FORM HPCE-3
2007 Annual Report
8/2008

THIS REPORT IS DUE ON OR BEFORE NOVEMBER 30, 2008
2007 REPORT

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4109
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100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104
FAX: (334) 242-4113
paul.may@shpda.alabama.gov

2007 ANNUAL REPORT FOR INPATIENT HOSPICES

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 October 1, 2006, through September 30, 2007*; or for partial year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

*Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. ***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 facility.

PRINTED NAME OF PREPARER	SIGNATURE OF PREPARER	DATE
DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS

A member of administration <u>MUST</u> 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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I. FACILITIES

A. Total beds **licensed** by the Alabama Department of Public Health _____

B. Number of **staffed and operational beds** on last day of reporting period _____

II. ADMISSIONS BY DEMOGRAPHICS

A. ADMISSIONS BY RACE

1. White/Caucasian	
2. Black/African American/Negro	
3. Hispanic/Spanish/Latino	
4. Asian	
5. American Indian/Alaskan Native	
6. Pacific Islander	
7. India	
8. Middle Eastern	
9. Other	
Total Admissions for the Reporting Period by Race	**

B. ADMISSIONS BY AGE AND GENDER (Use the age of the patient at the time of admission)

AGE GROUPS	MALE	FEMALE	TOTALS
18 & under			
19 – 34 Years			
35 – 54 Years			
55 – 64 Years			
65 – 74 Years			
75 – 84 Years			
85 Years and Older			
Total Admissions			**

****Total Admissions in sections A and B must equal.**

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III. DISCHARGES

Total Discharges (including deaths) _____

Discharges due to death _____

IV PATIENT DAYS

(The total days of care provided to all patients during the reporting period)

Total Patient Days _____

V. EXPENSES AND REVENUES

Only those costs related to hospice should be reported. These amounts **DO NOT** have to be **AUDITED** prior to reporting.

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