

**Provide the Hospital Owner and Year of Report per Section 130061(e)**

Facility Number:

11549

Facility Name:

Community &amp; Mission Hsp of Huntington Pk-Slauson

Address:

2623 E. Slauson Ave.

City:

Huntington Park

Hospital Owner/Licensee:

Avanti Health System

Year of Reporting:

2010

Contact 1 e-mail Address:

Contact 2 e-mail Address:

Contact 3 e-mail Address::

Name of Submitter:

Avanti Hospitals

Submission Date:

1/25/2011 3:00:00 PM

Report Year:

2010

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For buildings which are planned for retrofit or replacement the report shall identify: Whether the hospital owner intends to retrofit or replace the building to SPC 2 or SPC 5 per section [130061\(c\)\(1\)\(A\)](#). The deadline, as described in [Section 130060](#) or [130061.5](#), for retrofit or replacement of the bulding that the hospital owner intends to meet, and the applicable extension for which the hospital owner has been approved per [Section 130061\(c\)\(1\)\(B\)](#)

Bldg. No.	Building Name	Alternate Building Address	Building Resolution	Final SPC Rating If Required	Extension Date	Anticipated Completion Date
01	Main Hospital	2623 E. Slauson Ave.	Retrofit	SPC2	01/01/2013	01/01/2015

Report Year:

2010

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Report Status: **Data Last Update:** 11/01/2010

**Submission Date:** 01/25/2011

**Print Date:** 1/26/2011 8:38 AM

Provide the number of inpatient beds and patient days per type of service per building per **Section 130061(c)(1)(F)**

Building Number: 01

Building Name: Main Hospital

**Type of Service Provided**

<input checked="" type="checkbox"/> Nursing	Inpatient Beds	<input type="text" value="77"/>	Inpatient Days	<input type="text" value="10912"/>	<input checked="" type="checkbox"/> Surgical	<input type="checkbox"/> Obstetrical Recovery
<input checked="" type="checkbox"/> IntensiveCare	Inpatient Beds	<input type="text" value="4"/>	Inpatient Days	<input type="text" value="241"/>	<input checked="" type="checkbox"/> Anesthesia	<input type="checkbox"/> Newborn/WellBaby
<input type="checkbox"/> Pediatric/Adolescent	Inpatient Beds	<input type="text" value="0"/>	Inpatient Days	<input type="text" value="0"/>	<input checked="" type="checkbox"/> Clinical Lab	<input checked="" type="checkbox"/> Emergency
<input type="checkbox"/> Psychiatric Nursing	Inpatient Beds	<input type="text" value="0"/>	Inpatient Days	<input type="text" value="0"/>	<input checked="" type="checkbox"/> Radiological/Imaging	<input checked="" type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> Obstetrical Ante/Postpartum	Inpatient Beds	<input type="text" value="0"/>	Inpatient Days	<input type="text" value="0"/>	<input checked="" type="checkbox"/> Pharmaceutical	<input checked="" type="checkbox"/> Rehabilitation Therapy
<input type="checkbox"/> Intermediate Care	Inpatient Beds	<input type="text" value="0"/>	Inpatient Days	<input type="text" value="0"/>	<input checked="" type="checkbox"/> Dietetic	<input type="checkbox"/> Renal Dialysis
<input type="checkbox"/> Skilled Nursing	Inpatient Beds	<input type="text" value="0"/>	Inpatient Days	<input type="text" value="0"/>	<input checked="" type="checkbox"/> Administration	<input checked="" type="checkbox"/> Outpatient Surgery
				Total Beds this Building	<input type="text" value="81"/>	<input checked="" type="checkbox"/> Support Services
						<input checked="" type="checkbox"/> Obstetrical Cesarean/Deliv
						<input checked="" type="checkbox"/> Central Plant

## Provide the number of Inpatient beds and patient days per type of unit per building per Section 130061(c)(1)(F)

Building Number:

01

Building Name:

