

Section 2

OSHPD Facility ID No. _____

LICENSEE TYPE OF CONTROL

| | | |
|----------|---|-----|
| Line No. | | (1) |
| 1 | From the list below, select the ONE category that best describes the licensee type of control of your home health agency, i.e. the type of organization that owns the license. (There will be a drop down box in ALIRTS -see list of choices below.) | |

LICENSEE TYPE OF CONTROL CHOICES

| | | | |
|---|---|---|--------------------------------------|
| 1 | City and/or County | 6 | Investor - Individual |
| 2 | District | 7 | Investor - Partnership |
| 3 | Non-profit Corporation (incl. Church-related) | 8 | Investor - Limited Liability Company |
| 4 | University of California | 9 | Investor - Corporation |
| 5 | State | | |

MEDICARE/MEDI-CAL CERTIFICATION

| | |
|----------|---|
| Line No. | |
| 5 | Select: Medicare only <input type="checkbox"/> Medicare & Medi-Cal <input type="checkbox"/> Medi-Cal only <input type="checkbox"/> Neither <input type="checkbox"/> |

AGENCY ACCREDITATION STATUS (Check all applicable ones.)

| | |
|----------|--|
| Line No. | |
| 10 | Accredited by ACHC (1) Accredited <input type="checkbox"/> (2) Deemed <input type="checkbox"/> (3) None <input type="checkbox"/> |
| 11 | Accredited by CHAP (1) Accredited <input type="checkbox"/> (2) Deemed <input type="checkbox"/> (3) None <input type="checkbox"/> |
| 12 | Accredited by JCAHO (1) Accredited <input type="checkbox"/> (2) Deemed <input type="checkbox"/> (3) None <input type="checkbox"/> |
| 13 | Accredited by other: (1) Accredited <input type="checkbox"/> (2) Deemed <input type="checkbox"/> (3) None <input type="checkbox"/> |

HOME INFUSION THERAPY/PHARMACY ONLY

| | | |
|----------|--|--|
| Line No. | | (1) |
| 15 | Is your agency a licensed Pharmacy? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 16 | Do you have a Registered Nurse on staff who makes home visits? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Note: If the agency is a licensed pharmacy that provides **only** home infusion therapy equipment then there is no need to complete the remainder of the report.

SPECIAL SERVICES (Check all applicable ones.)

| | | | | | |
|----------|-----------------------------------|--------------------------|----------|-------------------------------|--------------------------|
| Line No. | | (1) | Line No. | | (1) |
| 20 | AIDS Services | <input type="checkbox"/> | 25 | Pediatric | <input type="checkbox"/> |
| 21 | Blood Transfusions | <input type="checkbox"/> | 26 | Psychiatric Nursing | <input type="checkbox"/> |
| 22 | Enterostomal Therapy | <input type="checkbox"/> | 27 | Respiratory/Pulmonary Therapy | <input type="checkbox"/> |
| 23 | IV Therapy (Includes Chemo & TPN) | <input type="checkbox"/> | 28 | Other | <input type="checkbox"/> |
| 24 | Mental Health Counseling | <input type="checkbox"/> | | | |

PERSONS RECEIVING SERVICES

| | | |
|----------|---|-----|
| Line No. | | (1) |
| 30 | Number of unduplicated persons seen by your agency during the reporting year. | |

Section 2 (Cont'd)

OSHPD Facility ID No. _____

HOME HEALTH CARE

| Line No. | Other Home Health Visits | No. of Visits (1) |
|----------|---------------------------------------|----------------------|
| 31 | Pre-Admission Screening / Evaluations | |
| 32 | Outpatient Visits | |
| 33 | Other | |
| 34 | TOTAL | |

OTHER HOME HEALTH SERVICES (Home Care Service, e.g. Continuous Care)

NOTE: Do not complete Lines 50-54 if these services were provided by an organization other than your licensed agency.

| Line No. | | (1) |
|----------|--|--|
| 40 | Did your agency perform other Home Care Services? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 41 | How many total hours of other Home Care did your agency provide? | |

Other Home Care Services, Staff, and Functions (Check all applicable ones.)

| Line No. | | (1) |
|----------|-------------------------------------|-----|
| 50 | Certified Nurse Assistant (CNA) | |
| 51 | Home Health Aide | |
| 52 | Homemaker Services | |
| 53 | Non-intermittent Nursing (RN / LVN) | |
| 54 | Other | |

