+II-C+IID must equal CON Authorized Beds reported in Section I-B* | |
| TOTAL CON AUTHORIZED BEDS SECTION II | 0 |
| **Staffed and Operational Beds by Service** | |
| Page 2, Section I-B-2. | 0 |
| Page 4, Section II-A | 0 |
| Page 4, Section II-B | 0 |
| Page 5, Section II-C | 0 |
| Page 5, Section II-D | 0 |
| *Staffed and Operational Beds in Sections II-A+II-B+IIC+IID must equal Staffed and Operational Beds reported in Section I-B* | |
| TOTAL STAFFED AND OPERATIONAL BEDS SECTION II | 0 |
| **Patient Days** | |
| Page 2, Section I-B-5. | 0 |
| Page 3, Section I-C | 0 |
| *Patient Days in Section I-C must equal Patient Days reported in Section I-B* | |
| Page 4, Section II-A | 0 |
| Page 4, Section II-B | 0 |
| Page 5, Section II-C | 0 |
| Page 5, Section II-D | 0 |
| *Patient Days in Sections II-A+II-B+II-C+II-D must equal Patient Days reported in Section I-B* | |
| TOTAL PATIENT DAYS SECTION II | 0 |
| **Discharges** | |
| Page 2, Section I-B-6. | 0 |
| Page 3, Section I-C | 0 |
| *Discharges in Section I-C must equal Discharges reported in Section I-B* | |
| Page 4, Section II-A | 0 |
| Page 4, Section II-B | 0 |
| Page 5, Section II-C | 0 |
| Page 5, Section II-D | 0 |
| *Discharges in Sections II-A+II-B+II-C+II-D must equal Discharges reported in Section I-B* | |
| TOTAL DISCHARGES SECTION II | 0 |

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**PROCESSING NOTES & LEGEND FOR SUBMISSIONS OF THE FY 2017 PATIENT ORIGIN SURVEY DATA SUPPLEMENT**
**MUST INCLUDE DISCHARGE DATA FOR OCTOBER 1, 2016 - SEPTEMBER 30, 2017**

The Patient Origin section of the annual report submitted on behalf of hospitals (Form BHD 134A) shall be submitted as a separate file/document. This data shall be submitted only in Microsoft Excel (v. 2003 or later) or CSV formats. All submissions must comply with the filing requirements set forth in Ala. Admin. Code 410-1-3-.09. Submission must include the cover sheet located in this report. Both the Annual Report (Form BHD 134A) AND the Patient Origin data electronic file must be submitted for the annual report to be deemed materially complete by the Agency. A provider whose report is deemed materially incomplete by the Agency is subject to penalties as defined in Ala. Admin. Code 410-1-3-.11.

| **FIELD NAME** (electronic & paper submissions) | **INSTRUCTIONS (electronic & paper submissions)** | **FIELD LENGTH (for electronic submissions only)**<br><br>**Field Length Requirements** |
|---|---|---|
| **Hospital ID #** | SHPDA Hospital ID number | |
| **Patient Number** | Patient identification number. *This number may be a blind number assigned in sequential order.* Patient ID numbers **cannot** be duplicated. | **6** |
| **Age** | The numeric value of the patient's age, consisting of three (3) digits. For example, if the patient is 78, the entry would be 078. If the patient is 103, the entry would be 103. ***INCLUDE ALL NEWBORNS & PEDIATRICS, USING 000 FOR ALL INFANTS UNDER 1 YEAR OF AGE.*** | **3** |
| **Sex** | Use the following values:<br><br>***MALE:*** **1** ***FEMALE:*** **2** | **1** |

