APA-1
Revised 4/2018

TRANSMITTAL SHEET FOR
NOTICE OF INTENDED ACTION

Control **410** Department or Agency **State Health Planning and Development Agency (Certificate of Need Review Board)**
Rule No. **410-1**
Rule Title: **Appendix**
_____New **X** Amend _____Repeal _____Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety?	**No**
Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare?	**Yes**
Is there another, less restrictive method of regulation available that could adequately protect the public?	**No**
Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree?	**No**
Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule?	**No**
Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public?	**Yes**
Does the proposed action relate to or affect in any manner any litigation which the agency is a party to concerning the subject matter of the proposed rule?	**No**

****

Does the proposed rule have an economic impact?	**No**

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

****

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Services Agency.

Signature of certifying officer Emily T. Marsh

Date **March 22, 2021**

REC'D & FILED (DATE FILED)
(STAMP)
MAR 22 2021
LEGISLATIVE SVC AGENCY

APA-2

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

NOTICE OF INTENDED ACTION

AGENCY NAME: **State Health Planning and Development Agency (Certificate of Need Review Board)**

RULE NO. & TITLE: **410-1, Appendix**

INTENDED ACTION: **Amend the Appendix Section of the Alabama Certificate of Need Program Rules and Regulations**

SUBSTANCE OF PROPOSED ACTION:

To amend the Annual Report for Specialty Care Assisted Living Facilities to collect data on the county of residence for patients admitted to each SCALF pursuant to the requirements of Ala. Admin. Code r. 410-2-4-.04(2)(h); update the submission instructions to comply with Ala. Admin. Code r. 410-1-3-.09; and modify identifying page numbers throughout the Appendix section due to the additional page added to the SCALF reporting form and to complement identifying page numbers as published in the Administrative Code resulting from formatting differences.

TIME, PLACE, MANNER OF PRESENTING VIEWS:

All interested persons are invited to submit data, views, comments and/or arguments, orally or in writing. Any and all such data, comments, arguments and/or requests to orally address the Certificate of Need Review Board shall be made in writing on or before May 6, 2021, at 5:00 p.m. to the State Health Planning and Development Executive Director.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:

On May 20, 2021, at 10:00 a.m., the Certificate of Need Review Board will conduct a public hearing at which time it shall consider adoption of the proposed amendment, along with all written and oral submissions in respect to the proposed amendment. Only those interested persons who have made timely written requests will be afforded the opportunity to speak. The location and manner of meeting will be determined and publicly announced prior to the scheduled meeting.

CONTACT PERSON AT AGENCY:

Mrs. Emily T. Marsal, Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104
(334) 242-4103, shpda.online@shpda.alabama.gov

Emily T. Marsal

(Signature of officer authorized to promulgate and adopt rules or his or her deputy)

APA-7

TRANSMITTAL SHEET FOR
BUSINESS ECONOMIC IMPACT STATEMENT
(Section 41-22-5.1)

Control No. **410** Department/Agency **State Health Planning and Development Agency (Certificate of Need Review Board)**

Rule No. **410-1**

Rule Title: **Appendix**

_____New _____**X**___Amend _____Repeal _____Adopt by Reference

Attached is a Business Economic Impact Statement filed pursuant to Section 41-22-5.1, Code of Alabama 1975.

Signature of Filing Officer Emily T. Marsh

Date **March 22, 2021**

(DATE FILED)
(STAMP)

ECONOMIC IMPACT STATEMENT
FOR APA RULE
(Section 41-22-23(f))

Control No. 410 Department or Agency **State Health Planning and Development Agency (Certificate of Need Review Board)**

Rule No: **410-1**

Rule Title: **Appendix**

_____New **X** Amend _____Repeal _____Adopt by Reference

X This rule has no economic impact.

_____ This rule has an economic impact, as explained below:

1. NEED/EXPECTED BENEFIT OF RULE:

2. COSTS/BENEFITS OF RULE AND WHY RULE IS THE MOST EFFECTIVE, EFFICIENT, AND FEASIBLE MEANS FOR ALLOCATING RESOURCES AND ACHIEVING THE STATED PURPOSE:

3. EFFECT OF THIS RULE ON COMPETITION:

4. EFFECT OF THIS RULE ON COST-OF-LIVING AND DOING BUSINESS IN THE GEOGRAPHICAL AREA WHERE THE RULE IS TO BE IMPLEMENTED:

5. EFFECT OF THIS RULE ON EMPLOYMENT IN THE GEOGRAPHICAL AREA WHERE THE RULE IS TO BE IMPLEMENTED:

6. SOURCE OF REVENUE TO BE USED FOR IMPLEMENTING AND ENFORCING THIS RULE:

7. THE SHORT-TERM/LONG-TERM ECONOMIC IMPACT OF THIS RULE ON AFFECTED PERSONS, INCLUDING ANALYSIS OF PERSONS WHO WILL BEAR THE COSTS AND THOSE WHO WILL BENEFIT FROM THE RULE:

8. UNCERTAINTIES ASSOCIATED WITH THE ESTIMATED BENEFITS AND BURDENS OF THE RULE, INCLUDING QUALITATIVE/QUANTITATIVE BENEFITS AND BURDEN COMPARISON:

9. THE EFFECT OF THIS RULE ON THE ENVIRONMENT AND PUBLIC HEALTH:

10. DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE RULE IS NOT IMPLEMENTED:

****Additional pages may be used if needed.**

APPENDIX
FORMS

Forms

Alabama Certificate of Need Application

Application for Extension of Certificate of Need, BHD-162

Supplement to Application: Budget and Utilization, HD-161-E

Request for Determination of Exemption Status for Replacement of Existing Equipment

Annual Report Forms

Notice of Change of Ownership/Control

Rev. 6-16

ALABAMA
CERTIFICATE OF NEED APPLICATION

For Staff Use Only

Filing Fee Remitted: $_____

Project # _____

Date Rec. _____

INSTRUCTIONS: Please submit an electronic pdf copy of this completed form and the appropriate attachments to the State of Alabama, State Health Planning and Development Agency, in accordance with ALA. ADMIN. CODE r. 410-1-7-.06 (Filing of a Certificate of Need Application) and 410-1-3-.09 (Electronic Filing). Electronic filings meeting the requirements of the aforementioned rules shall be considered provisionally received pending receipt of the required filing fee and shall be considered void should the proper filing fee not be received by the end of the next business day. Refer to ALA. ADMIN. CODE r. 410-1-7-.06 to determine the required filing fee.

Filing fees should be remitted to: State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

or the fee may be submitted electronically via the payment portal available through the State Agency's website at www.shpda.alabama.gov.

PART ONE: APPLICANT IDENTIFICATION AND PROJECT DESCRIPTION

I. APPLICANT IDENTIFICATION (Check One) HOSPITAL (____) NURSING HOME (____)
OTHER (____) (Specify) _____

A._____
Name of Applicant (in whose name the CON will be issued if approved)

_____
Address City County

_____
State Zip Code Phone Number

B._____
Name of Facility/Organization (if different from A)

_____
Address City County

_____
State Zip Code Phone Number

C._____
Name of Legal Owner (if different from A or B)

_____
Address City County

_____
State Zip Code Phone Number

D._____
Name and Title of Person Representing Proposal and with whom SHPDA should communicate

_____
Address City County

_____
State Zip Code Phone Number

I. APPLICANT IDENTIFICATION (continued)

E. Type Ownership and Governing Body

1. Individual (____)
2. Partnership (____)
3. Corporate (for profit) (____) _____
   Name of Parent Corporation
4. Corporate (non-profit) (____) _____
   Name of Parent Corporation
5. Public (____)
6. Other (specify) (____) _____

F. Names and Titles of Governing Body Members and Owners of This Facility

OWNERS	GOVERNING BOARD MEMBERS
_____	_____
_____	_____
_____	_____

II. PROJECT DESCRIPTION

Project/Application Type (check all that apply)

_____ New Facility
Type_____

_____ New Service
Type_____

_____ Construction/Expansion/Renovation

_____ Change in Service

_____ Major Medical Equipment
Type_____

_____ Termination of Service or Facility

_____ Other Capital Expenditure
Type_____

III. EXECUTIVE SUMMARY OF THE PROJECT (brief description)

_____

_____

_____

_____

_____

IV. COST

A. Construction (includes modernization expansion)

1.	Predevelopment	$_____
2.	Site Acquisition	_____
3.	Site Development	_____
4.	Construction	_____
5.	Architect and Engineering Fees	_____
6.	Renovation	_____
7.	Interest during time period of construction	_____
8.	Attorney and consultant fees	_____
9.	Bond Issuance Costs	_____
10.	Other _____	_____
11.	Other_____	_____
	TOTAL COST OF CONSTRUCTION	$_____

B. Purchase

1.	Facility	$_____
2.	Major Medical Equipment	_____
3.	Other Equipment	_____
	TOTAL COST OF PURCHASE	$_____

C. Lease

1.	Facility Cost Per Year ____x _____ Years =	$_____
2.	Equipment Cost per Month _____ x _____ Months =	_____
3.	Land-only Lease Cost per Year _____ x _____ Years	_____
	TOTAL COST OF LEASE(s) (compute according to generally accepted accounting principles)	$_____
	Cost if Purchased	$_____