**HOME HEALTH AGENCY PATIENTS
AND VISITS**

ANNUAL UTILIZATION REPORT OF HOME HEALTH AGENCIES - 2011

OSHPD Facility ID No. _____

Section 3

PATIENTS AND VISITS BY AGE

| Line No. | Age | Patients (1) | Visits (2) |
|----------|--------------------|-----------------|---------------|
| 1 | 0-10 Years | | |
| 2 | 11-20 Years | | |
| 3 | 21-30 Years | | |
| 4 | 31-40 Years | | |
| 5 | 41-50 Years | | |
| 6 | 51-60 Years | | |
| 7 | 61-70 Years | | |
| 8 | 71-80 Years | | |
| 9 | 81-90 Years | | |
| 10 | 91 Years and Older | | |
| 15 | TOTAL | | |

ADMISSIONS BY SOURCE OF REFERRAL

| Line No. | Source of Referral | Admissions (1) |
|----------|------------------------------------|-------------------|
| 21 | Another Home Health Agency | |
| 22 | Clinic | |
| 23 | Family / Friend | |
| 24 | Hospice | |
| 25 | Hospital (Discharge Planner, etc.) | |
| 26 | Local Health Department | |
| 27 | Long Term Care Facility (SN / IC) | |
| 28 | MSSP | |
| 29 | Payer (Insurance, HMO, etc.) | |
| 30 | Physician | |
| 30 | Self | |
| 32 | Social Service Agency | |
| 34 | Other | |
| 35 | TOTAL | |

**HOME HEALTH AGENCY PATIENTS
AND VISITS**

OSHPD Facility ID No. _____

Section 3 (Cont'd)

DISCHARGES BY REASONS

| Line No. | Reason for Discharge | Discharges (1) |
|----------|--|-------------------|
| 41 | Admitted to Hospital | |
| 42 | Admitted to SN / IC Facility | |
| 43 | Death | |
| 44 | Family / Friends Assumed Responsibility | |
| 45 | Lack of Funds | |
| 46 | Lack of Progress | |
| 47 | No Further Home Health Care Needed | |
| 48 | Patient Moved out of Area | |
| 49 | Patient Refused Service | |
| 50 | Physician Request | |
| 51 | Transferred to Another HHA | |
| 52 | Transferred to Home Care (Personal Care) | |
| 53 | Transferred to Hospice | |
| 54 | Transferred to Outpatient Rehabilitation | |
| 59 | Other | |
| 60 | TOTAL | |

VISITS BY TYPE OF STAFF

| Line No. | Type of Staff | Visits (1) |
|----------|----------------------------------|---------------|
| 71 | Home Health Aide | |
| 72 | Nutritionist (Diet Counseling) | |
| 73 | Occupational Therapist | |
| 74 | Physical Therapist | |
| 75 | Physician | |
| 76 | Skilled Nursing | |
| 77 | Social Worker | |
| 78 | Speech Pathologist / Audiologist | |
| 79 | Spiritual and Pastoral Care | |
| 84 | Other | |
| 85 | TOTAL | |

**HOME HEALTH AGENCY PATIENTS
AND VISITS**

OSHPD Facility ID No. _____

Section 3 (Cont'd)

VISITS BY PRIMARY SOURCE OF PAYMENT

| Line No. | Source of Payment | Visits (1) |
|----------|---|---------------|
| 91 | Medicare | |
| 92 | Medi-Cal | |
| 93 | TRICARE (CHAMPUS) | |
| 94 | Other Third Party (Insurance, etc.) | |
| 95 | Private (Self Pay) | |
| 96 | HMO / PPO (Includes Medicare and Medi-Cal HMOs) | |
| 97 | No Reimbursement | |
| 99 | Other (Includes MSSP) | |
| 100 | TOTAL | |

