

**CERTIFICATION OF EMERGENCY RULES  
FILED WITH THE  
LEGISLATIVE SERVICES AGENCY  
OTHNI LATHRAM, DIRECTOR**

Pursuant to Code of Alabama 1975, §§41 22 5(b) and 41 22 6(c) (2)a. and b.

I certify that the attached emergency amendment is a correct copy as promulgated and adopted on Wednesday, May 20, 2026.

**AGENCY NAME:** Health Planning And Development Agency

**RULE NO. AND TITLE:** Chapter 410-X-A Appendix Forms

**EXPIRATION DATE OF RULE:** Thursday, September 17, 2026

**NATURE OF EMERGENCY:** Compliance with the normal rulemaking procedures of the Alabama Administrative Procedure Act, including the 35-day notice requirement, would prevent timely implementation of the rule necessary to facilitate such funding and the public benefits associated therewith. The failure to adopt an emergency rule would impair the ability of rural health care providers to enter into cooperative engagements, hinder their ability to apply for or receive funding under the Alabama Rural Health Transformation Program, and adversely affect the public health, safety, and welfare of the citizens of Alabama.

**STATUTORY AUTHORITY:** Act 2026-522, Code of Alabama, 1975

**SUBJECT OF RULE TO BE ADOPTED  
ON A PERMANENT BASIS:** Yes

**NAME, ADDRESS, AND TELEPHONE  
NUMBER OF PERSON TO CONTACT  
FOR COPY OF RULE:** Emily T. Marsal, Executive Director  
State Health Planning and Development Agency  
100 North Union Street, Suite 870  
Montgomery, AL 36104  
(334) 242-4103  
shpda.online@shpda.alabama.gov

Emily T. Marsal  
Emily Marsal

Signature of officer authorized  
to promulgate and adopt rules and  
regulations or his or her deputy

**REC'D & FILED**  
**MAY 20, 2026**  
**LEGISLATIVE SVC AGENCY**

HEALTH PLANNING AND DEVELOPMENT AGENCY  
ADMINISTRATIVE CODE

CHAPTER 410-X-A  
APPENDIX FORMS

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Rev. 6-16

**ALABAMA  
CERTIFICATE OF NEED APPLICATION**

**For Staff Use Only**

Filing Fee Remitted: \$ \_\_\_\_\_

Project # \_\_\_\_\_

Date Rec. \_\_\_\_\_

INSTRUCTIONS: Please submit an electronic pdf copy of this completed form and the appropriate attachments to the State of Alabama, State Health Planning and Development Agency, in accordance with ALA. ADMIN. CODE r. 410-1-7-.06 (Filing of a Certificate of Need Application) and 410-1-3-.09 (Electronic Filing). Electronic filings meeting the requirements of the aforementioned rules shall be considered provisionally received pending receipt of the required filing fee and shall be considered void should the proper filing fee not be received by the end of the next business day. Refer to ALA. ADMIN. CODE r. 410-1-7-.06 to determine the required filing fee.

Filing fees should be remitted to: State Health Planning and Development Agency  
100 North Union Street, Suite 870  
Montgomery, Alabama 36104

or the fee may be submitted electronically via the payment portal available through the State Agency's website at [www.shpda.alabama.gov](http://www.shpda.alabama.gov).

**PART ONE: APPLICANT IDENTIFICATION AND PROJECT DESCRIPTION**

I. APPLICANT IDENTIFICATION (Check One) HOSPITAL (  ) NURSING HOME (  )

OTHER (  ) (Specify) \_\_\_\_\_

A. \_\_\_\_\_  
Name of Applicant (in whose name the CON will be issued if approved)

\_\_\_\_\_  
Address City County

\_\_\_\_\_  
State Zip Code Phone Number

B. \_\_\_\_\_  
Name of Facility/Organization (if different from A)

\_\_\_\_\_  
Address City County

\_\_\_\_\_  
State Zip Code Phone Number

C. \_\_\_\_\_  
Name of Legal Owner (if different from A or B)

\_\_\_\_\_  
Address City County

\_\_\_\_\_  
State Zip Code Phone Number

D. \_\_\_\_\_  
Name and Title of Person Representing Proposal and with whom SHPDA should communicate

\_\_\_\_\_  
Address City County

\_\_\_\_\_  
State Zip Code Phone Number

I. APPLICANT IDENTIFICATION (continued)

E. Type Ownership and Governing Body

- 1. Individual ( ) \_\_\_\_\_
- 2. Partnership ( ) \_\_\_\_\_
- 3. Corporate (for profit) ( ) \_\_\_\_\_  
Name of Parent Corporation
- 4. Corporate (non-profit) ( ) \_\_\_\_\_  
Name of Parent Corporation
- 5. Public ( ) \_\_\_\_\_
- 6. Other (specify) ( ) \_\_\_\_\_

F. Names and Titles of Governing Body Members and Owners of This Facility

OWNERS	GOVERNING BOARD MEMBERS
_____	_____
_____	_____
_____	_____

II. PROJECT DESCRIPTION

Project/Application Type (check all that apply)

- |   |   |
|---|---|
| _____ New Facility<br>Type _____        | _____ Major Medical Equipment<br>Type _____   |
| _____ New Service<br>Type _____         | _____ Termination of Service or Facility      |
| _____ Construction/Expansion/Renovation | _____ Other Capital Expenditure<br>Type _____ |
| _____ Change in Service                 |   |

III. EXECUTIVE SUMMARY OF THE PROJECT (brief description)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IV. COST

A.	Construction (includes modernization expansion)	
1.	Predevelopment	\$ _____
2.	Site Acquisition	_____
3.	Site Development	_____
4.	Construction	_____
5.	Architect and Engineering Fees	_____
6.	Renovation	_____
7.	Interest during time period of construction	_____
8.	Attorney and consultant fees	_____
9.	Bond Issuance Costs	_____
10.	Other _____	_____
11.	Other _____	_____
	<b>TOTAL COST OF CONSTRUCTION</b>	<b>\$ _____</b>
B.	Purchase	
1.	Facility	\$ _____
2.	Major Medical Equipment	_____
3.	Other Equipment	_____
	<b>TOTAL COST OF PURCHASE</b>	<b>\$ _____</b>
C.	Lease	
1.	Facility Cost Per Year _____ x _____ Years =	\$ _____
2.	Equipment Cost per Month _____ x _____ Months =	_____
3.	Land-only Lease Cost per Year _____ x _____ Years	_____
	<b>TOTAL COST OF LEASE(s)</b>	<b>\$ _____</b>
	(compute according to generally accepted accounting principles)	
	Cost if Purchased	\$ _____
D.	Services	
1.	_____ New Service	\$ _____
2.	_____ Expansion	\$ _____
3.	_____ Reduction or Termination	\$ _____
4.	_____ Other	\$ _____
	<b>FIRST YEAR ANNUAL OPERATING COST</b>	<b>\$ _____</b>
E.	Total Cost of this Project (Total A through D) (should equal V-C on page A-4)	\$ _____

IV. COST (continued)

F.	Proposed Finance Charges	
1.	Total Amount to Be Financed	\$ _____
2.	Anticipated Interest Rates	_____
3.	Term of Loan	_____
4.	Method of Calculating Interest on Principal Payment	_____

\_\_\_\_\_

\_\_\_\_\_

V. ANTICIPATED SOURCE OF FUNDING

A.	Federal	Amount	Source
1.	Grants	\$ _____	_____
2.	Loans	_____	_____
B.	Non-Federal		
1.	Commercial Loan	_____	_____
2.	Tax-exempt Revenue Bonds	_____	_____
3.	General Obligation Bonds	_____	_____
4.	New Earning and Revenues	_____	_____
5.	Charitable Fund Raising	_____	_____
6.	Cash on Hand	_____	_____
7.	Other	_____	_____
C.	TOTAL (should equal IV-E on page A-3)		\$ _____

VI. TIMETABLE

A.	Projected Start/Purchase Date	_____
B.	Projected Completion Date	_____

**PART TWO:PROJECT NARRATIVE**

Note: In this part, please submit the information as an attachment. This will enhance the continuity of reading the application.

The applicant should address the items that are applicable to the project.

I. MEDICAL SERVICE AREA

- A. Identify the geographic (medical service) area by county (ies) or city, if appropriate, for the facility or project. Include an 8 ½ x 11” map indicating the service area and the location of the facility.
- B. What population group(s) will be served by the proposed project? Define age groups, location and characteristics of the population to be served.
- C. If medical service area is not specifically defined in the State Health Plan, explain statistical methodologies or market share studies based upon accepted demographic or statistical data available with assumptions clearly detailed. If Patient Origin Study data is used, explain whether institution or county based, etc.

D.Are there any other factors affecting access to the project?

Geographic  Economic  Emergency  Medically Underserved

Please explain.

II. HEALTH CARE REQUIREMENTS OF THE MEDICAL SERVICE AREA

- A. What are the factors (inadequacies) in the existing health care delivery system which necessitate this project?
- B. How will the project correct the inadequacies?
- C. Why is your facility/organization the appropriate facility to provide the proposed project?
- D. Describe the need for the population served or to be served for the proposed project and address the appropriate sections of the State Health Plan and the Rules and Regulations under 410-1-6-.07. Provide information about the results of any local studies which reflect a need for the proposed project.
- E. If the application is for a specialized or limited-purpose facility or service, show the incidence of the particular health problem.
- F. Describe the relationship of this project to your long-range development plans, if you have such plans.

III. RELATIONSHIP TO EXISTING OR APPROVED SERVICES AND FACILITIES

- A. Identify by name and location the existing or approved facilities or services in the medical service area similar to those proposed in this project.
- B. How will the proposed project affect existing or approved services and facilities in the medical service area?
- C. Will there be a detrimental effect on existing providers of the service? Discuss methodologies and assumptions.
- D. Describe any coordination agreements or contractual arrangements for shared services that are pertinent to the proposed project.
- E. List the new or existing ancillary and/or supporting services required for this project and briefly describe their relationship to the project.

IV. POTENTIAL LESS COSTLY OR MORE EFFECTIVE ALTERNATIVES

- A. What alternatives to the proposed project exist? Why was this proposal chosen?
- B. How will this project foster cost containment?
- C. How does the proposal affect the quality of care and continuity of care for the patients involved?

V. DESCRIBE COMMUNITY REACTION TO THE PROJECT (Attach endorsements if desired)

VI. NON-PATIENT CARE

If appropriate, describe any non-patient care objectives of the facility, i.e., professional training programs, access by health professional schools and behavioral research projects which are designed to meet a national need.

VII. MULTI-AREA PROVIDER

If the applicant holds itself as a multi-area provider, describe those factors that qualify it as such, including the percentage of admissions which resides outside the immediate health service area in which the facility is located.

VIII. HEALTH MAINTENANCE ORGANIZATION

If the proposal is by or on behalf of a health maintenance organization (HMO), address the rules regarding HMOs, and show that the HMO is federally qualified.

IX. ENERGY-SAVING MEASURES

Discuss as applicable the principal energy-saving measures included in this project.

X. OTHER FACTORS

Describe any other factor(s) that will assist in understanding and evaluating the proposed project, including the applicable criteria found at 410-1-6 of the Alabama Certificate of Need Program Rules and Regulations which are not included elsewhere in the application.

**PART THREE: CONSTRUCTION OR RENOVATION ACTIVITIES**

Complete the following if construction/renovation is involved in this project. Indicate N/A for any questions not applicable.

- I. ARCHITECT \_\_\_\_\_  
Firm \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Contact Person \_\_\_\_\_  
Telephone \_\_\_\_\_  
Architect's Project Number \_\_\_\_\_

II. ATTACH SCHEMATICS AND THE FOLLOWING INFORMATION

- A. Describe the proposed construction/renovation  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- B. Total gross square footage to be constructed/renovated \_\_\_\_\_
- C. Net useable square footage (not including stairs, elevators, corridors, toilets) \_\_\_\_\_
- D. Acres of land to be purchased or leased \_\_\_\_\_
- E. Acres of land owned on site \_\_\_\_\_
- F. Anticipated amount of time for construction or renovations \_\_\_\_\_ (months)
- G. Cost per square foot\$ \_\_\_\_\_
- H. Cost per bed (if applicable)\$ \_\_\_\_\_

**PART FOUR: UTILIZATION DATA AND FINANCIAL INFORMATION**

This part should be completed for projects under \$500,000.00 and/or those projects for ESRD and home health. If this project is not one of the items listed above, please omit Part Four and complete Part Five. Indicate N/A for any questions not applicable.

