

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2022

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2022 ANNUAL REPORT FOR HOSPITALS AND RELATED FACILITIES

SHPDA ID NUMBER
FACILITY NAME

Mailing Address:

STREET ADDRESS CITY STATE ZIP

Physical Address:

STREET ADDRESS CITY STATE ZIP

County of Location:

Facility Telephone:

(AREA CODE) & TELEPHONE NUMBER

Facility Fax:

(AREA CODE) & TELEPHONE NUMBER

This reporting period is 10/1/2021, through 9/30/2022; 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:

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 **PLEASE VERIFY ALL TOTALS ON CHECKLIST, PAGE 13, PRIOR TO SUBMISSION**

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

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2022

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 (Non-Charity Care)		
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. Medicare Advantage		
m. Other (specify)		
TOTALS		

* 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				
2. Obstetric (maternity)				
3. Pediatric				

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2022

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

B. SPECIALTY HOSPITALS (excluding psychiatric)

- | | |
|--|---|
| <input type="checkbox"/> Rehabilitation Hospital | <input type="checkbox"/> Long-Term Acute Care Hospital |
| <input type="checkbox"/> Pediatric Hospital | <input type="checkbox"/> 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)				
2. Pediatric				
3. Intensive Care Units				
4. Rehabilitation				
5. LTACH				
6. Other (specify)				
TOTALS				

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2022

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
<u>Adolescent/Child</u>	_____	_____	_____	_____	_____
<u>Adult</u>	_____	_____	_____	_____	_____
<u>Geriatric</u>	_____	_____	_____	_____	_____
<u>TOTALS</u>	_____	_____	_____	_____	_____

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	_____	_____	_____	_____	_____
2. Medical Rehabilitation Inpatient Unit – <i>PPS-EXCLUDED</i>	_____	_____	_____	_____	_____
3. Burn Unit	_____	_____	_____	_____	_____

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

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2022

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

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

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

F. SURGERY

1. General Surgery

	Rooms	
a. Total number of inpatient operating rooms only		
b. Total number of outpatient operating rooms only		
c. Total number of "mixed-use" (inpatient and outpatient) operating 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? (Operating rooms used only for outpatient surgery, do not include separately licensed ASC's)		
	YES	NO

2. Specialized Surgery (Do not count general operating rooms)

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2022

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
_____	_____	_____

b. Transplants

Number of Rooms	Number of Cases	Number of Procedures
_____	_____	_____

c. Other Specialized Surgery

Number of Rooms	Number of Cases	Number of Procedures
_____	_____	_____

Please specify the type of Other Specialized Surgery :

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

Total number of operating rooms: _____

(Include all general AND specialized surgery operating rooms).

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2022

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

TOTAL NUMBER OF CON AUTHORIZED CATH LABS: _____

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2022

H. THERAPEUTIC SERVICES

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

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
_____	_____	_____	_____

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

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2022

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

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

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

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 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.

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2022

Hospital Annual Report Checklist

	Totals
CON Authorized Beds	
Page 2, Section I-B-1.	_____
Page 4, Section II-A	_____
Page 4, Section II-B	_____
Page 5, Section II-C	_____
Page 5, Section II-D	_____
<i>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</i>	
TOTAL CON AUTHORIZED BEDS SECTION II	_____
Staffed and Operational Beds by Service	
Page 2, Section I-B-2.	_____
Page 4, Section II-A	_____
Page 4, Section II-B	_____
Page 5, Section II-C	_____
Page 5, Section II-D	_____
<i>Staffed and Operational Beds in Sections II-A+II-B+II-C+IID must equal Staffed and Operational Beds reported in Section I-B</i>	
TOTAL STAFFED AND OPERATIONAL BEDS SECTION II	_____
Patient Days	
Page 2, Section I-B-5.	_____
Page 3, Section I-C	_____
<i>Patient Days in Section I-C must equal Patient Days reported in Section I-B</i>	
Page 4, Section II-A	_____
Page 4, Section II-B	_____
Page 5, Section II-C	_____
Page 5, Section II-D	_____
<i>Patient Days in Sections II-A+II-B+II-C+II-D must equal Patient Days reported in Section I-B</i>	
TOTAL PATIENT DAYS SECTION II	_____
Discharges	
Page 2, Section I-B-6.	_____
Page 3, Section I-C	_____
<i>Discharges in Section I-C must equal Discharges reported in Section I-B</i>	
Page 4, Section II-A	_____
Page 4, Section II-B	_____
Page 5, Section II-C	_____
Page 5, Section II-D	_____
<i>Discharges in Sections II-A+II-B+II-C+II-D must equal Discharges reported in Section I-B</i>	
TOTAL DISCHARGES SECTION II	_____

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2022

**PROCESSING NOTES & LEGEND FOR SUBMISSIONS OF THE
FY 2022 PATIENT ORIGIN SURVEY DATA SUPPLEMENT
MUST INCLUDE DISCHARGE DATA FOR OCTOBER 1, 2021 - SEPTEMBER 30, 2022**

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.

