Ohio | Department of Health

OHIO DEPARTMENT OF HEALTH
ANNUAL HOSPITAL REGISTRATION AND PLANNING REPORT
STATISTICAL INFORMATION
JANUARY 1, 20___ – DECEMBER 31, 20___

This report must be returned by March 1 Please return to: Ohio Department of Health
Bureau of Regulatory Operations
246 N. High Street
Columbus, OH 43215-2412

Completion of this report is required pursuant to section 3701.07 of the Ohio Revised Code.

SCHEDULE A. IDENTIFICATION

Name of Hospital: Hospital Registration Number:

Medicare Name: (if different from registration) Medicare Provider Number: National Provider Identifier:

Hospital Address/Location: (street name and number, city, county and zip code)

Telephone Number: County:

Mailing Address: (if different from above)

Hospital E-mail Address:

Name of Chief Executive Officer: Title:

Name of Person Submitting Report: Title: Telephone Number:

Accreditation/Certification Status:

Joint Commission (JC)
Date of last accreditation survey: (mmddyyyy) _____

Accreditation Commission for Health Care (HFAP)
Date of last accreditation survey: (mmddyyyy) _____

Det Norske Veritas (DNV)
Date of last accreditation survey: (mmddyyyy) _____

Medicare Certification (if not accredited by other entities prior)
Date of last accreditation survey: (mmddyyyy) _____

Satellite Units:

Indicate name, address, county and zip code of each satellite unit owned and operated by the hospital (i.e. emergency medical center, surgery center, ambulatory care center, hospice) which is a separate and distinct entity but is not independently registered. *[satellite unit is defined in OAC 3701-59-01 (SS)]*

Additional information required: *types of services provided and total number of patients treated (on an outpatient basis) for each type of service.*

1. Name of Satellite Unit: County:

   Address: (street address, city) Zip Code:

TYPE OF SERVICES PROVIDED	TOTAL PATIENTS TREATED FOR EACH SERVICE

2. Name of Satellite Unit: County:

   Address (street address, city) Zip Code:

TYPE OF SERVICES PROVIDED	TOTAL PATIENTS TREATED FOR EACH SERVICE

3. Name of Satellite Unit: County:

Address (street address, city) Zip Code:

TYPE OF SERVICES PROVIDED	TOTAL PATIENTS TREATED FOR EACH SERVICE

4. Name of Satellite Unit: County:

Address (street address, city) Zip Code:

TYPE OF SERVICES PROVIDED	TOTAL PATIENTS TREATED FOR EACH SERVICE

5. Name of Satellite Unit: County:

Zip Code:

Address (street address, city)

TYPE OF SERVICES PROVIDED	TOTAL PATIENTS TREATED FOR EACH SERVICE

6. Name of Satellite Unit: County:

Address (street address, city) Zip Code:

TYPE OF SERVICES PROVIDED	TOTAL PATIENTS TREATED FOR EACH SERVICE

7. Name of Satellite Unit: County:

Address (street address, city) Zip Code:

TYPE OF SERVICES PROVIDED	TOTAL PATIENTS TREATED FOR EACH SERVICE

8. Name of Satellite Unit: County:

Address (street address, city) Zip Code:

TYPE OF SERVICES PROVIDED	TOTAL PATIENTS TREATED FOR EACH SERVICE

SCHEDULE B. CLASSIFICATION

1. Indicate the type of organization responsible for establishing policy concerning overall operation of your hospital.
CHECK ONLY ONE

□ Government

□ Non-Federal
- □ State
- □ County
- □ City
- □ City-County
- □ Hospital District or Authority

□ Non-Government

□ Not-For-Profit
- □ Church-Operated
- □ Other Not-For-Profit

□ Investor-Owned
- □ For-Profit
- □ Individual
- □ Partnership
- □ Corporation

2. Is this hospital part of a multi-hospital system? □ yes □ no

3. Name of System:

4. Medicare Hospital Classification:

- □ Children's
- □ Critical Access
- □ Long-term acute care
- □ Psychiatric
- □ Rehabilitation
- □ Short-term acute care

4. Hospital's primary or specialty classification (if different from Medicare):

- □ Alcohol and drug
- □ Burn care
- □ Cancer
- □ Children's
- □ General
- □ Heart
- □ Psychiatric
- □ Rehabilitation
- □ Other: _____

5. Business name and Medicare certification number or state licensure number, if entities below are contained within hospital:

Distinct-part psychiatric unit: _____

Distinct-part rehabilitation unit: _____

Transplant center: _____

Maternity unit: _____

SCHEDULE C. FACILITIES AND SERVICES

HOSPITAL SERVICES

Inpatient **Outpatient**

Not Available	In House	Contracted	Shared

(Check all above that apply)

SURGICAL SERVICES

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Number of Surgical Cases: (Inpatient) _____ (Outpatient)_____

Number of Surgical Operating Rooms: (Inpatient) _____ (Outpatient)_____

Dual-Purpose Operating Rooms: _____

Total Operating Rooms Onsite: _____

Total Operating Rooms Offsite: _____

EMERGENCY SERVICES

☐ ☐ ☐ ☐

Number of Patients:

Treated and admitted to hospital:_____

Treated in ER and released: _____

CARDIAC SERVICES

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Number of cardiac catherizations performed:

Pediatric: _____

Adult: _____

Number of adult open-heart surgical procedures: _____

Number of pediatric cardiovascular surgery procedures: _____

OBSTETRIC AND NEWBORN DESIGNATION

Level designation of obstetric services: _____

Level designation of newborn: _____

TRAUMA LEVEL DESIGNATION

(As verified by American College of Surgeons)

