



**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 consistent 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		

**INPATIENT SERVICES**

**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
	<b>GAC Bed Designations</b>					
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	<b>SUBTOTAL - GAC</b>					
16	Chemical Dependency Recovery Hospital					
17	Acute Psychiatric					
18	Skilled Nursing					
19	Intermediate Care					
20	Intermediate Care / Developmentally Disabled					
25	<b>TOTAL (sum of lines 15 thru 20)</b>					

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

Line No.	Bed Classification	(1) Licensed Beds	(2)	(3) Hospital Discharges	(4)	(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	(2)	(3) *Nursery Infants	(4)	(5) Nursery Days
35	Newborn Nursery					

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

**INPATIENT SERVICES**

**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	<b>ACUTE PSYCHIATRIC TOTAL *</b>	

**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	<b>ACUTE PSYCHIATRIC TOTAL *</b>	

**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	<b>ACUTE PSYCHIATRIC TOTAL *</b>	

\* 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 <input type="checkbox"/> No <input type="checkbox"/>

**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 <input type="checkbox"/> No <input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/>

**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 <input type="checkbox"/> No <input type="checkbox"/>

**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	<b>TOTAL</b>				

\* 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 <input type="checkbox"/> No <input type="checkbox"/>

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	

**SURGERY AND RELATED SERVICES**

**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	<b>TOTAL OPERATING ROOMS</b>	

**AMBULATORY SURGICAL PROGRAM**

Line No.		(1)
15	Did your hospital have an organized ambulatory surgical program?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**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 <input type="checkbox"/> No <input type="checkbox"/>
32	Was your alternate setting approved as LDR?	Yes <input type="checkbox"/> No <input type="checkbox"/>
33	Was your alternate setting approved as LDRP?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**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?	

**SURGERY AND RELATED SERVICES**

**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	<b>TOTAL CARDIOVASCULAR SURGICAL OPERATIONS</b>		

\*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	<b>TOTAL CARDIAC CATHETERIZATION VISITS</b>		

**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	<b>TOTAL CATHETERIZATION PROCEDURES</b>	

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.

**MAJOR CAPITAL EXPENDITURES**

**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 <input type="checkbox"/> No <input type="checkbox"/>

**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 <input type="checkbox"/>	Lease <input type="checkbox"/>	Donation <input type="checkbox"/>	Other <input type="checkbox"/>
3				Purchase <input type="checkbox"/>	Lease <input type="checkbox"/>	Donation <input type="checkbox"/>	Other <input type="checkbox"/>
4				Purchase <input type="checkbox"/>	Lease <input type="checkbox"/>	Donation <input type="checkbox"/>	Other <input type="checkbox"/>
5				Purchase <input type="checkbox"/>	Lease <input type="checkbox"/>	Donation <input type="checkbox"/>	Other <input type="checkbox"/>
6				Purchase <input type="checkbox"/>	Lease <input type="checkbox"/>	Donation <input type="checkbox"/>	Other <input type="checkbox"/>
7				Purchase <input type="checkbox"/>	Lease <input type="checkbox"/>	Donation <input type="checkbox"/>	Other <input type="checkbox"/>
8				Purchase <input type="checkbox"/>	Lease <input type="checkbox"/>	Donation <input type="checkbox"/>	Other <input type="checkbox"/>
9				Purchase <input type="checkbox"/>	Lease <input type="checkbox"/>	Donation <input type="checkbox"/>	Other <input type="checkbox"/>
10				Purchase <input type="checkbox"/>	Lease <input type="checkbox"/>	Donation <input type="checkbox"/>	Other <input type="checkbox"/>
11				Purchase <input type="checkbox"/>	Lease <input type="checkbox"/>	Donation <input type="checkbox"/>	Other <input type="checkbox"/>

**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 <input type="checkbox"/> No <input type="checkbox"/>

**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			