Section 4

OSHPD Facility ID No. _____

PATIENTS AND VISITS BY PRINCIPAL DIAGNOSIS FOR WHICH CARE WAS GIVEN*

| Line No. | Principal Diagnosis | ICD-9-CM Code | Patients (1) | Visits (2) |
|----------|--|--|--------------|------------|
| 1 | Infectious and parasitic diseases (exclude HIV) | 001.0-041.9, 045.00-139.8 | | |
| 2 | HIV infections | 042 | | |
| 3 | Malignant neoplasms: Lung | 162.2-162.9, 197.0, 209.21, 231.2 | | |
| 4 | Malignant neoplasms: Breast | 174.0-174.9, 175.0-175.9, 198.2, 198.81, 233.0 | | |
| 5 | Malignant neoplasms: Intestines | 152.0-154.0, 159.0, 197.4, 197.5, 197.8, 209.00-209.17, 230.3, 230.4, 230.7 | | |
| 6 | Malignant neoplasms: All other sites, excluding those in lung, breast and intestines | 140.0-209.36, 230.0-234.9 | | |
| 7 | Non-malignant neoplasms: All sites | 209.40-209.79, 210.0-229.9, 235.0-238.9, 239.0-239.9 | | |
| 8 | Diabetes mellitus | 249.00-250.93 | | |
| 9 | Endocrine, metabolic, and nutritional diseases; Immunity disorders | 240.0-246.9, 251.0-279.9 | | |
| 10 | Diseases of blood and blood forming organs | 280.0-289.9 | | |
| 11 | Mental disorder | 290.0-319 | | |
| 12 | Alzheimer's disease | 331.0 | | |
| 13 | Diseases of nervous system and sense organs | 320.0-330.9, 331.11-389.9 | | |
| 14 | Diseases of cardiovascular system | 391.0-392.0, 393-402.91, 404.00-429.9 | | |
| 15 | Diseases of cerebrovascular system | 430-438.9 | | |
| 16 | Diseases of all other circulatory system | 390, 392.9, 403.00-403.91, 440.0-459.9 | | |
| 17 | Diseases of respiratory system | 460-519.9 | | |
| 18 | Diseases of digestive system | 520.0-579.9 | | |
| 19 | Diseases of genitourinary system | 580.0-608.9, 614.0-629.9 | | |
| 20 | Diseases of breast | 610.0-611.9 | | |
| 21 | Complications of pregnancy, childbirth, and the puerperium | 630-679.14 | | |
| 22 | Diseases of skin and subcutaneous tissue | 680.0-709.9 | | |
| 23 | Diseases of musculoskeletal system and connective tissue (include pathological fx, malunion fx, and nonunion fx) | 710.0-739.9 | | |
| 24 | Congenital anomalies and perinatal conditions (include birth fractures) | 740.0-779.9 | | |
| 25 | Symptoms, signs, and ill-defined conditions (exclude HIV positive test) | 780.01-795.6, 795.79, 796.0-799.9 | | |
| 26 | Fractures (exclude birth fx, pathological fx, malunion fx, nonunion fx) | 800.00-829.1 | | |
| 27 | All other injuries | 830.0-959.9 | | |
| 28 | Poisonings and adverse effects of external causes | 960.0-995.94 | | |
| 29 | Complications of surgical and medical care | 996.00-999.9 | | |
| 30 | Health services related to reproduction and development | V20.0-V26.9, V28.0-V29.9 | | |
| 31 | Infants born outside hospital (infant care) | V30.1, V30.2, V31.1, V31.2, V32.1, V32.2, V33.1, V33.2, V34.1, V34.2, V35.1, V35.2, V36.1, V36.2, V37.1, V37.2, V39.1, V39.2 | | |
| 32 | Health hazards related to communicable diseases | V01.0-V07.9, V09.0-V19.8, V40.0-V49.9 | | |
| 33 | Other health services for specific procedures and aftercare | V50.0-V58.9 | | |
| 34 | Visits for Evaluation and Assessment | V60.0-V91.99 | | |
| 45 | TOTAL | | | |

*The list of ICD-9-CM codes excluded: 795.71, V08, V27.0-V27.9, V30-V39 with 5th digits 0 or 1, V59.01-V59.9.

