STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
ALABAMA STATE HEALTH PLAN
2014-2017
ADMINISTRATIVE CODE

CHAPTER 410-2-4
FACILITIES

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410-2-4-.01 Introduction. This chapter focuses on existing health care facilities and the need for additional facilities. Methodologies for many facilities, i.e., general hospitals, nursing homes, specialty care assisted living facilities, rehabilitation, psychiatric and substance abuse, are specific in nature and project a finite number of beds needed. Swing beds, Long Term Acute Care Hospital beds, and Critical Care Access Hospital beds are allowed for hospitals, which meet the criteria as specified in the appropriate Federal Directive. The home health methodology allows at least two active providers for each county and is based on upon a minimum level of utilization. Located in the assisted living section is a methodology for standard assisted living facilities however, this is only a recommendation as these facilities are not covered under the

Certificate of Need requirements. The bed need projections contained in the adult day care sections are recommendations only and are not intended to be regulatory unless these facilities become regulated by the Certificate of Need requirements.
Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective May 18, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2 2014; effective January 6, 2015.

410-2-4-.02 Acute Care (Hospitals).

(1) Introduction. In this section, the methodology for computing acute care bed need will be described, criteria for making adjustments to the computed bed need will be discussed, and bed need for 2002, based on the methodology, will be presented.

(a) Definition: Hospital

1. Defined as printed in Rules of Alabama State Board of Health Division of Licensure and Certification Chapter 420-5-7 (effective September 26, 1990)

2. "Hospital" means a health institution planned, organized and maintained for offering to the public generally facilities and beds for use in the diagnosis and/or treatment of illness, disease, injury, deformity, infirmity, abnormality, or pregnancy, when the institution offers such care or service for not less than twenty-four (24) consecutive hours in any week to two (2) or more individuals not related by blood or marriage to the owner and/or administrator. In addition, the hospital may provide for the education of patients, medical and health personnel, as well as conduct research programs to promote progress and efficiency in clinical and administrative medicine.

(2) Purpose

(a) The purpose of the bed need methodology is to identify the number of acute general hospital beds, which will be needed at least three years into the future to assure the continued availability of quality hospital, care for residents of the state of Alabama. Such number, as identified later in this section, shall be the basis for statewide health planning and certificate of need approval, except:

1. in circumstances that pose a threat to public health, and/or

2. when the SHCC makes an adjustment based on criteria specified later in this section.

(b) All Alabama's Acute Care Hospitals, which are covered by this methodology.

(3) Methodology

(a) The planning area used in this methodology is the county, except for Choctaw, Cleburne, Coosa, Henry, Lamar, Lowndes, Macon, and Perry, which are grouped with Marengo, Calhoun, Tallapoosa, Houston, Fayette, Montgomery, and Lee, respectively. There are no hospitals in Choctaw, Cleburne, Coosa, Henry, Lamar, Lowndes, Macon, or Perry counties; therefore, each of these counties is grouped with a contiguous county where the majority of its population seeks hospitalization. Russell County had a hospital, which closed on April 1, 2002; however, a CON was issued January 30, 2003 for a new hospital to be constructed.

(b) The methodology involves:

applying recent utilization data
to
projected population
and
using desired occupancy rates
to
determine needed beds.

(c) Hospital annual reports (Form BHD 134-A) for the past three years, are used in computing a three-year weighted average daily census (ADC) to provide the utilization measure. The weighted average emphasizes the most current census levels while taking into consideration census for the previous two years.

(d) Desired occupancy rates for each of eight service categories are those which were established under the National Guidelines for Health Planning. These are:

Medical/Surgical (M/S)	80%
M/S in Small Hospitals (under 4,000 total admissions/yr.)	75%
Obstetrics	75%

Pediatrics	
0-39 beds	65%
40-79 beds	70%
80 or more beds	75%
ICU-CCU	65%
Other	75%

(e) Computations by Service Category

1. Compute Average Daily Census (ADC) for each of last three years.

$$\text{ADC} = \frac{\text{Patient Days in Service Category}}{\text{Days Operational in Year; Normally 365}}$$

2. Compute Weighted Average ADC (Weighted ADC).

$$\frac{(\text{Current Year minus 2 Years ADC} \times 1) + (\text{Previous Year ADC} \times 2) + (\text{Current Year ADC} \times 3)}{6}$$

3. Compute Projected ADC.

$$\text{Projected ADC} = \text{Weighted ADC} \times \frac{\text{3 Years above Current Year Projected Population}}{\text{Current Year Population}}$$

4. Compute Projected Beds Needed.

$$\text{Beds Needed} = \frac{\text{Projected ADC in Service Category}}{\text{Desired Occupancy Rate for Service Category}}$$

(f) Summation Across Service Categories

1. Compute Total Beds Needed

Beds Needed = Medical/Surgical Beds Needed
+ Obstetrical Beds Needed
+ Pediatric Beds Needed
+ ICU-CCU Beds Needed
+ Other Beds Needed

2. Compute Net Beds Needed or Excess

Net Beds Needed (Excess) = Beds Needed - Existing Beds

3. Beds currently existing, under construction, and approved for construction are assumed to be existing beds in determining excess beds or additional beds needed.

(4) Criteria for Plan Adjustments

(a) The SHCC may make adjustments to the needed beds determined by the methodology described above if evidence is introduced to the SHCC in each of the criteria, which follow, the exception to this is section 410-2-4-.02(5):

1. Evidence that residents of an area do not have access to necessary health services. Accessibility refers to the individual's ability to make use of available health resources. Problems which might affect access include persons living more than 30 minutes travel time from a hospital, the lack of health manpower in some counties, and individuals being without the financial resources to obtain access to healthcare facilities; and

2. Evidence that a plan adjustment would result in health care services being rendered in a more cost-effective manner. The SHCC, by adopting the bed need methodology herein, has decided that beds in excess of the number computed to be needed are not cost-effective. Therefore, the burden of proof that a plan adjustment would satisfy this criteria rests with the party seeking that adjustment; and

3. Evidence that a plan adjustment would result in improvements in the quality of health care delivered to residents of an area. Many organizations, including the Division of Licensure and Certification within the Alabama Department of Public Health, the Professional Review Organization for the State, the Joint Commission on Accreditation of Health Care, and major third-party payers, continually address the issue of the quality of hospital care. Evidence of substandard care in existing hospital(s) within a county and/or evidence that additional hospital beds would enhance quality in a cost-effective way could partially justify a plan adjustment.

(a) In applying these three plan adjustment criteria, special consideration should be given to requests from hospitals which have experienced average hospital-wide occupancy rates in excess of 80% for the most recent two-year period. It is presumed that the patients, physicians, and health plans using a hospital experiencing high occupancy rates have rendered positive judgments concerning the accessibility, cost-effectiveness, and/or quality of care of that hospital. Thus, the 80% occupancy standard adds a market-based element of validity to other evidence, which might be given in support of a plan adjustment for an area.

(b) Numbers of beds do not always reflect the adequacy of the programs available within hospitals. In applying the three plan adjustment criteria to specific services, consideration should be given to the adequacy of both numbers of beds and programs offered in meeting patient needs in a particular county.

(5) Bed Availability Assurance for Acute Care (Hospitals)

(a) In some parts of Alabama, existing acute care hospitals are experiencing inpatient census levels not seen since the 1970's and the expectation is these census levels will only increase. Typically, these existing acute care hospitals are located in counties having significant population growth and/or hospitals with broad geographical service areas/statewide missions. These existing acute care hospitals are experiencing a shortage of acute care beds due to population growth and other demographic factors such as the aging baby boomers. The shortage of acute care beds is expected to only worsen. This shortage of acute care beds is causing patient transfers to be refused and ambulances to be turned-away (diverted) to more distant facilities or causing delays in transfers from the ER to an inpatient bed, which is not in the best interests of patients or the provision of quality and cost-effective health care. The Acute Care Bed Need Methodology is on a county-wide basis and is an average of all days of the month as well as all months of the year. As such, it may not always adequately take into consideration the census level and acute care bed availability of an individual acute care hospital and the significant inpatient bed pressures on the existing hospital, its patients and its Medical Staff.

(b) Therefore, in order to assist those existing acute care hospitals that are experiencing high census levels, which cause the hospitals to close emergency rooms ("diversions") and refuse transfers from other acute care hospitals, which results in negative impacts on patients and their families, existing acute care hospitals may qualify to add acute care beds if the existing acute care hospital can demonstrate an average week day acute bed (including observation patients) occupancy rate/census (Monday through Friday at midnight, exclusive of national holidays) for two separate and distinct periods of thirty (30) consecutive calendar days of the most recent twelve month period at or above the desired average occupancy rate of eighty percent (80%) of total licensed acute care beds for that hospital.

(c) For existing acute care hospitals achieving the occupancy rate in paragraph 2, those hospitals may seek a CON to add up to ten percent of licensed bed capacity (not to exceed 50

beds), rounded to the nearest whole, or alternatively up to thirty (30) beds, whichever is greater (which shall be at the applicant's option). Such additional beds will be considered an exception to the bed methodology set forth elsewhere in this Section, provided, however, that any additional beds authorized by the CON Board pursuant to this provision shall be considered for purposes of other bed need methodology purposes. In addition to such additional information that may be required by SHPDA, a hospital seeking a CON for additional beds under this section must provide, as part of its CON application the following information:

1. Demonstration of compliance with the occupancy rate in paragraph 2 (Average of at least an 80% week day occupancy rate for two (2) separate and distinct periods of thirty (30) consecutive calendar week days of the most recent 12 month period);

2. The application for additional acute care beds does not exceed ten percent of licensed acute care bed capacity (not to exceed 50 beds), rounded to the nearest whole, or alternatively up to thirty (30) acute care beds, whichever is greater.

3. The existing acute care hospital has not been granted an increase of beds under this section within the preceding twelve month period, which time begins to run upon the issuance of a certificate of occupancy issued by the Alabama Department of Public Health; and

4. The hospital must have been licensed for at least one year as a general acute care hospital.

(d) Any acute care beds granted under this section can only be added at or/upon the existing campus of the applicant acute care hospital.

(6) Planning Policy. In a licensed general acute care hospital, the temporary utilization of inpatient rehabilitation beds, inpatient or residential alcohol and drug abuse beds, or inpatient psychiatric beds for medical/surgical purposes will not be considered a conversion of beds provided that the temporary utilization not exceed a total of twenty percent (20%) in any one specialty unit, as allowed by federal Medicare regulations in a facility's fiscal year.

(7) Beds Needed (Excess Beds). Pages 65 and 66 summarize the bed need calculations for each Alabama County. Calculations indicate that there is not a need for additional beds anywhere in the state. However, in Bullock and Jackson

counties the SHCC approved adjustments for additional beds, therefore those two counties show a need for beds. Overall, there are 7,569 excess hospital beds in Alabama; Jefferson County alone has 2,051. Following the bed need summary is a complete inventory of Alabama's hospitals.

(8) Long Term Acute Care Hospitals (LTAC)

(a) According to the Federal Centers for Medicare and Medicaid Services (CMS), a hospital is an excluded [from the Prospective Payment System] long term acute care hospital if it has in effect an agreement [with CMS] to participate as a general medical surgical acute care hospital and the average inpatient length of stay is greater than 25 days. Ordinarily, the determination regarding a hospital's average length of stay is based on the hospitals most recently filed cost report. However, if the hospital has not yet filed a cost report or if there is an indication that the most recently filed cost report does not accurately reflect the hospital's current average length of stay, data from the most recent six month period is used.

(b) Long term acute care hospitals provide a hospital level of care to patients with an acute illness, injury or exacerbation of a disease process that requires intensive medical and/or functional restorative care for an extended period of time, on average 25 days or longer. Generally, high technology monitoring or complex diagnostic procedures are not required. A long-term acute care hospital's primary patient service goal is to improve a patient's medical and functional status so that they can be successfully discharged to home or to a lower level of care. These patients generally do not meet admission criteria for nursing homes, rehabilitation, or psychiatric facilities.

(c) Alabama has an excess of licensed general acute care hospital beds, some of which could be used for long-term hospital care. Therefore, a general acute care hospital may apply for a certificate of need to convert acute care beds to long-term acute care hospital beds if the following conditions are met:

1. The hospital can satisfy the requirements of a long-term acute care hospital as outlined above.

2. The long term acute care hospital can demonstrate that it will have a separate governing body, a separate chief executive officer, a separate chief medical officer, a separate medical staff, and performs basic functions of an independent hospital.

3. The long term acute care hospital has written patient transfer agreements with hospitals other than the host hospital to show that it could provide at least 75 per cent of the admissions to the long term acute care hospital, based on the total average daily census for all participating hospitals.

4. The transfer agreements are with other hospitals in the same county and/or with hospitals in a region.

(d) To assure financial feasibility, the conversion of acute care beds to long-term acute care hospital beds shall be for a minimum of 25 beds.

(e) Needs Assessment.

1. The bed need for the proposed long term acute care hospital shall be for no more than five (5) percent of the combined average daily census (ADC) of all the acute care hospitals in the region of the proposed LTAC for the most recent annual reporting period.

2. As an alternative an applicant may justify bed need based on a detailed assessment of patient discharges after stays of 25 days or more.

3. An individual hospital's ADC or discharges shall not be used more than once in the computation of need for long term acute care hospital beds.

4. Due to accessibility issues all regions regardless of need methodology shall be permitted one LTACH facility with a maximum of 25 beds; which has proven financially feasible.

(f) The hospital must also comply with all statutes, rules, and regulations governing the Certificate of Need Review Program in Alabama.

(9) Pediatric Hospitals. Any licensed freestanding pediatric hospital or wholly owned subsidiary may make application for a Certificate of Need based on the latest obtainable pediatric data. The data submitted as part of the application shall be verified by the SHPDA staff prior to consideration by the Certificate of Need Review Board.

(10) Critical Access Hospitals (CAH).

(a) An existing hospital in Alabama must meet the following criteria to be considered for certification by CMS as a CAH (a new certificate of need is not required unless the

application is for a new CAH or the hospital where the CAH is to be located has been closed longer than twelve months):

1. Is a public, nonprofit, or for-profit medicare-certified hospital currently in operation and located on one of the following:

(i) A rural area as defined by the Office of Management and Budget (i.e.; outside a Metropolitan Statistical area);

(ii) A rural census tract of an Metropolitan Statistical Area (MSA) determined under the most recent version of the Goldsmith Modification Formula;

(iii) An area designated as Rural by law or regulation of the State of Alabama or in the State's Rural Health Plan as approved by the federal Centers for Medicaid and Medicare Services;

(iv) A hospital would qualify as a rural referral center or as a sole community hospital if the hospital were located in a rural area

2. Hospitals, which closed on or after November 29, 1989, or are currently licensed health clinics or health centers that were created by downsizing a hospital, may reopen as a CAH;

3. Is located more than a 35-mile drive (or, 15 mile drive in areas with mountainous terrain or with only secondary roads available) from another hospital or CAH, or is designated by the state as being a Necessary Provider of Health Care Services to area residents;

4. Makes available 24-hour emergency care services that the State determines are necessary for ensuring access to emergency care in each community served by the critical access hospital;

5. Provides not more than 25 beds for acute inpatient care (which in the case of a swing bed facility can be used interchangeably for acute or SNF-level care,) and the hospital may also provide up to 10 rehabilitation and 10 psychiatric beds so long as these are operated as separate units;

6. Maintains an average annual patient stay of no more than 96 hours;

7. Meets critical access hospital staffing requirements;

8. Is a member of a rural health network and has an agreement with at least one full-service hospital (Affiliate) in the network for:

- patient referral and transfer
- development and use of communications systems
- provision of emergency and non-emergency transportation;

9. Has an agreement regarding staff credentialing and quality assurance with one of the following:

(i) a hospital that is a joint member in the rural health network,

(ii) a peer review organization or equivalent entity, or

(iii) another appropriate and qualified entity identified in the state rural health plan;

10. Federal statutes and eligibility requirements governing the CAH Program allow states to designate an existing hospital as a Necessary Provider of Health Care Services for its area residents if it meets all requirements for a CAH except the mileage between hospitals requirement. Alabama will utilize this statutory provision and designate Necessary Provider of Health Care Services for existing hospitals located in a county considered "at risk" for losing primary health care access. Alabama has reviewed numerous indicators of under-service in communities to determine criteria most appropriate for Alabama. Five criteria have been selected.

If the hospital meets one or more of these criteria, Alabama's Bureau of Health Provider Standards, Division of Provider Services, in consultation with the Office of Primary Care and Rural Health, will declare the facility a Necessary Provider of Health Care Services.

Criteria 1. The hospital is located in an area designated as a Health Professional Shortage Area.

Criteria 2. The hospital is located in an area designated as Medically Underserved.

Criteria 3. The hospital is located in a county with an unemployment rate higher than the statewide rate of unemployment.

Criteria 4. The hospital is located in a county with a percentage of population age 65 years and older greater than the state's average.

Criteria 5. The hospital is located in a county where the percentage of families with incomes below 200% of the federal poverty level is higher than the state average for families with incomes below 200% of the federal poverty level.

Any existing hospital, which otherwise satisfies CAH criteria except the mileage requirement but does not meet at least one of the above criteria for certification as a Necessary Provider of Health Services, may appeal to Alabama's State Health Officer. Evaluation of appeals will be based on submission of objective information, which demonstrates the presence of extenuating circumstances, which may adversely impact an area's access to health care if the existing hospital is not declared a Necessary Provider of Health Services. Based on evidence presented, the State Health Officer may decide to issue a variance from established criteria and declare the appealing hospital a Necessary Provider of Health Care Services.

(b) In order to meet the federal CAH requirements as to the number of beds, an existing hospital may distinguish "authorized" and "licensed" general acute care and swing beds as in the rules established by the ADPH and SHPDA.

(c) The "Medicare Prescription Drug, Improvement and Modernization Act" (Public Law H.R. 1 and S. 1 June 27, 2003) was recently signed into law by the President. This law is a very extensive revision to the Medicare program and contains provisions relating the Critical Access Hospital Program found in Section 405 of the Act. These provisions will allow more flexibility for hospitals converting to CAH status. The provisions will not go into effect in Alabama until the rural health plan is revised/amended.

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective May 18, 1993. **Amended:** June 19, 1996; effective July 25, 1996. **Amended:** Filed August 1, 1996; effective September 5, 1996. **Amended:** Filed August 14, 1996; effective September 18, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2 2014; effective January 6, 2015.

Note: Statistically updated September 30, 1993. Rule No. 410-2-4-.02 through 410-2-4-.09, inclusive, have been revised to reflect more current inventories, population, and utilization statistics, effective September 30, 1993. Statistically updated August 3, 1994. These updates reflect changes in inventories, utilization, populations, and need projections; effective August 3, 1994. Statistically updated August 21, 1995. Statistically updated October 17, 1996.

ALABAMA STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
PROJECTED HOSPITAL BED NEED FOR 2005

COUNTY	POPULATION FACTOR 2000-2005	PROJECTED BEDS NEEDED	LICENSED BEDS EXISTING	CON ISSUED	NET NEED (EXCESS)
AUTAUGA	1.113	24	85	0	(61)
BALDWIN	1.156	191	287	0	(96)
BARBOUR	1.05	25	74	0	(49)
BIBB	1.095	5	35	0	(30)
BLOUNT	1.124	40	40	0	0
BULLOCK*	1.018	31	30	0	50
BUTLER	0.984	53	94	0	(41)
CALHOUN/CLEBURNE	1.003	306	586	0	(280)
CHAMBERS	0.995	64	115	0	(51)
CHEROKEE	1.091	15	60	0	(45)
CHILTON	1.098	10	60	0	(50)
CLARKE	1.01	33	134	0	(101)
CLAY	1.036	30	53	0	(23)
COFFEE	1.034	70	151	0	(81)
COLBERT	1.023	150	313	0	(163)
CONECUH	1.001	38	58	0	(20)
COVINGTON	1.008	78	223	0	(145)
CRENSHAW	1.001	22	65	0	(43)
CULLMAN	1.063	142	215	0	(73)
DALE	1.014	38	89	0	(51)
DALLAS	0.981	161	214	0	(53)
DEKALB	1.084	50	134	0	(84)
ELMORE	1.122	60	138	0	(78)
ESCAMBIA	1.028	106	142	0	(36)
ETOWAH	1.013	376	627	0	(251)
FAYETTE	1.008	29	61	0	(32)
FRANKLIN	1.054	62	133	0	(71)
GENEVA	1.034	34	83	0	(49)
GREENE	0.98	4	20	0	(16)
HALE	1.05	11	39	0	(28)
HOUSTON/HENRY	1.031	466	635	0	(169)

COUNTY	POPULATION FACTOR 2000-2005	PROJECTED BEDS NEEDED	LICENSED BEDS EXISTING	CON ISSUED	NET NEED (EXCESS)
JACKSON**	1.05	60	170	0	4
JEFFERSON	1.008	3163	5214	0	(2051)
LAUDERDALE	1.042	270	366	0	(96)
LAWRENCE	1.039	21	98	0	(77)
LEE/MACON	1.09	234	314	0	(80)
LIMESTONE	1.085	63	101	0	(38)
MADISON	1.062	671	1021	0	(350)
MARENGO/CHOCTAW	0.988	55	99	0	(44)
MARION	1.019	59	128	0	(69)
MARSHALL	1.073	150	240	0	(90)
MOBILE	1.022	1266	1987	0	(721)
MONROE	1.002	29	94	0	(65)
MONTGOMERY/LOWNDES	1.03	642	977	0	(355)
MORGAN	1.044	255	543	0	(288)
PICKENS	1.007	29	56	0	(27)
PIKE	1.038	38	97	0	(59)
RANDOLPH	1.055	28	126	0	(98)
RUSSELL	1.024	56	0	70	(14)
ST. CLAIR	1.117	22	82	0	(60)
SHELBY	1.166	158	192	0	(34)
SUMTER	0.963	5	33	0	(28)
TALLADEGA	1.035	106	270	0	(164)
TALLAPOOSA/COOSA	1.027	53	127	0	(74)
TUSCALOOSA	1.033	622	814	0	(192)
WALKER	1.018	102	267	0	(165)
WASHINGTON	1.031	4	25	0	(21)
WILCOX	0.988	4	32	0	(28)
WINSTON	1.056	34	99	0	(65)
STATE TOTALS	1.041	10,923	18,565	70	(7,569)

UPDATED JANUARY 2004

* The Statewide Health Coordinating Council approved an adjustment to the *State Health Plan* that became effective on September 9, 2003 for an additional 49 beds in Bullock County.

** The Statewide Health Coordinating Council approved an adjustment to the *State Health Plan* that became effective on September 9, 2003 for a 4-bed critical access hospital in Jackson County.

