



Department of Health
REGIONAL OFFICE III

ANNEX – E
A.O. No. 2012-0012

ANNUAL HOSPITAL STATISTICAL REPORT
YEAR _____

Name of Hospital: _____ Street Address: _____

Municipality: _____ Province _____ Region: _____

Contact No.: _____ Fax Number: _____

Email Address: _____

(PLEASE FILL OUT ALL ITEMS. PUT N/A IF NOT APPLICABLE.)

I. GENERAL INFORMATION

A. Classification

1. Service Capability

- Service capability: Capability of a hospital/other health facility to render administrative, clinical, ancillary and other services

General:

- Level 1 Hospital
- Level 2 Hospital
- Level 3 Hospital (Teaching/ Training)

Specialty: (Specify)

- Treats a particular disease (Specify): _____
- Treats a particular organ (Specify): _____
- Treats a particular class of patients (Specify): _____
- Others (Specify): _____

Trauma Capability: Trauma Capable Trauma Receiving

2. Nature of Ownership

Government:

- National –DOH Retained/ Renationalized
- Local (Specify):
 - Province
 - City
 - District
 - Municipality
- DND/ DOJ
- State Universities and Colleges (SUCs)
- Others (Specify): _____

Private:

- Single Proprietorship/Partnership/Corp.
- Religious
- Civic Organization
- Foundation
- Others (Specify): _____



Department of Health REGIONAL OFFICE III

ANNEX – E
A.O. No. 2012-0012

B. Quality Management

- Quality Management/ Quality Assurance Program: Organized set of activities designed to demonstrate on-going assessment of important aspects of patient care and services

[] ISO Certified (Specify ISO Certifying Body and area(s) of the hospital with Certification) Validity Period _____

[] International Accreditation Validity Period _____

[] PhilHealth Accreditation Validity Period _____

[] **Basic Participation**

[] **Advanced Participation**

[] PCAHO Validity Period _____

C. Bed Capacity/Occupancy

1. **Authorized Bed Capacity:** _____ beds

- Authorized bed: Approved number of beds issued by BHFS, the licensing agency of DOH.

2. **Implementing Beds:** _____ beds

- Implementing beds: Actual beds used (based on hospital management decision)

3. **Bed Occupancy Rate (BOR) Based on Authorized Beds:** _____%

(Total Inpatient service days for the period)**

(Total number of Authorized beds) x (Total days in the period) X 100

- Bed Occupancy Rate: The percentage of inpatient beds occupied over a period of time. It is a measure of the intensity of hospital resources utilized by in-patients.
- Inpatient Service days: Unit of measure denoting the services received by one in-patient in one 24 hour period.
- **Inpatient Service days (Bed days) = [(Inpatients remaining at midnight + Total admissions) – Total discharges/deaths) + (number of admissions and discharges on the same day)].

II. HOSPITAL OPERATIONS

A. Summary of Patients in the Hospital

For each category listed below, please report the total volume of services or procedures performed.

*Inpatient: A patient who stays in a health facility while under treatment.

*Bed day: Bed used for a continuous 24 hours by an inpatient.



**Department of Health
REGIONAL OFFICE III**

**ANNEX – E
A.O. No. 2012-0012**

Inpatient Care	Number
Total number of inpatients (admissions, including newborns)	
Total Discharges (Alive)	
Total patients admitted and discharged on the same day	
Total number of inpatient bed days (service days)	
Total number of inpatients transferred TO THIS FACILITY from another facility for inpatient care	
Total number of inpatients transferred FROM THIS FACILITY to another facility for inpatient care	
Total number of patients remaining in the hospital as of midnight last day of previous year	

B. Discharges

Kindly accomplish the “Type of Service and Total Discharges According to Specialty” in the table below.