I.	UTILIZATION	Years:	20____	20____	20____	20____
			CURRENT		PROJECTED	
	A. ESRD					
	# Patients		_____	_____	_____	_____
	# Procedures		_____	_____	_____	_____
	B. Home Health Agency					
	# Patients		_____	_____	_____	_____
	# of Visits		_____	_____	_____	_____
	C. New Equipment					
	# Patients		_____	_____	_____	_____
	# Procedures		_____	_____	_____	_____
	D. Other					
	# Patients		_____	_____	_____	_____
	# Procedures		_____	_____	_____	_____

II. PERCENT OF GROSS REVENUE

Source of Payment	Historical			Projected	
	20____	20____	20____	20____	20____
ALL Kids					
Blue Cross/Blue Shield					
Champus/Tricare					
Charity Care (see note below)					
Medicaid					
Medicare					
Other commercial insurance					
Self pay					
Other					
Veterans Administration					
Workers' Compensation					
<b>TOTAL</b>	%	%	%	%	%

Note: Refer to the Healthcare Financial Management Association (HFMA) Principles and Practices Board Statement Number 15, Section II.

III. CHARGE INFORMATION

- A. List schedule of current charges related to this project.
- B. List schedule of proposed charges after completion of this project. Discuss the impact of project cost on operational costs and charges of the facility or service.

**PART FIVE: UTILIZATION DATA AND FINANCIAL INFORMATION**

This part should be completed for projects which cost over \$500,000.00 or which propose a substantial change in service, or which would change the bed capacity of the facility in excess of ten percent (10%), or which propose a new facility. ESRD, home health, and projects that are under \$500,000.00 should omit this part and complete Part Four.

I. PERCENT OF GROSS REVENUE

Source of Payment	Historical			Projected	
	20__	20__	20__	20__	20__
ALL Kids					
Blue Cross/Blue Shield					
Champus/Tricare					
Charity Care (see note below)					
Medicaid					
Medicare					
Other commercial insurance					
Self pay					
Other					
Veterans Administration					
Workers' Compensation					
<b>TOTAL</b>	%	%	%	%	%

Note: Refer to the Healthcare Financial Management Association (HFMA) Principles and Practices Board Statement Number 15, Section II.

II. CHARGE INFORMATION

- C. List schedule of current charges related to this project.
- D. List schedule of proposed charges after completion of this project. Discuss the impact of project cost on operational costs and charges of the facility or service.

III. INPATIENT UTILIZATION DATA

A. Historical Data

Give information for last three (3) years for which complete data is available.

OCCUPANCY DATA

Occupancy	Number of Beds			Admissions or Discharges			Total Patient Days			Percentage (%)		
	Yr	Yr	Yr	Yr	Yr	Yr	Yr	Yr	Yr	Yr	Yr	Yr
Medicine & Surgery												
Obstetrics												
Pediatrics												
Psychiatry												
Other												
<b>TOTALS</b>												

B. Projected Data

Give information to cover the first two (2) years of operation after completion of project.

OCCUPANCY DATA

Occupancy	Number of Beds		Admissions or Discharges		Total Patient Days		Percentage (%)	
	1st Year	2nd Year	1st Year	2nd Year	1st Year	2nd Year	1st Year	2nd Year
Medicine & Surgery								
Obstetrics								
Pediatrics								
Psychiatry								
Other								
<b>TOTALS</b>								

**IV. OUTPATIENT UTILIZATION DATA**

**A. HISTORICAL DATA**

	<b>Number of Outpatient Visits</b>			<b>Percentage of Outpatient Visits</b>		
	Yr _____	Yr _____	Yr _____	Yr _____	Yr _____	Yr _____
<b>Clinical</b>						
<b>Diagnostic</b>						
<b>Rehabilitation</b>						
<b>Surgical</b>						

**B. PROJECTED DATA**

	<b>Number of Outpatient Visits</b>		<b>Percentage of Outpatient Visits</b>	
	1st year	2nd year	1st year	2nd year
<b>Clinical</b>				
<b>Diagnostic</b>				
<b>Rehabilitation</b>				
<b>Surgical</b>				

V. A. ORGANIZATION FINANCIAL INFORMATION

STATEMENT OF INCOME AND EXPENSE	HISTORICAL DATA (Give information for last 3 years for which complete data are available)			PROJECTED DATA (First 2 years after completion of project)	
	20__ (Total)	20__ (Total)	20__ (Total)	20__ (Total)	20__ (Total)
Revenue from Services to Patients					
Inpatient Services					
Routine (nursing service areas)					
Other					
Outpatient Services					
Emergency Services					
Gross Patient Revenue					
Deductions from Revenue					
Contractual Adjustments					
Discount/Miscellaneous Allowances					
Total Deductions					
NET PATIENT REVENUE (Gross patient revenue less deductions)					
Other Operating Revenue					
<b>NET OPERATING REVENUE</b>					
OPERATING EXPENSES					
Salaries, Wages, and Benefits					
Physician Salaries and Fees					
Supplies and other					
Uncompensated Care (less recoveries) per State Health Plan 410-2-2-.06(d)					
Other Expenses					
Total Operating Expenses					
NON-OPERATING EXPENSES					
Taxes					
Depreciation					
Interest (other than mortgage)					
Existing Capital Expenditures				N/A	N/A
Interest				N/A	N/A
Total Non-Operating Expenses					
<b>TOTAL EXPENSES (Operating &amp; Capital)</b>					
Operating Income (Loss)					
Other Revenue (Expense) -- Net					
NET INCOME (Loss)					
Projected Capital Expenditure	N/A	N/A	N/A		
Interest	N/A	N/A	N/A		

B. PROJECT SPECIFIC FINANCIAL INFORMATION

STATEMENT OF INCOME AND EXPENSE	HISTORICAL DATA (Give information for last 3 years for which complete data are available)			PROJECTED DATA (First 2 years after completion of project)	
	20__ (Total)	20__ (Total)	20__ (Total)	20__ (Total)	20__ (Total)
Revenue from Services to Patients					
Inpatient Services					
Routine (nursing service areas)					
Other					
Outpatient Services					
Emergency Services					
Gross Patient Revenue					
Deductions from Revenue					
Contractual Adjustments					
Discount/Miscellaneous Allowances					
Total Deductions					
NET PATIENT REVENUE(Gross patient revenue less deductions)					
Other Operating Revenue					
<b>NET OPERATING REVENUE</b>					
OPERATING EXPENSES					
Salaries, Wages, and Benefits					
Physician Salaries and Fees					
Supplies and other					
Uncompensated Care (less recoveries) per State Health Plan 410-2-2-.06(d)					
Other Expenses					
Total Operating Expenses					
NON-OPERATING EXPENSES					
Taxes					
Depreciation					
Interest (other than mortgage)					
Existing Capital Expenditures				<u>N/A</u>	<u>N/A</u>
Interest				<u>N/A</u>	<u>N/A</u>
Total Non-Operating Expenses					
<b>TOTAL EXPENSES (Operating &amp; Capital)</b>					
Operating Income (Loss)					
Other Revenue (Expense) – Net					
NET INCOME (Loss)					
Projected Capital Expenditure	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>		
Interest	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>		

**STATEMENT OF COMMUNITY PARTNERSHIP FOR EDUCATION AND REFERRALS**

A. This section is declaration of those activities your organization performs outside of inpatient and outpatient care in the community and for the underserved population. Please indicate historical and projected data by expenditures in the columns specified below.

Services and/or Programs	Historical Data (total dollars spent in last 3 years)			Projected Data (total dollars budgeted for next 2 years)	
	Year	Year	Year	Year	Year
Health Education (nutrition, fitness, etc.)					
Community service workers (school nurses, etc.)					
Health screenings					
Other					
<b>TOTAL</b>					

B. Please describe how the new services specified in this project application will be made available to and address the needs of the underserved community. If the project does not involve new services, please describe how the project will address the underserved population in your community.

Please briefly describe some of the current services or programs presented to the underserved in your community.

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**PART SIX: ACKNOWLEDGEMENT AND CERTIFICATION BY THE APPLICANT**

**I. ACKNOWLEDGEMENT**

In submitting this application, the applicant understands and acknowledges that:

- A. The rules, regulations and standards for health facilities and services promulgated by the SHPDA have been read, and the applicant will comply with same.
- B. The issuance of a certificate of need will depend on the approval of the CON Review Board, and no attempt to provide the service or incur an obligation will be made until a bona fide certificate of need is issued.
- C. The certificate of need will expire in twelve (12) months after date of issuance, unless an extension is granted pursuant to the applicable portions of the SHPDA rules and regulations.
- D. The certificate of need is not transferrable, and any action to transfer or assign the certificate will render it null and void.
- E. The applicant will notify the State Health Planning and Development Agency when a project is started, completed or abandoned.
- F. The applicant shall file a progress report on each active project every six (6) months until the project is completed.
- G. The applicant must comply with all state and local building codes, and failure to comply will render the certificate of need null and void.
- H. The applicants and their agents will construct and operate in compliance with appropriate state licensure rules, regulations, and standards.
- I. Projects are limited to the work identified in the Certificate of Need as issued.
- J. Any expenditure in excess of the amount approved on the Certificate of Need must be reported to the State Health Planning and Development Agency and may be subject to review.
- K. The applicant will comply with all state statutes for the protection of the environment.
- L. The applicant is not presently operating with a probational (except as may be converted by this application) or revoked license.

I. CERTIFICATION

The information contained in this application is true and correct to the best of my knowledge and belief.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Applicant's Name and Title  
(Type or Print)

\_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

\_\_\_\_\_  
Notary Public (Affix seal on Original)

**Author:** Alva M. Lambert

**Statutory Authority:** Code of Ala. 1975, §§22-21-267, 271, 275.

**History: Amended:** Filed March 13, 1997; effective April 18, 1997. **Amended:** Filed June 20, 2002; effective July 25, 2002.

**Amended:** Filed July 24, 2013; effective August 28, 2013.

**Amended:** Filed August 23, 2016; effective October 7, 2016.

**Amended (ER):** Filed May 20, 2026; effective May 20, 2026; expires 120 days, September 17, 2026.

**Application For Extension Of Certificate Of Need,  
BHD-162.**

BHD-162  
(8-77)  
Revised (5-13)

**State Health Planning and Development Agency**  
Mailing address: Post Office Box 303025, Montgomery, Alabama 36130-3025  
Street address: 100 North Union Street, Suite 870, Montgomery, Alabama 36104

APPLICATION FOR EXTENSION OF CERTIFICATE OF NEED  
A filing fee in the amount of \$ \_\_\_\_\_ has been submitted with this application.

1. APPLICATION. Application is hereby made for a twelve (12) month extension of the Certificate of Need issued for the health facility described below. (All items must be completed in full before extension of Certificate of Need can be considered.)				
2. PROJECT NUMBER		3. CERTIFICATE NUMBER		4. CERTIFICATE EXPIRES
5. LEGAL NAME OF APPLICANT			6. ADDRESS OF APPLICANT	
7. NAME OF PROPOSED FACILITY			8. LOCATION OF PROPOSED FACILITY	
9. TYPE OF FACILITY			10. ANTICIPATED DATE ON WHICH OBLIGATION IS EXPECTED TO OCCUR AND/OR CONSTRUCTION STARTED	
11. ESTIMATED DATE CONSTRUCTION IS SCHEDULED FOR COMPLETION				
12. BED CAPACITY				
	Gen. Hosp.	Nursing Home SK ICF		Psychiatric
Existing Bed Capacity	_____	_____	_____	_____
Beds provided by New Facility Addition	_____	_____	_____	_____
Remodeling	_____	_____	_____	_____
Replacement	_____	_____	_____	_____
Capacity Upon Completion	_____	_____	_____	_____
13. ESTIMATED COST OF THE PROJECT			14. PROPOSED FINANCING OF THE PROJECT	
Construction \$ _____			Total Estimated Cost \$ _____	
Fixed Equipment \$ _____			DHEW Loan/Grant \$ _____	
Movable Equipment \$ _____			SBA Loan \$ _____	
Arch. & Eng. \$ _____			FHA Mortgage Insurance \$ _____	
Site Improvements \$ _____			Private Financing \$ _____	
Financing Charges \$ _____			Other (Specify) \$ _____	
Total Cost \$ _____				
13a. ATTACH COST ESTIMATE SIGNED BY PROJECT ARCHITECT (Required)			14a. ATTACH STATEMENT FROM FINANCING AGENCY(IES) OF LOAN FEASIBILITY (Required)	
15. SITE INFORMATION (Check One)			16. ARCHITECTURAL PROGRESS	
Acquired _____			Architect Employed _____	
Option _____			Schematic Drawings _____	
Under Construction _____			Working Drawings _____	
Not Acquired _____			Advertised for Bids _____	