<u>FIELD NAME</u>	<u>INSTRUCTIONS</u>
Hospital ID #	SHPDA Hospital ID number
Patient Number	Patient identification number. <i><u>This number may be a blind number assigned in sequential order.</u></i> Patient ID numbers cannot be duplicated.
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. <u>INCLUDE ALL NEWBORNS & PEDIATRICS, USING 000 FOR ALL INFANTS UNDER 1 YEAR OF AGE.</u>
Sex	Use the following values: MALE: 1 FEMALE: 2 OTHER/UNKNOWN: 9

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2022

<u>FIELD NAME</u>	<u>INSTRUCTIONS</u>
Race or National Origin	<p>Use the following values:</p> <p>WHITE/CAUCASIAN----- 1</p> <p>BLACK/AFRICAN AMERICAN ----- 2</p> <p>HISPANIC/SPANISH/LATINO----- 3</p> <p>ASIAN----- 4</p> <p>AMERICAN INDIAN/ALASKAN NATIVE----- 5</p> <p>PACIFIC ISLANDER----- 6</p> <p>INDIA----- 7</p> <p>MIDDLE EASTERN----- 8</p> <p>OTHER----- 9</p>
Zip Code	Patient's residence zip code. <u>5 digits only</u> , report unknown zip codes as "99999".
Length of Stay (LOS)	<p>The number of days calculated from the date of admission until the date of <u>discharge</u> or <u>death</u>. 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.</p> <p>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.</p>
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.

<u>FIELD NAME</u>	<u>INSTRUCTIONS</u>
Service Code	<p>Record only the PRIMARY service when more than one clinical service is provided during the hospital stay:</p> <p>MEDICINE: 01</p> <p>SURGERY: 02</p> <p>PEDIATRICS: 03 (use only if your facility has an organized pediatric unit and only for patients <u>17 and under</u>). 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.</p> <p>GYNECOLOGY 04 (<u>NO MALES</u>), (medicine or surgery)</p> <p>OBSTETRICS 05 (<u>NO MALES</u>)</p> <p>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.</p> <p>PSYCHIATRIC 07 (include alcoholism and substance abuse treatments)</p> <p>REHABILITATION 08</p> <p>OTHER 09</p>
DRG/CMG	<p>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.</p>

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2022

<u>FIELD NAME</u>	<u>INSTRUCTIONS</u>																										
Payer Source	<p>Use the following values:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding-left: 20px;">SELF PAY/PRIVATE PAY-----</td> <td style="text-align: right; vertical-align: bottom;">1</td> </tr> <tr> <td style="padding-left: 20px;">WORKMAN'S COMPENSATION-----</td> <td style="text-align: right; vertical-align: bottom;">2</td> </tr> <tr> <td style="padding-left: 20px;">MEDICARE-----</td> <td style="text-align: right; vertical-align: bottom;">3</td> </tr> <tr> <td style="padding-left: 20px;">MEDICAID-----</td> <td style="text-align: right; vertical-align: bottom;">4</td> </tr> <tr> <td style="padding-left: 20px;">TRI-CARE-----</td> <td style="text-align: right; vertical-align: bottom;">5</td> </tr> <tr> <td style="padding-left: 20px;">BLUE CROSS/BLUE SHIELD-----</td> <td style="text-align: right; vertical-align: bottom;">6</td> </tr> <tr> <td style="padding-left: 20px;">NO CHARGE/CHARITY-----</td> <td style="text-align: right; vertical-align: bottom;">7</td> </tr> <tr> <td style="padding-left: 20px;">HMO-----</td> <td style="text-align: right; vertical-align: bottom;">8</td> </tr> <tr> <td style="padding-left: 20px;">ALL KIDS-----</td> <td style="text-align: right; vertical-align: bottom;">9</td> </tr> <tr> <td style="padding-left: 20px;">OTHER INSURANCE-----</td> <td style="text-align: right; vertical-align: bottom;">10</td> </tr> <tr> <td style="padding-left: 20px;">HOSPICE-----</td> <td style="text-align: right; vertical-align: bottom;">11</td> </tr> <tr> <td style="padding-left: 20px;">MEDICARE ADVANTAGE-----</td> <td style="text-align: right; vertical-align: bottom;">12</td> </tr> <tr> <td style="padding-left: 20px;">OTHER-----</td> <td style="text-align: right; vertical-align: bottom;">13</td> </tr> </table>	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
SELF PAY/PRIVATE PAY -----	1																										
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HOSPICE -----	11																										
MEDICARE ADVANTAGE -----	12																										
OTHER -----	13																										
ICD-10	<p>Patient's ICD-10 primary diagnosis code. Please report the full 7 digit ICD code WITHOUT THE DECIMAL POINT</p>																										

