

APA-4
10/91

**CERTIFICATION OF EMERGENCY RULES
FILED WITH LEGISLATIVE REFERENCE SERVICE
JERRY L. BASSETT, DIRECTOR**

Pursuant to Code of Alabama 1975, §§ 41-22-5(b) and 41-22-6.

I certify that the attached emergency amendment is a copy as promulgated and adopted on the 16th day of September, 2009.

AGENCY NAME: State Health Planning and Development Agency

RULE NO. AND TITLE: 410-1-5C-01ER In-Home Hospice Service Providers

EFFECTIVE DATE OF RULE: The Agency desires the Emergency Rule to become effective on the date of filing with the Legislative Reference Service-that is, September 21, 2009

EXPIRATION DATE: The Agency desires the Emergency Rule to remain in effect for 120 days, through January 19, 2010.

NATURE OF EMERGENCY:

On May 13, 2009, Alabama Act 2009-492 (the "Act") was signed into law. The Act amended ALA. CODE §22-21-260(6) (1975 amended) to include "hospice service providers" within the definition of a "health care facility." The Act also amended ALA. CODE § 22-4-2(7) (1975 as amended) to include "hospice services" within the definition of a "health care facility" and amended ALA. CODE § 22-21-29 (1975 as amended) by eliminating the provision that had placed a moratorium on the Alabama Department of Public Health's licensing of hospices. It is critical that existing patients of such providers continue to receive hospice services and that these services continue to be available to new patients. This emergency rule is necessary to address an immediate danger to the public health and welfare.

STATUTORY AUTHORITY: §§ 22-21-260 (6), (13), (15), Code of Alabama, 1975.

SUBJECT OF RULE TO BE ADOPTED ON PERMANENT BASIS

YES NO

REC'D & FILED

SEP 21 2009

LEGISLATIVE REF SERVICE

NAME, ADDRESS, AND TELEPHONE NUMBER OF PERSON TO CONTACT FOR COPY OF RULE:

James E. Sanders, Deputy Director
State Health Planning and Development Agency
100 North Union Street
P. O. Box 303025
Montgomery, AL 36130-3025
(334) 242-4103


Alva M. Lambert
Executive Director

FILING DATE
(For APA Use Only)

410-1-5C-.01ER IN-HOME HOSPICE SERVICE PROVIDERS

- (1) On May 13, 2009, Governor Riley signed Alabama Act 2009-492 (the "Act") into law, which amended ALA. CODE § 22-21-260(6) (1975 as amended) to include "hospice service providers" within the definition of a "health care facility" for state health planning and development purposes. The Act also amended ALA. CODE § 22-4-2(7) (1975 as amended) to include "hospice services" within the definition of a "health care facility" and amended ALA. CODE § 22-21-29 (1975 as amended) by eliminating the provision that had placed limitations on the Alabama Department of Public Health's ("ADPH") licensing of hospices, except those that obtained a letter of non-reviewability from SHPDA by July 7, 2006 and filed an application for licensure as a hospice with ADPH within twelve (12) months of the date of the letter of non-reviewability. By its terms, the Act became effective immediately upon approval of the Governor. On August 17, 2009 the Alabama Attorney General issued an Opinion finding that all existing providers are required to obtain a Certificate of Need ("CON") to continue operations, however, SHPDA may adopt an emergency rule allowing such providers to continue to operate pending expedited consideration of the CON applications upon a finding of an immediate danger to the public health, safety or welfare.

- (2) On August 31, 2009, Governor Riley approved Rule 410-2-3-10ER, which was passed by the Statewide Health Coordinating Council ("SHCC") on August 20, 2009. The emergency rule provides that in-home hospice service providers in existence as of the effective date of Alabama Act 2009-492 can obtain CONs under a non-substantive review procedure, thus preventing any unnecessary disruption of services in authorized counties. The rule also provides for the collection of data needed for the development of long-term methodology. Need is presumed for any provider that demonstrates it was providing service under ADPH license in a particular county as of May 13, 2009, or the preceding twelve months. The SHCC rule contemplates that SHPDA will also adopt regulations providing for the consideration of applications under the emergency rule and recommends that SHPDA reduce the standard application fee for such applications.

