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

August 12, 2013

Honorable Robert Bentley, Governor
State of Alabama
State Capitol
Montgomery, Alabama 36130

Dear Governor Bentley:

At the August 9, 2013 meeting of the Statewide Health Coordinating Council (SHCC), the SHCC adopted the attached adjustment to Section 410-2-4-.02 of the *2004-2007 Alabama State Health Plan*. This proposed adjustment allows for the addition of forty-nine (49) acute care beds to the inventory in Clarke County upon the earlier of (1) the termination or expiration of the forty-nine (49) beds that were licensed to and held pursuant to CON 2169-H issued to Southwest Alabama Medical Center or (2) the failure to consummate the sale of Southwest Alabama Medical Center's existing assets, including the hospital building and its CON for a replacement hospital, prior to the termination or expiration of the beds.

This rule was processed in accordance with the *State Health Plan* and the Alabama Administrative Procedure Act. Rule 410-2-5-.04(4)(c) of the *State Health Plan* provides that a plan adjustment shall be deemed disapproved by the Governor if not acted upon within fifteen (15) days. Upon your approval, the adjustment will be added to Section 410-2-4-.02 of the *2004-2007 Alabama State Health Plan*.

You have the approval/disapproval authority for the *Alabama State Health Plan* and all amendments/adjustments thereto. I recommend your approval.

Call me at 242-4103 if you have questions about this proposed amendment.

Sincerely,

Alva M. Lambert
Executive Director

Attachment: as stated

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PHONE: (334) 242-4103 FAX: (334) 242-4113

APPROVED: Robert Bentley
Gov. Robert Bentley

Date August 13, 2013

DISAPPROVED: ______________________
Gov. Robert Bentley

Date ______________________

410-2-4-.02 **Acute Care (Hospitals)**

(1) Introduction. In this section, the methodology for computing acute care bed need will be described, criteria for making adjustments to the computed bed need will be discussed, and bed need for 2002, based on the methodology, will be presented.

(a) Definition: Hospital

Defined as printed in Rules of Alabama State Board of Health Division of Licensure and Certification Chapter 420-5-7 (effective September 26, 1990)

"Hospital" means a health institution planned, organized and maintained for offering to the public generally facilities and beds for use in the diagnosis and/or treatment of illness, disease, injury, deformity, infirmity, abnormality, or pregnancy, when the institution offers such care or service for not less than twenty-four (24) consecutive hours in any week to two (2) or more individuals not related by blood or marriage to the owner and/or administrator. In addition, the hospital may provide for the education of patients, medical and health personnel, as well as conduct research programs to promote progress and efficiency in clinical and administrative medicine.

(2) Purpose

(a) The purpose of the bed need methodology is to identify the number of acute general hospital beds, which will be needed at least three years into the future to assure the continued availability of quality hospital, care for residents of the state of Alabama. Such number, as identified later in this section, shall be the basis for statewide health planning and certificate of need approval, except:

1. in circumstances that pose a threat to public health, and/or

2. when the SHCC makes an adjustment based on criteria specified later in this section.

(b) All Alabama's Acute Care Hospitals, which are covered by this methodology.

(3) Methodology

(a) The planning area used in this methodology is the county, except for Choctaw, Cleburne, Coosa, Henry, Lamar, Lowndes, Macon, and Perry, which are grouped with Marengo, Calhoun, Tallapoosa, Houston, Fayette, Montgomery, and Lee, respectively. There are no hospitals in Choctaw, Cleburne, Coosa, Henry, Lamar, Lowndes, Macon, or Perry counties; therefore, each of these counties is grouped with a contiguous county where the majority of its population seeks hospitalization. RussellCounty had a hospital, which closed on April 1, 2002; however, a CON was issued January 30, 2003 for a new hospital to be constructed.

(b) The methodology involves:

applying recent utilization data
to
projected population
and
using desired occupancy rates
to
determine needed beds.

(c) Hospital annual reports (Form BHD 134-A) for the past three years, are used in computing a three-year weighted average daily census (ADC) to provide the utilization measure. The weighted average emphasizes the most current census levels while taking into consideration census for the previous two years.

