FORM HPCE4
HOSPICES
09/2009

Appendix - D

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

TYPE FACILITY ID # HERE

TYPE FACILITY NAME HERE

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 _____ (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.

*****<u>This report is a requirement for maintaining state licensure</u>*****

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 <u>MUST</u> 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:	

SECTION A: PROGRAM

A1: PROGRAM TYPE

A. **Agency Type**

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

B. **Ownership**

- ◯ Corporation
- ◯ Non-Profit Organization
- ◯ Partnership
- ◯ Individual
- ◯ Healthcare Authority
- ◯ LLC
- ◯ Joint Venture
- ◯ Government
- ◯ 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? ◯ **YES** ◯ **NO**

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

If no, does your hospice lease beds in another facility? ◯ **YES** ◯ **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:

☐ Hospital ☐ SNF ☐ Hospice Inpatient Facility

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			0
b. Total New (Unduplicated) Admissions			0
c. Re-Admissions (Duplicated Admissions) from Prior Years			0
d. Re-Admissions (Duplicated Admissions) in 2009			0
e. Total Carry-overs			0
f. Total Deaths			0
g. Total Live Discharges			0

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						0
b. Long Term Care Facility						0
c. Assisted Living Facility						0
d. Free-standing or leased inpatient hospice facility						0
General Inpatient Days						0
Inpatient Respite Days						0
Continuous Care Hours						0

B3: ADMISSONS 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	* 0	* 0

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

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			0.00

B5: LIVE DISCHARGES

TYPE OF LIVE DISCHARGE	Home Hospice Care	Inpatient Facility*	Agency Totals
a. Discharges			0
b. Revocations			0
c. Transfers			0
TOTALS	0	0	0

*** 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			0
8 to 14 days			0
15 to 29 days			0
***30 to 59 days**			0
***60 to 89 days**			0
***90 to 179 days**			0
***180 days or more**			0

***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".

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			0
Unduplicated Medicaid			0
Private Insurance			0
Private Pay			0
Charity Care			0
***TOTALS**	0	0	0

***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			0
Unduplicated Medicaid			0
Private Insurance			0
Private Pay			0
Charity Care			0
TOTALS	0	0	0

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		* 0	* 0	* 0	0

***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				
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	Inpatient Care				
	Home Hospice Care				
	Inpatient Care				
	Home Hospice Care				
	Inpatient Care				
	Home Hospice Care				
	Inpatient Care				
Totals		* 0	* 0	* 0	* 0

***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.**

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	** 0

****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			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

****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	$ 0.00	**TOTAL REVENUES**	$ 0 .00

1. Please provide below the licensed hospice locations included in this report.

SHPDA ID #:	NAME OF LICENSED HOSPICE AGENCY