

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

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2008 ANNUAL REPORT FOR INPATIENT HOSPICES

Mailing Address:

STREET ADDRESS	CITY	STATE	ZIP
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Physical Address:

STREET ADDRESS	CITY	AL	ZIP
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County of Location:

Facility Telephone:

(AREA CODE) & TELEPHONE NUMBER

Facility Fax:

(AREA CODE) & TELEPHONE NUMBER

This reporting period is for October 1, 2007, through September 30, 2008*; or for partial year of operation beginning _____ and ending _____ a period of _____ days.
MONTH DAY MONTH DAY

*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
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DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS
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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
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DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS
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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