Please return to the American Hospital Assocation, 840 North Lake Shore Drive, Chicago, Illinois 60611

AMERICAN HOSPITAL ASSOCIATION

ANNUAL SURVEY OF HOSPITALS

1980

HOSPITAL FILE COPY

GENERAL INSTRUCTIONS

Two copies of the Survey questionnaire are enclosed. Please return one copy to the American Hospital Association in the enclosed envelope. Federal hospitals, other than Veterans Administration hospitals, should forward this copy to their central agency which will send it to the American Hospital Association. The second copy is a hospital file copy which should be completed and retained in your files for reference.

THE ITEMS PRINTED IN BLUE* ARE ITEMS THAT WERE INCLUDED ON THE 1979 ANNUAL SURVEY OF HOSPITALS. RESPONSES TO THESE ITEMS SHOULD BE CONSISTENT WITH RESPONSES YOUR HOSPITAL MADE LAST YEAR TO THE ANNUAL SURVEY. ATTACH A NOTE TO EXPLAIN ANY MAJOR DISCREPANCIES.

REPORT UTILIZATION, REVENUE, EXPENSES, AND CAPITAL EXPENDITURES FOR A FULL 12-MONTH PERIOD, PREFERABLY THE PERIOD ENDING SEPTEMBER 30, 1980. REPORT PERSONNEL DATA AS OF SEPTEMBER 30, 1980 REGARDLESS OF THE END OF THE REPORTING PERIOD. REPORT ALL OTHER INFORMATION AS OF THE END OF THE REPORTING PERIOD.

MAKE AN ENTRY FOR EVERY ITEM ON THE FORM. ENTER "0" IF ZERO IS APPROPRIATE; ENTER "NA" ONLY WHEN DATA ARE NOT AVAILABLE FROM YOUR RECORDS AS REQUESTED.

*Shown here in black.

AMERICAN HOSPITAL ASSOCIATION
ANNUAL SURVEY OF HOSPITALS 1980

PLEASE REFER TO THE INSTRUCTIONS AND DEFINITIONS

A. REPORTING PERIOD

Report data for a full 12-month period, preferably October 1, 1979 through September 30, 1980 (366 days).

1. Indicate period used: Beginning date ☐ ☐ ☐ (Month Day Year) Ending date ☐ ☐ ☐ (Month Day Year) Number of days ______
2. Were you in operation 12 full months at the end of your reporting period? . . . . Yes ☐ No ☐
3. Indicate the beginning of your current fiscal year. ☐ ☐ ☐ (Month Day Year)

B. CLASSIFICATION

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

Government, nonfederal	Nongovernment, not-for-profit	Investor-owned, for-profit	Government, federal	
☐ 12 State	☐ 21 Church-operated	☐ 31 Individual	☐ 41 Air Force	☐ 45 Veterans Administration
☐ 13 County	☐ 23 Other not-for-profit	☐ 32 Partnership	☐ 42 Army	☐ 46 Fed. other than 41-45 or 47-48
☐ 14 City		☐ 33 Corporation	☐ 43 Navy	☐ 47 PHS Indian Service
☐ 15 City-County			☐ 44 Pblc. Hlth. Srvc.	☐ 48 Department of Justice
☐ 16 Hospital district or authority				

2. MANAGEMENT CONTRACT. Has the controlling organization, through a contract, placed responsibility for the administration of the hospital with ANOTHER organization? . . . . Yes ☐ No ☐
   If YES, Please give the name of the organization that MANAGES the hospital ______________________________