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS			UTILIZATION DATA (OCT. 2001 – SEPT. 2002)		
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
Prattville Baptist Hospital	Autauga	Prattville	85	85		6,796	18.62	21.90
Autauga County Totals			***85***	***85***		***6,796***	***18.62***	***21.90***
North Baldwin Infirmary	Baldwin	Bay Minette	55	55		4,637	12.70	23.10
Thomas Hospital	Baldwin	Fairhope	150	150		24,257	66.46	44.31
South Baldwin Regional Medical Center	Baldwin	Foley	82	82		19,844	54.37	66.30
Baldwin County Totals			***287***	***287***		***48,738***	***133.53***	***46.53***
Lakeview Community Hospital	Barbour	Eufaula	74	74		6,664	18.26	24.67
Barbour County Totals			***74***	***74***		***6,664***	***18.26***	***24.67***
Bibb Medical Center	Bibb	Centreville	35	35		1,705	4.67	13.35
Bibb County Totals			***35***	***35***		***1,705***	***4.67***	***13.35***
Medical Center Blount	Blount	Oneonta	40	40		8,550	23.42	58.56
Blount County Totals			***40***	***40***		***8,550***	***23.42***	***58.56***
Bullock County Hospital	Bullock	Union Springs	30	30		9,856	27.00	90.01
Bullock County Totals			***30***	***30***		***9,856***	***27.00***	***90.01***
Georgiana Hospital	Butler	Georgiana	22	22		5,023	13.76	62.55
L. V. Stabler Memorial Hospital	Butler	Greenville	72	59		8,646	23.69	40.15
Butler County Totals			***94***	***81***		***13,669***	***37.45***	***46.23***

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS			UTILIZATION DATA (OCT. 2001 – SEPT. 2002)		
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
Jacksonville Hospital	Calhoun	Jacksonville	89	89		5,583	15.30	17.19
Northeast AL Regional Medical Center	Calhoun	Anniston	372	352		66,448	182.05	51.72
Stringfellow Memorial Hospital	Calhoun	Anniston	125	125		17,288	47.36	37.89
Calhoun County Totals			***586***	***566***		***89,319***	***244.71***	***43.23***
George H. Lanier Memorial Hospital	Chambers	Valley	115	115		16,594	45.46	39.53
Chambers County Totals			***115***	***115***		***16,594***	***45.46***	***39.53***
Baptist Medical Center Cherokee	Cherokee	Centre	60	60		4,481	12.28	20.46
Cherokee County Totals			***60***	***60***		***4,481***	***12.28***	***20.46***
Chilton Medical Center	Chilton	Clanton	60	60		2,264	6.20	10.34
Chilton County Totals			***60***	***60***		***2,264***	***6.20***	***10.34***
Grove Hill Memorial Hospital	Clarke	Grove Hill	50	50		3,997	10.95	21.90
Jackson Medical Center	Clarke	Jackson	35	35		3,202	8.77	25.06
Thomasville Infirmary	Clarke	Thomasville	49	49		3,511	9.62	19.63
Clarke County Totals			***134***	***134***		***10,710***	***29.34***	***21.90***
Clay County Hospital	Clay	Ashland	53	53		7,714	21.13	39.88
Clay County Totals			***53***	***53***		***7,714***	***21.13***	***39.88***
Elba General Hospital	Coffee	Elba	20	20		4,077	11.17	55.85
Medical Center Enterprise	Coffee	Enterprise	131	131		16,705	45.77	34.94
Coffee County Totals			***151***	***151***		***20,782***	***56.94***	***37.71***

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS			UTILIZATION DATA (OCT. 2001 – SEPT. 2002)		
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
Helen Keller Memorial Hospital	Colbert	Sheffield	185	165		27,768	76.08	46.11
Shoals Hospital	Colbert	Muscle Shoals	128	128		14,015	38.40	30.00
Colbert County Totals			***313***	***293***		***41,783***	***114.47***	***39.07***
Evergreen Medical Center	Conecuh	Evergreen	58	44		9,525	26.10	59.31
Conecuh County Totals			***58***	***44***		***9,525***	***26.10***	***59.31***
Andalusia Regional Hospital	Covington	Andalusia	101	101		14,489	39.70	39.30
Florala Memorial Hospital	Covington	Florala	23	23		2,221	6.08	26.46
Mizell Memorial Hospital	Covington	Opp	99	99		8,025	21.99	22.21
Covington County Totals			***223***	***223***		***24,735***	***67.77***	***30.39***
Crenshaw Community Hospital	Crenshaw	Luverne	65	45		2,114	5.79	12.87
Crenshaw County Totals			***65***	***45***		***2,114***	***5.79***	***12.87***
Cullman Regional Medical Center	Cullman	Cullman	115	115		32,465	88.95	77.34
Woodland Medical Center	Cullman	Cullman	100	80		8,102	22.20	27.75
Cullman County Totals			***215***	***195***		***40,567***	***111.14***	***57.00***
Dale Medical Center	Dale	Ozark	89	89	-10*	9,949	27.26	30.63
Dale County Totals			***89***	***89***		***9,949***	***27.26***	***30.63***
Vaughan Regional Medical Center-Parkway	Dallas	Selma	214	151		35,125	96.23	63.73
Dallas County Totals			***214***	***151***		***35,125***	***96.23***	***63.73***

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS			UTILIZATION DATA (OCT. 2001 – SEPT. 2002)		
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
Baptist Medical Center - DeKalb	DeKalb	Fort Payne	134	134		14,504	39.74	29.65
DeKalb County Totals			***134***	***134***		***14,504***	***39.74***	***29.65***
Community Hospital, Inc.	Elmore	Tallassee	69	69	-10*	8,692	23.81	34.51
Elmore Community Hospital	Elmore	Wetumpka	69	49		2,987	8.18	16.70
Elmore County Totals			***138***	***118***		***11,679***	***32.00***	***27.12***
Atmore Community Hospital	Escambia	Atmore	51	51		7,469	20.46	40.12
D. W. McMillan Memorial Hospital	Escambia	Brewton	91	91		12,247	33.55	36.87
Escambia County Totals			***142***	***142***		***19,716***	***54.02***	***38.04***
Gadsden Regional Medical Center	Etowah	Gadsden	346	326		53,779	147.34	45.20
Riverview Regional Medical Center	Etowah	Gadsden	281	281		53,515	146.62	52.18
Etowah County Totals			***627***	***607***		***107,294***	***293.96***	***48.43***
Fayette Medical Center	Fayette	Fayette	61	61		8,897	24.38	39.96
Fayette County Totals			***61***	***61***		***8,897***	***24.38***	***39.96***
Russellville Hospital	Franklin	Russellville	100	100		13,518	37.04	37.04
Red Bay Hospital	Franklin	Red Bay	33	33		4,373	11.98	36.31
Franklin County Totals			***133***	***133***		***17,891***	***49.02***	***36.85***
Wiregrass Medical Center	Geneva	Geneva	83	83		9,652	26.44	31.86
Geneva County Totals			***83***	***83***		***9,652***	***26.44***	***31.86***

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS			UTILIZATION DATA (OCT. 2001 – SEPT. 2002)		
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
Greene County Hospital	Greene	Eutaw	20	20		1,710	4.68	23.42
Greene County Totals			***20***	***20***		***1,710***	***4.68***	***23.42***
Hale County Hospital	Hale	Greensboro	39	39		2,586	7.08	18.17
Hale County Totals			***39***	***39***		***2,586***	***7.08***	***18.17***
Flowers Hospital	Houston	Dothan	235	235		55,135	151.05	64.28
Southeast Alabama Medical Center	Houston	Dothan	400	381		90,903	249.05	65.37
Houston County Totals			***635***	***616***		***146,038***	***400.10***	***64.95***
Jackson County Hospital	Jackson	Scottsboro	170	170		14,346	39.30	23.12
Jackson County Totals			***170***	***170***		***14,346***	***39.30***	***23.12***
UAB Medical Center West	Jefferson	Bessemer	300	258		45,091	123.54	47.88
Baptist Medical Center-Princeton	Jefferson	Birmingham	499	474		71,939	197.09	41.58
Baptist Medical Center Montclair	Jefferson	Birmingham	496	438		75,125	205.82	46.99
Carraway Methodist Medical Center	Jefferson	Birmingham	617	548		48,855	133.85	24.43
Children's Hospital of Alabama (The)	Jefferson	Birmingham	225	202		58,977	161.58	79.99
Brookwood Medical Center	Jefferson	Birmingham	586	389		81,291	222.72	57.25
Medical Center East	Jefferson	Birmingham	282	262		57,858	158.52	60.50
Callahan Eye Foundation at UAB	Jefferson	Birmingham	106	106		856	2.35	2.21
Cooper Green Hospital	Jefferson	Birmingham	319	319		23,202	63.57	19.93
St. Vincent's Hospital	Jefferson	Birmingham	338	338		80,907	221.66	65.58
HealthSouth Medical Center	Jefferson	Birmingham	219	219		29,700	81.37	37.16
University of Alabama Hospital	Jefferson	Birmingham	908	761		210,338	576.27	75.73

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS			UTILIZATION DATA (OCT. 2001 – SEPT. 2002)		
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
HealthSouth Metro West Hospital	Jefferson	Fairfield	319	295		16,658	45.64	15.47
Jefferson County Totals			***5,214***	***4,609***		***800,797***	***2,193.96***	***47.60***
Eliza Coffee Memorial Hospital	Lauderdale	Florence	366	269		65,246	178.76	66.45
Lauderdale County Totals			***366***	***269***		***65,246***	***178.76***	***66.45***
Lawrence Baptist Medical Center	Lawrence	Moulton	98	98		5,643	15.46	15.78
Lawrence County Totals			***98***	***98***		***5,643***	***15.46***	***15.78***
East Alabama Medical Center	Lee	Opelika	314	276		58,253	159.60	57.82
Lee County Totals			***314***	***276***		***58,253***	***159.60***	***57.82***
Athens Limestone Hospital	Limestone	Athens	101	101		16,501	45.21	44.76
Limestone County Totals			***101***	***101***		***16,501***	***45.21***	***44.76***
Huntsville Hospital (The)	Madison	Huntsville	901	846		162,462	445.10	52.61
Crestwood Medical Center	Madison	Huntsville	120	108		20,408	55.91	51.77
Madison County Totals			***1,021***	***954***		*182,870*	***501.01***	***52.52***
Bryan W. Whitfield Memorial Hospital	Marengo	Demopolis	99	99		14,291	39.15	39.55
Marengo County Totals			***99***	***99***		***14,291***	***39.15***	***39.55***
Marion Regional Medical Center	Marion	Hamilton	57	57		5,859	16.05	28.16
Northwest Medical Center	Marion	Winfield	71	56		10,114	27.71	49.48
Marion County Totals			***128***	***113***		***15,973***	***43.76***	***38.73***

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS			UTILIZATION DATA (OCT. 2001 – SEPT. 2002)		
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
Marshall Medical Center South	Marshall	Boaz	150	150		22,186	60.78	40.52
Marshall Medical Center	Marshall	Guntersville	90	90		18,561	50.85	56.50
Marshall County Totals			***240***	***240***		***40,747***	***111.64***	***46.51***
USA Knollwood Park	Mobile	Mobile	124	124		11,762	32.22	25.99
USA Children's and Women's Hospital	Mobile	Mobile	152	152		32,215	88.26	58.07
USA Medical Center	Mobile	Mobile	406	406		38,912	106.61	26.26
Mobile Infirmary	Mobile	Mobile	704	613		122,700	336.16	54.84
Providence Hospital	Mobile	Mobile	349	349		79,943	219.02	62.76
Springhill Memorial Hospital	Mobile	Mobile	252	252		50,584	138.59	54.99
Mobile County Totals			***1,987***	***1,896***		***336,116***	***920.87***	***48.57***
Monroe County Hospital	Monroe	Monroeville	94	94		9,507	26.05	27.71
Monroe County Totals			***94***	***94***		***9,507***	***26.05***	***27.71***
Baptist Medical Center East	Montgomery	Montgomery	150	150		28,030	76.79	51.20
Jackson Hospital and Clinic, Inc.	Montgomery	Montgomery	373	351		65,731	180.08	51.31
Baptist Medical Center South	Montgomery	Montgomery	454	422		71,525	195.96	46.44
Montgomery County Totals			***977***	***923***		***165,286***	***452.84***	***49.06***
Decatur General Hospital	Morgan	Decatur	273	273		42,617	116.76	42.77
Parkway Medical Center	Morgan	Decatur	120	120		10,677	29.25	24.38
Hartselle Medical Center	Morgan	Hartselle	150	130		6,156	16.87	12.97
Morgan County Totals			***543***	***523***		***59,450***	***162.88***	***31.14***

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS			UTILIZATION DATA (OCT. 2001 – SEPT. 2002)		
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
Pickens County Medical Center	Pickens	Carrollton	56	46		7,621	20.88	45.39
Pickens County Totals			***56***	***46***		***7,621***	***20.88***	***45.39***
Edge Regional Medical Center	Pike	Troy	97	97		10,608	29.06	29.96
Pike County Totals			***97***	***97***		***10,608***	***29.06***	***29.96***
Randolph Medical Center	Randolph	Roanoke	92	92		4,612	12.64	13.73
Wedowee Hospital	Randolph	Wedowee	34	34		1,670	4.58	13.46
Randolph County Totals			***126***	***126***		***6,282***	***17.21***	***13.66***
Shelby Baptist Medical Center	Shelby	Alabaster	192	180		40,476	110.89	61.61
Shelby County Totals			***192***	***180***		***40,476***	***110.89***	***61.61***
St. Clair Regional Hospital	St. Clair	Pell City	82	82		5,619	15.39	18.77
St. Clair County Totals			***82***	***82***		***5,619***	***15.39***	***18.77***
Hill Hospital of Sumter County	Sumter	York	33	33		1,305	3.58	10.83
Sumter County Totals			***33***	***33***		***1,305***	***3.58***	***10.83***
Coosa Valley Baptist Medical Center	Talladega	Sylacauga	148	148		19,712	54.01	36.49
Citizens Baptist Medical Center	Talladega	Talladega	122	122		10,835	29.68	24.33
Talladega County Totals			***270***	***270***		***30,547***	***83.69***	***31.00***
Russell Medical Center	Tallapoosa	Alexander City	81	81		12,506	34.26	42.30
Lake Martin Community Hospital	Tallapoosa	Dadeville	46	46		3,167	8.68	18.86
Tallapoosa County Totals			***127***	***127***		***15,673***	***42.94***	***33.81***

ALABAMA'S INVENTORY OF HOSPITALS

IDENTIFICATION			NUMBER OF BEDS			UTILIZATION DATA (OCT. 2001 – SEPT. 2002)		
NAME	COUNTY	CITY	TOTAL LICENSED BEDS	TOTAL ACUTE BEDS	CON ISSUED	PATIENT DAYS	AVERAGE DAILY CENSUS	% OCCUPANCY
Northport Medical Center	Tuscaloosa	Northport	204	108		27,293	74.78	69.24
DCH Regional Medical Center	Tuscaloosa	Tuscaloosa	610	610		129,355	354.40	58.10
Tuscaloosa County Totals			***814***	***718***		***156,648***	***429.17***	***59.77***
Walker Baptist Medical Center	Walker	Jasper	267	243		27,437	75.17	30.93
Walker County Totals			***267***	***243***		***27,437***	***75.17***	***30.93***
Washington County Infirmary	Washington	Chatom	25	25		1,271	3.48	13.93
Washington County Totals			***25***	***25***		***1,271***	***3.48***	***13.93***
J. Paul Jones Hospital	Wilcox	Camden	32	32		1,246	3.41	10.67
Wilcox County Totals			***32***	***32***		***1,246***	***3.41***	***10.67***
Burdick West Medical Center	Winston	Haleyville	99	99		8,451	23.15	23.39
Winston County Totals			***99***	***99***		***8,451***	***23.15***	***23.39***
CON Issued plus/minus					50*			
Alabama State Totals			***18,505***	***17,147***	***17,144***	***2,849,817***	***7,807.72***	***45.53***

* These beds due to CONs issued for conversion of acute beds and a CON for a 70 bed hospital to be built in Russell County.

UPDATED July 2004 SOURCE: SHPDA ANNUAL HOSPITAL REPORTS

ALABAMA'S INVENTORY OF LONG TERM ACUTE CARE HOSPITALS

Facility	Region	City/Town	County	Exist Beds	Con Iss	Total Beds	Patient Days	ADC	Ave Length 0f Stay	% Occ
Select Specialty Hospital – Birmingham	III	Birmingham	Jefferson	38		38	7,482	20.50	29.5	53.9
Medical Center East/Lloyd Noland	III	Birmingham	Jefferson	45		45	*	*	*	*
HealthSouth Metro West/Lloyd Noland	III	Fairfield	Jefferson		55	55	*	*	*	*
The Long Term Care Hospital at Carraway – Lloyd Noland Foundation	III	Birmingham	Jefferson		27	27	*	*	*	*
Select Specialty Hospitals, Inc.	III	Birmingham	Jefferson		27	27	*	*	*	*
Total for Region				**83**	**109**	**192**				
The Long Term Care Hospital at Regional Medical Center	IV	Anniston	Calhoun	34		34	*	*	*	*
Total for Region				**34**		**34**				
The Long Term Care Hospital at DCH Regional Medical Center	V	Tuscaloosa	Tuscaloosa		27	27	*	*	*	*
Total for Region					**27**	**27**				
The Long Term Care Hospital at Jackson	VI	Montgomery	Montgomery	60	5	65	10,913	29.90	26.9	83.1
Total for Region				**60**	**5**	**65**				
USA Knollwood Park LTC Hospital	VII	Mobile	Mobile	191		191	13,317	36.48	26.7	19.1
Total for Region				**191**		**191**				
Southeast Alabama Medical Center, LLC by the Lloyd Noland Foundation, Inc.	VIII	Dothan	Houston	30		30				
Total for Region				30		**30**				
Total for State				**398**	**141**	**539**				

* Data not available

Utilization Data based upon Annual Hospital Reports (Oct. 2001-Sept. 2002)

Licensed Beds and CON Issued effective August 4, 2004

Revised as of 8/04/2004

LONG TERM ACUTE CARE HOSPITALS (LTACH)
PROJECTED BED NEED BY REGION
EXCLUDING PEDIATRICS

LONG TERM ACUTE CARE BED NEED STATUS AS OF AUGUST 2004

REGION	COUNTY	CON APPLICATIONS PENDING
II	Madison	AL2004-027 Select Specialty Hospital- Huntsville, Inc. construct and establish 44 bed LTACH freestanding facility.
II	Madison	AL2004-032 The Long Term Care Hospital of Huntsville, LLC, by the Lloyd Noland Foundation Inc. Construct and establish a new freestanding 49 bed LTACH facility.
II	Madison	AL2004-035 HealthSouth LTCH of Huntsville, Inc. Construct a 40 bed long-term acute care hospital in Huntsville, Alabama.
VII	Mobile	AL2003-016 Semper Care Hospital of Mobile, Inc d/b/a Mobile Infirmary. Convert 33 acute care beds to LTACH. Application denied by CONRB 4/21/04. Appealed to Circuit Court.

Long Term Acute Care Hospitals (LTACH)
Projected Bed Need by Region
Excluding Pediatrics

	Projected Beds	Existing Beds	CON Issued	Net Need
Region I				
Colbert	6			6
Franklin	2			2
Lauderdale	9			9
Lawrence	1			1
I Total	18			18
Region II				
Jackson	2			2
Limestone	2			2
Madison	24			24
Marshall	6			6
Morgan	8			8
Region II Total	42			42
Region III				
Bibb	0			0
Blount	1			1
Cullman	6			6
Jefferson	102	83	109	-90
Marion	2			2
Saint Clair	1			1
Shelby	6			6
Talladega	4			4
Walker	4			4
Winston	1			1
III Total	127	83	109	-65
Region IV				
Calhoun	12	34		-22
Cherokee	1			1
Clay	1			1
Cleburne	0			0
Dekalb	2			2
Etowah	15			15
Randolph	1			1
IV Total	32	34		-2
Region V				
Fayette	1			1
Greene	0			0
Hale	0			0
Lamar	0			0
Pickens	1			1
Sumter	0			0
Tuscaloosa	21		27	-6
V Total	23		27	-4
Region VI				
Autauga	1			1
Bullock	1			1
Butler	2			2
Chambers	2			2
Chilton	0			0
Coosa	0			0
Crenshaw	0			0
Dallas	5			5
Elmore	2			2
Lee	8			8
Lowndes	0			0
Macon	0			0
Marengo	2			2
Montgomery	21	60	5	-44
Perry	0			0
Pike	1			1
Russell	0			0
Tallapoosa	2			2
Wilcox	0			0
VI Total	47	60	5	-18

Long Term Acute Care Hospitals (LTACH)
Projected Bed Need by Region
Excluding Pediatrics

	Projected Beds	Existing Beds	CON Issued	Net Need
Region VII				
Baldwin	6			6
Choctaw	0			0
Clarke	1			1
Conecuh	1			1
Escambia	3			3
Mobile	43	191		-148
Monroe	1			1
Washington	0			0
VII Total	55	191		-136

	Projected Beds	Existing Beds	CON Issued	Net Need
Region VIII				
Barbour	1			1
Coffee	3			3
Covington	3			3
Dale	1			1
Geneva	1			1
Henry	0			0
Houston	20	30		-10
VIII Total	29	30		-1

	Projected Beds	Existing Beds	CON Issued	Net Need
State Total	**373**	**398**	**141**	**-166**

410-2-4-.03 Nursing Homes.

(1) Definition. Nursing homes may be identified as licensed facilities providing inpatient care for convalescents or other persons not acutely ill and not in need of acute general hospital care, but requiring skilled nursing care. Nursing home care is not to be confused with long-term hospital care. Some hospitals, however, may have nursing homes beds attached as an identifiable part which is reflected in their license. Such beds are included in this chapter. Hospital swing beds are not included.

(2) Analysis of Existing Facilities

(a) As of March 1996, there were 224 licensed nursing homes, excluding state owned and operated facilities, totaling 23,475 beds operating in the state of Alabama Average occupancy for the 224 facilities was approximately 94.8 percent for Fiscal Year 1995. Currently, there exists approximately 44.5 beds per one thousand persons 65 and older (down from 48 beds per thousand in 1980).

(b) Approximately 92 percent of nursing home beds in Alabama are occupied by persons 65 and older. This aged population represents 13.5 percent of the state's total population and is projected to increase gradually during the coming years.

(3) State Owned and Operated Facilities

(a) Five mental retardation facilities have been certified as Intermediate Care Facilities/Mental Retardation (ICF/MR). They are:

1. Albert P. Brewer Developmental Center; 210 beds; Mobile, Alabama

2. Glen Ireland II Developmental Center; 119 beds; Tarrant, Alabama

3. J. S. Tarwater Developmental Center; 107 beds; Wetumpka, Alabama

4. L. B. Wallace Developmental Center; 247 beds; Decatur, Alabama

5. William D. Partlow Developmental Center; 310 beds; Tuscaloosa, Alabama

(b) Three state-owned Intermediate Care Facilities for the mentally diseased are located in Alabama. They are:

1. Alice M. Kidd Intermediate Care Facility; 216 beds; Tuscaloosa, Alabama

2. S. D. Allen Intermediate Care Facility; 138 beds; Tuscaloosa, Alabama

3. Claudette Box Nursing Facility; 142 beds; Mt. Vernon, Alabama

(4) Alternatives to Institutionalization

(a) Efforts should be made to maintain an optimum quality of life for long-tern care residents in their home for as long as possible. The types and amounts of service needed for long-term care residents vary. In order to enhance opportunities for residents needing long-term care services, which would allow them to remain in their homes for as long as possible, the health care and social needs of these residents should be evaluated by an independent multidisciplinary team, composed of a registered nurse and a social worker, prior to nursing home admission. This team should also evaluate the ability of resources within the local community to meet the needs of these residents.

(b) In an effort to encourage the development and utilization of alternatives to nursing home care, the Alabama Medicaid Agency now has a program which reimburse certain health, social, and related services provided in the community. Individuals who might otherwise require admission to a nursing home are now able to remain in their homes because of the home and community based services provided through this program. Currently, there are nearly 8,200 residents whose long-term care needs can be met through the program.

(5) Financing

(a) The Alabama Medicaid program was started in 1970, and as a result, the nursing home industry grew rapidly during the 70s. Since the 1980 adoption of a more restrictive bed need methodology, the number of beds added tapered off considerably. Also, with the containment of health care costs as a primary concern, a moratorium or additional nursing home beds was established in August of 1984, and was not lifted until June of 1989. Medicaid patients now occupy 68 percent of the available beds (as compared to 72 percent in 1980), private pay patients 27 percent, and Medicare the remainder.