(d) Desired occupancy rates for each of eight service categories are those which were established under the National Guidelines for Health Planning. These are:

Medical/Surgical (M/S)	80%
M/S in Small Hospitals (under 4,000 total admissions/yr.)	75%
Obstetrics	75%
Pediatrics	
0-39 beds	65%
40-79 beds	70%
80 or more beds	75%
ICU-CCU	65%
Other	75%

(e) Computations by Service Category

1. Compute Average Daily Census (ADC) for each of last three years.

$$ADC = \frac{\text{Patient Days in Service Category}}{\text{Days Operational in Year; Normally 365}}$$

2. Compute Weighted Average ADC (Weighted ADC).

$$\frac{(\text{Current Year minus 2 Years ADC} \times 1) + (\text{Previous Year ADC} \times 2) + (\text{Current Year ADC} \times 3)}{6}$$

3. Compute Projected ADC.

$$\text{Projected ADC} = \text{Weighted ADC} \times \frac{\text{3 Years above Current Year Projected Population}}{\text{Current Year Population}}$$

4. Compute Projected Beds Needed.

$$\text{Beds Needed} = \frac{\text{Projected ADC in Service Category}}{\text{Desired Occupancy Rate for Service Category}}$$

(f) Summation Across Service Categories

1. Compute Total Beds Needed

Beds Needed = Medical/Surgical Beds Needed
+ Obstetrical Beds Needed
+ Pediatric Beds Needed
+ ICU-CCU Beds Needed
+ Other Beds Needed

2. Compute Net Beds Needed or Excess

Net Beds Needed (Excess) = Beds Needed - Existing Beds

3. Beds currently existing, under construction, and approved for construction are assumed to be existing beds in determining excess beds or additional beds needed.

(4) Criteria for Plan Adjustments

(a) The SHCC may make adjustments to the needed beds determined by the methodology described above if evidence is introduced to the SHCC in each of the criteria, which follow, the exception to this is section 410-2-4-.02 (5):

1. Evidence that residents of an area do not have access to necessary health services. Accessibility refers to the individual's ability to make use of available health resources. Problems which might affect access include persons living more than 30 minutes travel time from a hospital, the lack of health manpower in some counties, and individuals being without the financial resources to obtain access to healthcare facilities; and

2. Evidence that a plan adjustment would result in health care services being rendered in a more cost-effective manner. The SHCC, by adopting the bed need methodology herein, has decided that beds in excess of the number computed to be needed are not cost-effective. Therefore, the burden of proof that a plan adjustment would satisfy this criteria rests with the party seeking that adjustment; and

3. Evidence that a plan adjustment would result in improvements in the quality of health care delivered to residents of an area. Many organizations, including the Division of

Licensure and Certification within the Alabama Department of Public Health, the Professional Review Organization for the State, the Joint Commission on Accreditation of Health Care, and major third-party payers, continually address the issue of the quality of hospital care. Evidence of substandard care in existing hospital(s) within a county and/or evidence that additional hospital beds would enhance quality in a cost-effective way could partially justify a plan adjustment.

(a) In applying these three plan adjustment criteria, special consideration should be given to requests from hospitals which have experienced average hospital-wide occupancy rates in excess of 80% for the most recent two-year period. It is presumed that the patients, physicians, and health plans using a hospital experiencing high occupancy rates have rendered positive judgments concerning the accessibility, cost-effectiveness, and/or quality of care of that hospital. Thus, the 80% occupancy standard adds a market-based element of validity to other evidence, which might be given in support of a plan adjustment for an area.

(b) Numbers of beds do not always reflect the adequacy of the programs available within hospitals. In applying the three plan adjustment criteria to specific services, consideration should be given to the adequacy of both numbers of beds and programs offered in meeting patient needs in a particular county.

(5) Bed Availability Assurance for Acute Care (Hospitals)

(a) In some parts of Alabama, existing acute care hospitals are experiencing inpatient census levels not seen since the 1970's and the expectation is these census levels will only increase. Typically, these existing acute care hospitals are located in counties having significant population growth and/or hospitals with broad geographical service areas/statewide missions. These existing acute care hospitals are experiencing a shortage of acute care beds due to population growth and other demographic factors such as the aging baby boomers. The shortage of acute care beds is expected to only worsen. This shortage of acute care beds is causing patient transfers to be refused and ambulances to be turned-away (diverted) to more distant facilities or causing delays in transfers from the ER to an inpatient bed, which is not in the best interests of patients or the provision of quality and cost-effective health care. The Acute Care Bed Need Methodology is on a county-wide basis and is an average of all days of the month as well as all months of the year. As such, it may not always adequately take into consideration the census level and acute care bed availability of an individual acute care hospital and the significant inpatient bed pressures on the existing hospital, its patients and its Medical Staff.