Section 4 (Cont'd)

OSHPD Facility ID No. _____

How many of the patients you reported in Section 3 "Patients and Visits by Age" Table had a **principal** or **secondary** diagnosis of HIV or Alzheimer's Disease and how many health care visits were made to them? The principal diagnosis for which an HIV or Alzheimer's patient was visited may have been a fracture, a skin infection, cancer, or any number of principal diagnoses. What we are asking relates to the number of HIV or Alzheimer's patients among your total patient load, regardless of the nature of the treatment received or the principal diagnosis of the patient.

| Line No. | | ICD-9-CM Code | Patients (1) | Visits (2) |
|----------|---------------------|---------------|-----------------|---------------|
| 51 | HIV | 042 | | |
| 52 | Alzheimer's Disease | 331.0 | | |

HOSPICE DESCRIPTION

Section 5

OSHPD Facility ID No. _____

DO NOT COMPLETE SECTIONS 5 THROUGH 10 UNLESS YOU HAVE A HOSPICE.

LICENSEE TYPE OF CONTROL

| | | |
|----------|---|-----|
| Line No. | | (1) |
| 1 | From the list below, select the ONE category that best describes the licensee type of control of your hospice, i.e. the type of organization that owns the license, (There will be a drop down box in ALIRTS -see list of choices below.) | |

LICENSEE TYPE OF CONTROL CODES

| | | | |
|---|---|---|--------------------------------------|
| 1 | City and/or County | 6 | Investor - Individual |
| 2 | District | 7 | Investor - Partnership |
| 3 | Non-profit Corporation (incl. Church-related) | 8 | Investor - Limited Liability Company |
| 4 | University of California | 9 | Investor - Corporation |
| 5 | State | | |

MEDICARE/MEDI-CAL CERTIFICATION

| | |
|----------|---|
| Line No. | |
| 5 | Select: Medicare only <input type="checkbox"/> Medicare & Medi-Cal <input type="checkbox"/> Medi-Cal only <input type="checkbox"/> Neither <input type="checkbox"/> |

AGENCY ACCREDITATION STATUS (Check all applicable ones.)

| | |
|----------|--|
| Line No. | |
| 10 | Accredited by ACHC (1) Accredited <input type="checkbox"/> (2) Deemed <input type="checkbox"/> (3) None <input type="checkbox"/> |
| 11 | Accredited by CHAP (1) Accredited <input type="checkbox"/> (2) Deemed <input type="checkbox"/> (3) None <input type="checkbox"/> |
| 12 | Accredited by JCAHO (1) Accredited <input type="checkbox"/> (2) Deemed <input type="checkbox"/> (3) None <input type="checkbox"/> |
| 13 | Accredited by other: (1) Accredited <input type="checkbox"/> (2) Deemed <input type="checkbox"/> (3) None <input type="checkbox"/> |

AGENCY TYPE AS REPORTED ON MEDICARE COST REPORT

| | | |
|----------|--|-----|
| Line No. | | (1) |
| 20 | From the list below, select ONE category. (There will be a drop down box in ALIRTS.) | |

AGENCY TYPE CATEGORIES

| | | | |
|----------|-------------------|----------|-------------------------------|
| Line No. | | Line No. | |
| 1 | Free Standing | 4 | Long-Term Care Facility-based |
| 2 | Hospital-based | 5 | Veteran Administration-based |
| 3 | Home Health-based | 6 | Other |

LOCATION OF SERVICE DELIVERY (Check one)

| | |
|----------|--|
| Line No. | |
| 25 | Primarily Urban <input type="checkbox"/> Primarily Rural <input type="checkbox"/> Mixed Urban and Rural <input type="checkbox"/> |

HOSPICE SERVICES

Section 6

OSHPD Facility ID No. _____

BEREAVEMENT SERVICES

| Line No. | Bereavement Services | People Served (1) |
|----------|---|----------------------|
| 1 | Survivors of hospice patients | |
| 2 | Survivors of persons not receiving hospice care | |

VOLUNTEER SERVICES

| Line No. | Volunteer Services | Volunteer Hours (2) |
|----------|---|------------------------|
| 3 | Patient / Family Services | |
| 4 | Bereavement | |
| 5 | Administrative Directly Related to Patient Care | |
| 6 | Medicare Reportable Hours (sum lines 3-5) | |
| 7 | Fundraising | |
| 9 | Other | |
| 10 | TOTAL | |

ADDITIONAL AND SPECIALIZED SERVICES

Check all services directly provided by OR contracted for by the hospice.

| Line No. | Additional and Specialized Hospice Services | Services (1) |
|----------|---|-----------------|
| 11 | Hospice Inpatient Facility / Unit (1) | |
| 12 | Specialized Pediatric Program | |
| 13 | Bereavement services to survivors of persons not receiving hospice care | |
| 14 | Adult Day Care | |
| 15 | Hospice physician consultation visits | |
| 16 | Non-hospice palliative care service provided | |
| 17 | Other | |

(1) If Line 11 is checked then complete Section 11, Lines 1 through 20.