3. Is your hospital a division of another corporation that owns or operates more than one hospital? . . . . Yes ☐ No ☐

4. SERVICE. Indicate the ONE category that BEST describes the type of service that your hospital provides to the MAJORITY of admissions:
   - ☐ 10 General medical and surgical
   - ☐ 11 Hospital unit of an institution (prison hospital, college infirmary)
   - ☐ 12 Hospital unit within an institution for the mentally retarded
   - ☐ 22 Psychiatric
   - ☐ 33 Tuberculosis and other respiratory diseases
   - ☐ 44 Obstetrics and gynecology
   - ☐ 45 Eye, ear, nose, and throat
   - ☐ 46 Rehabilitation
   - ☐ 47 Orthopedic
   - ☐ 48 Chronic disease
   - ☐ 62 Institution for mentally retarded
   - ☐ 82 Alcoholism and other chemical dependency
   - ☐ 49 Other — specify treatment area ______________

5. Does your hospital restrict admissions primarily to children? . . . . Yes ☐ No ☐

6. Does your hospital provide treatment to members of a Health Maintenance Organization on any basis other than emergency, out-of-area care? . . . . Yes ☐ No ☐

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1. Medical/
2. Pediatric
3. Psychiat
4. Obstetric
5. Alcoholi
6. Medical/
7. Cardiac
8. Pediatric
9. Neonata
10. Burn car
11. Psychiat
12. Newbor
13. Prematu
14. Long ter
15. Psychiat
16. Interme
17. Interme
18. Residen
19. Self care
20. Rehabili
21. Tubercu
22. General
23. Kidney
24. Organ tr
25. Open-he
26. Neurosu
27. Anesthe
28. Postope
29. Abortio
30. Ambula
31. CT scan
32. CT scan
33. Cardiac
34. Clinical

FACILITIES AND SERVICES

1. GENERAL MEDICAL, SURGICAL, AND ANCILLARY SERVICES. For each service listed below, please check the one column that best describes the status of the facility or service in your hospital. The column definitions are as follows:

Column Number	Description
1	Service is provided in a distinct unit that is an organizational entity of the hospital.
2	Service is provided by hospital personnel and located within the hospital, but not in a separate unit.
3	Service contracted but hospital-based. The contractor, rather than the hospital, staffs the service.
4	Service not maintained in the hospital but available through a formal shared service/referral arrangement with another hospital.
5	Service not available either within the hospital or through a formal shared service/referral arrangement with another hospital.

	DESCRIPTION				
	(1) Hospital-based distinct unit	(2) Hospital-based not in a distinct unit	(3) Hospital-based contracted	(4) Provided by another hospital through formal arrangement	(5) Service is not available
1. Medical/surgical, acute					
2. Pediatric, acute					
3. Psychiatric, acute					
4. Obstetrics					
5. Alcoholism and chemical dependency					
6. Medical/surgical intensive care					
7. Cardiac intensive care					
8. Pediatric intensive care					
9. Neonatal intensive care					
10. Burn care					
11. Psychiatric intensive care					
12. Newborn nursery					
13. Premature nursery					
14. Long term-skilled nursing					
15. Psychiatric long-term care					
16. Intermediate care, mentally retarded					
17. Intermediate care, other					
18. Residential care					
19. Self care					
20. Rehabilitation					
21. Tuberculosis and other respiratory diseases					
22. General surgical services					
23. Kidney transplant					
24. Organ transplant (other than kidney)					
25. Open-heart surgery					
26. Neurosurgery					
27. Anesthesia services					
28. Postoperative recovery room					
29. Abortion services (inpatient)					
30. Ambulance services					
31. CT scanner (head)					
32. CT scanner (body)					
33. Cardiac catheterization laboratory					
34. Clinical psychology services					