(b) Therefore, in order to assist those existing acute care hospitals that are experiencing high census levels, which cause the hospitals to close emergency rooms ("diversions") and refuse transfers from other acute care hospitals, which results in negative impacts on patients and their families, existing acute care hospitals may qualify to add acute care beds if the existing acute care hospital can demonstrate an average week day acute bed (including observation patients) occupancy rate/census (Monday through Friday at midnight, exclusive of national holidays) for two separate and distinct periods of thirty (30) consecutive calendar days of the most recent twelve month period at or above the desired average occupancy rate of eighty percent (80%) of total licensed acute care beds for that hospital.

(c) For existing acute care hospitals achieving the occupancy rate in paragraph 2, those hospitals may seek a CON to add up to ten percent of licensed bed capacity (not to exceed 50 beds), rounded to the nearest whole, or alternatively up to thirty (30) beds, whichever is greater (which shall be at the applicant's option). Such additional beds will be considered an exception to the bed methodology set forth elsewhere in this Section, provided, however, that any additional beds authorized by the CON Board pursuant to this provision shall be considered for purposes of other bed need methodology purposes. In addition to such additional information that may be required by SHPDA, a hospital seeking a CON for additional beds under this section must provide, as part of its CON application the following information:

1. Demonstration of compliance with the occupancy rate in paragraph 2 (Average of at least an 80% week day occupancy rate for two (2) separate and distinct periods of thirty (30) consecutive calendar week days of the most recent 12 month period);

2. The application for additional acute care beds does not exceed ten percent of licensed acute care bed capacity (not to exceed 50 beds), rounded to the nearest whole, or alternatively up to thirty (30) acute care beds, whichever is greater.

3. The existing acute care hospital has not been granted an increase of beds under this section within the preceding twelve month period, which time begins to run upon the issuance of a certificate of occupancy issued by the Alabama Department of Public Health; and

4. The hospital must have been licensed for at least one year as a general acute care hospital.

(d) Any acute care beds granted under this section can only be added at or/upon the existing campus of the applicant acute care hospital.

(6) Planning Policy. In a licensed general acute care hospital, the temporary utilization of inpatient rehabilitation beds, inpatient or residential alcohol and drug abuse beds, or inpatient psychiatric beds for medical/surgical purposes will not be considered a conversion of beds provided that the temporary utilization not exceed a total of twenty percent (20%) in any one specialty unit, as allowed by federal Medicare regulations in a facility's fiscal year.

(7) Beds Needed (Excess Beds). Pages 65 and 66 summarize the bed need calculations for each AlabamaCounty. Calculations indicate that there is not a need for additional beds anywhere in the state. However, in Bullock and Jackson counties the SHCC approved adjustments for additional beds, therefore those two counties show a need for beds. Overall, there are 7,569 excess hospital beds in Alabama; JeffersonCounty alone has 2,051. Following the bed need summary is a complete inventory of Alabama's hospitals.

(8) Long Term Acute Care Hospitals (LTAC)

(a) According to the Federal Centers for Medicare and Medicaid Services (CMS), a hospital is an excluded [from the Prospective Payment System] long term acute care hospital if it has in effect an agreement [with CMS] to participate as a general medical surgical acute care hospital and the average inpatient length of stay is greater than 25 days. Ordinarily, the determination regarding a hospital's average length of stay is based on the hospitals most recently filed cost report. However, if the hospital has not yet filed a cost report or if there is an indication that the most recently filed cost report does not accurately reflect the hospital's current average length of stay, data from the most recent six month period is used.

(b) Long term acute care hospitals provide a hospital level of care to patients with an acute illness, injury or exacerbation of a disease process that requires intensive medical and/or functional restorative care for an extended period of time, on average 25 days or longer. Generally, high technology monitoring or complex diagnostic procedures are not required. A long-term acute care hospital's primary patient service goal is to improve a patient's medical and functional status so that they can be successfully discharged to home or to a lower level of care. These patients generally do not meet admission criteria for nursing homes, rehabilitation, or psychiatric facilities.

(c) Alabama has an excess of licensed general acute care hospital beds, some of which could be used for long-term hospital care. Therefore, a general acute care hospital may apply for a certificate of need to convert acute care beds to long-term acute care hospital beds if the following conditions are met:

1. The hospital can satisfy the requirements of a long-term acute care hospital as outlined above.

2. The long term acute care hospital can demonstrate that it will have a separate governing body, a separate chief executive officer, a separate chief medical officer, a separate medical staff, and performs basic functions of an independent hospital.

