INSTRUCTIONS FOR COMPLETION OF THE 2012 ANNUAL REPORT FOR HOSPICE FACILITIES

Form HPCE4

These instructions for the 2012 Annual Report for Hospice Providers are intended to assist in the completion and submission of accurate data. To ensure data integrity, and determine utilization rates of inpatient and outpatient hospice services, 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), Bradford L. Williams, at (334) 242-4109, or e-mail: bradford.williams@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 are not to be completed.

Page 1

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

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

One report must be filed for each provider issued CON Authority. Each satellite office operating under CON Authority granted to a parent (all providers operating under the same Medicare Provider Number) must be listed on Page 12, providing the name of the satellite provider(s) as indicated on the license issued by the Alabama Department of Public Health (ADPH), as well as the county of location.

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 provider.

Physical Address: Provide the complete physical address of the provider issued CON Authority as indicated on the ADPH license.

County of Location: Provide the county of physical location of the provider issued CON Authority.

Web Address: Provide the web address of the parent provider if applicable, or corporate web address if websites are not provided for individual providers.

Facility Telephone: Provide the general telephone number of the provider issued CON Authority, including the area code.

Facility Fax: Provide the general fax telephone number of the provider issued CON Authority, 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 explanation or additional/ corrected information.

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SECTION A: PROGRAM

A1: Program Type

A. Agency Type: Indicate the structure of the hospice provider issued CON Authority.

B. Ownership: Provide the organizational structure of the provider as filed with the Secretary of State's Office, or as reported to the IRS in abstention of Secretary of State filing.

C. Waiting List: Indicate whether patients were placed on a waiting list for admission due to a temporary inability to provide needed services as a result of utilization of current available resources. Patients not placed on a waiting list but referred to another provider are not to be included.

A2: Licensed Inpatient Facilities

NOTE: *As of December 17, 2012, only three (3) providers had CON Authorization to provide inpatient-level services.* For providers with CON Authorization to provide inpatient services, indicate the total number of Inpatient CON Authorized beds reporting under the same Medicare Provider Number as all providers included in pages 1 and 12 of the annual report. Also provide breakdowns of CON Authorized inpatient beds according to structure of location of inpatient services.

For providers without separate CON Authorization to provide Inpatient-level care, "N/A" should be indicated in this section.

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A3: Contractual Inpatient Services

Providers not holding separate CON Authorization to provide Inpatient-level services, indicate all locations where required Inpatient-level care has been provided through contractual services for the reporting period. Enter the total number of contracts held with each type of provider throughout the entire reporting period, regardless of the number of actual contracts held on the last day of the reporting period. Enter "N/A" for Inpatient-level care not provided through contractual services via facility types not applicable.

A4: Volunteer Services

Enter the total annual percentage of volunteer care hours provided to patients for the reporting period as reported to CMS for all providers under common CON Authorization as indicated on pages 1 and 12 of the report.

SECTION B: PATIENT VOLUME

Page 4

B1: Patients Served

a. Total Patient Days: Report all Patient Days of care provided during the reporting period, broken down according to level of care as defined in Section B of the reporting form. The total number of Patient Days reported in this section **MUST** equal the number of Patient Days reported in all sections of the reporting form (Sections B3, C3, C4, and D1).

b. Total New (Unduplicated) Admissions: Report the total number of patients admitted, broken down according to level of care as defined in Section B of the reporting form, for patients not previously served by this provider.

c. Re-Admissions from Prior Years: Report the total number of patients re-admitted, broken down according to level of care as defined in Section B of the reporting form, for patients previously served by this provider but who were discharged/ revoked/transferred in a prior year.

d. Total (Unduplicated) Admissions During this Reporting Period: Sum each category of B1b. and B1c. to determine the total number of Unduplicated Admissions for the reporting period.

e. Re-Admissions (Duplicated Admissions) from Current Reporting Year: Report the total number of patients previously served by this provider in the current reporting year, discharged/revoked/ transferred during the reporting year, and re-admitted during the same reporting year (initial admission has also been counted in B1b.).

f. Total Admissions for Reporting Period: Sum each category of B1d. and B1e. to determine the total number of Admissions for the Reporting Period. The total number of Admissions for the Reporting Period reported in this section **MUST** equal the number of Total Admissions for the Reporting Period reported in all sections of the reporting form (Section B2, C1, C4, D1, D2, and D3).