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 2022

**PROCESSING NOTES & LEGEND FOR SUBMISSIONS OF THE
FY 2022 INPATIENT REHABILITATION PATIENT ORIGIN SURVEY DATA SUPPLEMENT
MUST INCLUDE DISCHARGE DATA FOR OCTOBER 1, 2021 - SEPTEMBER 30, 2022**

The data in this section should only be reported by CON authorized Inpatient Rehabilitation Facilities or those hospitals with CON authorized inpatient rehabilitation beds. This information should be provided as a separate Microsoft Excel or CSV file and should be provided **IN ADDITION TO** the data required on pages 14-17 of this survey. All submissions must comply with the filing requirements set forth in Ala. Admin. Code 410-1-3-.09. The Annual Report (Form BHD 134A) AND both Patient Origin data electronic files 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	INSTRUCTIONS	FIELD LOCATION
Hospital ID #	SHPDA Hospital ID number	SHPDA Assigned
Patient Number	Patient identification number. <i>This number may be a blind number assigned in sequential order.</i> Patient ID numbers cannot be duplicated.	IRF-PAI P1 5b
Age	The numeric value of the patient's age.	IRF-PAI P1 6
Sex	Use the following values: MALE: 1 FEMALE: 2 OTHER/UNKNOWN: 9	IRF-PAI P1 8
Race or National Origin	Use the following values: WHITE/CAUCASIAN----- 1 BLACK/AFRICAN AMERICAN----- 2 HISPANIC/SPANISH/LATINO----- 3 ASIAN----- 4 AMERICAN INDIAN/ALASKAN NATIVE----- 5 PACIFIC ISLANDER----- 6 INDIA----- 7 MIDDLE EASTERN----- 8 OTHER----- 9	IRF-PAI P3 A1010
ZipCode	Patient's residence zip code. Report only the 5 digit zip code where possible. Report unknown zip codes as "99999".	IRF-PAI P1 11

FIELD NAME	INSTRUCTIONS	FIELD LOCATION
LengthOfStay	The number of days calculated from the date of admission until the date of discharge. Discharges for this year include any patients admitted in previous years and discharged during the current reporting period.	IRF-PAI P2 40 (Calculated Field)
DateOfDischarge	Date the patient was discharged from care. Submit in MM/DD/YYYY format.	IRF-PAI P2 40
Service Code	All Service Codes for patients discharged from an Inpatient Rehabilitation Facility should be assigned a service code of '8'.	N/A (Assign all patients a code of '8')
DRG	Primary DRG code for patient	UB-04 71
Payor	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	IRF-PAI P1 20
ICD-10Primary	Etiologic Diagnosis ICD-10 Code #1	IRF-PAI P1 22A
ICD-10Primary2	Etiologic Diagnosis ICD-10 Code #2	IRF-PAI P1 22B
ICD-10Primary3	Etiologic Diagnosis ICD-10 Code #3	IRF-PAI P1 22C
ICD-10Secondary	Comorbid Condition ICD-10 Code #1	IRF-PAI P1 24A
ICD-10Secondary2	Comorbid Condition ICD-10 Code #2	IRF-PAI P1 24B
ICD-10Secondary3	Comorbid Condition ICD-10 Code #3	IRF-PAI P1 24C
ICD-10Secondary4	Comorbid Condition ICD-10 Code #4	IRF-PAI P1 24D

