INSTRUCTIONS FOR COMPLETING THE 2007-2008 ANNUAL REPORTS FOR HOSPICE FACILITIES

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
100 NORTH UNION STREET, SUITE 870
MONTGOMERY, AL 36104
(334) 242-4109
www.shpda.alabama.gov

INSTRUCTIONS FOR COMPLETION OF THE 2007-2008 ANNUAL REPORT FOR HOSPICE FACILITIES

Form HPCE2

These instructions for the 2007-2008 Annual Report for Hospice Facilities are intended to assist in the completion and submission of accurate data reported. To ensure data integrity, and determine utilization rates of inpatient and outpatient services provided by hospice providers, information reported must be consistent throughout the state. These instructions are intended to assist in the collection of data and in minimizing the number of errors. Selected verification procedures for reported information are also outlined, and are indicated by (**). Should these instructions not address a particular concern, please request additional assistance by contacting the State Health Planning and Development Agency (SHPDA), Paul C. May, Data/Planning Director, at (334) 242-4109 or paul.may @shpda.alabama.gov.

Note that for each section, areas that are not applicable for the type of service or the listed location provided are grayed out on the form, and should not be filled out.

Page 1

The identification number as indicated on the mailing label is assigned by SHPDA.

Verify the name of the facility identified on the mailing label is the name of the facility as indicated on the license issued by the Alabama Department of Public Health (ADPH). Make any necessary changes to the label.

Mailing Address: Provide the complete mailing address to be used by SHPDA for the mailing of annual reports, data, and requests for additional information. This address may be different from the mailing/physical address of the facility.

Physical Address: Provide the complete physical address of this facility as indicated on the ADPH license.

County of Location: Provide the county of physical location of the facility.

Facility Telephone: Provide the general telephone number of the facility, including the area code.

Facility Fax: Provide the general fax telephone number of the facility, including the area code.

The signatures and requested identifying information must be provided by two separate individuals. The primary preparer of the annual report will be contacted first for additional/corrected information. If the primary preparer is not available at the time of attempted contact, the administration official will be contacted to provide additional/corrected information, and to answer any questions.

Page 2

SECTION I: PROGRAM DEMOGRAPHICS

A. Agency Type: Indicate the nature of the individual hospice facility.

B. Ownership: Provide the organizational structure of the facility as reported to ADPH.

C. Reporting Entity: This section is used to determine how the overall patient care will be reported to the Agency by the corporate entity. If the provider has the ability to provide data for its location, please answer yes and skip question 2. If the answer is no, please provide the information corresponding who has the ability to provide this information in question 2. If this provider will not be reporting information for another branch, answer no for question 3 and skip question 4. Otherwise, answer yes for question 3 and provide **both the provider number and provider name** in question 4.

Page 3

SECTION II: ADMISSIONS

A. Admissions by County of Residence

In this section, please provide the following information, broken down by **county where the services are provided, regardless of the patient's residential location.**

Number of Admissions: Indicate the total number of admissions to the provider in a particular county during the reporting period.

Number of Deaths: Indicate the total number of deaths of patients cared for by the provider in a particular county during the reporting period.

Number of Non-Death Discharges: Indicate the total number of discharges from the provider for any reason other than death in a particular county during the reporting period.

Number of Patients Served: Indicate the total number of patients served by the provider in a particular county during the reporting period. **Note: This total will include any patients carried over from the previous year.**

Number of Routine Home Care Days: Indicate the total number of routine home care days in a particular county during the reporting period.

Number of Continuous Care Days: Indicate the total number of continuous care **days** in a particular county during the reporting period.

Number of Inpatient Care Days: Indicate the total number of inpatient care days in a particular county during the reporting period.

Number of Respite Care Days: Indicate the total number of respite care days in a particular county during the reporting period.

Number of Total Care Days: Indicate the total number of total care days in a particular county during the reporting period. **Note: this will be the sum of the routine home care, continuous care, inpatient care, and respite care days.**

Note: At the bottom of each column, please total all numbers. The total number of admissions should match the total number of admissions listed on Page 4, Section II-C, and on Page 5, Section II-D.

Page 4

B. Patient Days by Payment Source

In this section, please provide the number of patient days for all patients, regardless of either location or type of service, for the entire reporting period, broken down by payer source.

Number of Patients Served: Provide the total number of patients served whose care was paid primarily by each of the listed payer sources.

Days of Routine Home Care: List the total number of days of routine home care provided, which was paid for primarily by each of the listed payer sources.

Days of Inpatient Care: List the total number of days of inpatient care provided, which was paid for primarily by each of the listed payer sources.

Days of Respite Care: List the total number of days of respite care provided, which was paid for primarily by each of the listed payer sources.

Days of Continuous Care: List the total number of days of continuous care provided, which was paid for primarily by each of the listed payer sources.

Total Patient Care Days: List the total number of days of care provided, which was paid for primarily by each of the listed payer sources. **Note: this total will be the sum of routine home care, inpatient care, respite care, and continuous care days.**

C. Admissions by Demographics

In this section, please provide the total number of admissions as broken down by both age and gender of the patient at the time of their admission.

Note: The total number of admissions listed in this section should match the number listed on Page 3, Section II-B, and Page 5, Section II-D.

Page 5

D. Total Admissions by Race

In this section, please provide the total number of admissions as broken down by race of the patient during the reporting period.

Note: The total number of admissions listed in this section should match the number listed on Page 3, Section II-B, and on Page 4, Section II-C.

SECTION III: REVENUES AND EXPENSES

(Amounts do not have to be audited)

DEFINITIONS:

Payroll: Total expenses for the reporting period spent on payroll for employees of the provider.

Non-payroll: Total expenses for the reporting period spent on matters other than payroll for the provider.

Transportation: Total expenses for transportation for the hospice. This includes mileage, vehicle purchase and maintenance costs, etc.

Bad Debt: Bad debt is defined by the *Alabama State Health Plan,* Section 410-2-2-.06 as "the unpaid charges/rates for services rendered from a patient and/or third party payer, for which the provider reasonably expected payment."

Charity: Charity is defined by the *Alabama State Health Plan*, Section 410-2-2-.06 as "health services for which a provider's policies determine that a patient is unable to pay. Charity Care could result from a provider's policies to provide health care services free of charge to individuals who meet certain pre-established criteria. Charity care is measured as revenue forgone, at full-established rates or charges. Charity care would not include contractual write-offs, but could include partial write-offs for persons unable to pay the full amount of a particular patient's bill."

Medicare: Any payments received from Medicare.

Medicaid: Any payments received from Medicaid.

Commercial Insurance: Any payments received from Commercial Insurance companies.

Private Pay: Any payments received directly from a patient or patient's primary caregiver.

Other: Any/all other revenues gathered by the provider.

REMINDER

The annual report MUST be signed by both the preparer and an administrative official.