APA-1

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control: 410

Department or Agency: State Health Planning and Development Agency
2024-2027 State Health Plan

Rule No.: 410-2-4-.02

Rule Title: Acute Care (Hospitals)

Intended Action: Amend

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety? No

Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare? Yes

Is there another, less restrictive method of regulation available that could adequately protect the public? No

Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved? No

To what degree?: N/A

Is the increase in cost more harmful to the public than the harm that might result from the absence of the proposed rule? No

Are all facets of the rule-making process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public? No

Does the proposed action relate to or affect in any manner any litigation which the agency is a party to concerning the subject matter of the proposed rule? No

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Does the proposed rule have an economic impact? No

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

Certification of Authorized Official

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

Signature of certifying officer: *Emily T. Marsal*
Emily Marsal

REC'D & FILED
JUN 17, 2026
LEGISLATIVE SVC AGENCY

Date: Wednesday, June 17, 2026

APA-2

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

2024-2027
STATE HEALTH PLAN

NOTICE OF INTENDED ACTION

AGENCY NAME: State Health Planning and Development Agency

RULE NO. & TITLE: 410-2-4-.02 Acute Care (Hospitals)

INTENDED ACTION: Amend

SUBSTANCE OF PROPOSED ACTION:
This amendment immediately establishes a framework for the approval and process of Rural Emergency

TIME, PLACE AND MANNER OF PRESENTING VIEWS:
On September 10, 2026, at 10:00 a.m., the Statewide Health Coordinating Council (SHCC) will conduct a public hearing at which time it shall consider the proposed amendment, along with all written and oral submissions in respect to the proposal. Only those interested persons who have made timely written requests will be allowed to speak. The location of the meeting will be posted to the Agency's website, www.shpda.alabama.gov.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:
Friday, August 14, 2026

CONTACT PERSON AT AGENCY:
Ms. Emily T. Marsal, Executive
Director
State Health Planning and
Development Agency
100 North Union Street, Suite 870
Montgomery, AL 36104
(334) 242-4103

Emily T. Marsal
Emily Marsal

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

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

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

(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 August 26, 2013):

(i) "Hospital" means a health institution planned, organized and maintained for offering to the public, facilities and beds for use in the diagnosis and treatment of patients requiring in-patient medical care, out-patient medical care, or other care performed by or under the supervision of physicians due to illness, disease, injury, deformity, abnormality, or pregnancy.

(2) Purpose

(a) The purpose of the bed need methodology is to identify the number of acute general hospital beds 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.

(3) Methodology

(a) The planning area used in this methodology is the county with the exception of certain counties which are grouped together into one planning area due to a current or previous lack of an extant hospital in the area: Calhoun/Cleburne, Fayette/Lamar, Houston/Henry, Lee/Macon, Marengo/Choctaw/ Perry, Montgomery/Lowndes, and Tallapoosa/Coosa.

(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	65%
40-79	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.

$$ADC = \frac{\text{Patient Days in Service Category}}{\text{Days Operational in Year (normally 365)}}$$

2. Compute Weighted Average ADC (Weighted ADC).

(Current Year minus 2 Years ADC x 1) +
(Previous Year ADC x 2) + (Current Year ADC x 3)

3. Compute Projected ADC.

Projected ADC = Weighted ADC x 3 Years above Current Year Projected Population Current Year Population

4. Compute Projected Beds Needed.

Beds Needed = Projected ADC in Service Category
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. All CON Authorized beds shall be considered as Existing Beds for the purposes of need calculations for this section.

(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.

(i) In applying these three (3) 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.

(ii) 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) On occasion, 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 based on a county-planning area and is an average of all days of the month and all months of the year. 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, patients, and medical staff.

(b) In order to assist those existing acute care hospitals that are experiencing high census levels, existing acute care hospitals may qualify to add acute care beds if the existing acute care hospital can demonstrate an average weekday 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 (12) 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 (10%) 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% weekday occupancy rate for two (2) separate and distinct periods of thirty (30) consecutive calendar weekdays of the most recent 12-month period);

2. The application for additional acute care beds does not exceed ten percent (10%) 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) 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 twenty-five (25) days. Ordinarily, the determination regarding a hospital's average length of stay is based on the hospital's 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 twenty-five (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 perform 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 seventy-five percent (75%) 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 twenty-five (25) beds.

(e) Needs Assessment.

1. The bed need for the proposed long term acute care hospital shall be for no more than five percent (5%) of the combined average daily census (ADC) of all the acute care hospitals in the region of the proposed LTACH 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 twenty-five (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 twenty-five (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.

