FORM HPCE4
HOSPICES
1/2012

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2012

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2011 ANNUAL REPORT FOR HOSPICE PROVIDERS

TYPE FACILITY ID # HERE

TYPE FACILITY NAME HERE

This report is a requirement for maintaining state licensure*

Mailing Address: _____ (STREET ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Physical Address: _____ (STREET ADDRESS) _____ (CITY) **AL** _____ (ZIP)

County of Location: _____ **Website Address:** _____

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

This reporting period is for January 1, 2011, through December 31, 2011*; or for partial year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

If there was a change in ownership during the reporting period, data for the full year should be reported by the current owner.

We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this provider.

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

A member of administration separate from the preparer above MUST also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above.

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

FOR OFFICE USE ONLY

Facility Verified:		Initial Scan:		Completed:	
Entered:		Final Scan:		Audited:	

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SECTION A: PROGRAM

A1: PROGRAM TYPE

A. Agency Type

- ◯ Free Standing
- ◯ Home Health Based
- ◯ Other (Specify) _____
- ◯ Hospital Based
- ◯ Nursing Home Based

B. Ownership

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

C. Waiting List for Services

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

Home Care Services ◯ YES ◯ NO

Inpatient Care Services ◯ YES ◯ NO

A2: LICENSED INPATIENT FACILITIES

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

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

Does this provider currently own and operate a CON Authorized Inpatient Hospice? ◯ YES ◯ NO

Number of total CON Authorized Inpatient beds: _____

Free Standing Facility _____ NUMBER OF BEDS

Leased Beds within Another Licensed Facility _____ NUMBER OF BEDS

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A3: CONTRACTUAL INPATIENT SERVICES

For In-Home Hospice providers not also holding CON Authority as an Inpatient Hospice provider, contractual Inpatient services are provided at:

Hospital	Number of Contracts:	_____
SNF	Number of Contracts:	_____
CON Authorized Inpatient Hospice Facility	Number of Contracts:	_____

A4: VOLUNTEER SERVICES

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

_____ %

SECTION B: PATIENT VOLUME

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

In-Home Hospice Care: All In-Home hospice level of care information, regardless of the location in which it was provided, should be reported in this category, except where the report requests Continuous Care days and in-home days to be separated.

Contractual Care: All General Inpatient or Respite care provided by a CON Authorized Hospice provider in any location other than a CON Authorized Inpatient Hospice facility must be reported in this space. GIP or Respite Care provided in a CON Authorized Inpatient Hospice not owned by the reporting entity should be reported under Inpatient Care, along with the name of the CON Authorized Inpatient Hospice where the care was provided.

Inpatient Care: Only General Inpatient or Respite care provided in a CON Authorized Inpatient Hospice Facility should be provided in this space. Any Inpatient Hospice care provided by the Owner of the CON Authorized Inpatient Hospice in ANY location OTHER than the CON Authorized Inpatient Hospice should be reported as Contractual Care.

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

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B1: PATIENTS SERVED

Admission location is the actual location of the patient at the time of the initial admission. Patient Day location is the actual location of the patient on that day, regardless of admission location.

	In-Home Hospice Care	Contractual Care (Section B)	Inpatient Hospice (Section B)	Agency Totals
a. Total Patient Days				0
b. Total New (Unduplicated) Admissions				0
c. Re-Admissions (Duplicated Admissions) from Prior Years				0
d. Total (Unduplicated) Admissions during this Reporting Period (sum of b. and c.)				0
e. Re-Admissions (Duplicated Admissions) from current reporting year (Initial admission of patient was counted in B1b)				0
f. Total Admissions for Reporting Period (sum of d. and e.)				0
g. Total Carryovers (patients were in hospice care on both 12/31 and 1/1)				0
h. Total Unduplicated Patients Served During Reporting Period (sum of d. and g.)				0
i. Total Deaths				0
j. Total Live Discharges/Revocations/Transfers				0

