FORM BHD 134A
REVISED 9/2015

THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2015

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
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MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
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MONTGOMERY AL 36104
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bradford.williams@shpda.alabama.gov

2015 ANNUAL REPORT FOR HOSPITALS AND RELATED FACILITIES

Print **Save** **Submit**

ENTER FACILITY ID NUMBER HERE
ENTER FACILITY NAME HERE

Pencil submission of this report will not be accepted. (This report should be completed and submitted electronically. All TOTAL 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: _____ (AREA CODE) & TELEPHONE NUMBER **Facility Fax:** _____ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for October 1, 2014, through September 30, 2015*; or for **partial** year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

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

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

PRINTED NAME OF PREPARER	SIGNATURE OF PREPARER	DATE
DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS

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

PRINTED NAME OF ADMINISTRATION OFFICIAL	SIGNATURE OF ADMINISTRATION OFFICIAL	DATE
DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS

FOR OFFICE USE ONLY

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

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OWNERSHIP (check one)

◯ Corporation	◯ Non-Profit Organization	◯ Partnership
◯ Individual	◯ Healthcare Authority	◯ LLC
◯ Joint Venture	◯ Government	◯ Other

Does this facility operate under a management contract? ◯ Yes ◯ No

Management Firm: _____
NAME

_____
BASE ADDRESS CITY STATE ZIP

I. FACILITIES

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

◯ General Medical & Surgical ***(acute care)***	◯ Pediatric
◯ Psychiatric	◯ Rehabilitation
◯ Long Term Acute Care ***(LTACH)***	◯ Chronic Disease (Long Term Care)
◯ Critical Access Hospital	◯ Other (specify) _____

B. Totals ****PLEASE VERIFY ALL TOTALS ON CHECKLIST, PAGE 11, PRIOR TO SUBMISSION****

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

		PATIENT DAYS (exclude *all* newborns and NICU patients)	DISCHARGES (include deaths, exclude *all* newborns and NICU patients)
a.	**Self Pay**		
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		0	0

* ☐ 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			XXXXXX
11.	**Other** (specify)				
	TOTALS	0	0	0	0

B. <u>PSYCHIATRIC UNITS/PSYCHIATRIC HOSPITALS</u> (for formal CON-authorized 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. <u>SPECIALTY UNITS</u> (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 other sections)

	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)			
Level _____			
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)	0

	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	0	0	0	0	0	0
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

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V. HOSPICE SERVICES

1. Are in-home hospice services provided by this facility or by a separate entity under common ownership with this facility? ○ YES ○ NO

2. Has a Letter of Non-Reviewability been issued by SHPDA to this facility to provide inpatient hospice services through rural exemption? ○ YES ○ NO

3. Does this facility have **contracts** with hospice providers to provide respite and/or inpatient hospice services as needed? ○ YES ○ NO

4. If yes, how many providers have **current contracts** with this facility? _____

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 facility's records before submitting to SHPDA.

This report should be submitted to SHPDA only once electronically, hard copy, or fax. The preferred method is electronic submission to bradford.williams@shpda.alabama.gov. **If submitted electronically please do not also submit via hard copy unless specifically requested to do so by SHPDA staff.**

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2015 Hospital Annual Report Checklist

	Totals
Licensed Beds	
Page 2, Section I-B-1.	0
Page 4, Section II-A	0
Page 4, Section II-B	0
Page 4, Section II-C	0
Licensed Beds in Sections II-A+II-B+II-C must equal Licensed Beds reported in Section I-B	
TOTAL LICENSED BEDS SECTION II	0
Staffed Beds	
Page 2, Section I-B-2.	0
Page 4, Section II-A	0
Page 4, Section II-B	0
Page 4, Section II-C	0
Staffed Beds in Sections II-A+II-B+IIC must equal Staffed Beds reported in Section I-B	
TOTAL STAFFED BEDS SECTION II	0
Patient Days	
Page 2, Section I-B-5.	0
Page 3, Section I-C	0
Patient Days in Section I-C must equal Patient Days reported in Section I-B	
Page 4, Section II-A	0
Page 4, Section II-B	0
Page 4, Section II-C	0
Patient Days in Sections II-A+II-B+II-C must equal Patient Days reported in Section I-B	
TOTAL PATIENT DAYS SECTION II	0
Discharges	
Page 2, Section I-B-6.	0
Page 3, Section I-C	0
Discharges in Section I-C must equal Discharges reported in Section I-B	
Page 4, Section II-A	0
Page 4, Section II-B	0
Page 4, Section II-C	0
Discharges in Sections II-A+II-B+II-C must equal Discharges reported in Section I-B	
TOTAL DISCHARGES SECTION II	0