3. The long term acute care hospital has written patient transfer agreements with hospitals other than the host hospital to show that it could provide at least 75 per cent of the admissions to the long term acute care hospital, based on the total average daily census for all participating hospitals.

4. The transfer agreements are with other hospitals in the same county and/or with hospitals in a region.

(d) To assure financial feasibility, the conversion of acute care beds to long-term acute care hospital beds shall be for a minimum of 25 beds.

(e) Needs Assessment.

1. The bed need for the proposed long term acute care hospital shall be for no more than five (5) percent of the combined average daily census (ADC) of all the acute care hospitals in the region of the proposed LTAC for the most recent annual reporting period.

2. As an alternative an applicant may justify bed need based on a detailed assessment of patient discharges after stays of 25 days or more.

3. An individual hospital's ADC or discharges shall not be used more than once in the computation of need for long term acute care hospital beds.

4. Due to accessibility issues all regions regardless of need methodology shall be permitted one LTACH facility with a maximum of 25 beds; which has proven financially feasible.

(f) The hospital must also comply with all statutes, rules, and regulations governing the Certificate of Need Review Program in Alabama.

(9) Pediatric Hospitals. Any licensed freestanding pediatric hospital or wholly owned subsidiary may make application for a Certificate of Need based on the latest obtainable pediatric data. The data submitted as part of the application shall be verified by the SHPDA staff prior to consideration by the Certificate of Need Review Board.

(10) Critical Access Hospitals (CAH).

(a) An existing hospital in Alabama must meet the following criteria to be considered for certification by CMS as a CAH (a new certificate of need is not required unless the application is for a new CAH or the hospital where the CAH is to be located has been closed longer than twelve months):

1. Is a public, nonprofit, or for-profit Medicare-certified hospital currently in operation and located on one of the following:

(i) A rural area as defined by the Office of Management and Budget (i.e.; outside a Metropolitan Statistical area);

(ii) A rural census tract of an Metropolitan Statistical Area (MSA) determined under the most recent version of the Goldsmith Modification Formula;

(iii) An area designated as Rural by law or regulation of the State of Alabama or in the State's rural Health Plan as approved by the federal Centers for Medicaid and Medicare Services;

(iv) A hospital would qualify as a rural referral center or as a sole community hospital if the hospital were located in a rural area

2. Hospitals, which closed on or after November 29, 1989, or are currently licensed health clinics or health centers that were created by downsizing a hospital, may reopen as a CAH;

3. Is located more than a 35-mile drive (or, 15 mile drive in areas with mountainous terrain or with only secondary roads available) from another hospital or CAH, or is designated by the state as being a Necessary Provider of Health Care Services to area residents;

4. Makes available 24-hour emergency care services that the State determines are necessary for ensuring access to emergency care in each community served by the critical access hospital;

5. Provides not more than 25beds for acute inpatient care (which in the case of a swing bed facility can be used interchangeably for acute or SNF-level care) and the hospital may also provide up to 10 rehabilitation and 10 psychiatric beds so long as these are operated as separate units;

6. Maintains an average annual patient stay of no more than 96 hours;

7. Meets critical access hospital staffing requirements;

8. Is a member of a rural health network and has an agreement with at least one full-service hospital (Affiliate) in the network for:

- patient referral and transfer
- development and use of communications systems
- provision of emergency and non-emergency transportation;

9. Has an agreement regarding staff credentialing and quality assurance with one of the following:

(i) a hospital that is a joint member in the rural health network,

(ii) a peer review organization or equivalent entity, or

(iii) another appropriate and qualified entity identified in the state rural health plan;

10. Federal statutes and eligibility requirements governing the CAH Program allow states to designate an existing hospital as a Necessary Provider of Health Care Services for its area residents if it meets all requirements for a CAH except the mileage between hospitals requirement. Alabama will utilize this statutory provision and designate Necessary Provider of Health Care Services for existing hospitals located in a county considered "at risk" for losing primary health care access. Alabama has reviewed numerous indicators of under-service in communities to determine criteria most appropriate for Alabama. Five criteria have been selected.

If the hospital meets one or more of these criteria, Alabama's Bureau of Health Provider Standards, Division of Provider Services, in consultation with the Office of Primary Care and Rural Health, will declare the facility a Necessary Provider of Health Care Services.