- (3) Without implementation of a procedure to quickly and efficiently issue CONs to existing in-home hospice providers, there exists a risk that said services will be interrupted. This represents an immediate threat to the health, safety and welfare of hospice patients and their families. Accordingly, the following procedures are adopted for the consideration of CON applications for in-home hospice services:
 - (a) Any provider that demonstrates that it was providing service under ADPH licensure as of May 13, 2009, or the preceding twelve months, may seek a CON by filing an application by November 1, 2009, to be granted a CON before May 1, 2010, which shall be the date after which all in-home hospice providers existing as of the effective date of the Act must have a CON under this provision.

- (b) SHDPA shall seek assistance from ADPH in verifying that applicants meet the requirements of subsection (a) above and Rule 410-2-3-10ER. Applicants should provide evidence of their qualifications as an existing provider in each county to be encompassed in their CON, as well as of their continuing ability to meet licensure standards. Applicants that meet the aforementioned criteria and affirm that their application does not involve a capital expenditure in excess of \$500,000¹ shall have their applications considered as part of a non-substantive review process, as allowed under Ala. Code § 22-21-275(4) (1975 as amended) and Ala. Admin. Code § 410-1-10-.02, which shall include direct consideration and approval by the Certificate of Need Review Board. Such applications shall be filed utilizing the form attached to this rule as Appendix "A".
- (c) A fee of \$250.00 shall be charged for each CON application submitted as an in-home hospice service provider under this section.
- (d) The granting of a CON under this provision shall be conditioned on timely compliance with any data request issued on an annual basis by the SHPDA Staff in conjunction with the adoption of long-term need methodology, including form HPCE:2 for 2007 and 2008, attached as Appendix B and C. The 2009 annual report, HPCE-4, attached as Appendix D, must be completed and filed with SHPDA by April 15, 2010.
- (e) An existing provider obtaining a CON that subsequently fails to substantially comply on a timely basis to an annual data request from the SHPDA staff, adopted in conjunction with long-term need methodology (subject to any authorized extensions), shall be assumed to have ceased operations as of the end of such period until such time as the provider complies fully with all outstanding SHPDA data requests. Any provider that has deemed to have ceased operations under this chapter shall be prohibited from submitting any CON application for additional authority or from seeking consideration by SHPDA of such facility's utilization data to oppose another provider's CON application. In accordance with Rule 410-1-11-.08(2), should such cessation of operation continue for an uninterrupted period of twelve months or longer, the provider's CON shall be deemed abandoned. SHPDA shall report to the ADPH any provider who is deemed to have abandoned its CON under this section.
- (f) Existing hospice providers obtaining a CON pursuant to this Section (3) shall file a single application and be granted a single CON encompassing all of the counties served under ADPH licensure as provided in Section (3)(a) above. For purposes of this Section only, an entity shall be considered a separate hospice provider for each Medicare Provider

¹ Applies only to new capital expenditures that have, or may be incurred in the twelve months after May 13, 2009, in order to maintain such services that were being provided prior to that date.

Number held at the time of application (e.g., if an entity has multiple hospice provider numbers, as separate application must be filed, and CON issued, for each) provided, however, that a corporate entity having multiple provider numbers shall not receive more than one CON per county. Such CON authority may not be subsequently divided, e.g., a hospice provider may not separate such authority into separate CONs for future disposition. This restriction shall not apply to CONs granted outside of the provisions of 410-2-3-.10(2)(b) and (c) nor shall this restriction prohibit a provider from conducting internal organizational restructurings within entities under common ownership and control which are unrelated to a contemplated sale or change of control. All applications submitted pursuant to the non-substantive review provisions of 410-2-3-.10(2)(b) and (c) shall include an acknowledgement of this restriction.

(g) Hospice providers that have obtained CON authority as a result of the relocation of administrative offices since May 13, 2009, shall not be required to obtain a new CON for any counties specifically addressed in such CONs but shall be otherwise subject to compliance with the data collection requirements of section (e) above. In addition, no application fee shall be required under this Section for hospice providers, as defined in subsection (f) above, who have already obtained a CON for relocation of a facility within such provider's licensed area.

(h) Pending the development of long-term methodology, the Agency shall not accept applications for in-home hospice services except as provided herein or as may be required under law for the relocation of existing facilities.

