ANNUAL UTILIZATION REPORT OF HOSPITALS - 2015

1. Facility DBA (Doing Business As) Name:		2. OSHPD Facility No.:	
3. Street Address:	4. City:		5. Zip Code:
6. Facility Phone No.: ( )	7. Administrator Name:	8. Administrator's E-Mail Address:	
9. Was this hospital in operation at any time during the year? Yes ☐ No ☐		Dates of Operation (MMDDYYYY): 10. From:	11. Through:
12. Name of Parent Corporation:			
13. Corporate Business Address:	14. City:	15. State	16. Zip Code:
17. Person Completing Report		18. Phone No. ( )	Ext.
19. Fax No. ( )		20. E-mail Address:	

CERTIFICATION

I declare the following under penalty of perjury: that I am the current administrator of this health facility, duly authorized by the governing body to act in an executive capacity; that I am familiar with the record keeping systems of this facility; that the records and logs are true and correct to the best of my knowledge and belief; that I have read this annual report and am thoroughly familiar with its contents; and that its contents represent an accurate and complete summarization from medical records and logs of the information requested.

Date

Administrator Signature

Administrator Name (Please Print)

Completion of the Annual Utilization Report of Hospitals is required by Section 127285 of the Health and Safety Code, and is a requirement for the licensure of your health facility pursuant to Section 70735 and 71533 of Title 22 of the California Code of Regulations. Failure to complete and file this report by February 15 may result in action against the hospital's license.

Office of Statewide Health Planning and Development
Healthcare Information Division
Accounting and Reporting Systems Section
Licensed Services Data and Compliance Unit
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Section 2

OSHPD FACILITY ID No. _____

LICENSE CATEGORY (TYPE) (Completed by OSHPD)

Line No.		(1)
1	General Acute Care	
	Acute Psychiatric	
	Psychiatric Health Facility	
	Chemical Dependency Recovery Hospital	

LICENSEE TYPE OF CONTROL

Line No.		(1)
5	Select the category that best describes the licensee type of control of your hospital (the type of organization that owns the license) from the list 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		

PRINCIPAL SERVICE TYPE

Line No.		(1)
25	From the list below, select the ONE category that best describes the type of service provided to the majority of your patients. (The type or service is usually consistant with majority of, or mix of reported patient days.) (There will be drop down box in ALIRTS - see list of choices below.)	

PRINCIPAL SERVICE TYPE CHOICES

10	General Medical / Surgical	18	Physical Rehabilitation
12	Long-Term Care (SN / IC)	19	Orthopedic or Pediatric Orthopedic
13	Psychiatric	22	Developmentally Disabled
15	Chemical Dependency (Alcohol / Drug)	23	Other
17	Pediatric		

Section 3

OSHPD FACILITY ID No. _____

INPATIENT BED UTILIZATION - *DO NOT INCLUDE NORMAL NEWBORNS IN BED UTILIZATION DATA*

Line No.	Bed Classification and Bed Designation	(1) Licensed Beds as of 12/31	(2) Licensed Bed Days	(3) Hospital Discharges (including deaths)	(4) Intra-hospital Transfers	(5) Patient (Census) Days
	GAC Bed Designations					
1	Medical / Surgical (Include GYN)					
2	Perinatal (exclude Newborn / GYN)					
3	Pediatric					
4	Intensive Care					
5	Coronary Care					
6	Acute Respiratory Care					
7	Burn					
8	Intensive Care Newborn Nursery					
9	Rehabilitation Center					
15	**SUBTOTAL - GAC**					
16	Chemical Dependency Recovery Hospital					
17	Acute Psychiatric					
18	Skilled Nursing					
19	Intermediate Care					
20	Intermediate Care / Developmentally Disabled					
25	**TOTAL (sum of lines 15 thru 20)**					

CHEMICAL DEPENDENCY RECOVERY SERVICES IN LICENSED GAC AND ACUTE PSYCHIATRIC BEDS *

Line No.	Bed Classification	(1) Licensed Beds		(3) Hospital Discharges		(5) Patient (Census) Days
30	GAC - Chemical Dep Recovery Services					
31	Acute Psych - Chemical Dep Recovery Svcs					

* The licensed services data for these CDRS are to be included in lines 1 through 25 above.

NEWBORN NURSERY INFORMATION

Line No.		(1) Nursery Bassinets		(3) *Nursery Infants		(5) Nursery Days
35	Newborn Nursery					

* Nursery Infants are the "normal" newborn nursery equivalent to discharges from licensed beds.

Section 3 (Con't)

OSHPD FACILITY ID No. _____

SKILLED NURSING SWING BEDS (Completed by OSHPD.)

Line No.		(1)
40	Number of licensed General Acute Care beds approved for skilled nursing care.	