B2: ADMISSONS AND DEATHS BY LOCATION

LOCATION	Number of Admissions (B1f.)	Number of Deaths (B1i.)
Home		
Nursing Facility		
Assisted Living Facility/Specialty Care Assisted Living Facility		
Hospital		
CON Authorized Free Standing Inpatient Hospice Facility		
CON Authorized Dedicated, Leased Hospice Beds		
Totals	0	0

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B3: LEVEL OF CARE

	ROUTINE HOME CARE DAYS		CONTINUOUS CARE DAYS BILLED
a. Patient's home/residence			
b. Long Term Care Facility			
c. Assisted Living Facility			
d. Licensed Inpatient Provider			
e. TOTALS	0		0

CONTRACTUAL INPATIENT CARE (Section B Definition)	HOSPITALS	SNF	CON AUTHORIZED FACILITY	AGENCY TOTALS
f. General Inpatient Days				0
g. Inpatient Respite Days				0
INPATIENT HOSPICE CARE (Section B Definition)			**CON AUTHORIZED FACILITY**	**AGENCY TOTALS**
h. General Inpatient Days				0
i. Inpatient Respite Days				0
Name of CON Authorized Inpatient Hospice where h. and i. were provided				

TOTAL PATIENT CARE DAYS (sum of Routine Home Care, Continuous Care, f. and g., h. and i. (if applicable) Agency Totals	0
TOTAL CONTINUOUS CARE HOURS (Include all billable and non-billable continuous care hours provided during reporting period)	

B4: LENGTH OF SERVICE

LENGTH OF SERVICE	In-Home Hospice Care	Contractual (Section B)	Inpatient (Section B)	Agency Totals
Average Length of Service (ALOS)				
Median Length of Service (MLOS)				
Average Daily Census				0.00

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B5: LIVE DISCHARGES

TYPE OF LIVE DISCHARGE	In-Home Hospice Care	Contractual (Section B)	Inpatient (Section B)	Agency Totals
a. Discharges				0
b. Revocations				0
c. Transfers				0
TOTALS (B1j.)	0	0	0	0

B6: LENGTH OF SERVICE FOR DEATHS/LIVE DISCHARGES/TRANSFERS

LOS Category	Patients Served
1 to 7 days	
8 to 14 days	
15 to 29 days	
*30 to 59 days	
*60 to 89 days	
*90 to 179 days	
*180 days or more	
TOTALS (sum of B1i. and B1j.)	0

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SECTION C: PATIENT DIAGNOSIS AND REIMBURSEMENT

C1: ADMISSIONS BY REIMBURSEMENT SOURCE

Source of Reimbursement	In-Home Hospice Care	Contractual (Section B)	Inpatient (Section B)	Agency Totals
Medicare				0
Medicaid				0
Private Insurance				0
Private Pay				0
Charity				0
TOTALS (Must equal B1f totals.)	0	0	0	0

C2: PATIENTS SERVED BY REIMBURSEMENT SOURCE

Source of Reimbursement	In-Home Hospice Care	Contractual (Section B)	Inpatient (Section B)	Agency Totals
Medicare				0
Medicaid				0
Private Insurance				0
Private Pay				0
Charity				0
TOTALS (Must equal B1h totals.)	0	0	0	0

C3: PATIENT DAYS BY REIMBURSEMENT SOURCE

Source of Reimbursement	In-Home Hospice Care	Contractual (Section B)	Inpatient (Section B)	Agency Totals
Medicare				0
Medicaid				0
Private Insurance				0
Private Pay				0
Charity				0
TOTALS (Must equal B1a totals.)	0	0	0	0

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

○ YES ○ NO

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C4: DIAGNOSIS (Refer to Section B for In-Home, Contractual, and Inpatient definitions)