APPLICATION FOR EXTENSION OF CERTIFICATE OF NEED

17. BRIEF DESCRIPTION OF PROPOSED WORK. Include any proposed deletion, new or substantial change in the scope of the project as described in the Program Narrative submitted in support of the original Application.	
18. BUDGET AND UTILIZATION DATA. If there has been a material change in the estimated cost of the construction and/or operation of the facility (or if data were not submitted with the original application) it will be necessary to complete PART FIVE of the original application form. Part Five attached: ____ Yes ____ No	
19. COST CONTAINMENT. Attach Cost Containment Statement showing how the project will foster cost containment through improved efficiency and productivity, including promotion of cost-effective factors such as ambulatory care, preventive health care services, home health care, sharing of services with other facilities, and design and construction economies.	
20. In submitting this Application, the Applicant: Understands that extension of the Certificate will depend upon compliance with minimum criteria. A. Needs of the Area as set forth in the up-dated Alabama State Health Plan. B. 1. Site Procurement: Must have acquired or holds option to purchase. Site must be inspected and approved. 2. Architectural Progress: Must have approved working drawings. 3. Financial Status: Must present evidence that appropriate and necessary financing is final and immediately available. 4. Program Narrative: Must be updated to show change in scope of service. 5. Budget and Utilization Data: Must be on file and up-to-date. Maximum increase in costs and charges must be within Cost of Living Council guidelines. 6. Cost Containment: Satisfactory statement must be on file. C. Understands that the Certificate if issued, will expire not more than twelve (12) months from date of issuance and will not be subject to further extension. D. Agrees to notify Health Development, State Health Planning and Development Agency, if and when the project is abandoned or is placed under contract. E. The Certificate of Need, if issued, is not transferable and any action on the part of the Applicant to transfer or assign the Certificate of Need will render the Certificate of Need null and void.	
21. SIGNATURE OF RESPONSIBLE OFFICER  _____	22. TITLE OF OFFICER  _____
23. NAME OF RESPONSIBLE OFFICER  _____	24. DATE  _____

Attachments:

- \_\_\_\_\_ Cost Estimate
- \_\_\_\_\_ Statement from Financing Agency
- \_\_\_\_\_ Part Five Budget and Utilization Data
- \_\_\_\_\_ Cost Containment Statement

SUPPLEMENT TO APPLICATION: BUDGET AND UTILIZATION

1. NAME OF APPLICANT				2. NAME OF FACILITY								
3. TYPE OF FACILITY				4. LOCATION OF FACILITY								
5. HISTORICAL DATA: Give information for last three (3) years for which complete data are available												
A. OCCUPANCY DATA												
1. OCCUPANCY	NUMBER OF BEDS			ADMISSIONS OR DISCHARGES			TOTAL PATIENT DAYS			% OCCUPANCY		
	YR	YR	YR	YR	YR	YR	YR	YR	YR	YR	YR	
MEDICINE AND SURGERY												
OBSTETRICS												
PEDIATRICS												
PSYCHIATRY												
OTHER												
<b>TOTALS</b>												
PERCENT OF GROSS REVENUE												
B. SOURCE OF PAYMENT												
	YR _____			YR _____			YR _____					
BLUE CROSS												
OTHER INSURANCE												
MEDICARE												
MEDICAID												
SELF-PAY												
FREE CARE												
OTHER												
SUBTOTAL												
BAD DEBTS						%			%			%
TOTALS						100%			100%			100%

HD-161-E Revised (5-13)  
 BUDGET AND UTILIZATION DATA  
 5. HISTORICAL DATA (Cont'd)

2. NAME OF FACILITY _____
---------------------------

C. Statement of Income and Expense (Give information for last three years for which complete data are available.)	20_____ Total	20_____ Total	20_____ Total	20_____ Per Diem
Revenue from Services to Patients				
Inpatient Services				
Routine (Nursing Service Areas)				
Other				
Outpatient Services				
Emergency Services				
Other Operating Revenue				
Recoveries				
Other				
Gross Operating Revenue				
Deductions from Operating Revenue				
Contract Adjustments				
Discounts/Misc. Allowances				
Provision for Charity Services				
Provision for Uncollectables				
Total Deductions				
Net Operating Revenue				
Operating Expenses				
Salaries and Wages				
Physician's Salaries and Fees				
Supplies				
Depreciation				
Interest (Other than Mortgage)				
Other Expenses				
Total Operating Expenses				
Capital Expenditure				
Retirement of Principal				
Interest				
Total Capital Expenditure				
Total Expenses (Operating and Capital)				
Operating Income (Loss)				
Other Revenue (Expense)- Net				
Net Income (Loss)				

HD-161-E  
 Revised (5-13)

SUPPLEMENT TO APPLICATION: BUDGET AND UTILIZATION DATA

1. NAME OF APPLICANT		2. NAME OF FACILITY						
3. TYPE OF FACILITY		4. LOCATION OF FACILITY						
5. PROJECTED DATA: Give information projected to cover the first two (2) years of operation after completion of project.								
A. OCCUPANCY DATA								
1. OCCUPANCY	NUMBER OF BEDS		ADMISSIONS OR DISCHARGES		TOTAL PATIENT DAYS		% OCCUPANCY	
	1 <sup>st</sup> Year	2 <sup>nd</sup> Year	1 <sup>st</sup> Year	2 <sup>nd</sup> Year	1 <sup>st</sup> Year	2 <sup>nd</sup> Year	1 <sup>st</sup> Year	2 <sup>nd</sup> Year
MEDICINE AND SURGERY								
OBSTETRICS								
PEDIATRICS								
PSYCHIATRY								
OTHER								
<b>TOTALS</b>								
B. SOURCE OF PAYMENT								
	YR _____		YR _____		YR _____			
BLUE CROSS								
OTHER INSURANCE								
MEDICARE								
MEDICAID								
SELF-PAY								
FREE CARE								
OTHER								
SUBTOTAL								
BAD DEBTS			%		%		%	
<b>TOTALS</b>			100%		100%		100%	

*Note: Include both inpatient and outpatient data.*

HD-161-E Revised (5-13)  
 BUDGET AND UTILIZATION

NAME OF FACILITY \_\_\_\_\_

5. PROJECTED DATA (Cont'd)

C. Statement of Projected Income and Expenses (First two (2) years after completion of project.)	20____		20____	
	Total	Per Diem	Total	Per Diem
Revenue from Services to Patients				
Inpatient Services				
Routine (Nursing Service Areas)				
Other				
Outpatient Services				
Emergency Services				
Other Operating Revenue				
Recoveries				
Other				
Gross Operating Revenue				
Deductions from Operating Revenue				
Contract Adjustments				
Discount/Misc. Allowances				
Provision for Charity Services				
Provision for Uncollectables				
Total Deductions				
Net Operating Revenue				
Operating Expenses				
Salaries and Wages				
Physician's Salaries and Fees				
Supplies				
Depreciation				
Interest (Other than Mortgage)				
Other Expenses				
Total Operating Expenses				
Capital Expenditure				
Incurred Prior to this Project				
- Retirement of Principal				
- Interest				
This Project				
- Retirement of Principal				
- Interest				
Total Capital Expenditure				
Total Expenses (Operating & Capital)				
Operating Income (Loss)				
Other Revenue (Expense) – Net				

BUDGET AND UTILIZATION

6. INFORMATION REGARDING PROPOSED FINANCING

Total amount to be borrowed \$ \_\_\_\_\_

Anticipated interest rate \_\_\_\_\_ %

Term of loan \_\_\_\_\_ years

Method of calculating interest and principal payments:

7. ATTACHMENTS

- (1) Schedule of current charges.
- (2) Schedule of proposed charges after completion of this project.
- (3) State of existing capital indebtedness.
- (4) Schedule showing projected annual depreciation for buildings, fixed equipment, and movable equipment.

**Author:** [Emily T. Marsal](#)

**Statutory Authority:** [Act 2026-522, Code of Alabama, 1975.](#)

**History: Amended:** Filed March 13, 1997; effective April 18, 1997. **Amended:** Filed July 24, 2013; effective August 28, 2013.

**Amended (ER):** [Filed May 20, 2026; effective May 20, 2026; expires 120 days, September 17, 2026.](#)

**Supplement To Application: Budget And Utilization, HD-161-E.**

**State Health Planning and Development Agency**

Mailing address: Post Office Box 303025, Montgomery, Alabama 36130-3025

Street address: 100 North Union Street, Suite 870, Montgomery, Alabama 36104

Request # _____
Date Rec. _____
Received by: _____

**REQUEST FOR DETERMINATION OF EXEMPTION STATUS FOR REPLACEMENT OF EXISTING EQUIPMENT**

A filing fee in the amount of \$ \_\_\_\_\_ has been submitted with this application.

REQUESTER IDENTIFICATION (Check One) HOSPITAL (  ) NURSING HOME (  ) OTHER (  ) (Specify) \_\_\_\_\_

A. \_\_\_\_\_  
Name of requester

Address \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

B. \_\_\_\_\_  
Name of Facility/Organization (if different from A)

Address \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

C. \_\_\_\_\_  
Name of Legal Owner (if different from A or B)

Address \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

D. \_\_\_\_\_  
Name and Title of Person Representing Proposal and With Whom SHPDA Should Communicate

Address \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

**DESCRIPTION OF EQUIPMENT TO BE REPLACED    DESCRIPTION OF PROPOSED NEW EQUIPMENT**

A.    Manufacturer:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Serial #

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

B.    Model:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

C.    Name of equipment:

_____	_____
_____	_____
_____	_____
_____	_____

D.    Fair market value of equipment at present:

_____
_____
_____

E.    Cost of equipment (include written price quote):

_____
_____
_____

F.    Describe use of current equipment:

_____
_____

Describe use of proposed equipment:

_____
_____

G.    List any attachments or additional procedures associated with this equipment that could not be performed by old equipment:

_____
_____
_____

H. Can any procedures be performed with the proposed new equipment that cannot be performed with the replaced equipment? If yes, describe in detail:

---

---

---

---

---

I. Location of existing equipment (include room #):

---

---

---

---

J. List specially trained or qualified personnel necessary for operation of equipment:

---

---

---

---

K. What use will be made of old equipment when replaced?  
(Trade in on new equipment, used as back up, save for parts, etc.)

---

---

---

---

L. List job titles of any additional personnel that will be required to operate the new equipment.

---

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---

M. Describe any renovation or new construction that will be necessary for the installation of the replacement equipment and cost.

---

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---

N. Describe any new annual operating cost associated with this project such as maintenance contracts, salaries of new employees hired due to equipment, etc.

---

---

---

---

III. COST

A. Equipment costs \$ \_\_\_\_\_  
(Costs have to be supported by price quote on manufacturer's stationery or letterhead.) Cost of equipment only; do not list lease cost.

B. Less trade-in of old equipment \$ \_\_\_\_\_

C. Total cost of equipment \$ \_\_\_\_\_

Calculation of fee for this determination:

Multiply dollar amount in III.C. (total cost of equipment) times 1% (the application fee for a Certificate of Need); 20% of this amount is the application fee for non-rural hospitals.

For rural hospitals, the application fee is 25% of the application fee as calculated above for non-rural hospitals.

Include manufacturer's literature on old equipment, if available, and on the new equipment.

Include any other information pertinent to the determination.

The Executive Director may request any other information which is relevant to his decision.

IV. CERTIFICATION

I certify that the information provided herein is true and correct and that there is no additional information which would be pertinent to this application which has not been provided. Further, I understand that any misrepresentation on this application or failure to include relevant information may void any favorable determination secured by such misrepresentation or omission.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Applicant's Name and Title  
(Type or Print)

Sworn to and subscribed before me this  
\_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_  
Notary Public (affix seal on original)

**Author:** [Emily T. Marsal](#)  
**Statutory Authority:** [Act 2026-522, Code of Alabama, 1975.](#)  
**History: Amended:** [Filed July 24, 2013; effective August 28, 2013. Amended \(ER\): Filed May 20, 2026; effective May 20, 2026; expires 120 days, September 17, 2026.](#)

**Request For Determination Of Exemption Status For Replacement Of Existing Equipment.**

FORM ASC-1  
Revised \*\*/\*\*

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\_\_

**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

**20-- 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:** \_\_\_\_\_ **Facility Fax:** \_\_\_\_\_

(AREA CODE) & TELEPHONE NUMBER (AREA CODE) & TELEPHONE NUMBER  
This reporting period is for 10/1/20-- through 9/30/20--; or for **partial** year of operation beginning \_\_\_\_\_ and ending \_\_\_\_\_ a period of \_\_\_\_\_ days.

