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

AMERICAN HOSPITAL ASSOCIATION

ANNUAL SURVEY OF HOSPITALS

1982

GENERAL INSTRUCTIONS

Two copies of the Annual Survey questionnaire are enclosed. Please return one completed 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 should be completed and retained in your files for reference. All hospitals should forward a photocopy of the completed questionnaire to your state hospital association.

HOSPITAL. For purposes of this survey, a hospital is defined as the organization or corporate entity licensed or registered as a hospital by a state to provide diagnostic and therapeutic patient services for a variety of medical conditions, including both surgical and nonsurgical.

REPORT UTILIZATION, REVENUE, EXPENSES, AND CAPITAL EXPENDITURES FOR A FULL 12-MONTH PERIOD, PREFERABLY THE PERIOD ENDING SEPTEMBER 30, 1982. REPORT PERSONNEL DATA AS OF SEPTEMBER 30, 1982 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.

AMERICAN HOSPITAL ASSOCIATION

PLEASE REFER TO THE INSTRUCTIONS AND DEFINITIONS

A. REPORTING PERIOD

Report data for a full 12-month period, preferably October 1, 1981 through September 30, 1982 (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

CONTROL

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

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 Federal other than 41-45 or 47-48
- ☐ 47 PHS Indian Service
- ☐ 48 Department of Justice

2. Is the hospital owned, leased, or sponsored by another corporation? YES ☐ NO ☐

   If YES, please check the appropriate box and report the name of the corporation. The hospital is:

   - ☐ OWNED BY_____
   - ☐ LEASED BY_____
   - ☐ SPONSORED BY_____

3. Does the hospital itself own or lease other corporation(s)? YES ☐ NO ☐

   If YES, please check the appropriate box and provide the name of the corporation(s). The hospital:

   - ☐ OWNS_____
   - ☐ LEASES_____

   (Please report additional information on a separate sheet of paper if necessary.)

4. Is the hospital operated under a management contract? YES ☐ NO ☐

   If YES, please give the name of the organization that manages the hospital.

   _____

5. Does the hospital operate other hospitals under a management contract? YES ☐ NO ☐

   If YES, please give the names of the hospitals that are contract-managed.

   _____

   _____

   _____

   _____

SERVICE

6. 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 metally 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

GENERAL MEDICAL, SURGICAL, AND ANCILLARY SERVICES

1. 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. Please note that the facilities/services listed below need not be provided in a formal organizational unit unless specifically stated in the definitions for that service

Column Number	Description
1	Service is available within the hospital.
2	Service is not maintained in the hospital, but is available through a formal contractual arrangement with another hospital or provider

	(1) Hospital-Based	(2) Provided by Another Hospital or Provider
1. Medical/surgical, acute	☐	☐
2. Pediatric acute	☐	☐
3. Psychiatric, acute	☐	☐
4. Obstetrics	☐	☐
5. Rehabilitation	☐	☐
6. Alcoholism and chemical dependency	☐	☐
7. Medical/surgical intensive care	☐	☐
8. Cardiac intensive care	☐	☐
9. Pediatric intensive care	☐	☐
10. Neonatal intensive care	☐	☐
11. Burn care	☐	☐
12. Psychiatric intensive care	☐	☐
13. Other special care	☐	☐
14. Skilled nursing long-term care	☐	☐
15. Psychiatric long-term care	☐	☐
16. Mental retardation	☐	☐
17. Other long-term care (include ICF)	☐	☐
18. Sheltered care	☐	☐
19. Self-care	☐	☐
20. Tuberculosis and other respiratory diseases	☐	☐
21. Newborn nursery	☐	☐
22. Abortion services	☐	☐
23. Alcoholism/chemical dependency outpatient services	☐	☐