Diagnosis	Location of Service	Number of Admissions (B1f)	Number of Deaths (B1i)	Number of Live Discharges (B1j)	Patient Days (B1a)	Number of Patients Served (B1h)
Cancer	In-Home					
	Contractual					
	Inpatient					
Heart	In-Home					
	Contractual					
	Inpatient					
Alzheimer's Disease and/or Dementia	In-Home					
	Contractual					
	Inpatient					
Lung	In-Home					
	Contractual					
	Inpatient					
Kidney	In-Home					
	Contractual					
	Inpatient					
Liver	In-Home					
	Contractual					
	Inpatient					
HIV	In-Home					
	Contractual					
	Inpatient					
SUB-TOTALS (Page 8)	In-Home	0	0	0	0	
	Contractual	0	0	0	0	
	Inpatient	0	0	0	0	0

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Diagnosis	Location of Service	Total Number of Admissions (B1f)	Number of Deaths (B1i)	Number of Live Discharges (B1j)	Patient Days (B1a)	Number of Patients Served (B1h)
Debility Unspecified	In-Home					
	Contractual					
	Inpatient					
Other Motor Neuron Disease	In-Home					
	Contractual					
	Inpatient					
Stroke/Coma	In-Home					
	Contractual					
	Inpatient					
ALS	In-Home					
	Contractual					
	Inpatient					
All Others	In-Home					
	Contractual					
	Inpatient					
SUB-TOTALS (Page 9)	In-Home	0	0	0	0	
	Contractual	0	0	0	0	
	Inpatient	0	0	0	0	0
TOTALS		0	0	0	0	0

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SECTION D: PATIENT DEMOGRAPHICS

D1: COUNTY OF RESIDENCE

Make copies of this page before completing if necessary. Report only those admissions occurring in Alabama; Do not include out of state admissions.

County	Location of Care	Total Number of Admissions (B1f.)	Number of Deaths (B1i.)	Number of Live Discharges (B1j.)	Patient Days (B1a)	Number of Patients Served (B1h)
	In-Home					
	Contractual					
	Inpatient					
	In-Home					
	Contractual					
	Inpatient					
	In-Home					
	Contractual					
	Inpatient					
	In-Home					
	Contractual					
	Inpatient					
	In-Home					
	Contractual					
	Inpatient					
	In-Home					
	Contractual					
	Inpatient					
	In-Home					
	Contractual					
	Inpatient					
	In-Home					
	Contractual					
	Inpatient					
Sub-Totals	In-Home	0	0	0	0	
	Contractual	0	0	0	0	
	Inpatient	0	0	0	0	0
TOTALS		0	0	0	0	0

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D2: TOTAL ADMISSIONS BY RACE

RACE	ADMISSIONS (B1f.)
a. White/Caucasian	
b. Black/African American/Negro	
c. Hispanic/Spanish/Latino	
d. Asian	
e. American Indian/Alaskan Native	
f. Pacific Islander	
g. India	
h. Middle Eastern	
i. Other	
TOTAL ADMISSIONS	0

D3: TOTAL ADMISSIONS BY AGE AND GENDER

AGE GROUPS	MALE	FEMALE	TOTAL (B1f.)
18 and under			0
19 – 34			0
35 – 54			0
55 – 64			0
65 – 74			0
75 – 84			0
85 years and older			0
TOTAL ADMISSIONS	0	0	0

SECTION E: REVENUES AND EXPENSES (*AMOUNTS DO NOT HAVE TO BE AUDITED)*

EXPENSES		REVENUES	
Payroll	$ .00	Medicare	$ .00
Non-Payroll	$ .00	Medicaid	$ .00
Transportation	$ .00	Commercial Insurance	$ .00
Bad Debt	$ .00	Private Pay	$ .00
Charity	$ .00	Other	$ .00
TOTAL EXPENSES	$ 0.00	**TOTAL REVENUES**	$ 0.00

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List all satellite hospice providers licen sed by ADPH at any time during this reporting period included in this report.

COUNTY	LICENSED HOSPICE PROVIDER