

ANNUAL UTILIZATION REPORT OF PRIMARY CARE CLINICS - 2009

Licensed Community and Free Clinics

1. Facility DBA (Doing Business As) Name:		2. OSHPD Facility ID 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 clinic in operation at any time during the year? Yes <input type="checkbox"/> No <input type="checkbox"/>		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 Primary Care Clinics is required by Section 127285 and Section 1216 of the Health and Safety Code. Failure to complete and file this report by February 15 may result in suspension of the clinic's license.

Office of Statewide Health Planning and Development
Accounting and Reporting Systems Section
Licensed Services Data and Compliance Unit
400 R Street, Suite 250
Sacramento, CA 95811

Phone: (916) 326-3854
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CLINIC SERVICES
SECTION 2

LICENSE CATEGORY (TYPE) (Completed by OSHPD)

Line No.		(1)
1	Community Free	

FEDERALLY QUALIFIED HEALTH CLINIC (FQHC)

Line No.	Federally Qualified Health Clinics	(1)
2	Indicate clinic type, if applicable:	FQHC <input type="checkbox"/> FQHC Look-Alike <input type="checkbox"/> Neither <input type="checkbox"/>

RURAL HEALTH CLINIC

Line No.	Rural Health Clinic	(1)
3	Is this a 95-210 Rural Health Clinic?	Yes <input type="checkbox"/> No <input type="checkbox"/>

COMMUNITY SERVICES (Indicate Community Services offered.)

Line No.		(1) Offered
10	Adult Day Care	
11	Child Care	
12	Community Education	
13	Community Nutrition	
14	Disaster Relief	
15	Environmental Health	
16	Homeless	
17	Legal	
18	Outreach	
19	Social Services	
20	Substance Abuse	
21	Transportation	
22	Vocational Training Placement	
23	Other	

CLINIC SERVICES

SECTION 2 (continued)

LANGUAGES SPOKEN BY STAFF

AND PATIENTS* (do not input any commas)

Line No.		(1) Staff	(2) Patients
30	Arabic		
31	Armenian		
32	Cambodian		
33	Chinese		
34	Hindustani		
35	Hmong		
36	Japanese		
37	Korean		
38	Laotian		
39	Portuguese		
40	Punjabi		
41	Russian		
42	Sign Language		
43	Spanish		
44	Tagalog		
45	Vietnamese		

***Staff** - Indicate if one or more of your staff members speak a listed language. **Patients** - Indicate if 100 patients (or more than 1% of your patient populations) are best served in a listed language. Estimates are acceptable if exact counts are not available

LANGUAGE SUMMARY

Line No.		(1)
55	Percentage (%) of patient population best served in a non-English language (round to nearest WHOLE percent)	
56	From the languages listed above, enter the primary language (other than English) spoken by your patient population. (There will be a drop down box in ALIRTS.)	

CLINIC SERVICES

SECTION 2 (continued)

FTEs AND ENCOUNTERS BY PRIMARY CARE PROVIDER (do not input any commas)

Line No.	Primary Care Providers	(1) No. of Salaried FTEs*	(2) No. of Contract FTEs*	(3) No. of Volunteer FTEs*	(4) Total FTEs*	(5) No. of Encounters
60	Physicians					
61	Physician Assistants					
62	Family Nurse Practitioners					
63	Certified Nurse Midwives					
64	Visiting Nurses					
65	Dentists					
66	Registered Dental Hygienists (Alternative Practice)					
67	Psychiatrists					
68	Clinical Psychologists					
69	Licensed Clinical Social Workers (LCSW)					
70	Other Providers billable to Medi-Cal**					
74	Other Certified CPSP providers not listed above***					
75	Totals					

**Other Providers billable to Medi-Cal - Included here are Chiropractors, Physical Therapists, Optometrists and any other professionals who are able to be reimbursed through the Medi-Cal program.

*** Comprehensive Perinatal Services Program - List all other professionals not listed above that are certified by the CPSP program to render services and can be reimbursed.

