FORM HPCE4
Revised 02/2024

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2024

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
www.shpda.alabama.gov

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

2023 ANNUAL REPORT FOR HOSPICE PROVIDERS

PRINT

SAVE

SELECT TEXT WITH MOUSE TO OVERTYPE IN FIELDS BELOW

ENTER ID NUMBER ASSIGNED BY SHPDA

ENTER NAME OF PROVIDER AS REFLECTED ON CURRENT ADPH LICENSURE

SUBMIT REPORT

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: CHOOSE COUNTY...

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

This reporting period is for January 1, 2023, through December 31, 2023; 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: _____

FORM HPCE4
Revised 02/2024

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2024

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**

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2024

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.)	0
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.)	0
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.)	0

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.

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2024

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	0

B3: TOTAL ADMISSIONS BY AGE AND GENDER

AGE GROUPS	MALE	FEMALE	TOTAL (B1e.)
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

B4: DEATHS/DISCHARGES

	Agency Totals
a. Total Deaths	
b. Total Live Discharges/Revocations/Transfers	
c. Total Deaths/Live Discharges/Revocations/Transfers	0
d. Total Patient Days of service for ALL Deaths/Discharges (patients counted in a. and b.) during reporting period.	

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2024

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	0
CONTRACTUAL INPATIENT DAYS (Section B definition)	
d. General Inpatient Days	
e. General Respite Days	
f. Total Contractual Inpatient Days	0
INPATIENT HOSPICE DAYS (Section B definition)	
g. General Inpatient Days	
h. Inpatient Respite Days	
i. Total Inpatient Hospice Days	0
j. TOTAL PATIENT CARE DAYS	0
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.

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2024

C2: PATIENT DAYS BY REIMBURSEMENT SOURCE

SOURCE OF REIMBURSEMENT	PATIENT DAYS
Medicare	
Medicaid	
Private Insurance	
Private Pay	
Charity	
TOTALS (Must equal C1j. Total)	**0**

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)	**0**

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2024

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
AUTAUGA				
BALDWIN				
BARBOUR				
BIBB				
BLOUNT				
BULLOCK				
BUTLER				
CALHOUN				
CHAMBERS				
CHEROKEE				
CHILTON				
CHOCTAW				
CLARKE				
CLAY				
CLEBURNE				
COFFEE				
COLBERT				
CONECUH				
COOSA				
TOTALS	**0**	**0**	**0**	**0**
	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.

FORM HPCE4
Revised 02/2024

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2024

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	**0**	**0**	**0**	**0**
COVINGTON				
CRENSHAW				
CULLMAN				
DALE				
DALLAS				
DEKALB				
ELMORE				
ESCAMBIA				
ETOWAH				
FAYETTE				
FRANKLIN				
GENEVA				
GREENE				
HALE				
HENRY				
HOUSTON				
JACKSON				
JEFFERSON				
LAMAR				
LAUDERDALE				
LAWRENCE				
LEE				
LIMESTONE				
LOWNDES				
MACON				
TOTALS	**0**	**0**	**0**	**0**
	Final totals must equal B4a.	**Final totals must equal B4b.**	**Final totals must equal C1j.**	**Final totals must equal B1g.**

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2024

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	**0**	**0**	**0**	**0**
MADISON				
MARENGO				
MARION				
MARSHALL				
MOBILE				
MONROE				
MONTGOMERY				
MORGAN				
PERRY				
PICKENS				
PIKE				
RANDOLPH				
RUSSELL				
SAINT CLAIR				
SHELBY				
SUMTER				
TALLADEGA				
TALLAPOOSA				
TUSCALOOSA				
WALKER				
WASHINGTON				
WILCOX				
WINSTON				
TOTALS	**0**	**0**	**0**	**0**
	Final totals must equal B4a.	**Final totals must equal B4b.**	**Final totals must equal C1j.**	**Final totals must equal B1g.**

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2024

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	365
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.

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2024

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
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____
_____	.....	☐	☐	_____

FORM HPCE4
Revised 02/2024

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2024

Hospice Annual Report Checklist

	TOTALS
PATIENT DAYS	
Page 5, Section C1j.	**0**
Patient Days throughout report must equal days reported directly above	
Page 6, Section C2	0
Page 6, Section C3	0
Page 7, Section D1	0
ADMISSIONS	
Page 3, Section B1e.	**0**
Admissions throughout report must equal Admissions reported directly above	
Page 4, Section B2	0
Page 4, Section B3	0
UNDUPLICATED PATIENTS SERVED	
Page 3, Section B1g.	**0**
Unduplicated Patients Served throughout report must equal Unduplicated Patients Served reported directly above	
Page 7, Section D1	0
DEATHS	
Page 4, Section B4a.	**0**
Deaths throughout report must equal Deaths reported directly above	
Page 7, Section D1	0
LIVE DISCHARGES/REVOCATIONS/TRANSFERS	
Page 4, Section B4b.	**0**
Live Discharges/Revocations/Transfers throughout report must equal Deaths reported directly above	
Page 7, Section D1	0