FORM BHD 134A
REVISED 09/18

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2018

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2018 ANNUAL REPORT FOR HOSPITALS AND RELATED FACILITIES

Save

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SHPDA ID NUMBER

FACILITY NAME

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 10/1/2017 (MONTH DAY), through 9/30/2018 (MONTH DAY); 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 13, PRIOR TO SUBMISSION****

	TOTALS
1. Total Certificate of Need (CON) approved beds	0
2. Number of **staffed and operational beds** on last day of reporting period	0
3. Number of CON-authorized **swing beds**	0
4. Number of admissions for reporting period, excluding **all** newborns and NICU patients	0
5. Patients days for reporting period, excluding **all** newborns and NICU patients	0
6. Number of discharges for reporting period, excluding all newborns and NICU patients	0

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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 (Non-Charity Care)**	0	0
b.	**Worker's Compensation**	0	0
c.	**Medicare**	0	0
d.	**Medicaid**	0	0
e.	**Tricare**	0	0
f.	**Blue Cross**	0	0
g.	**Other Insurance Companies**	0	0
h.	**No Charge (charity & other free care)***	0	0
i.	**Health Maintenance Organization (HMO)**	0	0
j.	**All Kids**	0	0
k.	**Hospice**	0	0
l.	**Medicare Advantage**	0	0
m.	**Other (specify)**	0	0
TOTALS		0	0

***** 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**	0	0	0	0
2.	**Obstetric (maternity)**	0	0	0	0
3.	**Pediatric**	0	0	0	0

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	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	0	0	0	0
5. Intensive Care Units	0	0	0	0
6. Swing Beds	XXXX	0	0	XXXXXX
7. Other (specify)	0	0	0	0
TOTALS	0	0	0	0

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)	0	0	0	0
2. Pediatric	0	0	0	0
3. Intensive Care Units	0	0	0	0
4. Rehabilitation	0	0	0	0
5. LTACH	0	0	0	0
6. Other (specify)	0	0	0	0
TOTALS	0	0	0	0

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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
Adolescent/Child	0	0	0	0	0
Adult	0	0	0	0	0
Geriatric	0	0	0	0	0
TOTALS	0	0	0	0	0

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**	0	0	0	0	0
2.	**Medical Rehabilitation Inpatient Unit – *PPS-EXCLUDED***	0	0	0	0	0
3.	**Burn Unit**	0	0	0	0	0

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E. OBSTETRICS & NURSERY (do not include newborn data in other sections)

	Number of Rooms	Total Number of Live Births	Total Number of Fetal Deaths
Delivery Rooms/LDR/Obstetrical Recovery	0	0	0
C-Section Rooms	0	0	0

Please check the appropriate level of neonatal care provided at your facility (check one) based on the Alabama Perinatal Regionalization System Guidelines found at: http://www.alabamapublichealth.gov/perinatal/assets/perinatal_regionalization_system_guidelines.pdf. *The Guidelines were endorsed by the State Committee of Public Health and are based on guidance from the American Academy of Pediatrics.*

☐ Level I ☐ Level II ☐ Level III ☐ Level IV

Neonatal Levels of Care	Number of Bassinets	Number of Infants	Newborn Days
Newborn (Well Baby) Unit (DO NOT include any newborns shown in separately designated special-care units)	0	0	0
Special Care Nursery (include newborns in separate special-monitoring units that are not NICU level care)	0	0	0
Neonatal Intensive Care Unit (NICU)	0	0	0
Regional Neonatal Intensive Care Unit	0	0	0
Other (specify: i.e., specialty newborn cardiac NICU) _____	0	0	0

F. SURGERY

1. General Surgery

		Rooms
a.	Total number of inpatient operating rooms only	0
b.	Total number of outpatient operating rooms only	0
c.	Total number of "mixed-use" (inpatient and outpatient) operating rooms	0
	Total number of operating rooms available for general surgeries (exclude specialized surgeries)	0

		Number of Persons (cases)	Number of Procedures
d.	Inpatient	0	0
e.	Outpatient	0	0
f.	Does this facility have a designated separate/organized outpatient surgical unit? (Operating 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 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
0	0	0

b. Transplants

Number of Rooms	Number of Cases	Number of Procedures
0	0	0

c. Other Specialized Surgery

Number of Rooms	Number of Cases	Number of Procedures
0	0	0

Please specify the type of Other Specialized Surgery :

3. Total Inpatient and Outpatient Operating Rooms Available for all Surgeries

Total number of operating rooms: 0

(Include all general AND specialized surgery operating rooms).