C. FACILITIES AND SERVICES (continued)

	DESCRIPTION				
	(1) Hospital-based distinct unit	(2) Hospital-based not in a distinct unit	(3) Hospital based contracted	(4) Provided by another hospital through formal arrangement	(5) Service is not available
35. Dental services					
36. Electrocardiography					
37. Electroencephalography					
38. Electromyography					
39. Hemodialysis (inpatient)					
40. Hemodialysis (outpatient)					
41. Hemodialysis (home care/mobile unit)					
42. General laboratory services					
43. Histopathology laboratory					
44. Autopsy services					
45. Blood bank					
46. Organ bank					
47. Diagnostic radioisotope facility					
48. Megavoltage radiation therapy					
49. Radioactive implants					
50. Therapeutic radioisotope facility					
51. X-ray radiation therapy					
52. Occupational therapy					
53. Physical therapy					
54. Recreational therapy					
55. Speech pathology					
56. Respiratory therapy					
57. Podiatric services					
58. Pulmonary function laboratory					
59. Pharmacy with full-time registered pharmacist					
60. Pharmacy with part-time registered pharmacist					
61. Intravenous admixture services					
62. Pharmacy unit dose system					
63. Social work services					

2. Does your hospital provide any of the following services on an inpatient basis in a satellite facility that is owned or leased by the hospital? The policy of the satellite facility must be determined by the hospital's board of directors. Do not include facilities that provide ambulatory care services only; these are described in the following section.

a. Medical/surgical acute care (adult and/or pediatric) . . . . . Yes ☐ No ☐
b. Psychiatric . . . . . Yes ☐ No ☐
c. Rehabilitation . . . . . Yes ☐ No ☐
d. Skilled and/or intermediate nursing care . . . . . Yes ☐ No ☐
e. Residential care . . . . . Yes ☐ No ☐

C. FACILITIES AND SERVICES (continued)

3. AMBULATORY CLINICAL SERVICES. For each ambulatory service listed below, check the column in section A that best describes the hospital's role in providing the service. CHECK ONE DESCRIPTION ONLY.

   If the service is provided, check all the applicable columns in section B describing the physical location in which the service is provided, and check column C if the service is provided in a distinct unit that is an organizational entity of the hospital.

   Explanation of Column Headings:

   A. HOSPITAL ROLE
      1. Hospital-controlled: completely governed, managed and financed by the hospital.
      2. Hospital-associated: governed and managed by the hospital, financed through a contractual arrangement of shared expenses and revenue with physicians or other organized providers.
      3. Hospital-owned but not controlled: hospital owns the physical facility in which the program is located but does not govern, manage, or finance the ambulatory services rendered.
      4. Service not provided: hospital does not provide this service, or it is only available at another hospital through a shared service agreement.

   B. LOCATION
      1. Hospital-based: service maintained at hospital main campus.
      2. Satellite: service available at a satellite facility off the hospital campus.

   C. ORGANIZATION
      1. Service is provided in a distinct unit that is an organizational entity of the hospital (check column if yes).

	A. HOSPITAL ROLE (CHECK ONLY ONE COLUMN)				B. LOCATION (CHECK ALL APPLICABLE COLUMNS)		C. ORGANIZATION (CHECK IF APPLICABLE)
	Hospital-controlled	Hospital-associated	Hospital owned, not controlled	Service not provided	Hospital-based	Satellite	Service is provided in distinct unit
1. Abortion							
2. Alcoholism/chemical dependency							
3. Cardiology							
4. Chest diseases							
5. Dentistry							
6. Dermatology							
7. Diabetes							
8. Ear, nose, throat							
9. Eye							
10. Walk-in clinic							
11. General medicine							
12. Gynecology							
13. Hypertension							
14. Neonatology							
15. Neurology							
16. Obstetrics							
17. Oncology							
18. Orthopedics							
19. Pediatrics, general							
20. Pediatrics, allergy							
21. Pediatrics, cardiology							
22. Pediatrics, psychology							
23. Podiatry							
24. Psychiatry							
25. Rehabilitation							
26. Rheumatology							
27. Ambulatory surgery services							
28. Urology							
29. Venereal disease							
30. Emergency services							
31. Psychiatric emergency services							
32. Dental emergency services							

4. Are your emergency services staffed with a physician present 24 hours a day? . . . . . Yes ☐ No ☐

4a. Are your emergency services organized as a department? . . . . . Yes ☐ No ☐

C. FACILITIES AND SERVICES (continued)

5. OTHER SERVICES. Mark "YES" for every item listed below which is located within the hospital. Mark "NO" if the item is not available at the hospital or is only available at another hospital through a shared service agreement.

