FORM HPCE4
HOSPICES
11/2010

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2011

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2010 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: _____ **E-Mail Address:** _____

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

This reporting period is for January 1, 2010, through December 31, 2010*; 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 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:	

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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

Has this provider, at any time during this reporting period, had a waiting list for home care services? _____ **YES** _____ **NO**

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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 at the time of the initial admission.

	In-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) from current reporting year (Initial admission of patient was counted in B1b)			
e. Total Carryovers (Patients were in hospice care on both 12/31 and 1/1)			
f. Total Deaths			
g. Total Live Discharges (including discharges, revocations, and transfers)			

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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: 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	*	*

***ADMISSIONS SHOULD EQUAL THE TOTAL OF ADMISSIONS REPORTED IN SECTIONS B1b + B1c + B1d; DEATHS SHOULD EQUAL DEATHS REPORTED IN SECTION B1f.**

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B4: LENGTH OF SERVICE

LENGTH OF SERVICE	In-Home Hospice Care	Inpatient Facility*	Agency Totals
Average Length of Service (ALOS)			
Median Length of Service (MLOS)			
Average Daily Census for FY2010			

B5: LIVE DISCHARGES

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

*** EITHER LEASED BEDS OR HOSPICE INPATIENT FACILITY**
**** Totals should match B1g**

B6: LENGTH OF SERVICE BY CATEGORY

LOS Category	In-Home Hospice Care Deaths/Live Discharges	Inpatient Hospice Facility Deaths/Live Discharges	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 DIAGNOSIS AND REIMBURSEMENT

C1: ADMISSIONS BY REIMBURSEMENT SOURCE

The number of admissions reported in this section includes all admissions.

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

***ADMISSIONS SHOULD EQUAL THE TOTAL OF ADMISSIONS REPORTED IN SECTIONS B1b + B1c + B1d**

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.

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

PATIENTS SERVED SHOULD EQUAL THE TOTAL OF ADMISSIONS REPORTED IN SECTIONS B1b + B1c + B1e.
PATIENTS IN B1d ARE NOT INCLUDED AS THEY ARE ALREADY COUNTED IN B1b

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C3: DIAGNOSIS

Diagnosis	Location of Service	Number of New (Unduplicated) Admissions (B1b + B1c)	Number of Deaths (B1f)	Number of Live Discharges (B1g)	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		*	*	*	

***THE TOTAL ADMISSIONS SHOULD EQUAL THE TOTAL OF ADMISSIONS IN SECTIONS B1b + B1c; DEATHS SHOULD EQUAL TOTAL DEATHS REPORTED IN SECTION B1f; TOTAL LIVE DISCHARGES SHOULD EQUAL THE TOTAL LIVE DISCHARGES REPORTED IN SECTION B1g.**

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SECTION D: ADMISSIONS BY COUNTY AND DEMOGRAPHICS

D1: ADMISSIONS BY COUNTY OF RESIDENCE

Make copies of this page before completing if necessary. Report only those admissions occurring in Alabama. Out of state admissions should not be reported.

County	Location of Care	Number of Admissions (B1b + B1c + B1d)	Number of Deaths (B1f)	Number of Live Discharges (B1g)	Number of Patients Served (Include Carryover)
	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 SHOULD EQUAL THE TOTAL OF ADMISSIONS REPORTED IN SECTIONS B1b+B1c+B1d; TOTAL DEATHS SHOULD EQUAL THE TOTAL DEATHS REPORTED IN SECTION B1f; TOTAL LIVE DISCHARGES SHOULD EQUAL THE TOTAL LIVE DISCHARGES IN SECTION B1g. TOTAL PATIENTS SERVED SHOULD EQUAL THE TOTAL ADMISSIONS AND CARRYOVERS REPORTED IN SECTIONS B1b + B1c + B1d + B1e.**

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D2: 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+B1c+B1d, D1, & D3.**

D3: 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+B1c+B1d, D1, & D2.**

SECTION E: 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

Average annual percentage of direct patient care hours that were provided by volunteers instead of paid staff (listed per office, not per corporate entity).

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1. Please list below all licensed satellite offices whose data is included in this report.

COUNTY	NAME OF LICENSED HOSPICE AGENCY