D. Services

1.	_____	New Service	$ _____
2.	_____	Expansion	$_____
3.	_____	Reduction or Termination	$_____
4.	_____	Other	$_____
		FIRST YEAR ANNUAL OPERATING COST	$_____

E. Total Cost of this Project (Total A through D)
(should equal V-C on page A-4) $_____

IV. COST (continued)

F. Proposed Finance Charges

1. Total Amount to Be Financed $_____
2. Anticipated Interest Rates _____
3. Term of Loan _____
4. Method of Calculating Interest on Principal Payment _____

_____

_____

V. ANTICIPATED SOURCE OF FUNDING

		Amount	Source
A.	Federal		
1.	Grants	$_____	_____
2.	Loans	_____	_____
B.	Non-Federal		
1.	Commercial Loan	_____	_____
2.	Tax-exempt Revenue Bonds	_____	_____
3.	General Obligation Bonds	_____	_____
4.	New Earning and Revenues	_____	_____
5.	Charitable Fund Raising	_____	_____
6.	Cash on Hand	_____	_____
7.	Other	_____	_____

C. TOTAL (should equal IV-E on page A-3) $_____

VI. TIMETABLE

A. Projected Start/Purchase Date _____
B. Projected Completion Date _____

PART TWO: PROJECT NARRATIVE

Note: In this part, please submit the information as an attachment. This will enhance the continuity of reading the application.

The applicant should address the items that are applicable to the project.

I. MEDICAL SERVICE AREA

A. Identify the geographic (medical service) area by county (ies) or city, if appropriate, for the facility or project. Include an 8 ½ x 11" map indicating the service area and the location of the facility.

B. What population group(s) will be served by the proposed project? Define age groups, location and characteristics of the population to be served.

C. If medical service area is not specifically defined in the State Health Plan, explain statistical methodologies or market share studies based upon accepted demographic or statistical data available with assumptions clearly detailed. If Patient Origin Study data is used, explain whether institution or county based, etc.

D. Are there any other factors affecting access to the project?

(__) Geographic (__) Economic (__) Emergency (____) Medically Underserved

Please explain.

II. HEALTH CARE REQUIREMENTS OF THE MEDICAL SERVICE AREA

A. What are the factors (inadequacies) in the existing health care delivery system which necessitate this project?

B. How will the project correct the inadequacies?

C. Why is your facility/organization the appropriate facility to provide the proposed project?

D. Describe the need for the population served or to be served for the proposed project and address the appropriate sections of the State Health Plan and the Rules and Regulations under 410-1-6-.07. Provide information about the results of any local studies which reflect a need for the proposed project.

E. If the application is for a specialized or limited-purpose facility or service, show the incidence of the particular health problem.

F. Describe the relationship of this project to your long-range development plans, if you have such plans.

III. RELATIONSHIP TO EXISTING OR APPROVED SERVICES AND FACILITIES

A. Identify by name and location the existing or approved facilities or services in the medical service area similar to those proposed in this project.

B. How will the proposed project affect existing or approved services and facilities in the medical service area?

C. Will there be a detrimental effect on existing providers of the service? Discuss methodologies and assumptions.

D. Describe any coordination agreements or contractual arrangements for shared services that are pertinent to the proposed project.

E. List the new or existing ancillary and/or supporting services required for this project and briefly describe their relationship to the project.

IV. POTENTIAL LESS COSTLY OR MORE EFFECTIVE ALTERNATIVES

A. What alternatives to the proposed project exist? Why was this proposal chosen?

B. How will this project foster cost containment?

C. How does the proposal affect the quality of care and continuity of care for the patients involved?

V. DESCRIBE COMMUNITY REACTION TO THE PROJECT (Attach endorsements if desired)

VI. NON-PATIENT CARE

If appropriate, describe any non-patient care objectives of the facility, i.e., professional training programs, access by health professional schools and behavioral research projects which are designed to meet a national need.

VII. MULTI-AREA PROVIDER

If the applicant holds itself as a multi-area provider, describe those factors that qualify it as such, including the percentage of admissions which resides outside the immediate health service area in which the facility is located.

VIII. HEALTH MAINTENANCE ORGANIZATION

If the proposal is by or on behalf of a health maintenance organization (HMO), address the rules regarding HMOs, and show that the HMO is federally qualified.

IX. ENERGY-SAVING MEASURES

Discuss as applicable the principal energy-saving measures included in this project.

X. OTHER FACTORS

Describe any other factor(s) that will assist in understanding and evaluating the proposed project, including the applicable criteria found at 410-1-6 of the Alabama Certificate of Need Program Rules and Regulations which are not included elsewhere in the application.

PART THREE: CONSTRUCTION OR RENOVATION ACTIVITIES

Complete the following if construction/renovation is involved in this project. Indicate N/A for any questions not applicable.

I. ARCHITECT _____

Firm _____

Address _____

City/State/Zip _____

Contact Person _____

Telephone _____

Architect's Project Number_____

II. ATTACH SCHEMATICS AND THE FOLLOWING INFORMATION

A. Describe the proposed construction/renovation

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

B. Total gross square footage to be constructed/renovated_____

C. Net useable square footage (not including stairs, elevators, corridors, toilets) _____

D. Acres of land to be purchased or leased _____

E. Acres of land owned on site _____

F. Anticipated amount of time for construction or renovations _____(months)

G. Cost per square foot $_____

H. Cost per bed (if applicable) $_____

PART FOUR: UTILIZATION DATA AND FINANCIAL INFORMATION

This part should be completed for projects under $500,000.00 and/or those projects for ESRD and home health. If this project is not one of the items listed above, please omit Part Four and complete Part Five. Indicate N/A for any questions not applicable.

I. UTILIZATION

		CURRENT		PROJECTED	
	Years:	20_____	20_____	20_____	20_____
A.	ESRD				
	# Patients	_____	_____	_____	_____
	# Procedures	_____	_____	_____	_____
B.	Home Health Agency				
	# Patients	_____	_____	_____	_____
	# of Visits	_____	_____	_____	_____
C.	New Equipment				
	# Patients	_____	_____	_____	_____
	# Procedures	_____	_____	_____	_____
D.	Other				
	# Patients	_____	_____	_____	_____
	# Procedures	_____	_____	_____	_____

II. PERCENT OF GROSS REVENUE

	Historical			**Projected**	
Source of Payment	**20___**	**20___**	**20___**	**20___**	**20___**
ALL Kids					
Blue Cross/Blue Shield					
Champus/Tricare					
Charity Care (see note below)					
Medicaid					
Medicare					
Other commercial insurance					
Self pay					
Other					
Veterans Administration					
Workers' Compensation					
TOTAL	%	%	%	%	%

Note: Refer to the Healthcare Financial Management Association (HFMA) Principles and Practices Board Statement Number 15, Section II.

III. CHARGE INFORMATION

A. List schedule of current charges related to this project.

B. List schedule of proposed charges after completion of this project. Discuss the impact of project cost on operational costs and charges of the facility or service.

PART FIVE: UTILIZATION DATA AND FINANCIAL INFORMATION

This part should be completed for projects which cost over $500,000.00 or which propose a substantial change in service, or which would change the bed capacity of the facility in excess of ten percent (10%), or which propose a new facility. ESRD, home health, and projects that are under $500,000.00 should omit this part and complete Part Four.

I. PERCENT OF GROSS REVENUE

	Historical			**Projected**	
Source of Payment	**20___**	**20___**	**20___**	**20___**	**20___**
ALL Kids					
Blue Cross/Blue Shield					
Champus/Tricare					
Charity Care (see note below)					
Medicaid					
Medicare					
Other commercial insurance					
Self pay					
Other					
Veterans Administration					
Workers' Compensation					
TOTAL	%	%	%	%	%

Note: Refer to the Healthcare Financial Management Association (HFMA) Principles and Practices Board Statement Number 15, Section II.

II. CHARGE INFORMATION

C. List schedule of current charges related to this project.

D. List schedule of proposed charges after completion of this project. Discuss the impact of project cost on operational costs and charges of the facility or service.

III. INPATIENT UTILIZATION DATA

A. Historical Data

Give information for last three (3) years for which complete data is available.

OCCUPANCY DATA

Occupancy	Number of Beds			Admissions or Discharges			Total Patient Days			Percentage (%)		
	Yr___	Yr___	Yr___	Yr___	Yr___	Yr___	Yr___	Yr___	Yr___	Yr___	Yr___	Yr___
Medicine & Surgery												
Obstetrics												
Pediatrics												
Psychiatry												
Other												
TOTALS												

B. Projected Data

Give information to cover the first two (2) years of operation after completion of project.