MONTH DAY MONTH DAY  
Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. **If there was a change in ownership during the reporting period, data for the full year should be reported by the current owner.**

*We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this facility.*

PRINTED NAME OF PREPARER SIGNATURE OF PREPARER DATE

DIRECT TELEPHONE NUMBER TITLE OF PREPARER E-MAIL ADDRESS

**A member of administration MUST also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above; and must be separate from the preparer.**

PRINTED NAME OF ADMINISTRATION OFFICIAL SIGNATURE OF ADMINISTRATION OFFICIAL DATE

DIRECT TELEPHONE NUMBER TITLE OF ADMINISTRATION OFFICIAL E-MAIL ADDRESS

**FOR OFFICE USE ONLY**

Facility Verified: \_\_\_\_\_ Initial Scan: \_\_\_\_\_ Completed: \_\_\_\_\_  
Entered: \_\_\_\_\_ Final Scan: \_\_\_\_\_ Audited: \_\_\_\_\_

**THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\_\_**

**I. OWNERSHIP**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Corporation   | <input type="checkbox"/> Non-Profit           | <input type="checkbox"/> Partnership     |
| <input type="checkbox"/> Individual    | <input type="checkbox"/> Healthcare Authority | <input type="checkbox"/> LLC             |
| <input type="checkbox"/> Joint Venture | <input type="checkbox"/> Government           | <input type="checkbox"/> Other (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) _____	_____	_____
<b>TOTALS</b> (note: these totals should equal the totals as reported in Section II)	_____	_____

**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) _____	
<b>TOTALS</b> (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			
<b>TOTALS</b>			*

\* This total should equal the total reported in Section V-B.

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\_\_\_\_

**B. ADMISSIONS BY RACE** *(entire reporting period)*

	<b>TOTAL</b>
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):	
<b>TOTALS</b>	<b>*</b>

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

**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). This data shall be submitted as a Microsoft Excel (v. 2003 or later) or CSV formatted file, and shall be submitted at the same time as the remainder of this report. The annual report will not be deemed received by the Agency on behalf of the submitting provider unless and until both the PDF document containing the first four pages of the report and the Excel or CSV file containing the data for this section 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 if supplied. Also, please ensure that the Facility ID Number supplied in the first column and the Facility ID Number reported on Page 1 are the same, and are correct.

FacilityIDNumber	PatZipCode	NumberOfPatientCases
999-U9999	99999	9999

**Author:** [Emily T. Marsal](#)

**Statutory Authority:** [Act 2026-522, Code of Alabama, 1975.](#)

**History:** New Form: Filed March 18, 2016; effective May 2, 2016.

**Amended:** Filed September 19, 2018; effective November 3, 2018.

**Amended (ER):** [Filed May 20, 2026; effective May 20, 2026; expires 120 days, September 17, 2026.](#)

Annual Report Forms.

FORM DM-1  
Revised \*\*/20\*\*

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, \*\*\*\*

**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](http://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](mailto:bradford.williams@shpda.alabama.gov)

**20-- 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:** \_\_\_\_\_ **Facility Fax:** \_\_\_\_\_  
(AREA CODE) & TELEPHONE NUMBER (AREA CODE) & TELEPHONE NUMBER

This reporting period is for **October 1, 20--**, through **September 30, 20--** \*; or for partial year of operation beginning \_\_\_\_\_ and ending \_\_\_\_\_ 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.*

<small>PRINTED NAME OF PREPARER</small>	<small>SIGNATURE OF PREPARER</small>	<small>DATE</small>
<small>DIRECT TELEPHONE NUMBER</small>	<small>TITLE OF PREPARER</small>	<small>E-MAIL ADDRESS</small>

**A member of administration MUST also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above; and must be separate from the preparer.**

<small>PRINTED NAME OF ADMINISTRATION OFFICIAL</small>	<small>SIGNATURE OF ADMINISTRATION OFFICIAL</small>	<small>DATE</small>
<small>DIRECT TELEPHONE NUMBER</small>	<small>TITLE OF ADMINISTRATION OFFICIAL</small>	<small>E-MAIL ADDRESS</small>

**FOR OFFICE USE ONLY**

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

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, \*\*\*\*

**I Agency Operations**

Days of week services are regularly available  Monday – Friday  Sunday-Saturday  Other (specify) \_\_\_\_\_

Days on-call **only**  Weekends  Holidays  Other (specify) \_\_\_\_\_

**II Ownership**

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

**III Branch Offices**

Does the organization of your service include a staffed satellite or branch office?

CITY OF LOCATION	YES		NO	
	OPENED IN LAST 12 MONTHS?		DAYS OF WEEK SERVICES AVAILABLE	
	YES	NO	REGULAR SCHEDULE	ON-CALL ONLY
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**IV Drop Sites**

Has this agency received authorization to operate a drop site? NOTE: A drop site is considered to be a location from which supplies **only** are stored. A drop site may not be staffed, accept referrals, advertise, or operate in any manner as a branch office (CMS S&C-05-07). Drop sites can only be operated in CON approved/exempt counties.

CITY OF LOCATION	YES		NO	
	OPENED IN LAST 12 MONTHS?		OPENED IN LAST 12 MONTHS?	
	YES	NO	YES	NO
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____





THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, \*\*\*\*

**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:

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

\*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.

<b>SERVICE</b>	<b>VISITS BY SERVICE</b>
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): _____	_____
<b>TOTAL VISITS BY SERVICE</b>	*

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

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, \*\*\*\*

**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	_____	_____	_____
<b>TOTALS</b>	_____	_____	* _____

\*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):	_____
<b>TOTALS</b>	* _____

\*THIS TOTAL MUST EQUAL  
THE TOTAL ADMISSIONS  
IN SECTIONS VI, VII, AND  
IX-A



THIS REPORT IS DUE ON OR BEFORE APRIL 15, \*\*\*\*

**SECTION A: PROGRAM**

**A1: PROGRAM TYPE**

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

- |  |   |
|--|---|
| <input type="checkbox"/> Free Standing         | <input type="checkbox"/> Hospital Based     |
| <input type="checkbox"/> Home Health Based     | <input type="checkbox"/> Nursing Home Based |
| <input type="checkbox"/> Other (specify) _____ |   |

**b. Ownership** *(choose one type only)*

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Corporation   | <input type="checkbox"/> Non-Profit Organization | <input type="checkbox"/> Partnership           |
| <input type="checkbox"/> Individual    | <input type="checkbox"/> Healthcare Authority    | <input type="checkbox"/> LLC                   |
| <input type="checkbox"/> Joint Venture | <input type="checkbox"/> Government              | <input type="checkbox"/> Other (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      | <input type="checkbox"/> YES | <input type="checkbox"/> NO |  |
| Inpatient Care Services | <input type="checkbox"/> YES | <input type="checkbox"/> 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?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|------------------------------|-----------------------------|

Number of total CON Authorized Inpatient beds: \_\_\_\_\_

- |                        |                               |  |                               |
|------------------------|-------------------------------|--|-------------------------------|
| Free Standing Facility | _____                         | Leased Beds within Another Licensed Facility | _____                         |
|                        | <small>NUMBER OF BEDS</small> |  | <small>NUMBER OF BEDS</small> |

THIS REPORT IS DUE ON OR BEFORE APRIL 15, \*\*\*\*

**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 1<sup>st</sup> 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 APRIL 15, \*\*\*\*

**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	
<b>TOTAL ADMISSIONS</b>	

**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			
<b>TOTAL ADMISSIONS</b>			

**B4: DEATHS/DISCHARGES**

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

THIS REPORT IS DUE ON OR BEFORE APRIL 15, \*\*\*\*

**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 APRIL 15, \*\*\*\*

**C2: PATIENT DAYS BY REIMBURSEMENT SOURCE**

SOURCE OF REIMBURSEMENT	PATIENT DAYS
Medicare	
Medicaid	
Private Insurance	
Private Pay	
Charity	
<b>TOTALS (Must equal C1j. Total)</b>	

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	
<b>TOTALS (Must equal C1j. Total)</b>	







THIS REPORT IS DUE ON OR BEFORE APRIL 15, \*\*\*\*

**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](mailto: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.



THIS REPORT IS DUE ON OR BEFORE APRIL 15, \*\*\*\*

### Hospice Annual Report Checklist

	<b>TOTALS</b>
<b>PATIENT DAYS</b>	
Page 5, Section C1j.	_____
<i>Patient Days throughout report must equal days reported directly above</i>	
Page 6, Section C2	_____
Page 6, Section C3	_____
Page 7, Section D1	_____
 <b>ADMISSIONS</b>	
Page 3, Section B1e.	_____
<i>Admissions throughout report must equal Admissions reported directly above</i>	
Page 4, Section B2	_____
Page 4, Section B3	_____
 <b>UNDUPLICATED PATIENTS SERVED</b>	
Page 3, Section B1g.	_____
<i>Unduplicated Patients Served throughout report must equal Unduplicated Patients Served reported directly above</i>	
Page 7, Section D1	_____
 <b>DEATHS</b>	
Page 4, Section B4a.	_____
<i>Deaths throughout report must equal Deaths reported directly above</i>	
Page 7, Section D1	_____
 <b>LIVE DISCHARGES/REVOCATIONS/TRANSFERS</b>	
Page 4, Section B4b.	_____
<i>Live Discharges/Revocations/Transfers throughout report must equal Deaths reported directly above</i>	
Page 7, Section D1	_____

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

**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](http://www.shpda.alabama.gov)

*STREET ADDRESS (Commercial Carrier)*  
100 NORTH UNION STREET STE 870  
MONTGOMERY AL 36104  
FAX: (334) 242-4113  
[data.submit@shpda.alabama.gov](mailto:data.submit@shpda.alabama.gov)

**20\*\* 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:** \_\_\_\_\_ **Facility Fax:** \_\_\_\_\_

This reporting period is (AREA CODE) & TELEPHONE NUMBER 10/1/20\*\*, through (AREA CODE) & TELEPHONE NUMBER 9/30/20\*\*; or for **partial** year of operation beginning \_\_\_\_\_ and ending \_\_\_\_\_ a period of \_\_\_\_\_ days.

MONTH DAY MONTH DAY  
Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. **If there was a change in ownership during the reporting period, data for the full year should be reported by the current owner.**

**We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this facility.**

PRINTED NAME OF PREPARER	SIGNATURE OF PREPARER	DATE
--------------------------	-----------------------	------

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

**A member of administration MUST also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above; and must be separate from the preparer.**

PRINTED NAME OF ADMINISTRATION OFFICIAL	SIGNATURE OF ADMINISTRATION OFFICIAL	DATE
---	--------------------------------------	------

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

**FOR OFFICE USE ONLY**

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

**OWNERSHIP** (check one)

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

Does this facility operate under a management contract?  Yes  No

Management Firm: \_\_\_\_\_  
NAME  
 \_\_\_\_\_  
BASE ADDRESS CITY STATE ZIP

**I. FACILITIES**

**A. Check the ONE category that best describes the type of service provided to the majority of admissions.**

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

**B. Totals** \*\*PLEASE VERIFY ALL TOTALS ON CHECKLIST, PAGE 13, PRIOR TO SUBMISSION\*\*

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

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

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

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

\* 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				

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

	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)				
<b>TOTALS</b>				

**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)				
<b>TOTALS</b>				

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

**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
<u>Adolescent/Child</u>	_____	_____	_____	_____	_____
<u>Adult</u>	_____	_____	_____	_____	_____
<u>Geriatric</u>	_____	_____	_____	_____	_____
<u>TOTALS</u>	_____	_____	_____	_____	_____

**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 – <i>PPS-EXCLUDED</i>	_____	_____	_____	_____	_____
3. Burn Unit	_____	_____	_____	_____	_____



THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

**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).

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

**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
<b>Heart Catheterization Diagnostic</b>						
<b>Heart Catheterization Therapeutic/ Interventional</b> (Including PTCA, directional coronary atherectomy, rotational atherectomy and similar complex therapeutic procedures)						
<b>Pediatric Catheterization</b>						
<b>Electrophysiology Diagnostic</b>						
<b>Electrophysiology Therapeutic</b>						
<b>Pacemaker Implants (permanent)</b>						
<b>Other (specify below)</b>						
<b>TOTAL PROCEDURES</b>						
<b>TOTAL PATIENTS (cases)</b>	<b>INPATIENT</b>	<b>OUTPATIENT</b>	<b>INPATIENT</b>	<b>OUTPATIENT</b>	<b>INPATIENT</b>	<b>OUTPATIENT</b>
<b>TOTAL NUMBER OF CON AUTHORIZED CATH LABS:</b>						