(4) Applications filed by existing providers pursuant to this section are not required to first file a Letter of Intent unless their application involves a construction project. Since need shall be presumed for all existing providers as of May 13, 2009, who meet the requirements of this section, there will be no batching cycle established with respect to any applications for a CON under the provisions of this emergency rule.

Author: Certificate of Need Review Board

Statutory Authority: §§ 41-22-5, 22-21-260(6), -264 and -275, Code of Alabama (1975)

History: Effective September 21, 2009 (Emergency Rule)

APPENDIX A

**ALABAMA CERTIFICATE OF NEED
APPLICATION FOR PROVIDERS OF
IN-HOME HOSPICE SERVICES AS OF MAY 13, 2009
SEEKING A CERTIFICATE OF NEED UNDER "NON-SUBSTANTIVE"
REVIEW PROCEDURES**

For Staff Use Only

INSTRUCTIONS: Please submit an original and twelve (12) copies of this form and the appropriate attachments to the State of Alabama, State Health Planning and Development Agency, 100 North Union Street, Suite 870, Montgomery, Alabama 36104. (Post Office Box 303025 Montgomery, AL 36130-3025)

Project # _____
Date Rec. _____
Rec by: _____

Attached is a check in the amount of \$250.00
Refer to Rule 410-1-5C-.01 of the Certificate of Need Program Rules and Regulations to determine the required filing fee.

PART ONE: APPLICANT IDENTIFICATION AND PROJECT DESCRIPTION

A. _____
Name of Applicant (in whose name the CON will be issued if approved) Medicare Provider #

Address _____ City _____ County _____

State _____ Zip Code _____ Phone Number _____

B. _____
Name of Facility/Organization (if different from A)

Address _____ City _____ County _____

State _____ Zip Code _____ Phone Number _____

C. _____
Name of Legal Owner (if different from A or B)

Address _____ City _____ County _____

State _____ Zip Code _____ Phone Number _____

D. _____
Name and Title of Person Representing Proposal and with whom SHPDA should communicate

Address _____ City _____ County _____

State _____ Zip Code _____ Phone Number _____

_____ E-Mail Address

Form # CON—In Home Hospice

I. APPLICANT IDENTIFICATION (continued)

E. Type Ownership and Governing Body

- 1. Individual
- 2. Partnership
- 3. Corporate (for profit) _____
Name of Parent Corporation
- 4. Corporate (non-profit) _____
Name of Parent Corporation
- 5. Public
- 6. Other (specify) _____

F. Names and Titles of Governing Body Members and Owners of This Facility

OWNERS

GOVERNING BOARD MEMBERS

II. PROJECT DESCRIPTION

A. Please attach a copy of the current ADPH licenses associated with the Medicare Provider Number under which this application is submitted.¹ List all counties in which Applicant provided in-home hospice services under the Medicare Provider Number, and ADPH license, as of May 13, 2009, or the preceding twelve months, for which this CON is sought.

B. Evidence of Continuing Ability to Meet Licensure Standards:

- 1. Prior to May 13, 2009, has applicant received pending notice of license revocation, probation or non-renewal of licensure from the ADPH relating to its in-home hospice operations?
 Yes No

If yes, please describe the nature of such notice in a separate attachment (with appropriate redaction of patient information, as needed).

- 2. Please describe the Applicant's quality of care and compliance programs.

C. Applicant is the sole hospice provider under common control applying for such counties.

- Yes No

¹ Under Ala. Admin. Code 410-2-3-.10(2)(b), need is presumed for any Applicant that has provided in-home hospice service pursuant to an ADPH license as of May 13, 2009, or the preceding twelve months. Pursuant to Ala. Admin. Code 410-1-5C-.01, for purposes of this application, an entity shall be considered a separate hospice provider for purposes of each Medicare Provider Number held.