C. FACILITIES AND SERVICES (Continued)

	(1) Hospital-Based	(2) Provided by Another Hospital or Provider
24. Cardiac catheterization laboratory	☐	☐
25. Chaplaincy services	☐	☐
26. Day hospital	☐	☐
27. Dental services	☐	☐
28. Emergency department	☐	☐
29. Electrocardiography	☐	☐
30. Family planning	☐	☐
31. Genetic counseling	☐	☐
32. Comprehensive geriatric assessment service	☐	☐
33. Health promotion	☐	☐
34. Hemodialysis	☐	☐
35. Home care program	☐	☐
36. Hospice	☐	☐
37. Hospital auxiliary	☐	☐
38. Laboratory services:		
a. Histopathology laboratory	☐	☐
b. Blood bank	☐	☐
39. Optometric services	☐	☐
40. Organized outpatient department	☐	☐
41. Premature nursery	☐	☐
42. Podiatric services	☐	☐
43. Therapy services:		
a. Occupational therapy	☐	☐
b. Physical therapy	☐	☐
c. Recreational therapy	☐	☐
d. Respiratory therapy	☐	☐
e. Speech pathology	☐	☐
f. Rehabilitation outpatient services	☐	☐

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	(1) Hospital-Based	(2) Provided by Another Hospital or Provider
44. 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	☐	☐
45. Pharmacy services:		
a. Pharmacy	☐	☐
b. Intravenous admixture service	☐	☐
c. Pharmacy unit dose system	☐	☐
46. Radiology diagnostic:		
a. CT scanner	☐	☐
b. Diagnostic radioisotope facility	☐	☐
c. Ultrasound	☐	☐
47. Radiation therapy:		
a. Megavoltage radiation therapy	☐	☐
b. Radioactive implants	☐	☐
c. Therapeutic radioisotope facility	☐	☐
d. X-ray radiation therapy	☐	☐
48. Social work services	☐	☐
49. Patient representative services	☐	☐
50 Surgical services:		
a. Ambulatory surgical services	☐	☐
b. Kidney transplant	☐	☐
c. Organ transplant (other than kidney)	☐	☐
d. Open-heart surgery	☐	☐
e. Postoperative recovery room	☐	☐
51. Volunteer services department	☐	☐

C. FACILITIES AND SERVICES (Continued)

Explanation of column headings:

A. HOSPITAL ROLE

Hospital-sponsored:

a. Hospital assumes total fiscal and legal accountability for the ambulatory care program. Physicians are salaried.

b. Hospital assumes total fiscal and legal accountability for the ambulatory care program. Physicians bill separately for their professional fees.

Hospital-associated: Hospital and physicians share fiscal accountability for the ambulatory care program for example, deficits or surplus ope revenue are shared between the hospital and physicians.

Hospital as landlord: Hospital provides or leases space in which physicians locate their office practices, but the physicians assume total accountability for their ambulatory care office practices.

B. LOCATION

Hospital-based: Services are maintained at the hospital main campus.

Satellite: Services are available at a facility geographically remote from the hospital campus.

2. ORGANIZED AMBULATORY SERVICES

	A. HOSPITAL ROLE (CHECK ONLY ONE COLUMN)					B. LOCATION (CHECK ALL APPLICABLE COLUMNS)	
	Hospital-Sponsored a.	Hospital-Sponsored b.	Hospital-Associated	Hospital as Landlord	Services not Provided	Hospital-Based	Satellite
1. General and internal medicine	☐	☐	☐	☐	☐	☐	☐
2. Surgical specialities	☐	☐	☐	☐	☐	☐	☐
3. Pediatrics	☐	☐	☐	☐	☐	☐	☐
4. Obstetrics and gynecology	☐	☐	☐	☐	☐	☐	☐
5. Multispeciality	☐	☐	☐	☐	☐	☐	☐
6. All other	☐	☐	☐	☐	☐	☐	☐

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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. Hospitals with separate nursing home-type units as reported in section E and F should list the beds contained in those units under the appropriate subacute care categories in this section.