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

**H. THERAPEUTIC SERVICES**

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

**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
_____	_____	_____	_____

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

#### **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

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

**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			
<b>TOTALS</b>			*

*\* 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):	
<b>TOTALS</b>	*

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

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

**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.

**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](mailto:data.submit@shpda.alabama.gov).**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

### Hospital Annual Report Checklist

	Totals
<b>CON Authorized Beds</b>	
Page 2, Section I-B-1.	_____
Page 4, Section II-A	_____
Page 4, Section II-B	_____
Page 5, Section II-C	_____
Page 5, Section II-D	_____
<i>CON Authorized Beds in Sections II-A+II-B+II-C+IID should equal Authorized Beds reported in Section I-B if exempted non-CON Authorized beds are not reported in Section II-C</i>	
TOTAL CON AUTHORIZED BEDS SECTION II	_____
<b>Staffed and Operational Beds by Service</b>	
Page 2, Section I-B-2.	_____
Page 4, Section II-A	_____
Page 4, Section II-B	_____
Page 5, Section II-C	_____
Page 5, Section II-D	_____
<i>Staffed and Operational Beds in Sections II-A+II-B+IIC+IID must equal Staffed and Operational Beds reported in Section I-B</i>	
TOTAL STAFFED AND OPERATIONAL BEDS SECTION II	_____
<b>Patient Days</b>	
Page 2, Section I-B-5.	_____
Page 3, Section I-C	_____
<i>Patient Days in Section I-C must equal Patient Days reported in Section I-B</i>	
Page 4, Section II-A	_____
Page 4, Section II-B	_____
Page 5, Section II-C	_____
Page 5, Section II-D	_____
<i>Patient Days in Sections II-A+II-B+II-C+II-D must equal Patient Days reported in Section I-B</i>	
TOTAL PATIENT DAYS SECTION II	_____
<b>Discharges</b>	
Page 2, Section I-B-6.	_____
Page 3, Section I-C	_____
<i>Discharges in Section I-C must equal Discharges reported in Section I-B</i>	
Page 4, Section II-A	_____
Page 4, Section II-B	_____
Page 5, Section II-C	_____
Page 5, Section II-D	_____
<i>Discharges in Sections II-A+II-B+II-C+II-D must equal Discharges reported in Section I-B</i>	
TOTAL DISCHARGES SECTION II	_____

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

**PROCESSING NOTES & LEGEND FOR SUBMISSIONS OF THE  
FY 20\*\* PATIENT ORIGIN SURVEY DATA SUPPLEMENT  
MUST INCLUDE DISCHARGE DATA FOR OCTOBER 1, 20\*\* - SEPTEMBER 30, 20\*\***

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.

<u>FIELD NAME</u>	<u>INSTRUCTIONS</u>
<b>Hospital ID #</b>	SHPDA Hospital ID number
<b>Patient Number</b>	Patient identification number. <i>This number may be a blind number assigned in sequential order.</i> Patient ID numbers <b>cannot</b> be duplicated.
<b>Age</b>	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. <b><u>INCLUDE ALL NEWBORNS &amp; PEDIATRICS, USING 000 FOR ALL INFANTS UNDER 1 YEAR OF AGE.</u></b>
<b>Sex</b>	Use the following values:  <b>MALE: 1 FEMALE: 2 OTHER/UNKNOWN: 9</b>

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

<u>FIELD NAME</u>	<u>INSTRUCTIONS</u>
<b>Race or National Origin</b>	<p>Use the following values:</p> <p><b>WHITE/CAUCASIAN</b>----- 1</p> <p><b>BLACK/AFRICAN AMERICAN</b> ----- 2</p> <p><b>HISPANIC/SPANISH/LATINO</b>----- 3</p> <p><b>ASIAN</b>----- 4</p> <p><b>AMERICAN INDIAN/ALASKAN NATIVE</b>----- 5</p> <p><b>PACIFIC ISLANDER</b>----- 6</p> <p><b>INDIA</b>----- 7</p> <p><b>MIDDLE EASTERN</b>----- 8</p> <p><b>OTHER</b>----- 9</p>
<b>Zip Code</b>	Patient's residence zip code. <b>5 digits only, report unknown zip codes as "99999"</b> .
<b>Length of Stay (LOS)</b>	<p>The number of days calculated from the date of admission until the date of <u>discharge</u> or <u>death</u>. <b>Discharges for this year</b> 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.</p> <p><b>Examples:</b> A patient admitted on April 30th and discharged on May 4<sup>th</sup> would have a LOS of 004. A patient admitted on May 3<sup>rd</sup> and discharged on May 13<sup>th</sup> would have a LOS of 010. A patient admitted on September 28<sup>th</sup> and not discharged by September 30th would not be included.</p>
<b>Date of Discharge</b>	For every discharge, Please include the date of discharge for that patient. This should be submitted in a <b>MM/DD/YYYY</b> format.

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

<u>FIELD NAME</u>	<u>INSTRUCTIONS</u>
<b>Service Code</b>	<p>Record only the <b>PRIMARY</b> service when more than one clinical service is provided during the hospital stay:</p> <p><b>MEDICINE:</b>           <b>01</b></p> <p><b>SURGERY:</b>           <b>02</b></p> <p><b>PEDIATRICS:</b>       <b>03</b> (use only if your facility has an organized pediatric unit and only for patients <u>17 and under</u>). 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.</p> <p><b>GYNECOLOGY</b>       <b>04</b> (<u>NO MALES</u>), (medicine or surgery)</p> <p><b>OBSTETRICS</b>         <b>05</b> (<u>NO MALES</u>)</p> <p><b>ORTHOPEDICS</b>       <b>06</b> (use only if your facility has an organized orthopedic unit.) Facilities without an organized orthopedic unit should report these patients under the appropriate service.</p> <p><b>PSYCHIATRIC</b>       <b>07</b> (include alcoholism and substance abuse treatments)</p> <p><b>REHABILITATION</b>   <b>08</b></p> <p><b>OTHER</b>               <b>09</b></p>
<b>DRG/CMG</b>	<p>Patient's <b>DRG</b> (Diagnosis Related Group) or <b>CMG</b> (Case Mix Group) code. <b>As a reminder, please indicate which version of DRG codes your facility is using.</b></p>

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

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

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

**PROCESSING NOTES & LEGEND FOR SUBMISSIONS OF THE  
FY 20\*\* INPATIENT REHABILITATION PATIENT ORIGIN SURVEY DATA SUPPLEMENT  
MUST INCLUDE DISCHARGE DATA FOR OCTOBER 1, 20\*\* - SEPTEMBER 30, 20\*\***

The data in this section should only be reported by CON authorized Inpatient Rehabilitation Facilities or those hospitals with CON authorized inpatient rehabilitation beds. This information should be provided as a separate Microsoft Excel or CSV file and should be provided **IN ADDITION TO** the data required on pages 14-17 of this survey. All submissions must comply with the filing requirements set forth in Ala. Admin. Code 410-1-3-.09. The Annual Report (Form BHD 134A) AND both Patient Origin data electronic files 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	INSTRUCTIONS	FIELD LOCATION
<b>Hospital ID #</b>	SHPDA Hospital ID number	<b>SHPDA Assigned</b>
<b>Patient Number</b>	Patient identification number. <i>This number may be a blind number assigned in sequential order.</i> Patient ID numbers <b>cannot</b> be duplicated.	<b>IRF-PAI P1 5b</b>
<b>Age</b>	The numeric value of the patient's age.	<b>IRF-PAI P1 6</b>
<b>Sex</b>	Use the following values:  <b>MALE: 1 FEMALE: 2 OTHER/UNKNOWN: 9</b>	<b>IRF-PAI P1 8</b>
<b>Race or National Origin</b>	Use the following values: <b>WHITE/CAUCASIAN</b> ----- 1 <b>BLACK/AFRICAN AMERICAN</b> ----- 2 <b>HISPANIC/SPANISH/LATINO</b> ----- 3 <b>ASIAN</b> ----- 4 <b>AMERICAN INDIAN/ALASKAN NATIVE</b> ----- 5 <b>PACIFIC ISLANDER</b> ----- 6 <b>INDIA</b> ----- 7 <b>MIDDLE EASTERN</b> ----- 8 <b>OTHER</b> ----- 9	<b>IRF-PAI P3 A1010</b>
<b>ZipCode</b>	Patient's residence zip code. <b>Report only the 5 digit zip code where possible. Report unknown zip codes as "99999".</b>	<b>IRF-PAI P1 11</b>

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

FIELD NAME	INSTRUCTIONS	FIELD LOCATION
<b>LengthOfStay</b>	The number of days calculated from the date of admission until the date of discharge. Discharges for this year include any patients admitted in previous years and discharged during the current reporting period.	<b>IRF-PAI P2 40</b> (Calculated Field)
<b>DateOfDischarge</b>	Date the patient was discharged from care. Submit in MM/DD/YYYY format.	<b>IRF-PAI P2 40</b>
<b>Service Code</b>	All Service Codes for patients discharged from an Inpatient Rehabilitation Facility should be assigned a service code of '8'.	<b>N/A</b> (Assign all patients a code of '8')
<b>DRG</b>	Primary DRG code for patient	<b>UB-04 71</b>
<b>Payor</b>	Use the following values: <i>SELF PAY/PRIVATE PAY</i> ----- 1 <i>WORKMAN'S COMPENSATION</i> ----- 2 <i>MEDICARE</i> ----- 3 <i>MEDICAID</i> ----- 4 <i>TRI-CARE</i> ----- 5 <i>BLUE CROSS/BLUE SHIELD</i> ----- 6 <i>NO CHARGE/CHARITY</i> ----- 7 <i>HMO</i> ----- 8 <i>ALL KIDS</i> ----- 9 <i>OTHER INSURANCE</i> ----- 10 <i>HOSPICE</i> ----- 11 <i>MEDICARE ADVANTAGE</i> ----- 12 <i>OTHER</i> ----- 13	<b>IRF-PAI P1 20</b>
<b>ICD-10Primary</b>	Etiologic Diagnosis ICD-10 Code #1	<b>IRF-PAI P1 22A</b>
<b>ICD-10Primary2</b>	Etiologic Diagnosis ICD-10 Code #2	<b>IRF-PAI P1 22B</b>
<b>ICD-10Primary3</b>	Etiologic Diagnosis ICD-10 Code #3	<b>IRF-PAI P1 22C</b>
<b>ICD-10Secondary</b>	Comorbid Condition ICD-10 Code #1	<b>IRF-PAI P1 24A</b>
<b>ICD-10Secondary2</b>	Comorbid Condition ICD-10 Code #2	<b>IRF-PAI P1 24B</b>
<b>ICD-10Secondary3</b>	Comorbid Condition ICD-10 Code #3	<b>IRF-PAI P1 24C</b>
<b>ICD-10Secondary4</b>	Comorbid Condition ICD-10 Code #4	<b>IRF-PAI P1 24D</b>

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FIELD NAME	INSTRUCTIONS	FIELD LOCATION
<b>ICD-10Secondary5</b>	Comorbid Condition ICD-10 Code #5	<b>IRF-PAI P1 24E</b>
<b>ICD-10Secondary6</b>	Comorbid Condition ICD-10 Code #6	<b>IRF-PAI P1 24F</b>
<b>ICD-10Secondary7</b>	Comorbid Condition ICD-10 Code #7	<b>IRF-PAI P1 24G</b>
<b>ICD-10Secondary8</b>	Comorbid Condition ICD-10 Code #8	<b>IRF-PAI P1 24H</b>
<b>ICD-10Secondary9</b>	Comorbid Condition ICD-10 Code #9	<b>IRF-PAI P1 24I</b>
<b>ICD-10Secondary10</b>	Comorbid Condition ICD-10 Code #10	<b>IRF-PAI P1 24J</b>
<b>ICD-10Secondary11</b>	Comorbid Condition ICD-10 Code #11	<b>IRF-PAI P1 24K</b>
<b>ICD-10Secondary12</b>	Comorbid Condition ICD-10 Code #12	<b>IRF-PAI P1 24L</b>
<b>ICD-10Secondary13</b>	Comorbid Condition ICD-10 Code #13	<b>IRF-PAI P1 24M</b>
<b>ICD-10Secondary14</b>	Comorbid Condition ICD-10 Code #14	<b>IRF-PAI P1 24N</b>
<b>ICD-10Secondary15</b>	Comorbid Condition ICD-10 Code #15	<b>IRF-PAI P1 24O</b>
<b>ICD-10Secondary16</b>	Comorbid Condition ICD-10 Code #16	<b>IRF-PAI P1 24P</b>
<b>ICD-10Secondary17</b>	Comorbid Condition ICD-10 Code #17	<b>IRF-PAI P1 24Q</b>
<b>ICD-10Secondary18</b>	Comorbid Condition ICD-10 Code #18	<b>IRF-PAI P1 24R</b>
<b>ICD-10Secondary19</b>	Comorbid Condition ICD-10 Code #19	<b>IRF-PAI P1 24S</b>
<b>ICD-10Secondary20</b>	Comorbid Condition ICD-10 Code #20	<b>IRF-PAI P1 24T</b>
<b>ICD-10Secondary21</b>	Comorbid Condition ICD-10 Code #21	<b>IRF-PAI P1 24U</b>
<b>ICD-10Secondary22</b>	Comorbid Condition ICD-10 Code #22	<b>IRF-PAI P1 24V</b>
<b>ICD-10Secondary23</b>	Comorbid Condition ICD-10 Code #23	<b>IRF-PAI P1 24W</b>
<b>ICD-10Secondary24</b>	Comorbid Condition ICD-10 Code #24	<b>IRF-PAI P1 24X</b>
<b>ICD-10Secondary25</b>	Comorbid Condition ICD-10 Code #25	<b>IRF-PAI P1 24Y</b>
<b>Admit</b>	Facility Type from which patient was admitted	<b>IRF-PAI P1 15A</b>
<b>Discharge</b>	Facility type/location to which patient was discharged	<b>IRF-PAI P2 44D</b>
<b>Wk1PIThery</b>	Week 1 Physical Therapy Individual Therapy	<b>IRF-PAI P2 00401A a</b>
<b>Wk1PCThery</b>	Week 1 Physical Therapy Concurrent Therapy	<b>IRF-PAI P2 00401A b</b>
<b>Wk1PGThery</b>	Week 1 Physical Therapy Group Therapy	<b>IRF-PAI P2 00401A c</b>
<b>Wk1PTThery</b>	Week 1 Physical Therapy Co-Treatment Therapy	<b>IRF-PAI P2 00401A d</b>

