ANNUAL UTILIZATION REPORT OF PRIMARY CARE CLINICS – 2018

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 E-mail Address:
9. Was this clinic in operation at any time during the year? Yes ☐ No ☐	Dates of Operation (MM/DD/YYYY) 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, 2019 may result in suspension of the clinic's license.

Office of Statewide Health Planning and Development
Information Services Division
Accounting and Reporting Systems Section
Licensed Services Data and Compliance Unit
2020 West El Camino Avenue, Suite 1100
Sacramento, CA 95833

Phone: (916) 326-3854
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Report Page 2

OSHPD FACILITY ID No. ___________________

LICENSE CATEGORY (Completed by OSHPD)

Line No.	License Category	(1)
1	Community	
	Free	

FEDERALLY QUALIFIED HEALTH CLINIC (FQHC)

Line No.	Federally Qualified Health Clinics	(1)
2	Indicate clinic type, if applicable:	FQHC ☐ FQHC Look-Alike ☐ Neither ☐

RURAL HEALTH CLINIC

Line No.	Rural Health Clinic	(1)
3	Is this a 95-210 Rural Health Clinic?	Yes ☐ No ☐

COMMUNITY SERVICES (Check one or more boxes for each service provided.)

Line No.		Offered (1)
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	☐

HEALTH SERVICES (Check one or more boxes for each service provided.)

Line No.		Offered (1)
30	Medical	☐
31	Dental	☐
32	Vision	☐
33	Mental Health (Psychology / Psychiatry / Behavioral Health)	☐
34	Substance Abuse (Alcohol / Drug Services)	☐
35	Domestic Violence	☐
36	Basic Lab	☐
37	Radiological Services	☐
38	Urgent Care	☐
39	Pharmacy	☐
40	Women’s Health (Ob-Gyn / Family Planning / Midwives)	☐

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OSHPD FACILITY ID No. ___________________

LANGUAGES SPOKEN BY STAFF AND PATIENTS*

Line No.		Staff (1)	Patients (2)
50	Arabic		
51	Armenian		
52	Cambodian		
53	Chinese		
54	Hindustani		
55	Hmong		
56	Japanese		
57	Korean		
58	Laotian		
59	Portuguese		
60	Punjabi		
61	Russian		
62	Sign Language		
63	Spanish		
64	Tagalog		
65	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)
70	Percentage (%) of patient population best served in a non-English language (round to nearest whole percent).	
71	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 SIERA Utilization.)	

Report Page 2 (continued) OSHPD FACILITY ID No. ___________________

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

Line No.	Primary Care Providers	No. of Salaried FTEs* (1)	No. of Contract FTEs* (2)	No. of Volunteer FTEs* (3)	Total FTEs* (4)	No. of Encounters (5)
75	Physicians					
76	Physician Assistants					
77	Family Nurse Practitioners					
78	Certified Nurse Midwives					
79	Visiting Nurses					
80	Dentists					
81	Registered Dental Hygienists (Alternative Practice)					
82	Psychiatrists					
83	Clinical Psychologists					
84	Licensed Clinical Social Workers (LCSW)					
85	Other Providers Billable to Medi-Cal**					
86	Other Certified CPSP Providers Not Listed Above***					
87	Total					

* Report FTEs to two decimal places, e.g. 2.25. If less than 1, include leading zero, e.g. 0.25 instead of .25.

** 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	No. of Salaried FTEs* (1)	No. of Contract FTEs* (2)	No. of Volunteer FTEs* (3)	Total FTEs* (4)	No. of Contacts (5)
90	Registered Dental Hygienists (Not Alternative Practice)					
91	Registered Dental Assistants					
92	Dental Assistants – Not Licensed					
93	Marriage and Family Therapists (MFT)					
94	Registered Nurses					
95	Licensed Vocational Nurses					
96	Medical Assistants – Not Licensed (1)					
97	Non-Licensed Patient Education Staff					
98	Substance Abuse Counselors (2)					
99	Billing Staff (3)					
100	Other Administrative Staff (4)					
101	Other Providers Not Listed Above					
102	Total					

* Report FTEs to two decimal places, e.g. 2.25. If less than 1, include leading zero, e.g. 0.25 instead of .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, CFOs, Medical and Dental Records staff, Medical and Dental Receptionists, and other management staff.