	Item	Yes	No
1.	Cancer tumor registry	Yes ☐	No ☐
2.	Chaplaincy services	Yes ☐	No ☐
3.	Family planning	Yes ☐	No ☐
4.	Genetic counseling	Yes ☐	No ☐
5.	Home care program	Yes ☐	No ☐
6.	Hospice	Yes ☐	No ☐
7.	Hospital auxiliary	Yes ☐	No ☐
8.	Intravenous therapy team	Yes ☐	No ☐
9.	Medical library	Yes ☐	No ☐
10.	Patient representative	Yes ☐	No ☐
11.	Psychiatric consultation and education	Yes ☐	No ☐
12.	Psychiatric foster and/or home care program	Yes ☐	No ☐
13.	Psychiatric partial hospitalization program	Yes ☐	No ☐
14.	Toxicology/antidote information	Yes ☐	No ☐
15.	Volunteer services department	Yes ☐	No ☐

6. SELECTED SERVICE UTILIZATION (SEE ACCOMPANYING INSTRUCTIONS AND DEFINITIONS, page 6)

a. Heart surgery:
- (1) Adult open-heart surgical operations . . . . ______
- (2) Pediatric open-heart surgical operations . . . . ______
- (3) Pediatric heart surgical operations (exclude open-heart) . . . . ______

b. Cardiac catheterizations:
- (1) Total adult procedures . . . . ______
- (2) Adult intracardiac and/or coronary artery procedures . . . . ______
- (3) Total pediatric procedures . . . . ______

c. Megavoltage radiation therapy:
- (1) Number of units . . . . ______
- (2) Treatments . . . . ______

d. CT Scanners – head unit:
- (1) Number of head units . . . . ______
- (2) Total procedures . . . . ______

e. CT Scanners – body unit:
- (1) Number of body units . . . . ______
- (2) Total body procedures . . . . ______
- (3) Total head procedures . . . . ______

f. Physical therapy department:
- Visits . . . . ______

g. Home care department:
- Visits . . . . ______

h. Family planning service:
- Visits . . . . ______

D. BEDS AND UTILIZATION BY INPATIENT SERVICE

Account for all adult and pediatric inpatient beds set up and staffed for use at the end of the reporting period. List beds for a particular service area only if a unit is specifically designated for the service area. For each specifically designated service area, also report the total bed days available during the reporting period. List total licensed/registered beds at the end of the reporting period only if the state licensing (certifying) agency regulates beds by inpatient service area. If the state does not regulate beds, please leave the LICENSED/REGISTERED BEDS column blank. TOTAL HOSPITAL (line 34) beds set up and staffed for use and inpatient days should equal beds and inpatient days reported under E5c and E5e. Do not count beds more than once. (SEE ACCOMPANYING INSTRUCTIONS AND DEFINITIONS, pages 6 and 7.)

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No ☐
No ☐
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No ☐

