APA-1
11/96

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control 410 Department or Agency State Health Planning and Development Agency (Certificate of Need Review Board)
Rule No. Appendix
Rule Title: Forms
____ New X Amend ____ Repeal ____ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety? NO

Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare? YES

Is there another, less restrictive method of regulation available that could adequately protect the public? NO

Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree? NO

Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule? NO

Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public? YES

* *

Does the proposed rule have an economic impact? NO

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

* *

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Reference Service.

Signature of certifying officer Abra M. Lambert

Date 1-21-16

DATE FILED
(STAMP)

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
100 NORTH UNION STREET, SUITE 870
MONTGOMERY, ALABAMA 36104

NOTICE OF INTENDED ACTION

AGENCY NAME: STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
(Certificate of Need Review Board)

RULE NO. & TITLE: Appendix Forms

INTENDED ACTION:
The State Health Planning and Development Agency and the Certificate of Need Review Board propose to amend Appendix of the *Alabama Certificate of Need Rules and Regulations.*

SUBSTANCE OF PROPOSED ACTION:
This amendment will insert the Annual Report Forms in Appendix

TIME, PLACE, MANNER OF PRESENTING VIEWS:
In response to this Proposed Amendment, all interested persons are invited to submit data, views, comments and/or arguments, orally or in writing. Any and all such data, comments, arguments and/or requests to orally address the Certificate of Need Review Board shall be made in writing on or before March 7, 2016, and shall be made to:

Nicole Horn, Executive Secretary
State Health Planning and Development Agency
P. O. Box 303025
Montgomery, Alabama 36130-3025

On March 16, 2016, at 10:00 a.m., the Certificate of Need Review Board shall conduct a public hearing in the State Capitol, Capitol Auditorium, 600 Dexter Avenue, Montgomery, Alabama, at which time it shall consider the Proposed Amendment, along with all written and oral submissions respecting the Proposed Amendment. Only those interested persons who have made timely written requests will be afforded the opportunity to speak.

Copies of the proposed changes are available for review at 100 North Union Street, RSA Union Building, Suite 870, Montgomery, Alabama. Phone (334) 242-4103 or visit the office Monday through Friday from 8:00 a.m. to 5:00 p.m., excluding State holidays.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:
March 7, 2016

CONTACT PERSON AT AGENCY:
Nicole Horn
100 North Union Street
RSA Union, STE 870
Montgomery, AL 36104
(334) 242-4103

Alva M. Lambert

Alva M. Lambert, Executive Director

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
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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

ANNUAL REPORT FOR AMBULATORY SURGERY CENTERS (ASCs)

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 _____, through _____; 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: _____

FORM ASC-1
Revised ***

THIS REPORT IS DUE ON OR BEFORE ***

I. OWNERSHIP

____ Corporation	____ Non-Profit	____ Partnership
____ Individual	____ Healthcare Authority	____ LLC
____ Joint Venture	____ Government	____ Other (specify)

II. FACILITIES

A. Total number of operating rooms

B. Number of operating rooms for general anesthesia

C. Number of beds available for extended recovery (less than 24 hours)

D. Total number of operations (cases)

E. Total number of procedures performed

F. Is this facility a designated separate/organized outpatient surgical unit of a hospital?

YES NO

G. Number of weekdays procedures are routinely performed

III. SERVICES PROVIDED

	Number of Operations (cases)	Number of Procedures
General Surgery		
Dentistry		
Dermatology		
Eye, Ear, Nose & Throat		
Gastroenterology		
Gynecology		
Neurosurgery		
Ophthalmology		
Orthopedic		
Pain Management		
Plastic Surgery		
Podiatry		
Urology		
Other (specify) _____		
TOTALS (*note: these totals should equal the totals as reported in Section II)*		

FORM ASC-1
Revised ***

THIS REPORT IS DUE ON OR BEFORE ***

IV. PRINCIPAL SOURCE OF PAYMENT

	Number of Operations (cases)
Self Pay	
Workman's Compensation	
Medicare	
Medicaid	
Tricare	
Blue Cross	
Other Insurance Companies	
No Charge (charity & others)	
Health Maintenance Organization (HMO)	
All Kids	
Other (specify) _____	
TOTALS *(NOTE: This total should equal the total reported in Section II)*	

V. PATIENT ADMISSION DEMOGRAPHICS

A. ADMISSIONS BY AGE AND GENDER *(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 V-B*

THIS REPORT IS DUE ON OR BEFORE ***

B. ADMISSIONS BY RACE *(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 V-A.***

THIS REPORT IS DUE ON OR BEFORE ***

VI. PATIENT ORIGIN BY ZIP CODE (entire reporting period)

Please report, by zip code of residence, the total number of cases treated by this provider. (This total should equal the total reported in Section II-D). Make additional copies of this page and attach as required.

