

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**

OSHPD Facility ID No. _____

Section 3

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**

OSHDP 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 - 208.91, 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				
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, 586				
106	Liver, excluding cancer	570-573.9				
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	250.00 - 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	759.9				
115	General Debility and Failure to Thrive	783.7 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

ANNUAL UTILIZATION REPORT OF HOSPICES - 2010

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 0, 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	759.9					
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 - 2010

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 - 2010
 OSHPD Facility ID No. _____

Section 10 (Cont'd)

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 - 2010

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	