(8) 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.

(9) 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 (12) months):

1. Is a public, nonprofit, or for-profit Medicare-certified hospital currently in operation and located in 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 a 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 twenty-five (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 ten (10) rehabilitation and ten (10) psychiatric beds so long as these are operated as separate units;

6. Maintains an average annual patient stay of no more than ninety-six (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.

(i) 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.

(ii) The "Medicare Prescription Drug, Improvement and Modernization Act" (Public Law H.R. 1 and S. 1 June 27, 2003) is an extensive revision to the Medicare program and contains provisions relating the Critical Access Hospital Program found in Section 405 of the Act. These provisions allow more flexibility for hospitals converting to CAH status.

(10) Rural Emergency Hospitals

(a) A Rural Emergency Hospital (REH) is a specialized hospital that provides outpatient services, does not operate any inpatient beds, and meets all of the requirements for licensure under Ala. Admin. Code r. 420-5-23, which is incorporated herein by reference.

(b) Any hospital seeking to convert from either a Critical Access Hospital or a general acute care hospital to an REH shall file a Request for Determination of Reviewability with SHPDA to ensure that no part of their proposed conversion is reviewable under Certificate of Need law.

(c) Any REH seeking to convert back to either a Critical Access Hospital or a general acute care hospital shall require a Certificate of Need to add inpatient beds to its existing outpatient services. For the limited purpose of this conversion, need shall be presumed for that facility to add up to the total number of general acute care beds it possessed Certificate of Need authority to operate as of the date of its conversion to an REH. This presumed need shall exist only for that provider and only for the location at which the REH was operated. Need shall not be presumed for that provider at any other location in the planning area, nor shall it be presumed for any other type of specialized bed defined elsewhere in this plan. Further, need shall not be presumed for any other provider seeking to establish a new facility in the same planning area. This need shall be presumed for a period of time not to exceed eight (8) years following the conversion of the facility to an REH through

the issuance of a license by the Alabama Department of Public Health.

(d) The SHCC is aware that the loss of existing general acute care beds through the conversion of hospitals to REH status may place a strain on general acute care hospitals in other counties due to the need to provide inpatient acute care services to patients located in the planning area in which the hospital that has converted to an REH no longer provides general inpatient acute care services. Because of this concern, the SHCC has made the determination that, in certain limited circumstances, the *State Health Plan* should allow for beds to be transferred from hospitals that have converted to REH status to certain general acute care hospitals located in contiguous planning areas to the planning area of the new REH. These bed transfers from one planning area to another will be deemed 'consistent' with this plan if and only if each of the following conditions apply:

1. The general acute care hospital seeking to transfer the beds (the "Applying Hospital") must show, using substantial evidence to be included as a part of the application, that the Applying Hospital is the primary provider of inpatient general acute care services and contiguous to the planning area in which the REH is located. The Applying Hospital must be the sole acute care hospital in its planning area and the Applying Hospital must be owned by a single, common owner. If the REH and the Applying Hospital are not owned by a single, common owner, any application to transfer CON authorized beds from the REH must show, with substantial evidence included as a part of the application, that the Applying Hospital is acquiring sole ownership of the REH as a part of the transaction to acquire and relocate the beds. The applicant shall also attest, as a part of the application, that they shall maintain sole ownership of the REH for a minimum of five (5) years following the successful licensure of the beds to be transferred to ensure the financial viability and stability of the REH.

2. The beds being transferred will only be used for the following, limited purpose:

The REH beds will be added to the bed complement of the Applying Hospital only for as long as all of the conditions of this Section remain satisfied by the applying hospital.

(e) Should an Applying Hospital not meet all the criteria defined in (d) above, an application to transfer beds across planning areas will be deemed "inconsistent" with this Plan and shall not be approved.

(f) Should an REH, having transferred beds to an Applying Hospital through the provisions of (d) above, determine that it needs to convert back to general acute care status for the purposes of financial viability, need shall be presumed for that REH provider to convert back to general acute care status for a maximum of the same number of general acute care beds held by the REH when the conversion occurred. The acquiring hospital would be required to transfer the beds back to the REH. The purpose of this requirement is to ensure that no new general acute care beds would be added to the total acute care bed inventory in the State. That presumed need, however, shall only last for a period not to exceed eight (8) years following the conversion of the facility to an REH through the issuance of a license by the Alabama Department of Public Health. If an REH is acquired by another hospital after this amendment becomes effective, the Applying Hospital shall initially only be eligible to receive a transfer of a maximum of twenty-five (25) general acute care beds from the acquired REH. If the Applying Hospital needs additional general acute care beds it is still free to use the State Health Plan Adjustment process in 410-2-4-.02(4) and the Bed Availability Assurance for Acute Care (Hospitals) in 410-2-4-.02(5). The REH will still be eligible for eight years to obtain the total general acute care beds that were initially released in order to qualify for REH status, to include the twenty-five (25) beds transferred to the Applying Hospital.

