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

AMERICAN HOSPITAL ASSOCIATION

ANNUAL SURVEY OF HOSPITALS

1981

HOSPITAL FILE COPY

GENERAL INSTRUCTIONS

Two copies of the Annual 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 that should be completed and retained in your files for references. All hospitals should forward a photocopy of the completed questionnaire to your state hospital association.

REPORT UTILIZATION, REVENUE, EXPENSES, AND CAPITAL EXPENDITURES FOR A FULL 12-MONTH PERIOD, PREFERABLY THE PERIOD ENDING SEPTEMBER 30, 1981. REPORT PERSONNEL DATA AS OF SEPTEMBER 30, 1981 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.

AMERICAN HOSPI[illegible] ASSOCIATION

PLEASE REFER TO THE INSTRUCTIONS AND DEFINITIONS

A. REPORTING PERIOD

Report data for a full 12-month period, preferably October 1, 1980 through September 30, 1981 (365 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
   - ☐ 12 State
   - ☐ 13 County
   - ☐ 14 City
   - ☐ 15 City-County
   - ☐ 16 Hospital district or authority

   Nongovernment, not-for-profit
   - ☐ 21 Church-operated
   - ☐ 23 Other not-for-profit

   Investor-owned, for profit
   - ☐ 31 Individual
   - ☐ 32 Partnership
   - ☐ 33 Corporation

   Government, federal
   - ☐ 41 Air Force
   - ☐ 42 Army
   - ☐ 43 Navy
   - ☐ 44 Public Health Service
   - ☐ 45 Veterans Administration
   - ☐ 46 Fed. other than 41-45 or 47-48
   - ☐ 47 PHS Indian Service
   - ☐ 48 Department of Justice

2. Does the controlling organization own the physical assets of the hospital? . . . . . Yes _____ No _____

3. Does the controlling organization lease the physical plant from another organization? . . . . . Yes _____ No _____

4. 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 and classification code of the organization that manages the hospital. For classification code, please refer to th control code categories stated in B1, for example, 23 for a nongovernment, other not-for-profit organization; 33 for an investor-owne for-profit corporation; and so forth.

   _____ CODE ☐☐

5. Is your hospital a unit of another organization that owns, leases, manages, or sponsors more than one hospital? . . . Yes _____ No _____

6. 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 _____

7. Does your hospital restrict admissions primarily to children? . . . . . Yes _____ No _____

8. 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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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 as of the last day of the reporting period. The column definitions are as follows:

Column Number	Description
1	Service is provided by hospital personnel and located within the hospital.
2	Service is contracted but hospital-based. The contractor, rather than the hospital, staffs the service.
3	Service is not maintained in the hospital, but is available through a formal (shared service/referral) arrangement with another hospital or provider.
4	Service is neither available within the hospital nor through a formal shared service/referral arrangement with another hospital or provider.

	(1) Hospital-based and staffed	(2) Hospital-based contracted	(3) Provided by another hospital or provider	(4) 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. Other special care				
13. Skilled nursing long-term				
14. Psychiatric long-term care				
15. Mental retardation, intermediate care				
16. Intermediate care, other				
17. Sheltered care				
18. Self care				
19. Rehabilitation				
20. Tuberculosis and other respiratory diseases				
21. Newborn nursery				
22. Abortion services, inpatient				
23. Abortion services, outpatient				
24. Alcoholism/chemical dependency outpatient services				