g. Total Carryovers: Report the total number of patients under continuous admission status on both December 31, 2011, and January 1, 2012.

h. Total Unduplicated Patients Served During Reporting Period: Sum each category of B1d. and B1g. to determine the total number of Unduplicated Patients served during the reporting period. The total number of Unduplicated Patients served reported in this section **MUST** equal the number of Unduplicated Patients served during the reporting period reported in all sections of the reporting form (Sections C2, C4, and D1).

i. Total Deaths: Report the total number of patient Deaths, broken down according to level of care as defined in Section B of the reporting form at the time of death, for all patients who died during the reporting period regardless of the year of admission or number of admissions. The total number of Deaths reported in this section **MUST** equal the number of Deaths reported in all sections of the reporting form (Sections B2, C4, and D1).

j. Total Live Discharges/Revocations/ Transfers: Report the total number of patient Discharges/Revocations/Transfers, broken down according to level of care as defined in Section B of the reporting form at the time of live discharge/revocation/transfer, regardless of the year of admission or number of admissions. The total number of Live Discharges/Revocations/Transfers reported in this section **MUST** equal the number of Live Discharges/ Revocations/Transfers reported in all sections of the reporting form (Sections B5, B6, C4, and D1).

B2: Admissions and Deaths by Location

Number of Admissions: Report the total number of admissions during the reporting period, including duplicated admissions, broken down by physical location at time of each admission. The total number of Admissions reported in this section **MUST** equal the number of Agency Total Admissions reported in Section B1f.

Number of Deaths: Report the total number of deaths during the reporting period, regardless of year of admissions or number of admissions, broken down by physical location at time of death. The total number of Deaths reported in this section **MUST** equal the number of Agency Total Deaths reported in Section B1i.

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B3: Level of Care

Routine Home Care Days: Provide the total number of Routine In-Home level care patient days provided during the reporting period, broken down by physical location of care, regardless of reimbursement source.

Continuous Care Days Billed: Provide the total number of Continuous Care level care patient days billed during the reporting period, broken down by physical location of continuous care, regardless of reimbursement source. Continuous Care Days **NOT** billed should be reported as In-Home level of care, and will be reported elsewhere in this report.

B3e. TOTALS: The sum of Routine Home Care Days and Continuous Care Days Billed reported **MUST** equal the number of In-Home Hospice Care Patient Days reported on Page 4, Section B1a.

Contractual Inpatient Care:

f. and g.: Report the number of General Inpatient and Inpatient Respite levels of care patient days provided during the reporting period, broken down by location of care, provided through contracts. The sum of Contractual Inpatient Days reported **MUST** equal the number of Contractual Care Patient Days reported on Page 4, Section B1a.

Inpatient Hospice Care:

h. and i.: Report the number of General Inpatient and Inpatient Respite patient care days levels of care provided during the reporting period in a CON Authorized Inpatient Facility. The sum of Inpatient Hospice Care days reported **MUST** equal the number of Inpatient Hospice Care Patient Days reported on Page 4, Section B1a.

A*s of December 31, 2012, only three (3) providers had CON Authorization to provide inpatient-level services. List the names of all CON Authorized Inpatient authorized facilities for which days reported for these sections was provided.*

Total Patient Care Days: Provide the sum of all Patient Care Days reported in items e. through i. of this section. The number of total Patient Care Days reported MUST equal the number of total Patient Care Days reported on Page 4, Section B1a.

Total Continuous Care Hours: Provide the total number of Continuous Care Hours level of care provided during the reporting period regardless of whether the care met requirements for CMS or private insurance billing. This total should be reported in hours only.

B4: Length of Service

Average Length of Service (ALOS): Divide the number of patient care days (B1a.) by the correlating number of Unduplicated Patients Served (B1h.) for each level of care provided during the reporting period.

Median Length of Service (MLOS): Arrange the LOS numbers for all Unduplicated Patients Served (B1h.) for the reporting period from lowest to highest (1, 2, 3…), for each level of patient care provided. The number that falls in the exact middle of each list is the median LOS for the specified level of care.

***Example 1* - Odd number of patients:** Seven patients with the following LOS: 25, 34, 2, 17, 33, 60, 22. Arrange numbers in sequence from lowest to highest: 2, 17, 22, **25**, 33, 34, 60. The number 25 is the exact middle number in the list. Therefore, the median LOS is 25.