(g) Only acute care beds may be transferred pursuant to this subsection (10), whether from an REH to an Applying Hospital or back to a former REH upon its conversion back to general acute care status. All beds transferred pursuant to this section from an REH to an applying Hospital shall remain classified as general acute care beds and shall not be used

or operated as swing beds or for skilled nursing or other SNF-level care.

(11) Birthing Centers

(a) In addition to other applicable criteria, any entity proposing to establish a birthing center must demonstrate, through substantial evidence, that their project will meet all of the requirements for licensure under Ala. Admin. Code r. 420-5-13, which is incorporated herein by reference.

(b) Any entity seeking to establish a birthing center that does not offer any services that would require the entity to be licensed by the Alabama Department of Public Health as a hospital or as an ambulatory surgery center may file a Request for Determination of Reviewability with SHPDA in order to determine if a Certificate of Need is required to establish the facility.

(c) Any entity seeking to establish a birthing center that offers services that would require the entity to be licensed by the Alabama Department of Public Health as a hospital or as an ambulatory surgery center shall constitute a new institutional health service requiring a Certificate of Need under Alabama law. An applicant seeking to establish a birthing center, in this instance, shall not be required to show a need for acute hospital beds or for additional ambulatory surgery center operating rooms, but shall instead provide substantial evidence in its application to demonstrate to the Certificate of Need Review Board that the proposed facility is necessary to the health and welfare of the citizens of the proposed planning area. Specifically, data related to maternal and infant mortality, distances between the proposed location and existing acute care hospitals providing obstetric and maternity care, the policy regarding the types of patients who will be treated versus the types of patients that would automatically be referred to an acute care facility, and copies of transfer agreements regarding the care of high-risk patients and/or patients requiring care above and beyond that available at the proposed facility between the proposed facility and existing acute care providers should all be included as part of the application to create a new birthing center. The grant of a Certificate of Need for the establishment of a birthing center shall not constitute authority for the creation of new acute care beds, other ambulatory surgical services, or any other service requiring a Certificate of Need.

(d) The SHCC is aware that there is currently ongoing litigation between representatives seeking to establish

birthing centers and the Alabama Department of Public Health regarding licensure rules for these facilities. Once a final decision is issued in this ongoing litigation, the SHCC will review and revise this section as appropriate based on the ruling issued by the courts.

For a listing of Acute Care, Long Term Acute Care, or Critical Access Hospitals or the most current statistical need projections in Alabama contact the Data Division as follows:

MAILING ADDRESS STREET ADDRESS
(U.S. Postal Service) (Commercial Carrier)
PO BOX 303025 100 NORTH UNION STREET, SUITE 870
MONTGOMERY, AL 36130-3025 MONTGOMERY, AL 36104

TELEPHONE: FAX:
(334) 242-4103 (334) 242-4113

EMAIL: WEBSITE:
data.submit@shpda.alabama.gov http://www.shpda.alabama.gov

Appendix A

LTACH Regional County Listings

REGION I

Colbert

Franklin

Lauderdale

Lawrence

REGION II

Jackson

Limestone

Madison

Marshall

Morgan

REGION III

Bibb

Blount

Cullman

Jefferson

Marion

Saint Clair

REGION V

Fayette

Greene

Hale

Lamar

Pickens

Sumter

Tuscaloosa

REGION VI

Autauga

Bullock

Butler

Chambers

Chilton

Coosa

Crenshaw

Dallas

Elmore

Lee

Lowndes

REGION VII

Baldwin

Choctaw

Clarke

Conecuh

Escambia

Mobile

Monroe

Washington

REGION VIII

Barbour

Coffee

Covington

Dale

Geneva

Henry

Houston

Shelby

Talladega

Walker

Winston

Macon

Marengo

Montgomery

Perry

Pike

Russell

Tallapoosa

Wilcox

REGION IV

Calhoun

Cherokee

Clay

Cleburne

DeKalb

Etowah

Randolph

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. **Repealed and New Rule:** Published March 31, 2020; effective May 15, 2020. **Repealed and New Rule:** Published April 30, 2024; effective June 14, 2024. **Amended:** Published ; effective .