FORM HPCE4
12/2013

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2014

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2013 ANNUAL REPORT FOR IN-HOME HOSPICE PROVIDERS

This report is a requirement for maintaining state licensure*

This report should be typewritten or completed in ink only; no pencil submissions

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

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

County of Location: _____

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

This reporting period is for January 1, 2013, through December 31, 2013*; 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; and must be separate from the preparer.

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

FOR OFFICE USE ONLY

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

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SECTION A: PROGRAM

A1: PROGRAM TYPE

A. **Agency Type** *(choose one type only)*

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

B. **Ownership** *(choose one type only)*

_____ Corporation
_____ Non-Profit Organization
_____ Partnership
_____ Individual
_____ Healthcare Authority
_____ LLC
_____ Joint Venture
_____ Government
_____ 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:
(Refer to Instructions for additional information and examples)

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 by In-Home Providers: Information regarding General Inpatient and Inpatient Respite Care Patient Days is to be reported by location of service. If care is provided at a CON-Authorized Inpatient Hospice facility (not under common ownership), report the facility name(s) where indicated.

Contractual Care by Inpatient Providers Information regarding General Inpatient and Inpatient Respite Care Patient Days provided at any location **other** than the CON-Authorized Inpatient Hospice facility operated by the provider; or Inpatient care provided under contract with an In-Home provider **(not under common ownership)**, to be reimbursed by the In-Home provider (patient is considered to remain a patient of the In-Home provider at all times).

Inpatient Care: Only General Inpatient or Respite care provided in a CON Authorized Inpatient Hospice Facility for patients of the Inpatient Hospice or In-Home Hospice **under common ownership**, should be reported as Inpatient Care. 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.

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

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		

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B3: LEVEL OF CARE

Patient Day location is the actual location of the patient on that day, regardless of admission location.

	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			

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

J. TOTAL PATIENT CARE DAYS sum of Routine Home Care, Continuous Care, f. and g., h. and i. (if applicable) Agency Totals	
k. 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				

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B5: LIVE DISCHARGES/REVOCATIONS/TRANSFERS

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

B6: LENGTH OF SERVICE FOR DEATHS/LIVE DISCHARGES/REVOCATIONS/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.)	

* **Stays in a CON-Authorized Inpatient Facility greater than 29 days should have an explanation listed below. If needed, additional sheets can be used. The additional sheets should be attached to the back of this report and titled "Annual Report of Hospice Providers – Section B6 Continued".**

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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				
Medicaid				
Private Insurance				
Private Pay				
Charity				
TOTALS (Must equal B1f totals.)				

C2: PATIENTS SERVED BY REIMBURSEMENT SOURCE

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

C3: PATIENT DAYS BY REIMBURSEMENT SOURCE

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

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					
	Contractual					
	Inpatient					

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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 (this page)	In-Home					
	Contractual					
	Inpatient					
SUB-TOTALS (Page 8)	**In-Home**					
	Contractual					
	Inpatient					
SUB-TOTALS	**In-Home**					
	Contractual					
	Inpatient					
TOTALS						

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SECTION D: PATIENT DEMOGRAPHICS

D1: COUNTY OF RESIDENCE

Make copies of this page before completing if necessary. List ALL counties for which CON Authorization is held by this provider (common CON Authorization or single CON Authorization reporting under a common Medicare Provider number). For those counties with no patients served during the reporting period, enter "0's" for requested demographics. Report only those admissions occurring in Alabama; do not include out of state admissions. General Inpatient and Respite care is to be reported based on patient's county of residence, not location of care, whether such care is contractual or provided in a CON-Authorized Inpatient facility.

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					
	Contractual					
	Inpatient					
TOTALS						

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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	

D3: TOTAL ADMISSIONS BY AGE AND GENDER

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

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

EXPENSES	
Payroll	$ .00
Non-Payroll	$ .00
Transportation	$ .00
Bad Debt	$ .00
Charity	$ .00
TOTAL EXPENSES	$ .00

REVENUES	
Medicare	$ .00
Medicaid	$ .00
Commercial Insurance	$ .00
Private Pay	$ .00
Other	$ .00
TOTAL REVENUES	$ .00

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List ALL satellite providers for which CON Authorization is held by this provider (common CON Authorization or single CON Authorization reporting under a common Medicare Provider number), for which information is included in this report; and from which services were provided at any time during the reporting period.

SATELLITE HOSPICE PROVIDER	COUNTY	OPERATIONAL ENTIRE REPORTING PERIOD YES	OPERATIONAL ENTIRE REPORTING PERIOD NO	NUMBER OF DAYS OPERATIONAL IF INITIALLY LICENSED/CLOSED DURING REPORTING PERIOD
		☐	☐	
		☐	☐	
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2013 Hospice Annual Report Checklist

	In-Home	Contractual Care	Inpatient	Totals
Patient Days				
Page 4, Section B1a.				
Patient Days throughout report must equal days reported directly above				
Page 5, Section B3e. Routine Home Care + Continuous Care Days Totals				
Page 5, Section B3f + B3g Agency Totals				
Page 5, Section B3h + B3i Agency Totals				
Page 5, Section B3j. Agency Totals				
Page 7, Section C3 Totals				
Page 9, Section C4 Patient Days Sub-Totals & Total				
Page 10, Section D1, Patient Days Sub-Totals & Total				
Admissions				
Page 4, Section B1f.				
Admissions throughout report must equal Admissions reported directly above				
Page 4, Section B2 Totals				
Page 7, Section C1 Totals				
Page 9, Section C4 Admissions Sub-Totals & Total				
Page 10, Section D1 Admissions Sub-Totals & Total				
Page 11, Section D2 Total				
Page 11, Section D3 Total				
Unduplicated Patients Served				
Page 4, Section B1h.				
Unduplicated Patients Served throughout report must equal Unduplicated Patients Served reported directly above				
Page 7, Section C2 Totals				
Page 9, Section C4 Total				
Page 10, Section D1 Total				
Deaths				
Page 4, Section B1i.				
Deaths throughout report must equal Deaths reported directly above				
Page 4, Section B2 Total				
Page 9, Section C4, Deaths Sub-Totals & Total				
Page 10, Section D1, Deaths Sub-Totals & Total				
Live Discharges/Revocations/ Transfers				
Page 4, Section B1j				
Discharges/Revocations/Transfers throughout report must equal those reported above				
Page 6, Section B5, Totals must equal directly above				
Page 9, Section C4, Discharges Sub-Totals & Total				
Page 10, Section D1, Discharges Sub-Totals & Total				