(6) Availability

(a) The 224 licensed nursing homes (excluding state owned) located in Alabama, are generally geographically well distributed and are accessible to the majority of the elderly population within 30 minutes normal driving time. Every Alabama county has a least one nursing home, with the exception of Lowndes County.

(7) Continuity

(a) Discussion

1. Nursing homes should provide care appropriate to resident needs. To ensure that comprehensive services are available and to ensure residents are at a proper level of care, nursing homes should provide, or should have agreements with other health care providers to provide, a broad range of care. When providing these services, or a part of any agreement to provide these services, transfer of residents and support service should be provided as necessary.

(b) Planning Policy. The rendering of complementary long-term care services, such as home health care adult day care, senior citizen nutrition programs, hospice, etc., to long-term care recipients should be fostered and encouraged. In areas where such services are sufficiently developed, health care facilities should be encouraged to have agreements that increase the availability of such services to residents. In areas where such services are not sufficiently available, facilities should be encouraged to develop and offer such services. The Division of Licensure and Certification is encouraged to make the appropriate changes to the licensure requirements.

(8) Quality

(a) Quality care is an obligation of all nursing homes operating in Alabama. Each facility must meet standards of care as established by the federal government (Medicare and Medicaid Conditions of Participation) and the Alabama State Board of Health Rules and Regulations. The Division of Licensure and Certification of the Alabama Department of Public Health is responsible for determining compliance. Additionally, the Professional Review Organization (PRO) now includes some nursing homes in its review.

(9) Nursing Home Bed Need Methodology

(a) Purpose. The purpose of this nursing home bed need methodology is to identify, by county, the number of nursing home beds needed to assure the continued availability,

accessibility, and affordability of quality nursing home care for residents of Alabama.

(b) General. Formulation of this bed need methodology was accomplished by a committee of the Statewide Health Coordinating Council (SHCC). The committee which provided its recommendations to the SHCC, was composed of providers and consumers of health care. Only the SHCC, with the Governor's final approval, can make changes to this methodology except that the SHPDA staff shall annually update bed need projections and inventories to reflect more current population and utilization statistics. Such updated information is available for a fee upon request. Adjustments are addressed in paragraph (e).

(c) Basic Methodology. Considering the availability of more community and home based services for the elderly in Alabama, there should be a minimum of 40 beds per 1,000 population 65 and older for each county.

1. The beds need formula is as follows:

(40 beds per thousand) x (population 65 and older) =
Projected Bed Need

2. Due to budgetary limitations of the Alabama Medicaid Agency, additional nursing home beds cannot be funded by Medicaid funds. Therefore, applications for additional nursing home beds to be funded by Medicaid should not be approved. Based upon the funding shortage, projects for additional nursing home beds would not be financially feasible. Therefore, until further action by the Statewide Health Coordinating Council, there shall be no need for additional skilled nursing beds in the State of Alabama.

(d) Planning Policies

1. The county's annual occupancy for the most recent reporting year should be at least 97 percent before additional nursing home beds are approved.

2. Conversion of existing hospital beds to nursing home beds should be given priority over new construction when the conversion is significantly less costly and the existing structure can be adapted economically to meet licensure and certification requirements. The conversion shall result in a decrease in the facility’s licensed acute care beds equal to or greater than the number of beds to be converted.

3. Bed need projections will be based on a three-year planning horizon.

4. Planning will be on a county-wide basis.

5. Subject to SHCC adjustments, no beds will be added in any county where that county's projected ratio exceeds 40 beds per 1,000 population 65 and older.

6. No new free-standing nursing home should be constructed having less than 50 beds.

7. ICF/MR facilities, state and privately owned, will not be included in the application of the SHCC adopted nursing home bed need methodology.

8. When any nursing home facility relinquishes its license to operate, either voluntarily or involuntarily other than by a Certificate of Need approved transfer, or by obtaining title by a foreclosure as specified in the opinion rendered by the Alabama Attorney General, November 17, 1980, the need for the facility and its resources will automatically be eliminated from the facilities portion of the State Health Plan. The new bed need requirement in the county where the facility was located will be that number which will bring the county ratio up to 40 beds per 1,000 population 65 and older.

(e) Adjustments. The bed need, as determined by the methodology, is subject to adjustments by the SHCC. The nursing home bed need may be adjusted by the SHCC if an applicant can prove that the identified needs of a targeted population are not being met by existing nursing homes in the county of the targeted population.

For a listing of Nursing Homes or the most current statistical need projections in Alabama, you may contact the Data Division, as follows:

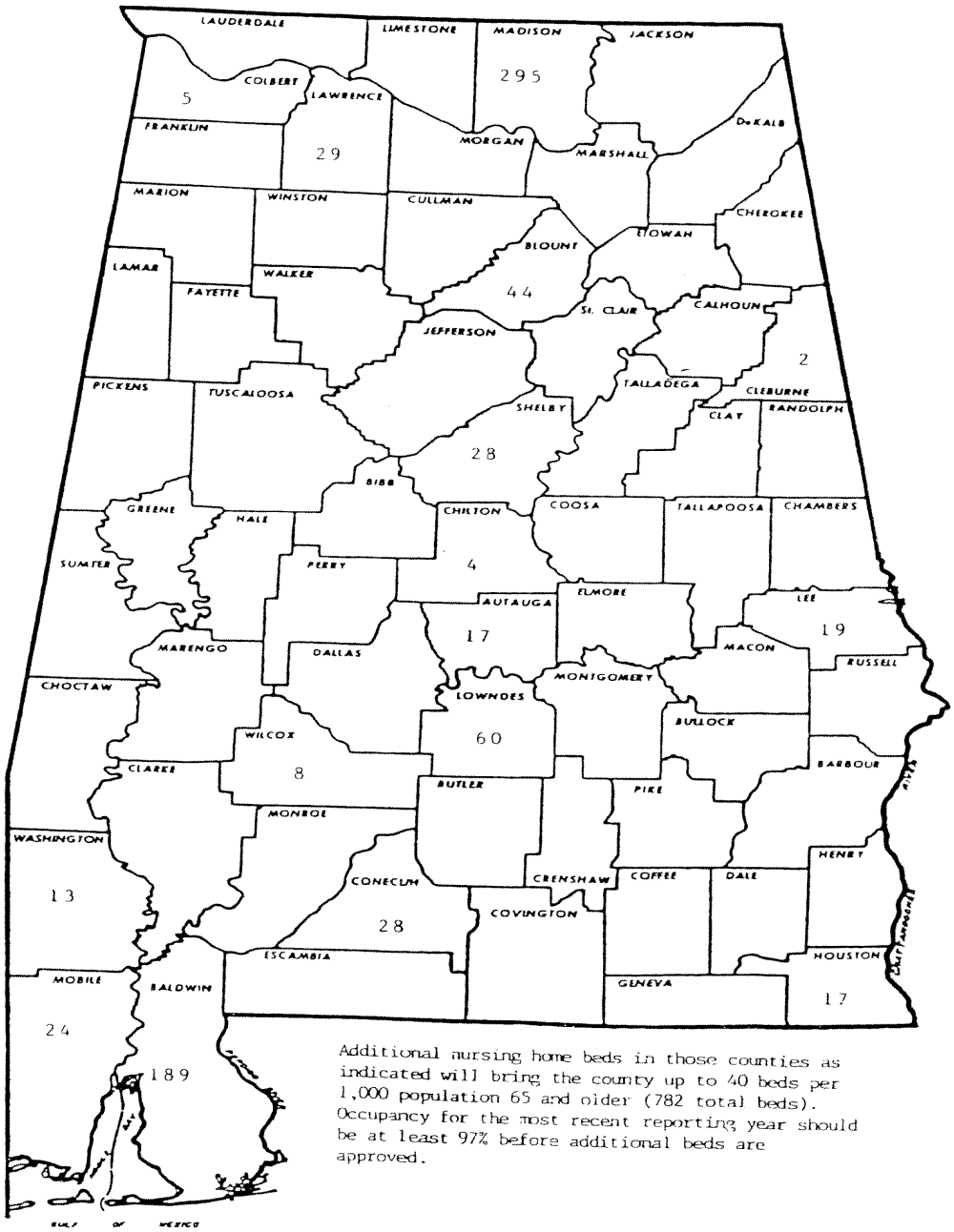
MAILING ADDRESS (U.S. Postal Service	STREET ADDRESS (Commercial Carrier)
PO BOX 303025 MONTGOMERY, AL 36130-3025	100 N. UNION STREET, SUITE 870 MONTGOMERY, AL 36104
TELEPHONE: (334) 242-4103	FAX: (334) 242-4113

E-MAIL: Bradford.Williams@shpda.alabama.gov
WEBSITE: http://www.shpda.Alabama.gov
Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).

History: Effective March 8, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Amended:** Filed August 14, 2012; effective September 18, 2012. **Amended (SHP Year Only):** Filed December 2 2014; effective January 6, 2015. **Amended:** Filed December 18 2015; effective February 1, 2016.

Note: Statistically updated September 30, 1993. Rule No. 410-2-4-.02 through 410-2-4-.09, inclusive, have been revised to reflect more current inventories, population, and utilization statistics, effective September 30, 1993. Statistically updated August 3, 1994. These updates reflect changes in inventories, utilization, populations, and need projections; effective August 3, 1994. Statistically updated August 21, 1995.

NURSING HOME BEDS NEEDED



Additional nursing home beds in those counties as indicated will bring the county up to 40 beds per 1,000 population 65 and older (782 total beds). Occupancy for the most recent reporting year should be at least 97% before additional beds are approved.

NURSING HOME
BED NEED PROJECTIONS

COUNTY	POP 65 & OLDER (1998)	40 BEDS PER 1,000 POP 65 & OLDER	LIC BEDS	CON ISSUED	10% BILL	NET BEDS NEEDED
AUTAUGA	3,817	153	92	44	0	17 *
BALDWIN	20,104	804	600 **	15	0	189 *
BARBOUR	3,585	143	180	0	0	-37
BIBB	2,113	85	103	0	10	-28
BLOUNT	5,520	221	177	0	0	44 *
BULLOCK	1,621	65	112	0	0	-47
BUTLER	3,561	142	179	0	10	-47
CALHOUN	15,526	621	620	30	12	-41
CHAMBERS	5,851	234	260	0	30	-56
CHEROKEE	3,310	132	139	0	0	-7
CHILTON	4,888	196	119	73	0	4 *
CHOCTAW	2,251	90	101	0	0	-11
CLARKE	3,580	143	151	0	0	-8
CLAY	2,411	96	144	0	20	-68
CLEBURNE	1,793	72	65	0	5	2 *
COFFEE	5,957	238	290	0	24	-76
COLBERT	8,018	321	302	14	0	5 *
CONECUH	2,237	89	51	0	10	28 *
COOSA	1,561	62	42	29	0	-9
COVINGTON	6,035	241	321	0	36	-116
CRENSHAW	2,407	96	137	0	14	-55
CULLMAN	11,078	443	486	0	32	-75
DALE	5,339	214	237	0	23	-46
DALLAS	6,220	249	283	0	34	-68
DEKALB	8,346	334	406	0	12	-84
ELMORE	6,189	248	305	0	0	-57
ESCAMBIA	4,944	198	204	15	10	-31
ETOWAH	16,378	655	805	0	55	-205
FAYETTE	2,820	113	122	0	0	-9
FRANKLIN	4,530	181	230	0	30	-79
GENEVA	4,086	163	154	8	10	-9
GREENE	1,458	58	52	0	10	-4
HALE	2,361	94	160	0	20	-86
HENRY	2,712	108	117	0	0	-9
HOUSTON	12,044	482	415	50	0	17 *
JACKSON	6,350	254	238	20	11	-15
JEFFERSON	92,225	3,689	3,964	0	79	-354
LAMAR	2,493	100	144	0	14	-58
LAUDERDALE	12,708	508	548	0	54	-94
LAWRENCE	4,113	165	136	0	0	29 *
LEE	8,686	347	324	4	0	19 *
LIMESTONE	7,254	290	285	0	14	-9
LOWNDES	1,502	60	0	0	0	60 *
MACON	3,381	135	209	0	10	-84
MADISON	28,175	1,127	677 **	142	13	295 *
MARENGO	3,179	127	143	0	0	-16
MARION	4,778	191	243	0	0	-52
MARSHALL	11,572	463	484	0	33	-54
MOBILE	48,563	1,943	1,797	122	0	24 *
MONROE	3,281	131	129	0	20	-18
MONTGOMERY	25,943	1,038	1,222	0	60	-244

NURSING HOME
BED NEED PROJECTIONS

COUNTY	POP 65 & OLDER (1998)	40 BEDS PER 1,000 POP 65 & OLDER	LIC BEDS	CON ISSUED	10% BILL	NET BEDS NEEDED
MORGAN	13,536	541	603	0	69	-131
PERRY	1,681	67	132	0	10	-75
PICKENS	3,664	147	165	0	10	-28
PIKE	3,727	149	194	0	0	-45
RANDOLPH	3,412	136	152	0	10	-26
RUSSELL	6,259	250	287	0	10	-47
ST. CLAIR	7,451	298	305	0	10	-17
SHELBY	10,228	409	248	133	0	28 *
SUMTER	2,157	86	104	0	10	-28
TALLADEGA	10,039	402	415	0	17	-30
TALLAPOOSA	6,586	263	506 **	0	51	-294
TUSCALOOSA	19,855	794	809	0	25	-40
WALKER	10,142	406	506	0	20	-120
WASHINGTON	2,150	86	73	0	0	13 *
WILCOX	2,066	83	75	0	0	8 *
WINSTON	3,495	140	197	0	20	-77
TOTALS	**565,302**	**22,612**	**23,475**	**699**	**977**	**782 ***

***** **Beds needed subject to decrease as a result of Contested Case Hearings, Fair Hearings, and Certificate of Need (CON) Review Board Decisions.**

****** **Does not include 150 Veterans Administration beds in each of these counties.**

NURSING HOME BEDS PER 1,000 POPULATION 65 AND OLDER (COUNTIES LISTED FROM LOWEST TO HIGHEST)

	COUNTY	65 & OLDER (1998)	BEDS EXISTING (*)	NH BEDS PER 1000 65 & OLDER
1	LOWNDES	1,502	0	0.00
2	CONECUH	2,237	61	27.27
3	MADISON	28,175	832	29.53
4	BALDWIN	20,104	615	30.59
5	BLOUNT	5,520	177	32.07
6	LAWRENCE	4,113	136	33.07
7	WASHINGTON	2,150	73	33.95
8	AUTAUGA	3,817	136	35.63
9	WILCOX	2,066	75	36.30
10	SHELBY	10,228	381	37.25
11	LEE	8,686	328	37.76
12	HOUSTON	12,044	465	38.61
13	CLEBURNE	1,793	70	39.04
14	CHILTON	4,888	192	39.28
15	COLBERT	8,018	316	39.41
16	MOBILE	48,563	1,919	39.52
17	LIMESTONE	7,254	299	41.22
18	CHEROKEE	3,310	139	41.99
19	TUSCALOOSA	19,855	834	42.00
20	GENEVA	4,086	172	42.09
21	CLARKE	3,580	151	42.18
22	ST. CLAIR	7,451	315	42.28
23	JACKSON	6,350	269	42.36
24	GREENE	1,458	62	42.52
25	CALHOUN	15,526	662	42.64
26	TALLADEGA	10,039	432	43.03
27	HENRY	2,712	117	43.14
28	FAYETTE	2,820	122	43.26
29	JEFFERSON	92,225	4,043	43.84
30	MARSHALL	11,572	571	44.67
31	CHOCTAW	2,251	101	44.87
32	MARENGO	3,179	143	44.98
33	MONROE	3,281	149	45.41
34	COOSA	1,561	71	45.48
35	ESCAMBIA	4,944	229	46.32
36	CULLMAN	11,078	518	46.76
37	LAUDERDALE	12,708	602	47.37
38	RUSSELL	6,259	297	47.45
39	RANDOLPH	3,412	162	47.48
40	PICKENS	3,664	175	47.76
41	DALE	5,339	260	48.70
42	ELMORE	6,189	305	49.28
43	MONTGOMERY	25,943	1,282	49.42
44	CHAMBERS	5,851	290	49.56
45	MORGAN	13,536	672	49.65
46	DEKALB	8,346	418	50.08
47	BARBOUR	3,585	180	50.21

NURSING HOME BEDS PER 1,000 POPULATION 65 AND OLDER (COUNTIES LISTED FROM LOWEST TO HIGHEST)

	COUNTY	65 & OLDER (1998)	BEDS EXISTING (*)	NH BEDS PER 1000 65 & OLDER
48	MARION	4,778	243	50.86
49	DALLAS	6,220	317	50.96
50	WALKER	10,142	526	51.86
51	PIKE	3,727	194	52.05
52	ETOWAH	16,378	860	52.51
53	COFFEE	5,957	314	52.71
54	SUMTER	2,157	114	52.85
55	BUTLER	3,561	189	53.07
56	BIBB	2,113	113	53.48
57	FRANKLIN	4,530	260	57.40
58	COVINGTON	6,035	357	59.15
59	WINSTON	3,495	217	62.09
60	CRENSHAW	2,407	151	62.73
61	LAMAR	2,493	158	63.38
62	MACON	3,381	219	64.77
63	CLAY	2,411	164	68.02
64	BULLOCK	1,621	112	69.09
65	HALE	2,361	180	76.24
66	PERRY	1,681	142	84.47
67	TALLAPOOSA	6,586	557	84.57
	TOTALS	**565,302**	**25,151**	**44.49**

(*) INCLUDES BEDS APPROVED BUT NOT YET LICENSED

410-2-4-.04 Limited Care Facilities – Specialty Care Assisted Living Facilities.

(1) Definition. Specialty Care Assisted Living Facilities are intermediate care facilities which provide their residents with increased care and/or supervision which is designed to address the residents' special needs due to the onset of dementia, Alzheimer's disease or similar cognitive impairment and which is in addition to assistance with normal daily activities including, but not limited to, restriction of egress for residents where appropriate and necessary to protect the resident and which require a license from the Department of Public as a Specialty Care Assisted Living Facilities pursuant to Ala. Admin. Code §420-5-20, *et seq.*

(2) Specialty Care Assisted Living Facility Bed Need Methodology

(a) Purpose. The purpose of this specialty care assisted living facility bed need methodology is to identify, by county, the number of beds needed to assure the continued availability, accessibility, and affordability of quality care for residents of Alabama.

(b) General. Formulation of this bed need methodology was accomplished by a committee of the Statewide Health Coordinating Council (SHCC). The committee which provided its recommendations to the SHCC, was composed of providers and consumers of health care. Only the SHCC, with the Governor's final approval, can make changes to this methodology except that the SHPDA staff shall annually update bed need projections and inventories to reflect more current population and utilization statistics. Such updated information is available for a fee upon request. Adjustments are addressed in paragraph (E).

(c) Basic Methodology. Considering the availability of more community and home based services for the elderly in Alabama, there should be a minimum of 4 beds per 1,000 population 65 and older for each county.

The bed need formula is as follows:

(4 beds per thousand) x (population 65 and older) =
Projected Bed Need

(d) Planning Policies

1. Projects to develop specialty care assisted living facilities or units in areas where there exist medically underserved, low income, or minority populations should be given priority over projects not being developed in these critical areas when the project to develop specialty care assisted living facilities in areas where there exists medically underserved, low income or minority populations is not more costly to develop than other like projects.

2. Bed need projections will be based on a three-year planning horizon.

3. Planning will be on a countywide basis.

4. Subject to SHCC adjustments, no beds will be added in any county where that county's projected ratio exceeds 4 beds per 1,000 population 65 and older.

5. When any specialty care assisted living facility relinquishes its license to operate, either voluntarily or

involuntarily other than by a Certificate of Need approved transfer, or by obtaining title by a foreclosure as specified in the opinion rendered by the Alabama Attorney General, November 17, 1980, the need for the facility and its resources will automatically be eliminated from the facilities portion of the State Health Plan. The new bed need requirement in the county where the facility was located will be that number which will bring the county ratio up to 4 beds per 1,000 population 65 and older.

6. Additional need may be shown in situations involving a sustained high occupancy rate either for a county or for a single facility. An applicant may apply for additional beds, and thus the establishment of need above and beyond the standard methodology, utilizing one of the following two policies. Once additional beds have been applied for under one of the policies, that applicant shall not qualify to apply for additional beds under either of these policies unless and until the established time limits listed below have passed. All CON authorized SCALF beds shall be included in consideration of occupancy rate and bed need.

(i) If the occupancy rate for a county is greater than 92% utilizing the census data in the most recent full year "Annual Report(s) for Specialty Care Assisted Living Facilities (Form DM-1)" published by or filed with SHPDA, an additional need of the greater of either ten percent (10%) of the current total CON Authorized bed capacity of that county or sixteen (16) total beds may be approved for either the creation of a new facility or for the expansion of existing facilities within that county. However, due to the priority of providing the most cost effective health care services available, a new facility created under this policy shall only be allowed through the conversion of existing beds at an Assisted Living Facility currently in possession of a regular, non-probationary license from the Alabama Department of Public Health. Once additional need has been shown under this policy, no new need shall be shown in that county based upon this rule for twenty-four (24) months following issuance of the initial CON, to allow for the impact of those beds in that county to be analyzed. Should the initial applicant for beds in a county not apply for the total number of beds allowed to be created under this rule, the remaining beds would then be available to be applied for by other providers in the county, so long as said providers meet the conditions listed in this rule.

(ii) If the occupancy rate for a single facility is greater than 92% utilizing the census data in the last two (2) most recent full year "Annual Report(s) for Specialty Care Assisted Living Facilities (Form DM-1)" published by or filed with SHPDA, irrespective of the total occupancy rate of the

county over that time period, up to sixteen (16) additional beds may be approved for the expansion of that facility only. Once additional beds have been approved under this policy, no new beds shall be approved for that facility for twenty-four (24) months following issuance of the CON, to allow for the impact of those beds at that facility to be analyzed.

7. No application for the establishment of a new, freestanding SCALF shall be approved for fewer than sixteen (16) beds, to allow for the financial feasibility and viability of a project. Because of this, need may be adjusted by the Agency for any county currently showing a need of more than zero (0) but fewer than sixteen (16) total beds to a total need of sixteen (16) new beds, but only in the consideration of an application for the construction of a new facility in that county. Need shall not be adjusted in consideration of an application involving the expansion of a currently authorized and licensed SCALF or for the conversion of beds at an existing Assisted Living Facility.

8. Any CON Application filed by a licensed SCALF shall not be deemed complete until, and unless:

(i) The applicant has submitted all survey information requested by SHPDA prior to the application date; and

(ii) The SHPDA Executive Director determines that the survey information is complete.

9. No licensed SCALF filing an intervention notice or statement in opposition in any CON proceeding may cite or otherwise seek consideration by SHPDA of such facility's utilization data until, and unless:

(i) The intervenor or opponent has submitted all survey information requested by SHPDA prior to the application date; and

(ii) The SHPDA Executive Director determines that the survey information is complete.

(e) Adjustments. The bed need, as determined by the methodology, is subject to adjustments by the SHCC. The specialty care assisted living facility bed need may need to be adjusted by the SHCC if an applicant can prove that the identified needs of a targeted population are not being met by existing specialty care assisted living facilities in the county of the targeted population.

(f) Notwithstanding the foregoing, any application for certificate of need for specialty care assisted living facility beds for which a proper letter of intent was duly filed with SHPDA prior to the adoption of the bed need methodology shall not be bound by this bed need methodology.

(g) The determination of need for specialty care assisted living facility beds shall not be linked to the number of existing assisted living beds in the county.

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: New Rule: Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed January 16, 2001; effective February 20, 2001. **Amended:** Filed July 29, 2003; effective September 2, 2003. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended:** Filed August 18, 2012, effective September 18, 2012. **Amended (SHP Year Only):** Filed December 2 2014; effective January 6, 2015.