	Beds Set Up and Staffed Last Day of the 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. Other acute (specify type: _____)		
6. TOTAL ACUTE CARE (add lines 1-5)		
7. Medical/surgical intensive care (include mixed ICU/CCU)		
8. Cardiac intensive care		
9. Neonatal intensive care		
10. Neonatal intermediate care		
11. Pediatric intensive care		
12. Burn care		
13. Psychiatric intensive care		
14. Other special care		
15. Other intensive care (specify type: _____)		
16. TOTAL INTENSIVE CARE (added lines 7-15)		
17. Skilled nursing long-term care		
18. Psychiatric long-term care		
19. Other long-term (include ICF)		
20. Mental retardation		
21. Sheltered care		
22. Self care		
23. Other subacute care (specify type _____)		
24. TOTAL SUBACUTE CARE (add lines 17-23)		
25. Rehabilitation		
26. TB and other respiratory diseases		
27. Chronic disease		
28. Hospice		
29. Alcoholism and chemical dependency		
30. Other (specify type: _____)		
31 TOTAL OTHER (add lines 25-30)		
32. TOTAL FACILITY (Add lines 6, 16, 24, 31)		

E. TOTAL FACILITY 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. Ambulatory _____

c. Total _____

4. OUTPATIENT UTILIZATION

	Emergency Care Visits 1	Other Ambulatory Care Program Visits 2
a. Ambulatory visits (include only contact with physicians, dentists, nurse practitioners, or physician assistants)		
b. Ambulatory therapy and treatment visits (such as occupational and physical therapy, EKG, EEG, and nuclear medicine)		
c. Ambulatory ancillary service visist (such as blood test and urinalysis)		
d. Total ambulatory utilization visits		

5. ADULT, PEDIATRIC AND NEONATAL BEDS (exclude newborn nursery, include neonatal care units):

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

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TOTAL HOSPITAL BEDS AND UTILIZATION (Continued)

5. ADULT, PEDIATRIC, AND NEONATAL BEDS (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 the opposite page.) ..... YES ☐ NO ☐

If NO, Report total facility 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 institutions fill out:	Fill out only if hospital has separate units for nursing home type of long-term care:	
	(1) Total Facility Statistics	(2) Hospital	(3) Nursing Home-Type Unit
c. Beds set up and staffed for use at the end of the reporting period (if number differs from 1981, answer E5a on previous page)			
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)			

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 .....

8 65 AND OLDER UTILIZATION

a. Age 65 and older admissions .....
b. Age 65 and older inpatient days .....

9. SWING-BEDS

a. Does your hospital utilize swing-beds as defined on the opposite page? ..... YES ☐ NO ☐

b. If YES, please report the total number of swing-beds set up and staffed at the end of the reporting period .....

c. Please report the number of inpatient days for the reporting period that the swing-beds were used in the provision of acute and subacute care services

Inpatient Days

1. Acute care swing-beds _____
2 Skilled nursing care swing-beds _____
3. Intermediate care swing-beds _____

Because of unit transfers, column 1 may be less than the sum of columns 2 and 3.

F. FINANCIAL DATA

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

	All institutions fill out:	Fill out only if hospital has separate units for nursing home type of long-term care:	
	(1) Total Facility Statistics	(2) Hospital	(3) Nursing Home Type Unit
1. REVENUE** (for reporting period only):			
a. Gross revenue from service to INPATIENTS (based on full established rates)	.00	.00	
b. Gross revenue from service to OUTPATIENTS (based on full established rates)	.00	.00	
c. TOTAL GROSS revenue from service to PATIENTS (a+b)	.00	.00	.0
d. Sources of gross patient revenue:			
(1) Medicare	.00	.00	
(2) Medicaid	.00	.00	
(3) Self pay	.00	.00	
(4) Blue Cross/Blue Shield	.00	.00	
(5) Commercial insurers	.00	.00	
(6) Other sources of payment	.00	.00	
(7) Total sources of gross patient revenue [add d(1) – d(6); (total should equal line F1c)]	.00	.00	
e. Deductions from revenue:			
(1) Deductions for contractual adjustments	.00	.00	
(2) Deductions for bad debts	.00	.00	
(3) Deductions for charity	.00	.00	
(4) Other deductions	.00	.00	
(5) Total deductions [add e(1) – e(4)]	.00	.00	
f. TOTAL NET REVENUE from service to PATIENTS [1c – e(5)]	.00	.00	.0
g. Source of net patient revenue:			
(1) Medicare	.00	.00	
(2) Medicaid			
(3) Self pay	.00	.00	
(4) Blue Cross/Blue Shield	.00	.00	
(5) Commercial insurers	.00	.00	
(6) Other sources of payment	.00	.00	
(7) Total sources of net patient revenue [add g(1) – g(6) (total should equal line F1f)]	.00	.00	
h. OTHER OPERATING REVENUE:			
(1) Tax appropriations	.00	.00	
(2) Other (include cafeteria, gift shop, educational programs, and so forth)	.00	.00	
(3) TOTAL OTHER OPERATING REVENUE [add lines h(1) and h(2)]	.00	.00	
i. NONOPERATING REVENUE (contributions, grants, interests income)	.00	.00	
j. TOTAL REVENUE [(f + h(3) + i)]	.00	.00	.0