Form # CON—In Home Hospice

VI. CHARGE INFORMATION

A. List schedule of current charges related to this project.

B. List schedule of proposed charges after completion of this project.

PART SIX: ACKNOWLEDGEMENT AND CERTIFICATION BY THE APPLICANT

- I. **ACKNOWLEDGEMENT.** In submitting this application, the applicant understands and acknowledges that:
- A. The rules, regulations and standards for health facilities and services promulgated by the SHPDA have been read, and the applicant will comply with same.
 - B. Upon the granting of a CON pursuant to this application, the applicant shall provide confirmation that they are continuing to operate in the counties encompassed by the CON, which shall result in the automatic vesting of the CON.
 - C. Applicants seeking a CON herein under the non-substantive review procedures authorized by Ala. Admin. Code 410-2-3-.10(2)(b) and (c) shall be granted a single CON encompassing all of the counties served under a Medicare Provider Number. Such CON authority may not be subsequently divided, e.g., a hospice provider may not separate such authority into separate CONs for future disposition. Any action to transfer or assign the certificate in violation of this or any other restriction found in Alabama law or the SHPDA rules will render it null and void.
 - D. Pursuant to Ala. Admin. Code 410-2-3-.10(2)(c), the granting of a CON under this provision shall be conditioned on timely compliance with any data request, issued on an annual basis by the SHPDA staff in conjunction with the adoption of long-term need methodology, including any request for 2007-2009 information that may be required as part of the application process.
 - E. Pursuant to Ala. Admin. Code 410-2-3-.10(2)(d) an existing provider that obtains a CON that subsequently fails to substantially comply on a timely basis (subject to any authorized extensions) to an annual data request from the SHPDA staff adopted in conjunction with long-term need methodology shall be assumed to have ceased operations as of the end of such period until the provider complies fully with all outstanding SHPDA data requests. Any provider that has deemed to have ceased operations under such provision chapter shall be prohibited from submitting any CON application for additional authority or from seeking consideration by SHPDA of such facility's utilization data to oppose another provider's CON application. In accordance with Rule 410-1-11-.08(2), should such cessation of operation continue for an uninterrupted period of twelve months or longer, the provider's CON shall be deemed abandoned. SHPDA shall report to the Alabama Department of Public Health any provider who is deemed to have abandoned its CON under this section.
 - F. The applicant will notify the State Health Planning and Development Agency when a project is started, completed, or abandoned.
 - G. The applicant must comply with all state and local building codes, and failure to comply will render the Certificate of Need null and void.
 - H. The applicants and their agents will construct and operate in compliance with appropriate state licensure rules, regulations, and standards.
 - I. Projects are limited to the work identified in the Certificate of Need as issued.
 - J. Any expenditure in excess of the amount approved on the Certificate of Need must be reported to the State Health Planning and Development Agency and may be subject to review.
 - K. The applicant will comply with all state statutes for the protection of the environment.
 - L. The applicant is not presently operating with a probational (except as may be converted by this application) or revoked license.

Form # CON—In Home Hospice

I. CERTIFICATION

The information contained in this application is true and correct to the best of my knowledge and belief, and I agree to be bound by the restrictions contained herein.

Signature of Applicant

Applicant's Name and Title
(Type or Print)

_____ day of _____ 20____

Alabama Notary Public (Affix seal on Original)

Author: Alva M. Lambert

Statutory Authority: § 22-21-267, 271, 275, Code of Alabama, 1975

History: Adopted, September [], 2009

THIS REPORT MUST BE FILED PRIOR TO OR WITH YOUR CON APPLICATION
2007 REPORT

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4109
www.shpda.alabama.gov

STREET ADDRESS (Commercial Carrier)
100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104
FAX: (334) 242-4113
paul.may@shpda.alabama.gov

2007 ANNUAL REPORT FOR IN-HOME HOSPICES

Mailing Address: _____
STREET ADDRESS CITY STATE ZIP

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

County of Location: _____

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

This reporting period is for October 1, 2006, through September 30, 2007*; or for partial year of operation beginning _____ and ending _____ a period of _____ days.