Specialty Care Assisted Living Facility
CON'S Issued

Facility Name	City	County	Type Application	Beds
Canterbury Health Care Facility	Phenix City	Russell	Conversion	35
Liveoak Village Dementia Care Facility	Foley	Baldwin	Initial	30
NHC Place, Anniston	Anniston	Calhoun	Conversion	68
Our Southern Home West	Mobile	Mobile	Conversion	16
Our Southern Home – Three Notch	Mobile	Mobile	Conversion	54
Southern Home Place	Vernon	Lamar	Initial	10
Trinity Health Care Blount, Inc.	Not Determined	Blount	Initial	70
Trinity Health Care Talladega, Inc.	Not Determined	Talladega	Initial	150
Trinity Health Care St. Clair, Inc.	Not Determined	St. Clair	Initial	150
Trinity Health Care Morgan, Inc.	Not Determined	Morgan	Initial	150
Trinity Health Care Marshall, Inc.	Not Determined	Marshall	Initial	150
Trinity Health Care Etowah, Inc.	Not Determined	Etowah	Initial	150
Trinity Health Care Dekalb, Inc.	Not Determined	Dekalb	Initial	150
Trinity Health Care Cherokee, Inc.	Not Determined	Cherokee	Initial	150
Trinity Health Care Cullman, Inc.	Not Determined	Cullman	Initial	150
Trinity Health Care Calhoun, Inc.	Not Determined	Calhoun	Initial	150
Wesley Manor Retirement Center	Dothan	Houston	Initial	30
Wesley Gardens Retirement Center Specialty Care	Montgomery	Montgomery	Conversion	16
Capstone Village, Inc	Tuscaloosa	Tuscaloosa	Initial	16
Total Additional Beds				1695

SPECIALTY CARE ASSISTED LIVING BED NEED PROJECTIONS

COUNTY	Pop 65 & Older 2006	4 Per 1,000 Pop 65 & Older	Total Beds Needed	Licensed Beds	CON Issued	Net Beds Needed
AUTAUGA	5,622	22	22	80	0	-58
BALDWIN	27,411	110	110	73	30	7
BARBOUR	4,034	16	16	0	0	16
BIBB	2,817	11	11	16	0	-5
BLOUNT	7,881	32	32	50	70	-88
BULLOCK	1,530	6	6	0	0	6
BUTLER	3,490	14	14	16	0	-2
CALHOUN	16,539	66	66	43	162	-139
CHAMBERS	5,901	24	24	56	0	-32
CHEROKEE	4,677	19	19	36	150	-167
CHILTON	5,840	23	23	0	0	23
CHOCTAW	2,593	10	10	0	0	10
CLARKE	4,143	17	17	0	0	17
CLAY	2,589	10	10	0	0	10
CLEBURNE	2,188	9	9	0	0	9
COFFEE	6,799	27	27	16	0	11
COLBERT	8,986	36	36	45	0	-9
CONECUH	2,231	9	9	0	0	9
COOSA	1,897	8	8	0	0	8
COVINGTON	7,017	28	28	0	0	28
CRENSHAW	2,298	9	9	0	0	9
CULLMAN	12,563	50	50	0	150	-100
DALE	6,733	27	27	0	0	27
DALLAS	6,476	26	26	16	0	10
DEKALB	9,668	39	39	16	150	-127
ELMORE	8,319	33	33	22	0	11
ESCAMBIA	5,646	23	23	0	0	23
ETOWAH	16,620	66	66	52	150	-136
FAYETTE	3,209	13	13	8	0	5
FRANKLIN	4,939	20	20	0	0	20
GENEVA	4,539	18	18	0	0	18
GREENE	1,469	6	6	0	0	6
HALE	2,356	9	9	0	0	9
HENRY	2,784	11	11	0	0	11
HOUSTON	13,210	53	53	16	30	7
JACKSON	8,279	33	33	32	0	1
JEFFERSON	87,197	349	349	740	0	-391
LAMAR	2,702	11	11	0	10	1
LAUDERDALE	14,401	58	58	16	0	42
LAWRENCE	4,735	19	19	0	0	19
LEE	10,862	43	43	150	0	-107
LIMESTONE	8,334	33	33	32	0	1
LOWNDES	1,851	7	7	0	0	7

SPECIALTY CARE ASSISTED LIVING BED NEED PROJECTIONS

COUNTY	Pop 65 & Older 2006	4 Per 1,000 Pop 65 & Older	Total Beds Needed	Licensed Beds	Net CON Issued	Beds Needed
MACON	3,295	13	13	0	0	13
MADISON	35,374	141	141	216	0	-75
MARENGO	3,365	13	13	0	0	13
MARION	5,438	22	22	0	0	22
MARSHALL	12,936	52	52	22	150	-120
MOBILE	50,084	200	200	290	70	-160
MONROE	3,559	14	14	0	0	14
MONTGOMERY	26,974	108	108	260	16	-168
MORGAN	15,010	60	60	30	150	-120
PERRY	1,761	7	7	0	0	7
PICKENS	3,343	13	13	0	0	13
PIKE	4,193	17	17	48	0	-31
RANDOLPH	3,797	15	15	0	0	15
RUSSELL	6,794	27	27	0	35	-8
SHELBY	16,461	66	66	128	0	-62
ST. CLAIR	9,153	37	37	15	150	-128
SUMTER	1,966	8	8	0	0	8
TALLADEGA	11,409	46	46	32	150	-136
TALLAPOOSA	7,161	29	29	46	0	-17
TUSCALOOSA	19,139	77	77	32	16	29
WALKER	11,251	45	45	14	0	31
WASHINGTON	2,474	10	10	0	0	10
WILCOX	1,787	7	7	0	0	7
WINSTON	3,990	16	16	16	0	0
TOTALS	624,090	2,480	2,480	2,664	1639	-1823

ALABAMA'S INVENTORY OF SPECIALTY CARE ASSISTED LIVING FACILITIES

Facility		City				Beds
AUTAUGA *County*						
001-S0109	CAMELLIA LANE I	PRATTVILLE				16
001-S0105	CAMELLIA LANE II	PRATTVILLE				16
001-S0104	GREENSPRINGS I	PRATTVILLE				16
001-S1001	HICKORY HILL	PRATTVILLE				32
	AUTAUGA County	Totals:	Number Of Facilities:	4	Number Of Beds:	80
BALDWIN *County*						
003-S0110	AZALEA PLACE ASSISTED LIVING FACILITY	BAY MINETTE				9
003-S0111	JOHN MCCLURE SNOOK REGIONAL CENTER	DAPHNE				48
003-S0210	OAKLAND PLACE	FAIRHOPE				16
	BALDWIN County	Totals:	Number Of Facilities:	3	Number Of Beds:	73
BIBB *County*						
007-S0112	OAKWOOD ASSISTED LIVING	CENTREVILLE				16
	BIBB County	Totals:	Number Of Facilities:	1	Number Of Beds:	16
BLOUNT *County*						
009-S5001	JACOBS HOUSE I SPECIALTY CARE, THE	HAYDEN				16
009-S5002	OLIVE HOME, INC. - ONEOTA #2, LLC	ONEONTA				18
009-S5003	WARDEN MANOR ASSISTED LIVING, LLC	HAYDEN				16
	BLOUNT County	Totals:	Number Of Facilities:	3	Number Of Beds:	50
BUTLER *County*						
013-S7002	HOMEWOOD OF GREENVILLE, L.L.C.	GREENVILLE				16
	BUTLER County	Totals:	Number Of Facilities:	1	Number Of Beds:	16
CALHOUN *County*						
015-S8001	AUTUMN COVE MEMORY CARE	ANNISTON				27
015-S0801	EASTSIDE MANOR RETIREMENT HOME	ANNISTON				16
	CALHOUN County	Totals:	Number Of Facilities:	2	Number Of Beds:	43
CHAMBERS *County*						
017-S9001	RIVER BEND	VALLEY				56
	CHAMBERS County	Totals:	Number Of Facilities:	1	Number Of Beds:	56
CHEROKEE *County*						
019-S1001	CHEROKEE VILLAGE SPECIALTY CARE ASSISTED LIVING FACILITY	CENTRE				36
	CHEROKEE County	Totals:	Number Of Facilities:	1	Number Of Beds:	36
COFFEE *County*						
031-S1601	KELLEY PLACE (SCALF)	ENTERPRISE				16
	COFFEE County	Totals:	Number Of Facilities:	1	Number Of Beds:	16

ALABAMA'S INVENTORY OF SPECIALTY CARE ASSISTED LIVING FACILITIES

Facility		City				Beds
COLBERT *County*						
033-S1786	BRENTWOOD RETIREMENT COMMUNITY II	MUSCLE				16
033-S1785	BRENTWOOD RETIREMENT COMMUNITY I	MUSCLE				16
033-S1701	WELLINGTON PLACE OF MUSCLE SHOALS SPECIALTY CARE	MUSCLE				13
	COLBERT County	Totals:	Number Of Facilities:	3	Number Of Beds:	45
DALLAS *County*						
047-S2401	HOMEWOOD OF SELMA, INC.	SELMA				16
	DALLAS County	Totals:	Number Of Facilities:	1	Number Of Beds:	16
DEKALB *County*						
049-S2501	ROSE MANOR OF GERALDINE, INC.	GERALDINE				16
	DEKALB County	Totals:	Number Of Facilities:	1	Number Of Beds:	16
ELMORE *County*						
051-S2601	RIVER RIDGE SPECIALTY CARE ASSISTED LIVING	WETUMPKA				22
	ELMORE County	Totals:	Number Of Facilities:	1	Number Of Beds:	22
ETOWAH *County*						
055-S2802	MEADOWOOD SPECIALTY CARE FACILITY	GLENCOE				40
055-S2801	ROYAL HAVEN AT REGENCY POINTE	RAINBOW CITY				12
	ETOWAH County	Totals:	Number Of Facilities:	2	Number Of Beds:	52
FAYETTE *County*						
057-S5004	MORNINGSIDE OF FAYETTE SPECIALTY CARE	FAYETTE				8
	FAYETTE County	Totals:	Number Of Facilities:	1	Number Of Beds:	8
HOUSTON *County*						
069-S3501	TERRACE AT GROVE PARK SPECIALTY CARE ASSIST LIV FACILITY	DOTHAN				16
	HOUSTON County	Totals:	Number Of Facilities:	1	Number Of Beds:	16
JACKSON *County*						
071-S3602	ROSE WOOD MANOR, INC	SCOTTSBORO				16
071-S3604	ROSE WOOD MANOR, INC II	SCOTTSBORO				16
	JACKSON County	Totals:	Number Of Facilities:	2	Number Of Beds:	32
JEFFERSON *County*						
073-S3707	BANKHEAD SPECIALTY CARE	DORA				11
073-S3710	FAIR HAVEN RETIREMENT CENTER-SPECIALTY CARE	BIRMINGHAM				64
073-S3701	GALLERIA OAKS	BIRMINGHAM				110
073-S3702	HOLLY COTTAGE AT COUNTRY COTTAGES	HOOVER				16
073-S3711	KIRKWOOD BY THE RIVER SPECIALTY CARE	BIRMINGHAM				20
073-S3712	LAKE VILLA SPECIALTY CARE ASSISTED LIVING	BIRMINGHAM				175
073-S3704	MOUNT ROYAL TOWERS SPECIALTY CARE ASST LIVING FACILITY	BIRMINGHAM				129
073-S3713	ORCHARD, THE	BIRMINGHAM				32

ALABAMA'S INVENTORY OF SPECIALTY CARE ASSISTED LIVING FACILITIES

Facility		City				Beds
073-S3705	PARK AT RIVERCHASE SPECIALTY CARE, THE	HOOVER				38
073-S3715	PLANTATION MANOR ASSISTED LIVING I	MC CALLA				16
073-S3716	PLANTATION MANOR ASSISTED LIVING II	MC CALLA				16
073-S3717	PLANTATION MANOR ASSISTED LIVING III	MC CALLA				16
073-S3714	SOMBERBY AT UNIVERSITY PARK SPECIALTY CARE	BIRMINGHAM				30
073-S3706	ST MARTIN'S-IN-THE-PINES SPECIALTY CARE ASST LIVING	BIRMINGHAM				35
073-S3709	TANNEHILL HAVEN, INC. (scalf)	MCCALLA				32
	JEFFERSON County	Totals:	Number Of Facilities:	15	Number Of Beds:	740
LAUDERDALE *County*						
077-S3901	GREEN OAKS INN-CREEL HOUSE	FLORENCE				16
	LAUDERDALE County	Totals:	Number Of Facilities:	1	Number Of Beds:	16
LEE *County*						
081-S4103	CAMBRIDGE PLACE	OPELIKA				36
081-S4101	CAMELLIA PLACE AT AUBURN MEDICAL PARK	AUBURN				58
081-S4102	MAGNOLIA PLACE SPECIALTY CARE	AUBURN				40
081-S4104	NORTHRIDGE	OPELIKA				16
	LEE County	Totals:	Number Of Facilities:	4	Number Of Beds:	150
LIMESTONE *County*						
083-S4201	LIMESTONE LODGE EAST	ATHENS				16
083-S4202	LIMESTONE LODGE WEST	ATHENS				16
	LIMESTONE County	Totals:	Number Of Facilities:	2	Number Of Beds:	32
MADISON *County*						
089-S4503	AGAPE VILLAGE	HAZEL GREEN				16
089-S4502	AGAPE VILLAGE II (SCALF)	HAZEL GREEN				16
089-S4501	EDENBROOK OF HUNTSVILLE, KEEPSAKE GARDENS	HUNTSVILLE				38
089-S4506	HAVEN FOR GREATER LIVING, INC., THE	NEW MARKET				16
089-S4504	PINE CREST ESTATE, INC.	HUNTSVILLE				16
089-S3754	REGENCY MANOR ASSISTED LIVING FACILITY	GURLEY				16
089-S4507	REMEMBRANCES CENTER AT WYNDHAM PARK, THE	HUNTSVILLE				16
089-S4508	VENONA ACRES NORTH	HUNTSVILLE				16
089-S4506	VENONA ACRES SOUTH	HUNTSVILLE				16
089-S4505	WELLINGTON PLACE AT HAMPTON COVE	HAMPTON				50
	MADISON County	Totals:	Number Of Facilities:	10	Number Of Beds:	216
MARSHALL *County*						
095-S4801	MERRILL GARDENS AT ALBERTVILLE GARDEN HOUSE	ALBERTVILLE				22
	MARSHALL County	Totals:	Number Of Facilities:	1	Number Of Beds:	22

ALABAMA'S INVENTORY OF SPECIALTY CARE ASSISTED LIVING FACILITIES

Facility		City				Beds
MOBILE *County*						
097-S4950	ASHBURY MANOR	MOBILE				16
097-S4903	ATRA ASSISTED LIVING REGENCY SPECIALTY CARE	MOBILE				20
097-S4902	BROOKSIDE ASSISTED LIVING	MOBILE				32
097-S4914	GORDON OAKS CONVALESCENT CENTER INC.	MOBILE				34
097-S4905	GORDON OAKS SCALF	MOBILE				100
097-S4901	LAKEFRONT SPECIALTY CARE ASSISTED LIVING	MOBILE				16
097-S4906	NORTH MOBILE RETIREMENT CENTER	SATSUMA				40
097-S4904	OUR SOUTHERN HOME	MOBILE				16
097-S4918	TAY-CON MAGNOLIA HOUSE-DAUPHIN	MOBILE				16
	MOBILE County	Totals:	Number Of Facilities:	9	Number Of Beds:	290
MONTGOMERY *County*						
101-S5101	ANGELS FOR THE ELDERLY II, INC.	MONTGOMERY				16
101-S5102	ANGELS FOR THE ELDERLY III, INC	MONTGOMERY				16
101-S5110	ANGELS FOR THE ELDERLY IV INC	MONTGOMERY				16
101-S5102	BETH MANOR	MONTGOMERY				16
101-S5113	CEDARS, THE	MONTGOMERY				61
101-S5127	Country Cottage-Holly	MONTGOMERY				16
101-S5128	EAST HAVEN ASSISTED II	MONTGOMERY				16
101-S5129	ELMCROFT OF HALCYON SPECIALTY CARE	MONTGOMERY				16
101-S5104	GOD'S GRACE SPECIALTY CARE ASSISTED LIVING FACILITY	MONTGOMERY				13
101-S5122	MON PETITE MAISON	MONTGOMERY				8
101-S5106	ROSEWOOD TERRACE, INC.	MONTGOMERY				16
101-S5103	WATERFORD PLACE	MONTGOMERY				50
	MONTGOMERY County	Totals:	Number Of Facilities:	12	Number Of Beds:	260
MORGAN *County*						
	SUNSHINE HAVEN ASSISTED LIVING	HARTSELLE				15
	MORGAN County	Totals:	Number Of Facilities:	3	Number Of Beds:	30
PIKE ***County***						
109-S5503	MAGNOLIA WOOD LODGE II	TROY				16
109-S5504	MAGNOLIA WOOD LODGE III	TROY				16
109-S5505	MAGNOLIA WOOD LODGE IV	TROY				16
	PIKE County	Totals:	Number Of Facilities:	3	Number Of Beds:	48
SHELBY *County*						
117-S5911	LAKE VIEW ESTATES ASSISTED LIVING	BIRMINGHAM				64
117-S5913	SHANGRI-LA ASSISTED LIVING, LLC	COLUMBIA				16
117-S5912	SPRINGS MANOR SPECIALTY CARE	BIRMINGHAM				48
	SHELBY County	Totals:	Number Of Facilities:	3	Number Of Beds:	128

ALABAMA'S INVENTORY OF SPECIALTY CARE ASSISTED LIVING FACILITIES

Facility		City				Beds
ST. CLAIR *County*						
115-S5801	SPRINGS MANOR SPECIALTY CARE	COOK SPRINGS				15
	ST. CLAIR County	Totals:	Number Of Facilities:	1	Number Of Beds:	15
TALLADEGA *County*						
121-S6101	AUTUMN TRACE	TALLADEGA				16
121-S6102	MOUNTAIN VIEW LAKE RETIREMENT VILLAGE	SYLACAUGA				16
	TALLADEGA County	Totals:	Number Of Facilities:	2	Number Of Beds:	32
TALLAPOOSA *County*						
123-S6201	CHAPMAN SPECIALTY CARE ASSISTED LIVING FACILITY	ALEXANDER				46
	TALLAPOOSA County	Totals:	Number Of Facilities:	1	Number Of Beds:	46
TUSCALOOSA *County*						
125-S6301	MARTINVIEW EAST	NORTHPORT				16
125-S6302	MERRILL GARDENS AT NORTHPORT GARDEN HOUSE	NORTHPORT				16
	TUSCALOOSA County	Totals:	Number Of Facilities:	2	Number Of Beds:	32
WALKER *County*						
127-S6401	TERRACE AT JASPER SPECIALTY CARE ASSISTED LIVING FACILITY	JASPER				14
	WALKER County	Totals:	Number Of Facilities:	1	Number Of Beds:	14
WINSTON *County*						
133-S6701	ROSE MANOR OF HALEYVILLE	HALEYVILLE				16
	WINSTON County	Totals:	Number Of Facilities:	1	Number Of Beds:	16
		State Totals:	Number Of Facilities:	98	Number Of Beds:	2680

Revised as of: 07/28/2004

410-2-4-.05 Assisted Living Facilities.

(1) Definition. Assisted living facilities are licensed facilities that consist of permanent buildings, portions of buildings, or groups of buildings (not to include mobile homes and trailers) in which room, board, meals, laundry, assistance with personal care, and other services are provided for not less than twenty-four hours in any week to a minimum of two ambulatory adults not related by blood or marriage to the owner and/or administrator.

(2) Existing Assisted Living Facilities. As of January 2004, there were 247 licensed assisted living facilities totaling 7,572 beds operating in the state of Alabama, or approximately 12.1 beds per 1,000 persons 65 and older. Assisted living is available in Alabama on a private-pay basis only.

(3) Availability. The 247 licensed assisted living facilities are concentrated in the more populated counties. Three counties contain 35% of the assisted living beds and 10 counties contain 65% of the assisted living beds. Fifty-four of the 67 counties have assisted living facilities and 13 counties have no assisted living facilities. Generally, these facilities are distributed geographically; however, there are two counties in northwest Alabama, and ten counties in central and south Alabama that have no assisted living facilities. Cherokee and Cleburne are the only northeast Alabama counties without an assisted living facility.

(4) Continuity

(a) Discussion. Assisted living facilities should provide assistance appropriate to resident needs. To insure that comprehensive services are available and to be certain residents are at a proper level of care, assisted living facilities should provide, or should have agreements with health care providers to provide, a broad range of care. When providing these services, transfer of residents and support services should be provided as necessary.

(b) Self-Help Program. Assisted living providers will be encouraged to provide a level of assistance that would help and encourage the residents to be self-sufficient for as long as possible before requiring a change to a more dependent home.

(5) Quality. Quality assistance is an obligation of all assisted living facilities operating in Alabama. Each facility must meet standards established by the Alabama Department of Public Health (see paragraph 4 above). The

Division of Licensure and Certification of the Alabama Department of Public Health is responsible for determining compliance.

(6) Assisted Living Facilities Bed Need Methodology.

(a) Purpose. The purpose of this assisted living bed need methodology is to identify, by county, the number of assisted living beds needed to assure the continued availability, accessibility, and affordability of quality supervised assistance for residents of Alabama. Bed need projections contained in this section are recommendations only and are not intended to be regulatory.

(b) Basic Methodology. When reviewing the existing nursing homes and assisted living facilities, it was found that the total combined beds came to approximately 54.7 beds/1,000 sixty-five and older. The adjacent states combined totals were: 53.7 for Mississippi, 83.7 for Georgia, 68.3 for Tennessee, and 51.7 for Florida. Considering the availability of community and home based services and nursing homes for the elderly in Alabama, the methodology in determining the number of beds needed is based on the following formula which will bring Alabama up to 55 combined beds/1,000 sixty-five and older.

Formula

(16 beds per 1,000) x (population 65 and older) = Projected Bed Need.

(c) Planning Policies

1. Population projections will be based on a three-year planning horizon.

2. Planning will be on a countywide basis.

3. Subject to SHCC adjustments, beds should not be added in any county where that county’s projected ratio exceeds 16 beds per 1,000 populations 65 and older.

4. No new freestanding assisted living facility should be constructed having less than eight beds.

5. When any assisted living facility relinquishes its license to operate, either voluntarily or involuntarily, the facility and its resources will automatically be eliminated from this section of the State Health Plan. The new bed need in the county where the facility was located will be that number which will bring the county ratio up to 16 beds per 1,000 population 65 and older.

For a listing of Nursing Homes or the most current statistical need projections in Alabama, you may contact the Data Division, as follows:

MAILING ADDRESS (U.S. Postal Service	STREET ADDRESS (Commercial Carrier)
PO BOX 303025 MONTGOMERY, AL 36130-3025	100 N. UNION STREET, SUITE 870 MONTGOMERY, AL 36104
TELEPHONE: (334) 242-4103	FAX: (334) 242-4113

E-MAIL: Bradford.Williams@shpda.alabama.gov
WEBSITE: http://www.shpda.Alabama.gov
Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective October 29, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended:** Filed August 18, 2012, effective September 18, 2012. **Amended (SHP Year Only):** Filed December 2 2014; effective January 6, 2015.

Note: Statistically updated September 30, 1993. Rule No. 410-2-4-.02 through 410-2-4-.09, inclusive, have been revised to reflect more current inventories, population, and utilization statistics, effective September 30, 1993. Statistically updated August 3, 1994. These updates reflect changes in inventories, utilization, populations, and need projections; effective August 3, 1994. Statistically updated August 21, 1995.

410-2-4-.06 Adult Day Care Programs.