HOSPICE SERVICES

Section 6 (cont'd)

OSHPD Facility ID No. _____

VISITS BY TYPE OF STAFF (Include After-Hours and Bereavement Visits)

| Line No. | Type of Staff | Visits (1) |
|----------|--------------------------------|---------------|
| 21 | Nursing - RN | |
| 22 | Nursing - LVN | |
| 23 | Social Services | |
| 24 | Hospice Physician Services | |
| 25 | Homemaker and Home Health Aide | |
| 26 | Chaplain | |
| 29 | Other Clinical Services | |
| 30 | TOTAL | |

Section 7

OSHPD Facility ID No. _____

UNDUPLICATED HOSPICE PATIENTS BY GENDER AND AGE CATEGORY

| Line No. | Age Category | Male (1) | Female (2) | Other / Unknown (3) | Total (4) |
|----------|--------------|-------------|---------------|---------------------------|--------------|
| 1 | 0-1 Years | | | | |
| 2 | 2-5 Years | | | | |
| 3 | 6-10 Years | | | | |
| 4 | 11-20 Years | | | | |
| 5 | 21-30 Years | | | | |
| 6 | 31-40 Years | | | | |
| 7 | 41-50 Years | | | | |
| 8 | 51-60 Years | | | | |
| 9 | 61-70 Years | | | | |
| 10 | 71-80 Years | | | | |
| 11 | 81-90 Years | | | | |
| 12 | 91 + Years | | | | |
| 15 | TOTAL | | | | |

UNDUPLICATED HOSPICE PATIENTS BY GENDER AND RACE

| Line No. | Race | Male (1) | Female (2) | Other / Unknown (3) | Total (4) |
|----------|------------------------|-------------|---------------|---------------------------|--------------|
| 21 | White | | | | |
| 22 | Black | | | | |
| 23 | Native American | | | | |
| 24 | Asian/Pacific Islander | | | | |
| 25 | Other / Unknown | | | | |
| 26 | More than one race | | | | |
| 30 | TOTAL | | | | |

UNDUPLICATED HOSPICE PATIENTS BY GENDER AND ETHNICITY

| Line No. | Ethnicity | Male (1) | Female (2) | Other / Unknown (3) | Total (4) |
|----------|--------------|-------------|---------------|---------------------------|--------------|
| 31 | Hispanic | | | | |
| 32 | Non-Hispanic | | | | |
| 33 | Unknown | | | | |
| 35 | TOTAL | | | | |

Section 7 (Cont'd)

OSHPD Facility ID No. _____

HOSPICE PATIENT DISCHARGES BY REASON

| Line No. | Reason for Discharge | Patients (1) |
|----------|--------------------------------------|-----------------|
| 61 | Death | |
| 62 | Patient Moved Out of Area | |
| 63 | Patient Refused Service | |
| 64 | Transferred to Another Local Hospice | |
| 65 | Prognosis Extended | |
| 66 | Patient Desired Curative Treatment | |
| 69 | Other | |
| 70 | TOTAL | |

HOSPICE PATIENTS DISCHARGED BY LENGTH OF STAY

| Line No. | Length of Stay (Days) | Patients (1) |
|----------|-----------------------|-----------------|
| 71 | 0 - 7 Days | |
| 72 | 8 - 30 Days | |
| 73 | 31 - 90 Days | |
| 74 | 91 - 179 Days | |
| 75 | 180+ Days | |
| 85 | TOTAL | |

HOSPICE PATIENT ADMISSIONS BY COUNTY AND DISCHARGES BY DISPOSITION

| Line No. | County of Patient's Residence at Time of Admission (1) | No. of Admissions (2) | No. of Deaths (3) | No. of Non-Death Discharges (4) | No. of Patients Served (5) |
|----------|---|-----------------------------|-------------------------|--|----------------------------------|
| 91 | | | | | |
| 92 | | | | | |
| 93 | | | | | |
| 94 | | | | | |
| 95 | | | | | |
| 96 | | | | | |
| 97 | | | | | |
| 98 | | | | | |
| 99 | | | | | |
| 100 | TOTAL | | | | |

Section 7 (Con't)

OSHPD Facility ID No. _____

Please provide the number of hospice patients who were first time admitted and patients who were re-admitted from another program or from the reporting hospice.