Type of Service	No of Pts	Total Length of Stay/ Total No. of Days Stay	Type of Accomodation						Condition on Discharge											
			Non- Philhealth			Philhealth			H M O	O W A	R / I	T	H	A	U	Deaths			Total Dis- charges	
			Pay	Service Charity	Total	Pay	Service									Total	< 48 hrs	≥ 48 hrs		Total
							Member/ Dependent	Indi- gent												
Medicine																				
Obstetrics																				
Gynecology																				
Pediatrics																				
Surgery:																				
Pedia																				
Adult																				
Others, Specify																				
TOTAL																				
Total Newborn																				
-Pathologic																				
-Non-Patho																				

* R/I – Recovered/Improved T- Transferred U - Unimproved
 H- Home Against Medical Advice A – Absconded D – Died (died upon admission)



**Department of Health
REGIONAL OFFICE III**

**ANNEX – E
A.O. No. 2012-0012**

1. Average Length of Stay (ALOS) of Admitted Patients

Total length of stay of discharged patients (including Deaths) in the period = _____

Total discharges and deaths in the period

- Average length of stay: Average number of days each inpatient stays in the hospital for each episode of care.

2. Ten Leading causes of Morbidity based on final discharge diagnosis

For each category listed below, please report the total number of cases for the top 10 illnesses/injury.

Cause of Morbidity/Illness/Injury	Number	ICD-10 Code (Individual)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		



**Department of Health
REGIONAL OFFICE III**

**ANNEX – E
A.O. No. 2012-0012**

Kindly accomplish the “Ten Leading Causes of Morbidity/Diseases Disaggregated as to Age and Sex” in the table below.

Cause of Morbidity (Underlying)	Age Distribution of Patients																												Total	ICD-10 CODE/ TABULAR LIST							
	Under 1		1 – 4		5 – 9		10 -14		15 –19		20 – 24		25-29		30-34		35-39		40-44		45-49		50-54		55-59		60-64				65-69		70 & over		Subtotal		
Spell out. Do not abbreviate.	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
1.																																					
2.																																					
3.																																					
4.																																					
5.																																					
6.																																					
7.																																					
8.																																					
9.																																					
10.																																					



**Department of Health
REGIONAL OFFICE III**

**ANNEX – E
A.O. No. 2012-0012**

3. Total Number of Deliveries

For each category of delivery listed below, please report the total number of deliveries.

Deliveries	Number	ICD-10 Code
Total number of in-facility deliveries		
Total number of live-birth vaginal deliveries (normal)		
Total number of live-birth C-section deliveries (Caesarians)		
Total number of other deliveries		

4. Outpatient Visits, including Emergency Care, Testing and Other Services

For each category of visit of service listed below, please report the total number of patients receiving the care.

Outpatient visits	Number
Number of outpatient visits, new patient	
Number of outpatient visits, re-visit	
Number of outpatient visits, adult	
Number of outpatient visits, pediatric	
Number of adult general medicine outpatient visits	
Number of specialty (non-surgical) outpatient visits	
Number of surgical outpatient visits	
Number of antenatal care visits	
Number of postnatal care visits	



**Department of Health
REGIONAL OFFICE III**

**ANNEX – E
A.O. No. 2012-0012**

Emergency visits	Number
Total number of emergency department visits	
Total number of emergency department visits, adult	
Total number of emergency department visits, pediatric	
Total number of patients transported FROM THIS FACILITY'S EMERGENCY DEPARTMENT to another facility for inpatient care	
Testing	Number
Total number of medical imaging tests (all types including x-rays, ultrasound, CT scans, etc.)	
Total number of laboratory and diagnostic tests (all types, excluding medical imaging)	
Other services and diseases seen	Number
Total number of outreach or home visits	
Total number of immunization doses administered to children 0-59 months at this facility or during outreach or home visits. Include immunizations administered during child health weeks.	
Total number of newly diagnosed cases of TB	
Total number of confirmed cases of dengue	

C. Deaths

For each category of death listed below, please report the total number of deaths.

