

THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2012

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4109
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

2012 ANNUAL REPORT FOR HOSPITALS AND RELATED FACILITIES

Mailing Address:

_____ STREET ADDRESS _____ CITY _____ STATE _____ ZIP

Physical Address:

_____ STREET ADDRESS _____ CITY _____ **AL** _____ ZIP

County of Location:

Facility Telephone:

_____ (AREA CODE) & TELEPHONE NUMBER

Facility Fax:

_____ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for October 1, 2011, through September 30, 2012*; 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
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DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS
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A member of administration MUST also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above.

PRINTED NAME OF ADMINISTRATION OFFICIAL	SIGNATURE OF ADMINISTRATION OFFICIAL	DATE
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DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS
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FOR OFFICE USE ONLY

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

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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

	TOTALS
1. Number of licensed beds on last day of reporting period	_____
2. Number of staffed and operational beds on last day of reporting period	_____
3. Number of CON-authorized, certified swing beds	_____
4. Number of admissions for reporting period, excluding all newborns and NICU patients	_____
5. Patients days for reporting period, excluding all newborns and NICU patients	_____
6. Number of discharges for reporting period, excluding all newborns and NICU patients	_____
7. Outpatient visits	_____

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C. Information provided should be for the reporting period for each of the following PRINCIPAL source of payment categories.

	PATIENT DAYS (exclude <i>all</i> newborns and NICU patients)	DISCHARGES (include deaths, exclude <i>all</i> newborns and NICU patients)
a. Self Pay		
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. Other (specify) _____		
TOTALS		

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 (excluding formal psychiatric, newborn, substance and rehabilitation units)

	NUMBER OF LICENSED BEDS BY SERVICE	NUMBER OF DISCHARGES BY SERVICE	PATIENT DAYS BY SERVICE	STAFFED BEDS BY SERVICE (Last day of reporting period only)
1. Medicine				
2. Surgery				
3. Medicine-Surgery				
4. Obstetric (maternity)				
5. Pediatric				
6. Orthopedic				

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	NUMBER OF LICENSED BEDS BY SERVICE	NUMBER OF DISCHARGES BY SERVICE	PATIENT DAYS BY SERVICE	STAFFED BEDS BY SERVICE (Last day of reporting period only)
7. Intensive Care Unit (cardiac only)				
8. Intensive Care Unit				
9. Cardiac & Intensive Care Units (mixed)				
10. Swing Beds	XXXXXX			XXXXXX
11. Other (specify)				
TOTALS				

B. PSYCHIATRIC UNITS/PSYCHIATRIC HOSPITALS (for formal psychiatric units). Hospitals not having formal, CON-authorized, psychiatric units should report psychiatric days above under "General Hospital" information.

	NUMBER LICENSED BEDS	NUMBER OF ADMISSIONS	NUMBER OF DISCHARGES	PATIENT DAYS	STAFFED BEDS BY SERVICE (LAST DAY OF REPORTING PERIOD ONLY)
Inpatient Unit					

C. SPECIALTY UNITS (do not duplicate data reported in other sections)

	NUMBER LICENSED BEDS	NUMBER OF ADMISSIONS	NUMBER OF DISCHARGES	PATIENT DAYS	STAFFED BEDS BY SERVICE (LAST DAY OF REPORTING PERIOD ONLY)
1. Substance Abuse					
2. Long-Term Care Unit of Hospital (DO NOT include if this is licensed as a nursing home)					
3. Long-Term Acute Care Hospital (LTACH)					
4. Medical Rehabilitation Inpatient Unit					
5. Burn Unit					

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D. OBSTETRICS & NURSERY (do not include newborn data in more than one place)

	Number of Rooms	Total Number of Live Births	Total Number of Fetal Deaths	Total Number of Other Procedures/Cases
Delivery Rooms/ LDR/Obstetrical Recovery	_____	_____	_____	_____
C-Section Rooms	_____	_____	_____	_____
Well Newborn Unit		Number of Bassinets	Number of Infants	Newborn Days
Newborn (Well Baby) Unit (DO NOT include any newborns shown in separately designated special-care units)		_____	_____	_____
Newborn ICU and NICU		_____	_____	_____
Intermediate Care Unit (ICU) (include newborns in separate special-monitoring units that are not NICU level care)		_____	_____	_____
Neonatal Intensive Care Unit (NICU) <i>Level</i> _____		_____	_____	_____
Other (specify) _____		_____	_____	_____

E. SURGERY

1. General Surgery

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

	Number of Persons (cases)	Number of Procedures
d. Inpatient	_____	_____
e. Outpatient	_____	_____
f. Does this facility have a designated separate/organized outpatient surgical unit? (OR rooms used only for outpatient surgery, do not include separately licensed ASC's)	_____	_____
	YES	NO

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2. Specialized Surgery
(Do not count normal OR procedures.)

Specialized Surgery

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 Persons	Number of Procedures
_____	_____	_____

b. Transplants

Number of Rooms	Number of Persons	Number of Procedures
_____	_____	_____

c. Other Specialized Surgery

Number of Rooms	Number of Persons	Number of Procedures
_____	_____	_____

Please specify the type of Other specialized surgery : _____

Total number of surgery rooms:

Include all inpatient, outpatient and mixed use, general surgery rooms as well as specialized surgery rooms.

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F. 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 under right heart catheterization. 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 ELECTRO-PHYSIOLOGY LAB		OTHER LOCATION (specify)	
	Inpatient Procedures	Outpatient Procedures	Inpatient Procedures	Outpatient Procedures	Inpatient Procedures	Outpatient Procedures
	Left Heart Catheterization (to include coronary cine angiograms)					
Right Heart Catheterization (to include endocardial biopsy, Swan/Ganz insertions, right heart and pulmonary angiograms)						
Right & Left Heart Catheterization (to include coronary cine angiograms)						
P.T.C.A.						
Pacemaker Implants (permanent)						
Other (specify below)						
TOTAL PROCEDURES						
TOTAL PATIENTS (cases)						
	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT

TOTAL NUMBER OF CON AUTHORIZED CATH LABS:

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G. DIAGNOSTIC EQUIPMENT

	Number of Fixed Units	Number of Mobile Units	Total Number of Patients
Magnetic Resonance Imaging (MRI)			
Lithotripsy			
Positron Emission Tomography (PET)			

H. THERAPEUTIC SERVICES

	Number of Units (pieces of equipment)	Number of Inpatient Persons	Number of Outpatient Persons
Gamma Knife			
Linear Accelerator			
Megavoltage Therapy			
Renal Dialysis (number of stations)			

I. CLINICAL EQUIPMENT

	Number of Adult Ventilators	Number of Pediatric/Neonatal Ventilators
Mechanical Ventilators (Do not include manual resuscitators or therapeutic IPPB)		

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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 your 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
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IV. EXPENSES & REVENUES

NOTE: These amounts **DO NOT** have to be **AUDITED** prior to reporting.

	INPATIENT	OUTPATIENT
TOTAL EXPENSES	\$.00	\$.00
TOTAL REVENUES	\$.00	\$.00
TOTAL BAD DEBT	\$.00	\$.00
TOTAL CHARITY	\$.00	\$.00

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 licensed beds **dedicated** for use by hospice providers **only** for the provision of respite and/or inpatient hospice services?

_____ YES _____ NO

6. If yes, how many beds are **dedicated** for this service?

7. How many respite and/or inpatient hospice days were provided (billed) during the reporting period?