Zip Code of Residence	Total Number of Cases

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
www.shpda.alabama.gov

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

ANNUAL REPORT FOR HOME HEALTH AGENCIES

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 _____, through _____ *; 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 provider.

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 must be separate from the preparer.

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: _____

PHOME

FORM DM-1
Revised ***

THIS REPORT IS DUE ON OR BEFORE ***

VI. **ADMISSIONS BY SOURCE OF PAYMENT.** List below the total number of admissions, broken down by county of residence, f each payment source category during this annual reporting period. Since a patient may be discharged and readmitted several tim during an annual reporting period, and payment source may vary for subsequent readmission(s), most agencies will show mc admissions than patients served. Attach additional sheets if necessary.

County of Residence	Self-Pay	Workman Comp	Medicare	Medicaid	Tricare	Blue Cross	All Kids	Other Ins.	Charity	HMO	Other**
Category Totals											

TOTAL ADMISSIONS *

*THIS TOTAL MUST EQUAL THE TOTAL ADMISSIONS IN SECTIONS VII, IX-A, AND IX-B.

**Please specify "other" payment source category: _____

Revised ***

THIS REPORT IS DUE ON OR BEFORE ***

VII. ADMISSIONS BY REFERRAL SOURCE.

While it is acknowledged that all patient services are rendered in accordance with a physician's treatment plan, the entity which **initiates** the patient's entry into the Home Health Care System should be indicated below:

SOURCE	NUMBER OF ADMISSIONS
Physicians	
Hospital	
Nursing Home	
Family or Self	
Department of Human Resources	
Public Health or Agency Nurse	
Other (including Social Service Agencies)	
Specify Other _____	
TOTAL ADMISSIONS	*

**THIS TOTAL MUST EQUAL THE TOTAL ADMISSIONS IN SECTIONS VI, IX-A, AND IX-B.*

VIII. SERVICES OFFERED.

List below the total number of services provided, broken down by services provided, for all visits made during this reporting period.

SERVICE	VISITS BY SERVICE
Skilled Nursing Services (RN/LPN)	
Home Health Aide	
Homemaker	
Orderly	
Medical Social Service	
Physical Therapy	
Speech Therapy	
Occupational Therapy	
Medical Equipment	
Other (please specify other service offered): _____	
TOTAL VISITS BY SERVICE	*

**TOTAL MUST EQUAL THE TOTAL VISITS ON PAGE 3, SECTION V.*

Revised ***

THIS REPORT IS DUE ON OR BEFORE *****

IX. PATIENT ADMISSION DEMOGRAPHICS

A. ADMISSIONS BY AGE AND GENDER *(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 MUST EQUAL THE TOTAL ADMISSIONS IN SECTIONS VI, VII, AND IX-B*

B. ADMISSIONS BY RACE *(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 MUST EQUAL THE TOTAL ADMISSIONS IN SECTIONS VI, VII, AND IX-A*

FORM HPCE4
Revised ***

THIS REPORT IS DUE ON OR BEFORE ***

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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MONTGOMERY AL 36130-3025
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FAX: (334) 242-4113
bradford.williams@shpda.alabama.gov

ANNUAL REPORT FOR HOSPICE PROVIDERS

SHPDA ID NUMBER
FACILITY NAME

This report is a requirement for maintaining state licensure

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 _____ (MONTH DAY), through _____ (MONTH DAY); or for partial year of operation beginning _____ and ending _____ a period of _____ days.

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 provider.