Types of deaths	Number
Total deaths	
Total number of inpatient deaths	
<ul style="list-style-type: none"> ▪ Total deaths < 48 hours 	
<ul style="list-style-type: none"> ▪ Total deaths ≥ 48 hours 	



Department of Health REGIONAL OFFICE III

ANNEX – E
A.O. No. 2012-0012

Total number of emergency room deaths	
Total number of cases declared ‘dead on arrival’	
Total number of stillbirths	
Total number of neonatal deaths	
Total number of maternal deaths	

1. Gross Death Rate _____%

$$\text{Gross Death Rate} = \frac{\text{Total Deaths (including newborn for a given period)}}{\text{Total Discharges and Deaths for the same period}} \times 100$$

2. Net Death Rate _____%

$$\text{Net Death Rate} = \frac{\text{Total Death (including newborn for a given period) – death <48 hours for the period}}{\text{Total Discharges (including deaths and newborn) – death <48 hours for the period}} \times 100$$

3. Ten Leading Causes of Mortality/Deaths and Total Number of Mortality/Deaths.

Mortality/Deaths	Number	ICD-10 Code (Individual)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		



**Department of Health
REGIONAL OFFICE III**

**ANNEX – E
A.O. No. 2012-0012**

Kindly accomplish the “Ten Leading Causes of Mortality/Deaths Disaggregated as to Age and Sex” in the table below.

Cause of Death (Underlying)	Age Distribution of Patients																												Total	ICD-10 CODE/ TABULAR LIST								
	Under 1		1 – 4		5 – 9		10 -14		15 –19		20 – 24		25-29		30-34		35-39		40-44		45-49		50-54		55-59		60-64				65-69		70 & over		Subtotal			
Spell out. Do not abbreviate.	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F				
1.																																						
2.																																						
3.																																						
4.																																						
5.																																						
6.																																						
7.																																						
8.																																						
9.																																						
10.																																						



**Department of Health
REGIONAL OFFICE III**

ANNEX – E
A.O. No. 2012-0012

D. Healthcare Associated Infections (HAI)

HAI are infections that patients acquire as a result of healthcare interventions. For purposes of Licensing, the four (4) major HAI would suffice.

For All Hospitals (Levels 1, 2, 3 General and Specialty)

$$\text{INFECTION RATE} = \frac{\text{Number of Healthcare Associated Infections}}{\text{Number of Discharges}} \times 100$$

a. Device Related Infections

1. Ventilator Acquired Pneumonia (VAP) = $\frac{\text{Number of Patients with VAP}}{\text{Total Number of Ventilator Days}} \times 1000$

2. Blood Stream Infection (BSI) = $\frac{\text{Number of Patients with BSI}}{\text{Total Number of Central Line}} \times 1000$

3. Urinary Tract Infection (UTI) = $\frac{\text{Number of Patients with UTI}}{\text{Total Number of Catheter Days}} \times 1000$

b. Non-Device Related Infections

Surgical Site Infections (SSI) = $\frac{\text{Number of Surgical Site Infections}}{\text{Total number of Procedures}} \times 100$

E. Surgical Operations

- Major Operation refers to surgical procedures requiring anesthesia/ spinal anesthesia to be performed in an operating theatre. (The definition of a major operation shall be based on the definitions of the different cutting specialties.)
- Minor Operation refers to surgical procedures requiring only local anesthesia/ no OR needed, example suturing.

10 Leading Major Operations (excluding Caesarian Sections)	Number	ICD-10 Code
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		