	Licensed/ registered beds	Beds set up and staffed	Bed days available	Discharges for reporting period	Inpatient days for reporting period
1. General medical and surgical (adult) (include gynecology) . .					
2. General medical and surgical (pediatric)					
3. Psychiatric, acute					
4. Obstetrics (indicate level of unit ________). (See instructions, Section D)					
5. Orthopedic.					
6. Eye, ear, nose, and throat					
7. Other acute (specify type ________________)					
8. Swing beds (short-term/long-term only)					
9. TOTAL ACUTE CARE (add lines 1 through 8)					
10. Medical/surgical intensive care. . .					
11. Cardiac intensive care.					
12. Pediatric intensive care.					
13. Neonatal intensive care (See instructions, Section D)					
14. Neonatal intermediate care (See instructions, Section D) . .					
15. Burn care.					
16. Psychiatric intensive care.					
17. Other intensive care (specify type ______________)					
18. TOTAL INTENSIVE CARE (add lines 10 through 17)					
19. Long term-skilled nursing					
20. Psychiatric long term care					
21. Other long-term (include ICF). . . .					
22. Mental retardation					
23. Residential care					
24. Self care					
25. Rehabilitation.					
26. Other subacute care (specify type ________________)					
27. Swing beds (short-term/long-term only)					
28. TOTAL SUBACUTE CARE (add lines 19 through 27)					
29. TB and other respiratory diseases.					
30. Chronic disease					
31. Alcoholism and chemical dependency					
32. Other (specify type ________________)					
33. TOTAL OTHER (add lines 29 through 32)					
34. TOTAL HOSPITAL (add lines 9, 18, 28 and 33)					

E. TOTAL HOSPITAL BEDS AND UTILIZATION

All statistics reported in E, F, and G must be CONSISTENT. For example, all data in section E must be reflected in sections F and G and vice versa.

1. LICENSED BED CAPACITY: The maximum number of beds authorized by state licensing (certifying) agency. If state does not regulate number, please report "NONE" . . . . ________
2. NEWBORN NURSERY
   a. Number of bassinets set up and staffed for use at the end of the reporting period (exclude pediatric and neonatal beds) . . . . ________
   b. Total births (exclude fetal deaths) . . . . ________
   c. Newborn days . . . . ________
3. SURGICAL OPERATIONS, whether major or minor, performed in the operating room(s):
   a. Inpatient . . . . ________
   b. Outpatient . . . . ________
   c. Total . . . . ________
4. OUTPATIENT UTILIZATION. Please record BOTH the number of outpatient visits and the number of outpatient occasions of service, if available, for each of the categories below:

	Visits	Occasions of service
a. Emergency	________	________
b. Other	________	________
c. Total	________	________

5. ADULT AND PEDIATRIC INPATIENTS (exclude newborn nursery):
   a. Was there a permanent change or a significant temporary change in the total number of adult and pediatric beds during the reporting period? . . . . Yes ☐ No ☐

      If YES, give beds added or withdrawn (show increase by + and decrease by —) and dates of change. If more than two changes occurred during the reporting period, please report all changes on a separate sheet of paper.

      (1) Bed change (+ or —): ________ Date [|] Month [|] Day [|] Year

      (2) Bed change (+ or —): ________ Date [|] Month [|] Day [|] Year

   b. Does your hospital maintain separate units specifically designated for short-term and long-term care (exclude newborn nursery)? . . . . Yes ☐ No ☐

      If NO, report total hospital statistics only in column (1) below.

      If YES, report data for both short-term and long-term units in columns (2) and (3) below in addition to total hospital statistics in column (1).

	All hospitals fill out (1) Total hospital statistics	Fill out only if hospital has SEPARATE units for short-term and long-term care. (2) Short-term units	(3) Long-term units
c. Beds set up and staffed for use at the end of the reporting period. (If number differs from 1979, answer E5a above)	________	________	________
d. Admissions (exclude newborns)	________ *	________ *	________ *
e. Inpatient days (exclude newborns)	________	________	________
f. Discharges (exclude newborns, include deaths)	________ *	________ *	________ *
g. Discharge days (exclude newborns, include deaths)	________	________	________
6. CENSUS on the last day of your reporting period (exclude newborns)	________	________	________

*Because of internal transfers, column (1) may be less than the sum of columns (2) and (3).

7. MEDICARE/MEDICAID UTILIZATION
   a. Total Medicare (Title XVIII) admissions . . . . ________
   b. Total Medicare (Title XVIII) inpatient days . . . . ________
   c. Total Medicaid (Title XIX) admissions . . . . ________
   d. Total Medicaid (Title XIX) inpatient days . . . . ________

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FINANCIAL DATA (If actual figures are not available, please estimate; round to the nearest dollar.)