PRINTED NAME OF PREPARER | SIGNATURE OF PREPARER | DATE

DIRECT TELEPHONE NUMBER | TITLE OF PREPARER | E-MAIL ADDRESS

*A member of administration separate from the preparer above **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

DIRECT TELEPHONE NUMBER | TITLE OF ADMINISTRATION OFFICIAL | E-MAIL ADDRESS

FOR OFFICE USE ONLY

Facility Verified: _____ Initial Scan: _____ Completed: _____

Entered: _____ Final Scan: _____ Audited: _____

Revised ***

THIS REPORT IS DUE ON OR BEFORE

SECTION A: PROGRAM

A1: PROGRAM TYPE

a. Agency Type *(choose one type only)*

_____ Free Standing
_____ Hospital Based
_____ Home Health Based
_____ Nursing Home Based
_____ Other (specify) _____

b. Ownership *(choose one type only)*

_____ Corporation
_____ Non-Profit Organization
_____ Partnership
_____ Individual
_____ Healthcare Authority
_____ LLC
_____ Joint Venture
_____ Government
_____ Other (specify)
_____

c. Waiting List for Services

Has this provider had a waiting list for the provision of services at any time during this reporting period?

Home Care Services

_____ YES _____ NO

Inpatient Care Services

_____ YES _____ NO

A2: LICENSED INPATIENT FACILITIES

To qualify as an Inpatient Hospice Facility, the following criteria must be met:

a. Consist of one or more beds that are owned or leased (*not contracted*) by the hospice;
b. Be staffed by hospice staff.

Does this provider currently own and operate a CON Authorized Inpatient Hospice?

_____ YES _____ NO

Number of total CON Authorized Inpatient beds: _____

Free Standing Facility _____ NUMBER OF BEDS

Leased Beds within Another Licensed Facility _____ NUMBER OF BEDS

PHONE: (___) -

SECTION B: PATIENT VOLUME

For the purpose of gathering statistics for this report, the following definitions apply:

(Refer to Instructions for additional information and examples)

In-Home Hospice Care:	Routine level of care, regardless of the location in which it was provided; and continuous care days provided whether or not billed separately.
Contractual Inpatient Care	General Inpatient and Inpatient Respite levels of care provided by any CON-Authorized hospice provider which does not also own and operate a CON-Authorized inpatient facility; or inpatient care provided by a CON-Authorized Inpatient Hospice in a location other than the inpatient facility owned and operated by the provider.
Inpatient Hospice Care:	General Inpatient or Respite care provided in a CON Authorized Inpatient Hospice Facility for patients of the Inpatient Hospice or In-Home Hospice **under common ownership.** Inpatient Hospice care provided by the owner of the CON Authorized Inpatient Hospice in ANY location other than the CON Authorized Inpatient Hospice should be reported as Contractual Inpatient Care.

Please note that, for the purposes of this report, only patients whose legal residence is in the state of Alabama should be reported.

B1: PATIENTS SERVED

	Agency Totals
a. Total New (Unduplicated) Admissions	
b. Re-Admissions (Duplicated Admissions) from Prior Years	
c. Total (Unduplicated) Admissions during this Reporting Period (sum of a. and b.)	
d. Re-Admissions (Duplicated Admissions) from current reporting year (Initial admission of patient was counted in B1a)	
e. Total Admissions (sum of c. and d.)	
f. Total Carryovers (patients were in hospice care on both 12/31 and 1/1)	
g. Total Unduplicated Patients Served During Reporting Period (sum of c. and f.)	

Explanation of B1a through B1d

a. Brand new patients, admitted for 1st time to agency during reporting year.
b. Patients readmitted during reporting year, but initial admission was NOT in reporting year.
c. Total number of patients admitted during reporting period.
d. Patients readmitted during reporting year and initial admission was during reporting year.