Criteria 1. The hospital is located in an area designated as a Health Professional Shortage Area.

Criteria 2. The hospital is located in an area designated as Medically Underserved.

Criteria 3. The hospital is located in a county with an unemployment rate higher than the statewide rate of unemployment.

Criteria 4. The hospital is located in a county with a percentage of population age 65 years and older greater than the state's average.

Criteria 5. The hospital is located in a county where the percentage of families with incomes below 200% of the federal poverty level is higher than the state average for families with incomes below 200% of the federal poverty level.

Any existing hospital, which otherwise satisfies CAH criteria except the mileage requirement but does not meet at least one of the above criteria for certification as a Necessary Provider of Health Services, may appeal to Alabama's State Health Officer. Evaluation of appeals will be based on submission of objective information, which demonstrates the presence of extenuating circumstances which may adversely impact an area's access to health care if the existing hospital is not declared a Necessary Provider of Health Services. Based on evidence presented, the State Health Officer may decide to issue a variance from established criteria and declare the appealing hospital a Necessary Provider of Health Care Services.

(b) In order to meet the federal CAH requirements as to the number of beds, an existing hospital may distinguish "authorized" and "licensed" general acute care and swing beds as in the rules established by the ADPH and SHPDA.

(c) The "Medicare Prescription Drug, Improvement and Modernization Act" (Public Law H.R. 1 and S. 1 June 27, 2003) was recently signed into law by the President. This law is a very extensive revision to the Medicare program and contains provisions relating the Critical Access Hospital Program found in Section 405 of the Act. These provisions will allow more flexibility for hospitals converting to CAH status. The provisions will not go into effect in Alabama until the rural health plan is revised/amended.

(11) Assurance of Acute Care Hospital Services in Cities in Exceeding 60, 000 Residents

(a) In Some areas of Alabama, due to population growth and/or shifts in population within areas of particular counties, there are cities of significant size which do not have an acute care hospital located within the city limits, yet are not eligible for new acute care beds under this Acute Care Bed Need Methodology because the planning area used is the county. In cities experiencing such high population growth which do not have a hospital, it is common for residents to face traffic congestion and long travel times in order to access existing acute care and critical care beds with emergency, obstetrical, surgical, cardiac and other necessary health care services which are only available in hospitals located elsewhere. Residents in such cities suffer potentially critical delays in accessing these necessary health care services. These delays are dangerous as well as being a burden to patients and their families. As such, the lack of ready availability of such beds and necessary health care services demonstrates a community need for a new hospital in cities meeting the criteria described below.

(b) Therefore, in order to respond to geographic accessibility and to assure the availability of at least one acute care hospital with adequate acute care and critical care beds, emergency, obstetrical, surgical, cardiac and other necessary health care services for cities of 60,000 residents or more, an applicant which meets the criteria set forth below may seek a certificate of need for a new acute care hospital, up to a maximum of 140 beds, to be located within the same city. Such new hospital will be considered an exception to the bed methodology set forth elsewhere in this Section. In order to be awarded a certificate of need for such a new hospital, the applicant must demonstrate the following:

1. The new acute care hospital shall be located in an incorporated city which has a population of at least 60,000 residents and within a county that has a population of at least 180,000 residents according to either the most recent decennial U.S. Census or estimated current year data provided by the Center for Business and Economic Research, University of Alabama;

2. There is currently no licensed acute care hospital providing emergency, obstetrical, surgical, cardiac and other necessary health care services within the city where the new hospital is to be located, nor is there any such hospital under construction, nor has a certificate of need been issued for construction of such hospital within the city;

3. The new hospital shall offer full-time (twenty-four hours a day, seven days a week) emergency room service, with continuous on-site physician coverage. In addition, the new hospital shall offer both critical care and acute care beds and shall offer obstetrical, neonatal, surgical, cardiac and other health care services; and

4. The applicant must demonstrate previous service to the community by historical participation in community benefit programs including, but not limited to, the following:

- Participation in the Medicaid OB Waiver Program;
- Participation in the local or regional emergency medical services program; and
- Support for Charitable Organizations

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: November 22, 2004; Amended January 22, 2009, Effective February 27, 2009; Amended _______, 2013, Effective _______, 2013.

