FORM HPCE4
Revised 2/7/2020

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2020

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2019 ANNUAL REPORT FOR HOSPICE PROVIDERS

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: ______________

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

This reporting period is for January 1, 2019, through December 31, 2019; 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:

a. Consist of one or more beds that are owned or leased (*not contracted*) by the hospice;
b. 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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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:	Routine level of care, regardless of the location in which it was provided; and continuous care days provided whether or not billed separately.
Contractual Inpatient Care	General Inpatient and Inpatient Respite levels of care provided by any CON-Authorized hospice provider which does not also own and operate a CON-Authorized inpatient facility; or inpatient care provided by a CON-Authorized Inpatient Hospice in a location other than the inpatient facility owned and operated by the provider.
Inpatient Hospice Care:	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.** 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 Inpatient Care.

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

B1: PATIENTS SERVED

		Agency Totals
a.	**Total New (Unduplicated) Admissions**	
b.	**Re-Admissions (Duplicated Admissions) from Prior Years**	
c.	**Total (Unduplicated) Admissions during this Reporting Period** (sum of a. and b.)	
d.	**Re-Admissions (Duplicated Admissions) from current reporting year** (Initial admission of patient was counted in B1a)	
e.	**Total Admissions** (sum of c. and d.)	
f.	**Total Carryovers** (patients were in hospice care on both 12/31 and 1/1)	
g.	**Total Unduplicated Patients Served During Reporting Period** (sum of c. and f.)	

Explanation of B1a through B1d

a. Brand new patients, admitted for 1st time to agency during reporting year.
b. Patients readmitted during reporting year, but initial admission was NOT in reporting year.
c. Total number of patients admitted during reporting period.
d. Patients readmitted during reporting year and initial admission was during reporting year.

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B2: TOTAL ADMISSIONS BY RACE

RACE	ADMISSIONS (B1e.)
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	

B3: TOTAL ADMISSIONS BY AGE AND GENDER

AGE GROUPS	MALE	FEMALE	TOTAL (B1e.)
18 and under			
19 – 34			
35 – 54			
55 – 64			
65 – 74			
75 – 84			
85 years and older			
TOTAL ADMISSIONS			

B4: DEATHS/DISCHARGES

	Agency Totals
a. Total Deaths	
b. Total Live Discharges/Revocations/Transfers	
c. Total Deaths/Live Discharges/Revocations/Transfers	
d. Total Patient Days of service for ALL Deaths/Discharges (patients counted in a. and b.) during reporting period.	

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SECTION C: PATIENT DAYS

C1: PATIENT DAYS BY LEVEL OF CARE

IN-HOME PATIENT DAYS (Section B definition)	AGENCY TOTALS
a. Routine Home Care Days	
b. Continuous Care Days Billed	
c. Total In-Home Patient Days	
CONTRACTUAL INPATIENT DAYS (Section B definition)	
d. General Inpatient Days	
e. General Respite Days	
f. Total Contractual Inpatient Days	
INPATIENT HOSPICE DAYS (Section B definition)	
g. General Inpatient Days	
h. Inpatient Respite Days	
i. Total Inpatient Hospice Days	
j. TOTAL PATIENT CARE DAYS	
IN-HOME HOSPICE CARE ONLY	
k. Routine Hospice Care Days provided in a Skilled Nursing Facility (SNF)	
l. Total Percentage of In-Home Hospice Care Days provided in a Skilled Nursing Facility (SNF)	

Hospice Rules of the Alabama State Board of Health

Alabama Department of Public Health Administrative Rule 420-5-17-.03(1)(c)(8) states: Any person licensed to provide a hospice care program shall establish a written interdisciplinary plan of care for each hospice patient and family that provides care in individual's homes and provides or coordinates care on an inpatient basis. Not more than 50% of the home care days shall be provided to residents of nursing homes.