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20\*\*

<b>FIELD NAME</b>	<b>INSTRUCTIONS</b>	<b>FIELD LOCATION</b>
<b>Wk1OITherapy</b>	Week 1 Occupational Therapy Individual Therapy	<b>IRF-PAI P2 O0401B a</b>
<b>Wk1OCTherapy</b>	Week 1 Occupational Therapy Concurrent Therapy	<b>IRF-PAI P2 O0401B b</b>
<b>Wk1OGTherapy</b>	Week 1 Occupational Therapy Group Therapy	<b>IRF-PAI P2 O0401B c</b>
<b>Wk1OTTtherapy</b>	Week 1 Occupational Therapy Co-Treatment Therapy	<b>IRF-PAI P2 O0401B d</b>
<b>Wk1SITherapy</b>	Week 1 Speech-Language Therapy Individual Therapy	<b>IRF-PAI P2 O0401C a</b>
<b>Wk1SCTherapy</b>	Week 1 Speech-Language Therapy Concurrent Therapy	<b>IRF-PAI P2 O0401C b</b>
<b>Wk1SGTherapy</b>	Week 1 Speech-Language Therapy Group Therapy	<b>IRF-PAI P2 O0401C c</b>
<b>Wk1STTherapy</b>	Week 1 Speech-Language Therapy Co-Treatment Therapy	<b>IRF-PAI P2 O0401C d</b>
<b>Wk2PITherapy</b>	Week 2 Physical Therapy Individual Therapy	<b>IRF-PAI P2 O0402A a</b>
<b>Wk2PCTherapy</b>	Week 2 Physical Therapy Concurrent Therapy	<b>IRF-PAI P2 O0402A b</b>
<b>Wk2PGTherapy</b>	Week 2 Physical Therapy Group Therapy	<b>IRF-PAI P2 O0402A c</b>
<b>Wk2PTTherapy</b>	Week 2 Physical Therapy Co-Treatment Therapy	<b>IRF-PAI P2 O0402A d</b>
<b>Wk2OITherapy</b>	Week 2 Occupational Therapy Individual Therapy	<b>IRF-PAI P2 O0402B a</b>
<b>Wk2OCTherapy</b>	Week 2 Occupational Therapy Concurrent Therapy	<b>IRF-PAI P2 O0402B b</b>
<b>Wk2OGTherapy</b>	Week 2 Occupational Therapy Group Therapy	<b>IRF-PAI P2 O0402B c</b>
<b>Wk2OTTtherapy</b>	Week 2 Occupational Therapy Co-Treatment Therapy	<b>IRF-PAI P2 O0402B d</b>
<b>Wk2SITherapy</b>	Week 2 Speech-Language Therapy Individual Therapy	<b>IRF-PAI P2 O0402C a</b>
<b>Wk2SCTherapy</b>	Week 2 Speech-Language Therapy Concurrent Therapy	<b>IRF-PAI P2 O0402C b</b>
<b>Wk2SGTherapy</b>	Week 2 Speech-Language Therapy Group Therapy	<b>IRF-PAI P2 O0402C c</b>
<b>Wk2STTherapy</b>	Week 2 Speech-Language Therapy Co-Treatment Therapy	<b>IRF-PAI P2 O0402C d</b>

**THIS REPORT IS DUE ON OR BEFORE AUGUST 16, 20\*\***

**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](http://www.shpda.alabama.gov)

*STREET ADDRESS (Commercial Carrier)*  
100 NORTH UNION STREET STE 870  
MONTGOMERY AL 36104  
FAX: (334) 242-4113  
[data.submit@shpda.alabama.gov](mailto:data.submit@shpda.alabama.gov)

**20\*\* ANNUAL REPORT FOR SKILLED NURSING FACILITIES**



Pencil submissions of this report will not be accepted. This report should be completed and submitted electronically. All dark gray fields contain formulas to help with the accuracy of the report. Please do NOT complete this report manually.

**Mailing Address:** \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP

**Physical Address:** \_\_\_\_\_  
STREET ADDRESS CITY **AL** ZIP

**County of Location:** \_\_\_\_\_

**Facility Telephone:** \_\_\_\_\_ **Facility Fax:** \_\_\_\_\_  
(AREA CODE) & TELEPHONE NUMBER (AREA CODE) & TELEPHONE NUMBER

This reporting period is for July 1, 20\*\*, through June 30, 20\*\*\*; or for **partial** year of operation beginning \_\_\_\_\_ and ending \_\_\_\_\_ a period of \_\_\_\_\_ days.

MONTH DAY MONTH DAY  
*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.***

<small>PRINTED NAME OF PREPARER</small>	<small>SIGNATURE OF PREPARER</small>	<small>DATE</small>
<small>DIRECT TELEPHONE NUMBER</small>	<small>TITLE OF PREPARER</small>	<small>E-MAIL ADDRESS</small>

***A member of administration MUST also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above; and must be separate from the preparer.***

<small>PRINTED NAME OF ADMINISTRATION OFFICIAL</small>	<small>SIGNATURE OF ADMINISTRATION OFFICIAL</small>	<small>DATE</small>
<small>DIRECT TELEPHONE NUMBER</small>	<small>TITLE OF ADMINISTRATION OFFICIAL</small>	<small>E-MAIL ADDRESS</small>

**FOR OFFICE USE ONLY**

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

**THIS REPORT IS DUE ON OR BEFORE AUGUST 16, 20\*\***

**OWNERSHIP** (check one)

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

Does this facility operate under a management contract?  Yes  No

Management Firm:

Name _____
Base Address _____ City _____ State _____ Zip _____

**I. FACILITIES**

- |  |  |      |      |       |       |
|--|--|------|------|-------|-------|
| a. Total beds <b>licensed</b> by the Alabama Department of Public Health   | _____  |      |      |       |       |
| b. Number of beds certified for Medicare patients ( <b>NOTE: Medicaid patients ARE ALLOWED</b> 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?                | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">YES</td> <td style="width: 50%; text-align: center;">NO</td> </tr> </table>   | YES  | NO   |       |       |
| YES  | NO   |      |      |       |       |
| e. If "No" was answered in item (d), indicate the number of licensed beds and the number of days those beds were licensed. | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">BEDS</td> <td style="width: 50%; text-align: center;">DAYS</td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </table> | BEDS | DAYS | _____ | _____ |
| BEDS   | DAYS   |      |      |       |       |
| _____  | _____  |      |      |       |       |
| f. Additional licensed beds and the number of days those beds were licensed  | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">BEDS</td> <td style="width: 50%; text-align: center;">DAYS</td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </table> | BEDS | DAYS | _____ | _____ |
| 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) _____                                    | _____ |

**THIS REPORT IS DUE ON OR BEFORE AUGUST 16, 20\*\***

**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			
<b>TOTALS</b>			

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

Total discharges (including deaths) \_\_\_\_\_

**THIS REPORT IS DUE ON OR BEFORE AUGUST 16, 20\*\***

**V. RESIDENT DAYS**

(This information is to be provided for the number of individuals in residence during the reporting period.)

	OCCUPIED RESIDENT DAYS	BED HOLDING DAYS	TOTAL RESIDENT DAYS
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) _____	_____	_____	_____
<b>TOTALS</b>	_____	_____	_____

**VI. HOSPICE**

- A.** Total hospice service days (regardless of payer source): \_\_\_\_\_
- B.** Number of hospice discharges:
- 1. Deaths \_\_\_\_\_
  - 2. Home \_\_\_\_\_
  - 3. Hospital \_\_\_\_\_
- C.** Number of hospice provider contracts: \_\_\_\_\_
- D.** Dedicated hospice unit?                   
YES                      NO
- E.** (If Yes) Number of beds in dedicated hospice unit: \_\_\_\_\_

**THIS REPORT IS DUE ON OR BEFORE AUGUST 16, 20\*\***

**PROCESSING NOTES & LEGEND FOR SUBMISSIONS OF THE  
FY 20\*\* INPATIENT REHABILITATION PATIENT ORIGIN SURVEY DATA SUPPLEMENT  
MUST INCLUDE DISCHARGE DATA FOR JULY 1, 20\*\* - JUNE 30, 20\*\***

The data in this section should be reported by all Skilled Nursing Facilities providing inpatient rehabilitation services. This information should be provided as a separate Microsoft Excel or CSV file and should be provided **IN ADDITION TO** the data required on pages 1-4 of this survey. All submissions must comply with the filing requirements set forth in Ala. Admin. Code 410-1-3-.09. 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	INSTRUCTIONS	FIELD LOCATION
<b>FacilityID#</b>	SHPDA Nursing Home ID number	<b>SHPDA Assigned</b>
<b>PatientNumber</b>	Patient identification number. <i>This number may be a blind number assigned in sequential order.</i> Patient ID numbers <b>cannot</b> be duplicated.	<b>MDS A1300</b>
<b>Age</b>	The numeric value of the patient's age.	<b>MDS A0900</b> (calculated from patient Date of Birth)
<b>Sex</b>	Use the following values:  <b>MALE: 1 FEMALE: 2 OTHER/UNKNOWN: 9</b>	<b>MDS A0800</b>
<b>Race</b>	Use the following values:  <i>WHITE/CAUCASIAN</i> ----- 1 <i>BLACK/AFRICAN AMERICAN</i> ----- 2 <i>HISPANIC/SPANISH/LATINO</i> ----- 3 <i>ASIAN</i> ----- 4 <i>AMERICAN INDIAN/ALASKAN NATIVE</i> ----- 5 <i>PACIFIC ISLANDER</i> ----- 6 <i>INDIA</i> ----- 7 <i>MIDDLE EASTERN</i> ----- 8 <i>OTHER</i> ----- 9	<b>MDS A1000</b>
<b>ZipCode</b>	Patient's residence zip code. <b>Report only the 5 digit zip code where possible. Report unknown zip codes as "99999".</b>	<b>UB-04 9d</b>