FIELD NAME	INSTRUCTIONS	FIELD LOCATION
ICD-10Secondary5	Comorbid Condition ICD-10 Code #5	IRF-PAI P1 24E
ICD-10Secondary6	Comorbid Condition ICD-10 Code #6	IRF-PAI P1 24F
ICD-10Secondary7	Comorbid Condition ICD-10 Code #7	IRF-PAI P1 24G
ICD-10Secondary8	Comorbid Condition ICD-10 Code #8	IRF-PAI P1 24H
ICD-10Secondary9	Comorbid Condition ICD-10 Code #9	IRF-PAI P1 24I
ICD-10Secondary10	Comorbid Condition ICD-10 Code #10	IRF-PAI P1 24J
ICD-10Secondary11	Comorbid Condition ICD-10 Code #11	IRF-PAI P1 24K
ICD-10Secondary12	Comorbid Condition ICD-10 Code #12	IRF-PAI P1 24L
ICD-10Secondary13	Comorbid Condition ICD-10 Code #13	IRF-PAI P1 24M
ICD-10Secondary14	Comorbid Condition ICD-10 Code #14	IRF-PAI P1 24N
ICD-10Secondary15	Comorbid Condition ICD-10 Code #15	IRF-PAI P1 24O
ICD-10Secondary16	Comorbid Condition ICD-10 Code #16	IRF-PAI P1 24P
ICD-10Secondary17	Comorbid Condition ICD-10 Code #17	IRF-PAI P1 24Q
ICD-10Secondary18	Comorbid Condition ICD-10 Code #18	IRF-PAI P1 24R
ICD-10Secondary19	Comorbid Condition ICD-10 Code #19	IRF-PAI P1 24S
ICD-10Secondary20	Comorbid Condition ICD-10 Code #20	IRF-PAI P1 24T
ICD-10Secondary21	Comorbid Condition ICD-10 Code #21	IRF-PAI P1 24U
ICD-10Secondary22	Comorbid Condition ICD-10 Code #22	IRF-PAI P1 24V
ICD-10Secondary23	Comorbid Condition ICD-10 Code #23	IRF-PAI P1 24W
ICD-10Secondary24	Comorbid Condition ICD-10 Code #24	IRF-PAI P1 24X
ICD-10Secondary25	Comorbid Condition ICD-10 Code #25	IRF-PAI P1 24Y
Admit	Facility Type from which patient was admitted	IRF-PAI P1 15A
Discharge	Facility type/location to which patient was discharged	IRF-PAI P2 44D
Wk1PITherapy	Week 1 Physical Therapy Individual Therapy	IRF-PAI P2 00401A a
Wk1PCTherapy	Week 1 Physical Therapy Concurrent Therapy	IRF-PAI P2 00401A b
Wk1PGTherapy	Week 1 Physical Therapy Group Therapy	IRF-PAI P2 00401A c
Wk1PTTherapy	Week 1 Physical Therapy Co-Treatment Therapy	IRF-PAI P2 00401A d

FIELD NAME	INSTRUCTIONS	FIELD LOCATION
Wk1OITherapy	Week 1 Occupational Therapy Individual Therapy	IRF-PAI P2 O0401B a
Wk1OCTherapy	Week 1 Occupational Therapy Concurrent Therapy	IRF-PAI P2 O0401B b
Wk1OGTherapy	Week 1 Occupational Therapy Group Therapy	IRF-PAI P2 O0401B c
Wk1OTTherapy	Week 1 Occupational Therapy Co-Treatment Therapy	IRF-PAI P2 O0401B d
Wk1SITherapy	Week 1 Speech-Language Therapy Individual Therapy	IRF-PAI P2 O0401C a
Wk1SCTherapy	Week 1 Speech-Language Therapy Concurrent Therapy	IRF-PAI P2 O0401C b
Wk1SGTherapy	Week 1 Speech-Language Therapy Group Therapy	IRF-PAI P2 O0401C c
Wk1STTherapy	Week 1 Speech-Language Therapy Co-Treatment Therapy	IRF-PAI P2 O0401C d
Wk2PITherapy	Week 2 Physical Therapy Individual Therapy	IRF-PAI P2 O0402A a
Wk2PCTherapy	Week 2 Physical Therapy Concurrent Therapy	IRF-PAI P2 O0402A b
Wk2PGTherapy	Week 2 Physical Therapy Group Therapy	IRF-PAI P2 O0402A c
Wk2PTTherapy	Week 2 Physical Therapy Co-Treatment Therapy	IRF-PAI P2 O0402A d
Wk2OITherapy	Week 2 Occupational Therapy Individual Therapy	IRF-PAI P2 O0402B a
Wk2OCTherapy	Week 2 Occupational Therapy Concurrent Therapy	IRF-PAI P2 O0402B b
Wk2OGTherapy	Week 2 Occupational Therapy Group Therapy	IRF-PAI P2 O0402B c
Wk2OTTherapy	Week 2 Occupational Therapy Co-Treatment Therapy	IRF-PAI P2 O0402B d
Wk2SITherapy	Week 2 Speech-Language Therapy Individual Therapy	IRF-PAI P2 O0402C a
Wk2SCTherapy	Week 2 Speech-Language Therapy Concurrent Therapy	IRF-PAI P2 O0402C b
Wk2SGTherapy	Week 2 Speech-Language Therapy Group Therapy	IRF-PAI P2 O0402C c
Wk2STTherapy	Week 2 Speech-Language Therapy Co-Treatment Therapy	IRF-PAI P2 O0402C d