CERTIFICATION OF ADMINISTRATIVE RULES
FILED WITH THE LEGISLATIVE SERVICES AGENCY
OTHNI LATHRAM, DIRECTOR

(Pursuant to <u>Code of Alabama 1975</u>, §41-22-6, as amended).

I certify that the attached is/are correct copy/copies of rule/s as promulgated and adopted on the **19th** day of **September**, 20**18**, and filed with the agency secretary on the **19th** day of **September**, 20**18**.

AGENCY NAME: **State Health Planning and Development Agency**
　　　　　　　　(Certificate of Need Review Board, "CONRB")
　X　Amendment ＿＿＿＿＿New ＿＿＿＿＿Repeal (Mark appropriate space)

Rule No. **410-1, Pages 1 through 18**
(If amended rule, give specific paragraph, subparagraphs, etc., being amended)

Rule Title: **Appendix, Annual Report for Hospitals and Related Facilities**

ACTION TAKEN: State whether the rule was adopted <u>with or without</u> changes from the proposal due to written or oral comments:

Additional changes were made to page 12 from the proposed amendment as published for comment in the Alabama Administrative Monthly, clarifying that completed forms must be submitted online through the Agency's website at data.submit@shpda.alabama.gov.

NOTICE OF INTENDED ACTION PUBLISHED IN VOLUME **XXXVI**,
ISSUE NO. **10**, AAM, DATED **July 31**, 20**18**.

Statutory Rulemaking Authority: **Code of Alabama §§ 22-4-34 and -35.**

(Date Filed)
(For LRS Use Only)

Alva M. Lambert
Certifying Officer or his or her
Deputy

(NOTE: In accordance with §41-22-6(b), as amended, a proposed rule is required to be certified within 90 days after completion of the notice.

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: _____ _____ **AL** _____
                      STREET ADDRESS   CITY   ZIP

**County of
Location:** _____

Facility Telephone: _____   **Facility Fax:** _____
                        (AREA CODE) & TELEPHONE NUMBER   (AREA CODE) & TELEPHONE NUMBER

This reporting period is   __10/1/20--__ , through   __9/30/20--__ ;   or for **partial** year of operation beginning

_____ and ending _____ a period of _____ days.
MONTH   DAY   MONTH   DAY

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

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│ *We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this facility.* │
│   │
│ _____   _____   _____   │
│ PRINTED NAME OF PREPARER   SIGNATURE OF PREPARER   DATE   │
│   │
│ _____   _____   _____   │
│ DIRECT TELEPHONE NUMBER   TITLE OF PREPARER   E-MAIL ADDRESS   │
│   │
│ *A member of administration __MUST__ also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above; and __must be separate from the preparer__.* │
│   │
│ _____   _____   _____   │
│ PRINTED NAME OF ADMINISTRATION OFFICIAL   SIGNATURE OF ADMINISTRATION OFFICIAL   DATE   │
│   │
│ _____   _____   _____   │
│ DIRECT TELEPHONE NUMBER   TITLE OF ADMINISTRATION OFFICIAL   E-MAIL ADDRESS   │
└──┘

┌──┐
│   FOR OFFICE USE ONLY   │
│ Facility Verified: _____   Initial Scan: _____   Completed: _____ │
│ Entered: _____   Final Scan: _____   Audited: _____   │
└──┘

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				

	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				

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					

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│ THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20____ │
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E. **OBSTETRICS & NURSERY** (do not include newborn data in other sections)

	Number of Rooms	Total Number of Live Births	Total Number of Fetal Deaths
Delivery Rooms/LDR/Obstetrical Recovery	_____	_____	_____
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).

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20

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

IV.   OUTPATIENT SURGERY

A. PATIENT ORIGIN BY ZIP CODE

Please report, by zip code of residence, the total number of outpatient surgery persons (cases) treated by this provider during the reporting period. (This total should equal the totals reported in Section II-F-1-e on page 6). Any outpatient surgeries reported in Section II-F-2 should also be reported in this section. This data shall be submitted as a Microsoft Excel (v. 2003 or later) or CSV formatted file with the remainder of this report. The annual report will not be deemed received by the Agency on behalf of the submitting provider until the utilization portion (the remainder of this PDF document), this Excel or CSV file, AND the Patient Origin file (referenced on pages 14 – 18) are received.

The submitted file should contain the column headers and data formatting shown in the example provided below. Please submit only a 5-digit zip code, not the full 9-digit zip code. Also, please ensure that the Facility ID Number entered in the first column and the Facility ID Number reported on Page 1 are the same, and are correct.

Facility ID	Out Pt Surg_Zip Code	Out Pt Surg_Persons
123-4567890	99999	9999

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20

B. PERSONS (CASES) BY AGE AND GENDER – Only report outpatient surgery cases in this section for the entire reporting period

	MALE	FEMALE	TOTAL
18 & under			
19 – 34 years of age			
35 – 54 years of age			
55 – 64 years of age			
65 – 74 years of age			
75 – 84 years of age			
85 years and older			
TOTALS			*

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

C. PERSONS (CASES) BY RACE – Only report outpatient surgery cases in this section for the entire reporting period

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

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

V. HOSPICE SERVICES

1. Are in-home hospice services provided by this facility or by a separate entity under common ownership with this facility?

   _____   _____
   YES   NO

2. Has a Letter of Non-Reviewability been issued by SHPDA to this facility to provide inpatient hospice services through rural exemption?

   _____   _____
   YES   NO

3. Does this facility have **contracts** with hospice providers to provide respite and/or inpatient hospice services as needed?

   _____   _____
   YES   NO

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

   _____

5. Does this facility have any beds **dedicated only** for use by hospice providers for the provision of respite and/or inpatient hospice services, but for which the facility still maintains bed licensure?

   _____   _____
   YES   NO

6. If yes, how many beds are **dedicated** for this service?

   _____

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

Pursuant to ALA. ADMIN. CODE r 410-1-3-.09, all Mandatory Reports shall be submitted electronically [via e-mail] to data.submit@shpda.alabama.gov.

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20

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

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, 20

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, 20

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:		2
	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	
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, 20

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

THIS REPORT IS DUE ON OR BEFORE DECEMBER 15, 20

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 Rule. Filed: March 18, 2016; effective May 2, 2016. Filed: September 19, 2018; effective November 3, 2018.