FIELD NAME	INSTRUCTIONS	FIELD LOCATION
<b>LengthOfStay</b>	The number of days calculated from the date of admission until the date of discharge. Discharges for this year include any patients admitted in previous years and discharged during the current reporting period.	<b>MDS A2000 – MDS A1900</b>
<b>DateOfDischarge</b>	Date the patient was discharged from care. Submit in MM/DD/YYYY format.	<b>MDS A2000</b>
<b>Service</b>	All Service Codes for patients receiving inpatient rehabilitation services should be assigned a service code of '8'.	<b>N/A</b> (Assign all patients a code of '8')
<b>HIPPS</b>	Primary HIPPS Code for Patient	<b>MDS Z0100</b>
<b>Payor</b>	Use the following values:  <b>SELF PAY/PRIVATE PAY----- 1</b> <b>WORKMAN'S COMPENSATION----- 2</b> <b>MEDICARE----- 3</b> <b>MEDICAID----- 4</b> <b>TRI-CARE----- 5</b> <b>BLUE CROSS/BLUE SHIELD----- 6</b> <b>NO CHARGE/CHARITY----- 7</b> <b>HMO----- 8</b> <b>ALL KIDS----- 9</b> <b>OTHER INSURANCE----- 10</b> <b>HOSPICE----- 11</b> <b>MEDICARE ADVANTAGE----- 12</b> <b>OTHER----- 13</b>	<b>MDS Z0300</b>
<b>ICD-10Primary</b>	Patient's Primary ICD-10 Diagnosis Code	<b>MDS I0020B</b>
<b>ICD-10Secondary</b>	Additional Active Diagnosis ICD-10 Code #1	<b>MDS I8000A</b>
<b>ICD-10Secondary2</b>	Additional Active Diagnosis ICD-10 Code #2	<b>MDS I8000B</b>
<b>ICD-10Secondary3</b>	Additional Active Diagnosis ICD-10 Code #3	<b>MDS I8000C</b>
<b>ICD-10Secondary4</b>	Additional Active Diagnosis ICD-10 Code #4	<b>MDS I8000D</b>
<b>ICD-10Secondary5</b>	Additional Active Diagnosis ICD-10 Code #5	<b>MDS I8000E</b>
<b>ICD-10Secondary6</b>	Additional Active Diagnosis ICD-10 Code #6	<b>MDS I8000F</b>
<b>ICD-10Secondary7</b>	Additional Active Diagnosis ICD-10 Code #7	<b>MDS I8000G</b>

FIELD NAME	INSTRUCTIONS	FIELD LOCATION
<b>ICD-10Secondary8</b>	Additional Active Diagnosis ICD-10 Code #8	<b>MDS I8000H</b>
<b>ICD-10Secondary9</b>	Additional Active Diagnosis ICD-10 Code #9	<b>MDS I8000I</b>
<b>ICD-10Secondary10</b>	Additional Active Diagnosis ICD-10 Code #10	<b>MDS I8000J</b>
<b>Condition</b>	Patient's primary medical condition category	<b>MDS I0020</b>
<b>Admit</b>	Facility Type from which patient was admitted	<b>MDS A1800</b>
<b>Discharge</b>	Facility type/location to which patient was discharged	<b>MDS A2100</b>
<b>Cancer</b>	Cancer Diagnosis	<b>MDS I0100</b>
<b>Anemia</b>	Anemia (e.g. aplastic, iron deficiency, pernicious, and sickle cell) diagnosis	<b>MDS I0200</b>
<b>Atrial</b>	Atrial Fibrillation or Other Dysrhythmias Diagnosis	<b>MDS I0300</b>
<b>Coronary</b>	Coronary Artery Disease (CAD) (e.g. angina, myocardial infarction, and atherosclerotic heart disease (ASHD)) diagnosis	<b>MDS I0400</b>
<b>DVT</b>	Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE) or Pulmonary Thrombo-Embolism (PTE) diagnosis	<b>MDS I0500</b>
<b>Heart</b>	Heart Failure (e.g. congestive heart failure (CHF) and pulmonary edema) Diagnosis	<b>MDS I0600</b>
<b>Hypertension</b>	Hypertension Diagnosis	<b>MDS I0700</b>
<b>Orthostatic</b>	Orthostatic Hypotension Diagnosis	<b>MDS I0800</b>
<b>PVD</b>	Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD) Diagnosis	<b>MDS I0900</b>
<b>Cirrhosis</b>	Cirrhosis Diagnosis	<b>MDS I1100</b>
<b>GERD</b>	Gastroesophageal Reflux Disease (GERD) or Ulcer (e.g. esophageal, gastric, and peptic ulcers) Diagnosis	<b>MDS I1200</b>
<b>Colitis</b>	Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease Diagnosis	<b>MDS I1300</b>
<b>BPH</b>	Benign Prostatic Hyperplasia (BPH) Diagnosis	<b>MDS I1400</b>
<b>ESRD</b>	Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD) Diagnosis	<b>MDS I1500</b>
<b>Bladder</b>	Neurogenic Bladder Diagnosis	<b>MDS I1550</b>
<b>Uropathy</b>	Obstructive Uropathy Diagnosis	<b>MDS I1650</b>
<b>MDRO</b>	Multidrug-Resistant Organism (MDRO) Diagnosis	<b>MDS I1700</b>
<b>Pneumonia</b>	Pneumonia Diagnosis	<b>MDS I2000</b>
<b>Septicemia</b>	Septicemia Diagnosis	<b>MDS I2100</b>
<b>Tuberculosis</b>	TB Diagnosis	<b>MDS I2200</b>
<b>UTI</b>	Urinary Tract Infection (UTI) (Last 30 days) Diagnosis	<b>MDS I2300</b>
<b>Hepatitis</b>	Viral Hepatitis (e.g. Hepatitis A, B, C, D and E) Diagnosis	<b>MDS I2400</b>

<b>FIELD NAME</b>	<b>INSTRUCTIONS</b>	<b>FIELD LOCATION</b>
<b>Infection</b>	Wound Infection (other than foot) Diagnosis	<b>MDS I2500</b>
<b>Diabetes</b>	Diabetes Mellitus (DM) (e.g. diabetic retinopathy, nephropathy and neuropathy) Diagnosis	<b>MDS I2900</b>
<b>Hyponatremia</b>	Hyponatremia Diagnosis	<b>MDS I3100</b>
<b>Hyperkalemia</b>	Hyperkalemia Diagnosis	<b>MDS I3200</b>
<b>Hyperlipidemia</b>	Hyperlipidemia Diagnosis	<b>MDS I3300</b>
<b>Thyroid</b>	Thyroid Disorder (e.g. hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis) Diagnosis	<b>MDS I3400</b>
<b>Arthritis</b>	Arthritis (e.g. degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA) Diagnosis	<b>MDS I3700</b>
<b>Osteoporosis</b>	Osteoporosis Diagnosis	<b>MDS I3800</b>
<b>Hip</b>	Hip Fracture (any hip fracture that has a relationship to current status, treatments, monitoring (e.g. sub-capital fractures, and fractures of the trochanter and femoral neck)) Diagnosis	<b>MDS I3900</b>
<b>Fracture</b>	Other Fracture Diagnosis	<b>MDS I4000</b>
<b>Alzheimers</b>	Alzheimer's Disease Diagnosis	<b>MDS I4200</b>
<b>Aphasia</b>	Aphasia Diagnosis	<b>MDS I4300</b>
<b>Palsy</b>	Cerebral Palsy Diagnosis	<b>MDS I4400</b>
<b>CVA</b>	Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA) or Stroke Diagnosis	<b>MDS I4500</b>
<b>Dementia</b>	Non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia, mixed dementia, frontotemporal dementia such as Pick's disease, and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases) Diagnosis	<b>MDS I4800</b>
<b>Hemiplegia</b>	Hemiplegia or Hemiparesis Diagnosis	<b>MDS I4900</b>
<b>Paraplegia</b>	Paraplegia Diagnosis	<b>MDS I5000</b>
<b>Quadriplegia</b>	Quadriplegia Diagnosis	<b>MDS I5100</b>
<b>MS</b>	Multiple Sclerosis Diagnosis	<b>MDS I5200</b>
<b>Huntingtons</b>	Huntington's Disease Diagnosis	<b>MDS I5250</b>
<b>Parkinsons</b>	Parkinson's Disease Diagnosis	<b>MDS I5300</b>
<b>Tourettes</b>	Tourette's Syndrome Diagnosis	<b>MDS I5350</b>
<b>Epilepsy</b>	Seizure Disorder or Epilepsy Diagnosis	<b>MDS I5400</b>
<b>TBI</b>	Traumatic Brain Injury (TBI) Diagnosis	<b>MDS I5500</b>
<b>Malnutrition</b>	Malnutrition (protein or calorie) or at risk for malnutrition Diagnosis	<b>MDS I5600</b>
<b>Anxiety</b>	Anxiety Disorder Diagnosis	<b>MDS I5700</b>

FIELD NAME	INSTRUCTIONS	FIELD LOCATION
<b>Depression</b>	Depression (other than bipolar) Diagnosis	<b>MDS I5800</b>
<b>Bipolar</b>	Bipolar Disorder Diagnosis	<b>MDS I5900</b>
<b>Psychotic</b>	Psychotic Disorder (other than schizophrenia) Diagnosis	<b>MDS I5950</b>
<b>Schizophrenia</b>	Schizophrenia (e.g. schizoaffective and schizophreniform disorders) Diagnosis	<b>MDS I6000</b>
<b>PTSD</b>	Post Traumatic Stress Disorder (PTSD) Diagnosis	<b>MDS I6100</b>
<b>Asthma</b>	Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g. chronic bronchitis and restrictive lung diseases such as asbestosis) Diagnosis	<b>MDS I6200</b>
<b>Respiratory</b>	Respiratory Failure Diagnosis	<b>MDS I6300</b>
<b>Cataracts</b>	Cataracts, Glaucoma or Macular Degeneration Diagnosis	<b>MDS I6500</b>
<b>None</b>	None of the above active Diagnoses	<b>MDS I7900</b>
<b>PITherapyDischarge</b>	Physical Therapy Individual Therapy minutes, total since start date of most recent stay	<b>MDS O0425 C1</b>
<b>PCTherapyDischarge</b>	Physical Therapy Concurrent Therapy minutes, total since start date of most recent stay	<b>MDS O0425 C2</b>
<b>PGTherapyDischarge</b>	Physical Therapy Group Therapy minutes, total since start date of most recent stay	<b>MDS O0425 C3</b>
<b>PTTherapyDischarge</b>	Physical Therapy Co-Treatment Therapy minutes, total since start date of most recent stay	<b>MDS O0425 C4</b>
<b>PTherapyDaysDischarge</b>	Physical Therapy days, total number of days therapy administered since start date of most recent stay	<b>MDS O0425 C5</b>
<b>OITherapyDischarge</b>	Occupational Therapy Individual Therapy minutes, total since start date of most recent stay	<b>MDS O0425 B1</b>
<b>OCTherapyDischarge</b>	Occupational Therapy Concurrent Therapy minutes, total since start date of most recent stay	<b>MDS O0425 B2</b>
<b>OGTherapyDischarge</b>	Occupational Therapy Group Therapy minutes, total since start date of most recent stay	<b>MDS O0425 B3</b>
<b>OTTherapyDischarge</b>	Occupational Therapy Co-Treatment Therapy minutes, total since start of most recent stay	<b>MDS O0425 B4</b>
<b>OTherapyDaysDischarge</b>	Occupational Therapy days, total number of days therapy administered since start date of most recent stay	<b>MDS O0425 B5</b>
<b>SITherapyDischarge</b>	Speech-Language Pathology and Audiology Services Individual Therapy minutes, total since start date of most recent stay	<b>MDS O0425 A1</b>
<b>SCTherapyDischarge</b>	Speech-Language Pathology and Audiology Services Concurrent Therapy minutes, total since start date of most recent stay	<b>MDS O0425 A2</b>
<b>SGTherapyDischarge</b>	Speech-Language Pathology and Audiology Services Group Therapy minutes, total since start date of most recent stay	<b>MDS O0425 A3</b>
<b>STTherapyDischarge</b>	Speech-Language Pathology and Audiology Services Co-Treatment Therapy minutes, total since start date of most recent stay	<b>MDS O0425 A4</b>
<b>STherapyDaysDischarge</b>	Speech-Language Pathology and Audiology Services days, total number of days therapy administered since start date of most recent stay	<b>MDS O0425 A5</b>

**THIS REPORT IS DUE ON OR BEFORE APRIL 15, 20\*\***

**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](http://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](mailto:bradford.williams@shpda.alabama.gov)

**20\*\* 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:** \_\_\_\_\_ **Facility Fax:** \_\_\_\_\_  
(AREA CODE) & TELEPHONE NUMBER (AREA CODE) & TELEPHONE NUMBER

This reporting period is for March 1, 20--, through February 2<sup>1</sup>, 20--; or for partial year of operation beginning \_\_\_\_\_ and ending \_\_\_\_\_ a period of \_\_\_\_\_ days.