OCCUPANCY DATA

Occupancy	Number of Beds		Admissions or Discharges		Total Patient Days		Percentage (%)	
	1st Year	2nd Year	1st Year	2nd Year	1st Year	2nd Year	1st Year	2nd Year
Medicine & Surgery								
Obstetrics								
Pediatrics								
Psychiatry								
Other								
TOTALS								

IV. OUTPATIENT UTILIZATION DATA

A. HISTORICAL DATA

	Number of Outpatient Visits			**Percentage of Outpatient Visits**		
	Yr_____	Yr_____	Yr_____	Yr_____	Yr_____	Yr_____
Clinical						
Diagnostic						
Rehabilitation						
Surgical						

B. PROJECTED DATA

	Number of Outpatient Visits		**Percentage of Outpatient Visits**	
	1st year	2nd year	1st year	2nd year
Clinical				
Diagnostic				
Rehabilitation				
Surgical				

V. A. ORGANIZATION FINANCIAL INFORMATION

STATEMENT OF INCOME AND EXPENSE	**HISTORICAL DATA** (Give information for last 3 years for which complete data are available)			**PROJECTED DATA** (First 2 years after completion of project)	
	20___ (Total)	20___ (Total)	20___ (Total)	20___ (Total)	20___ (Total)
Revenue from Services to Patients					
Inpatient Services					
Routine (nursing service areas)					
Other					
Outpatient Services					
Emergency Services					
Gross Patient Revenue					
Deductions from Revenue					
Contractual Adjustments					
Discount/Miscellaneous Allowances					
Total Deductions					
NET PATIENT REVENUE (Gross patient revenue less deductions)					
Other Operating Revenue					
NET OPERATING REVENUE					
OPERATING EXPENSES					
Salaries, Wages, and Benefits					
Physician Salaries and Fees					
Supplies and other					
Uncompensated Care (less recoveries) per State Health Plan 410-2-2-.06(d)					
Other Expenses					
Total Operating Expenses					
NON-OPERATING EXPENSES					
Taxes					
Depreciation					
Interest (other than mortgage)					
Existing Capital Expenditures				N/A	N/A
Interest				N/A	N/A
Total Non-Operating Expenses					
TOTAL EXPENSES (Operating & Capital)					
Operating Income (Loss)					
Other Revenue (Expense) -- Net					
NET INCOME (Loss)					
Projected Capital Expenditure	N/A	N/A	N/A		
Interest	N/A	N/A	N/A		

B. PROJECT SPECIFIC FINANCIAL INFORMATION

STATEMENT OF INCOME AND EXPENSE	**HISTORICAL DATA** (Give information for last 3 years for which complete data are available)			**PROJECTED DATA** (First 2 years after completion of project)	
	20___ (Total)	20___ (Total)	20___ (Total)	20___ (Total)	20___ (Total)
Revenue from Services to Patients					
Inpatient Services					
Routine (nursing service areas)					
Other					
Outpatient Services					
Emergency Services					
Gross Patient Revenue					
Deductions from Revenue					
Contractual Adjustments					
Discount/Miscellaneous Allowances					
Total Deductions					
NET PATIENT REVENUE(Gross patient revenue less deductions)					
Other Operating Revenue					
NET OPERATING REVENUE					
OPERATING EXPENSES					
Salaries, Wages, and Benefits					
Physician Salaries and Fees					
Supplies and other					
Uncompensated Care (less recoveries) per State Health Plan 410-2-2-.06(d)					
Other Expenses					
Total Operating Expenses					
NON-OPERATING EXPENSES					
Taxes					
Depreciation					
Interest (other than mortgage)					
Existing Capital Expenditures				N/A	N/A
Interest				N/A	N/A
Total Non-Operating Expenses					
TOTAL EXPENSES (Operating & Capital)					
Operating Income (Loss)					
Other Revenue (Expense) – Net					
NET INCOME (Loss)					
Projected Capital Expenditure	N/A	N/A	N/A		
Interest	N/A	N/A	N/A		

STATEMENT OF COMMUNITY PARTNERSHIP FOR EDUCATION AND REFERRALS

A. This section is declaration of those activities your organization performs outside of inpatient and outpatient care in the community and for the underserved population. Please indicate historical and projected data by expenditures in the columns specified below.

Services and/or Programs	**Historical Data (total dollars spent in last 3 years)**			**Projected Data (total dollars budgeted for next 2 years)**	
	Year	Year	Year	Year	Year
Health Education (nutrition, fitness, etc.					
Community service workers (school nurses, etc.)					
Health screenings					
Other					
TOTAL					

B. Please describe how the new services specified in this project application will be made available to and address the needs of the underserved community. If the project does not involve new services, please describe how the project will address the underserved population in your community.

Please briefly describe some of the current services or programs presented to the underserved in your community.

PART SIX: ACKNOWLEDGEMENT AND CERTIFICATION BY THE APPLICANT

I. ACKNOWLEDGEMENT

In submitting this application, the applicant understands and acknowledges that:

A. The rules, regulations and standards for health facilities and services promulgated by the SHPDA have been read, and the applicant will comply with same.

B. The issuance of a certificate of need will depend on the approval of the CON Review Board, and no attempt to provide the service or incur an obligation will be made until a bona fide certificate of need is issued.

C. The certificate of need will expire in twelve (12) months after date of issuance, unless an extension is granted pursuant to the applicable portions of the SHPDA rules and regulations.

D. The certificate of need is <u>not transferrable</u>, and any action to transfer or assign the certificate will render it null and void.

E. The applicant will notify the State Health Planning and Development Agency when a project is started, completed or abandoned.

F. The applicant shall file a progress report on each active project every six (6) months until the project is completed.

G. The applicant must comply with all state and local building codes, and failure to comply will render the certificate of need null and void.

H. The applicants and their agents will construct and operate in compliance with appropriate state licensure rules, regulations, and standards.

I. Projects are limited to the work identified in the Certificate of Need <u>as issued</u>.

J. Any expenditure in excess of the amount approved on the Certificate of Need must be reported to the State Health Planning and Development Agency and may be subject to review.

K. The applicant will comply with all state statutes for the protection of the environment.

L. The applicant is not presently operating with a probational (except as may be converted by this application) or revoked license.

I. CERTIFICATION

The information contained in this application is true and correct to the best of my knowledge and belief.

_____
Signature of Applicant

_____
Applicant's Name and Title
(Type or Print)

_____day of _____ 20_____

_____
Notary Public (Affix seal on Original)

Author: Alva M. Lambert
Statutory Authority: §§ 22-21-267, -271, -275, Code of Alabama, 1975
History: **Amended:** March 19, 1996; **Amended:** July 25, 2002; **Amended:** Filed: July 22, 2013; effective August 26, 2013; **Amended:** Filed August 23, 2016, effective October 7, 2016.

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BHD-162
(8-77)
Revised (5-13)

State Health Planning and Development Agency

Mailing address: Post Office Box 303025, Montgomery, Alabama 36130-3025
Street address: 100 North Union Street, Suite 870, Montgomery, Alabama 36104

APPLICATION FOR EXTENSION OF CERTIFICATE OF NEED
A filing fee in the amount of $_____ has been submitted with this application.

1. APPLICATION. Application is hereby made for a twelve (12) month extension of the Certificate of Need issued for the health facility described below. (All items must be completed in full before extension of Certificate of Need can be considered.)

2. PROJECT NUMBER	3. CERTIFICATE NUMBER	4. CERTIFICATE EXPIRES

5. LEGAL NAME OF APPLICANT	6. ADDRESS OF APPLICANT
7. NAME OF PROPOSED FACILITY	8. LOCATION OF PROPOSED FACILITY
9. TYPE OF FACILITY	10. ANTICIPATED DATE ON WHICH OBLIGATION IS EXPECTED TO OCCUR AND/OR CONSTRUCTION STARTED

11. ESTIMATED DATE CONSTRUCTION IS SCHEDULED FOR COMPLETION

12. BED CAPACITY

	Gen. Hosp.	Nursing Home SK	Nursing Home ICF	Psychiatric	Other _____
Existing Bed Capacity	_____	_____	_____	_____	_____
Beds provided by New Facility	_____	_____	_____	_____	_____
Addition	_____	_____	_____	_____	_____
Remodeling	_____	_____	_____	_____	_____
Replacement	_____	_____	_____	_____	_____
Capacity Upon Completion	_____	_____	_____	_____	_____

13. ESTIMATED COST OF THE PROJECT	14. PROPOSED FINANCING OF THE PROJECT
Construction $_____ Fixed Equipment $_____ Movable Equipment $_____ Arch. & Eng. $_____ Site Improvements $_____ Financing Charges $_____ Total Cost $_____	Total Estimated Cost $_____ DHEW Loan/Grant $_____ SBA Loan $_____ FHA Mortgage Insurance $_____ Private Financing $_____ Other (Specify) $_____
13a. ATTACH COST ESTIMATE SIGNED BY PROJECT ARCHITECT (Required)	14a. ATTACH STATEMENT FROM FINANCING AGENCY(IES) OF LOAN FEASIBILITY (Required)
15. SITE INFORMATION (Check One) Acquired _____ Option _____ Under Construction _____ Not Acquired _____	16. ARCHITECTURAL PROGRESS Architect Employed _____ Schematic Drawings_____ Working Drawings_____ Advertised for Bids_____

APPLICATION FOR EXTENSION OF CERTIFICATE OF NEED

17. BRIEF DESCRIPTION OF PROPOSED WORK. Include any proposed deletion, new or substantial change in the scope of the project as described in the Program Narrative submitted in support of the original Application.