FTEs AND CONTACTS BY CLINICAL SUPPORT STAFF (do not input any commas)

Line No.	Clinical Support Staff	(1) No. of Salaried FTEs*	(2) No. of Contract FTEs*	(3) No. of Volunteer FTEs*	(4) Total FTEs*	(5) No. of Contacts
80	Registered Dental Hygienists (not Alternative Practice)					
81	Registered Dental Assistants					
82	Dental Assistants - Not licensed					
83	Marriage and Family Therapists (MFT)					
84	Registered Nurses					
85	Licensed Vocational Nurses					
86	Medical Assistants - Not licensed (1)					
87	Non-Licensed Patient Education Staff					
88	Substance Abuse Counselors (2)					
89	Billing Staff (3)					
90	Other Administrative Staff (4)					
94	Other Providers not listed above					
95	Totals					

* Report FTEs to two decimal places, e.g., 2.25

(1) Also includes Certified Medical Assistants

(2) Does not include substance abuse counseling performed by providers listed elsewhere

(3) Staff must spend 80% of time on billing

(4) Includes Executive Directors, CFO's, Medical & Dental Records staff, Medical & Dental Receptionists & other management staff

PATIENT DEMOGRAPHICS

SECTION 3

(Do not input any commas for the following tables)

RACE

Line No.		(1) No. of Patients
1	White (include Hispanic)	
2	Black	
3	Native American / Alaskan Native	
4	Asian / Pacific Islander	
5	More than one race	
9	Other / Unknown	
10	Total Patients*	

FEDERAL POVERTY LEVEL

	(1) No. of Patients	Line No.
Under 100%		20
100 - 200%		21
Above 200%		22
Unknown		23
Total Patients*		24

ETHNICITY

Line No.		(1) No. of Patients
11	Hispanic	
12	Non-Hispanic	
13	Unknown	
15	Total Patients*	

AGE CATEGORY

	(1) Males	(2) Females	Line No.
Under 1 year			40
1 - 4 years			41
5 - 12 years			42
13 - 14 years			43
15 - 19 years			44
20 - 34 years			45
35 - 44 years			46
45 - 64 years			47
65 and over			48
Total Patients*			55

SEASONAL AGRICULTURAL AND MIGRATORY WORKERS

Line No.		(1) Number
30	Total Patients	
31	Total Encounters	

PATIENT COVERAGE

Line No.		(1) No. of Patients
60	Medicare	
61	Medicare - Managed Care	
62	Medi-Cal	
63	Medi-Cal - Managed Care	
64	County Indigent / CMSP / MISP	
65	Healthy Families	
66	Private Insurance	
67	Alameda Alliance for Health	
68	LA Co. Public Private Partnership	
69	PACE Program	
70	Self-Pay / Sliding Fee	
71	Free	
74	All Other Payers	
75	Total Patients*	

EPISODIC PROGRAMS

	(1) No. of Patients	Line No.
BCCCP		80
CHDP		81
EAPC		82
Family PACT		83
Other County Programs		84
Children's Treatment Program		85
Other Payer - covered by a grant		89
Total Episodic Patients (duplicated)		90

CHILD HEALTH AND DISABILITY PREVENTION (CHDP)

	(1) Number	Line No.
CHDP Assessments		95

* Totals for these tables must agree.

ENCOUNTERS BY PRINCIPAL DIAGNOSIS

SECTION 4

Report the diagnosis (or symptom, condition, problem or complaint) as the main reason for the encounter. Do not report the secondary diagnosis(es). There should be one (and only one) principal diagnosis for each encounter.

ENCOUNTERS BY PRINCIPAL DIAGNOSIS (do not input any commas)

Line No.	Classification of Diseases and/or Injuries for each Principal Diagnosis	ICD-9-CM Codes	(1) No. of Encounters	Line No.
1	Infectious and Parasitic Diseases	001 - 139		1
2	Neoplasms	140 - 239		2
3	Endocrine, Nutritional, and Metabolic Diseases, and Immunity Disorders	240 - 279		3
4	Blood and Blood Forming Disorders	280 - 289		4
5	Mental Disorders	290 - 319		5
6	Nervous System and Sense Organs Diseases	320 - 389		6
7	Circulatory System Diseases	390 - 459		7
8	Respiratory System Diseases	460 - 519		8
9	Digestive System Diseases, excluding dental diagnoses	530 - 579		9
10	Genitourinary System Diseases	580 - 629		10
11	Pregnancy, Childbirth & the Puerperium	630 - 679		11
12	Skin and Subcutaneous Tissue Diseases	680 - 709		12
13	Musculoskeletal System and Connective Tissue Diseases	710 - 739		13
14	Congenital Anomalies	740 - 759		14
15	Certain Conditions Originating in the Perinatal Period	760 - 779		15
16	Symptoms, Signs, and Ill-defined Conditions	780 - 799		16
17	Injury and Poisoning	800 - 999		17
18	Factors Influencing Health Status and Contact with Health Services	V01 - V89		18
19	Dental Diagnoses	520 - 529		19
20	Family Planning S-Codes			20
21	Other	All other codes not in lines 1-20		21
25	Total			25

ENCOUNTERS BY PRINCIPAL SERVICE

ANNUAL UTILIZATION REPORT OF PRIMARY CARE CLINICS 2009

SECTION 5

OSHPD FACILITY ID # _____

Classify each encounter by the principal CPT code that was reported on the billing document for this encounter. Do not report secondary procedures. There should be one and only one procedure code reported for each encounter.