(1) Definition. Adult day care programs may be identified as structured, comprehensive programs designed to offer lower cost alternative to institutionalization for newly or chronically disabled adults who cannot stay alone during the day, but who do not need 24-hour inpatient care. Designed to promote maximum independence, participants usually attend on a scheduled basis. Services may include nursing, counseling, social services, restorative services, medical and health care monitoring, exercise sessions, field trips, recreational activities, physical, occupational and speech therapy, medication

administration, well balanced meals, and transportation to and from the facility. Adult day care can provide the respite family members require to sustain healthy relationships while caring for their elderly loved one at home. Adult day care programs provide services to one or more adults not related by blood or marriage to the owner and/or administrator.

(2) Analysis of Existing Adult Day Care Programs. Adult day care programs do not currently have to be licensed by any department of the State of Alabama. As a consequence, it is extremely difficult to ascertain the actual number of such programs within Alabama. However, Adult Day Care Centers are approved through ADPH, ADSS and Medicaid. Mental Health also uses adult day care. It has also been reported that the Birmingham area has numerous private Adult Day Care Centers. Because there is no regulation it is difficult to develop an accurate methodology.

(3) Adult Day Care Programs as Alternatives to Nursing Home Admission.

(a) Efforts should be made to maintain an optimum quality of life for individuals who require extended or long-term care. The types and amounts of services needed for these individuals vary. In order to enhance opportunities for individuals needing extended or long-term care services, the needs of these individuals should be evaluated prior to admission to any extended care or long-term care program, including nursing homes, assisted living homes, and adult day care programs.

(b) In an effort to encourage the development and utilization of alternatives to nursing home and assisted living (domiciliary) care, adult day care programs and services for the elderly should be utilized to the greatest extent possible. It is the intent to provide for the establishment of additional adult day care programs in order that: (i) the elderly will be given the opportunity to remain with their families and in their communities, rather than being placed in nursing homes or state institutions; (ii) families, particularly those with one or more members working outside of the home, may keep their elderly parents and relatives with them, instead of having to place them in impersonal institutions; and (iii) the State of Alabama can deal more effectively and economically with the needs of its elderly citizens.

(4) Financing. Historically, all adult day care programs have been private pay with some assistance coming from public and community sources.

(5) Availability. Adult day care programs are concentrated in the more populated counties. Many counties have no adult day care programs and a number are without assisted living facilities.

(6) Continuity.

(a) Discussion. Adult day care programs should provide care appropriate to the needs of their participants. To insure that comprehensive services are available and that certain participants receive a proper level of care, adult day care programs should provide, or should have agreements with other health care providers to provide, a broad range of care. When providing these services, transportation and support services for participants should be provided as necessary.

(b) Self-Help Program. Adult day care program providers should be encouraged to provide a level of care that will help maintain and improve function and encourage participants to be as independent as they can for as long as possible before the condition of such participants requires a change to a more dependent level of care.

(7) Quality. Quality care is an obligation of all adult day care programs operating in Alabama. Each program should comply with applicable state and local building regulations, and zoning, fire, and health codes or ordinances. In addition, each program must comply with all requirements of its funding sources, including requirements with respect to a Medicaid Waiver, if applicable.

(8) Promotion of adult day care programs. The alternate special affordable care offered by adult day care programs should be publicized by responsible agencies using some or all of the following:

(a) Public Service Announcements

(b) Physicians (provide literature)

(c) Hospitals (discharge planners)

(d) Nursing Homes

(e) The Alabama Commission on Aging

(f) The American Association of Retired Persons

(g) Community Service Agencies/Projects

(h) Religious Organizations

(i) The Department of Human Resources

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: **New Rule:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2 2014; effective January 6, 2015.

410-2-4-.07 Home Health.

(1) Definitions

(a) Home Health Agency. A home health agency is an organization that is primarily engaged in providing skilled nursing services and other therapeutic services. Services are provided on an intermittent basis. Each visit must be less than four hours in duration. Any visit made to or procedures performed on a patient at their home must only be made upon a physician's written order. Home health providers shall provide at least the following services, including, but not limited to, skilled nursing care, personal care, physical therapy, occupational therapy, speech therapy, medical social services, and medical supplies services.

(b) Home Health Care. Home health care is that component of a continuum of comprehensive health care whereby intermittent health services are provided to individuals and families in their places of residence for the purpose of promoting, maintaining or restoring health, or of maximizing the level of independence, while minimizing the effects of disability and illness, including terminal illness. Services appropriate to the needs of the individual patient and family are planned, coordinated, and made available by providers organized for the delivery of home health care through the use of employed staff, contractual arrangements, or a combination of employed staff and contractual arrangements. There is no licensure requirement for home health agencies in Alabama.

(c) Home Health Services. Home health services are made available based upon patient care needs as determined by an objective patient assessment administered by a multidisciplinary team or a single health professional. Centralized professional coordination and case management are included. These services are provided under a plan of treatment certified by a physician that may include, but are not limited to, appropriate service

components, such as medical, nursing, social work, respiratory therapy, physical therapy, occupational therapy, speech therapy, nutrition, homemaker home health aide service, and provision of medical equipment and supplies.

(d) Section 22-21-265, Code of Ala. 1975, allows an existing home health agency to accept referrals from a county which is contiguous to the county where the CON is held (see the referenced section above for restrictions as provided in the section with regards to contiguous counties; also this information is posted on the SHPDA website at http://www.shpda.alabama.gov.)

(2) Inventory of Existing Resources. The State Health Planning and Development Agency annually compiles several home health agency reports and identifies counties which are in need of an additional agency. These publications are available for a fee upon request. A current listing of home health agencies is located at http://www.shpda.alabama.gov or http://www.adph.org.

(3) Planning Policy – (Availability). Home health visits are scheduled on an intermittent basis and must be available seven days a week at such times as may be ordered by referring physicians. While availability must include provision for weekend and evening services, emergency services are not within the scope or purpose of home health providers.

(4) Accessibility

(a) Home health services must be obtainable by the general public in every county in the state.

(b) Because physicians and other referral sources are sometimes unfamiliar with the total scope of services offered by home health providers, patients' accessibility is also limited by failure to refer appropriately to home health services. Every agency should provide an active community information program to educate consumers and professionals to the availability, nature, and extent of home health services.

(c) Because services are provided in patients' own homes, accessibility to services is not dependent upon physical or geographic accessibility to the home health provider's offices. The essential characteristics are location of home health visiting staff in proximity to patients' places of residence and telephone accessibility of the provider to patients, physicians, and other referral sources.

(5) Acceptability and Continuity

(a) Acceptability is the willingness of consumers, physicians, discharge planners, and others to use home health services as a distinct component of the health care continuum.

(b) Continuity reflects a case management approach that allows patient entry into the health care continuum at the point that ensures delivery of appropriate services. Home health care provides a balanced program of clinical and social services, and may serve as a transitional level of care between inpatient treatment and infrequent physician office visits. Home health also extends certain intensive, specialized treatments into the home setting.

(c) Planning Guides and Policies

1. Planning Guide. Home health providers shall maintain referral contacts with appropriate community providers of health and social services, to facilitate continuity of care and to coordinate services not provided directly by the home health provider.

2. Planning Policy. Home health providers must furnish discharge-planning services for all patients.

(6) Quality

(a) Quality is that characteristic, which reflects professionally appropriate and technically adequate patient services.

(b) The state home health industry, through development of ethical standards and a peer review process, can foster provision of quality home health care services. Each provider must establish mechanisms for quality assurance, including procedures for resolving concerns identified by patients, physicians, families or others involved in patient referral or patient care.

(c) Planning Policies

1. Planning Policy. The county will be the geographic unit for need determination, based upon population.

2. Planning Policy – (New Providers). When a new provider is approved for a county, that provider will have eighteen months from the date of the Certificate of Need to meet the identified need in the county before a new provider may apply for a Certificate of Need to serve a county.

3. Planning Policy – (Existing Providers). If an existing provider ceases to operate in a county, once the Certificate of Need is deemed null and void then a provider can apply under the current published statistical need.

4. Planning Policy – Favorable Consideration. Home health agencies that achieve or agree to achieve Charity Care plus Self Pay at the statewide average percent for all home health providers shall be given favorable CON consideration over home health applicants that do not achieve or agree to achieve the statewide average for Charity Care plus Self Pay, but not less than one (1) percent. The latest published SHPDA data report HH-11 shall be used to determine the statewide average percent for Charity Care plus Self Pay, which was 1.3 percent for 2005. Donations of assets to governmental and non-profit organizations at the individual county level may be considered. See section 410-2-2-.06 for the definition of charity care.

5. Planning Policy – CON Intervention/Opposition.

(i) Any CON application filed by a health care facility shall not be deemed complete until, and unless:

(I) The applicant has submitted all survey information requested by SHPDA prior to the application date; and

(II) The SHPDA Executive Director determines that the survey information is substantially complete.

(ii) No Home Health Agency or Hospice Agency filing an intervention notice or statement in opposition in any CON proceeding may cite or otherwise seek consideration by SHPDA of such facility's utilization data until, and unless:

(I) the intervenor or opponent has submitted all survey information requested by SHPDA prior to the application date; and

(II) the SHPDA Executive Director determines that the survey information is substantially complete.

6. Home Health Need Methodology

(i) Purpose. The purpose of this home health need methodology is to identify, by county, the number of home health agencies needed to assure the continued availability, accessibility, and affordability of quality home health care for residents of Alabama.

(ii) Basic Methodology.

The SHCC finds that the current home health methodology, set forth below, is in need of review prior to the grant or consideration of new home health agencies. Consequently, no new home health applications shall be accepted until the earlier of (1) January 1, 2016; or (2) the adoption of a revised home health need methodology.

In order to perform the calculations for this methodology, population data from the Center for Business and Economic Research (CBER) was used. All time frames are based on the year of the latest reported data.

Step 1:

1. Data required to perform the calculations in this methodology are: population data for the current reporting year, the two reporting years immediately prior to the current reporting year, and the projected data for three years immediately following the current reporting year.

2. Persons served data for the current reporting year, and the two reporting years immediately prior to the current reporting year, are required to perform the calculations in this methodology. This information can be gathered off of the HH-2 report as generated by SHPDA.

3. The ratio for the change in population for two age cohorts, Population under 65 and Population age 65 and over, needs to be determined per county. The ratio for the change will be for a three year period. Therefore, the current reporting year will be compared to the year three years following the current reporting year. The year immediately prior to the current reporting year will be compared to the year two years following the current reporting year. The year two years prior to the current reporting year will be compared to the year immediately following the current reporting year. To show this another way:

Current Reporting Year	--	Current Reporting Year + 3
Current Reporting Year -1	--	Current Reporting Year + 2
Current Reporting Year -2	--	Current Reporting Year + 1

4. Projected patients served under the age of 65 for future reporting years are calculated on a county basis by: multiplying the year's total persons served by 25% (0.25) to determine the approximate number of persons served under the age of 65. This number is divided by the county population under the age of 65 to determine a utilization rate. To determine the

projected patients served under the age of 65, this total is then multiplied by the total projected population for the target year for each county.

5. Projected patients served age 65 and older for future reporting years are calculated on a county basis by: multiplying the year's total persons served by 75% (0.75) to determine the approximate number of persons served age 65 and older. This number is divided by the county population age 65 and older to determine a utilization rate. To determine the *projected patients served age 65 and older*, this total is then multiplied by the total projected population for the target year for each county.

6. To determine the *total number of projected persons served per county*, add the totals from steps 4 and 5.

7. Add the total number of *projected persons served*, by county, to determine the *statewide projected total persons served*.

8. Multiply the target year's *projected total persons served* for the target year by 25% (0.25) to reflect the *projected statewide total persons served* under the age of 65.

9. Divide the total statewide population under the age of 65 for the target year by 1000.

10. Divide the numeric result from step 8 by the numeric result in step 9.

11. Multiply the target year's *projected total persons served* by 75% (0.75) to reflect the projected statewide total persons served ages 65 and over.

12. Divide the total statewide population age 65 and over for the target year by 1000.

13. Divide the numeric result from step 11 by the numeric result in step 12.

14. Add the results from steps 10 and 13. This is the *projected average statewide persons served per 1000 population*, by county, for the target year.

15. Repeat steps 4 through 14 for the second target year.

16. Repeat steps 4 through 14 for the third target year.

17. To determine the *projected weighted statewide average persons served*, perform the following calculation: multiply the *projected statewide average persons served per 1000 population* for 3 years after the current reporting year by 3; multiply the *projected statewide average persons served per 1000 population* for 2 years after the current reporting year by 2; and multiply the *projected statewide average persons served per 1000 population* for 1 year after the current reporting year by 1.

18. Add the three results determined in step 17 and divide the total by 6 for the *projected statewide average persons served per 1000 population*.

19. To determine the *Current Home Health Comparative Value*, multiply the number derived in step 18 by 85% (0.85). This is the value that will be utilized in the comparisons in step 2.

Step 2:

1. Using the data created above for the target year (the year three years after the current reporting year), follow the steps below to determine the future projected need for Home Health Services by county.

2. Multiply the target year's total persons served by 25% (0.25) to reflect the *county wide total persons served under the age of 65*.

3. Divide the total county wide population under the age of 65 by 1000.

4. Divide the numeric result from step 2 by the numeric result in step 3.

5. Multiply the current year's total persons served by 75% (0.75) to reflect the *county wide total persons served ages 65 and over*.

6. Divide the total county wide population age 65 and over by 1000.

7. Divide the numeric result from step 5 by the numeric result in step 6.

8. Add the results from steps 4 and 7. This is the *projected total persons served per 1000 population* used to determine need for Home Health Services in a county.

9. Subtract the result from step 8, by county, from the *Current Home Health Comparative Value*. If this number is negative, there is no need for a new Home Health provider in a county. If the number is positive, continue to step 10.

10. This number is then divided by the SUM of 0.75 (75%) times 1000 divided by the county population aged 65 and over AND 0.25 (25%) times 1000 divided by the county population under the age of 65. This number is the number of new persons required to be served in a county to bring the county persons served per 1000 value up to the statewide comparative value.

11. A threshold level of 100 new patients needed to be served is required for a determination of need in a county. If the number of new patients needed to be served is less than 100, there is no need for a new Home Health provider in a county. If the number is equal to or greater than 100, there is a need for a new Home Health Care provider in a county.

Step 1:
For each target year by county:

(reported year persons served * 0.25) / (reported year population under 65)

= utilization rate population under 65

Utilization rate * target year population under 65 = projected persons served under 65

(reported year persons served * 0.75) / (reported year population age 65 and over)

= utilization rate population age 65 and over

Utilization rate * target year population age 65 and over = projected persons served age 65 and over

Projected persons served under 65 + projected persons served age 65 and over

= Target year projected persons served by county

For each target year:

Sum of all Target year projected persons served by county = Target year projected total persons served

(Target year projected total persons served * 0.25)/(Projected population under 65 /1000) + (Target year projected total persons served * 0.75) / (Projected population age 65 and over /1000)

= Projected Statewide Average Persons Served per 1000 Population

To Determine Current Home Health Comparative Value for Step 2:

$$\frac{((3\text{ Years after Current Reporting Year Projected Average Persons Served} * 3) + (2\text{ Years after Current Reporting Year Projected Average Persons Served} * 2) + (1\text{ Year after Current Reporting Year Projected Average Persons Served} * 1))}{6}$$

= Projected Weighted Average Persons Served per 1000 Population

Projected Weighted Average Persons Served per 1000 Population * 0.85

= Current Home Health Comparative Value

Step 2: *(Using population and persons served projections for 3 years after current reporting year)*

$$\frac{(\text{countywide total persons served} * 0.25)}{(\text{county population under 65}/1000)} + \frac{(\text{countywide total persons served} * 0.75)}{(\text{county population 65 and over}/1000)}$$

= County Persons Served per 1000 Population

Current Home Health Comparative Value - County Persons Served per 1000 Population

= County Projected Persons Per 1000 Population in Need of Home Health Services.

$$\frac{\text{County Projected Persons Per 1000 Population in need of Home Health Services}}{(0.75*1000/\text{Population age 65 and over}) + (0.25*1000/\text{Population under 65})}$$

= New persons required to be served in county to equal Current Home Health Comparative Value

If number is negative, there is no need in a county.
If number is less than 100, there is no need in a county.
If number is 100 or more, there is a need for a new Home Health provider in a county.

For a listing of Home Health Agencies or the most current statistical need projections in Alabama you may contact the Data Division as follows:

MAILING ADDRESS (U.S. Postal Service)	STREET ADDRESS (Commercial Carrier)
PO BOX 303025 MONTGOMERY AL 36130-3025	100 NORTH UNION STREET STE 870 MONTGOMERY AL 36104
TELEPHONE: (334) 242-4103	FAX: (334) 242-4113
E-Mail: info@shpda.alabama.gov	Website: http://www.shpda.alabama.gov

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective 8, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Amended:** Filed January 8, 1997; effective February 12, 1997. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Repealed and New Rule:** Filed December 12, 2006; effective January 16, 2008. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Amended:** Filed February 10, 2015; effective March 17, 2015.

Note: Statistically updated September 30, 1993. Rule No. 410-2-4-.02 through 410-2-4-.09, inclusive, have been revised to reflect more current inventories, population, and utilization statistics, effective September 30, 1993. Statistically updated August 3, 1994. These updates reflect changes in inventories, utilization, populations, and need projections; effective August 3, 1994. Statistically updated August 21, 1995.

COUNTY ASSESSMENT OF NEED FOR HOME HEALTH AGENCIES

	VISITS	PERS SERV	POP 65 + 2003	VISIT PER 1,000 65 +	PERS SERV/ 1,000 65 +	PERS NEEDED TO = 138	METHODOLOGY CONCLUSION
AUTAUGA	30,298	860	5,007	6,051	172		
BALDWIN	66,015	2,532	24,392	2,706	104	829	Possibly Underserved
*BARBOUR	24,984	797	3,928	6,360	203		
*BIBB	9,424	380	2,593	3,634	147		
BLOUNT	20,796	704	7,183	2,895	98	287	Possibly Underserved
*BULLOCK	5,937	200	1,525	3,893	131	21	**
*BUTLER	16,709	599	3,481	4,800	172		
CALHOUN	52,671	1,719	16,169	3,258	106	517	Possibly Underserved
*CHAMBERS	12,589	653	5,874	2,143	111	188	Possibly Underserved
*CHEROKEE	6,645	323	4,225	1,573	76	262	Possibly Underserved
*CHILTON	31,257	861	5,435	5,751	158		
*CHOCTAW	24,677	640	2,449	10,076	261		
*CLARKE	16,463	521	3,939	4,179	132	24	**
*CLAY	20,292	531	2,467	8,225	215		
*CLEBURNE	2,536	125	2,045	1,240	61	27	**
*COFFEE	26,980	859	6,470	4,170	133	52	**
COLBERT	53,686	1,404	8,711	6,163	161		
*CONECUH	27,740	621	2,213	12,535	281		
*COOSA	3,152	142	1,824	1,728	78	109	Possibly Underserved
*COVINGTON	28,479	906	6,871	4,145	132	41	**
*CRENSHAW	9,755	282	2,308	4,227	122	95	**
*CULLMAN	56,261	1,586	11,920	4,720	133	60	**
DALE	17,995	665	6,260	2,875	106	232	Possibly Underserved
*DALLAS	37,655	1,188	6,445	5,843	184		
*DEKALB	34,977	1,195	9,238	3,786	129	83	**
ELMORE	24,232	1,367	7,665	3,161	178		
*ESCAMBIA	20,281	696	5,428	3,736	128	54	**
ETOWAH	64,290	1,784	16,549	3,885	108	496	Possibly Underserved
*FAYETTE	9,901	431	3,084	3,210	140		
*FRANKLIN	40,091	944	4,786	8,377	197		
*GENEVA	18,784	627	4,358	4,310	144		
*GREENE	11,019	276	1,465	7,522	188		
*HALE	21,480	450	2,324	9,243	194		
*HENRY	5,215	226	2,710	1,924	83	149	Possibly Underserved
HOUSTON	44,638	1,531	12,630	3,534	121	215	Possibly Underserved
*JACKSON	39,214	1,123	7,720	5,080	145		
JEFFERSON	286,078	12,400	88,407	3,236	140		
*LAMAR	22,473	539	2,617	8,587	206		
LAUDERDALE	30,957	1,414	13,785	2,246	103	620	Possibly Underserved
LAWRENCE	34,648	861	4,436	7,811	194		
LEE	27,481	1,188	10,037	2,738	118	351	Possibly Underserved
LIMESTONE	39,301	1,140	7,771	5,057	147		
*LOWNDES	6,392	209	1,745	3,663	120	58	**

COUNTY ASSESSMENT OF NEED FOR HOME HEALTH AGENCIES

	VISITS	PERS SERV	POP 65 + 2003	VISIT PER 1,000 65 +	PERS SERV/ 1,000 65 +	PERS NEEDED TO = 138	METHODOLOGY CONCLUSION
*MACON	13,279	596	3,303	4,020	180		
MADISON	82,481	3,537	32,677	2,524	108	980	Possibly Underserved
*MARENGO	15,882	480	3,319	4,785	145		
*MARION	35,104	1,022	5,171	6,789	198		
*MARSHALL	62,023	1,916	12,290	5,047	156		
MOBILE	492,952	7,142	48,819	10,098	146		
*MONROE	33,695	608	3,446	9,778	176		
MONTGOMERY	93,382	3,734	26,553	3,517	141		
MORGAN	57,857	1,884	14,305	4,045	132	86	**
*PERRY	6,477	195	1,762	3,676	111	48	**
*PICKENS	21,370	637	3,316	6,445	192		
*PIKE	28,289	945	3,805	7,435	248		
*RANDOLPH	19,512	607	3,674	5,311	165		
RUSSELL	32,406	1,145	6,658	4,867	172		
ST. CLAIR	25,025	771	8,293	3,018	93	373	Possibly Underserved
SHELBY	26,537	1,270	14,140	1,877	90	679	Possibly Underserved
*SUMTER	17,090	478	2,006	8,519	238		
*TALLADEGA	66,798	1,993	10,985	6,081	181		
*TALLAPOOSA	18,785	857	6,973	2,694	123	300	Possibly Underserved
TUSCALOOSA	101,008	3,589	18,783	5,378	191		
*WALKER	72,028	1,839	10,828	6,652	170		
*WASHINGTON	16,668	462	2,349	7,096	197		
*WILCOX	5,950	171	1,791	3,322	95	77	**
*WINSTON	31,169	869	3,744	8,325	232		
TOTALS	2,760,215	84,246	599,479	4,604	141		

*Designated as Rural by the Health Care Financing Administration.

**Under Section 410-2-4-.07(8) a county will be considered for an additional agency only when the number required to bring the county up to the set number of persons served per 1,000 population 65 and older equals, at a minimum, 100 new person.

Note: Counties below 138 persons served per 1,000 population 65 and older are possibly underserved, utilizing the three year weighted average methodology.

Note: Methodology per *Alabama State Health Plan* 2004-2007
Section 410-2-4-.07.