C. FACILITIES AND SERVICES (Continued)

	(1) Hospital-based and staffed	(2) Hospital-based contracted	(3) Provided by another hospital or provider	(4) Service is not available
25. Ambulance services				
26. Cancer tumor registry				
27. Cardiac catheterization laboratory				
28. Chaplaincy services				
29. Day hospital				
30. Dental services				
31. Emergency department				
32. Electrocardiography				
33. Electroencephalography				
34. Electromyography				
35. Family planning				
36. Genetic counseling				
37. Health promotion				
38. Hemodialysis, inpatient				
39. Hemodialysis, outpatient				
40. Hemodialysis, home care/mobile unit				
41. Home care program				
42. Hospice				
43. Hospital auxiliary				
44. Laboratory services				
a. General laboratory services				
b. Histopathology laboratory				
c. Autopsy services				
d. Blood bank				
45. Medical library				
46. Optometric services				
47. Organized outpatient department				
48. Premature nursery				
49. Podiatric services, inpatient				
50. Podiatric services, outpatient				

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FACILITIES AND SERVICES (Continued)

	(1) Hospital-based and staffed	(2) Hospital-based contracted	(3) Provided by another hospital or provider	(4) Service is not available
51. Physical therapy services				
a. Occupational therapy				
b. Physical therapy				
c. Recreational therapy				
d. Respiratory therapy				
e. Speech pathology				
f. Rehabilitation outpatient services				
52. Psychiatric services				
a. Psychiatric services, pediatric				
b. Psychiatric emergency services				
c. Clinical psychology services				
d. Psychiatric consultation and education				
e. Psychiatric foster and/or home care program				
f. Psychiatric outpatient services				
g. Psychiatric partial hospitalization program				
53. Pharmacy services				
a. Pharmacy with full-time registered pharmacist				
b. Pharmacy with part-time registered pharmacist				
c. Intravenous admixture service				
d. Pharmacy unit dose system				
e. Toxicology/antidote information				
54. Pulmonary function laboratory				
55. Radiology diagnostic				
a. CT scanner, head				
b. CT scanner, body				
c. Diagnostic radioisotope facility				
d. Ultrasound				
56. Radiation therapy				
a. Megavoltage radiation therapy				
b. Radioactive implants				
c. Therapeutic radioisotope facility				
d. X-ray radiation therapy				
57. Social work services				
58. Patient representative services				

C. FACILITIES AND SERVICES (Continued)

	(1) Hospital-based and staffed	(2) Hospital-based contracted	(3) Provided by another hospital or provider	(4) Service is not available
59. Surgical services				
a. General surgical services				
b. Ambulatory surgical services				
c. Kidney transplant				
d. Organ transplant (other than kidney)				
e. Organ bank				
f. Open-heart surgery				
g. Neurosurgery services				
h. Anesthesia services				
i. Postoperative recovery room				
60. Volunteer services department				
61. Other (please specify)				

2. ORGANIZED AMBULATORY SERVICES. For each group of 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 more than one column in section A applies to a group, pick the dominant model.

If the service is provided, check all the applicable columns in section B describing the physical location in which the service is provided.

Explanation of column headings:

A. HOSPITAL ROLE

1. Hospital-controlled: Hospital assumes total fiscal accountability for the ambulatory care program, including payment of physicians.
2. Hospital-associated: Hospital and physicians share fiscal accountability for the ambulatory care program such that deficits or surplus operating revenue are shared between the hospital and physicians.
3. Hospital as landlord: Hospital provides or leases space in which physicians locate their office practices, but the physicians assume total fiscal accountability for their ambulatory care office practices.
4. Service not provided: Service is not provided by the organized hospital ambulatory care program or in a medical office building owned by the hospital. Service may be provided in offices by independent physicians who have staff privileges at the hospital.

B. LOCATION

1. Hopital-based: Service maintained at hospital main campus.
2. Satellite: Service available at a satellite facility off the hospital campus.

	A. HOSPITAL ROLE (CHECK ONLY ONE COLUMN)				B. LOCATION (CHECK ALL APPLICABLE COLUMNS)	
	Hospital-controlled	Hospital associated	Hospital as landlord	Service not provided	Hospital based	Satellite
1. Primary care						
2. Other medical specialties and sub-specialties						
3. Other surgical specialties and sub-specialties						
4. Other specialties						

C. FACILITIES AND SERVICES (Continued)

3. SELECTED SERVICE UTILIZATION (SEE ACCOMPANYING INSTRUCTIONS AND DEFINITIONS, OPPOSITE PAGE.)

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 rendered by body unit . . . . . _____

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.