1. REVENUE (for reporting period only): CONFIDENTIAL **
   a. Gross revenue from service to INPATIENTS (based on full established rates) . . . . . $ ______ .00
   b. Gross revenue from service to OUTPATIENTS (based on full established rates) . . . . . $ ______ .00
   c. TOTAL GROSS revenue from service to PATIENTS (a + b) . . . . . $ ______ .00
   d. Sources of gross patient revenue:
      (1) Medicare . . . . . $ ______ .00
      (2) Medicaid . . . . . $ ______ .00
      (3) Self pay . . . . . $ ______ .00
      (4) Blue Cross/Blue Shield . . . . . $ ______ .00
      (5) Commercial insurers . . . . . $ ______ .00
      (6) Other sources of payment . . . . . $ ______ .00
      (7) Total sources of gross patient revenue [add (1) through (6)]. (Total should equal F1c.) . $ ______ .00

   e. Deductions from revenue:
      (1) Deductions for contractual adjustments . . . . . $ ______ .00
      (2) Deductions for bad debts . . . . . $ ______ .00
      (3) Deductions for charity . . . . . $ ______ .00
      (4) Other deductions . . . . . $ ______ .00
      (5) Total deductions [add (1) through (4)] . . . . . $ ______ .00
   f. TOTAL NET revenue from service to PATIENTS [c—e (5)] . . . . . $ ______ .00

   g. Sources of net patient revenue:
      (1) Medicare . . . . . $ ______ .00
      (2) Medicaid . . . . . $ ______ .00
      (3) Self pay . . . . . $ ______ .00
      (4) Blue Cross/Blue Shield . . . . . $ ______ .00
      (5) Commercial insurers . . . . . $ ______ .00
      (6) Other sources of payment . . . . . $ ______ .00
      (7) Total sources of net patient revenue [add (1) through (6)]. (Total should equal F1f.) . . $ ______ .00

   h. Other OPERATING REVENUE:
      (1) Tax appropriations . . . . . $ ______ .00
      (2) Other (include cafeteria, gift shop, educational programs, and so forth) . . . . . $ ______ .00
      (3) TOTAL OTHER OPERATING REVENUE [add lines (1) and (2)] . . . . . $ ______ .00

   i. NONOPERATING REVENUE (contributions, grants) . . . . . $ ______ .00

   j. TOTAL REVENUE [f + h (3) + i] . . . . . $ ______ .00

2. EXPENSES (for the reporting period only):
   a. PAYROLL EXPENSES for all categories of personnel specified below:
      (1) Physicians and dentists (include only salaries) . . . . . $ ______ .00
      (2) Medical and dental residents (include medical and dental interns) . . . . . $ ______ .00
      (3) Other trainees (medical technology, x-ray therapy, administrative, and so forth) . . . . . $ ______ .00
      (4) Registered and licensed practical nurses . . . . . $ ______ .00
      (5) All other personnel . . . . . $ ______ .00
      (6) TOTAL PAYROLL EXPENSES [add (1) through (5)] . . . . . $ ______ .00

   b. NONPAYROLL EXPENSES:
      (1) Employee benefits (social security, group insurance, retirement benefits) . . . . . $ ______ .00
      (2) Professional fees (medical, dental, legal, auditing, consultant, and so forth) . . . . . $ ______ .00
      (3) Depreciation expense (FOR REPORTING PERIOD ONLY) . . . . . $ ______ .00
      (4) Interest expense . . . . . $ ______ .00
      (5) All other expenses (supplies, purchased services, and so forth) . . . . . $ ______ .00
      (6) TOTAL NONPAYROLL EXPENSES [add (1) through (5)] . . . . . $ ______ .00
   c. TOTAL EXPENSES [a(6) + b(6)] . . . . . $ ______ .00