NUMBER OF HOSPICE ADMISSIONS BY DIAGNOSIS

| Line No. | Diagnosis | ICD-9-CM Codes | No. of New Admissions (1) | Re-admissions Previously Seen by Another Hospice Program (2) | Re-admissions Previously Seen by This Hospice Program (3) | Total Admissions (1)+(2)+(3) (4) |
|----------|--|---|---------------------------|--|---|----------------------------------|
| 101 | Cancer | 140.0 - 209.30, 230.0 - 234.9 | | | | |
| 102 | Heart | 391.0 - 392.0, 393 - 402.91 404.0 - 404.9 with fifth digit 1 or 3 410.00-429.9 996.00 - 996.09, 996.61, 996.71, 996.72, 996.83 | | | | |
| 103 | Dementia & Cerebral Degeneration | 290.0 - 294.9 331.0 - 331.9 | | | | |
| 104 | Lung, excluding cancer | 460 - 519.9, 996.84, 997.31 - 997.39 | | | | |
| 105 | Kidney, excluding cancer | 403.00 - 403.91, 404.0-404.9 with fifth digit 2 or 3, 405.0 - 405.9 with fifth digit 1 580.0 - 589.9, 996.73, 996.81 | | | | |
| 106 | Liver, excluding | 570-573.9, 996.82 | | | | |
| 107 | HIV | 042 | | | | |
| 108 | Brain Stroke and late effects | 430 - 436, 438.0 - 438.9 997.02 | | | | |
| 109 | Coma, with or without brain injury | 780.01 - 780.09, 850.4 851.0 - 854.1 with fifth digit 5 | | | | |
| 110 | Diabetes | 249.00 - 250.93 | | | | |
| 111 | ALS* | 335.20 | | | | |
| 112 | GI disease, excluding cancer | 531.00 - 534.91 535.0 - 535.7 (with fifth digit 1) 537.83 - 537.84, 562.02 - 562.03, 562.12 - 562.13, 569.89, 578.0 - 578.9 | | | | |
| 113 | Multiple Sclerosis | 340 | | | | |
| 114 | Congenital Defects | 740 - 759 | | | | |
| 115 | General Debility and Failure to Thrive | 783.41, 783.7, 797 and 799.3 | | | | |
| 119 | Other | All other codes that are not in lines 101-115. | | | | |
| 120 | TOTAL | | | | | |

*Amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's Disease

HOSPICE UTILIZATION

Section 8

OSHPD Facility ID No. _____

Please provide the number of patients discharged during calendar year reported regardless of payment source. Count the patient only under the principal diagnosis for which the patient was admitted for hospice care. Report each patient only once. The ICD-9-CM codes are provided only as a guide for you. You may use your hospice's existing definitions for diagnosis groups or the LMRP (Local Medical Review Policy) diagnosis codes from your fiscal intermediary, provided they match in a general way with the ICD-9-CM codes.

DISCHARGED HOSPICE PATIENTS, VISITS AND PATIENT DAYS BY DIAGNOSIS(do not input any commas)

