

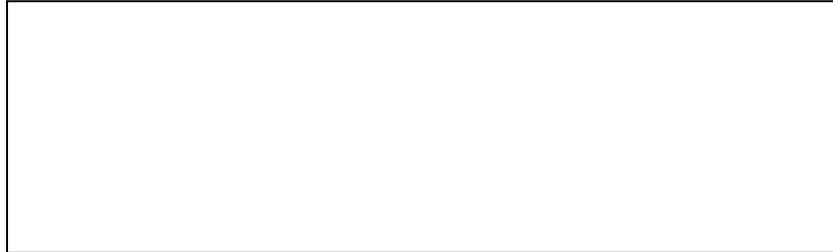
THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2013

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2013 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, 2012, through September 30, 2013*; 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: _____

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

	PATIENT DAYS (exclude <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. Hospice		
l. Other (specify) _____		
TOTALS		

* For the purposes of this section only, charity care Patient Days and Discharges are included in Self Pay reimbursement source.

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)				

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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)
5. Pediatric				
6. Orthopedic				
7. Intensive Care Unit (cardiac only)				
8. Intensive Care Unit				
9. Cardiac & Intensive Care Units (mixed)				
10. Swing Beds	XXXX			XXXXXXXX
11. Other (specify)				
TOTALS				

B. PSYCHIATRIC UNITS/PSYCHIATRIC HOSPITALS (for formal PPS-excluded psychiatric units). Acute Care 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)
Inpatient Unit					

C. SPECIALTY UNITS (do not duplicate data reported in other sections; for CON-Authorized services only except Burn Units, which may not hold CON-Authorization).

	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) – PPS-EXCLUDED					
3. Long-Term Acute Care Hospital (LTACH) - PPS-EXCLUDED					
4. Medical Rehabilitation Inpatient Unit – PPS-EXCLUDED					
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 : _____

3. TOTAL ROOMS AVAILABLE FOR ALL SURGERIES

Total number of surgery rooms: _____

(Include all general surgery AND 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 and Adult/Pediatric 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 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

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 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?