THIS REPORT IS DUE ON OR BEFORE ***

B2: TOTAL ADMISSIONS BY RACE

RACE	ADMISSIONS (B1e.)
a. White/Caucasian	
b. Black/African American/Negro	
c. Hispanic/Spanish/Latino	
d. Asian	
e. American Indian/Alaskan Native	
f. Pacific Islander	
g. India	
h. Middle Eastern	
i. Other	
TOTAL ADMISSIONS	

B3: TOTAL ADMISSIONS BY AGE AND GENDER

AGE GROUPS	MALE	FEMALE	TOTAL (B1e.)
18 and under			
19 – 34			
35 – 54			
55 – 64			
65 – 74			
75 – 84			
85 years and older			
TOTAL ADMISSIONS			

B4: DEATHS/DISCHARGES

	Agency Totals
a. Total Deaths	
b. Total Live Discharges/Revocations/Transfers	
c. Total Deaths/Live Discharges/Revocations/Transfers	
d. Total Patient Days of service for ALL Deaths/Discharges (patients counted in a. and b.) during reporting period	

Revised ***

THIS REPORT IS DUE ON OR BEFORE

SECTION C: PATIENT DAYS

C1: PATIENT DAYS BY LEVEL OF CARE

IN-HOME PATIENT DAYS (Section B definition)	AGENCY TOTALS
a. Routine Home Care Days	
b. Continuous Care Days Billed	
c. Total In-Home Patient Days	
CONTRACTUAL INPATIENT DAYS (Section B definition)	
d. General Inpatient Days	
e. General Respite Days	
f. Total Contractual Inpatient Days	
INPATIENT HOSPICE DAYS (Section B definition)	
g. General Inpatient Days	
h. Inpatient Respite Days	
i. Total Inpatient Hospice Days	
j. TOTAL PATIENT CARE DAYS	
IN-HOME HOSPICE CARE ONLY	
k. Routine Hospice Care Days provided in a Skilled Nursing Facility (SNF)	
l. Total Percentage of In-Home Hospice Care Days provided in a Skilled Nursing Facility (SNF)	

Hospice Rules of the Alabama State Board of Health

Alabama Department of Public Health Administrative Rule 420-5-17-.03(1)(c)(8) states: Any person licensed to provide a hospice care program shall establish a written interdisciplinary plan of care for each hospice patient and family that provides care in individual's homes and provides or coordinates care on an inpatient basis. Not more than 50% of the home care days shall be provided to residents of nursing homes.

THIS REPORT IS DUE ON OR BEFORE ***

C2: PATIENT DAYS BY REIMBURSEMENT SOURCE

SOURCE OF REIMBURSEMENT	PATIENT DAYS
Medicare	
Medicaid	
Private Insurance	
Private Pay	
Charity	
TOTALS (Must equal C1j Total)	

For purposes of accounting, does this facility combine charity care and private pay information together as one group?

_____ YES _____ NO

C3: PATIENT DAYS BY DIAGNOSIS

DIAGNOSIS	PATIENT DAYS
Cancer	
Cardiopulmonary	
Alzheimer's Disease and/or Dementia	
All Other	
TOTALS (Must equal C1j Total)	

SECTION D: PATIENT LOCATION

D1: COUNTY OF RESIDENCE

Complete as many pages as necessary to report ALL counties for which CON Authorization is held by this provider (common CON Authorization or single CON Authorization reporting under a common Medicare Provider number). For those counties with no patients served during the reporting period, enter "0's" for requested demographics. Report only those admissions occurring in Alabama; do NOT include out of state admissions. *General Inpatient and Respite care is to be reported based on patient's county of residence, not location of care.*

COUNTY	NUMBER OF DEATHS	NUMBER OF LIVE DISCHARGES	PATIENT DAYS	NUMBER OF PATIENTS SERVED
TOTALS				
	Final totals must equal B4a.	Final totals must equal B4b.	Final totals must equal C1j.	Final totals must equal B1g.

☐ **FOR CON-AUTHORIZED INPATIENT FACILITIES ONLY:** In-Home services were not provided to patients residing in any county reported in this section, for which this provider does not possess CON Authority to provide In-Home services.

SECTION D: PATIENT LOCATION (cont'd)

D1: COUNTY OF RESIDENCE

COUNTY	NUMBER OF DEATHS	NUMBER OF LIVE DISCHARGES	PATIENT DAYS	NUMBER OF PATIENTS SERVED
TOTALS FROM PREVIOUS PAGE				
TOTALS				
	Final totals must equal B4a.	Final totals must equal B4b.	Final totals must equal C1j.	Final totals must equal B1g.