Adult Trauma Level Designation: _____

Pediatric Trauma Level Designation: _____

SCHEDULE D. BEDS AND UTILIZATION

1. Inpatient Services

Bed Category	**Number of Admissions (including transfers)**	**Patients Days of Care**	**Beds in Use**
Adult medical/surgical			
Adult special care (ICU/CCU)			
Alcohol or drug abuse rehabilitation			
Burn			
Hospice			
Long-term care			
LTAC – LTA less than 30 days stay			
Newborn care – level I			
Newborn care – level II			
Newborn care – level III			
Obstetrics – level I			
Obstetrics – level II			
Obstetrics – level III			
Pediatric - general			
Pediatric intensive care (PICU)			
Physical rehabilitation			
Psychiatric			
Special skilled nursing			
Total of all bed categories			

SCHEDULE D. BEDS AND UTILIZATION (continued)

2. Inpatient Discharges: (indicate the number of inpatients discharged by category)

Home without referral to home care or hospice services:_____

Home with referral to home care:_____

Home with referral to hospice care program:_____

To inpatient service of a hospice care program:_____

Transfers to other hospitals:_____

Transfers to a nursing home:_____

Expired:_____

TOTAL DISCHARGES:_____

SCHEDULE E. HOSPITAL PERSONNEL

1. Licensed or Certified Professional Employees

	Total Number of Employees	Total F.T.E.s (include part-time and full-time)
All Other Licensed Health Professionals/Tech Staff		
Certified Nurse Practitioners		
Certified Nurse-Midwives		
Certified RN Anesthetists (CRNA)		
Clinical Nurse Specialists		
Contracted Physicians		
Dental/Dental Residents		
Dietetic Technicians		
Dietitians (registered, eligible)		
Interns		
Licensed Practical Nurses		
Medical Technicians		
Medical Technologists		
Nursing Assistants		
Occupational Therapists		
Other licensed/certified laboratory personnel		
Other licensed/certified radiological personnel		
Pharmacists, licensed		
Pharmacy Technicians		
Physical Therapists		
Physician Assistants		
Psychiatric Social Workers		
Psychologists		
Radiological Personnel		
Radiological Technologists-Technicians		
Registered Nurses		
Residents		
Respiratory Therapists		
Salaried Physicians		
Medical Social Workers (exclude psych.)		
Speech/Audiology Therapists		
Totals		

SCHEDULE E. HOSPITAL PERSONNEL (continued)

2. Medical Staff (count only once by primary area of specialization)	Number of Active/ Associate Medical Staff	Number of Board Certified Active/ Associate Medical Staff	Number of House Sfaff	Number of House Staff in ACGME or AOA Approved Training Positions	Number of House Staff in ADA Approved Training Positions
Allergy/Immunology					
Anesthesiology					
Cardiology					
Dentistry					
Dermatology					
Emergency medicine					
Family medicine					
Family practice					
Gastroenterology					
General internal medicine					
General medicine rotation program					
General practice					
Hematology					
Neonatology					
Neurology					
Nuclear medicine					
Obstetrics and gynecology					
Oncology					
Ophthalmology					
Other medical specialties					
Otorhinolaryngology					
Pathology					
Pediatrics					
Physical medicine					
Podiatry					
Psychiatry					
Radiology					
Rheumatology					
Surgery: cardiovascular vascular					
Surgery: colon and rectal					
Surgery: general					
Surgery: neurological					
Surgery: orthopedic					
Surgery: other surgery specialties					
Surgery: plastic					
Surgery: rotation program					
Surgery: thoracic					
Urology					
Totals:					

PATIENTS COUNTY (OR STATE IF OTHER THAN OHIO) OF RESIDENCE
AT TIME OF ADMISSION (REPORTED IN THE AGGREGATE)

ADAMS	GEAUGA	MIAMI	VINTON
ALLEN	GREENE	MONROE	WARREN
ASHLAND	GUERNSEY	MONTGOMERY	WASHINGTON
ASHTABULA	HAMILTON	MORGAN	WAYNE
ATHENS	HANCOCK	MORROW	WILLIAMS
AUGLAIZE	HARDIN	MUSKINGUM	WOOD
BELMONT	HARRISON	NOBLE	WYANDOT
BROWN	HENRY	OTTAWA	
BUTLER	HIGHLAND	PAULDING	**OTHER STATES**:
CARROLL	HOCKING	PERRY	INDIANA
CHAMPAIGN	HOLMES	PICKAWAY	KENTUCKY
CLARK	HURON	PIKE	MICHIGAN
CLERMONT	JACKSON	PORTAGE	PENNSYLVANIA
CLINTON	JEFFERSON	PREBLE	WEST VIRGINIA
COLUMBIANA	KNOX	PUTNAM	
COSHOCTON	LAKE	RICHLAND	
CRAWFORD	LAWRENCE	ROSS	
CUYAHOGA	LICKING	SANDUSKY	
DARKE	LOGAN	SCIOTO	
DEFIANCE	LORAIN	SENECA	
DELAWARE	LUCAS	SHELBY	
ERIE	MADISON	STARK	
FAIRFIELD	MAHONING	SUMMIT	
FAYETTE	MARION	TRUMBALL	
FRANKLIN	MEDINA	TUSCARAWAS	
FULTON	MEIGS	UNION	
GALLIA	MERCER	VAN WERT	