COMPLETE LINES 43 THROUGH 70 ONLY IF YOUR HOSPITAL HAS LICENSED ACUTE PSYCHIATRIC OR PHF BEDS. INCLUDE CHEMICAL DEPENDENCY RECOVERY SERVICES PROVIDED IN LICENSED PSYCHIATRIC BEDS.

ACUTE PSYCHIATRIC PATIENTS BY UNIT ON DECEMBER 31

Line No.		(1) Number of Patients
43	Locked	
44	Open	
45	**ACUTE PSYCHIATRIC TOTAL ***	

*** ACUTE PSYCHIATRIC TOTAL on lines 45, 50 and 65 must agree.**

ACUTE PSYCHIATRIC PATIENTS BY AGE CATEGORY ON DECEMBER 31

Line No.		(1) Number of Patients
46	0 - 17 Years	
47	18 - 64 Years	
49	65 Years and Older	
50	**ACUTE PSYCHIATRIC TOTAL ***	

*** ACUTE PSYCHIATRIC TOTAL on lines 45, 50 and 65 must agree.**

ACUTE PSYCHIATRIC PATIENTS BY PRIMARY PAYER ON DECEMBER 31

Line No.		(1) Number of Patients
51	Medicare - Traditional	
52	Medicare - Managed Care	
53	Medi-Cal - Traditional	
54	Medi-Cal - Managed Care	
55	County Indigent Programs	
56	Other Third Parties - Traditional	
57	Other Third Parties - Managed Care	
58	Short-Doyle (includes Short-Doyle Medi-Cal)	
59	Other Indigent	
64	Other Payers	
65	**ACUTE PSYCHIATRIC TOTAL ***	

*** ACUTE PSYCHIATRIC TOTAL on lines 45, 50 and 65 must agree.**

SHORT DOYLE CONTRACT SERVICES

Line No.		(1)
70	During the reporting period, did you provide any acute psychiatric care under a Short-Doyle contract?	Yes ☐ No ☐

Section 3 (Con't)

OSHPD FACILITY ID No. _____

INPATIENT HOSPICE PROGRAM

Line No.		(1)
71	Did your hospital offer an inpatient hospice program during the report period?	Yes ☐ No ☐

If 'yes' on line 71, what type of bed classification is used for this service? (Check all that apply.)

Line No.	Bed Classification	(1)
72	General Acute Care	
73	Skilled Nursing (SN)	
74	Intermediate Care (IC)	

PALLIATIVE CARE PROGRAM

Line No.		(1)
80	Did your hospital have an inpatient palliative care program during the report period?	Yes ☐ No ☐

PALLIATIVE CARE PROGRAM - An interdisciplinary team that sees patients, identifies needs, makes treatment recommendations, facilitates patient and /or family decision making, and/or directly provides palliative care for patients with serious illness and their families.

If 'yes' on line 80, please answer the questions below.

Line No.		(1) Number
81	How many Advanced Practice Nurses(APN)/Registered Nurses(RN) are on the inpatient palliative care team?	
82	How many of these APN/RNs are board certified by the National Board for Certification for Hospice and Palliative Nursing?	
83	How many Physicians are on the inpatient palliative care team?	
84	How many of these Physicians are board certified by the American Board of Medical Specialties?	
85	How many Social Workers are on the inpatient palliative care team?	
86	How many of these Social Workers hold an Advanced Certified Hospice and Palliative Social Worker credential from the National Association of Social Worker?	
87	How many Chaplains are on the inpatient palliative care team?	

*Staffing data should only reflect inpatient palliative care team.

Line No.		(1)
90	Did your hospital have outpatient palliative care services during the report period?	Yes ☐ No ☐

Section 4

OSHPD FACILITY ID No. _____

EMSA TRAUMA CENTER DESIGNATION ON DECEMBER 31 (Completed by OSHPD from EMSA data.)

Line No.	EMSA Trauma Designation	(1) Designation	(2) Pediatric
1	Level I		
	Level II		
	Level III		
	Level IV		

LICENSED EMERGENCY DEPARTMENT LEVEL (Completed by OSHPD from CDPH data.)

Line No.	ED Level	(1) January 1	(2) December 31
2	Standby		
	Basic		
	Comprehensive		

SERVICES AVAILABLE ON PREMISES (Check all that apply.)

Line No.	Services Available	(1) 24 Hour	(2) On-Call
11	Anesthesiologist		
12	Laboratory Services		
13	Operating Room		
14	Pharmacist		
15	Physician		
16	Psychiatric ER		
17	Radiology Services		

EMERGENCY DEPARTMENT SERVICES (enter all information applicable for col.1 & 2, including the totals on line 30**)**

Line No.	EDS Visit Type	CPT Codes	(1) Visits not Resulting in Admission*	(2) Admitted from ED (Enter Total Only if Details not Available)	(3) Total ED Traffic (1) + (2)
21	Minor	99281			
22	Low/Moderate	99282			
23	Moderate	99283			
24	Severe, w/o threat	99284			
25	Severe, w threat	99285			
30	**TOTAL**				

* DO NOT INCLUDE patients who registered but left without being seen, employee physicals and scheduled Clinic-type visits.