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C2: PATIENT DAYS BY REIMBURSEMENT SOURCE

SOURCE OF REIMBURSEMENT	PATIENT DAYS
Medicare	
Medicaid	
Private Insurance	
Private Pay	
Charity	
TOTALS (Must equal C1j. Total)	

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

________ YES ________ NO

C3: PATIENT DAYS BY DIAGNOSIS

DIAGNOSIS	PATIENT DAYS
Cancer	
Cardiopulmonary	
Alzheimer's Disease and/or Dementia	
All Other	
TOTALS (Must equal C1j. Total)	

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SECTION D: PATIENT LOCATION

D1: COUNTY OF RESIDENCE

Complete as many pages as necessary to report 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.*

COUNTY	NUMBER OF DEATHS	NUMBER OF LIVE DISCHARGES	PATIENT DAYS	NUMBER OF PATIENTS SERVED
TOTALS				
	Final totals must equal B4a.	**Final totals must equal B4b.**	**Final totals must equal C1j.**	**Final totals must equal B1g.**

☐ **FOR CON-AUTHORIZED INPATIENT FACILITIES ONLY:** In-Home services were not provided to patients residing in any county reported in this section, for which this provider does not possess CON Authority to provide In-Home services.

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SECTION D: PATIENT LOCATION (cont'd)

D1: COUNTY OF RESIDENCE

COUNTY	NUMBER OF DEATHS	NUMBER OF LIVE DISCHARGES	PATIENT DAYS	NUMBER OF PATIENTS SERVED
TOTALS FROM PREVIOUS PAGE				
TOTALS				
	Final totals must equal B4a.	Final totals must equal B4b.	Final totals must equal C1j.	Final totals must equal B1g.

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SECTION D: PATIENT LOCATION (cont'd)

D1: COUNTY OF RESIDENCE

COUNTY	NUMBER OF DEATHS	NUMBER OF LIVE DISCHARGES	PATIENT DAYS	NUMBER OF PATIENTS SERVED
TOTALS FROM PREVIOUS PAGE				
TOTALS				
	Final totals must equal B4a.	Final totals must equal B4b.	Final totals must equal C1j.	Final totals must equal B1g.

SECTION E: AGENCY INFORMATION

E1: 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).

__________%

E2: LENGTH OF SERVICE

LENGTH OF SERVICE	AGENCY TOTALS
Average Length of Service (ALOS)	
Median Length of Service (MLOS)	
Number of Days in Reporting Period	
Average Daily Census	

***Make and keep a copy of the completed report for the provider's records before submitting to SHPDA.

This report should be submitted to SHPDA only one time. ***The preferred method is electronic submission*** to data.submit@shpda.alabama.gov.
If submitted electronically please do not also submit via hard copy unless specifically requested to do so by SHPDA staff.

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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	NO	NUMBER OF DAYS OPERATIONAL IF INITIALLY LICENSED/CLOSED DURING REPORTING PERIOD
		☐	☐	
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		☐	☐	

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Hospice Annual Report Checklist

	TOTALS
PATIENT DAYS	
Page 5, Section C1j.	______
Patient Days throughout report must equal days reported directly above	
Page 6, Section C2	______
Page 6, Section C3	______
Page 7, Section D1	______
ADMISSIONS	
Page 3, Section B1e.	______
Admissions throughout report must equal Admissions reported directly above	
Page 4, Section B2	______
Page 4, Section B3	______
UNDUPLICATED PATIENTS SERVED	
Page 3, Section B1g.	______
Unduplicated Patients Served throughout report must equal Unduplicated Patients Served reported directly above	
Page 7, Section D1	______
DEATHS	
Page 4, Section B4a.	______
Deaths throughout report must equal Deaths reported directly above	
Page 7, Section D1	______
LIVE DISCHARGES/REVOCATIONS/TRANSFERS	
Page 4, Section B4b.	______
Live Discharges/Revocations/Transfers throughout report must equal Deaths reported directly above	
Page 7, Section D1	______