MONTH DAY MONTH DAY  
 \*Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. *If there was a change in ownership during the reporting period, data for the full year should be reported by the current owner.*

*We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this facility.*

<small>PRINTED NAME OF PREPARER</small>	<small>SIGNATURE OF PREPARER</small>	<small>DATE</small>
<small>DIRECT TELEPHONE NUMBER</small>	<small>TITLE OF PREPARER</small>	<small>E-MAIL ADDRESS</small>
<b><i>A member of administration MUST also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above; and must be separate from the preparer</i></b>		
<small>PRINTED NAME OF ADMINISTRATION OFFICIAL</small>	<small>SIGNATURE OF ADMINISTRATION OFFICIAL</small>	<small>DATE</small>
<small>DIRECT TELEPHONE NUMBER</small>	<small>TITLE OF ADMINISTRATION OFFICIAL</small>	<small>E-MAIL ADDRESS</small>

**FOR OFFICE USE ONLY**

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



THIS REPORT IS DUE ON OR BEFORE APRIL 15, 20\*\*

**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) _____		_____
<b>TOTAL</b>		_____

**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	_____	_____	_____
<b>TOTALS</b>	_____	_____	_____

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 20\*\*

**VII. RESIDENT DAYS**

- |    |   |   |       |
|----|---|---|-------|
| 1. | Number of licensed beds<br>(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)   |   | _____ |



Amended (ER): Filed May 20, 2026; effective May 20, 2026; expires 120 days, September 17, 2026.

**NOTICE OF CHANGE OF OWNERSHIP/CONTROL**

The following notification of intent is provided pursuant to all applicable provisions of ALA. CODE § 22-21-270 (1975 as amended) and ALA. ADMIN. CODE r. 410-1-7-.04. This notice must be filed at least twenty (20) days prior to the transaction.

- Change in Direct Ownership or Control (of a vested Facility; ALA. CODE §§ 22-20-271(d), (e))
- Change in Certificate of Need Holder (ALA. CODE § 22-20-271(f))
- Change in Facility Management (Facility Operator)

Any transaction other than those above-described requires an application for a Certificate of Need.

**Part I: Facility Information**

SHPDA ID Number: \_\_\_\_\_  
(This can be found at [www.shpda.alabama.gov](http://www.shpda.alabama.gov), Health Care Data, ID Codes)

Name of Facility/Provider: \_\_\_\_\_  
(ADPH Licensure Name)

Physical Address: \_\_\_\_\_  
\_\_\_\_\_

County of Location: \_\_\_\_\_

Number of Beds/ESRD Stations: \_\_\_\_\_

CON Authorized Service Area (Home Health and Hospice Providers Only). Attach additional pages if necessary. \_\_\_\_\_

**Part II: Current Authority** (Note: If this transaction will result in a change in direct ownership or control, as defined under ALA. CODE § 22-20-271(e), please attach organizational charts outlining current and proposed structures.)

Owner (Entity Name) of Facility named in Part I: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Operator (Entity Name): \_\_\_\_\_

**Part III: Acquiring Entity Information**

Name of Entity: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Operator (Entity Name): \_\_\_\_\_

Proposed Date of Transaction is on or after: \_\_\_\_\_

**Part IV: Terms of Purchase**

Monetary Value of Purchase: \$ \_\_\_\_\_

Type of Beds: \_\_\_\_\_

Number of Beds/ESRD Stations: \_\_\_\_\_

**Financial Scope:** to Include Preliminary Estimate of the Cost Broken Down by Equipment, Construction, and Yearly Operating Cost:

Projected Equipment Cost: \$ \_\_\_\_\_

Projected Construction Cost: \$ \_\_\_\_\_

Projected Yearly Operating Cost: \$ \_\_\_\_\_

Projected Total Cost: \$ \_\_\_\_\_

**On an Attached Sheet Please Address the Following:**

- 1.) The services to be offered by the proposal (the applicant will state whether he has previously offered the service, whether the service is an extension of a presently offered service, or whether the service is a new service).
- 2.) Whether the proposal will include the addition of any new beds.
- 3.) Whether the proposal will involve the conversion of beds.
- 4.) Whether the assets and stock (if any) will be acquired.

**Part V: Certification of Information**

**Current Authority Signature(s):**

The information contained in this notification is true and correct to the best of my knowledge and belief.

Owner(s): \_\_\_\_\_

Operator(s): \_\_\_\_\_

Title/Date: \_\_\_\_\_

SWORN to and subscribed before me, this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

(Seal)

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

**Acquiring Authority Signature(s):**

I agree to be responsible for reporting of all services provided during the current annual reporting period, as specified in ALA. ADMIN. CODE r. 410-1-3-.12. The information contained in this notification is true and correct to the best of my knowledge and belief.

Purchaser(s): \_\_\_\_\_

Operator(s): \_\_\_\_\_

Title/Date: \_\_\_\_\_

SWORN to and subscribed before me, this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

(Seal)

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

**Author:** Alva M. Lambert

**Statutory Authority:** Code of Ala. 1975, §22-21-271(c).

**History:** New Form: Filed August 23, 2016; effective October 7, 2016. **Amended:** Published May 28, 2021; effective July 12, 2021. \_\_\_

Amended (ER): Filed May 20, 2026; effective May 20, 2026; expires 120 days, September 17, 2026.

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[Added image:]

Form CPA-1

**APPLICATION FOR CERTIFICATE OF PUBLIC ADVANTAGE**  
(Rule 410-1-13)

For SHPDA Use Only

Project No.: \_\_\_\_\_

Date Filed: \_\_\_\_\_

Staff Reviewer: \_\_\_\_\_

**PART ONE: APPLICANT IDENTIFICATION AND CONTACT INFORMATION**

A. Name of Applicant:

\_\_\_\_\_

B. Address of Applicant:

\_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

C. Contact Person:

Name and Title \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

D. Additional Parties (attach if needed).

**PART TWO: DESCRIPTION OF PROPOSED COOPERATIVE ENGAGEMENT**

(attach additional pages if needed)

A. Nature and Scope of Cooperative Engagement:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Parties to the Engagement:

\_\_\_\_\_  
\_\_\_\_\_

C. Anticipated Effects of the Cooperative Engagement:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[Added image:]

**PART THREE: STATUTORY FACTORS AND PUBLIC BENEFITS ANALYSIS**

Please address, to the extent applicable, the public benefits of the Cooperative Activities in the following areas (attach additional pages if needed):

1. Quality of hospital and related care provided to rural Alabama citizens.

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2. Continued availability of hospital facilities in close geographic proximity.

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3. Potential cost efficiencies.

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4. Efficient use of healthcare resources and avoidance of duplication.

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5. Improvements in health outcomes.

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6. Access to care for medically underserved populations.

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[Added image:]

Form CPA-1

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7. Ability of payors to negotiate appropriate arrangements.

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8. Impact on competition.

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9. Quality, availability, and price of services.

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10. Whether alternatives could achieve similar benefits with fewer anticompetitive effects.

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**PART FOUR: SUPPORTING DOCUMENTATION**

Attach copies of any agreements, charts, or other supporting materials you wish to be considered in evaluating the application.

**PART FIVE: CERTIFICATION AND AFFIDAVIT**

The undersigned certifies that the information contained in this application is true and correct to the best of his or her knowledge and belief; that the proposed Cooperative Engagement is undertaken in good faith; and that the proposed engagement is reasonably necessary to further the state policy set forth in Act 2026-522.

[Added image:]

Form CPA-1

Applicant: \_\_\_\_\_

By: \_\_\_\_\_

Printed Name and Title: \_\_\_\_\_

Date: \_\_/\_\_/\_\_

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

Subscribed and sworn before me this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Notary Public: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

Author: Emily T. Marsal

Statutory Authority: Act 2026-522, Code of Alabama, 1975

History: New Rule (ER): Filed May 20, 2026; effective May 20, 2026; expires 120 days, September 17, 2026.

[Added image:]

Form CPA-3

**APPLICATION FOR MODIFICATION OF CERTIFICATE OF PUBLIC ADVANTAGE**  
(Rule 410-1-13)

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For SHPDA Use Only

Project No.: \_\_\_\_\_

Date Filed: \_\_\_\_\_

Staff Reviewer: \_\_\_\_\_

**PART ONE: APPLICANT IDENTIFICATION AND CONTACT INFORMATION**

A. Name of Applicant:

\_\_\_\_\_

B. Address of Applicant:

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

C. Contact Person:

Name and Title \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

D. Additional Parties (attach if needed).

**PART TWO: DESCRIPTION OF CURRENT CERTIFICATE AND REQUESTED MODIFICATION**

(attach additional pages if needed)

A. Date Issued: \_\_/\_\_/\_\_

B. Nature and Scope of Cooperative Engagement, identifying the basis for the requested modification, including any material change to the Cooperative Engagement

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Parties to the Engagement:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[Added image:]

Form CPA-3

**PART THREE: STATUTORY FACTORS AND PUBLIC BENEFITS ANALYSIS**

Please address, to the extent applicable, how the engagement under the Certificate has furthered the public benefits identified in the original application, as follows: (attach additional pages if needed):

1. Quality of hospital and related care provided to rural Alabama citizens.

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2. Continued availability of hospital facilities in close geographic proximity.

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3. Potential cost efficiencies.

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4. Efficient use of healthcare resources and avoidance of duplication.

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5. Improvements in health outcomes.

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6. Access to care for medically underserved populations.

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[Added image:]

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7. Ability of payors to negotiate appropriate arrangements.

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8. Impact on competition.

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9. Quality, availability, and price of services.

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---

10. Whether alternatives could achieve similar benefits with fewer anticompetitive effects.

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**PART FOUR: SUPPORTING DOCUMENTATION**

Attach copies of any agreements, charts, or other supporting materials you wish to be considered in evaluating the application.

**PART FIVE: CERTIFICATION AND AFFIDAVIT**

The undersigned certifies that the information contained in this application is true and correct to the best of his or her knowledge and belief; that the Cooperative Engagement

*[Added image:]*

Form CPA-3

is undertaken in good faith; and that the proposed Cooperative Engagement, as modified, is reasonably necessary to further the state policy set forth in Act 2026-522.

Applicant: \_\_\_\_\_

By: \_\_\_\_\_

Printed Name and Title: \_\_\_\_\_

Date: \_\_/\_\_/\_\_

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

Subscribed and sworn before me this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Notary Public: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

Author: Emily T. Marsal

Statutory Authority: Act 2026-522, Code of Alabama, 1975.

History: New Rule (ER): Filed May 20, 2026; effective May 20, 2026; expires 120 days, September 17, 2026.

[Added image:]

Form CPA-2

**APPLICATION FOR RENEWAL OF CERTIFICATE OF PUBLIC ADVANTAGE**  
(Rule 410-1-13)

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For SHPDA Use Only

Project No.: \_\_\_\_\_

Date Filed: \_\_\_\_\_

Staff Reviewer: \_\_\_\_\_

**PART ONE: APPLICANT IDENTIFICATION AND CONTACT INFORMATION**

A. Name of Applicant:

\_\_\_\_\_

B. Address of Applicant:

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

C. Contact Person:

Name and Title \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

D. Additional Parties (attach if needed).

**PART TWO: DESCRIPTION OF CURRENT CERTIFICATE**

(attach additional pages if needed)

A. Date Issued: \_\_/\_\_/\_\_

B. Nature and Scope of Cooperative Engagement:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Parties to the Engagement:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[Added image:]

Form CPA-2

**PART THREE: STATUTORY FACTORS AND PUBLIC BENEFITS ANALYSIS**

Please address, to the extent applicable, how the engagement under the Certificate has furthered the public benefits identified in the original application, as follows: (attach additional pages if needed):

1. Quality of hospital and related care provided to rural Alabama citizens.

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2. Continued availability of hospital facilities in close geographic proximity.

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3. Potential cost efficiencies.

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4. Efficient use of healthcare resources and avoidance of duplication.

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5. Improvements in health outcomes.

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6. Access to care for medically underserved populations.

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[Added image:]

Form CPA-2

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7. Ability of payors to negotiate appropriate arrangements.

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8. Impact on competition.

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9. Quality, availability, and price of services.

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10. Whether alternatives could achieve similar benefits with fewer anticompetitive effects.

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**PART FOUR: SUPPORTING DOCUMENTATION**

Attach copies of any agreements, charts, or other supporting materials you wish to be considered in evaluating the application.

**PART FIVE: CERTIFICATION AND AFFIDAVIT**

The undersigned certifies that the information contained in this application is true and correct to the best of his or her knowledge and belief; that the Cooperative Engagement

[Added image:]

Form CPA-2

is undertaken in good faith; and that the Cooperative Engagement continues to be reasonably necessary to further the state policy set forth in Act 2026-522.

Applicant: \_\_\_\_\_

By: \_\_\_\_\_

Printed Name and Title: \_\_\_\_\_

Date: \_\_/\_\_/\_\_

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

Subscribed and sworn before me this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Notary Public: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_

**Author:** Emily T. Marsal

**Statutory Authority:** Act 2026-522, Code of Alabama, 1975.

**History: New Rule (ER):** Filed May 20, 2026; effective May 20, 2026; expires 120 days, September 17, 2026.