***Example 2* - Even number of patients:** Eight patients with the following LOS: 25, 34, 2, 17, 33, 60, 22, 35. Arrange numbers in sequence from lowest to highest: 2, 17, 22, 25, 33, 34, 35, 60. There is no number in the exact middle. The numbers 25 and 33 share the middle position so the median falls between those two numbers. To determine the median LOS, add the two numbers and divide by 2 (25 + 33 = 58 / 2 = 29 [Median LOS])

Average Daily Census (ADC): Divide the number of Patient Care Days (B1a.) by the number of days in the reporting period (365 or 366 for a leap year), for each level of patient care provided.

Example: 28,756 patient days divided by 365 service days = ADC of 78.78.

Page 6

B5: Live Discharges

a. Discharges: Enter the number of patients discharged from hospice services for any reason other than death, broken down by level of care location at time of discharge.

b. Revocations: Enter the number of patients whose certifications for hospice care were revoked for any reason other than death, broken down by level of care location at time of revocation.

c, Transfers: Enter the number of patients who transferred from the services of this provider to that of another hospice provider, for whatever reason, broken down by level of care location at the time of transfer. NOTE: Transfer to another provider does not refer to physical transfer.

Totals: The number of Live Discharges reported by level of care provided must correlate with the number of Live Discharges reported for each level of care in Section B1j.

B6: Length of Service by Deaths/Live Discharges

List the number of Patients Served according to total length of service provided from admission to death/discharge, broken down into the appropriate ranges of lengths of service. **Note: Stays in a CON-Authorized Inpatient Facility greater than 29 days should have an explanation listed in the space provided at the bottom of page 6. If needed, additional sheets can be used. The additional sheets should be attached to the back of the report and titled "Annual Report of Hospice Providers – Section B6 Continued".**

Page 7

SECTION C: PATIENT DIAGNOSIS AND REIMBURSEMENT

C1: Admissions by Reimbursement Source: Enter the number of Duplicated Admissions, broken down by initial level of care location provided, further broken down by primary source of reimbursement. The Totals reported must correlate to the Totals reported in Section B1f.

C2: Patients Served by Reimbursement Source: Enter the number of Patients Served broken down by initial level of care location provided, further broken down by primary source of reimbursement. The Totals reported in this section **MUST** correlate to the Totals reported in Section B1h.

C3: Patient Days by Reimbursement Source: Enter the number of Patient Care Days provided during the reporting period for each level of care location provided according to the primary reimbursement source. The Totals reported in this section **MUST** correlate to the Totals reported in Section B1a.

Example: A patient whose primary source of reimbursement is Medicare, was provided 35 days of In-Home hospice care, 2 days of Respite care through contractual services, and was admitted to a CON-Authorized Inpatient facility for 2 days prior to death. All care days are reported as Medicare reimbursed days, further reported as 35 In-Home Hospice Care patient care days, 2 Contractual patient care days, 2 Inpatient patient care days, for an Agency Total of 39 patient care days for that patient.

Indicate as yes or no if this provider includes care provided where there is no primary source of reimbursement (charity care), and the primary source of reimbursement is self-pay (private pay) together as one source throughout this report.

Pages 8 & 9

C4: Diagnosis

Number of Admissions: Enter the number of Duplicated Admissions for each listed diagnosis, broken down the by physical level of care provided at the time of admission, regardless of year of admission or number of admissions, during the reporting period. The Total Number of Admissions entered on Page 9 **MUST** correlate with the number of admissions reported in Section B1f.

Number of Deaths: Enter the number of deaths occurring during the reporting period for the primary cause of death, broken down by the physical level of care being provided at the time of death. The Total Number of Deaths entered on Page 9 **MUST** correlate with the number of deaths reported in Section B1i.

Number of Live Discharges: Enter the number of Live Discharges/Revocations/Transfers of all patients for any reason other than death, occurring during the reporting period for the primary diagnosis at the time of admission, broken down by the physical level of care being provided at the time of discharge/ revocation/transfer. The Total Number of Live Discharges entered on Page 9 **MUST** correlate with the number of live discharges/revocations/transfers reported in Section B1j.

Patient Days: Enter the number of Patient Days provided for each level of care of all patients served during the reporting period, broken down by primary diagnosis. The Total Number of Patient Days entered on Page 9 **MUST** correlate with the number of patient days reported in Section B1a.

Number of Patients Served: Enter the number of Unduplicated Patients Served during the reporting period, by primary diagnosis, counting each patient only once. The Total Number of Patients Served entered on Page 9 **MUST** equal the total number of patients served reported in Section B1h.