**Department of Health
REGIONAL OFFICE III**

ANNEX – E
A.O. No. 2012-0012

10 Leading Minor Operations	Number	ICD-10 Code
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

III. STAFFING PATTERN (Total Staff Complement)

Profession/ Position/ Designation	Total staff working full time (at least 40 hours/week)			Total staff working part time (at least 20 hours/week)			Active Rotating or Visiting/ Affiliate (For Private Facilities)	Out- sourced
	Number of permanent staff	Number of contractual staff	Number of volunteer staff	Number of permanent staff	Number of contractual staff	Number of volunteer staff		
A. Medical								
1. Consultants (indicate One-Peso consultant)								
1.1. Internal Medicine								
a. Generalist								
b. Cardiologist								
c. Endocrinologist								
d. Gastro- Enterologist								
e. Pulmonologist								
f. Nephrologist								
g. Neurologist								
h. Others (Specify)								
1.2. Obstetrics/ Gynecology (and subspecialty)								
1.3. Pediatrics (and subspecialty)								
1.4. Surgery (and subspecialty)								
1.5. Anesthesiologist								



Department of Health
REGIONAL OFFICE III

ANNEX – E
A.O. No. 2012-0012

1.6. Radiologist									
1.7. Pathologist									
2. Post-Graduate Fellows									
(Indicate specialty/ subspecialty)									
3. Residents									
3.1. Internal Medicine									
3.2. Obstetrics- Gynecology									
3.3. Pediatrics									
3.4. Surgery									
3.5. Others (Specify)									
B. Allied Medical									
1. Nurses									
2. Midwives									
3. Nursing Aides									
4. Nutritionist									
5. Physical Therapist									
6. Pharmacists									
7. Medical Technologist									
8. Others (Specify)									
C. Non-Medical									
1. Social Workers									
2. Medical Records Officer/ Hospital Health Information Officer with formal training in medical records management									
3. Laboratory Technicians									
4. X-Ray Technicians									
5. Administrative Officer									
6. Accounting/ Finance Officer									



**Department of Health
REGIONAL OFFICE III**

**ANNEX – E
A.O. No. 2012-0012**

7. General Support Staff (maintenance, janitorial, secretarial) – indicate if outsourced								
--	--	--	--	--	--	--	--	--

IV. EXPENSES

Report all money spent by the facility on each category.

Expenses	Amount in Pesos
Amount spent on personnel salaries and wages	
Amount spent on benefits for employees (benefits are in addition to wages/salaries. Benefits include for example: social security contributions, health insurance)	
Allowances provided to employees at this facility (Allowances are in addition to wages/salaries. Allowances include for example: clothing allowance, PERA, vehicle maintenance allowance and hazard pay.)	
TOTAL amount spent on all personnel including wages, salaries, benefits and allowances for last year (PS)	
Total amount spent on medicines funded by the Revolving Fund	
Total amount spent on medicines funded by the Government of the Philippines (from any level of government, including the central, provincial and municipal governments)	
Total amount spent on medical supplies (i.e. syringe, gauze, etc.; exclude pharmaceuticals)	
Total amount spent on utilities	
Total amount spent on non-medical services (For example: security, food service, laundry, waste management)	
TOTAL amount spent on maintenance and other operating expenditures (MOOE)	
Amount spent on infrastructure (i.e., new hospital wing, installation of ramps)	
Amount spent on equipment (i.e. x-ray machine, CT scan)	
TOTAL amount spent on capital outlay (CO)	



**Department of Health
REGIONAL OFFICE III**

**ANNEX – E
A.O. No. 2012-0012**

V. REVENUES

Please report the total revenue this facility collected last year. This includes all monetary resources acquired by this facility from all sources, and for all purposes.

Revenues	Amount in Pesos
Total amount of money received from the Department of Health	
Total amount of money received from the local government	
Total amount of money received from donor agencies (for example JICA, USAID, and others)	
Total amount of money received from private organizations (donations from businesses, NGOs, etc.)	
Total amount of money received from Phil Health	
Total amount of money received from direct patient/out-of-pocket charges/fees	
Total amount of money received from reimbursement from private insurance/HMOs	
Total amount of money received from other sources (PDAF, PCSO, etc.)	
TOTAL Revenue	

Report Prepared by : _____
Designation/Section/Department : _____ *Date:* _____

Report Approved and Certified by : _____ *Date:* _____
Chief of Hospital/Medical Director