	Licensed/ registered beds	Beds set up and staffed	Average beds 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 1-8)					
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 special care					
18. Other intensive care (specify type _____)					
19. TOTAL INTENSIVE CARE (add lines 10-18)					
20. Skilled nursing long-term					
21. Psychiatric long-term care					
22. Other long-term (include ICF)					
23. Mental retardation					
24. Sheltered care					
25. Self care					
26. Other subacute care (specify type _____)					
27. Swing beds (short-term/long-term only)					
28. TOTAL SUBACUTE CARE (add lines 20-27)					
29. Rehabilitation					
30. TB and other respiratory diseases					
31. Chronic disease					
32. Alcoholism and chemical dependency					
33. Other (specify type _____)					
34. TOTAL OTHER (add lines 29-33)					
35. TOTAL HOSPITAL (add lines 9, 19, 28 and 34)					

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TOTAL HOSPITAL BEDS AND UTILIZATION (Continued)

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. Ambulatory . . . . . _____

   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, include neonatal care units):

   a. Was there a permanent change or a significant temporary change in the total number of adult and pediatric beds set up 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_____

E. TOTAL HOSPITAL BEDS AND UTILIZATION (Continued)

5. ADULT AND PEDIATRIC INPATIENTS (exclude newborn nursery, include neonatal care units) — (Continued)

b. Does your hospital maintain a separate nursing home type of long-term care unit? (Please refer to the instructions and definitions for section E on opposite page.) Yes _____ No _____

IF NO, report total hospital statistics only in column (1) below.
IF YES, report data for both the hospital and nursing home units in columns (2) and (3) below, in addition to total facility statistics in column (1).

	All hospitals fill out (1) Total Facility Statistics	Fill out only if hospital has SEPARATE units for nursing home type of long-term care. (2) Hospital	(3) Nursing Home
c. Beds set up and staffed for use at the end of the reporting period. (If number differs from 1980, answer E5a above)			
d. Admissions (exclude newborns, include neonatal)	*	*	*
e. Inpatient days, (exclude newborns, include neonatal)			
f. Discharges (exclude newborns, include neonatal and deaths) . .	*	*	*
g. Discharge days (exclude newborns, include neonatal and deaths)			