Revised ***

THIS REPORT IS DUE ON OR BEFORE

SECTION D: PATIENT LOCATION (cont'd)

D1: COUNTY OF RESIDENCE

COUNTY	NUMBER OF DEATHS	NUMBER OF LIVE DISCHARGES	PATIENT DAYS	NUMBER OF PATIENTS SERVED
TOTALS FROM PREVIOUS PAGE				
TOTALS				
	Final totals must equal B4a.	Final totals must equal B4b.	Final totals must equal C1j.	Final totals must equal B1g.

SECTION E: AGENCY INFORMATION

E1: VOLUNTEER SERVICES

Average annual percentage of patient care hours provided by volunteers (as reported to CMS) for all providers reporting under the Medicare Provider Number of this provider (including a CON Authorized inpatient facility if applicable), or the parent provider if satellite offices are included in this reporting (common CON Authorization).

_____ %

E2: LENGTH OF SERVICE

LENGTH OF SERVICE	AGENCY TOTALS
Average Length of Service (ALOS)	
Median Length of Service (MLOS)	
Number of Days in Reporting Period	
Average Daily Census	

***Make and 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.

List ALL satellite providers for which CON Authorization is held by this provider (common CON Authorization or single CON Authorization reporting under a common Medicare Provider number), for which information is included in this report; and from which services were provided at any time during the reporting period.

SATELLITE HOSPICE PROVIDER	COUNTY	OPERATIONAL ENTIRE REPORTING PERIOD YES	OPERATIONAL ENTIRE REPORTING PERIOD NO	NUMBER OF DAYS OPERATIONAL IF INITIALLY LICENSED/CLOSED DURING REPORTING PERIOD
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

THIS REPORT IS DUE ON OR BEFORE ***

Hospice Annual Report Checklist

TOTALS

PATIENT DAYS

Page 5, Section C1j _____

Patient Days throughout report must equal days reported directly above

Page 6, Section C2 _____

Page 6, Section C3 _____

Page 7, Section D1 _____

ADMISSIONS

Page 3, Section B1e. _____

Admissions throughout report must equal Admissions reported directly above

Page 4, Section B2 _____

Page 4, Section B3 _____

UNDUPLICATED PATIENTS SERVED

Page 3, Section B1g _____

Unduplicated Patients Served throughout report must equal Unduplicated Patients Served reported directly above

Page 7, Section D1 _____

DEATHS

Page 4, Section B4a. _____

Deaths throughout report must equal Deaths reported directly above

Page 7, Section D1 _____

LIVE DISCHARGES/REVOCATIONS/TRANSFERS

Page 4, Section B4b _____

Live Discharges/Revocations/Transfers throughout report must equal Deaths reported directly above

Page 7, Section D1 _____

REVISED *** | THIS REPORT IS DUE ON OR BEFORE ***

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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FAX: (334) 242-4113
bradford.williams@shpda.alabama.gov

ANNUAL REPORT FOR HOSPITALS AND RELATED FACILITIES

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 TO BE UPDATED ANNUALLY _____, through _____; or for **partial** year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

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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: _____

REVISED *** | THIS REPORT IS DUE ON OR BEFORE ***

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	_____
2. Number of **staffed and operational beds** on last day of reporting period	_____
3. Number of CON-authorized **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	_____

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)		
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			XXXXXX
7. Other (specify)				
TOTALS				

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)				
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 only)**

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)			
Level _____			
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 _____

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).

FORM BHD 134A
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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 (including PTCA, directional coronary atherectomy, rotational atherectomy and similar complex therapeutic procedures)						
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: _____

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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THIS REPORT IS DUE ON OR BEFORE ***

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)

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THIS REPORT IS DUE ON OR BEFORE ***

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.*

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 once electronically, hard copy, or fax. 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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THIS REPORT IS DUE ON OR BEFORE ***

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	
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	
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	
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	
Patient Days	
Page 2, Section I-B-5.	
Page 3, Section I-C	
Patient Days in Section I-C must equal Patient Days reported in Section I-B	
Page 4, Section II-A	
Page 4, Section II-B	
Page 5, Section II-C	
Page 5, Section II-D	
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	
Discharges	
Page 2, Section I-B-6	
Page 3, Section I-C	
Discharges in Section I-C must equal Discharges reported in Section I-B	
Page 4 Section II-A	
Page 4, Section II-B	
Page 5, Section II-C	
Page 5, Section II-D	
Discharges in Sections II-A+II-B+II-C+II-D must equal Discharges reported in Section I-B	
TOTAL DISCHARGES SECTION II	