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

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FINANCIAL DATA (Continued)

	All institutions 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-Type Unit
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	.00	
(2) Medical and dental residents (include medical and dental interns)	.00	.00	
(3) Other trainees (medical technology, x-ray therapy, administrative and so forth)	.00	.00	
(4) Registered and licensed practical nurses	.00	.00	
(5) All other personnel	.00	.00	
(6) TOTAL PAYROLL EXPENSES [add 2a(1) – (5)]	.00	.00	.00
b NONPAYROLL EXPENSES:			
(1) Employee benefits (social security, group insurance, retirement benefits)	.00	.00	
(2) Professional fees (medical, dental, legal, auditing, consultant, and so forth)	.00	.00	
(3) Contracted nursing services (include staff from nursing registries service contracts, and temporary help agencies)	.00	.00	
(4) Depreciation expense (FOR REPORTING PERIOD ONLY)	.00	.00	
(5) Interest expense	.00	.00	
(6) Utility expense	.00	.00	
(7) All other expenses (supplies, purchased services, and so forth)	.00	.00	
(8) TOTAL NONPAYROLL EXPENSES [add 2b(1) through (5)]	.00	.00	.00
c TOTAL EXPENSES [2a(6) + b(8)]	.00	.00	.00

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 and equipment assets (include land, buildings, and equipment)	$ .00		
(b) LESS: Deduction for accumulated depreciation	$ .00		
(c) NET plant and equipment assets (4a – 4b; if zero, please explain)			$ .00
(5) Long-term investments (at lower of cost or market value)			$ .00
(6) Other unrestricted assets			$ .00
(7) Total unrestricted assets [(1) + (2c) + (3) + (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 and fund balance [add b (1) through b(4)]	$ .00

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

F. FINANCIAL DATA (Continued)

4. RESTRICTED FUNDS** (report fund balances only)

(a) Specific purpose (specify: _____) $ _____.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 complete or incomplete capital acquisition projects

	Asset Account		Capital Expenditures
a	Land		$ _____.00
b	Buildings and improvements		$ _____.00
c.	(1) Fixed equipment	$ _____.00	
	(2) Movable equipment	$ _____.00	
	(3) TOTAL EQUIPMENT [(1) + (2)]		$ _____.00
d.	Construction in progress		$ _____.00
e.	TOTAL		$ _____.00

(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) During the reporting period, did the hospital acquire any debt for capital projects or acquisitions? YES ☐ NO ☐

If YES, give the amount and repayment period for each of the following sources:

	Amount	Repayment Period in Years
(a) Direct loans from banks	$ _____.00	_____
(b) Bond issues: 1) Tax exempt	$ _____.00	_____
2) Taxable	$ _____.00	_____
(c) Section 242 federally insured loans	$ _____.00	_____
(d) Other (please specify: _____)	$ _____.00	_____
TOTAL	$ _____.00	_____

(3) Did the hospital undertake any refinancing of existing debt totally unassociated with a new or ongoing capital project or acquisition YES ☐ NO ☐