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

6. CENSUS on the last day of your reporting period (exclude newborns, include neonatal) . . . . . _____

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.)	All hospitals Fill Out (1) Total Facility Statistics	Fill out only if hospital has SEPARATE units for nursing home type of long-term care. (2) Hospital	(3) Nursing Home
1. REVENUE (for reporting period only): CONFIDENTIAL**			
a. Gross revenue from service to INPATIENTS (based on full established rates)			
b. Gross revenue from service to OUTPATIENTS (based on full established rates)			
c. TOTAL GROSS revenue from service to PATIENTS (a + b)			
d. Sources of gross patient revenue:			
(1) Medicare			
(2) Medicaid			
(3) Self pay			
(4) Blue Cross/Blue Shield			
(5) Commercial insurers			
(6) Other sources of payment			
(7) Total sources of gross patient revenue [add d(1) - d(6);] (total should equal F1c)			
e. Deductions from revenue:			
(1) Deductions for contractual adjustments			
(2) Deductions for bad debts			
(3) Deductions for charity			
(4) Other deductions			
(5) Total deductions [add e(1) - e(4)]			
f. TOTAL NET revenue from service to PATIENTS [(1c - e(5)]			
g. Sources of net patient revenue:			
(1) Medicare			
(2) Medicaid			
(3) Self pay			
(4) Blue Cross/Blue Shield			
(5) Commercial insurers			
(6) Other sources of payment			
(7) Total sources of net patient revenue [(add g(1) - g(6)] (total should equal F1f)			
h. Other OPERATING REVENUE:			
(1) Tax appropriations			
(2) Other (include cafeteria, gift shop, educational programs, and so forth)			
(3) TOTAL OTHER OPERATING REVENUE [add lines h(1) and h(2)]			
i. NONOPERATING REVENUE (contributions, grants)			
j. TOTAL REVENUE [(f + h(3) + i)]			
2. EXPENSES (for the reporting period only):			
a. PAYROLL EXPENSES for all categories of personnel specified below:			
(1) Physicians and dentists (include only salaries)			
(2) Medical and dental residents (include medical and dental interns)			
(3) Other trainees (medical technology, x-ray therapy, administrative, and so forth)			
(4) Registered and licensed practical nurses			
(5) All other personnel			
(6) TOTAL PAYROLL EXPENSES [(add 2a(1) - (5)]			
b. NONPAYROLL EXPENSES:			
(1) Employee benefits (social security, group insurance, retirement benefits)			
(2) Professional fees (medical, dental, legal, auditing, consultant, and so forth)			
(3) Depreciation expense (FOR REPORTING PERIOD ONLY)			
(4) Interest expense			
(5) All other expenses (supplies, purchased services, and so forth)			
(6) TOTAL NONPAYROLL EXPENSES [Add 2b(1) through (5)]			
c. TOTAL EXPENSES [(2a(6) + b(6)]			

EVENUE 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 . . . . . $ .0

(2) (a) Current receivables . . . . . $ .00

(b) Uncollectables . . . . . $ .00

(c) Net receivables (2a − 2b) . . . . . $ .0

(3) Other current assets . . . . . $ .0

(4) (a) Gross plant and equipment assets (include land, buildings, equipment) . $ .00

(b) LESS: Deduction for accumulated depreciation . . . . . $ .00

(c) NET plant and equipment assets (4a − 4b; if zero, please explain) . . . . . $ .0

(5) Long-term investments (at lower of cost or market value) . . . . . $ .0

(6) Other unrestricted assets . . . . . $ .0

(7) Total unrestricted assets [(1) + (2c) + (3) + (4) + (5) + (6)] . . . . . $ .0

b. LIABILITIES AND FUND BALANCE**

(1) Current liabilities . . . . . $ .0

(2) Long-term debt . . . . . $ .0

(3) Other liabilities . . . . . $ .0

(4) Unrestricted fund balance . . . . . $ .0

(5) Total unrestricted liabilities & fund balance [(add b(1) through b(4)] . . . . . $ .0

4. RESTRICTED FUNDS — Report fund balances only**

a. Specific purpose (identify) _____) . . . . . $ .0

b. Plant replacement and expansion . . . . . $ .0

c. Endowment funds . . . . . $ .0

5. CAPITAL EXPENDITURES (for reporting period only)

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 Less than $150,000	Capital Expenditures Greater than $150,000	Disposals and Retirements
a.	Land	$ .00	$ .00	$ .0
b.	Buildings and improvements	$ .00	$ .00	$ .0
c.	(1) Fixed equipment	$ .00	$ .00	$ .0
	(2) Movable equipment	$ .00	$ .00	$ .0
	(3) TOTAL EQUIPMENT [(1) + (2)]	$ .00	$ .00	$ .0
d.	Construction in progress	$ .00	$ .00	$ .0
e.	TOTAL	$ .00	$ .00	$ .0

(1) Will a permanent increase or decrease in the number of adult and/or 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.