Main Hospital

**Medical / Surgical (Include GYN)**Inpatient  
Bed Inpatient  
Days   
**Acute Respiratory Care**Inpatient  
Bed Inpatient  
Days **Acute Psychiatric**Inpatient  
Bed Inpatient  
Days **Perinatal (exclude Newborn / GYN)**Inpatient  
Bed Inpatient  
Days **Burn**Inpatient  
Bed Inpatient  
Days **Skilled Nursing**Inpatient  
Bed Inpatient  
Days **Pediatric**Inpatient  
Bed Inpatient  
Days **intensive Care Newborn  
Nursery**Inpatient  
Bed Inpatient  
Days **Intermediate Card**Inpatient  
Bed Inpatient  
Days **Intensive Care**Inpatient  
Bed Inpatient  
Days **Rehabilitation  
Center**Inpatient  
Bed Inpatient  
Days **Int. Care / development  
Disabled**Inpatient  
Bed Inpatient  
Days **Coronary Care**Inpatient  
Bed Inpatient  
Days **Chemical  
Dependency**Inpatient  
Bed Inpatient  
Days **Total Beds this  
Building Per  
Unit**

81

**Total Beds this  
Building Per  
Service**

81

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For all buildings at the facility, indicate which ones are scheduled for general acute service removal.

Building Number	Building Name	Building to be Removed
01	Main Hospital	<input type="checkbox"/>



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Report any general acute care hospital inpatient service that is provided in any general acute care hospital building that is rated SPC-1 per [Section 130061\(c\)\(4\)](#)

Building Number:

01

Building Name:

Main Hospital

### Type of Service Provided

<input checked="" type="checkbox"/> Nursing	<input checked="" type="checkbox"/> Surgical	<input checked="" type="checkbox"/> Obstetrical Cesarean/Deliv	<input checked="" type="checkbox"/> Rehabilitation Therapy
<input checked="" type="checkbox"/> IntensiveCare	<input checked="" type="checkbox"/> Anesthesia	<input type="checkbox"/> Obstetrical Recovery	<input type="checkbox"/> Renal Dialysis
<input type="checkbox"/> Pediatric/Adol escent	<input checked="" type="checkbox"/> Clinical Lab	<input type="checkbox"/> Newborn/ WellBaby	<input checked="" type="checkbox"/> Outpatient Surgery
<input type="checkbox"/> Psychiatric Nursing	<input checked="" type="checkbox"/> Radiological/ Imaging	<input checked="" type="checkbox"/> Emergency	<input checked="" type="checkbox"/> Central Plant
<input type="checkbox"/> Obstetrical Ante/Postprtum	<input checked="" type="checkbox"/> Pharmaceutical	<input checked="" type="checkbox"/> Nuclear Medicine	<input checked="" type="checkbox"/> Support Services
<input type="checkbox"/> Intermediate Care	<input checked="" type="checkbox"/> Dietetic		
<input type="checkbox"/> Skilled Nursing	<input checked="" type="checkbox"/> Administration		

Report the final configuration of all buildings on the hospital campus showing how each building will comply with the SPC-5/NPC-4 or 5 requirements whether by retrofit or by replacement and the type of service that will be provided in each general acute care hospital building per [Section 130061\(c\)\(5\)](#)

Building Number:

01

Building Name:

Main Hospital

Configuration

:

Retrofit Non-Conforming building to SPC 2 and NPC 3 and remove from service by 2030

**Type of Service Provided**

Nursing

Surgical

Obstetrical  
Cesarean/DelivRehabilitation  
Therapy

IntensiveCare

Anesthesia

Obstetrical  
Recovery

Renal Dialysis

Pediatric/Adol  
escent

Clinical Lab

Newborn/  
WellBabyOutpatient  
SurgeryPsychiatric  
NursingRadiological/  
Imaging

Pharmaceutical

Emergency

Central Plant

Obstetrical  
Ante/Postprtum

Dietetic

Nuclear Medicine

Support  
ServicesIntermediate  
Care

Administration

Skilled Nursing