OMB No. 0920-0212; Expiration date XX/XX/20XX

|  |
| --- |
| **Assurance of confidentiality –** All information which would permit identification of an individual, a practice, or an establishment will be held confidential; will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls; and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).  **Notice –** Public reporting burden for this collection of information is estimated to average 120 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a current valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to: CDC/ATSDR Information Collection Review Office, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0212). |

**Part 1. Hospital Utilization Statistics**

1. What is the number of currently staffed inpatient beds in this hospital, not including “newborn” bassinets?

a) Total staffed inpatient beds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b) If you submit data combined with other hospital(s), what is the number of currently staffed inpatient beds, not including “newborn” bassinets, for all the hospitals that report together?

Combined total staffed inpatient beds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. What was the average length of stay (in days) for inpatients in this hospital in **calendar year 2014**?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part 2. General Questions**

3. What is the primary service type of this hospital?

* General acute care
* Specialty acute care hospital (e.g., surgical, maternity, cancer, heart, ENT, orthopedic, etc…)
* Children’s hospital (including general, orthopedic, ENT, cancer, heart, and other acute care)
* Psychiatric hospital (including children’s psychiatric and alcohol/chemical dependency)
* Long term acute care (including adult and children’s rehabilitation, chronic disease, TB)

4. Was this hospital open for the full calendar year 2014?

* Yes
* No 🡪Please provide the dates the hospital was open for inpatient service in 2014: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Never open in 2014

5. In the past year, has this hospital merged with or separated from another hospital?

* Merger 🡪 *Please continue with item 5a below.*
* Separation🡪 *Please continue with item 5a below.*
* Neither🡪 *Please proceed to item 7.*

5a. Please provide the name(s) and address(es) of the other hospital(s) involved:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. What is the primary service type(s) of the other hospital(s) involved? Check all that apply.

* General acute care
* Specialty hospital (e.g. surgical, maternity, cancer, heart, ENT, orthopedic, etc…)
* Children’s hospital (including general, orthopedic, ENT, cancer, heart, and other acute care)
* Psychiatric hospital (including children’s psychiatric and alcohol/chemical dependency)
* Long term acute care (including adult and children’s rehabilitation, chronic disease, TB)

7. In calendar year 2014, did your facility have any significant changes to the total number of inpatient beds?

* Yes 🡪 *Please explain***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* No

8. Do you anticipate any significant changes in your discharge volume in the coming year (for example, opening a cardiac wing or closing a birthing center)?

* Yes 🡪 *Please explain***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* No

**Part 3. Data Reporting**

9. When this hospital reports data to the State or to the hospital association, is the information solely for this hospital or are other hospital(s) included in the data submission?

* Solely for this hospital
* Combined with other hospital(s) 🡪 *Please provide the name(s) of the other hospital(s)*:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Do the data you provide to us include records from your hospital only?

* Yes 🡪 *Please proceed to item 11 below.*
* No 🡪 *Please continue with item 10a below.*
* Don’t know

10a. Is it possible to identify the records from your hospital separate from the other hospital(s) that report with you?

 Yes  No  Don’t know

11. Do the **inpatient data** you send to us include records for **all** discharges (including those paying with public or private insurance as well as self-pay, charity, workmen’s compensation, and court or law enforcement)?

 Yes  No (*skip to 11b*)

11a. If yes, how many (or approximately what percent) of the records you sent us for the calendar year 2014 were paid with public or private insurance (excluding workmen’s compensation)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11b. If no, then approximately what number or percent of total records **(including those for records not submitted**) for the calendar year 2014 were for other forms of payment (self-pay, charity, workmen’s compensation, and/or court or law enforcement)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Do the **ambulatory data** you send to us include records for **all** visits (including those paying with public or private insurance as well as self-pay, charity, workmen’s compensation, and court or law enforcement)?

 Yes  No (*skip to 12b*)

12a. If yes, how many (or approximately what percent) of the records you sent us for the calendar year 2014 were paid with public or private insurance (excluding workmen’s compensation)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12b. If no, then approximately what number or percent of total claims **(including those for records not submitted**) for the calendar year 2014 were for other forms of payment (self-pay, charity, workmen’s compensation, and/or court or law enforcement)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Please provide the counts or estimates for **ED visits** by quarter **or** year for calendar year 2014 for the following categories.

If you cannot separate **ED visits** from all Outpatient visits, please check here. 

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Number of ED VISITS for:** | **Annual** | **Quarter 1** | **Quarter 2** | **Quarter 3** | **Quarter 4** |
| **All** visits made to ED |  |  |  |  |  |
| **Insured** patients (public and private, exclude workmen’s compensation) |  |  |  |  |  |
| **All other forms of payment** (self-pay, charity, court/law enforcement) |  |  |  |  |  |

14. Please provide the counts or estimates for **OPD visits** by quarter **or** year for calendar year 2014 for the following categories.

If you cannot separate **OPD visits** from all Outpatient visits, please check here. 

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Number of OPD VISITS for:** | **Annual** | **Quarter 1** | **Quarter 2** | **Quarter 3** | **Quarter 4** |
| **All** visits made to OPD |  |  |  |  |  |
| **Insured** patients (public and private, exclude workmen’s compensation) |  |  |  |  |  |
| **All other forms of payment** (self-pay, charity, court/law enforcement) |  |  |  |  |  |

15. In calendar year 2014, does your hospital have a birthing unit or offer obstetric services for females with deliveries?

 Yes  No

15a. Please provide the total number of **inpatient discharges** (including live births) **or** the **total number of admissions** (and live births) by month **or** annually for calendar year 2014.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Total number of inpatient discharges**  (including live births) |  | **Total number of admissions** |  | **Total Number of Live births** |
| Annual |  | **OR** |  | **AND** |  |
|  | | | | | |
| January |  | **OR** |  | **AND** |  |
| February |  | **OR** |  | **AND** |  |
| March |  | **OR** |  | **AND** |  |
| April |  | **OR** |  | **AND** |  |
| May |  | **OR** |  | **AND** |  |
| June |  | **OR** |  | **AND** |  |
| July |  | **OR** |  | **AND** |  |
| August |  | **OR** |  | **AND** |  |
| September |  | **OR** |  | **AND** |  |
| October |  | **OR** |  | **AND** |  |
| November |  | **OR** |  | **AND** |  |
| December |  | **OR** |  | **AND** |  |