Diagnosis Definitions: All data reported by diagnosis should be made based on the primary diagnosis for which hospice services have been prescribed.

Cancer: All cancers, including lung, kidney, and liver

Heart: All heart disease including CHF and primary sclerotic heart disease

Alzheimer's Disease/Dementia: Include dementia, vascular dementia, etc.

Lung: COPD and other non-cancerous lung diseases

Kidney: End Stage and non-cancer renal disease

Liver: Cirrhosis, advanced hepatitis, and other non-cancer liver disease

HIV: All AIDS and HIV related conditions

Debility Unspecified: Include any terminal debility, failure to thrive

Other Motor Neuron Disease: Including Parkinson's, Huntington's, MS

Stroke/Coma

ALS

All Others: Any primary diagnosis not otherwise listed above

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SECTION D: PATIENT DEMOGRAPHICS

D1: County of Residence

Number of Admissions: Enter the number of Duplicated Admissions, broken down CON-Authorized county of residence (Alabama only) according to physical level of care provided at the time of admission, regardless of year of admission or number of admissions, during the reporting period. The Total Number of Admissions entered **MUST** correlate with the number of admissions reported in Section B1f.

Number of Deaths: Enter the number of deaths occurring during the reporting period, broken down by CON-Authorized county of residence (Alabama only) according to physical level of care being provided at the time of death. The Total Number of Deaths entered **MUST** correlate with the number of deaths reported in Section B1i.

Number of Live Discharges: Enter the number of Live Discharges/Revocations/Transfers of all patients for any reason other than death, broken down by CON-Authorized county of residence (Alabama only) according to physical level of care being provided at the time of discharge/revocation/transfer. The Total Number of Live Discharges entered **MUST** correlate with the number of live discharges/revocations/ transfers reported in Section B1j.

Patient Days: Enter the number of Patient Days provided for each level of care of all patients served during the reporting period, broken down by CON-Authorized county of residence (Alabama only). The Total Number of Patient Days entered **MUST** correlate with the number of patient days reported in Section B1a.

Number of Patients Served: Enter the number of Unduplicated Patients Served during the reporting period, broken down by CON-Authorized county of residence (Alabama only), counting each patient only once. The Total Number of Patients Served **MUST** correlate with the number of patients served reported in Section B1h.

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D2: Total Admissions by Race

Provide the total number of Duplicated Admissions, regardless of the year of admission or number of admissions, for the reporting period broken down by race. The Total Admissions **MUST** equal the total number of admissions reported in Section B1f.

D3: Total Admissions by Age and Gender

Provide the total number of Duplicated Admissions, regardless of the year of admission or number of admissions, for the reporting period broken down by age groups and gender. The Total Admissions **MUST** equal the total number of admissions reported in Section B1f.

SECTION E: 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, including benefits.

Non-payroll: Total remaining expenses for the reporting period of the provider for all items except payroll, employee benefits, and transportation expenses.

Transportation: Total for transportation related expenses, including reimbursement mileage, vehicle insurance coverage, vehicle purchases, 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."

All expenses reported should be rounded to whole numbers. Although considered acceptable accounting procedures, for the purposes of this report all expenses should be reported as positive numbers; negative numbers should not be reported, but instead should be reported as revenue. Enter "N/A" for any breakdowns requested which are not applicable to this provider.

Medicare: Total reimbursements received during the reporting period from Medicare for services provided.

Medicaid: Total reimbursements received during the reporting period from Medicaid for services provided.

Commercial Insurance: Total reimbursements received during the reporting period from insurance coverage not classified as Medicare or Medicaid for services provided.

Private Pay: Total reimbursements received during the reporting period directly from the patient or patient's caregiver(s) for services provided.

Other: Any other revenues received during the reporting period not classified otherwise above, including donations and grants.

All revenues reported should be rounded to whole numbers. Although considered acceptable accounting procedures, for the purposes of this report, all revenues should be reported as positive numbers; negative numbers should not be reported, but should be reported as expenses. Enter "N/A" for any breakdowns requested which are not applicable to this provider.

Page 12

Page 12 should be completed for all licensed providers for which singular CON-Authorization was granted (all providers reporting under the same Medicare Provider Number). Each licensed hospice provider reporting under the primary provider indicated on Page 1 **MUST** be listed on this page, indicating the county of administrative location for each additional provider listed.

REMINDERS

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

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