(a) Bed capacity before beginning of project _____

(b) Bed capacity after completion of project _____

(2) 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 _____

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

(4) If YES, what is the total capital authorization included in CON or Section 1122 approvals received during the reporting period? . . . . . $ .0

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

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PERSONNEL ON PAYROLL AS OF SEPTEMBER 30, 1981 (Continued)

1. HOSPITAL PERSONNEL BY OCCUPATIONAL CATEGORY. Report full-time and part-time personnel including trainees who were on the payroll as of SEPTEMBER 30, 1981 and whose payroll expenses are reported in F2a. For those hospitals that operate a nursing home as reported in E5b, DO NOT INCLUDE NURSING HOME STAFF ON THIS PAGE. If there are staff positions that are shared between the hospital and nursing home, please record these staff as part-time employees and report Total Paid Man-hours worked in the hospital setting. Include members of religious orders for whom dollar equivalents were reported. For each occupational category, please report the number of budgeted staff vacancies as of SEPTEMBER 30, 1981. Please report TOTAL PAID MAN-HOURS for all personnel on line G1(p). Also, please report separate breakdown of TOTAL PAID MAN-HOURS for physicians, medical residents, dentists, dental residents, registered nurses, and licensed practical (vocational) nurses.

	FULL-TIME (35 hr/wk. or more)	PART-TIME (less than 35 hr/wk)	TOTAL PAID MAN-HOURS for reporting period	BUDGETED VACANCIES (as of 9/30/81)
a. Administration:				
(1) Administrators and assistant administrators				
b. Physician and Dental Services:				
(1) Physicians				
(2) Medical residents				
(3) Dentists				
(4) Dental residents				
c. Nursing Services:				
(1) Registered nurses				
(2) Licensed practical (vocational) nurses				
(3) Ancillary personnel				
(4) Other nursing service personnel . . .				
d. Physician Assistants.				
e. Medical Record Services:				
(1) Medical record administrators				
(2) Medical record technicians.				
f. Pharmacy:				
(1) Pharmacists, licensed				
(2) Pharmacy technicians.				
g. Clinical Laboratory Services:				
(1) Medical technologists.				
(2) Other laboratory personnel				
h. Dietary Services:				
(1) Dietitians.				
(2) Dietetic technicians.				

G. PERSONNEL ON PAYROLL AS OF SEPTEMBER 30, 1981 (Continued)

	FULL-TIME (35 hr/wk or more)	PART-TIME (less than 35 hr/wk)	TOTAL PAID MAN-HOURS for reporting period	BUDGETED VACANCIES (as of 9/30/81
i. Radiological Services:				
(1) Radiographers (radiologic technologists)				
(2) Radiation therapy technologists				
(3) Nuclear medicine technologists				
(4) Other radiologic personnel				
j. Therapeutic Services:				
(1) Occupational therapists				
(2) Occupational therapy assistants and aides				
(3) Physical therapists				
(4) Physical therapy assistants and aides				
(5) Recreational therapists				
k. Speech and Hearing Services:				
(1) Speech pathologists/audiologists				
l. Respiratory Therapy Services:				
(1) Respiratory therapists				
(2) Respiratory therapy technicians				
m. Social Work Services:				
(1) Medical social workers				
n. All other health professional and technical personnel				
o. All other personnel				
p. 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 t payroll as of SEPTEMBER 30, 1981, whose payroll expenses are reported in F2a(3), and who were included in TOTAL HOSPITA PERSONNEL (G1p). Please do not include physician and dental residents.

	FULL-TIME (35 hr/wk or more)	PART-TIME (less than 35 hr/wk)	TOTAL PAID MAN-HOURS for reporting period
TOTAL OTHER TRAINEES (exclude physician and dental residents)			

3. NURSING HOME PERSONNEL. (Complete only if hospital has a separate nursing home unit as reported in E5b.) Report full-time and pa time nursing home personnel who were on the payroll as of September 30, 1981 and whose payroll expenses are reported in F2a column If nursing home staff is shared with the hospital, please report these staff as part-time employees.

	FULL-TIME (35 hr/wk or more)	PART TIME (less than 35 hr/wk)
TOTAL NURSING HOME PERSONNEL		

4. Does your hospital have a full-time salaried chief of staff who serves as the medical and administrative head of the medical staff?

Yes_____ No_____