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THIS REPORT IS DUE ON OR BEFORE ***

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

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) 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: ***MALE:*** **1** ***FEMALE:*** **2**	**1**

FIELD NAME (electronic & paper submissions)	INSTRUCTIONS (electronic & paper submissions)	FIELD LENGTH (for electronic submissions only) Field Length Requirements
Race or National Origin	Use the following values: ***WHITE/CAUCASIAN*** ---------- **1** ***BLACK/AFRICAN AMERICAN/NEGRO*** ---------- **2** ***HISPANIC/SPANISH/LATINO*** ---------- **3** ***ASIAN*** ---------- **4** ***AMERICAN INDIAN/ALASKAN NATIVE*** ---------- **5** ***PACIFIC ISLANDER*** ---------- **6** ***INDIA*** ---------- **7** ***MIDDLE EASTERN*** ---------- **8** ***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. ***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) Field Length Requirements
Service Code	Record only the ***PRIMARY*** service when more than one clinical service is provided during the hospital stay: ***MEDICINE:*** **01** ***SURGERY:*** **02** ***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. ***GYNECOLOGY*** **04** *(NO MALES)*, (medicine or surgery) ***OBSTETRICS*** **05** *(NO MALES)* ***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. ***PSYCHIATRIC*** **07** (include alcoholism and substance abuse treatments) ***REHABILITATION*** **08** ***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** (add leading 0's as necessary)

FIELD NAME (electronic & paper submissions)	INSTRUCTIONS (electronic & paper submissions)	FIELD LENGTH (for electronic submissions only) Field Length Requirements
Payer Source **Payer Source Continued**	Use the following values: *SELF PAY/PRIVATE PAY*---------- 1 *WORKMAN'S COMPENSATION*---------- 2 *MEDICARE*---------- 3 *MEDICAID*---------- 4 *TRI-CARE*---------- 5 *BLUE CROSS/BLUE SHIELD*---------- 6 *NO CHARGE/CHARITY*---------- 7 *HMO*---------- 8 *ALL KIDS*---------- 9 *OTHER INSURANCE*---------- 10 *HOSPICE*---------- 11 *MEDICARE ADVANTAGE*---------- 12 *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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THIS REPORT IS DUE ON OR BEFORE

FY ****
HOSPITAL PATIENT ORIGIN SURVEY CLOSEOUT RECORD

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

Hospital Name _____

Hospital ID # _____

Name of Person Responsible: _____

Title _____

Telephone Number _____

Version of DRG Codes: _____

Revised ***

THIS REPORT IS DUE ON OR BEFORE ***

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
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

ANNUAL REPORT FOR SKILLED NURSING FACILITIES

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 _____, through _____ *; or for **partial** year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

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 must be separate from the preparer.

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: _____

Revised ***

THIS REPORT IS DUE ON OR BEFORE ***

OWNERSHIP (check one)

_____ Corporation	_____ Non-Profit Organization	_____ Partnership
_____ Individual	_____ Healthcare Authority	_____ LLC
_____ Joint Venture	_____ Government	_____ Other (specify) _____

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

Management Firm: _____
Name

_____
Base Address City State Zip

I. FACILITIES

a. Total beds **licensed** by the Alabama Department of Public Health _____

b. Number of beds certified for Medicare patients (**NOTE:** Medicaid patients ***ARE ALLOWED*** to reside in Medicare beds) _____

c. Number of beds certified for Medicaid patients _____

d. Was this facility licensed for the number of beds indicated in item I-a for the entire reporting period? _____ YES _____ NO

e. If "No" was answered in item (e), indicate the number of licensed beds and the number of days those beds were licensed. _____ BEDS _____ DAYS

f. Additional licensed beds and the number of days those beds were licensed _____ BEDS _____ DAYS

II. ADMISSIONS *** *(REFER TO PAGE 2 OF INSTRUCTIONS FOR CORRECT COMPUTATION METHODS FOR ADMISSIONS, READMISSIONS, DISCHARGES, AND TRANSFERS)*