Source: SHPDA HH-2 report for period ending September 30, 2003

20-Jun-04

ALABAMA
Home Health Care Agencies

Facility Name		City	
BALDWIN *County*			
AMEDISYS HOME HEALTH INC. OF ALABAMA		FAIRHOPE	
MERCY MEDICAL HOME HEALTH		FAIRHOPE	
MID SOUTH HOME HEALTH AGENCIES, INC.		DAPHNE	
SOUTH BALDWIN HOSP HOME HEALTH AGENCY		FOLEY	
THOMAS HOSPITAL HOME HEALTH		DAPHNE	
	BALDWIN County Totals:	Number Of Facilities:	5
BARBOUR *County*			
LAKEVIEW COMMUNITY HOSPITAL HOME HEALTH		EUFAULA	
	BARBOUR County Totals:	Number Of Facilities:	1
BIBB *County*			
BIBB MEDICAL CENTER HOME HEALTH		CENTREVILLE	
	BIBB County Totals:	Number Of Facilities:	1
BLOUNT *County*			
MEDICAL CENTER BLOUNT HOME HEALTH		ONEONTA	
	BLOUNT County Totals:	Number Of Facilities:	1
BULLOCK *County*			
ASSOCIATES HOME HEALTH		UNION SPRINGS	
	BULLOCK County Totals:	Number Of Facilities:	1
BUTLER *County*			
LVSMH HOME HEALTH AGENCY		GREENVILLE	
RELIABLE HOME HEALTH SERVICES, INC.		GEORGIANA	
	BUTLER County Totals:	Number Of Facilities:	2
CALHOUN *County*			
AMEDISYS HOME HEALTH OF ANNISTON		ANNISTON	
GENTIVA HEALTH SERVICES Calhoun		ANNISTON	
NORTHEAST AL REG MEDICAL CENTER HOME HEALTH		ANNISTON	
	CALHOUN County Totals:	Number Of Facilities:	3
CHAMBERS *County*			
LANIER HOME HEALTH SERVICES		VALLEY	
	CHAMBERS County Totals:	Number Of Facilities:	1
CHEROKEE *County*			
CHEROKEE BMC HOME HEALTH		CENTRE	
	CHEROKEE County Totals:	Number Of Facilities:	1
CHILTON *County*			
CHILTON MEDICAL CENTER HOME HEALTH		CLANTON	
	CHILTON County Totals:	Number Of Facilities:	1
CHOCTAW *County*			
PRIMARY HOME CARE		GILBERTOWN	
	CHOCTAW County Totals:	Number Of Facilities:	1
CLARKE *County*			
INFIRMARY HOME HEALTH AGENCY		GROVE HILL	
JACKSON HOME HEALTH		JACKSON	
	CLARKE County Totals:	Number Of Facilities:	2
CLAY *County*			
CLAY COUNTY HOSPITAL HOME HEALTH		ASHLAND	
	CLAY County Totals:	Number Of Facilities:	1
COLBERT *County*			
TRI-COUNTY HOME HEALTH CARE AGENCIES		SHEFFIELD	
	COLBERT County Totals:	Number Of Facilities:	1

ALABAMA
Home Health Care Agencies

Facility Name	City
CONECUH *County*	
EVERGREEN HOME CARE	EVERGREEN
CONECUH County Totals:	Number Of Facilities: 1
COVINGTON *County*	
GENTIVA HEALTH SERVICES Covington	ANDALUSIA
HOME CARE SERVICE OF OPP	OPP
MIZELL MEMORIAL HOSPITAL HOME HEALTH CARE AGENCIES	OPP
COVINGTON County Totals:	Number Of Facilities: 3
CRENSHAW *County*	
CRENSHAW BAPTIST HOME HEALTH SERVICES	LUVERNE
CRENSHAW County Totals:	Number Of Facilities: 1
CULLMAN *County*	
CULLMAN REG MEDICAL CENTER HOME CARESERVICES	CULLMAN
WOODLAND MEDICAL HOSPITAL HOME HEALTH	CULLMAN
CULLMAN County Totals:	Number Of Facilities: 2
DALE *County*	
DALE MEDICAL CENTER HOME HEALTH	OZARK
DALE County Totals:	Number Of Facilities: 1
DALLAS *County*	
AMEDISYS HOME HEALTH, INC. OF SELMA	SELMA
MID SOUTH HOME HEALTH	SELMA
DALLAS County Totals:	Number Of Facilities: 2
DEKALB *County*	
BAPTIST DEKALB HOME CARE	COLLINSVILLE
DEKALB County Totals:	Number Of Facilities: 1
ELMORE *County*	
COMMUNITY HOME CARE	TALLASSEE
IVY CREEK HOME HEALTH OF ELMORE	WETUMPKA
ELMORE County Totals:	Number Of Facilities: 2
ESCAMBIA *County*	
ATMORE COMMUNITY HOSPITAL HOME HEALTH	ATMORE
D. W. MCMILLAN HOME HEALTH	BREWTON
ESCAMBIA County Totals:	Number Of Facilities: 2
ETOWAH *County*	
GADSDEN REGIONAL MEDICAL CENTER (HH)	ATTALLA
RIVERVIEW REGIONAL MED CTR HOME HEALTH	GADSDEN
ETOWAH County Totals:	Number Of Facilities: 2
FAYETTE *County*	
FAYETTE MEDICAL CENTER HOME HEALTH AGENCY	FAYETTE
FAYETTE County Totals:	Number Of Facilities: 1
FRANKLIN *County*	
COMMUNITY HOME HEALTH (Franklin)	RED BAY
NORTHWEST HOME HEALTH	RUSSELLVILLE
SOUTHERN RURAL HEALTH CARE CONSORTIUM (Franklin)	RUSSELLVILLE
FRANKLIN County Totals:	Number Of Facilities: 3
GREENE *County*	
GREENE COUNTY HOSPITAL HOME HEALTH	EUTAW
GREENE County Totals:	Number Of Facilities: 1
HALE *County*	
HALE COUNTY HOSPITAL HOME HEALTH	GREENSBORO
HALE County Totals:	Number Of Facilities: 1
HOUSTON *County*	
CARESOUTH-DOTHAN	DOTHAN
HORIZON HOME CARE OF DOTHAN	DOTHAN
MEDICAL CENTER HH SERVICES II	DOTHAN

ALABAMA
Home Health Care Agencies

Facility Name		City	
MEDICAL CENTER HH SERVICES, I		DOTHAN	
	HOUSTON County Totals:	Number Of Facilities:	4
JACKSON *County*			
HOSPITAL HOME HEALTH		SCOTTSBORO	
	JACKSON County Totals:	Number Of Facilities:	1
JEFFERSON *County*			
ABLE HOME HEALTH INC		BESSEMER	
ALACARE HOME HEALTH SERVICES, INC.		BIRMINGHAM	
Alacare Home Health Services, Inc. (Troy)		BIRMINGHAM	
AMEDISYS HOME HEALTH OF BIRMINGHAM		BIRMINGHAM	
BAPTIST HOME CARE SERVICES			
BROOKWOOD HOME HEALTH AGENCY		BIRMINGHAM	
CARE FIRST, INC.		BIRMINGHAM	
GENTIVA HEALTH SERVICES		BIRMINGHAM	
HEALTH SERVICES EAST, INC.		BIRMINGHAM	
HOME CARE PLUS, INC.		BIRMINGHAM	
JEFFERSON COUNTY HEALTH DEPARTMENT		BIRMINGHAM	
MIDSOUTH HOME HEALTH - SHELBY		PELHAM	
SOLEUS HC SERVICE OF NC AL, INC.		BIRMINGHAM	
ST MARTINS HOME HEALTH, INC.		BIRMINGHAM	
	JEFFERSON County Totals:	Number Of Facilities:	14
LAMAR *County*			
LAMAR HOME CARE, INC.		VERNON	
	LAMAR County Totals:	Number Of Facilities:	1
LAWRENCE *County*			
LAWRENCE BAPTIST MEDICAL CENTER HOME HEALTH		MOULTON	
MID SOUTH HOME HEALTH AGENCY INC.		MOULTON	
	LAWRENCE County Totals:	Number Of Facilities:	2
LEE *County*			
EAST AL MEDICAL CENTER HOME CARE		OPELIKA	
SOUTHERN HOME HEALTH SERVICES		OPELIKA	
	LEE County Totals:	Number Of Facilities:	2
LIMESTONE *County*			
ATHENS LIMESTONE HOSPITAL HOME HEALTH		ATHENS	
	LIMESTONE County Totals:	Number Of Facilities:	1
MADISON *County*			
AMEDISYS HOME HEALTH OF HUNTSVILLE		HUNTSVILLE	
HGA - HOME HEALTH GROUP - HUNTSVILLE		HUNTSVILLE	
SPECTRUM HOME HEALTH AGENCY		HUNTSVILLE	
	MADISON County Totals:	Number Of Facilities:	3
MARENGO *County*			
B. W. WHITFIELD MEM HOME HEALTH CARE AGENCIES		DEMOPOLIS	
	MARENGO County Totals:	Number Of Facilities:	1
MARION *County*			
MARION REGIONAL HOME HEALTH SERVICES		HAMILTON	
NORTHWEST HOME HEALTH-WINFIELD		WINFIELD	
	MARION County Totals:	Number Of Facilities:	2
MARSHALL *County*			
MEDICAL CENTER HOME HEALTH (Marshall)		ALBERTVILLE	
	MARSHALL County Totals:	Number Of Facilities:	1
MOBILE *County*			
AMEDISYS HOME HEALTH INC. OF AL MOBILE		MOBILE	
GENTIVA HEALTH SERVICES		MOBILE	

ALABAMA
Home Health Care Agencies

Facility Name	City
INFIRMARY HOME HEALTH AGENCY	MOBILE
KARE IN HOME HEALTH SERVICES OF ALA, INC	MOBILE
SAAD'S HEALTH CARE SERVICES	MOBILE
SPRINGHILL HOME HEALTH AGENCY	MOBILE
VANGUARD HOME HEALTH OF MOBILE	MOBILE
MOBILE County Totals:	Number Of Facilities: 7
MONROE *County*	
MONROE COUNTY HOSPITAL PROGRESSIVE HOME CARE	MONROEVILLE
VANGUARD HOME HEALTH OF MONROEVILLE	MONROEVILLE
MONROE County Totals:	Number Of Facilities: 2
MONTGOMERY *County*	
AMEDISYS HOME HEALTH	MONTGOMERY
BAPTIST HOME HEALTH SERVICES MONTGOMERY	MONTGOMERY
GENTIVA HEALTH SERVICES MONTGOMERY	MONTGOMERY
MID SOUTH HOME HEALTH AGENCY	MONTGOMERY
MONTGOMERY HOME CARE	MONTGOMERY
MONTGOMERY County Totals:	Number Of Facilities: 5
MORGAN *County*	
ALACARE HOME HEALTH & HOSPICE	DECATUR
HEALTH GROUP-HOME HEALTH GROUP-DECATUR	DECATUR
MORGAN County Totals:	Number Of Facilities: 2
PICKENS *County*	
AMEDISYS HOME HEALTH INC. OF AL PICKENS	REFORM
MEDICAL CENTER HOME HEALTH (Pickens)	CARROLLTON
PICKENS County Totals:	Number Of Facilities: 2
PIKE *County*	
TROY REGIONAL MEDICAL CENTER (HH)	TROY
PIKE County Totals:	Number Of Facilities: 1
RUSSELL *County*	
CHATTAHOOCHEE VALLEY HHC, INC.	PHENIX CITY
RUSSELL County Totals:	Number Of Facilities: 1
SHELBY *County*	
COMFORT CARE HOME HEALTH SERVICES	ALABASTER
SHELBY County Totals:	Number Of Facilities: 1
ST. CLAIR *County*	
ST CLAIR REGIONAL HOME HEALTH	PELL CITY
ST. CLAIR County Totals:	Number Of Facilities: 1
SUMTER *County*	
HILL HOSPITAL HOME HEALTH	YORK
SUMTER County Totals:	Number Of Facilities: 1
TALLADEGA *County*	
COOSA VALLEY BMC HOME HEALTH	SYLACAUGA
GENTIVIA HEALTH SERVICES	SYLACAUGA
TALLADEGA County Totals:	Number Of Facilities: 2
TALLAPOOSA *County*	
COMMUNITY HOME CARE (Tallapoosa)	DADEVILLE
TALLAPOOSA County Totals:	Number Of Facilities: 1
TUSCALOOSA *County*	
AMEDISYS HOME HEALTH OF TUSCALOOSA	TUSCALOOSA
COMMUNITY HOME HEALTH (Tuscaloosa)	TUSCALOOSA
DCH HOME HEALTH CARE AGENCIES AGENCY	TUSCALOOSA
TUSCALOOSA County Totals:	Number Of Facilities: 3

ALABAMA
Home Health Care Agencies

Facility Name		City	
WALKER *County*			
WALKER BMC HOME CARE SERVICES		JASPER	
	WALKER County Totals:	Number Of Facilities:	1
WILCOX *County*			
J PAUL JONES HOME HEALTH AGENCY		CAMDEN	
	WILCOX County Totals:	Number Of Facilities:	1
WINSTON *County*			
NORTHWEST HOME HEALTH - HALEYVILLE		HALEYVILLE	
	WINSTON County Totals:	Number Of Facilities:	1
	State Totals:	Number Of Facilities:	109

ALABAMA
ALABAMA HEALTH DEPARTMENT COUNTY HOME HEALTH AGENCIES

Facility	City
AUTAUGA COUNTY HEALTH DEPARTMENT	PRATTVILLE
BARBOUR COUNTY HEALTH DEPARTMENT	CLAYTON
CHOCTAW COUNTY HEALTH DEPARTMENT	LINDEN
CLAY COUNTY HEALTH DEPARTMENT	LINEVILLE
COFFEE COUNTY HEALTH DEPARTMENT	ENTERPRISE
NORTHWEST AL REGION HOME HEALTH DEPT	TUSCUMBIA
CONECUH COUNTY HEALTH DEPARTMENT	EVERGREEN
CULLMAN COUNTY HEALTH DEPARTMENT	CULLMAN
DALLAS COUNTY HEALTH DEPARTMENT	SELMA
DEKALB COUNTY HEALTH DEPARTMENT	FORT PAYNE
ETOWAH COUNTY HEALTH DEPARTMENT	GADSDEN
GENEVA COUNTY HEALTH DEPARTMENT	GENEVA
HOUSTON COUNTY HEALTH DEPARTMENT	DOTHAN
JACKSON COUNTY HEALTH DEPARTMENT	SCOTTSBORO
LAMAR COUNTY HEALTH DEPARTMENT	VERNON
LAWRENCE COUNTY HEALTH DEPARTMENT	MOULTON
LIMESTONE COUNTY HEALTH DEPARTMENT	ATHENS
MARION COUNTY HEALTH DEPARTMENT	HAMILTON
MARSHALL COUNTY HEALTH DEPARTMENT	GUNTERSVILLE
MOBILE COUNTY HEALTH DEPARTMENT	MOBILE
MONROE COUNTY HEALTH DEPARTMENT	MONROEVILLE
MONTGOMERY COUNTY HEALTH DEPARTMENT	MONTGOMERY
MORGAN COUNTY HEALTH DEPARTMENT	DECATUR
PIKE COUNTY HEALTH DEPARTMENT	TROY
RANDOLPH COUNTY HEALTH DEPARTMENT	ROANOKE
RUSSELL COUNTY HEALTH DEPARTMENT	PHENIX CITY
SUMTER COUNTY HEALTH DEPARTMENT	LIVINGSTON
TALLEDEGA/COOSA COUNTY HEALTH DEPARTMENT	SYLACAUGA
TUSCALOOSA COUNTY HEALTH DEPARTMENT	TUSCALOOSA
WASHINGTON COUNTY HEALTH DEPARTMENT	CHATOM
WINSTON COUNTY HEALTH DEPARTMENT	HAMILTON

State Totals: Number Of Facilities: 31

410-2-4-.08 Inpatient Physical Rehabilitation.

(1) Definition. Inpatient physical rehabilitation services are those designed to be provided on an integrated basis by a multidisciplinary rehabilitation team to restore the disabled individual to the highest physical usefulness of which he is capable. These services may be provided in a distinct part unit of a hospital, as defined in the Medicare and Medicaid Guidelines, or in a free-standing rehabilitation hospital.

(2) General. Rehabilitation can be viewed as the third phase of the medical care continuum, with the first being the prevention of illness, the second, the actual treatment of disease, and the third, rehabilitation or a constructive system of treatment designed to enable individuals to attain their highest degree of functioning. In many cases, all three phases can occur simultaneously. For the purposes of this section of the State Health Plan, only the need and inventory of inpatient rehabilitation facilities will be addressed.

(3) Need Determination. The Statewide Health Coordinating Council (SHCC) has determined that there is a need for 12 rehabilitation beds per 100,000 population for each region (see Table I).

(4) Planning Policies

(a) Planning Policy. Regional occupancy for the most recent reporting year should be at least 75% before the SHCC gives consideration to any requests for plan adjustments for additional bed capacity.

(b) Planning Policy. Conversion of existing hospital beds to rehabilitation beds should be given priority consideration over new construction when the conversion is significantly less costly and the existing structure can meet licensure and certification requirements.

(5) Accessibility-Distribution. Inpatient Rehabilitation services appear to be well distributed in the most populous regions of Alabama, with the exception of Region V, the largest of the seven planning regions. Future consideration should be given to locating a unit in Dallas County to serve the western counties of Region V.

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective March 11, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended:**

Filed June 30, 2006; effective August 4, 2006. **Amended (SHP Year Only):** Filed December 2 2014; effective January 6, 2015.

Note: Statistically updated September 30, 1993. Rule No. 410-2-4-.02 through 410-2-4-.09, inclusive, have been revised to reflect more current inventories, population, and utilization statistics, effective September 30, 1993. Statistically updated August 3, 1994. These updates reflect changes in inventories, utilization, populations, and need projections; effective August 3, 1994. Statistically updated August 21, 1995.

INPATIENT REHABILITATION BED REGIONS

REGION I

Lauderdale
Limestone
Madison
Jackson
Colbert
Franklin
Lawrence
Morgan
Marshall

REGION II

Lamar
Fayette
Pickens
Tuscaloosa
Sumter
Greene
Hale
Bibb

REGION III

Marion
Winston
Cullman
Blount
Walker
Jefferson
Shelby
Chilton
Coosa
Talladega
St. Clair

REGION IV

DeKalb
Etowah
Cherokee
Calhoun
Cleburne
Clay
Randolph

REGION V

Perry
Marengo
Wilcox
Dallas
Autauga
Lowndes
Butler
Crenshaw
Pike
Montgomery
Elmore
Macon
Bullock
Lee
Russell
Tallapoosa
Chambers

REGION VI

Choctaw
Washington
Mobile
Baldwin
Escambia
Conecuh
Monroe
Clarke

REGION VII

Covington
Coffee
Dale
Geneva
Houston
Barbour
Henry

TABLE I
INPATIENT PHYSICAL REHABILITATION
PROJECTION OF BED NEED
(Based on 12 Beds Per 100,000 Population)

Region	Population (2006)	Beds Needed	Beds Existing	CON Issued	Net Need (Excess)
	851,208	102	70	20	12
II	292,599	35	42	0	(7)
III	1,327,358	159	268	0	(109)
IV	368,285	44	0	40	4
V	825,755	99	87	31	(19)
VI	718,313	86	75	0	11
VII	299,847	36	34	12	(10)

TABLE II
REHABILITATION BEDS AUTHORIZED

COUNTY	FACILITY	TYPE LICENSE	BEDS	OCCUPANCY (2002)
Baldwin	Mercy Medical, A Corporation	REH	25	65.6%
Etowah	HealthSouth Rehabilitation Hospital of Gadsden	REH	40	*
Houston	HealthSouth Rehabilitation Hospital	REH	34	95.5%
Jefferson	Baptist Medical Center Montclair	GEN	17	72.2%
	Bessemer Carraway Medical Center	GEN	31	51.1%
	Carraway Methodist Medical Center	GEN	17	84.0%
	HealthSouth Lakeshore Rehabilitation Hospital	REH	100	90.6%
	Medical Center East	GEN	20	80.8%
	University of Alabama Hospital	GEN	78	50.0%
Madison	Huntsville Hospital	GEN	20	45.5%
	HealthSouth Rehabilitation Hospital of North Alabama	REH	50	99.0%
Mobile	Mobile Infirmary	REH	50	66.3%
Montgomery	HealthSouth Rehabilitation Hospital of Montgomery	REH	80	96.4%
Tuscaloosa	Northport Hospital DCH	REH	50	74.2%
	Totals		600	

Utilization Source: Annual Report for Hospitals & Related Facilities (Form BHD-134-A)

* Facility opened in October 2003 no occupancy data available.

CON 2014-H issued August 2, 2002 to HealthSouth Regional Rehabilitation Hospital for construction and operation of a 38 bed rehabilitation hospital in Phenix City, Russell County. Seven of these beds would be relocated from Montgomery County.

CON 2072-H issued October 29, 2003 to Andalusia Regional Hospital for the construction and operation of a patient wing to house 12 rehabilitation beds in Andalusia, Covington County.

410-2-4-.09 Swing Beds.

(1) Definition. A swing bed is a licensed hospital bed that can be used for either a hospital or skilled nursing home patient. A swing bed program is authorized in Alabama to include hospitals that meet the criteria as specified in Federal laws and regulations. In accordance with the appropriate directive and this State Health Plan, a swing bed hospital must meet the following requirements:

(a) must meet the federal requirements addressing the facility size, location, and utilization factors;

(b) must have a valid provider agreement under Medicare;

(c) must meet the discharge planning and social services standards applicable to participating skilled nursing facilities;

(d) must not have a waiver for 24-hour nursing coverage;

(e) must be granted a certificate of need by the State Health Planning and Development Agency to provide skilled nursing facility services;

(f) each participating hospital is limited to 10 swing beds;

(g) the average length of stay for swing bed patients must not exceed 30 days;

(h) beds authorized as swing beds will remain licensed as general hospital beds and be included in the general acute care inventory and bed need methodology;

(i) critical access hospitals shall be given special consideration in any application for a certificate of need for swing beds.

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective May 18, 1993. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2 2014; effective January 6, 2015.

Note: Statistically updated September 30, 1993. Rule No. 410-2-4-.02 through 410-2-4-.09, inclusive, have been revised to

reflect more current inventories, population, and utilization statistics, effective September 30, 1993.