18. BUDGET AND UTILIZATION DATA. If there has been a material change in the estimated cost of the construction and/or operation of the facility (or if data were not submitted with the original application) it will be necessary to complete PART FIVE of the original application form.
Part Five attached: _____ Yes _____ No

19. COST CONTAINMENT. Attach Cost Containment Statement showing how the project will foster cost containment through improved efficiency and productivity, including promotion of cost-effective factors such as ambulatory care, preventive health care services, home health care, sharing of services with other facilities, and design and construction economies.

20. In submitting this Application, the Applicant:
Understands that extension of the Certificate will depend upon compliance with minimum criteria.
A. Needs of the Area as set forth in the up-dated Alabama State Health Plan.
B. 1. Site Procurement: Must have acquired or holds option to purchase. Site must be inspected and approved.
2. Architectural Progress: Must have approved working drawings.
3. Financial Status: Must present evidence that appropriate and necessary financing is final and immediately available.
4. Program Narrative: Must be updated to show change in scope of service.
5. Budget and Utilization Data: Must be on file and up-to-date. Maximum increase in costs and charges must be within Cost of Living Council guidelines.
6. Cost Containment: Satisfactory statement must be on file.
C. Understands that the Certificate if issued, will expire not more than twelve (12) months from date of issuance and will not be subject to further extension.
D. Agrees to notify Health Development, State Health Planning and Development Agency, if and when the project is abandoned or is placed under contract.
E. The Certificate of Need, if issued, is not transferable and any action on the part of the Applicant to transfer or assign the Certificate of Need will render the Certificate of Need null and void.

21. SIGNATURE OF RESPONSIBLE OFFICER	22. TITLE OF OFFICER
_____	_____
23. NAME OF RESPONSIBLE OFFICER	24. DATE
_____	_____

Attachments:
_____ Cost Estimate
_____ Statement from Financing Agency
_____ Part Five Budget and Utilization Data
_____ Cost Containment Statement

HD-161-E
Revised (5-13)

SUPPLEMENT TO APPLICATION: BUDGET AND UTILIZATION

1. NAME OF APPLICANT	2. NAME OF FACILITY
3. TYPE OF FACILITY	4. LOCATION OF FACILITY

5. HISTORICAL DATA: Give information for last three (3) years for which complete data are available

A. OCCUPANCY DATA

1. OCCUPANCY	NUMBER OF BEDS			ADMISSIONS OR DISCHARGES			TOTAL PATIENT DAYS			% OCCUPANCY		
	YR	YR	YR	YR	YR	YR	YR	YR	YR	YR	YR	YR
MEDICINE AND SURGERY												
OBSTETRICS												
PEDIATRICS												
PSYCHIATRY												
OTHER												
TOTALS												

PERCENT OF GROSS REVENUE

B. SOURCE OF PAYMENT

	YR _____	YR _____	YR _____
BLUE CROSS			
OTHER INSURANCE			
MEDICARE			
MEDICAID			
SELF-PAY			
FREE CARE			
OTHER			
SUBTOTAL			
BAD DEBTS	%	%	%
TOTALS	100%	100%	100%

HD-161-E Revised (5-13)

BUDGET AND UTILIZATION DATA

5. HISTORICAL DATA (Cont'd)

2. NAME OF FACILITY _____

C. Statement of Income and Expense (Give information for last three years for which complete data are available.)	20 _____ Total	20 _____ Total	20 _____ Total	20 _____ Per Diem
Revenue from Services to Patients Inpatient Services Routine (Nursing Service Areas)				
Other				
Outpatient Services				
Emergency Services				
Other Operating Revenue Recoveries				
Other				
Gross Operating Revenue				
Deductions from Operating Revenue Contract Adjustments				
Discounts/Misc. Allowances				
Provision for Charity Services				
Provision for Uncollectables				
Total Deductions				
Net Operating Revenue				
Operating Expenses Salaries and Wages				
Physician's Salaries and Fees				
Supplies				
Depreciation				
Interest (Other than Mortgage)				
Other Expenses				
Total Operating Expenses				
Capital Expenditure Retirement of Principal				
Interest				
Total Capital Expenditure				
Total Expenses (Operating and Capital)				
Operating Income (Loss)				
Other Revenue (Expense) - Net				
Net Income (Loss)				

HD-161-E
Revised (5-13)

SUPPLEMENT TO APPLICATION: BUDGET AND UTILIZATION DATA

1. NAME OF APPLICANT	2. NAME OF FACILITY
3. TYPE OF FACILITY	4. LOCATION OF FACILITY

5. PROJECTED DATA: Give information projected to cover the first two (2) years of operation after completion of project.

A. OCCUPANCY DATA

1. OCCUPANCY	NUMBER OF BEDS		ADMISSIONS OR DISCHARGES		TOTAL PATIENT DAYS		% OCCUPANCY	
	1st Year	2nd Year	1st Year	2nd Year	1st Year	2nd Year	1st Year	2nd Year
MEDICINE AND SURGERY								
OBSTETRICS								
PEDIATRICS								
PSYCHIATRY								
OTHER								
TOTALS								

PERCENT OF GROSS REVENUE

B. SOURCE OF PAYMENT

	YR _____	YR _____	YR _____
BLUE CROSS			
OTHER INSURANCE			
MEDICARE			
MEDICAID			
SELF-PAY			
FREE CARE			
OTHER			
SUBTOTAL			
BAD DEBTS	%	%	%
TOTALS	100%	100%	100%

Note: Include both inpatient and outpatient data.

NAME OF FACILITY _____

5. PROJECTED DATA (Cont'd)

C. Statement of Projected Income and Expenses (First two (2) years after completion of project.)	20____		20____	
	Total	Per Diem	Total	Per Diem
Revenue from Services to Patients Inpatient Services Routine (Nursing Service Areas)				
Other				
Outpatient Services				
Emergency Services				
Other Operating Revenue Recoveries				
Other				
Gross Operating Revenue				
Deductions from Operating Revenue Contract Adjustments				
Discount/Misc. Allowances				
Provision for Charity Services				
Provision for Uncollectables				
Total Deductions				
Net Operating Revenue				
Operating Expenses Salaries and Wages				
Physician's Salaries and Fees				
Supplies				
Depreciation				
Interest (Other than Mortgage)				
Other Expenses				
Total Operating Expenses				
Capital Expenditure Incurred Prior to this Project - Retirement of Principal				
- Interest				
This Project - Retirement of Principal				
- Interest				
Total Capital Expenditure				
Total Expenses (Operating & Capital)				
Operating Income (Loss)				
Other Revenue (Expense) – Net				

BUDGET AND UTILIZATION

6. INFORMATION REGARDING PROPOSED FINANCING

Total amount to be borrowed $_____

Anticipated interest rate _____%

Term of loan _____ years

Method of calculating interest and principal payments:

7. ATTACHMENTS

(1) Schedule of current charges.

(2) Schedule of proposed charges after completion of this project.

(3) State of existing capital indebtedness.

(4) Schedule showing projected annual depreciation for buildings, fixed equipment, and movable equipment.

Author:
Statutory Authority:
History: Amended: Filed March 13, 1997; effective April 18, 1997. **Amended:** Filed July 24, 2013; effective August 28, 2013.

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State Health Planning and Development Agency

Mailing address: Post Office Box 303025, Montgomery, Alabama 36130-3025
Street address: 100 North Union Street, Suite 870, Montgomery, Alabama 36104

Request # _____
Date Rec. _____
Received by: _____

REQUEST FOR DETERMINATION OF EXEMPTION STATUS FOR REPLACEMENT OF EXISTING EQUIPMENT

A filing fee in the amount of $_____ has been submitted with this application.

REQUESTER IDENTIFICATION (Check One) HOSPITAL (___) NURSING HOME (___)
OTHER (___) (Specify) _____

A._____
Name of requester

_____
Address City County

_____
State Zip Phone

B._____
Name of Facility/Organization (if different from A)

_____
Address City County

_____
State Zip Phone

C._____
Name of Legal Owner (if different from A or B)

_____
Address City County

_____
State Zip Phone

D._____
Name and Title of Person Representing Proposal and With Whom SHPDA Should Communicate

_____
Address City County

_____
State Zip Phone

DESCRIPTION OF EQUIPMENT TO BE REPLACED **DESCRIPTION OF PROPOSED NEW EQUIPMENT**

A. Manufacturer:

Serial #

B. Model:

C. Name of equipment:

D. Fair market value of equipment at present:

E. Cost of equipment (include written price quote):

F. Describe use of current equipment:

Describe use of proposed equipment:

G. List any attachments or additional procedures associated with this equipment that could not be performed by old equipment:

H. Can any procedures be performed with the proposed new equipment that cannot be performed with the replaced equipment? If yes, describe in detail:

I. Location of existing equipment (include room #):

J. List specially trained or qualified personnel necessary for operation of equipment:

K. What use will be made of old equipment when replaced?
(Trade in on new equipment, used as back up, save for parts, etc.)