| Line No. | Diagnosis | ICD-9-CM Codes | Number of Live Discharges (1) | No. of Discharges due to Death (2) | Total Number of Discharges (3) | Visits for Discharged Patients (4) | Discharged Patients Total Days of Care (5) |
|----------|--|--|-------------------------------|------------------------------------|--------------------------------|------------------------------------|--|
| 1 | Cancer | 140.0 - 209.30, 230.0 - 234.9 | | | | | |
| 2 | Heart | 391.0 - 392.0, 393 - 402.91 404.0 - 404.9 with fifth digit 1 or 3 410.00 - 429.9 996.00 - 996.09, 996.61, 996.71, 996.72, 996.83 | | | | | |
| 3 | Dementia & Cerebral Degeneration | 290.0 - 294.9 331.0 - 331.9 | | | | | |
| 4 | Lung, excluding cancer | 460 - 519.9, 996.84, 997.31 - 997.39 | | | | | |
| 5 | Kidney, excluding cancer | 403.00 - 403.91, 404.0-404.9 with fifth digit 2 or 3, 405.0 - 405.9 with fifth digit 1 580.0 - 589.9, 996.73, 996.81 | | | | | |
| 6 | Liver, excluding cancer | 570 - 573.9, 996.82 | | | | | |
| 7 | HIV | 042 | | | | | |
| 8 | Brain Stroke and late effects | 430 - 436, 438.0 - 438.9, 997.02 | | | | | |
| 9 | Coma, with or without brain injury | 780.01 - 780.09, 850.4 851.0 - 854.1 with fifth digit 5 | | | | | |
| 10 | Diabetes | 249.00 - 250.93 | | | | | |
| 11 | ALS* | 335.20 | | | | | |
| 12 | GI disease, excluding cancer | 531.00 - 534.91 535.0 - 535.7 (with fifth digit 1) 537.83 - 537.84, 562.02 - 562.03 562.12 - 562.13, 569.89, 578.0 - 578.9 | | | | | |
| 13 | Multiple Sclerosis | 340 | | | | | |
| 14 | Congenital Defects | 740 - 759 | | | | | |
| 15 | General Debility and Failure to Thrive | 783.41, 783.7, 797, 799.3 | | | | | |
| 19 | Other | All other codes that are not in lines 1-15. | | | | | |
| 20 | TOTAL | | | | | | |

*Amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's Disease

HOSPICE CARE AND SOURCE OF PAYMENT

Section 9

OSHPD ID No. _____

Please provide patient days for all patients served, including those in nursing facilities during the calendar year reported. Patients who change primary pay source during the calendar year reported should be reported for each pay source with the number of days of care recorded for each source (count each day only once even if there is more than one pay source on any one day).

LEVEL OF CARE AND SOURCE OF PAYMENT (do not input any commas)

| Line No. | Source of Payment | No. of Patients Served (1) | Days of Routine Home Care (2) | Days of Inpatient Care (3) | Days of Inpatient Respite Care (4) | Days of Continuous Care (5) | Total Patient Care Days (6) |
|----------|-------------------------|----------------------------|-------------------------------|----------------------------|------------------------------------|-----------------------------|-----------------------------|
| 1 | Medicare | | | | | | |
| 2 | Medi-Cal | | | | | | |
| 3 | Medi-Cal Managed Care | | | | | | |
| 4 | Managed Care | | | | | | |
| 5 | Private Insurance | | | | | | |
| 6 | Self Pay | | | | | | |
| 7 | Charity | | | | | | |
| 8 | Veterans Administration | | | | | | |
| 9 | Other* | | | | | | |
| 10 | TOTAL | | | | | | |

* Other payment sources may include but not limited to Workers Comp., Home Health benefit, etc.

LOCATION OF CARE PROVIDED (do not input any commas)

| Line No. | Location of Care | No. of Patients Served (1) | Days of Routine Home Care (2) | Days of Inpatient Care (3) | Days of Inpatient Respite Care (4) | Days of Continuous Care (5) | Total Patient Care Days (6) |
|----------|--------------------|----------------------------|-------------------------------|----------------------------|------------------------------------|-----------------------------|-----------------------------|
| 21 | Home | | | | | | |
| 22 | Hospital | | | | | | |
| 23 | SNF | | | | | | |
| 24 | CLHF | | | | | | |
| 25 | RCFE / ARF / RCFCI | | | | | | |
| 26 | ICF / MR | | | | | | |
| 27 | Prison | | | | | | |
| 28 | Homeless | | | | | | |
| 29 | Other | | | | | | |
| 30 | TOTAL | | | | | | |

HOSPICE INCOME AND EXPENSES STATEMENT

ANNUAL UTILIZATION REPORT OF HOSPICES - 2011

Section 10

OSHPD Facility ID No. _____

DETAIL OF OPERATING EXPENSES (do not input "\$" signs, commas or decimals, round up to whole dollar)

Use data from Medicare Cost Report where applicable.