MONTH DAY MONTH DAY
*Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. *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 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: _____

I. PROGRAM DEMOGRAPHICS

A. Agency Type

<input type="checkbox"/> Free Standing	<input type="checkbox"/> Hospital Based
<input type="checkbox"/> Home Health Based	<input type="checkbox"/> Nursing Home Based
<input type="checkbox"/> Government/Healthcare Authority Based	

B. Ownership

<input type="checkbox"/> Corporation	<input type="checkbox"/> Non-Profit Organization	<input type="checkbox"/> Partnership
<input type="checkbox"/> Individual	<input type="checkbox"/> Healthcare Authority	<input type="checkbox"/> LLC
<input type="checkbox"/> Joint Venture	<input type="checkbox"/> Government	<input type="checkbox"/> Other (specify)

C. Reporting Entity

1. Does this agency have the capability to provide patient information, specific only to this licensed location?

YES NO

2. If no, provide the name of the licensed hospice agency that will be reporting patient information for this entity:

SHPDA ID #:

NAME OF REPORTING HOSPICE:

NAME OF CONTACT:

TELEPHONE NUMBER:

3. Will the information contained in this report include patient information from other licensed hospice agencies, for services offered and performed in the State of Alabama?

YES NO

4. If yes, provide the SHPDA ID # and the name of the licensed hospice agency(ies) for which information is included in this report:

SHPDA ID #:

NAME OF HOSPICE AGENCY

_____	_____
_____	_____
_____	_____
_____	_____

B. PATIENT DAYS BY PAYMENT SOURCE

Provide the number of patient days for all patients including those in hospitals, specialty care assisted living, and nursing facilities, for the reporting period.

HOSPICE PAYMENT SOURCE	NUMBER OF PATIENTS SERVED	DAYS OF ROUTINE HOME CARE	DAYS OF INPATIENT CARE	DAYS OF RESPITE CARE	DAYS OF CONTINUOUS CARE	TOTAL PATIENT CARE DAYS
Hospice Medicare	_____	_____	_____	_____	_____	_____
Hospice Medicaid	_____	_____	_____	_____	_____	_____
Private Insurance/ Managed Care (non-Medicare)	_____	_____	_____	_____	_____	_____
Charity/ Indigent	_____	_____	_____	_____	_____	_____
Private Pay	_____	_____	_____	_____	_____	_____
Other (VA, Worker's Comp, etc)	_____	_____	_____	_____	_____	_____
TOTALS	_____	_____	_____	_____	_____	_____

C. ADMISSIONS BY DEMOGRAPHICS

Use the patient's age on the first day of admission.

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

**TOTAL ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTIONS II-A AND II-D.

D. TOTAL ADMISSIONS BY RACE

	RACE	ADMISSIONS
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		**

**TOTAL ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTIONS II-A, AND II-C.

III. 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	\$ _____ .00	TOTAL REVENUES	\$ _____ .00

THIS REPORT MUST BE FILED PRIOR TO OR WITH YOUR CON APPLICATION
2008 REPORT

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4109
www.shpda.alabama.gov

STREET ADDRESS (Commercial Carrier)
100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104
FAX: (334) 242-4113
paul.may@shpda.alabama.gov

2008 ANNUAL REPORT FOR IN-HOME HOSPICES

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 October 1, 2007, through September 30, 2008*; or for partial year of operation beginning _____ and ending _____ a period of _____ days.

MONTH DAY MONTH DAY

*Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. *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 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: _____

I. PROGRAM DEMOGRAPHICS

A. Agency Type

- | | |
|--|--|
| <input type="checkbox"/> Free Standing
<input type="checkbox"/> Home Health Based
<input type="checkbox"/> Government/Healthcare Authority Based | <input type="checkbox"/> Hospital Based
<input type="checkbox"/> Nursing Home Based |
|--|--|

B. Ownership

- | | | |
|--|--|--|
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Non-Profit Organization | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Individual | <input type="checkbox"/> Healthcare Authority | <input type="checkbox"/> LLC |
| <input type="checkbox"/> Joint Venture | <input type="checkbox"/> Government | <input type="checkbox"/> Other (specify) |

C. Reporting Entity

1. Does this agency have the capability to provide patient information, specific only to this licensed location?

YES NO

2. If no, provide the name of the licensed hospice agency that will be reporting patient information for this entity:

SHPDA ID #:

NAME OF REPORTING HOSPICE:

NAME OF CONTACT:

TELEPHONE NUMBER:

3. Will the information contained in this report include patient information from other licensed hospice agencies, for services offered and performed in the State of Alabama?

YES NO

4. If yes, provide the SHPDA ID # and the name of the licensed hospice agency(ies) for which information is included in this report:

SHPDA ID #:

NAME OF HOSPICE AGENCY

B. PATIENT DAYS BY PAYMENT SOURCE

Provide the number of patient days for all patients including those in hospital, specialty care assisted living or nursing facilities, for the reporting period.