ALABAMA
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
PROJECTED HOSPITAL BED NEED FOR 2005

COUNTY	POPULATION FACTOR 2000-2005	PROJECTED BEDS NEEDED	LICENSED BEDS EXISTING	CON ISSUED	NET NEED (EXCESS)
AUTAUGA	1.113	24	85	0	(61)
BALDWIN	1.156	191	287	0	(96)
BARBOUR	1.05	25	74	0	(49)
BIBB	1.095	5	35	0	(30)
BLOUNT	1.124	40	40	0	0
BULLOCK*	1.018	31	30	0	50
BUTLER	0.984	53	94	0	(41)
CALHOUN/CLEBURNE	1.003	306	586	0	(280)
CHAMBERS	0.995	64	115	0	(51)
CHEROKEE	1.091	15	60	0	(45)
CHILTON	1.098	10	60	0	(50)
CLARKE***	1.01	33	134	0	(101)
CLAY	1.036	30	53	0	(23)
COFFEE	1.034	70	151	0	(81)
COLBERT	1.023	150	313	0	(163)
CONECUH	1.001	38	58	0	(20)
COVINGTON	1.008	78	223	0	(145)
CRENSHAW	1.001	22	65	0	(43)
CULLMAN	1.063	142	215	0	(73)
DALE	1.014	38	89	0	(51)
DALLAS	0.981	161	214	0	(53)
DEKALB	1.084	50	134	0	(84)
ELMORE	1.122	60	138	0	(78)
ESCAMBIA	1.028	106	142	0	(36)
ETOWAH	1.013	376	627	0	(251)
FAYETTE	1.008	29	61	0	(32)
FRANKLIN	1.054	62	133	0	(71)
GENEVA	1.034	34	83	0	(49)
GREENE	0.98	4	20	0	(16)
HALE	1.05	11	39	0	(28)
HOUSTON/HENRY	1.031	466	635	0	(169)
JACKSON**	1.05	60	170	0	4
JEFFERSON	1.008	3163	5214	0	(2051)
LAUDERDALE	1.042	270	366	0	(96)
LAWRENCE	1.039	21	98	0	(77)
LEE/MACON	1.09	234	314	0	(80)

LIMESTONE	1.085	63	101	0	(38)
MADISON	1.062	671	1021	0	(350)
MARENGO/CHOCTAW	0.988	55	99	0	(44)
MARION	1.019	59	128	0	(69)
MARSHALL	1.073	150	240	0	(90)
MOBILE	1.022	1266	1987	0	(721)
MONROE	1.002	29	94	0	(65)
MONTGOMERY/LOWNDES	1.03	642	977	0	(355)
MORGAN	1.044	255	543	0	(288)
PICKENS	1.007	29	56	0	(27)
PIKE	1.038	38	97	0	(59)
RANDOLPH	1.055	28	126	0	(98)
RUSSELL	1.024	56	0	70	(14)
ST. CLAIR	1.117	22	82	0	(60)
SHELBY	1.166	158	192	0	(34)
SUMTER	0.963	5	33	0	(28)
TALLADEGA	1.035	106	270	0	(164)
TALLAPOOSA/COOSA	1.027	53	127	0	(74)
TUSCALOOSA	1.033	622	814	0	(192)
WALKER	1.018	102	267	0	(165)
WASHINGTON	1.031	4	25	0	(21)
WILCOX	0.988	4	32	0	(28)
WINSTON	1.056	34	99	0	(65)
STATE TOTALS	1.041	10,923	18,565	70	(7,569)

UPDATED JANUARY 2004

* The Statewide Health Coordinating Council approved an adjustment to the *State Health Plan* that became effective on September 9, 2003 for an additional 49 beds in Bullock County.

** The Statewide Health Coordinating Council approved an adjustment to the *State Health Plan* that became effective on September 9, 2003 for a 4-bed critical access hospital in Jackson County.

*** On August 9, 2013, the Statewide Health Coordinating Council approved an adjustment to the State Health Plan for an additional 49 acute care beds to the Clarke County inventory upon the earlier of (1) the termination or expiration of the 49 beds that were licensed to and held pursuant to CON 2169-H issued to Southwest Alabama Medical Center, or (2) the failure to consummate the pending Section 363 purchase transaction under the U.S. Bankruptcy Code for the sale of Clarke County Healthcare, LLC d/b/a Southwest Alabama Medical Center's existing assets, including its hospital building on Highway 43 and its CON for the construction of a replacement hospital on or prior to November 11, 2013.