PATIENT DEMOGRAPHICS

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OSHPD FACILITY ID No. ___________________

Do not input any commas for the following tables.

RACE

Line No.	Race	No. of Patients (1)
1	White (include Hispanic)	
2	Black	
3	Native American / Alaskan Native	
4	Asian / Pacific Islander	
5	More Than One Race	
6	Other / Unknown	
7	Total Patients*	

FEDERAL POVERTY LEVEL

Line No.	Federal Poverty Level	No. of Patients (1)
20	Under 100%	
21	100 – 138%	
22	139 – 200%	
23	201 – 400%	
24	Above 400%	
25	Unknown	
26	Total Patients*	

ETHNICITY

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

AGE CATEGORY

Line No.	Age Category	Males (1)	Females (2)
30	Under 1 Year		
31	1 – 4 Years		
32	5 – 12 Years		
33	13 – 14 Years		
34	15 – 19 Years		
35	20 – 34 Years		
36	35 – 44 Years		
37	45 – 64 Years		
38	65 and Over		
39	Total Patients*		

SEASONAL AGRICULTURAL AND MIGRATORY WORKERS

Line No.		Number (1)
75	Total Patients	
76	Total Encounters	

PATIENT COVERAGE

Line No.	Patient Coverage	No. of Patients (1)
45	Medicare	
46	Medicare – Managed Care	
47	Medi-Cal	
48	Medi-Cal – Managed Care	
49	County Indigent / CMSP / MISP	
50	Private Insurance	
51	Covered California	
52	Alameda Alliance for Health	
53	My Health LA (MHLA)	
54	PACE Program	
55	Self-Pay / Sliding Fee	
56	Free	
57	All Other Payers	
58	Total Patients*	

* Totals for these tables must agre

EPISODIC PROGRAMS

Line No.	Episodic Programs	No. of Patients (1)
60	BCCCP	
61	CHDP	
62	Family PACT	
63	Other County Programs	
64	Children's Treatment Program	
65	Other Payer – Covered by Grant	
66	Total Episodic Patients (Duplicated)	

CHILD HEALTH AND DISABILITY PREVENTION (CHDP)

Line No.		Number (1)
70	CHDP Assessments	

OSHPD FACILITY ID No. ___________________

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 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-10-CM Codes	No. of Encounters (1)
1	Infectious and Parasitic Diseases	A00 - B99	
2	Neoplasms	C00 - D49	
3	Endocrine, Nutritional, and Metabolic Diseases; and Immunity Disorders	E00 - E89	
4	Blood and Blood Forming Disorders	D50 - D89	
5	Mental, Behavioral, and Neurodevelopment Disorders	F01 - F99	
6	Nervous System and Sense Organs Diseases	G00 - H95	
7	Circulatory System Diseases	I00 - I99	
8	Respiratory System Diseases	J00 - J99	
9	Digestive System Diseases, excluding dental diagnoses	K20 - K95	
10	Genitourinary System Diseases	N00 - N99	
11	Pregnancy, Childbirth & the Puerperium	O00 - O9A	
12	Skin and Subcutaneous Tissue Diseases	L00 - L99	
13	Musculoskeletal System and Connective Tissue Diseases	M00 - M99	
14	Congenital Anomalies	Q00 - Q99	
15	Certain Conditions Originating in the Perinatal Period	P00 - P96	
16	Symptoms, Signs, and Ill-defined Conditions	R00 - R99	
17	Injury and Poisoning	S00 - T88	
18	Factors Influencing Health Status and Contact with Health Services	Z00 - Z29, Z40 - Z99	
19	Dental Diagnosis	K00 - K14	
20	Family Planning "Z" Codes	Z30 - Z39	
21	Other	All other codes not in lines 1-20	
22	Total		

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OSHPD FACILITY ID No. ________________