L. List job titles of any additional personnel that will be required to operate the new equipment.

M. Describe any renovation or new construction that will be necessary for the installation of the replacement equipment and cost.

N. Describe any new annual operating cost associated with this project such as maintenance contracts, salaries of new employees hired due to equipment, etc.

Author:
Statutory Authority:
History: Amended: Filed July 24, 2013; effective August 28, 2013.

III. COST

A. Equipment costs $_____
(Costs have to be supported by price quote on manufacturer's stationery or letterhead.) Cost of equipment only; do not list lease cost.

B. Less trade-in of old equipment $_____

C. Total cost of equipment $_____

Calculation of fee for this determination:
Multiply dollar amount in III.C. (total cost of equipment) times 1% (the application fee for a Certificate of Need); 20% of this amount is the application fee for non-rural hospitals.
For rural hospitals, the application fee is 25% of the application fee as calculated above for non-rural hospitals.

Include manufacturer's literature on old equipment, if available, and on the new equipment.

Include any other information pertinent to the determination.

The Executive Director may request any other information which is relevant to his decision.

IV. CERTIFICATION

I certify that the information provided herein is true and correct and that there is no additional information which would be pertinent to this application which has not been provided. Further, I understand that any misrepresentation on this application or failure to include relevant information may void any favorable determination secured by such misrepresentation or omission.

_____
Signature of Applicant

_____
Applicant's Name and Title
(Type or Print)

Sworn to and subscribed before me this

_____ day of _____, 20 _____.

_____
Notary Public (affix seal on original)

Author:
Statutory Authority
History: **Amended:** Filed July 24, 2013; effective August 28, 2013.

FORM ASC-1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20____

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
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

20-- ANNUAL REPORT FOR AMBULATORY SURGERY CENTERS (ASCs)

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 for 10/1/20-- (MONTH DAY), through 9/30/20-- (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:	

FORM ASC-1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20____

I. OWNERSHIP

_____ Corporation	_____ Non-Profit	_____ Partnership
_____ Individual	_____ Healthcare Authority	_____ LLC
_____ Joint Venture	_____ Government	_____ Other (specify)

_____

II. FACILITIES

A. Total number of operating rooms _____

B. Number of operating rooms for general anesthesia _____

C. Number of beds available for extended recovery (less than 24 hours) _____

D. Total number of operations (cases) _____

E. Total number of procedures performed _____

F. Is this facility a designated separate/organized outpatient surgical unit of a hospital?

_____ YES _____ NO

G. Number of weekdays procedures are routinely performed _____

III. SERVICES PROVIDED

	Number of Operations (cases)	Number of Procedures
General Surgery		
Dentistry		
Dermatology		
Eye, Ear, Nose & Throat		
Gastroenterology		
Gynecology		
Neurosurgery		
Ophthalmology		
Orthopedic		
Pain Management		
Plastic Surgery		
Podiatry		
Urology		
Other (specify) _____		
TOTALS (***note: these totals should equal the totals as reported in Section II)***		

FORM ASC-1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20____

IV. PRINCIPAL SOURCE OF PAYMENT

	Number of Operations (cases)
Self Pay	
Workman's Compensation	
Medicare	
Medicaid	
Tricare	
Blue Cross	
Other Insurance Companies	
No Charge (charity & others)	
Health Maintenance Organization (HMO)	
All Kids	
Other (specify) _____	
TOTALS ***(NOTE: This total should equal the total reported in Section II)***	

V. PATIENT ADMISSION DEMOGRAPHICS

A. ADMISSIONS BY AGE AND GENDER *(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 V-B.***

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20____

B. ADMISSIONS BY RACE *(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 V-A.***

FORM ASC-1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20____

VI. PATIENT ORIGIN BY ZIP CODE (entire reporting period)

Please report, by zip code of residence, the total number of cases treated by this provider. (This total should equal the total reported in Section II-D). This data shall be submitted as a Microsoft Excel (v. 2003 or later) or CSV formatted file, and shall be submitted at the same time as the remainder of this report. The annual report will not be deemed received by the Agency on behalf of the submitting provider unless and until both the PDF document containing the first four pages of the report and the Excel or CSV file containing the data for this section 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 if supplied. Also, please ensure that the Facility ID Number supplied in the first column and the Facility ID Number reported on Page 1 are the same, and are correct.

FacilityIDNumber	PatZipCode	NumberOfPatientCases
999-U9999	99999	9999

Author: Alva M. Lambert
Statutory Authority: §§ 22-4-34 and -35, Code of Alabama, 1975.
History: New Form. Filed: March 18, 2016; effective May 2, 2016. **Filed:** September 19, 2018; effective November 3, 2018.

FORM DM-1
Revised **/20**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, **

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
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

20-- ANNUAL REPORT FOR HOME HEALTH AGENCIES

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 for **October 1, 20--**, through **September 30, 20--** *; 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 provider.

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 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:	_____

FORM DM-1
Revised **/20**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, **

I Agency Operations

Days of week services are regularly available ☐ Monday – Friday ☐ Sunday-Saturday ☐ Other (specify) _____

Days on-call **only** ☐ Weekends ☐ Holidays ☐ Other (specify) _____

II Ownership

_____ Corporation _____ Non-Profit Organization _____ Partnership
_____ Individual _____ Healthcare Authority _____ LLC
_____ Joint Venture _____ Government _____ Other (specify) _____

III Branch Offices

Does the organization of your service include a staffed satellite or branch office?

_____ YES _____ NO

CITY OF LOCATION	OPENED IN LAST 12 MONTHS? YES	OPENED IN LAST 12 MONTHS? NO	DAYS OF WEEK SERVICES AVAILABLE REGULAR SCHEDULE	DAYS OF WEEK SERVICES AVAILABLE ON-CALL ONLY

IV Drop Sites

Has this agency received authorization to operate a drop site? NOTE: A drop site is considered to be a location from which supplies **only** are stored. A drop site may not be staffed, accept referrals, advertise, or operate in any manner as a branch office (CMS S&C-05-07). Drop sites can only be operated in CON approved/exempt counties.

_____ YES _____ NO

CITY OF LOCATION	OPENED IN LAST 12 MONTHS? YES	OPENED IN LAST 12 MONTHS? NO

FORM DM-1
Revised **/20**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, **

V Authorized Service Area

List **all** counties for which your agency and branch offices are approved to provide services, number of visits, and number of persons (unduplicated) served during this reporting period. If no visits were made in an approved county, list "0" for the number of visits and persons served. A contiguous county is not considered to be "authorized" until the home health provider has accepted the first referral and has sent the required notification to SHPDA. A person receiving services during this reporting period should be counted only once, regardless of whether the person was admitted more than once and/or received more than one service. Attach additional sheets as necessary.

COUNTY	VISITS	PERSONS SERVED
TOTALS	*	

****THIS TOTAL MUST EQUAL THE TOTAL VISITS IN SECTION VIII.***

FORM DM-1
Revised **/20**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, **

VI. ADMISSIONS BY SOURCE OF PAYMENT. List below the total number of admissions, broken down by county of residence, for each payment source category during this annual reporting period. Since a patient may be discharged and readmitted several times during an annual reporting period, and payment source may vary for subsequent readmission(s), most agencies will show more admissions than patients served. Attach additional sheets if necessary.

County of Residence	Self-Pay	Workman Comp	Medicare	Medicaid	Tricare	Blue Cross	All Kids	Other Ins.	Charity	HMO	Other**
Category Totals											

TOTAL ADMISSIONS **THIS TOTAL MUST EQUAL THE TOTAL ADMISSIONS IN SECTIONS VII, IX-A, AND IX-B.* *

****Please specify "other" payment source category:** _____

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, **

VII. ADMISSIONS BY REFERRAL SOURCE. While it is acknowledged that all patient services are rendered in accordance with a physician's treatment plan, the entity which **initiates** the patient's entry into the Home Health Care System should be indicated below:

SOURCE	NUMBER OF ADMISSIONS
Physicians	
Hospital	
Nursing Home	
Family or Self	
Department of Human Resources	
Public Health or Agency Nurse	
Other (including Social Service Agencies)	
Specify Other _____	
TOTAL ADMISSIONS	*

****THIS TOTAL MUST EQUAL THE TOTAL ADMISSIONS IN SECTIONS VI, IX-A, AND IX-B.***

VIII. SERVICES OFFERED. List below the total number of services provided, broken down by services provided, for all visits made during this reporting period.

SERVICE	VISITS BY SERVICE
Skilled Nursing Services (RN/LPN)	
Home Health Aide	
Homemaker	
Orderly	
Medical Social Service	
Physical Therapy	
Speech Therapy	
Occupational Therapy	
Medical Equipment	
Other (please specify other service offered): _____	
TOTAL VISITS BY SERVICE	*

****TOTAL MUST EQUAL THE TOTAL VISITS ON PAGE 3, SECTION V.***

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, **

IX. PATIENT ADMISSION DEMOGRAPHICS

A. ADMISSIONS BY AGE AND GENDER *(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 MUST EQUAL THE TOTAL ADMISSIONS IN SECTIONS VI, VII, AND IX-B***

B. ADMISSIONS BY RACE *(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 MUST EQUAL THE TOTAL ADMISSIONS IN SECTIONS VI, VII, AND IX-A***

~~**Author:** Alva M. Lambert~~
~~**Statutory Authority:** §§22-4-34 and -35, Code of Alabama, 1975.~~
~~**History: New Form. Filed:** March 18, 2016; effective May 2, 2016.~~

Author: Alva M. Lambert
Statutory Authority: §§22-4-34 and -35, Code of Alabama, 1975.
History: New Form. **Filed:** March 18, 2016; effective May 2, 2016.