HOSPICE PAYMENT SOURCE	NUMBER OF PATIENTS SERVED	DAYS OF ROUTINE HOME CARE	DAYS OF INPATIENT CARE	DAYS OF RESPITE CARE	DAYS OF CONTINUOUS CARE	TOTAL PATIENT CARE DAYS
Hospice Medicare	_____	_____	_____	_____	_____	_____
Hospice Medicaid	_____	_____	_____	_____	_____	_____
Private Insurance/ Managed Care (non-Medicare)	_____	_____	_____	_____	_____	_____
Charity/ Indigent	_____	_____	_____	_____	_____	_____
Private Pay	_____	_____	_____	_____	_____	_____
Other (VA, Worker's Comp, etc)	_____	_____	_____	_____	_____	_____
TOTALS	_____	_____	_____	_____	_____	_____

C. ADMISSIONS BY DEMOGRAPHICS

Use the patient's age on the first day of admission.

AGE GROUPS	MALE	FEMALE	TOTAL
18 and under	_____	_____	_____
19 – 34	_____	_____	_____
35 – 54	_____	_____	_____
55 – 64	_____	_____	_____
65 – 74	_____	_____	_____
75 – 84	_____	_____	_____
85 years and older	_____	_____	_____
TOTAL ADMISSIONS	_____	_____	**

**TOTAL ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTIONS II-A AND II-D.

D. TOTAL ADMISSIONS BY RACE

	RACE	ADMISSIONS
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		**

**TOTAL ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTIONS II-A, AND II-C.

III. REVENUES AND EXPENSES (AMOUNTS DO NOT HAVE TO BE AUDITED)

EXPENSES		REVENUES	
Payroll	\$ <u> .00</u>	Medicare	\$ <u> .00</u>
Non-Payroll	\$ <u> .00</u>	Medicaid	\$ <u> .00</u>
Transportation	\$ <u> .00</u>	Commercial Insurance	\$ <u> .00</u>
Bad Debt	\$ <u> .00</u>	Private Pay	\$ <u> .00</u>
Charity	\$ <u> .00</u>	Other	\$ <u> .00</u>
TOTAL EXPENSES	\$ <u> .00</u>	TOTAL REVENUES	\$ <u> .00</u>

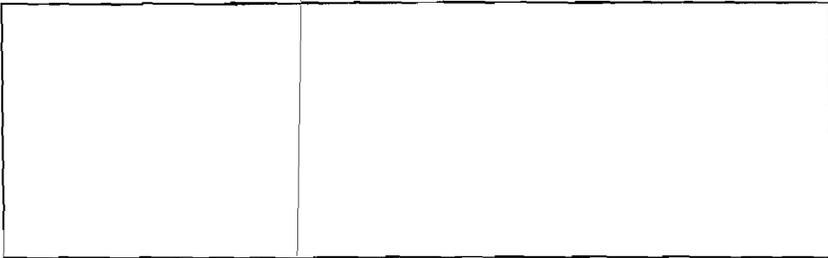
THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2010

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4109
www.shpda.alabama.gov

STREET ADDRESS (Commercial Carrier)
100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104
FAX: (334) 242-4113
paul.may@shpda.alabama.gov

2009 ANNUAL REPORT FOR HOSPICE PROVIDERS



ADPH License # _____

A separate report must be filed for each license number.

Mailing Address:

_____ STREET ADDRESS _____ CITY _____ STATE _____ ZIP

Physical Address:

_____ STREET ADDRESS _____ CITY _____ **AL** _____ ZIP

County of Location: _____

E-Mail Address: _____

Facility Telephone:

_____ (AREA CODE) & TELEPHONE NUMBER

Facility Fax:

_____ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for January 1, 2009, through December 31, 2009*; or for partial year of operation beginning _____ and ending _____ a period of _____ days.

