



ISDH Hospital Service Report  
 State Form 49476 (R /7-02)  
 IC 16-21-6

Status: Finalized

I. Hospital Information

Hospital Name: SELECT SPECIALTY HOSPITAL, INDIANAPOLIS

Provider #:

City:

County:

Year:

Person Completing the Report:

Email Address:

LICENSURE, ACCREDITATION, OR DESIGNATED UNITS (check all that apply)

State Licensure: Acute License LTC Certification

Private Accreditation: JCAHO HFAP

CMS Specialized Hosp: CAH TLC Rehab

DRG Exempt: Psych Rehab Swing Bed

Number of Total Hospital Full Time Equivalents

II. Hospital Service Utilization

Hospital Service Description	Number of Set-up Beds	Number of Discharges	Number of Patient Days	Annual Total Charges
Burn Care				
Cardiac Intensive				
ICU Medical/Surgical				
ICU Neonatal				
ICU Pediatric				
Medical/Surgical				
Neonatal Intermediate				
Normal Newborn				
Obstetrics				

Pediatric				
Psychiatric				
Rehabilitation				
Substance Abuse				
Swing Bed Program	NA			
Extended Care				
Observation Beds				
All Other Services				NA
Total Acute	45	362	9691	NA

III. Nursing Facility Utilization

	Number of Licensed Beds	Number of Discharges	Number of Patient Days
Nursing Facility			

IV. Number of Outpatient Encounters By Diagnostic Group

Please identify the number of outpatient encounters for your hospital by ICD-9-CM Diagnostic Categories

Diagnostic Categories	Number of Encounters	Diagnostic Categories	Number of Encounters
Infectious Disease		HIV	
Neoplasms		Endocrine	
Diseases of Blood		Mental Disorders	
Nervous		Circulatory	
Respiratory		Digestive Diseases	
Genitourinary		Pregnancy	
Skin		Musculoskeletal	
Congenital		Perinatal	
All Injuries			
Other/Known		Total Encounters	0

Total ED Visits	ED Injury Visits	ED Injury Admissions

Comments