FORM HPCE4
Revised ***

THIS REPORT IS DUE ON OR BEFORE APRIL 15, ****

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
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

ANNUAL REPORT FOR HOSPICE PROVIDERS

SHPDA ID NUMBER
FACILITY NAME

This report is a requirement for maintaining state licensure*

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 _____, through _____; or for partial year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

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 provider.

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

A member of administration separate from the preparer above 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:	_____

FORM HPCE4
Revised ***

THIS REPORT IS DUE ON OR BEFORE APRIL 15, ****

SECTION A: PROGRAM

A1: PROGRAM TYPE

a. Agency Type *(choose one type only)*

_____ Free Standing
_____ Hospital Based
_____ Home Health Based
_____ Nursing Home Based
_____ Other (specify) _____

b. Ownership *(choose one type only)*

_____ Corporation
_____ Non-Profit Organization
_____ Partnership
_____ Individual
_____ Healthcare Authority
_____ LLC
_____ Joint Venture
_____ Government
_____ Other (specify) _____

c. Waiting List for Services

Has this provider had a waiting list for the provision of services at any time during this reporting period?

Home Care Services
_____ **YES** _____ **NO**

Inpatient Care Services
_____ **YES** _____ **NO**

A2: LICENSED INPATIENT FACILITIES

To qualify as an Inpatient Hospice Facility, the following criteria must be met:

a. Consist of one or more beds that are owned or leased (*not contracted*) by the hospice;
b. Be staffed by hospice staff.

Does this provider currently own and operate a CON Authorized Inpatient Hospice?

_____ **YES** _____ **NO**

Number of total CON Authorized Inpatient beds: _____

Free Standing Facility _____ **NUMBER OF BEDS**

Leased Beds within Another Licensed Facility _____ **NUMBER OF BEDS**

THIS REPORT IS DUE ON OR BEFORE APRIL 15, ****

SECTION B: PATIENT VOLUME

For the purpose of gathering statistics for this report, the following definitions apply:

(Refer to Instructions for additional information and examples)

In-Home Hospice Care:	Routine level of care, regardless of the location in which it was provided; and continuous care days provided whether or not billed separately.
Contractual Inpatient Care	General Inpatient and Inpatient Respite levels of care provided by any CON-Authorized hospice provider which does not also own and operate a CON-Authorized inpatient facility; or inpatient care provided by a CON-Authorized Inpatient Hospice in a location other than the inpatient facility owned and operated by the provider.
Inpatient Hospice Care:	General Inpatient or Respite care provided in a CON Authorized Inpatient Hospice Facility for patients of the Inpatient Hospice or In-Home Hospice **under common ownership.** Inpatient Hospice care provided by the owner of the CON Authorized Inpatient Hospice in ANY location other than the CON Authorized Inpatient Hospice should be reported as Contractual Inpatient Care.

Please note that, for the purposes of this report, only patients whose legal residence is in the state of Alabama should be reported.

B1: PATIENTS SERVED

	Agency Totals
a. Total New (Unduplicated) Admissions	
b. Re-Admissions (Duplicated Admissions) from Prior Years	
c. Total (Unduplicated) Admissions during this Reporting Period (sum of a. and b.)	
d. Re-Admissions (Duplicated Admissions) from current reporting year (Initial admission of patient was counted in B1a)	
e. Total Admissions (sum of c. and d.)	
f. Total Carryovers (patients were in hospice care on both 12/31 and 1/1)	
g. Total Unduplicated Patients Served During Reporting Period (sum of c. and f.)	

Explanation of B1a through B1d

a. Brand new patients, admitted for 1st time to agency during reporting year.
b. Patients readmitted during reporting year, but initial admission was NOT in reporting year.
c. Total number of patients admitted during reporting period.
d. Patients readmitted during reporting year and initial admission was during reporting year.

FORM HPCE4
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THIS REPORT IS DUE ON OR BEFORE APRIL 15, ****

B2: TOTAL ADMISSIONS BY RACE

RACE	ADMISSIONS (B1e.)
a. White/Caucasian	
b. Black/African American/Negro	
c. Hispanic/Spanish/Latino	
d. Asian	
e. American Indian/Alaskan Native	
f. Pacific Islander	
g. India	
h. Middle Eastern	
i. Other	
TOTAL ADMISSIONS	

B3: TOTAL ADMISSIONS BY AGE AND GENDER

AGE GROUPS	MALE	FEMALE	TOTAL (B1e.)
18 and under			
19 – 34			
35 – 54			
55 – 64			
65 – 74			
75 – 84			
85 years and older			
TOTAL ADMISSIONS			

B4: DEATHS/DISCHARGES

	Agency Totals
a. Total Deaths	
b. Total Live Discharges/Revocations/Transfers	
c. Total Deaths/Live Discharges/Revocations/Transfers	
d. Total <u>Patient Days</u> of service for ALL Deaths/Discharges (patients counted in a. and b.) during reporting period.	

FORM HPCE4
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THIS REPORT IS DUE ON OR BEFORE APRIL 15, ****

SECTION C: PATIENT DAYS

C1: PATIENT DAYS BY LEVEL OF CARE

IN-HOME PATIENT DAYS (Section B definition)	AGENCY TOTALS
a. Routine Home Care Days	
b. Continuous Care Days Billed	
c. Total In-Home Patient Days	
CONTRACTUAL INPATIENT DAYS (Section B definition)	
d. General Inpatient Days	
e. General Respite Days	
f. Total Contractual Inpatient Days	
INPATIENT HOSPICE DAYS (Section B definition)	
g. General Inpatient Days	
h. Inpatient Respite Days	
i. Total Inpatient Hospice Days	
j. TOTAL PATIENT CARE DAYS	
IN-HOME HOSPICE CARE ONLY	
k. Routine Hospice Care Days provided in a Skilled Nursing Facility (SNF)	
l. Total Percentage of In-Home Hospice Care Days provided in a Skilled Nursing Facility (SNF)	

Hospice Rules of the Alabama State Board of Health

Alabama Department of Public Health Administrative Rule 420-5-17-.03(1)(c)(8) states: Any person licensed to provide a hospice care program shall establish a written interdisciplinary plan of care for each hospice patient and family that provides care in individual's homes and provides or coordinates care on an inpatient basis. Not more than 50% of the home care days shall be provided to residents of nursing homes.

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C2: PATIENT DAYS BY REIMBURSEMENT SOURCE

SOURCE OF REIMBURSEMENT	PATIENT DAYS
Medicare	
Medicaid	
Private Insurance	
Private Pay	
Charity	
TOTALS (Must equal C1j. Total)	

For purposes of accounting, does this facility combine charity care and private pay information together as one group?

_____ YES _____ NO

C3: PATIENT DAYS BY DIAGNOSIS

DIAGNOSIS	PATIENT DAYS
Cancer	
Cardiopulmonary	
Alzheimer's Disease and/or Dementia	
All Other	
TOTALS (Must equal C1j. Total)	

THIS REPORT IS DUE ON OR BEFORE APRIL 15, ****

SECTION D: PATIENT LOCATION

D1: COUNTY OF RESIDENCE

Complete as many pages as necessary to report ALL counties for which CON Authorization is held by this provider (common CON Authorization or single CON Authorization reporting under a common Medicare Provider number). For those counties with no patients served during the reporting period, enter "0's" for requested demographics. Report only those admissions occurring in Alabama; do NOT include out of state admissions. *General Inpatient and Respite care is to be reported based on patient's county of residence, not location of care.*

COUNTY	NUMBER OF DEATHS	NUMBER OF LIVE DISCHARGES	PATIENT DAYS	NUMBER OF PATIENTS SERVED
TOTALS				
	Final totals must equal B4a.	**Final totals must equal B4b.**	**Final totals must equal C1j.**	**Final totals must equal B1g.**

☐ **FOR CON-AUTHORIZED INPATIENT FACILITIES ONLY:** In-Home services were not provided to patients residing in any county reported in this section, for which this provider does not possess CON Authority to provide In-Home services.

THIS REPORT IS DUE ON OR BEFORE APRIL 15, ****

SECTION D: PATIENT LOCATION (cont'd)

D1: COUNTY OF RESIDENCE

COUNTY	NUMBER OF DEATHS	NUMBER OF LIVE DISCHARGES	PATIENT DAYS	NUMBER OF PATIENTS SERVED
TOTALS FROM PREVIOUS PAGE				
TOTALS				
	Final totals must equal B4a.	Final totals must equal B4b.	Final totals must equal C1j.	Final totals must equal B1g.