ENCOUNTERS BY PRINCIPAL SERVICE (do not input any commas)

Line No.	Principal Service	CPT Codes - 2009	(1) No. of Encounters	Line No.
	Evaluation and Management Services			
1	Evaluation and Management (new patient)	99201 - 99205		1
2	Evaluation and Management (established patient)	99211 - 99215		2
3	Hospital Related Services	99217 - 99223 99231 - 99239, 99477		3
4	Consultations	99241 - 99255 99441 - 99444		4
5	Other Evaluation and Management Services	99291 - 99292 99354 - 99360, 99450, 99455 - 99456, 99499		5
6	Nursing Facility Related Services	99304 - 99318		6
7	Case Management Services	99363 - 99364, 99366 - 99368		7
8	Preventive Medicine (infant, child, adolescent)	99381 - 99384 99391 - 99394 99461		8
9	Preventive Medicine (adults)	99385 - 99387 99395 - 99397		9
10	Counseling	99401 - 99429 99605 - 99607		10
	All Other Services			
11	Anesthesia	00100 - 01999, 99100, 99116, 99135, 99140 99143 - 99150		11
12	Integumentary System	10021 - 19499		12
13	Musculoskeletal System	20000 - 29999		13
14	Respiratory System	30000 - 32999		14
15	Cardiovascular System	33010 - 37799		15
16	Hemic and Lymphatic System	38100 - 38999		16
17	Mediastinum and Diaphragm System	39000 - 39599		17
18	Digestive System	40490 - 49999		18
19	Urinary System	50010 - 53899		19
20	Male Genital System	54000 - 55920		20
21	Intersex Surgery	55970, 55980		21
22	Female Genital System	56405 - 58999		22
23	Maternity Care and Delivery	59000 - 59899		23
24	Endocrine System	60000 - 60699		24
25	Nervous System	61000 - 64999		25
26	Eye and Ocular Adnexa System	65091 - 68899		26
27	Auditory System	69000 - 69990		27
28	Radiology	70010 - 79999		28
29	Pathology / Laboratory	80047 - 89356		29
30	Medicine - Special Services	90281 - 99091 99170 - 99199		30
31	Family Planning "Z" codes	"Z" codes		31
32	Dental encounters (CDT codes)	D0100-D0999		32
33	CPT Category III Codes	0016T- 9999T		33
44	Other	All other codes not in lines 1-33		44
45	Total			45

SELECTED PROCEDURES
SECTION 5 (continued)

Report the number of procedures for each code (or range of codes) regardless of whether it is the principal or secondary procedure code.

SELECTED PROCEDURE CODES (do not input any commas)

Line No.	Selected Procedures	CPT Codes - 2009	(1) No. of Procedures	Line No.
50	Mammogram	77051 - 77059		50
51	HIV Testing	86689, 86701 - 86703 87390 - 87391		51
52	Pap Smear	88141 - 88155 88164 - 88167 88174 - 88175		52
53	Contraceptive Management	11975 - 11977, 55250, 55300,55400, 55450, 57170, 58300 - 58301, 58600, 58605, 58611, 58670 - 58671		53
60	Vaccinations: DTaP, DTP, Diphtheria and Tetanus	90389, 90696, 90698, 90700 - 90703, 90714, 90715, 90718 - 90723		60
61	Hemophilus Influenza B (Hib)	90371, 90645 - 90648		61
62	Hepatitis A	90632 - 90634, 90636		62
63	Hepatitis B	90740, 90743 - 90744, 90747		63
64	HepB and Hib	90748		64
65	Influenza Virus Vaccine	90655 - 90658, 90660 - 90663		65
66	Measles, Mumps, Rubella and Varicella (MMRV)	90704 - 90708, 90710		66
67	Pneumococcal	90669, 90732		67
68	Poliovirus	90712 - 90713		68
69	Varicella	90396, 90716		69

REVENUE AND UTILIZATION BY PAYER

SECTION 6

REVENUE AND UTILIZATION BY PAYMENT SOURCE (do not input any "\$" signs, commas or decimals, round up to whole dollar)