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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
Heart Catheterization Diagnostic	0	0				
Heart Catheterization Therapeutic/ Interventional (Including PTCA, directional coronary atherectomy, rotational atherectomy and similar complex therapeutic procedures)	0	0				
Pediatric Catheterization	0	0				
Electrophysiology Diagnostic	0	0	0	0	0	0
Electrophysiology Therapeutic	0	0	0	0	0	0
Pacemaker Implants (permanent)	0	0	0	0	0	0
Other (specify below)	0	0	0	0	0	0
TOTAL PROCEDURES	0	0	0	0	0	0
TOTAL PATIENTS (cases)	0	0	0	0	0	0
	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT	INPATIENT	OUTPATIENT

TOTAL NUMBER OF CON AUTHORIZED CATH LABS: 0

H. THERAPEUTIC SERVICES

	Number of Units (pieces of equipment)	Number of Inpatient Persons	Number of Outpatient Persons
Gamma Knife	0	0	0
Linear Accelerator (Megavoltage Therapy)	0	0	0

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
0	0	0	0

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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

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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	0	0	0
19 – 34 years of age	0	0	0
35 – 54 years of age	0	0	0
55 – 64 years of age	0	0	0
65 – 74 years of age	0	0	0
75 – 84 years of age	0	0	0
85 years and older	0	0	0
TOTALS	0	0	* 0

**** 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	0
Black/African American/Negro	0
Hispanic/Spanish/Latino	0
Asian	0
American Indian/Alaskan Native	0
Pacific Islander	0
India	0
Middle Eastern	0
Other (please specify other race category):	0
TOTALS	* 0

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

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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? 0

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? 0

***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.

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Hospital Annual Report Checklist

	Totals
CON Authorized Beds	
Page 2, Section I-B-1.	0
Page 4, Section II-A	0
Page 4, Section II-B	0
Page 5, Section II-C	0
Page 5, Section II-D	0
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	
TOTAL CON AUTHORIZED BEDS SECTION II	0
Staffed and Operational Beds by Service	
Page 2, Section I-B-2.	0
Page 4, Section II-A	0
Page 4, Section II-B	0
Page 5, Section II-C	0
Page 5, Section II-D	0
Staffed and Operational Beds in Sections II-A+II-B+IIC+IID must equal Staffed and Operational Beds reported in Section I-B	
TOTAL STAFFED AND OPERATIONAL 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 5, Section II-C	0
Page 5, Section II-D	0
Patient Days in Sections II-A+II-B+II-C+II-D 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 5, Section II-C	0
Page 5, Section II-D	0
Discharges in Sections II-A+II-B+II-C+II-D must equal Discharges reported in Section I-B	
TOTAL DISCHARGES SECTION II	0

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PROCESSING NOTES & LEGEND FOR SUBMISSIONS OF THE FY 2018 PATIENT ORIGIN SURVEY DATA SUPPLEMENT
MUST INCLUDE DISCHARGE DATA FOR OCTOBER 1, 2017 - SEPTEMBER 30, 2018

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.

FIELD NAME (electronic & paper submissions)	**INSTRUCTIONS (electronic & paper submissions)**	**FIELD LENGTH (for electronic submissions only)** **Field Length Requirements**
Hospital ID #	SHPDA Hospital ID number	
Patient Number	Patient identification number. *This number may be a blind number assigned in sequential order.* Patient ID numbers **cannot** be duplicated.	**6**
Age	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. ***INCLUDE ALL NEWBORNS & PEDIATRICS, USING 000 FOR ALL INFANTS UNDER 1 YEAR OF AGE.***	**3**
Sex	Use the following values: ***MALE:*** **1** ***FEMALE:*** **2**	**1**

