FORM BHD 134A
REVISED 09/23

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2023

# STATE HEALTH PLANNING AND DEVELOPMENT AGENCY


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## 2023 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 10/1/2022, through 9/30/2023; 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 13, 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.** **All psychiatric beds, regardless of whether or not a CON has been obtained (including CON-exempt beds), must be reported in this section. This includes operational and non-operational beds. Providers with unrestricted psychiatric beds obtained prior to the 2018 Hospital Annual Report shall be allowed to change the bed category during the first two reporting periods. However, the bed category reported on the FY 2020 Hospital Annual Report will become the hospital's permanent bed category allocation. The psychiatric bed reporting requirement in this section is not applicable to pediatric specialty hospital providers operating their pediatric hospital specialty beds for the provision of pediatric psychiatric services.**

**Report information below by bed category as of the last day of the reporting period:**

| | TOTAL PSYCHIATRIC BEDS BY CATEGORY (include CON-authorized and non-CON authorized beds) | TOTAL ADMISSIONS BY CATEGORY | TOTAL DISCHARGES BY CATEGORY | TOTAL PATIENT DAYS BY CATEGORY | TOTAL OPERATIONAL BEDS BY CATEGORY |
|---|---|---|---|---|---|
| **Adolescent/Child** | 0 | 0 | 0 | 0 | 0 |
| **Adult** | 0 | 0 | 0 | 0 | 0 |
| **Geriatric** | 0 | 0 | 0 | 0 | 0 |
| **TOTALS** | 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 |

***Please check the appropriate level of neonatal care provided at your facility (check one) based on the Alabama Perinatal Regionalization System Guidelines found at: http://www.alabamapublichealth.gov/perinatal/assets/perinatal_regionalization_system_guidelines.pdf.*** *The Guidelines were endorsed by the State Committee of Public Health and are based on guidance from the American Academy of Pediatrics.*

☐ Level I ☐ Level II ☐ Level III ☐ Level IV

| ***Neonatal Levels of Care*** | 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 |
| **Special Care Nursery** (include newborns in separate special-monitoring units that are not NICU level care) | 0 | 0 | 0 |
| **Neonatal Intensive Care Unit (NICU)** | 0 | 0 | 0 |
| **Regional Neonatal Intensive Care Unit** | 0 | 0 | 0 |
| **Other** (specify: i.e., specialty newborn cardiac NICU) _____ | 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). Any outpatient surgeries reported in Section II-F-2 should also be reported in this section. This data shall be submitted as a Microsoft Excel (v. 2003 or later) or CSV formatted file with the remainder of this report. The annual report will not be deemed received by the Agency on behalf of the submitting provider until the utilization portion (the remainder of this PDF document), this Excel or CSV file, AND the Patient Origin file (referenced on pages 14 – 18) are received.**

**The submitted file should contain the column headers and data formatting shown in the example provided below. Please submit only a 5-digit zip code, not the full 9-digit zip code. Also, please ensure that the Facility ID Number entered in the first column and the Facility ID Number reported on Page 1 are the same, and are correct.**

| Facility ID | Out Pt Surg_Zip Code | Out Pt Surg_Persons |
|---|---|---|
| 123-4567890 | 99999 | 9999 |

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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.

**Pursuant to ALA. ADMIN. CODE r 410-1-3-.09, all Mandatory Reports shall be submitted electronically [via e-mail] to data.submit@shpda.alabama.gov.**

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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 should equal Authorized Beds reported in Section I-B if exempted non-CON Authorized beds are not reported in Section II-C* | |
| 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 |