ALABAMA HOSPITALS WITH CERTIFICATE OF NEED FOR SWING BEDS

	Hospital	County	Date Issued
1.	Greenlawn Hospital, Atmore	Escambia	8-14-1985
2.	Abernethy Memorial Hospital, Flomaton **	Escambia	11-21-1985
3.	Bullock County Hospital, Union Springs	Bullock	11-21-1985
4.	Georgiana Doctors Hospital, Georgiana	Butler	11-21-1985
5.	Perry County Hospital, Marion **	Perry	11-21-1985
6.	Wedowee Hospital, Wedowee	Randolph	11-21-1985
7.	Bibb Medical Center Hospital, Centreville	Bibb	1-24-1986
8.	Clay County Hospital, Ashland	Clay	1-24-1986
9.	Pickens County Medical Center, Carrollton	Pickens	1-24-1986
10.	Red Bay Hospital, Red Bay	Franklin	1-24-1986
11.	Elba General Hospital, Elba	Coffee	1-24-1986
12.	J. Paul Jones Hospital, Camden	Wilcox	3-27-1986
13.	Enterprise Hospital, Enterprise	Coffee	3-27-1986
14.	Hill Hospital of York, York	Sumter	5-29-1986
15.	Grove Hill Memorial Hospital, Grove Hill	Clarke	7-25-1986
16.	Thomasville Hospital, Thomasville	Clarke	2-11-1987
17.	Greene County Hospital, Eutaw	Greene	10-26-1987
18.	D.W. McMillian Memorial Hospital, Brewton	Escambia	5-25-1988
19.	Mizell Memorial Hospital, Opp	Covington	5-25-1988
20.	Clay County Hospital, Ashland	Clay	5-25-1988
21.	Wiregrass Hospital, Geneva	Geneva	5-26-1988
22.	Andalusia Hospital, Andalusia	Covington	5-26-1988
23.	Woodland Community Hospital, Cullman	Cullman	5-26-1988
24.	Washington County Infirmary, Chatom	Washington	5-26-1988
25.	Lakeview Community Hospital, Eufaula	Barbour	5-26-1988
26.	Evergreen Hospital, Evergreen	Conecuh	5-26-1988
27.	Clarke Hospital, Inc., Jackson	Clarke	5-26-1988
28.	Burdick-West Memorial Hospital, Haleyville	Winston	5-26-1988
29.	Humana Hospital, Russellville	Franklin	5-26-1988
30.	Lamar Regional Hospital, Vernon **	Lamar	5-26-1988
31.	Crenshaw County Hospital, Luverne	Crenshaw	5-26-1988
32.	Russell Hospital, Alexander City	Tallapoosa	5-26-1988
33.	Randolph County Hospital, Roanoke	Randolph	5-26-1988
34.	Central Alabama Community Hospital, Clanton	Chilton	5-26-1988
35.	Guntersville Hospital, Guntersville	Marshall	5-26-1988
36.	Arab Hospital, Arab	Marshall	5-26-1988
37.	Monroe County Hospital, Monroeville	Monroe	5-26-1988
38.	Marion County General Hospital, Hamilton	Marion	5-26-1988
39.	Bryan W. Whitfield Memorial Hospital, Demopolis	Marengo	5-26-1988
40.	Athens Limestone Hospital, Athens	Limestone	5-26-1988
41.	Baptist Medical Center – Cherokee, Centre	Cherokee	6-17-1988
42.	Fayette County Hospital, Fayette	Fayette	6-17-1988
43.	Winfield Carraway Hospital, Winfield	Marion	8-11-1988
44.	George H. Lanier Memorial Hospital, Valley	Chambers	9-15-1988
45.	Edge Regional Medical Center, Troy	Pike	1-11-1989
46.	Citizens Hospital, Talladega	Talladega	7-6-1989
47.	Coosa Valley Medical Center, Sylacauga	Talladega	7-6-1989
48.	Rush Hospital – Butler Inc., Butler **	Choctaw	6-25-1990
49.	Cullman Medical Center, Cullman	Cullman	10-29-1990
50.	Lakeview Community Hospital, Eufaula	Barbour	1-5-1999*
51.	L.V. Stabler Memorial Hospital, Greene	Butler	11-2-2001
52.	South Baldwin Regional Medical Center, Foley	Baldwin	5-2-2002
53.	Baptist Medical Center – Cherokee, Centre	Cherokee	9-5-2002*
54.	Jackson Medical Center	Clarke	7-19-2004

* These facilities had to have a new CON reissued because the initial CON expired.
** Facility is closed.

410-2-4-.10 Psychiatric Care.

(1) Background

(a) In the early 1990s, the Alabama Department of Mental Health and Mental Retardation developed a psychiatric bed need methodology that provided for an inventory of 37.1 beds per 100,000 population. Originally, the methodology was calculated using regions; however, in 2003 it was changed to reflect a statewide need methodology. Although the statewide need methodology was helpful in the early years to ensure access to care, it resulted in an uneven distribution of psychiatric beds, with higher concentrations of beds in some regions and shortages of psychiatric beds in other regions of the state.

(b) Over time, the number of psychiatric beds, both private beds and state beds, has declined. States have transitioned funding for mental health services from institutional care to community-based services, as state budgets have been cut and as more is known about the benefits of providing care in a non-institutional, community setting. Alabama mirrors these national trends, as it has closed three state facilities and downsized from 4,000 beds in 2009 to approximately 1,600 beds in 2017. In some areas, community-based services include crisis stabilization and access to timely follow-up care. In other areas, community resources may be limited, and those with psychiatric emergencies often present to a general acute care hospital emergency room for care; some of the more severely mentally ill remain for extended periods of time in private psychiatric facilities, waiting on a state bed to become available.

(2) Methodology

(a) Discussion.

The Statewide Health Coordinating Council (SHCC) developed a proposal for a new methodology based on the increasing need for psych beds and a better distribution of those beds. Approved by the full SHCC, the purpose of this inpatient psychiatric services need methodology is to identify, by region and by bed type, the number of inpatient psychiatric beds needed to ensure the continued availability, accessibility, and affordability of quality inpatient psychiatric care for residents of Alabama. Only the SHCC, with the Governor's approval, can make changes to this methodology. The State Health Planning and Development Agency (SHPDA) staff shall annually update statistical information to reflect more current utilization through the Hospital Annual Survey. Such updated information is available for a fee upon request.

(b) Bed Need Determined by Region and by Category of Bed.

The new methodology is based upon the regional needs of the state as opposed to a statewide need methodology. It also addresses need based on the category of patients served in the beds being used; the bed categories include: 1. Child/Adolescent; 2. Adult; and 3. Geriatric. Calculation of beds needed will be based on utilization of those beds by category and by region as reported annually in the Hospital Annual Report. The Hospital Annual Report must be amended to accomplish the purposes of this new methodology. This new methodology will become effective after the certification by the Healthcare Information and Data Advisory Council of the first new Hospital Annual Report following the passage of this amendment. All providers will report their licensed beds, operating beds and patient days by inpatient psychiatric category each year via the new Hospital Annual Report. Operating beds may be the same as or fewer than the total number of licensed psychiatric beds. Providers with unrestricted psychiatric beds obtained prior to the effective date of this new methodology shall be allowed to change the categories of their beds during the first two reporting periods. The bed allocation by category reported on the third Hospital Annual Report following the passage of this amendment shall be considered final for operating beds. Thereafter, any permanent change to a different inpatient psychiatric bed category for an existing operating bed or beds will require the approval of a new CON. This requirement will not apply to licensed beds not currently in use; however once beds are put into use, the provider will have to declare the category(ies) of the beds.

After this methodology becomes effective, applicants for new inpatient psychiatric beds will be required to select a category (Child/Adolescent, Adult, Geriatric) for which they are seeking inpatient psychiatric beds. Applicants may apply for more than one inpatient psychiatric category if a need is shown. See Section (3)(c), below regarding new beds.

Note: This new methodology is intended for planning purposes. The declaration of psychiatric beds by category on the Hospital Annual Report is not intended to preclude providers from using their psychiatric beds as necessary to address seasonal needs and surge situations. If a hospital determines that it needs to permanently change its psychiatric bed allocation, a new CON will be required. This new methodology, however, does not apply to pediatric specialty hospital providers, and is not intended: to preclude pediatric specialty hospital providers from using their pediatric specialty beds to provide pediatric psychiatric services, as necessary; to require such providers to report or

declare via the SHPDA Hospital Annual Report their pediatric specialty beds used for pediatric psychiatric services as psychiatric beds, with related patient days, by inpatient category; or require such providers to obtain a CON for any new or additional use of their pediatric specialty beds for the provision of any pediatric specialty services, including pediatric psychiatric services.

(3) Planning Policies

(a) Planning on a Regional Basis

Planning will be on a regional basis. Please see attached listing for the counties in each region as designated by the SHCC.*

(b) Planning Policies for applicants.

1. An applicant for an inpatient psychiatric bed must be either: 1) an established and licensed hospital provider that has been operational for at least twelve (12) months; or, 2) a new inpatient psychiatric hospital seeking a minimum of at least twenty (20) inpatient psychiatric beds. (Specialty, Free-Standing Psychiatric Hospitals must have at least twenty (20) inpatient beds pursuant to Rule 420-5-7-.03 Classification of Hospitals; found in Chapter 420-5-7 of the Alabama Department of Public Health Administrative Code.)

2. An applicant for inpatient psychiatric beds in a particular category must demonstrate the ability to comply with state law.

3. In certificate of need decisions concerning psychiatric services, the extent to which an applicant proposes to serve all patients in an area should be considered. The problem of indigent care should be addressed by certificate of need applicants.

(c) Applying for Additional beds.

Applicants may apply for new psychiatric beds using one of the following occupancy need determinations:

1. Regional occupancy calculation.

Any region that shows an occupancy rate of 75 percent (75%) or greater in any one of the three (3) bed categories would be eligible for additional beds in that category. The number of additional beds needed would be calculated by dividing the average daily census for the region by the desired occupancy rate

of 70 percent (70%) and then subtracting from this number the current beds in operation. Information for this calculation will be obtained from the most recent Hospital Annual Report as compiled by SHPDA. Beds granted under the regional methodology shall be deemed part of the official regional bed inventory at time of issuance. See formula below:

To calculate regional occupancy:

Total patient days/(Beds operating x days in Reporting Period)

To calculate beds needed to get the region to 70 percent (70%) occupancy:

(i) (Total patient days/days in Reporting Period)/.70 = total beds needed for the region to have a 70 percent (70%) occupancy rate.

(ii) To calculate additional beds needed for the region:

Total beds needed to reach 70 percent (70%) occupancy rate minus current beds in operation.

The total patient days and the beds in operation used for the calculations would come from the information reported to SHPDA through the most recent Hospital Annual Report.

The following is an example of how the regional methodology would be calculated if a single region had 25,000 adult patient days and 90 adult beds:

To calculate the regional occupancy:

25,000 adult days/(90 beds operating x days in Reporting Period) = 76 percent regional occupancy

To calculate beds needed to have a 70-percent occupancy:

(25,000 adult days/ days in Reporting Period)/.70 = 98 total beds needed for that occupancy level

Beds needed (98) minus current beds (90) = 8 additional adult beds needed for the region.

2. Individual Provider Occupancy Calculation.

If the average occupancy rate for a single facility within a region is 80 percent (80%) or greater for a continuous period of

twelve (12) months in any of the three (3) bed categories, as calculated by the SHPDA using data reported on the most recent Hospital Annual Report, that facility may apply for up to 10 percent (10%) additional beds or six (6) beds, whichever is greater. An individual facility may demonstrate a need based on occupancy irrespective of the total occupancy for the region in that bed category. Information for this calculation will be obtained from the most recent Hospital Annual Report as compiled by SHPDA.

Any beds obtained through the Individual Provider Occupancy Calculation will not be included in the regional bed calculation for a period of three years after the beds are brought into service. After this three-year period the beds would be included in the regional count. Any provider obtaining beds through this provision will not be eligible to use the 10 percent rule for 24 months from the date the CON is granted.

(4) **Plan Adjustments**

The psychiatric bed need for each region as determined by the methodology is subject to adjustments by the SHCC. The psychiatric bed need may be adjusted by the SHCC if an applicant can prove that the identified needs of a target population are not being met by the current bed need methodology.
Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §§22-21-260(13), (15).
History: Effective April 23, 1991. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2 2014; effective January 6, 2015. **Amended:** Filed June 21, 2018; effective August 5, 2018.

Note: Statistically updated September 30, 1993. Rule No. 410-2-4-.02 through 410-2-4-.09, inclusive, have been revised to reflect more current inventories, population, and utilization statistics, effective September 30, 1993.

PSYCHIATRIC BEDS AUTHORIZED

COUNTY	FACILITY	BEDS
Baldwin	Thomas Hospital	19
Bullock	Bullock County Hospital	11
Butler	L V Stabler Memorial Hospital	13
Calhoun	Northeast AL Regional Medical Center	37
Clarke	Grove Hill Memorial Hospital	9
Colbert	Helen Keller Memorial Hospital	15
Conecuh	Evergreen Medical Center	14
Crenshaw	Crenshaw Baptist Hospital	15
Cullman	Woodland Medical Center	20
Dale	Dale Medical Center	10
Dallas	Vaughan Regional Medical Center – Pkwy Campus	26
Elmore	Community Hospital	10
Etowah	Gadsden Regional Medical Center	25
	Mountain View Hospital	68
Houston	Laurel Oaks Behavioral Health Center	24
	Southeast Alabama Medical Center	19
Jefferson	UAB Medical Center West	15
	Baptist Medical Center – Princeton	25
	Baptist Medical Center Montclair	64
	Carraway Methodist Medical Center	90
	The Children's Hospital of Alabama	36
	Brookwood Medical Center	71
	Hill Crest Behavioral Health Services	80
	University of Alabama Hospital	78
	HealthSouth Metro West Hospital	24
Lauderdale	Eliza Coffee Memorial Hospital	21
Lee	East Alabama Medical Center	38
Madison	The Huntsville Hospital	35
	Crestwood Medical Center	12
Marion	Carraway Northwest Medical Center	10
Mobile	Mobile Infirmary	49
Montgomery	Baptist Medical Center South	32
Morgan	Decatur General West	64
	Hartselle Medical Center	20
Pickens	Pickens County Medical Center	10
Shelby	Shelby Baptist Medical Center and Shelby Ridge	24
Tuscaloosa	Northport Medical Center	54
Walker	Walker Baptist Medical Center	40
		1,232

(03/04)

PSYCHIATRIC BED NEED FOR ALABAMA

Population 2005 (5 years & over)	Total beds needed (37.1/100,000 population)	Existing Beds	Net Need/Excess
4,338,379	1,610	1,232	378

(03/04)

410-2-4-.11 Substance Abuse.

(1) Discussion

(a) The National Household Survey on Drug Abuse (NHSDA) estimated 16.6 million Americans age 12 or older in 2001 were classified with dependence on or abuse of either alcohol or illicit drugs, a figure significantly higher than in 2000 – about 14.5 million. Most of these persons (11.0 million) were dependent on or abused alcohol only. Another 2.4 million were dependent on or abused both alcohol and illicit drugs, while 3.2 million were dependent on or abused illicit drugs but not alcohol. Persons age 18 to 25 had the highest rates of alcohol dependence or abuse (14.8 percent). (Source: www.samhsa.gov)

(b) There are more deaths and disabilities each year in the United States from Substance Abuse than from any other cause. One-quarter of all emergency room visits, one-third of all suicides, and more than one half of all homicides and incidents of domestic violence are alcohol-related. (Source: www.ncadd.org)

(c) Alcohol and drug abuse costs the American economy an estimated $276 billion per year in lost productivity, health care expenditures, crime, motor vehicle crashes and other conditions. (Source: www.ncadd.org)

(2) Background

(a) Substance abuse services for persons with both dependence and abuse problems is provided through an array of private and public providers throughout the state. The array of services ranges from inpatient medical detoxification services to residential treatment services to a variety of outpatient types of services including various affiliated support groups.

(b) In the past few years the technology for treating individuals with dependence and abuse problems has changed rather dramatically from a traditional inpatient/residential mode to outpatient treatment. This has occurred for a variety of reasons

including financial considerations. These phenomena can be verified through analysis of current utilization of both inpatient and residential services.

(3) Methodology

(a) The Alabama Department of Mental Health/Mental Retardation (DMH/MR) has developed a substance abuse bed need methodology, which is based upon a formula utilized in other states, commonly referred to as the "Mardin Formula". This prevalence base formula was selected in lieu of utilization-based formulas due to the lack of comprehensive statistical information on the current utilization of residential treatment centers. Calculation of needed beds is performed as follows:

(b) Step 1: Multiply the population ages 10-17 by 19%, which is the proportion, assumed to have problems with chemical dependency;

(c) Step 2: Multiply the population ages 18 and over by 7%, which is the proportion assumed to have problems with chemical dependency;

(d) Step 3: Multiply the sum of steps 1 and 2 by 12%, which is the proportion who will seek treatment annually;

(e) Step 4: Multiply the product in step 3 by 60% which is the proportion of those seeking treatment who will require detoxification services for 3 days. Calculate total number of patient days;

(f) Step 5: Multiply those receiving detoxification services by 50%, which is the proportion who will need residential treatment for 10 days. Calculate total number of patient days;

(g) Step 6: Add the patient days in steps 4 and 5 to arrive at total patient days;

(h) Step 7: Divide by 365 to determine average daily census (ADC);

(i) Step 8: Divide by 80% occupancy to arrive at total needed beds;

(j) Step 9: Subtract existing public beds to arrive at total private bed need;

(k) Step 10: Subtract existing private beds to determine need or excess.

BED NEED CALCULATIONS
2005

Population		Persons with SA Problems	Persons Seeking Help	Detoxification Days	Residential Days	Total Days
Ages 10-17	Ages 18+					
531,145	3,507,562	346,447	41,574	74,832	124,720	199,552

Average Daily Census	80% Occupancy	Public Beds	Private Beds	Beds Needed
547	684	616	432	(364)

SUBSTANCE ABUSE BEDS AUTHORIZED

COUNTY	FACILITY	BEDS
	Hospitals	
Colbert	Helen Keller Memorial Hospital	13
Crenshaw	Crenshaw Baptist Hosptial	5
Jefferson	Carraway Methodist Medical Center	18
	Brookwood Medical Center	14
	University of Alabama Hospital	12
	Subtotal:	62
	Residential	
Jefferson	Bradford Parkside Lodge at Warrior	100
	Salvation Army Adult Rehabilitation Center	84
Madison	Bradford at Huntsville	84
Shelby	Bradford Adolescent	102
	Subtotal:	370
	State Total:	432

Updated September 2003
Alabama 2002 Hospital H-5 Report

(4) Methadone Treatment

(a) Definition. Methadone is an opioid agonist medication used to treat heroin and other opiate addiction. Methadone reduces the craving for heroin and other opiates by

blocking receptor sites that are affected by heroin and other opiates.

(b) Background

1. Prior to June 1991 Alabama operated two methadone clinics in Birmingham and in Mobile, both of which were operated through a DMH/MR contract. These clinics are part of the UAB Mental Health Center and the Mobile Mental Health Center. The average number of clients served in any given month never exceeded 380 of which fewer than 5% were clients from out of state.

2. As of April 2015, Alabama has twenty-two (22) certified methadone treatment programs.

(c) Recommendations

1. A methadone treatment program should provide adequate medical, counseling, vocational, educational, mental health assessment, and social services to patients enrolled in the opioid treatment program with the goal of the individual becoming free of opioid dependency, with oversight by the Alabama Department of Mental Health.

2. The Methadone Advisory Committee suggests the following information be submitted with Certificate of Need applications:

(i) The number of arrests for the previous year regarding the sale and possession of opioids by county for the area to be served.

(ii) Data from the Medical Examiner regarding all deaths related to overdose from opioids by county for the area to be served during the previous year.

(iii) Data from all hospital emergency rooms regarding the number of persons diagnosed and treated for an overdose of opioids by county for the area to be served.

(iv) The number of clients within specific geographic areas who, out of necessity, must travel in excess of 50 miles round-trip for narcotic treatment services.

(v) The name and number of existing narcotic treatment programs within 50 miles of the proposed sight.

(vi) Number of persons to be served by the proposed program and the daily dosing fee.

(vii) Applicant shall submit evidence of the ability to comply with all applicable rules and regulations of designated governing authorities.

(d) Need

1. Basic Methodology

(i) The purpose of this need methodology is to identify, by region, need for additional treatment facilities to ensure the continued availability, accessibility, and affordability of quality opioid replacement treatment services for residents of Alabama.

(ii) A multi-county region shall be the planning area for methadone treatment facilities. A listing of the counties in each region is attached as part of this section. These were derived from the regions used by the Alabama Department of Mental Health (ADMH), Division of Mental Health and Substance Abuse Services.

(iii) The Center for Business and Economic Research, University of Alabama, (CBER) population data shall be used in any determination of need for methadone treatment facilities in Alabama.

(iv) Data from the National Survey on Drug Use and Health (NSDUH) shall be used in the calculation of national rates of dependency on heroin or prescription pain relievers in Alabama.

(v) Data from ADMH shall be used in the determination of the number of current patients seen by each clinic within a region. ADMH shall supply, on an annual basis, an Annual Report to SHPDA with rates of prevalence, service utilization and epidemiological data to assist with implementation of the methodology and publication of statistical updates to this plan.

(vi) For each region, need shall be calculated using the following methodology:

(I) For each county in the region, list the population, ages 18 and over, as reported by CBER, for the year matching the year for which need is being projected.

(II) Using NSDUH data for the same time period, determine the rate of dependency on heroin and prescription pain relievers nationally.

(III) For each county in the region, multiply the population from step (a) above by the dependency rate in step (b) above to determine the projected number of residents in that county addicted to heroin or prescription pain relievers.

(IV) Multiply the estimate from step (c) above by 20% (0.2) to determine the projected number of residents of that county likely to seek Medication Assisted Therapy for opioid dependency.

(V) Add the county totals determined in step (d) above to determine the regional totals.

(VI) Using data supplied by ADMH, determine the current census of each treatment center in the region on the last day of the year matching the year of population and NSDUH dependency data used in step (a) and step (b) respectively.

(VII) Add the facility census totals determined in step (f) above to determine regional totals.

(VIII) If the number of residents projected to seek treatment in a region as determined in step (e) is greater than the current census of all treatment centers in the region as determined in step (g) by more than 10%, a need shall be shown for a new methadone treatment facility in that region.

(IX) Only one methadone treatment facility may be approved in any region showing a need under this methodology during any application cycle, defined here as the period of time between the date of publication of one statistical update and the date of publication of a successive update.

(X) Upon the issuance of a Certificate of Need for a new methadone treatment facility in a region, no additional CONs shall be issued for the development of a new methadone treatment facility in that region for a period of eighteen (18) months to allow for the impact of a new provider in the region to be shown and reflected in the next statistical update.

2. The provisions of subsection 1 above shall not prohibit the grant of a certificate of need for the relocation and replacement of an existing methadone treatment facility within the same planning region.

3. All methadone clinic applications shall be site specific. No CON shall be granted for a new methadone treatment facility to be located within fifty (50) linear miles of an existing methadone treatment facility.

(e) Adjustments – Need for additional methadone treatment facilities, as determined by the in subsection 1 above, is subject to adjustment by the SHCC as provided below. The SHCC may adjust the need for a new methadone treatment facility only upon demonstration of one or more of the following conditions listed in 1 through 3 below. Applicants seeking an adjustment under this section shall include, as part of the application, supporting documentation from ADMH.

1.1The opioid-related arrest or death rate in the region exceeds the national average, and there are no methadone treatment facilities within fifty (50) miles of the county for which the proposed adjustment applies.

2. Hospital emergency room admissions for opioid-overdose related conditions in the region exceed the national average, and there are no methadone treatment facilities within fifty (50) miles of the county for which the proposed adjustment applies.

3. Admissions to drug-free programs specifically treating opioid dependency in the region exceed the national average, and there are no methadone treatment facilities within fifty (50) miles of the county for which the proposed adjustment applies.

(f) Preference for Indigent Patients: In considering CON applications filed under this section, whether pursuant to the regular need methodology or an adjustment, preference shall be given to those applicants demonstrating the most comprehensive plan for treating patients regardless of their ability to pay.

Methadone Treatment Facility Regional County Listings

Region I	**Region II**	**Region III**	**Region IV**
Cherokee	Bibb	Autauga	Baldwin
Colbert	Blount	Bullock	Barbour
Cullman	Calhoun	Chambers	Butler
DeKalb	Chilton	Choctaw	Clarke
Etowah	Clay	Dallas	Coffee
Fayette	Cleburne	Elmore	Conecuh
Franklin	Coosa	Greene	Covington
Jackson	Jefferson	Hale	Crenshaw
Lamar	Pickens	Lee	Dale
Lauderdale	Randolph	Lowndes	Escambia
Lawrence	Shelby	Macon	Geneva
Limestone	St. Clair	Marengo	Henry
Madison	Talladega	Montgomery	Houston
Marion	Tuscaloosa	Perry	Mobile
Marshall		Pike	Monroe
Morgan		Russell	Washington
Walker		Sumter	
Winston		Tallapoosa	
		Wilcox	

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: Effective April 23, 1991. **Amended:** Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended:** Filed August 16, 2012, effective September 20, 2012. **Amended:** Filed November 20, 2013; effective December 25, 2013. **Amended (SHP Year Only):** Filed December 2 2014; effective January 6, 2015. **Amended:** Filed September 9 2015; effective October 14, 2015.

Note: Statistically updated September 30, 1993. Rule No. 410-2-4-.02 through 410-2-4-.09, inclusive, have been revised to reflect more current inventories, population, and utilization statistics, effective September 30, 1993.