FORM HPCE4
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THIS REPORT IS DUE ON OR BEFORE APRIL 15, ****

SECTION D: PATIENT LOCATION (cont'd)

D1: COUNTY OF RESIDENCE

COUNTY	NUMBER OF DEATHS	NUMBER OF LIVE DISCHARGES	PATIENT DAYS	NUMBER OF PATIENTS SERVED
TOTALS FROM PREVIOUS PAGE				
TOTALS				
	Final totals must equal B4a.	Final totals must equal B4b.	Final totals must equal C1j.	Final totals must equal B1g.

THIS REPORT IS DUE ON OR BEFORE APRIL 15, ****

SECTION E: AGENCY INFORMATION

E1: VOLUNTEER SERVICES

Average annual percentage of patient care hours provided by volunteers (as reported to CMS) for all providers reporting under the Medicare Provider Number of this provider (including a CON Authorized inpatient facility if applicable), or the parent provider if satellite offices are included in this reporting (common CON Authorization).

_____ %

E2: LENGTH OF SERVICE

LENGTH OF SERVICE	AGENCY TOTALS
Average Length of Service (ALOS)	
Median Length of Service (MLOS)	
Number of Days in Reporting Period	
Average Daily Census	

***Make and keep a copy of the completed report for the provider's records before submitting to SHPDA.

This report should be submitted to SHPDA only one time. ***The preferred method is electronic submission*** to data.submit@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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THIS REPORT IS DUE ON OR BEFORE APRIL 15, ****

List <u>ALL</u> satellite providers for which CON Authorization is held by this provider (common CON Authorization or single CON Authorization reporting under a common Medicare Provider number), for which information is included in this report; and from which services were provided at any time during the reporting period.

SATELLITE HOSPICE PROVIDER	COUNTY	OPERATIONAL ENTIRE REPORTING PERIOD YES	OPERATIONAL ENTIRE REPORTING PERIOD NO	NUMBER OF DAYS OPERATIONAL IF INITIALLY LICENSED/CLOSED DURING REPORTING PERIOD
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

FORM HPCE4
Revised ***

THIS REPORT IS DUE ON OR BEFORE APRIL 15, ****

Hospice Annual Report Checklist

	TOTALS
PATIENT DAYS	
Page 5, Section C1j.	
Patient Days throughout report must equal days reported directly above	
Page 6, Section C2	
Page 6, Section C3	
Page 7, Section D1	
ADMISSIONS	
Page 3, Section B1e.	
Admissions throughout report must equal Admissions reported directly above	
Page 4, Section B2	
Page 4, Section B3	
UNDUPLICATED PATIENTS SERVED	
Page 3, Section B1g.	
Unduplicated Patients Served throughout report must equal Unduplicated Patients Served reported directly above	
Page 7, Section D1	
DEATHS	
Page 4, Section B4a.	
Deaths throughout report must equal Deaths reported directly above	
Page 7, Section D1	
LIVE DISCHARGES/REVOCATIONS/TRANSFERS	
Page 4, Section B4b.	
Live Discharges/Revocations/Transfers throughout report must equal Deaths reported directly above	
Page 7, Section D1	

~~**Author:** Alva M. Lambert~~
~~**Statutory Authority:** §§ 22-4-34 and -35, Code of Alabama, 1975~~
~~**History: New Form. Filed:** March 18, 2016; effective May 2, 2016.~~

Author: Alva M. Lambert
Statutory Authority: §§ 22-4-34 and -35, Code of Alabama, 1975
History: New Form. Filed: March 18, 2016; effective May 2, 2016.

FORM BHD 134A
REVISED **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20**

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
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

20-- ANNUAL REPORT FOR HOSPITALS AND RELATED FACILITIES

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 10/1/20-- (MONTH DAY), through 9/30/20-- (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:	

FORM BHD 134A
REVISED **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20**

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	_____
2. Number of **staffed and operational beds** on last day of reporting period	_____
3. Number of CON-authorized **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	_____

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20**

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)		
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				

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THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20**

	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)

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

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, ****

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					
Adult					
Geriatric					
TOTALS					

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 –** ***PPS-EXCLUDED***					
3.	**Burn Unit**					

FORM BHD 134A
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, ****

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			
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

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)			
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

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20**

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

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).

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Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, ****

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 (Including PTCA, directional coronary atherectomy, rotational atherectomy and similar complex therapeutic procedures)						
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: _____

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

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, ****

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

FORM BHD 134A
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, ****

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.***

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, ****

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.

FORM BHD 134A
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, ****

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	
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	
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	
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	
Patient Days	
Page 2, Section I-B-5.	
Page 3, Section I-C	
Patient Days in Section I-C must equal Patient Days reported in Section I-B	
Page 4, Section II-A	
Page 4, Section II-B	
Page 5, Section II-C	
Page 5, Section II-D	
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	
Discharges	
Page 2, Section I-B-6.	
Page 3, Section I-C	
Discharges in Section I-C must equal Discharges reported in Section I-B	
Page 4, Section II-A	
Page 4, Section II-B	
Page 5, Section II-C	
Page 5, Section II-D	
Discharges in Sections II-A+II-B+II-C+II-D must equal Discharges reported in Section I-B	
TOTAL DISCHARGES SECTION II	

FORM BHD 134A
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, ****

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

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**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, ****

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**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, ****

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)

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, ****

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**

FORM BHD 134A
Revised **/**

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, ****

FY ****
HOSPITAL PATIENT ORIGIN SURVEY CLOSEOUT RECORD

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

Hospital Name _____

Hospital ID # _____

Name of Person Responsible: _____

Title _____

Telephone Number _____

Version of **DRG** Codes: _____

~~**Author:** Alva M. Lambert~~
~~**Statutory Authority:** §§22-4-34 and -35, Code of Alabama, 1975.~~
~~**History:** **New Form. Filed:** March 18, 2016; effective May 2, 2016. **Amended: Filed:** September 19, 2018; effective November 3, 2018.~~

Author: Alva M. Lambert
Statutory Authority: §§22-4-34 and -35, Code of Alabama, 1975.
History: New Form. Filed: March 18, 2016; effective May 2, 2016. **Amended: Filed:** September 19, 2018; effective November 3, 2018.

FORM SNH-F1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE AUGUST 15, **

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
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

20-- ANNUAL REPORT FOR SKILLED NURSING FACILITIES

SHPDA ID NUMBER
FACILITY NAME

Pencil submissions of this report will not be accepted. This report should be completed and submitted electronically. All dark gray 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 July 1, 20--, through June 30, 20--*; or for **partial** year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

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 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:	

FORM SNH-F1
Revised **/****

THIS REPORT IS DUE ON OR BEFORE AUGUST 15, ****

OWNERSHIP (check one)

_____ Corporation	_____ Non-Profit Organization	_____ Partnership
_____ Individual	_____ Healthcare Authority	_____ LLC
_____ Joint Venture	_____ Government	_____ Other (specify) _____

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

Management Firm: _____
Name

_____
Base Address City State Zip

I. FACILITIES

a. Total beds **licensed** by the Alabama Department of Public Health _____

b. Number of beds certified for Medicare patients (**NOTE**: Medicaid patients ***ARE ALLOWED*** to reside in Medicare beds) _____

c. Number of beds certified for Medicaid patients _____

d. Was this facility licensed for the number of beds indicated in item I-a for the entire reporting period? **YES** _____ **NO** _____

e. If "No" was answered in item (e), indicate the number of licensed beds and the number of days those beds were licensed. **BEDS** _____ **DAYS** _____

f. Additional licensed beds and the number of days those beds were licensed **BEDS** _____ **DAYS** _____

II. ADMISSIONS *(REFER TO PAGE 2 OF INSTRUCTIONS FOR CORRECT COMPUTATION METHODS FOR ADMISSIONS, READMISSIONS, DISCHARGES, AND TRANSFERS)*

A. TOTAL ADMISSIONS FOR THE REPORTING PERIOD _____

B. ADMISSIONS BY SOURCE OF PAYMENT:

Private Pay _____
Workman's Compensation _____
Medicare _____
Medicaid _____
Tricare _____
Blue Cross (**not Long Term Care Insurance)** _____
Other Insurance Companies (**not Long Term Care Insurance)** _____
No Charge (charity & other) _____
Hospice _____
Long Term Care Insurance _____
Other (specify) _____ _____

THIS REPORT IS DUE ON OR BEFORE AUGUST 15, **

III. DEMOGRAPHICS

A. TOTAL ADMISSIONS BY RACE *FOR THE ENTIRE REPORTING PERIOD*
(Total must agree with the totals provided in Sections II-A and III-B.) _____

1. White/Caucasian _____
2. Black/African American/Negro _____
3. Hispanic/Spanish/Latino _____
4. Asian _____
5. American Indian/Alaskan Native _____
6. Pacific Islander _____
7. India _____
8. Middle Eastern _____
9. Other (specify) _____ _____

B. TOTAL ADMISSIONS BY AGE AND GENDER *FOR THE ENTIRE REPORTING PERIOD*
(Total must agree with the totals provided in Section II and Section III-A.)