| Line No. | | Total (1) |
|----------|--|--------------|
| | General Service Cost Centers | |
| 30 | Administrative and General | |
| | Inpatient Care Service | |
| 31 | Inpatient - General Care | |
| 32 | Inpatient - Respite Care | |
| | Program Supervision | |
| 35 | Hospice Program / Team Supervision (Non-visit wages) | |
| | Visiting Services | |
| 36 | Physician Services | |
| 37 | Nursing Care | |
| 38 | Rehabilitation Services (PT, OT, Speech) | |
| 39 | Medical Social Services - Direct | |
| 40 | Spiritual Counseling | |
| 41 | Dietary Counseling | |
| 42 | Counseling - Other | |
| 43 | Home Health Aides and Homemakers | |
| 44 | Other Visiting Services | |
| | Hospice Service Cost Centers | |
| 45 | Drugs, Biologicals and Infusion | |
| 46 | Durable Medical Equipment / Oxygen | |
| 47 | Patient Transportation | |
| 48 | Imaging, Lab and Diagnostics | |
| 49 | Medical Supplies | |
| 50 | Outpatient Services (including ER Dept.) | |
| 51 | Radiation Therapy | |
| 52 | Chemotherapy | |
| 53 | Other Hospice Service Costs | |
| | Other Hospice Costs | |
| 54 | Bereavement Program Costs | |
| 55 | Volunteer Program Costs | |
| 56 | Fundraising Costs | |
| | Other Costs | |
| 57 | Other Program Costs * | |
| 59 | Total Operating Expenses | |

* Program costs including community education and outreach program costs.

HOSPICE INCOME AND EXPENSES STATEMENT

ANNUAL UTILIZATION REPORT OF HOSPICES - 2011

Section 10 (Cont'd)

OSHPD Facility ID No. _____

HOSPICE INCOME STATEMENT (do not input "\$" signs, commas or decimals, round up to whole dollar)

| Line No. | | Total (1) |
|----------|---|--------------|
| | Gross Patient Revenue | |
| | Gross Patient Revenue for Hospice Four Levels of Care | |
| 101 | Medicare | |
| 102 | Medi-Cal (Excluding SNF Room & Board) | |
| 103 | Medi-Cal Managed Care (Excluding SNF Room & Board) | |
| 104 | Managed Care (Non Medi-Cal) | |
| 105 | Private Insurance | |
| 106 | Self-Pay | |
| 109 | Other Payers | |
| 110 | Total Revenue for Hospices Four Levels of Care | |
| | Room & Board Revenue | |
| 1101 | SNF Room & Board Pass Through Receivable from Medi-Cal | |
| 1102 | Medi-Cal Room & Board Contractual Payments to SNF | () |
| 1103 | Net Room & Board Revenue | |
| 1104 | Total Gross Patient Revenue (sum of lines 110 and 1103) | |
| | Write-offs and Adjustments | |
| 111 | Contractual Adjustments | |
| 112 | Denials / Bad Debt | |
| 113 | Charity | |
| 119 | Other Write-offs and Adjustments | |
| 120 | Total Write-offs and Adjustments (sum of lines 111 through 119) | |
| 125 | Net Patient Revenue (line 1104 minus line 120) | |
| | Other Operating Revenue | |
| 131 | Grants | |
| 132 | Donations / Contributions | |
| 133 | Unrelated Business Income | |
| 139 | Other | |
| 140 | Total Other Operating Revenue (sum of lines 131 through 139) | |
| 145 | Total Operating Revenue (line 125 plus line 140) | |
| | Operating Expenses | |
| 160 | Total Operating Expenses (from line 59) | |
| 165 | Net from Operations (line 145 minus line 160) | |
| 170 | Income Tax | |
| 175 | Net Income (line 165 minus line 170) | |

HOSPICE INPATIENT FACILITY / UNIT

ANNUAL UTILIZATION REPORT OF HOSPICES - 2011

Section 11

OSHPD Facility ID No. _____

HOSPICE OPERATED SITES AND NUMBER OF BEDS

| Line No. | Name (1) | Address (2) | City (3) | State (4) | Zip (5) | Type of Licensed Beds (6) | No. of Beds (7) |
|----------|----------|-------------|----------|-----------|---------|---------------------------|-----------------|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |
| 9 | | | | | | | |
| 10 | | | | | | | |

LEVELS OF CARE HOSPICE SITES PROVIDE

| Line No. | Type of Care | No. of Patient Days (1) |
|----------|------------------------|-------------------------|
| 11 | General Inpatient Care | |
| 12 | Inpatient Respite Care | |
| 13 | Continuous Care | |
| 14 | Routine Care | |
| 20 | TOTAL | |