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	No. of Encounters (1)
	EVALUATION AND MANAGEMENT SERVICES		
1	Evaluation and Management (new patient)	99201 - 99205	
2	Evaluation and Management (established patient)	99211 - 99215	
3	Hospital Related Services	99217 - 99226, 99231 - 99239	
4	Consultations	99241 - 99245, 99444, 99451 - 99453	
5	Other Evaluation and Management Services	99291 - 99292, 99354 - 99360, 99415 - 99416, 99450, 99455 - 99456, 99499	
6	Nursing Facility Related Services	99304 - 99318	
7	Case Management Services	99366 - 99368	
8	Preventive Medicine (infant, child, adolescent)	99381 - 99384, 99391 - 99394, 99460 - 99463	
9	Preventive Medicine (adult)	99385 - 99387, 99395 - 99397, 99429	
10	Counseling	99401 - 99404, 99406 - 99409, 99411 - 99412	
	ALL OTHER SERVICES		
11	Anesthesia	00100 - 01999, 99100, 99116, 99135, 99140, 99151 - 99157	
12	Integumentary System	10004 - 19499	
13	Musculoskeletal System	20005 - 29999	
14	Respiratory System	30000 - 32999	
15	Cardiovascular System	33010 - 37799	
16	Hemic and Lymphatic System	38100 - 38999	
17	Mediastinum and Diaphragm System	39000 - 39599	
18	Digestive System	40490 - 49999	
19	Urinary System	50010 - 53899	
20	Male Genital System	54000 - 55899	
21	Intersex Surgery	55970, 55980	
22	Female Genital System	56405 - 58999	
23	Maternal Care and Delivery	59000 - 59899	
24	Endocrine System	60000 - 60699	
25	Nervous System	61000 - 64999	
26	Eye and Ocular Adnexa System	65091 - 68899	
27	Auditory System	69000 - 69979	
28	Radiology	70010 - 79999	
29	Pathology / Laboratory	80047 - 89356, 89398	
30	Medicine - Special Services	90281 - 99091, 99170 - 99199	
31	Family Planning "Z" Codes	"Z" codes	
32	Dental Encounters (CDT codes)	D0100 - D0999	
33	CPT Category III Codes	0042T - 0542T	
34	Other	All other codes not in lines 1-33	
35	Total		

Report Page 5 (continued)

OSHPD FACILITY ID No. ________________

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	No. of Procedures (1)
40	Mammogram	77053 - 77067	
45	HIV Testing	86689, 86701 - 86703, 87389 - 87391	
50	Pap Smear	88150 - 88153, 88164 - 88167, 88174 - 88175	
51	Contraceptive Management	11976, 11980, 55250, 55300, 55400, 57170, 58300 - 58301, 58600, 58605, 58611, 58615	
	VACCINATIONS		
52	DTap, DTP, Diphtheria and Tetanus	90389, 90696, 90702, 90714 - 90715, 90723	
53	Hemophilus Influenza B (Hib)	90644, 90647 - 90648	
60	Hepatitis A	90632 - 90634, 90636	
61	Hepatitis B	90739 - 90740, 90743 - 90744, 90746 - 90747	
62	HepB and Hib	90748	
63	Influenza Virus Vaccine	90630, 90653, 90662, 90664, 90666 - 90668, 90672 - 90673, 90682, 90685 - 90688, 90756	
64	Measles, Mumps and Rubella (MMR) and Varicella (MMRV)	90707, 90710, 90716	
65	Pneumococcal	90670, 90732	
66	Poliovirus	90713	
67	Varicella	90396, 90716	

REVENUE AND UTILIZATION BY PAYER

Report Page 6

OSHPD FACILITY ID No. ________

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

		PAYMENT SOURCE								
Line No.		Medicare (1)	Medicare – Managed Care (2)	Medi-Cal (3)	Medi-Cal – Managed Care (4)	County Indigent / CMSP / MISP* (5)	Private Insurance (6)	Covered California (7)	Self-Pay / Sliding Fee (8)	Free (9)
1	Encounters									
2	Gross Revenue (Charges at 100% Rate)									
	WRITE-OFFS AND ADJUSTMENTS									
3	Sliding Fee Scale									
4	Free / Complimentary									
5	Contractual Adjustments									
6	Bad Debt									
7	Grants (see Report Page 7)									
8	Other Adjustments									
9	Reconciliation									
10	Total Write-Offs and Adjustments (sum lines 3-9)									
11	Net Patient Revenue (Collected) (line 2 minus line 10)									

* Include LIHP encounters under County Indigent / CMSP / MISP.

