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 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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# 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 |