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FIELD NAME (electronic & paper submissions)	**INSTRUCTIONS (electronic & paper submissions)**	**FIELD LENGTH (for electronic submissions only)** **Field Length Requirements**
Race or National Origin	Use the following values: ***WHITE/CAUCASIAN*** ---------- **1** ***BLACK/AFRICAN AMERICAN/NEGRO*** ---------- **2** ***HISPANIC/SPANISH/LATINO*** ---------- **3** ***ASIAN*** ---------- **4** ***AMERICAN INDIAN/ALASKAN NATIVE*** ---------- **5** ***PACIFIC ISLANDER*** ---------- **6** ***INDIA*** ---------- **7** ***MIDDLE EASTERN*** ---------- **8** ***OTHER*** ---------- **9**	**1**
Zip Code	Patient's residence zip code. **5 digits only, report unknown zip codes as "99999".**	**5**
Length of Stay (LOS)	The number of days calculated from the date of admission until the date of discharge or death. **Discharges for this year** 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. ***Examples:*** A patient admitted on April 30th and discharged on May 4th would have a LOS of 004. A patient admitted on May 3rd and discharged on May 13th would have a LOS of 010. A patient admitted on September 28th and not discharged by September 30th would not be included.	**3**
Date of Discharge	For every discharge, Please include the date of discharge for that patient. This should be submitted in a **MM/DD/YYYY** format.	**10**

FIELD NAME (electronic & paper submissions)	**INSTRUCTIONS (electronic & paper submissions)**	**FIELD LENGTH (for electronic submissions only)** **Field Length Requirements**
Service Code	Record only the ***PRIMARY*** service when more than one clinical service is provided during the hospital stay: ***MEDICINE:*** **01** ***SURGERY:*** **02** ***PEDIATRICS:*** **03** (use only if your facility has an organized pediatric unit and only for patients 17 and under). 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. ***GYNECOLOGY*** **04** *(NO MALES)*, (medicine or surgery) ***OBSTETRICS*** **05** *(NO MALES)* ***ORTHOPEDICS*** **06** (use only if your facility has an organized orthopedic unit.) Facilities without an organized orthopedic unit should report these patients under the appropriate service. ***PSYCHIATRIC*** **07** (include alcoholism and substance abuse treatments) ***REHABILITATION*** **08** ***OTHER*** **09**	**2**
DRG/CMG	Patient's ***DRG*** (Diagnosis Related Group) or ***CMG*** (Case Mix Group) code. **As a reminder, please indicate which version of DRG codes your facility is using.**	**4** (add leading 0's as necessary)

FIELD NAME (electronic & paper submissions)	**INSTRUCTIONS (electronic & paper submissions)**	**FIELD LENGTH (for electronic submissions only)** **Field Length Requirements**
Payer Source **Payer Source Continued**	Use the following values: ***SELF PAY/PRIVATE PAY*** ---------- **1** ***WORKMAN'S COMPENSATION*** ---------- **2** ***MEDICARE*** ---------- **3** ***MEDICAID*** ---------- **4** ***TRI-CARE*** ---------- **5** ***BLUE CROSS/BLUE SHIELD*** ---------- **6** ***NO CHARGE/CHARITY*** ---------- **7** ***HMO*** ---------- **8** ***ALL KIDS*** ---------- **9** ***OTHER INSURANCE*** ---------- **10** ***HOSPICE*** ---------- **11** ***MEDICARE ADVANTAGE*** ---------- **12** ***OTHER*** ---------- **13**	**2**
ICD-10	Patient's **ICD-10** primary diagnosis code. Please report the full 7 digit ICD code **WITHOUT THE DECIMAL POINT**	**7**

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FY 2018
HOSPITAL PATIENT ORIGIN SURVEY CLOSEOUT RECORD

Please include this sheet as a cover to the FY 2018 Hospital Patient Origin Survey for all submissions. This survey is due by December 15, 2018.

Hospital Name _____

Hospital ID # _____

Name of Person Responsible: _____

Title _____

Telephone Number _____

Version of **DRG** Codes: _____