Line No.		PAYMENT SOURCE									Line No.
		(1) Medicare	(2) Medicare - Managed Care	(3) Medi-Cal	(4) Medi-Cal - Managed Care	(5) County Indigent / CMSP / MISP	(6) Healthy Families	(7) Private Insurance	(8) Self-Pay / Sliding Fee	(9) Free	
1	Encounters										1
2	Gross Revenue (Charges at 100% Rate)										2
3	Write-offs and Adjustments										
3	Sliding Fee Scale										3
4	Free/ Complimentary										4
5	Contractual Adjustments										5
6	Bad Debt										6
7	Grants (see Section 7)					()	()	()	()	()	7
8	Other Adjustments										8
9	Reconciliation										9
10	Total Write Offs & Adj. (sum lines 3-9)										10
15	Net Patient Revenue (collected) (line 2 - line 10)										15

REVENUE AND UTILIZATION BY PAYER

SECTION 6 (continued)

REVENUE AND UTILIZATION BY PAYMENT SOURCE (do not input any "\$" signs, commas or decimals, round up to whole dollar)

Line No.		PAYMENT SOURCE										Line No.
		(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	
		Breast Cancer Programs*	CHDP	EAPC	Family PACT	PACE Program**	LA Co. Public Private Partnership	Alameda Alliance for Health	Other County Programs	All Other Payers	Total	
1	Encounters											1
2	Gross Revenue (Charges at 100% Rate)											2
	Write-offs and Adjustments											
3	Sliding Fee Scale											3
4	Free/ Complimentary											4
5	Contractual Adjustments											5
6	Bad Debt											6
7	Grants (see Section 7)	()	()	()	()	()	()	()	()	()	()	7
8	Other Adjustments											8
9	Reconciliation											9
10	Total Write Offs & Adj. (sum lines 3-9)											10
15	Net Patient Revenue (collected) (line 2 - line 10)											15

*These include the following:
 Breast Cancer Early Detection Program
 Breast and Cervical Cancer Control Program

**Report number of patients on
 Line 1 for the PACE Program

INCOME STATEMENT
SECTION 7

ANNUAL UTILIZATION REPORT OF PRIMARY CARE CLINICS 2009

OSHPD FACILITY ID # _____

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

Line No.		(1) Total	Line No.
1	GROSS PATIENT REVENUE (from Sec 6, line 2, col. 19)		1
2	TOTAL WRITE-OFFS AND ADJUSTMENTS (from Sec 6, line 10, col. 19)		2
3	NET PATIENT REVENUE (from Sec 6, line 15, col. 19)		3
	OTHER OPERATING REVENUE:		
	Federal Funds		
4	Grants - all others (e.g. 330 funds)		4
400	Federal Stimulus Grants - American Recovery and Reinvestment Act (ARRA)		400
401	New Access Point (NAP)		401
402	Increased Demand for Services (IDS)		402
403	Capital Improvement project (CIP)		403
	State Funds		
5	EAPC		5
6	Other		6
	County Funds		
7	LA County Public Private Partnership		7
8			8
9			9
10	Other County Grant Programs		10
11	Local (City or District) Funds		11
12	Private		12
13	Donations / Contributions		13
19	Other		19
20	TOTAL OTHER OPERATING REVENUE (sum lines 4-19)		20
25	TOTAL OPERATING REVENUE (line 3 + line 20)		25
	OPERATING EXPENSES:		
30	Salaries, Wages and Employee Benefits		30
31	Contract Services - Professional		31
32	Supplies - Medical and Dental		32
33	Supplies - Office		33
34	Outside Patient Care Services		34
35	Rent / Depreciation / Mortgage Interest		35
36	Utilities		36
37	Professional Liability Insurance		37
38	Other Insurance		38
39	Continuing Education		39
40	Health Information Technology (including ERH)		40
44	All Other Expenses		44
45	TOTAL OPERATING EXPENSES (sum lines 30-44)		45
50	NET FROM OPERATIONS (line 25 - line 45)		50

MAJOR CAPITAL EXPENDITURES

SECTION 8

Section 127285 (3) of the Health and Safety Code requires each clinic 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 ACQUIRED DURING THE REPORT PERIOD

Line No.		(1)
1	Did your clinic 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"/>

EQUIPMENT DETAIL

Line No.	(1) Description of Equipment	(2) Value	(3) Date of Acquisition (MM/DD/YYYY)	(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 clinic to report the "commencement of projects during the reporting period that require a capital expenditure for the clinic in excess of one million dollars (\$1,000,000)."

Line No.		(1)
25	Did your clinic 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			

MAJOR CAPITAL EXPENDITURES

SECTION 8 (continued)

CAPITAL FUND

Line No.		(1)
40	Beginning Fund Balance	
41	Current Year Contributions	
42	Current Year Interest Earnings	
43	Current Year Expenditures	()
44	Ending Fund Balance (line 40+line 41+line 42-line 43)	