Section 4 (Con't)

OSHPD FACILITY ID No. _____

EMERGENCY MEDICAL TREATMENT STATIONS ON DECEMBER 31

Line No.		(1)
35	Enter the number of emergency medical treatment stations.	

Treatment Station - A specific place within the emergency department adequate to treat one patient at a time. Do not count holding or observation beds.

NON-EMERGENCY (CLINIC) VISITS SEEN IN EMERGENCY DEPARTMENT

Line No.		(1)
40	Enter the number of non-emergency (clinic) visits seen in ED.	

EMERGENCY REGISTRATIONS, BUT PATIENT LEAVES WITHOUT BEING SEEN*

Line No.		(1)
45	Enter the number of EDS registrations that did NOT result in treatment.	

* Include patients who arrived at ED, but did not register and left without being seen (if available).

EMERGENCY DEPARTMENT AMBULANCE DIVERSION HOURS

Line No.		(1)
50	Were there periods when the ED was unable to receive any and all ambulance patients during the year and as a result ambulances were diverted to other hospitals? If 'yes' fill out lines 51 through 62 below. Count only those hours in which the ED was unavailable TO ALL PATIENTS (see instructions).	Yes ☐ No ☐

Number of Ambulance Diversion Hours that occurred at Emergency Department

Line No.	Month	(1) Hours
51	January	
52	February	
53	March	
54	April	
55	May	
56	June	
57	July	
58	August	
59	September	
60	October	
61	November	
62	December	
65	Total Hours	

Section 5

OSHPD FACILITY ID No. _____

SURGICAL SERVICES

Line No.	Surgical Services	(1) Surgical Operations	(2) Operating Room Minutes
1	Inpatient		
2	Outpatient		

OPERATING ROOMS ON DECEMBER 31

Line No.	Operating Room Type	(1) Number
7	Inpatient only	
8	Outpatient Only	
9	Inpatient and Outpatient	
10	**TOTAL OPERATING ROOMS**	

AMBULATORY SURGICAL PROGRAM

Line No.		(1)
15	Did your hospital have an organized ambulatory surgical program?	Yes ☐ No ☐

LIVE BIRTHS

Line No.		(1) Number
20	Total Live Births (Count multiple births separately)*	
21	Live Births with Birth Weight Less Than 2500 grams (5lbs. 8 oz.)	
22	Live Births with Birth Weight Less Than 1500 grams (3lbs. 5 oz.)	

* TOTAL LIVE BIRTHS on line 20 should approximate the number of Perinatal discharges shown in Section 3, line 2, column 3. Include LDR or LDRP births and C-Section deliveries.

ALTERNATE BIRTHING (OUTPATIENT) CENTER INFORMATION

Line No.		(1)
31	Did your hospital have an approved alternate birthing (outpatient) program?	Yes ☐ No ☐
32	Was your alternate setting approved as LDR?	Yes ☐ No ☐
33	Was your alternate setting approved as LDRP?	Yes ☐ No ☐

OTHER LIVE BIRTH DATA

Line No.		(1) Number
36	How many of the live births reported on line 20 occurred in your alternative (outpatient) setting? Do not include C-Section deliveries.	
37	How many of the live births reported on line 20 were C-Section deliveries?	

Section 5 (con't)

OSHPD FACILITY ID No. _____

LICENSED CARDIOLOGY AND CARDIOVASCULAR SURGERY SERVICES (Completed by OSHPD.)

Line No.		(1) Licensure
41	Cardiovascular Surgery Services (Complete lines 42 to 85, if licensed.)	
	Cardiac Catheterization Only (Complete lines 55 to 85, if licensed.)	
	Not Licensed	

LICENSED CARDIOVASCULAR OPERATING ROOMS

Line No.		(1)
42	Number of operating rooms licensed to perform cardiovascular surgery on December 31.	

CARDIOVASCULAR SURGICAL OPERATIONS
(with and without the HEART/LUNG MACHINE*)

Line No.		(1) Cardio-Pulmonary Bypass USED*	(2) Cardio-Pulmonary Bypass NOT USED
43	Pediatric		
44	Adult		
45	**TOTAL CARDIOVASCULAR SURGICAL OPERATIONS**		

*Also referred to as Extracorporeal Bypass or "on-the-pump" (heart/lung machine).

CORONARY ARTERY BYPASS GRAFT (CABG) SURGERIES*

Line No.		(1)
50	Number of Coronary Artery Bypass Graft (CABG) surgeries performed.	