A. TOTAL ADMISSIONS FOR THE REPORTING PERIOD _____

B. ADMISSIONS BY SOURCE OF PAYMENT:

Private Pay _____
Workman's Compensation _____
Medicare _____
Medicaid _____
Tricare _____
Blue Cross (**not Long Term Care Insurance**) _____
Other Insurance Companies (**not Long Term Care Insurance**) _____
No Charge (charity & other) _____
Hospice _____
Long Term Care Insurance _____
Other (specify) _____ _____

Revised ***

THIS REPORT IS DUE ON OR BEFORE ***

III. DEMOGRAPHICS

A. TOTAL ADMISSIONS BY RACE *FOR THE ENTIRE REPORTING PERIOD*
(Total must agree with the totals provided in Sections II-A and III-B.)

1.	White/Caucasian	
2.	Black/African American/Negro	
3.	Hispanic/Spanish/Latino	
4.	Asian	
5.	American Indian/Alaskan Native	
6.	Pacific Islander	
7.	India	
8.	Middle Eastern	
9.	Other (specify) _____	

B. TOTAL ADMISSIONS BY AGE AND GENDER *FOR THE ENTIRE REPORTING PERIOD*
(Total must agree with the totals provided in Section II and Section III-A.)

AGE GROUPS	MALE	FEMALE	TOTALS
18 & under			
19 – 34 Years			
35 – 54 Years			
55 – 64 Years			
65 – 74 Years			
75 – 84 Years			
85 Years and Older			
TOTALS			

IV. DISCHARGES *** (*REFER TO PAGE 2 OF INSTRUCTIONS FOR CORRECT COMPUTATION METHODS FOR ADMISSIONS, READMISSIONS, DISCHARGES, AND TRANSFERS*)

Total discharges (including deaths) _____

Revised ***

THIS REPORT IS DUE ON OR BEFORE ***

***Make and 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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MONTGOMERY AL 36104
FAX: (334) 242-4113
bradford.williams@shpda.alabama.gov

ANNUAL REPORT FOR SPECIALTY CARE ASSISTED LIVING FACILITIES

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 _____, through _____; 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 must be separate from the preparer

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:	_____

Revised ***

I. OWNERSHIP

_____ Corporation	_____ Non-Profit Organization	_____ Partnership
_____ Individual	_____ Healthcare Authority	_____ LLC
_____ Joint Venture	_____ Government	_____ Other (specify)

_____

II. MANAGEMENT

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

Management Firm: _____

Name

_____

Base Address City State Zip

III. FACILITIES

Total number of licensed beds: _____

IV. ADMISSIONS

Total admissions for the reporting period: _____

Admissions by source of payment:

Private Pay _____

Other (specify) _____ _____

V. DISCHARGES

Total discharges (include deaths) _____

Revised ***

VI. DEMOGRAPHICS

A. TOTAL ADMISSIONS BY RACE *FOR THE ENTIRE REPORTING PERIOD*
(Total must agree with the totals provided in Section IV and Section VI-B.)

a.	White/Caucasian	
b.	Black/African American/Negro	
c.	Hispanic/Spanish/Latino	
d.	Asian	
e.	American Indian/Alaskan Native	
f.	Pacific Islander	
g.	India	
h.	Middle Eastern	
i.	Other (specify) _____	
	TOTAL	

B. TOTAL ADMISSIONS BY AGE AND GENDER *FOR THE ENTIRE REPORTING PERIOD* **(Total must agree with the totals provided in Section IV and Section VI-A.)**

AGE GROUPS	MALE	FEMALE	TOTALS
18 & under			
19 – 34 Years			
35 – 54 Years			
55 – 64 Years			
65 – 74 Years			
75 – 84 Years			
85 Years and Older			
TOTALS			

Revised ***

VII. RESIDENT DAYS

1. **Number of licensed beds**
   (Section III of this report)

x 365***

2. Multiply line 1 by 365*** for total available days = _____

3. **Total number of days beds were unoccupied** due to vacancies, discharges and deaths (also include 365*** days for each bed that is licensed but not set up for use in this facility) _____

4. **TOTAL RESIDENT DAYS** (subtract line 3 from line 2) _____

***Make and keep a copy of the completed report for the facility'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.