**REVENUE DATA ARE CONFIDENTIAL AND ARE NOT RELEASED WITHOUT WRITTEN PERMISSION.

F. FINANCIAL DATA (continued)

3. UNRESTRICTED FUNDS**

a. ASSETS recorded on the balance sheet at the end of the reporting period (include actual or estimated value of plant/equipment that is leased):

- (1) Current cash and short-term investments . . . . . $ ________ .00
- (2) (a) Current receivables . . . . . $ ________ .00
  - (b) Uncollectables . . . . . $ ________ .00
  - (c) Net receivables (2a – 2b) . . . . . $ ________ .00
- (3) Other current assets . . . . . $ ________ .00
- (4) (a) Gross plant & equip. assets (include land, bldgs., equip.) . . . . . $ ________ .00
  - (b) LESS: Deduction for accumulated depreciation . . . . . $ ________ .00
  - (c) NET plant & equip. assets (4a – 4b; if zero, please explain) . . . . . $ ________ .00
- (5) Long-term investments (at lower of cost or market) . . . . . $ ________ .00
- (6) Other unrestricted assets . . . . . $ ________ .00
- (7) Total unrestricted assets [(1) + (2c) + (3) + (4c) + (5) + (6)] . . . . . $ ________ .00

b. LIABILITIES AND FUND BALANCE**

- (1) Current liabilities . . . . . $ ________ .00
- (2) Long-term debt . . . . . $ ________ .00
- (3) Other liabilities . . . . . $ ________ .00
- (4) Unrestricted fund balance . . . . . $ ________ .00
- (5) Total unrestricted liabilities & fund balance [add (1) through (4)] . . . . . $ ________ .00

4. RESTRICTED FUNDS — Report fund balances only**

- a. Specific purpose (identify ________________) . . . . . $ ________ .00
- b. Plant replacement and expansion . . . . . $ ________ .00
- c. Endowment funds . . . . . $ ________ .00

5. CAPITAL EXPENDITURES

Report only the actual expenditures made during the reporting period on completed or incompleted capital acquisition projects. Capital expenditures greater than $150,000 refers to the value of operating assets booked during the reporting period that are part of a project that will ultimately exceed $150,000. Capital expenditures less than $150,000 refers to the value of operating assets booked during the reporting period that are part of a project that will ultimately not exceed $150,000. For Disposals and Retirements include only the net book value (that is, cost basis less accumulated depreciation) of assets disposed of or retired during the reporting period.

Asset Account	Capital Expenditures: Greater than $150,000	Capital Expenditures: Less than $150,000	Disposals and Retirements
Land	$ ________ .00	$ ________ .00	$ ________ .00
Buildings and improvements	$ ________ .00	$ ________ .00	$ ________ .00
Equipment			
(1) Fixed equipment	$ ________ .00	$ ________ .00	$ ________ .00
(2) Movable equipment	$ ________ .00	$ ________ .00	$ ________ .00
(3) TOTAL EQUIPMENT	$ ________ .00	$ ________ .00	$ ________ .00
Construction in progress	$ ________ .00	$ ________ .00	$ ________ .00
TOTAL	$ ________ .00	$ ________ .00	$ ________ .00

a. Will a permanent increase or decrease in the number of adult and pediatric beds result from any capital acquisition projects begun during the reporting period? . . . . . Yes ☐ No ☐

If YES, give the adult and pediatric bed capacity of the facility before the project began and the number of beds to be available after completion of the project.