* Subset of cardiovascular surgeries reported on line 45 above.

CARDIAC CATHETERIZATION LAB ROOMS

Line No.		(1)
55	Number of rooms equipped to perform cardiac catheterizations on December 31.	

CARDIAC CATHETERIZATION VISITS

Line No.		(1) Diagnostic	(2) Therapeutic
56	Pediatric - Inpatient		
57	Pediatric - Outpatient		
58	Adult - Inpatient		
59	Adult - Outpatient		
60	**TOTAL CARDIAC CATHETERIZATION VISITS**		

Section 5 (con't)

OSHPD FACILITY ID No. _____

DISTRIBUTION OF PROCEDURES PERFORMED IN CATHETERIZATION LABORATORY

Line No.		(1) Procedures
65	Diagnostic Cardiac Catheterization Procedures (LHC, R & LHC)	
66	Myocardial Biopsy	
71	Permanent Pacemaker Implantation	
711	Other Permanent Pacemaker Procedures (Generator or Lead Replacement)	
712	Implantable Cardioverter Defibrillator (ICD) Implantation	
713	Other ICD Procedures (Generator or Lead Replacement)	
72	Percutaneous Coronary Intervention (PCI) - WITH Stent	
73	Percutaneous Coronary Intervention (PCI) - WITHOUT Stent	
74	Atherectomy (PTCRA - rotablator, DCA, laser, other ablation, etc.)	
75	Thrombolytic Agents (Intracoronary only)	
76	Percutaneous Transluminal Balloon Valvuloplasty (PTBV)	
77	Diagnostic Electrophysiology (EP) Study	
78	Catheter Ablation Procedures (SVT, VT, AF)	
79	Peripheral Vascular Angiography	
80	Peripheral Vascular Interventional Procedures	
81	Carotid Stenting Procedures	
82	Intra-Aortic Balloon Pump Insertion	
83	Catheter-based Ventricular Assist Device Insertion	
84	All other catheterization procedures performed in the lab	
85	**TOTAL CATHETERIZATION PROCEDURES**	

NOTE: DO NOT INCLUDE ANY OF THE FOLLOWING AS A CATHETERIZATION

Defibrillation	Temporary Pacemaker Insertion
Cardioversion	Pericardiocentesis

Percutaneous Transluminal Balloon Valvuloplasty (PTBV) is very rarely done in these times. Those that are done are generally on pediatric patients.

AICD procedures are frequently done in the cath lab and are very similar to permanent pacemaker implants.

Section 6

OSHPD FACILITY ID No. _____

Section 127285 (3) of the Health and Safety Code requires each hospital to report "acquisitions of diagnostic or therapeutic equipment during the reporting period with a value in excess of five hundred thousand dollars ($500,000)."

DIAGNOSTIC AND THERAPEUTIC EQUIPMENT DURING THE REPORT PERIOD

Line No.		(1)
1	Did your hospital acquire any diagnostic or therapeutic equipment that had a value in excess of $500,000? (If 'Yes', fill out lines 2 through 11, as necessary, below.)	Yes ☐ No ☐

DIAGNOSTIC AND THERAPEUTIC EQUIPMENT DETAIL

Line No.	(1) Description of Equipment	(2) Value	(3) Date of Acquisition (MMDDYYYY)	(4) Means of Acquisition (Check one.)			
2				Purchase ☐	Lease ☐	Donation ☐	Other ☐
3				Purchase ☐	Lease ☐	Donation ☐	Other ☐
4				Purchase ☐	Lease ☐	Donation ☐	Other ☐
5				Purchase ☐	Lease ☐	Donation ☐	Other ☐
6				Purchase ☐	Lease ☐	Donation ☐	Other ☐
7				Purchase ☐	Lease ☐	Donation ☐	Other ☐
8				Purchase ☐	Lease ☐	Donation ☐	Other ☐
9				Purchase ☐	Lease ☐	Donation ☐	Other ☐
10				Purchase ☐	Lease ☐	Donation ☐	Other ☐
11				Purchase ☐	Lease ☐	Donation ☐	Other ☐

BUILDING PROJECTS COMMENCED DURING REPORT PERIOD COSTING OVER $1,000,000

Section 127285 (4) of the Health and Safety Code requires each hospital to report the "commencement of projects during the reporting period that require a capital expenditure for the facility or clinic in excess of one million dollars ($1,000,000)."

Line No.		(1)
25	Did your hospital commence any building projects during the report period which will require an aggregate capital expenditure exceeding $1,000,000? (If 'Yes', fill out lines 26 through 30, as necessary, below.)	Yes ☐ No ☐

DETAIL OF CAPITAL EXPENDITURES

Line No.	(1) Description of Project	(2) Projected Total Capital Expenditure	(3) OSHPD Project No. (if applicable)
26			
27			
28			
29			
30			