Report Page 6 (continued)

OSHPD FACILITY ID No. ________

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

		PAYMENT SOURCE								
Line No.		Breast Cancer Programs* (10)	CHDP (11)	Family PACT (12)	PACE Program** (13)	My Health LA (MHLA) (14)	Alameda Alliance for Health (15)	Other County Programs (16)	All Other Payers (17)	**Total (18)**
1	Encounters									
2	Gross Revenue (Charges at 100% Rate)									
	WRITE-OFFS AND ADJUSTMENTS									
3	Sliding Fee Scale									
4	Free / Complimentary									
5	Contractual Adjustments									
6	Bad Debt									
7	Grants (see Report Page 7)									
8	Other Adjustments									
9	Reconciliation									
10	Total Write-offs and Adjustments (sum lines 3-9)									
11	Net Patient Revenue (collected) (line 2 minus line 10)									

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

** Report number of patients on line 1 for the PACE Program.

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OSHPD FACILITY ID No. ____________

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

Line No.		Total (1)
1	Gross Patient Revenue (from Report Page 6, line 2, column 18)	
2	Total Write-Offs and Adjustments (from Report Page 6, line 10, column 18)	
3	Net Patient Revenue (from Report Page 6, line 11, column 18)	
	OTHER OPERATING REVENUE	
	Federal Funds	
5	Grants – All Others (e.g. 330 Funds)	
	Federal Stimulus Grants – American Recovery and Reimbursement Act (ARRA)	
10	New Access Point (NAP)	
11	Increased Demand for Services (IDS)	
12	Capital Improvement Project (CIP)	
	State Funds	
15	Other	
	County Funds	
20	Other County Grant Programs	
21	Local (City or District) Funds	
22	Private	
23	Donations / Contributions	
24	Other	
25	Total Other Operating Revenue (sum lines 5-24)	
30	Total Operating Revenue (line 3 plus line 25)	
	OPERATING EXPENSES	
31	Salaries, Wages, and Employee Benefits	
32	Contract Services – Professional	
33	Supplies – Medical and Dental	
34	Supplies – Office	
35	Outside Patient Care Services	
36	Rent / Depreciation / Mortgage Interest	
37	Utilities	
38	Professional Liability Insurance	
39	Other Insurance	
40	Continuing Education	
41	Information Technology (including EHR)	
42	All Other Expenses	
43	Total Operating Expenses (sum lines 31-42)	
44	Net from Operations (line 30 minus line 43)	

MAJOR CAPITAL EXPENDITURES

Report Page 8

OSHPD FACILITY ID No. ________________

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 2-11, as necessary, below.)	Yes ☐ No ☐

DIAGNOSTIC AND THERAPEUTIC EQUIPMENT DETAIL

Line No.	Description of Equipment (1)	Value (2)	Date of Acquisition (MM/DD/YYYY) (3)	Means of Acquisition (Check one) (4)
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 ☐

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 facility or clinic in excess of one million dollars ($1,000,000)."

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

Line No.		(1)
15	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 20-24, as necessary, below.)	Yes ☐ No ☐

DETAIL OF CAPITAL EXPENDITURES

Line No.	Description of Project (1)	Projected Total Capital Expenditure (2)	OSHPD Project No. (if applicable) (3)
20			
21			
22			
23			
24			

Report Page 8 (continued)

OSHPD FACILITY ID No. ________________

CAPITAL FUND

Line No.	Capital Fund	(1)
30	Beginning Fund Balance	
31	Current Year Contributions	
32	Current Year Interest Earnings	
33	Current Year Expenditures	
34	Ending Fund Balance (sum lines 30-32, minus line 33)	