- (1) Bed capacity before beginning of project ________________
- (2) Bed capacity after completion of project ________________

b. Will there be any change in the number or type of hospital services as a result of any capital acquisition projects begun during the reporting period? . . . . . Yes ☐ No ☐

c. Was Certificate of Need (CON) or Section 1122 approval received for any projects during the reporting period? . . . . Yes ☐ No ☐

d. If YES, what is the total capital authorization included in CON or Section 1122 approvals received during the reporting period? $ ________________ .00

**ASSETS AND LIABILITIES ARE CONFIDENTIAL AND ARE NOT RELEASED WITHOUT WRITTEN PERMISSION.

G. PERSONNEL ON PAYROLL AS OF SEPTEMBER 30, 1980

1. HOSPITAL PERSONNEL BY OCCUPATIONAL CATEGORY. Report full-time and part-time personnel including trainees who were on the payroll as of SEPTEMBER 30, 1980 and whose payroll expenses are reported in F2a. Include members of religious orders for whom dollar equivalents were reported. If figures are discrepant with F2a, please explain. For each occupational category, please report the number of staff vacancies as of SEPTEMBER 30, 1980. A vacancy is defined as a budgeted staff position which is unfilled as of SEPTEMBER 30, 1980 and for which the hospital is actively seeking either a full-time or part-time permanent replacement. Personnel who work in more than one area should be included only in the category of their primary responsibility and should be counted only once.

	FULL-TIME (35 hr/wk or more)	PART-TIME (less than 35 hr/wk)	VACANCIES (as of 9/30/80)
a. Administration:			
(1) Administrators			
(2) Assistant administrators			
b. Physician and Dental Services:			
(1) Physicians			
(2) Medical residents and interns			
(3) Dentists			
(4) Dental residents and interns			
c. Nursing Services:			
(1) Registered nurses (a + b)			
(a) Administrative and clinical support — RN			
(b) Staff nurses — RN			
(2) Licensed practical (vocational) nurses			
(3) Ancillary personnel			
(4) Other nursing service personnel			
d. Medical Record Services:			
(1) Medical record administrators			
(2) Medical record technicians			
e. Pharmacy:			
(1) Pharmacists, licensed			
(2) Pharmacy technicians			
f. Clinical Laboratory Services:			
(1) Medical technologists			
(2) Other laboratory personnel			
g. Dietary Services:			
(1) Dietitians			
(2) Dietetic technicians			
h. Radiological Services:			
(1) Radiographer (radiologic technologist)			
(2) Radiation therapy technologist			
(3) Nuclear medicine technologist			
(4) Other radiologic personnel			

G. PERSONNEL ON PAYROLL AS OF SEPTEMBER 30, 1980 (continued)

	FULL-TIME (35 hr/wk or more)	PART-TIME (less than 35 hr/wk	VACANCIES (as of 9/30/80)
i. Therapeutic Services:			
(1) Occupational therapists			
(2) Occupational therapy assistants and aides			
(3) Physical therapists			
(4) Physical therapy assistants and aides			
(5) Recreational therapists			
j. Respiratory Therapy Services:			
(1) Respiratory therapists			
(2) Respiratory therapy technicians			
k. Social Work Services:			
(1) Medical social workers			
l. All other health professional & technical personnel			
m. All other nonhealth professional & nontechnical personnel			
n. TOTAL HOSPITAL PERSONNEL			

2. OTHER TRAINEES. Report full-time and part-time trainees (medical technology, x-ray therapy, administrative, and so forth) who were on the payroll as of SEPTEMBER 30, 1980, whose payroll expenses are reported in F2a(3), and who were included in TOTAL HOSPITAL PERSONNEL (G1n). Please do not include physician and dental residents and interns.

	FULL-TIME (35 hr/wk or more)	PART-TIME (less than 35 hr/wk)
TOTAL OTHER TRAINEES (exclude physician and dental interns and residents)		

3. Does your hospital have a full-time chief of staff who serves as the medical and administrative head of the medical staff? Yes ☐ No ☐

Date of Completion	Signature of Administrator
/ /	

If there are any questions about your responses to this survey, who should be contacted?

Name (please print) Title ( ) Area Code Telephone Number

NOTE:

PLEASE COPY THE INFORMATION REPORTED FOR YOUR HOSPITAL FILE BEFORE RETURNING THE ORIGINAL SURVEY FORM TO THE AMERICAN HOSPITAL ASSOCIATION. THANK YOU.