MONTH DAY MONTH DAY

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

****This report is a requirement for maintaining state licensure****

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 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: _____
Entered: _____

Initial Scan: _____
Final Scan: _____

Completed: _____
Audited: _____

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2010

SECTION A: PROGRAM

A1: PROGRAM TYPE

A. Agency Type

<input type="checkbox"/> Free Standing <input type="checkbox"/> Home Health Based <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Hospital Based <input type="checkbox"/> Nursing Home Based
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B. Ownership

<input type="checkbox"/> Corporation	<input type="checkbox"/> Non-Profit Organization	<input type="checkbox"/> Partnership
<input type="checkbox"/> Individual	<input type="checkbox"/> Healthcare Authority	<input type="checkbox"/> LLC
<input type="checkbox"/> Joint Venture	<input type="checkbox"/> Government	<input type="checkbox"/> Other (specify) _____

A2: 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 by the hospice;
2. Be staffed by hospice staff.

Does your hospice operate a free standing inpatient hospice facility?

<input type="checkbox"/> YES	<input type="checkbox"/> NO
------------------------------	-----------------------------

If yes, number of licensed beds in the Inpatient Hospice Facility

If no, does your hospice lease beds in another facility?

<input type="checkbox"/> YES	<input type="checkbox"/> NO
------------------------------	-----------------------------

Number of beds in a hospice facility leased space

If inpatient hospice care is provided on a contractual basis, where is that care provided:

<input type="checkbox"/> Hospital	<input type="checkbox"/> SNF	<input type="checkbox"/> Hospice Inpatient Facility
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SECTION B: PATIENT VOLUME

For the purpose of gathering statistics, the following definitions apply:

Home Hospice Care: Patients who were admitted for hospice care to be provided in their place of residence.

Inpatient Care: Patients who were admitted for hospice care directly to an inpatient hospice facility (either leased beds or hospice owned-not contractual GIP level of care).

B1: PATIENTS SERVED

Admission location is the actual location of the patient on the first day of care.

	Home Hospice Care	Inpatient Facility	Agency Totals
a. Total Patient Days			
b. Total New (Unduplicated) Admissions			
c. Re-Admissions (Duplicated Admissions) from Prior Years			
d. Re-Admissions (Duplicated Admissions) in 2009			
e. Total Carry-overs			
f. Total Deaths			
g. Total Live Discharges			

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B2: LEVEL OF CARE

Care Level	Patient Residence	Free Standing Inpatient Hospice Facility	Leased Hospice Inpatient Beds	Contracted Hospitals	Contracted SNF	Agency Totals
Routine Home Care Days						
a. Patient's home/residence						
b. Long Term Care Facility						
c. Assisted Living Facility						
d. Free-standing or leased inpatient hospice facility						
General Inpatient Days						
Inpatient Respite Days						
Continuous Care Hours						

B3: ADMISSIONS AND DEATHS BY LOCATION

The admissions recorded in this section include new admissions (unduplicated) as well as re-admissions (duplicated). Deaths reflect all patients who died regardless of admission year.

Location	Number of Admissions	Number of Deaths
Home		
Nursing Facility		
Assisted Living Facility/Specialty Care Assisted Living Facility		
Hospice Leased Space		
Hospital		
Free Standing Inpatient Hospice Facility		
Total	*	*

*ADMISSIONS SHOULD EQUAL ADMISSIONS REPORTED IN SECTION B1b + B1c + B1d; DEATHS SHOULD EQUAL DEATHS REPORTED IN SECTION B1f.

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B4: LENGTH OF SERVICE

LENGTH OF SERVICE	Home Hospice Care	Inpatient Facility*	Agency Totals
Average Length of Service (ALOS)			
Median Length of Service (MLOS)			
Average Daily Census for FY2009			

B5: LIVE DISCHARGES

TYPE OF LIVE DISCHARGE	Home Hospice Care	Inpatient Facility*	Agency Totals
a. Discharges			
b. Revocations			
c. Transfers			
TOTALS			

* EITHER LEASED BEDS OR HOSPICE INPATIENT FACILITY

B6: LENGTH OF SERVICE BY CATEGORY

LOS Category	Home Hospice Care Deaths/Discharges/Revocations	Inpatient Hospice Facility Deaths/Discharges/Revocations	Agency Totals
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			

*INPATIENT STAYS GREATER THAN 29 DAYS SHOULD BE EXPLAINED IN THE SPACE PROVIDED BELOW.