AUTHORIZED METHADONE TREATMENT PROGRAMS

COUNTY	PROGRAM	EXECUTIVE DIRECTOR
Calhoun	Calhoun Treatment 118 Choccolocco Street Oxford, AL 35203	Wendy Sprayberry
Colbert	Shoals Treatment 520 Louisa Avenue Muscle Shoals, AL 35661	Becky Clayton James Beverly
Cullman	Cullman County Treatment 1912 Commerce Ave. NW Cullman, AL 35055	Brenda Heatherly
Etowah	Gadsden Treatment 1107 West Meighan Blvd. Gadsden, AL 35901	Becky Clayton
Houston	Houston Treatment 9283 West US 84 Newton, AL 36352	Dr. Henry Born
Jefferson	Birmingham Metro Treatment 151 Industrial Drive Birmingham, AL 35211	Norm Huggins, M.D. Bill Garrett
Jefferson	Northwest Treatment 709 Memorial Drive Bessemer, AL 35022	Susan Sidwell
Jefferson	Tri-County Treatment 1101 East Park Drive Birmingham, AL 35235	Brent Hamer
Jefferson	UAB 401 West Beacon Parkway Birmingham, AL 35209	Norm Huggins, M.D. Bill Garrett
Madison	Huntsville Metro Treatment 2227 Drake Avenue, Suite 19 Huntsville, AL 35805	Bill Pierce
Madison	Huntsville Recovery, Inc. 1300 Putman Drive Huntsville, AL 35816	C.E. Payne

COUNTY	PROGRAM	EXECUTIVE DIRECTOR
Marion	Marion County Treatment 1879 Military Street South Hamilton, AL 35570	Pat Waldrop Steven Kiser
Mobile	ECD P O Box 7395 Mobile, AL 36670	Brenda Heatherly Sharon Gibbs
Mobile	Gulf Coast Treatment 12271 Interchange Drive Grand Bay, AL 36541	Brenda Heatherly Linda Waite
Mobile	Mobile MH (Gateway) 4211 Government Blvd. Mobile, AL 36693	Susan Case
Mobile	Mobile Metro Treatment 3367 Dauphin Island Parkway Mobile, AL 36605	Amber Ellis
Montgomery	Montgomery Metro Treatment 4303 Norman Bridge Road Montgomery, AL 36105	Mark Shaw
Sumter	Sumter County Treatment 106 Hospital Road, Suite 101 Livingston, AL 35470	Steve Nippert
Tuscaloosa	Tuscaloosa Treatment 1001 Mimosa Park Road Tuscaloosa, AL 35405	Steve Nippert Tina McWilliams
Walker	Walker Recovery P O Box 2030 Jasper, AL 35501	T. Camp, M.D. Steven Kiser

* CON 2098-ORF was issued September 2, 2004 for the operation of an Opiate Replacement Center in Chambers County.

410-2-4-.12 Ambulatory Surgery.

(1) Discussion. During the last two decades, an evolution in the provision of surgical care has taken place. As a result of cost containment measures and advances in medical technology, many surgical procedures which previously required inpatient care (both before and after the procedure) are now done on an outpatient basis.

(2) Definition. Ambulatory surgery centers (ASC) are any health care facility, licensed by the Alabama Department of Public Health, with the primary purpose of providing medically necessary or elective surgical care on an outpatient basis and in which the patient stays less than 24 hours. Excluded from this definition are the offices of private physicians and dentists, including those organized as professional corporations, professional associations, partnerships, or individuals in sole proprietorship. Also excluded from this definition are health care facilities licensed as hospitals. Ambulatory surgery centers may be multi-specialty in which more than one surgical specialty is represented or a specialized ambulatory surgery center in which a single, exclusive surgical specialty is provided.

(3) Inventory of Existing Resources. Before meaningful planning policies can be developed, the SHCC must have at its disposal outpatient surgical utilization data for both licensed acute care hospitals and ambulatory surgery centers.

SHDPA shall survey annually all licensed and/or Medicare certified hospitals and ambulatory surgery centers, as defined herein, regarding outpatient surgical utilization. The SHCC recommends that SHPDA promulgate the following CON regulations:

(a) Any CON application filed by a licensed hospital or an ambulatory surgery center shall not be deemed complete until, and unless:

1. the applicant has submitted all survey information requested by SHPDA prior to the application date; and

2. the SHPDA Executive Director determines that the survey information is substantially complete.

(b) No licensed hospital or ambulatory surgery center filing an intervention notice or statement in opposition in any CON proceeding may cite or otherwise seek consideration by SHPDA of such facility’s utilization data until, and unless:

1. the intervenor or opponent has submitted all survey information requested by SHPDA prior to the application date; and

2. the SHPDA Executive Director determines that the survey information is substantially complete.

The SHCC recommends that the Certificate of Need Review Board adopt this and other CON regulations to further support and enforce SHPDA's survey of outpatient surgical utilization data as required under this Section.

The SHCC, upon receipt of meaningful utilization data from all licensed hospitals and ambulatory surgery centers, shall amend this section to include further definitions and planning policies as appropriate and applicable. Any amendment adopted as result of this provision shall be considered to have been generated by the SHCC and shall not be subject to any fees that may later be imposed on parties seeking a State Health Plan amendment or adjustment.

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: New Rule: Filed June 19, 1996; effective July 25, 1996. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2 2014; effective January 6, 2015.

ALABAMA
AMBULATORY SURGERY CENTERS

BALDWIN *County*		
INFIRMARY EASTERN SHORE AMBULATORY SURGERY CENTER	DAPHNE	
THOMAS MEDICAL CENTER AMBULATORY SURGERY CTR/DAPHN	DAPHNE	
BALDWIN County Totals:	Number Of Facilities:	2
CALHOUN *County*		
Surgery Center, The	OXFORD	
CALHOUN County Totals:	Number Of Facilities:	1
COFFEE *County*		
SOUTH ALABAMA OUTPATIENT SERVICES	ENTERPRISE	
COFFEE County Totals:	Number Of Facilities:	1
DALE *County*		
DALE MEDICAL CENTER AMBULATORY SURGERY CENTER	OZARK	
DALE County Totals:	Number Of Facilities:	1
ETOWAH *County*		
GADSDEN SURGERY CENTER	GADSDEN	
NORTHEAST ALABAMA EYE SURGERY CENTER INC	GADSDEN	
ETOWAH County Totals:	Number Of Facilities:	2
HOUSTON *County*		
AMERICAN SURGERY CENTER	DOTHAN	
DOTHAN SURGERY CENTER	DOTHAN	
HOUSTON County Totals:	Number Of Facilities:	2
JEFFERSON *County*		
BIRMINGHAM ENDO-SURGICAL CENTER	HOMEWOOD	
CHILDREN'S SOUTH OUTPATIENT CENTER	BIRMINGHAM	
HEALTHSOUTH OUTPATIENT CARECENTER	BIRMINGHAM	
KIRKLIN CLINIC AMBULATORY SURGICAL CENTER, THE	BIRMINGHAM	
OUTPATIENT SERVICES EAST INC	BIRMINGHAM	
JEFFERSON County Totals:	Number Of Facilities:	5
LAMAR *County*		
LAMAR HEALTHCARE SERVICES	SULLIGENT	
LAMAR County Totals:	Number Of Facilities:	1
LAUDERDALE *County*		
FLORENCE SURGERY CENTER	FLORENCE	
VALLEY SURGERY CENTER LLC	FLORENCE	
LAUDERDALE County Totals:	Number Of Facilities:	2
MADISON *County*		
HUNTSVILLE ENDOSCOPY CENTER INC	HUNTSVILLE	
SURGERY CENTER OF HUNTSVILLE, THE	HUNTSVILLE	
MADISON County Totals:	Number Of Facilities:	2

ALABAMA
AMBULATORY SURGERY CENTERS

MOBILE *County*		
DAUPHIN WEST SURGERY CENTER	MOBILE	
HEALTHSOUTH MOBILE SURGERY CENTER	MOBILE	
HEALTHSOUTH SURGICARE OF MOBILE	MOBILE	
MOBILE County Totals:	Number Of Facilities:	3
MONTGOMERY *County*		
42 MEDICAL GROUP	MONTGOMERY	0
MONTGOMERY EYE SURGERY CENTER	MONTGOMERY	
MONTGOMERY SURGICAL CENTER, LTD	MONTGOMERY	
MONTGOMERY County Totals:	Number Of Facilities:	3
MORGAN *County*		
DECATUR AMBULATORY SURGERY CENTER	DECATUR	
MORGAN County Totals:	Number Of Facilities:	1
SHELBY *County*		
MEDPLEX OUTPATIENT SURGERY CENTER	BIRMINGHAM	
SHELBY County Totals:	Number Of Facilities:	1
TUSCALOOSA *County*		
HEALTHSOUTH SURGICAL CENTER OF TUSCALOOSA	TUSCALOOSA	
NORTH RIVER SURGICAL CENTER INC	TUSCALOOSA	
TUSCALOOSA ENDOSCOPY CENTER	TUSCALOOSA	
TUSCALOOSA County Totals:	Number Of Facilities:	3
State Totals:	Number Of Facilities:	30

410-2-4-.13 Renovations.

(1) Renovation is defined as a project for modernization, improvement, alteration and/or upgrading of an existing physical plant and/or equipment. Renovation does not include the modernization or construction of a non clinical building, parking facility, or any other non institutional health services capital item on the existing campus of a health care facility, provided that construction or modernization does not allow the health care facility to provide new institutional health services subject to review and not previously provided on a regular basis.

(2) Planning Policies

(a) The applicant must demonstrate that the proposed renovation is the most cost effective or otherwise most appropriate alternative to provide patients with needed health care services and/or facility improvements.

(b) The applicant must provide evidence that the proposed square footage, construction cost per square foot, and cost of fixed equipment is appropriate and reasonable for the types and volumes of patients to be served.

(c) The applicant must demonstrate how the disruption of normal operations will be minimized during the period of construction.

(3) Needs Assessment.

(a) For the renovation of a health care facility an applicant must submit significant evidence of need for the project. Evidence of need for the project should include, but is not limited to, one or more of the following:

1. The service being provided by the applicant requires additional space or the facility requires renovation to meet minimum licensure and certification requirements.

2. There are operating problems, which can best be corrected by renovation of the existing facility.

3. The renovation will correct deficiencies that place the health and safety of patients and/or employees at significant risk.

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).

History: New Rule: Filed May 14, 1997; effective June 18, 1997. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2 2014; effective January 6, 2015.

410-2-4-.14 Replacements.

(1) Replacement is defined as a project for the erection, construction, creation or other acquisition of a physical plant or facility where the proposed new structure will replace an existing structure and will be located in the same county and market area. Replacement does not include the modernization or construction of a non clinical building, parking facility, or any other non institutional health services capital item on the existing campus of a health care facility, provided that construction or modernization does not allow the health care facility to provide new institutional health services subject to review and not previously provided on a regular basis.

(2) Planning Policies

(a) The applicant must demonstrate that the proposed replacement is the most cost effective or otherwise most appropriate alternative to provide patients with needed health care services and/or facility improvements.

(b) The applicant must provide evidence that the proposed square footage, construction cost per square foot, and cost of fixed equipment is appropriate and reasonable for the types and volumes of patients to be served.

(c) The applicant for the proposed replacement must be the same as the owner of the facility to be replaced.

(3) Needs Assessment

(a) For replacement of a health care facility an applicant must submit significant evidence of need for the project. Evidence of need for the project should include, but is not limited to, one or more of the following:

1. The existing structure requires replacement to meet minimum licensure and certification requirements.

2. There are operating problems, which can best be corrected by replacement of the existing facility.

3. The replacement of the existing structure will correct deficiencies that place the health and safety of patients and/or employees at significant risk.

(b) For replacement of hospitals, the occupancy rate for the most recent annual reporting period should have been at least 60 percent. If this occupancy level was not met, the hospital should agree to a reduction in bed capacity that will increase its occupancy rate to 60 percent. For example, if a 90-bed hospital had an average daily census (ADC) of 45 patients, its occupancy rate was 50 percent. (The ADC of 45 patients divided by 90 beds equals 50 percent). To determine a new bed capacity that would increase the hospital's occupancy rate to 60 percent, simply divide the ADC of 45 patients by .60 (A fraction of a bed should be rounded upward to the next whole bed) The hospital's new capacity should be 75 beds, a 15 bed reduction to its original capacity of 90 beds.

Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: New Rule: Filed May 14, 1997; effective June 18, 1997. **Repealed and New Rule:** Filed October 18, 2004; effective November 22, 2004. **Amended (SHP Year Only):** Filed December 2 2014; effective January 6, 2015.

410-2-4-.15 Inpatient Hospice Services.

(1) Discussion

(a) Hospice care is a choice made to enhance end of life. Hospice focuses on caring and comfort for patients and not curative care. In most cases, care is provided in the patient's place of residence.

(b) It is the intent of this section to address health planning concerns relating to hospice services provided on an inpatient basis. For coverage of hospice services provided primarily in the patient's place of residence, please see Section 410-2-3-.10.

(c) A hospice program is **required** by federal statutes as a Condition of Participation for hospice care (Title 42- Public Health; Chapter IV – CMS, Department of Health and Human Services; Part 418 – Hospice care; Section 418.98 or successors) and state statutes and regulations (Alabama State Board of Health, Department of Public Health; Administrative Code, Chapter 420-5-17; Section 420-5-17-.01 or successors) to provide general inpatient level of care and inpatient respite level of care as

two of the four levels of hospice care. As per the Medicare Condition of Participation (418.108), the total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in a 12-month period in a particular hospice may not exceed twenty (20) percent of the total number of hospice days consumed in total by this group of beneficiaries.

(d) A hospice program per federal statute **must** provide the inpatient levels of care that meets the conditions of participation specified. The approved locations for inpatient hospice care are a hospital, a skilled nursing facility ("SNF") or an inpatient hospice facility.

(e) A hospice program may provide the inpatient levels of care in a freestanding inpatient facility/unit which the hospice program owns and manages, through beds owned by either a hospital or a skilled nursing facility ("SNF") but leased and managed by a hospice program or through contracted arrangements with another hospice program's inpatient facility/unit.

(2) Definitions.

(a) All definitions included in Section 410-2-3-.10 are incorporated herein by reference.

(b) Inpatient hospice facility. An "Inpatient Hospice Facility" is defined as a freestanding hospice facility or a designated unit, floor or specific number of beds located in a skilled nursing facility or hospital that is leased or under the management of a hospice services provider.

(c) General Inpatient Level of Care: The general inpatient ("GIP") level of hospice care is intended for short term acute care for pain control and symptomatic management. It is not intended for long term care, residential or rehabilitation.

(d) Inpatient Respite Level of Care: The inpatient respite level of care is limited per Medicare and Medicaid to a maximum of 5 days per episode for the purpose of family respite.

(3) Availability and Accessibility

(a) Hospice services must be obtainable by all of the residents of the State of Alabama.

(b) Physicians and other referral sources may be unfamiliar with the total scope of services offered by hospice; accessibility may be limited due to lack of awareness. Every provider should provide an active community informational program

to educate consumers and professionals to the availability, nature, and extent of their hospice services provided.

(c) In order for a SNF to provide the inpatient levels of care for hospice patients, the SNF **must** meet the standards specified by CMS regarding items such as required staffing and facilities.

(d) Hospice agencies are limited in establishing contracts with hospitals for the inpatient levels of care. This is due to (a) the increased number of hospice providers that request contracts from the same hospitals in the same service areas and (b) the reimbursement hospitals receive from the hospice providers for the hospice inpatient levels of care.

(4) Inventory

(a)
The establishment of an inpatient hospice facility does not eliminate the need for contractual arrangements with hospitals or SNF for inpatient levels of care. If the inpatient hospice facility is at full capacity and a hospice patient is eligible for/requires inpatient care, the hospice remains responsible to provide that level of care at a contracted facility.

(5) Quality

(a) Quality is that characteristic which reflects professionally and technically appropriate patient services. Each provider must establish mechanisms for quality assurance, including procedures for resolving concerns identified by patients, physicians, family members, or others in patient care or referral. Providers should also develop internal quality assurance and grievance procedures.

(b) Providers are encouraged to achieve a utilization level, which promotes cost effective service delivery.

(c) Hospice programs are required to meet the most stringent or exceed the current Medicare Hospice Conditions of Participation, as adopted by CMS, and codified in the Code of Federal Regulations, along with State Licensure Regulations of the Department of Public Health.

(6) Inpatient Hospice Facility Need Methodology

(a) Purpose. The purpose of this inpatient hospice services need methodology is to identify, by region, the number of inpatient hospice beds needed to assure the continued

availability, accessibility, and affordability of quality of care for residents of Alabama.

(b) General. Formulation of this methodology was accomplished by a committee of the Statewide Health Coordinating Council (SHCC). The committee, which provided its recommendations to the SHCC, was composed of providers and consumers of health care, and received input from hospice providers and other affected parties. Only the SHCC, with the Governor's final approval, can make changes to this methodology, except that SHPDA staff shall annually update statistical information to reflect more current population and utilization. Such updated information is available for a fee upon request. Adjustments are addressed in paragraph (e) below.

(c) Basic Methodology.

1. The purpose of this need methodology is to identify, by region, the number of inpatient hospice beds needed to assure the continued availability, accessibility, and affordability of quality hospice care for residents of Alabama.

2. The need methodology shall be calculated by aggregating the reported average daily censuses (ADC) for all licensed hospices in the designated Region, as reported annually to SHPDA, and multiplying that aggregate regional ADC by 3%. The resulting figure shall be the regional need. The need cannot be established or updated until after the most current year's completed annual report is received and compiled by SHPDA.

3. Any increase in regional need shall be limited to no more than five percent (5%) per year with the sole exclusion of any need determined under Planning Policy 7 of this section.

(d) Planning Policies

1. Planning will be on a regional basis. Please see the attached listing for regional descriptions as designated by the SHCC.

2. An applicant for an inpatient hospice facility must be an established and licensed hospice provider and has been operational for at least thirty-six (36) months.

3. An applicant for an inpatient hospice facility must demonstrate the ability to comply with Medicare/Medicaid regulations.

4. An applicant for an inpatient hospice facility must demonstrate that existing inpatient hospice beds in the

region cannot meet the community demand for inpatient hospice services.

5. An applicant for an inpatient hospice facility must demonstrate that sharing arrangements with existing facilities have been studied and implemented when possible.

6. An applicant for an inpatient hospice facility may provided supplemental evidence in support of its application from other data reported by licensed hospices on an annual basis to the State of Alabama or the Federal Government.

7. Additional need may be shown in situations involving a sustained high occupancy rate either for a region or for a single facility. An applicant may apply for additional beds, and thus the establishment of need above and beyond the standard methodology, utilizing one of the following two policies. Once additional beds have been applied for under one of the policies, that applicant shall not qualify to apply for additional beds under either of these policies unless and until the established time limits listed below have passed. All CON Authorized Inpatient Hospice beds shall be included in consideration of occupancy rate and bed need.

(i) If the total combined occupancy rate for all CON Authorized Inpatient Hospice facilities in a region is above 90% as calculated by SHPDA using data reported on the most recent full year 'Annual Report for Hospice Providers (Form HPCE-4)' published by or filed with SHPDA, an additional need of the greater of five percent (5%) of the current total CON Authorized bed capacity of that region or five (5) total beds may be approved for the expansion of an existing facility within that region. Once additional bed need has been shown under this policy, no new need shall be shown in that region based upon this rule for twenty-four (24) months following issuance of the initial CON to allow for the impact of those beds in that region to be analyzed. Should the initial applicant for beds in a region not apply for the total number of beds allowed to be created under this rule, the remaining beds would then be available to be applied for by other providers in the region, so long as said providers meet the conditions listed in this rule.

(ii) If the occupancy rate for a single facility within a region is greater than 90% as calculated by SHPDA using data reported on the most recent full year 'Annual Report for Hospice Providers (Form HPCE-4)' published by or filed with SHPDA, irrespective of the total occupancy rate for all CON Authorized Inpatient Hospice facilities in that region, up to five (5) additional beds may be approved within that region for the expansion of that facility only. Once additional beds have been

approved under this policy, no new beds shall be approved for that facility for twenty-four (24) months following issuance of the CON to allow for the impact of those beds at that facility to be analyzed.

8. No application for the establishment of a new, freestanding Inpatient Hospice facility shall be approved for fewer than 10 beds to allow for the financial feasibility and viability of a project. Because of this, need may be modified by the Agency for any region currently showing a need of more than zero (0) but fewer than ten (10) total beds to a total need of ten (10) new beds, but only in the consideration of an application for the construction of a new, freestanding facility in a region in which no freestanding Inpatient Hospice currently exists. Need shall not be adjusted in consideration of an application involving the expansion of a CON Authorized Inpatient Provider, nor shall need be adjusted according to this rule in any region wherein a CON Authorized freestanding Inpatient Hospice facility already exists.

(e) Adjustments. The need for inpatient hospice beds, as determined by the methodology, is subject to adjustments by the SHCC. SHCC may adjust the need for inpatient hospice beds in a region if an applicant documents the existence of at least one of the following conditions:

(i) Absence of available inpatient beds for a hospice certified for Medicaid and Medicare in the proposed region, and evidence that the applicant will provide Medicaid and Medicare-certified hospice services in the region; or

(ii) Absence of services by a hospice in the proposed region that serves patients regardless of the patient's ability to pay, and evidence that the applicant will provide services for patients regardless of ability to pay.

(iii) A community need for additional inpatient hospice services greater than those supported by the numerical methodology.

(7) Inpatient Hospice Regions. The attached chart, listing "Inpatient Hospice Regional County Listings" is hereby adopted as an Appendix "A" to Section 410-2-4-.15

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: New Rule: Filed February 1, 2010; effective March 8, 2010. **Amended:** Filed January 24, 2012; effective February 28, 2012. **Amended:** Filed November 2, 2012; effective

December 7, 2012. **Amended:** Filed December 2 2014; effective January 6, 2015.

410-2-4-.16 **Freestanding Emergency Departments (FEDs).** A "Freestanding Emergency Department" or "FED" is a new institutional health service requiring a Certificate of Need under Alabama law. In addition to other applicable criteria, all proposed FEDs must demonstrate, through substantial evidence, that their project will meet all the requirements for licensure under Ala. Admin. Code R. 420-5-9, which is incorporated herein by reference.
Author: Statewide Health Coordinating Council (SHCC)
Statutory Authority: §§ 22-21-260(13), (15), Code of Alabama, 1975.
History: **New Rule:** Filed June 5, 2015; effective July 10, 2015.

Appendix A

***REGIONS:**

North Central Region
Blount
Calhoun
Cherokee
Chilton
Clay
Cleburne
Coosa
DeKalb
Etowah
Jefferson
Randolph
Shelby
St. Clair
Talladega
Tallapoosa
Walker

Southeast Region
Autauga
Barbour
Bullock
Butler
Chambers
Coffee
Covington
Crenshaw
Dale
Dallas
Elmore
Geneva
Henry
Houston
Lee
Lowndes
Macon
Montgomery
Pike
Russell
Wilcox

North Region
Colbert
Cullman
Franklin
Jackson
Lauderdale
Lawrence
Limestone
Madison
Marshall
Morgan

Southwest Region
Baldwin
Clarke
Conecuh
Escambia
Mobile
Monroe
Washington

West Region
Bibb
Choctaw
Fayette
Greene
Hale
Lamar
Marengo
Marion
Perry
Pickens
Sumter
Tuscaloosa
Winston

Author: Statewide Health Coordinating Council (SHCC).
Statutory Authority: Code of Ala. 1975, §22-21-260(4).
History: New Rule: Filed January 24, 2012; effective February 28, 2012. **Amended:** Filed November 2, 2012; effective December 7, 2012. **Amended (SHP Year Only):** Filed December 2, 2014; effective January 6, 2015. **Amended:** Filed June 21, 2018; effective August 5, 2018.