| **FIELD NAME** (electronic & paper submissions) | **INSTRUCTIONS (electronic & paper submissions)** | **FIELD LENGTH (for electronic submissions only)**<br><br>**Field Length Requirements** |
|---|---|---|
| **Race or National Origin** | Use the following values:<br>***WHITE/CAUCASIAN*** ---------- **1**<br>***BLACK/AFRICAN AMERICAN/NEGRO*** ---------- **2**<br>***HISPANIC/SPANISH/LATINO*** ---------- **3**<br>***ASIAN*** ---------- **4**<br>***AMERICAN INDIAN/ALASKAN NATIVE*** ---------- **5**<br>***PACIFIC ISLANDER*** ---------- **6**<br>***INDIA*** ---------- **7**<br>***MIDDLE EASTERN*** ---------- **8**<br>***OTHER*** ---------- **9** | **1** |
| **Zip Code** | Patient's residence zip code. **5 digits only, report unknown zip codes as "99999".** | **5** |
| **Length of Stay (LOS)** | The number of days calculated from the date of admission until the date of discharge or death. **Discharges for this year** include any patients admitted in previous years and discharged during the current reporting period. Patients must be in the hospital a minimum of 24 hours to be included in the Patient Origin Survey.<br><br>***Examples:*** A patient admitted on April 30th and discharged on May 4th would have a LOS of 004. A patient admitted on May 3rd and discharged on May 13th would have a LOS of 010. A patient admitted on September 28th and not discharged by September 30th would not be included. | **3** |
| **Date of Discharge** | For every discharge, Please include the date of discharge for that patient. This should be submitted in a **MM/DD/YYYY** format. | **10** |

| **FIELD NAME** (electronic & paper submissions) | **INSTRUCTIONS (electronic & paper submissions)** | **FIELD LENGTH (for electronic submissions only)**<br><br>**Field Length Requirements** |
|---|---|---|
| **Service Code** | Record only the ***PRIMARY*** service when more than one clinical service is provided during the hospital stay:<br><br>***MEDICINE:*** **01**<br><br>***SURGERY:*** **02**<br><br>***PEDIATRICS:*** **03** (use only if your facility has an organized pediatric unit and only for patients 17 and under). If your facility does not have an organized pediatric unit, report services under one of the remaining codes. For patients 18 and older, report under one of the remaining codes even if treatment occurred in an organized pediatric unit.<br><br>***GYNECOLOGY*** **04** *(NO MALES)*, (medicine or surgery)<br><br>***OBSTETRICS*** **05** *(NO MALES)*<br><br>***ORTHOPEDICS*** **06** (use only if your facility has an organized orthopedic unit.) Facilities without an organized orthopedic unit should report these patients under the appropriate service.<br><br>***PSYCHIATRIC*** **07** (include alcoholism and substance abuse treatments)<br><br>***REHABILITATION*** **08**<br><br>***OTHER*** **09** | **2** |
| **DRG/CMG** | Patient's ***DRG*** (Diagnosis Related Group) or ***CMG*** (Case Mix Group) code. **As a reminder, please indicate which version of DRG codes your facility is using.** | **4**<br>(add leading 0's as necessary) |

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| **FIELD NAME** (electronic & paper submissions) | **INSTRUCTIONS (electronic & paper submissions)** | **FIELD LENGTH (for electronic submissions only)**<br><br>**Field Length Requirements** |
|---|---|---|
| **Payer Source** | Use the following values:<br>***SELF PAY/PRIVATE PAY*---------- 1**<br>***WORKMAN'S COMPENSATION*---------- 2**<br>***MEDICARE*---------- 3**<br>***MEDICAID*---------- 4**<br>***TRI-CARE*---------- 5**<br>***BLUE CROSS/BLUE SHIELD*---------- 6**<br>***NO CHARGE/CHARITY*---------- 7**<br>***HMO*---------- 8**<br>***ALL KIDS*---------- 9**<br>***OTHER INSURANCE*---------- 10**<br>***HOSPICE*---------- 11**<br>***MEDICARE ADVANTAGE*---------- 12**<br>***OTHER*---------- 13** | **2** |
| **ICD-10** | Patient's **ICD-10** primary diagnosis code. Please report the full 7 digit ICD code **WITHOUT THE DECIMAL POINT** | **7** |

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# FY 2017
# HOSPITAL PATIENT ORIGIN SURVEY CLOSEOUT RECORD

Please include this sheet as a cover to the FY 2017 Hospital Patient Origin Survey for all submissions. This survey is due by November 30, 2017.

Hospital Name _____

Hospital ID # _____

Name of Person Responsible: _____

Title _____

Telephone Number _____

Version of **DRG** Codes: _____