If additional space is needed, please include a separate sheet of paper titled "Annual Report of Hospice Providers - B6".

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SECTION C: PATIENT DEMOGRAPHICS

C1: ADMISSIONS BY REIMBURSEMENT SOURCE

The admissions recorded in this section include new, unduplicated admissions.

	Home Hospice Care Number	Inpatient Hospice Facility Number	Agency Totals Number
Unduplicated Medicare			
Unduplicated Medicaid			
Private Insurance			
Private Pay			
Charity Care			
*TOTALS			

*ADMISSIONS SHOULD EQUAL ADMISSIONS REPORTED IN SECTION B1b

C2: PATIENTS SERVED BY REIMBURSEMENT SOURCE

This section reflects the total number of patients served (admissions + carry over patients on Jan 1). Each patient is counted only one time regardless of the number of re-admissions.

	Home Hospice Care Number	Inpatient Hospice Facility Number	Agency Totals Number
Unduplicated Medicare			
Unduplicated Medicaid			
Private Insurance			
Private Pay			
Charity Care			
TOTALS			

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C3: DIAGNOSIS

Diagnosis	Location of Service	Number of New (Unduplicated) Admissions	Number of Deaths	Number of Live Discharges	Patient Days for Patients Who Died or Were Live Discharges
Cancer	Home Hospice Care				
	Inpatient Care				
Heart	Home Hospice Care				
	Inpatient Care				
Alzheimer's Disease	Home Hospice Care				
	Inpatient Care				
Lung	Home Hospice Care				
	Inpatient Care				
Kidney	Home Hospice Care				
	Inpatient Care				
Liver	Home Hospice Care				
	Inpatient Care				
HIV	Home Hospice Care				
	Inpatient Care				
Debility Unspecified	Home Hospice Care				
	Inpatient Care				
Other Motor Neuron Disease	Home Hospice Care				
	Inpatient Care				
Stroke/Coma	Home Hospice Care				
	Inpatient Care				
ALS	Home Hospice Care				
	Inpatient Care				
All Others	Home Hospice Care				
	Inpatient Care				
TOTALS		*	*	*	

*TOTAL ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTION B1b; DEATHS SHOULD AGREE WITH TOTAL DEATHS IN SECTION B1f; TOTAL LIVE DISCHARGES SHOULD MATCH TOTAL LIVE DISCHARGES IN SECTION B1g.

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C4: ADMISSIONS BY COUNTY OF RESIDENCE

Make copies of this page before completing if necessary.

County	Location of Care	Number of Admissions	Number of Deaths	Number of Live Discharges	Number of Patients Served (Include Carry over)
	Home Hospice Care				
	Inpatient Care				
	Home Hospice Care				
	Inpatient Care				
	Home Hospice Care				
	Inpatient Care				
	Home Hospice Care				
	Inpatient Care				
	Home Hospice Care				
	Inpatient Care				
	Home Hospice Care				
	Inpatient Care				
	Home Hospice Care				
	Inpatient Care				
	Home Hospice Care				
	Inpatient Care				
	Home Hospice Care				
	Inpatient Care				
	Home Hospice Care				
	Inpatient Care				
Totals		*	*	*	*

*TOTAL ADMISSIONS/DEATHS SHOULD AGREE WITH TOTAL ADMISSIONS/DEATHS IN SECTION B1b+c+d; TOTAL DEATHS SHOULD AGREE WITH B1f; TOTAL LIVE DISCHARGES SHOULD MATCH TOTAL LIVE DISCHARGES IN SECTION B1g.

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C5: TOTAL ADMISSIONS BY RACE

RACE	ADMISSIONS
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	**

**TOTAL ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTIONS B1b+c+d, C4, & C6.

C6: TOTAL ADMISSIONS BY AGE AND GENDER

AGE GROUPS	MALE	FEMALE	TOTAL
18 and under			
19 - 34			
35 - 54			
55 - 64			
65 - 74			
75 - 84			
85 years and older			
TOTAL ADMISSIONS			**

**TOTAL ADMISSIONS SHOULD AGREE WITH TOTAL ADMISSIONS IN SECTIONS B1b+c+d, C4, & C5.

SECTION D: 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	\$.00	TOTAL REVENUES	\$.00