AGE GROUPS	MALE	FEMALE	TOTALS
18 & under			
19 – 34 Years			
35 – 54 Years			
55 – 64 Years			
65 – 74 Years			
75 – 84 Years			
85 Years and Older			
TOTALS			

IV. DISCHARGES (*REFER TO PAGE 2 OF INSTRUCTIONS FOR CORRECT COMPUTATION METHODS FOR ADMISSIONS, READMISSIONS, DISCHARGES, AND TRANSFERS)*

Total discharges (including deaths) _____

THIS REPORT IS DUE ON OR BEFORE AUGUST 15, ****

V. RESIDENT DAYS

(This information is to be provided for the number of individuals in residence during the reporting period.)

	OCCUPIED RESIDENT DAYS	BED HOLDING DAYS	TOTAL RESIDENT DAYS
Private Pay			
Workman's Compensation			
Medicare			
Medicaid			
Tricare			
Blue Cross **(not long term care insurance)**			
Other Insurance Companies **(not long term care insurance)**			
No Charge (charity & other)			
Hospice			
Long Term Care Insurance			
Other (specify) _____			
TOTALS			

VI. HOSPICE

A. Total hospice service days (regardless of payer source): _____

B. Number of hospice discharges:

1. Deaths _____

2. Home _____

3. Hospital _____

C. Number of hospice provider contracts: _____

D. Dedicated hospice unit? _____ **YES** _____ **NO**

E. (If Yes) Number of beds in dedicated hospice unit: _____

FORM SNH-F1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE AUGUST 15, **

***Make and keep a copy of the completed report for the provider's records before submitting to SHPDA.

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

~~**Author:** Alva M. Lambert~~
~~**Statutory Authority:** §§22-4-34 and -35, Code of Alabama, 1975.~~
~~**History:** **New** **Form.** **Filed:** March 18, 2016; effective May 2, 2016.~~

Author: Alva M. Lambert
Statutory Authority: §§22-4-34 and -35, Code of Alabama, 1975.
History: New Form. Filed: March 18, 2016; effective May 2,2016.

FORM SCALF-1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 20**

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
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

20** ANNUAL REPORT FOR SPECIALTY CARE ASSISTED LIVING FACILITIES

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 for March 1, 20--, through February 2*, 20--; 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 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:	

FORM SCALF-1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 20**

I. OWNERSHIP

_____ Corporation _____ Non-Profit Organization _____ Partnership

_____ Individual _____ Healthcare Authority _____ LLC

_____ Joint Venture _____ Government _____ Other (specify)

_____

II. MANAGEMENT

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

Management Firm: _____

Name

_____

Base Address City State Zip

III. FACILITIES

Total number of licensed beds: _____

IV. ADMISSIONS

Total admissions for the reporting period: _____

Admissions by source of payment:

Private Pay _____

Other (specify) _____ _____

V. DISCHARGES

Total discharges (include deaths) _____

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 20**

VI. DEMOGRAPHICS

A. TOTAL ADMISSIONS BY RACE *FOR THE ENTIRE REPORTING PERIOD*
(Total must agree with the totals provided in Section IV and Section VI-B.)

a.	White/Caucasian	
b.	Black/African American/Negro	
c.	Hispanic/Spanish/Latino	
d.	Asian	
e.	American Indian/Alaskan Native	
f.	Pacific Islander	
g.	India	
h.	Middle Eastern	
i.	Other (specify) _____	
	TOTAL	

B. TOTAL ADMISSIONS BY AGE AND GENDER *FOR THE ENTIRE REPORTING PERIOD* **(Total must agree with the totals provided in Section IV and Section VI-A.)**

AGE GROUPS	**MALE**	**FEMALE**	**TOTALS**
18 & under			
19 – 34 Years			
35 – 54 Years			
55 – 64 Years			
65 – 74 Years			
75 – 84 Years			
85 Years and Older			
TOTALS			

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 20**

VII. RESIDENT DAYS

1. **Number of licensed beds**
   (Section III of this report) _____ **x 365**

2. Multiply line 1 by 365 for total available days = _____

3. **Total number of days beds were unoccupied** due to vacancies, discharges and deaths (also include 365 days for each bed that is licensed but not set up for use in this facility) _____

4. **TOTAL RESIDENT DAYS** (subtract line 3 from line 2) _____

~~*******Make and keep a copy of the completed report for the facility's records before submitting to SHPDA.~~

~~This report should be submitted to SHPDA only one time. ***The preferred method is electronic submission to*** **data.submit@shpda.alabama.gov**. If submitted electronically please do not also submit via hard copy unless specifically requested to do so by SHPDA staff.~~

~~**Author:** Alva M. Lambert~~
~~**Statutory Authority:** §§ 22-4-34 and -35, Code of Alabama, 1975~~
~~**History: New Rule. Filed:** March 18, 2016; effective May 2, 2016.~~

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 20**

VIII. PATIENT ORIGIN BY ZIP CODE

Please report, by zip code of patient's residence, the total number of admissions to this provider during the reporting period. (This total should equal the totals reported in Sections IV, VI-A and VI-B) (Make additional copies of this page and attach as required)

ZIP CODE OF RESIDENCE	TOTAL NUMBER OF ADMISSIONS

FORM SCALF-1
Revised **/**

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 20**

*****Make and keep a copy of the completed report for the facility's records before submitting to SHPDA.

Pursuant to Ala. Admin. Code r 410-1-3-.09, all Mandatory Reports shall be submitted electronically [via email] to data.submit@shpda.alabama.gov.

Author: Alva M. Lambert
Statutory Authority: §§ 22-4-34 and -35, Code of Alabama, 1975
History: New Rule. Filed: March 18, 2016; effective May 2, 2016. Amended: _____; effective _____.

NOTICE OF CHANGE OF OWNERSHIP/CONTROL

The following notification of intent is provided pursuant to all applicable provisions of ALA. CODE § 22-21-270 (1975 as amended) and ALA. ADMIN. CODE r. 410-1-7-.04. This notice must be filed at least twenty (20) days prior to the transaction.

___ Change in Direct Ownership or Control (of a vested Facility; ALA. CODE §§ 22-20-271(d), (e))
___ Change in Certificate of Need Holder (ALA. CODE § 22-20-271(f))
___ Change in Facility Management (Facility Operator)
Any transaction other than those above-described requires an application for a Certificate of Need.

Part I: Facility Information

SHPDA ID Number: _____
(This can be found at www.shpda.alabama.gov, Health Care Data, ID Codes)

Name of Facility/Provider: _____
(ADPH Licensure Name)

Physical Address: _____

_____

County of Location: _____

Number of Beds/ESRD Stations: _____

CON Authorized Service Area (Home Health and Hospice Providers Only). Attach additional pages if necessary. _____
_____.

Part II: Current Authority (Note: If this transaction will result in a change in direct ownership or control, as defined under ALA. CODE § 22-20-271(e), please attach organizational charts outlining current and proposed structures.)

Owner (Entity Name) of
Facility named in Part I: _____

Mailing Address: _____

_____

Operator (Entity Name): _____

Part III: Acquiring Entity Information

Name of Entity: _____

Mailing Address: _____

_____

Operator (Entity Name): _____

Proposed Date of Transaction is on or after: _____

Part IV: Terms of Purchase

Monetary Value of Purchase: $ _____

Type of Beds: _____

Number of Beds/ESRD Stations: _____

Financial Scope: to Include Preliminary Estimate of the Cost Broken Down by Equipment, Construction, and Yearly Operating Cost:

Projected Equipment Cost: $ _____

Projected Construction Cost: $ _____

Projected Yearly Operating Cost: $ _____

Projected Total Cost: $ _____

On an Attached Sheet Please Address the Following:

1.) The services to be offered by the proposal (the applicant will state whether he has previously offered the service, whether the service is an extension of a presently offered service, or whether the service is a new service).

2.) Whether the proposal will include the addition of any new beds.

3.) Whether the proposal will involve the conversion of beds.

4.) Whether the assets and stock (if any) will be acquired.

Part V: Certification of Information

Current Authority Signature(s):

The information contained in this notification is true and correct to the best of my knowledge and belief.

Owner(s): _____ _____

Operator(s): _____ _____

Title/Date: _____ _____

SWORN to and subscribed before me, this _____ day of _____, _____.

(Seal) _____
Notary Public

My Commission Expires: _____

Acquiring Authority Signature(s):

I agree to be responsible for reporting of all services provided during the current annual reporting period, as specified in ALA. ADMIN. CODE r. 410-1-3-.12. The information contained in this notification is true and correct to the best of my knowledge and belief.

Purchaser(s): _____ _____

Operator(s): _____ _____

Title/Date: _____ _____

SWORN to and subscribed before me, this _____ day of _____, _____.

(Seal) _____
Notary Public

My Commission Expires: _____

~~**Author:** Alva M. Lambert~~
~~**Statutory Authority:** § 22-21-271(e), Code of Alabama, 1975 **History: New Form:** Filed August 23, 2016; effective October 7, 2016.~~

Author: Alva M. Lambert
Statutory Authority: § 22-21-271(c), Code of Alabama, 1975
History: New Form: Filed August 23, 2016; effective October 7, 2016.