

**STATE HEALTH PLANNING AND DEVELOPMENT AGENCY**

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**ANNUAL REPORT FOR HOSPICE PROVIDERS**

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**\*\*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, 2016, through December 31, 2016; or for partial year of operation beginning \_\_\_\_\_ and ending \_\_\_\_\_ a period of \_\_\_\_\_ days.

MONTH DAY

MONTH DAY

*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: \_\_\_\_\_

**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

## 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

- Brand new patients, admitted for 1<sup>st</sup> time to agency during reporting year.
- Patients readmitted during reporting year, but initial admission was NOT in reporting year.
- Total number of patients admitted during reporting period.
- Patients readmitted during reporting year and initial admission was during reporting year.

**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	
<b>TOTAL ADMISSIONS</b>	

**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			
<b>TOTAL ADMISSIONS</b>			

**B4: DEATHS/DISCHARGES**

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

## **SECTION C: PATIENT DAYS**

### **C1: PATIENT DAYS BY LEVEL OF CARE**

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

#### **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.

**C2: PATIENT DAYS BY REIMBURSEMENT SOURCE**

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

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	
<b>TOTALS (Must equal C1j. Total)</b>	



[illegible]



COUNTY	NUMBER OF DEATHS	NUMBER OF LIVE DISCHARGES	PATIENT DAYS	NUMBER OF PATIENTS SERVED
TOTALS FROM PREVIOUS PAGE				
TOTALS				

**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](mailto: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.**

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		NUMBER OF DAYS OPERATIONAL IF INITIALLY LICENSED/CLOSED DURING REPORTING PERIOD
		YES	NO	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
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		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	

## Hospice Annual Report Checklist

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