If YES, please give the amount and repayment period for the refinancing

Amount $ _____.00

Repayment period _____

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

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PERSONNEL ON PAYROLL AS SEPTEMBER 30, 1982

1. HOSPITAL PERSONNEL BY OCCUPATIONAL CATEGORY

Report full-time and part-time personnel including trainees who were on the payroll as of SEPTEMBER 30, 1982, and whose payroll expenses are reported in F2a. For those hospitals that operate a nursing home-type unit as reported in E5b, DO NOT INCLUDE NURSING HOME STAFF HERE. If there are staff positions that are shared between the hospital and nursing home-type unit, please record these staff as part-time employees under the appropriate occupational category. 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, 1982. Under CONTRACTED PERSONNEL, please report the number of persons who provided services within the hospital on September 30, 1982, and who were not on the hospital payroll. Include staff from contractual arrangements, nursing registries, temporary agencies, and so forth.

	Full-Time (35 hr/wk or more)	Part-Time (less than 35 hr/wk)	Contracted Personnel (as of 9/30/82)	Budgeted Vacancies (as of 9/30/82)
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 Nurse practitioners				
f Medical record services:				
(1) Medical record administrators				
(2) Medical record technicians				
g Pharmacy:				
(1) Pharmacists, licensed				
(2) Pharmacy technicians				
h Clinical laboratory services:				
(1) Medical technologists				
(2) Other laboratory personnel				
i Dietary services:				
(1) Dietitians				
(2) Dietetic technicians				

G. PERSONNEL ON PAYROLL AS OF SEPTEMBER 30, 1982 (Continued)

	Full-Time (35 hr/wk or more)	Part-Time (less than 35 hr/wk)	Contracted Personnel (as of 9/30/82)	Budgeted Vacancies (as of 9/30/82)
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				
(2) Audiologists				
l. Respiratory therapy services:				
(1) Respiratory therapists				
(2) Respiratory therapy technicians				
m. Social work services:				
(1) Medical social workers				
n. All other 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 the payroll as SEPTEMBER 30, 1982, whose payroll expenses are reported in line F2a(3), and who were included in TOTAL HOSPITAL PERSONNEL li G1p. Please do not include physician and dental residents.

	Full-Time (35 hr/wk or more)	Part-Time (less than 35 hr/wk)
TOTAL OTHER TRAINEES (exclude physician and dental residents)		

3. NURSING HOME PERSONNEL

Complete only if hospital has a separate nursing home-type unit as reported in E5b. Report full-time and part-time nursing home personn who were on the payroll as of September 30, 1982, and whose payroll expenses are reported in line F2a, column 3. If nursing home sta 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		

I. MEDIC

Please ind and the ni individuals estimates.

1. Medi
   a.
   b. I
   c.
   d.
2. Surgic
   a.
   b. C
   c. C
3. Other
   a. P
   b. R
   c. A
   d. O
4. Dental

How many

MEDICAL STAFF

Budgeted Vacancies as of 9/30/82

Please indicate the number of practitioners on the ACTIVE and ASSOCIATE (do not include courtesy, consulting, honorary, or other) medical staff and the number of house staff in each of the following specialty groups as of September 30, 1982. Under house staff please report the number of individuals as of September 30, 1982. Do not report full-time equivalents or portions. If the exact numbers are unavailable, please give your best estimates. If you cannot supply estimates for specialty categories, please fill in the total figures

	Number of Active and Associate Medical Staff	Number of Active and Associate Medical Staff Who Are Board Certified	Number of House Staff	Number of House Staff in ACGME or AOA Approved Training Positions
1. Medical Specialties				
a. General and family practice				
b. Pediatric				
c. General internal medicine				
d. Other medical specialties				
2. Surgical specialties				
a. General surgery				
b. Obstetrics and gynecology				
c. Other surgical specialties				
3. Other specialties				
a. Pathology				
b. Radiology				
c. Anesthesiology				
d. Other specialties				
4. Dental specialties				
TOTAL				

How many practitioners with ACTIVE or ASSOCIATE admitting privileges were added to the hospital's medical staff during the reporting period?

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