

American
Hospital
Association



1984 Annual Survey of Hospitals

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

Please return by:

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 their state hospital association.

In order to facilitate completion of the 1984 Annual Survey of Hospitals, responses to the 1983 survey for your facility have been printed on the current survey. In Sections B and C, please correct items where the printed data no longer apply to your facility. Only those items that need correction or clarification require a response. Items that did not appear on the 1983 survey are underlined; please check those that apply to your facility. In Sections D through H, selected items from the 1983 survey for your facility have been printed for comparative purposes. Please do not make any corrections to the 1983 data or re-copy the 1983 data in the space provided for the 1984 data. If your facility did not return a survey in 1983, please respond to all current year items that apply to your facility. Do not complete the 1983 section if it is blank.

Report utilization, revenue, expenses, and capital expenditures for a full 12-month period, preferably the period ending September 30, 1984. Report personnel data as of September 30, 1984, regardless of the end of the reporting period. Report all other information as of the end of the reporting period. You may use your fiscal year as 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, 1983 through September 30, 1984 (366 days). (Use for data reported in sections D, E, and F.)

1 Indicate period used: Beginning date MONTH DAY YEAR

Ending date MONTH DAY YEAR

2 Were you in operation 12 full months at the end of your reporting period? YES NO

Number of days open during reporting period

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 a corporation other than the controlling organization listed above? If YES, please complete the appropriate lines below YES NO

a What is the name of the controlling organization that is responsible for establishing policy concerning overall operation and management of the hospital? YES NO

b Does the controlling organization lease the physical property of the hospital from the owner(s) of the hospital? YES NO

c What is the name of the legal entity that owns and has title to the land and physical plant of the hospital?

d What is the name of the organization that sponsors the hospital?

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 your hospital or the type of service it 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 on any basis other than emergency or out of area care to members of a:

- a Health maintenance organization (HMO) YES NO
- b Preferred provider organization (PPO) YES NO

C. FACILITIES AND SERVICES

1. MEDICARE CERTIFICATION OF DISTINCT PART UNITS

Please indicate the Medicare subprovider status for each designated service area by checking the appropriate column.

Designated Service Area	Medicare Subprovider Status				
	(1) Obtained	(2) Denied	(3) Pending	(4) Not Applied For	(5) Not Provided In DPU
a <u>Rehabilitation</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b <u>Psychiatric</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c <u>Hospice</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d <u>Alcoholism and other chemical dependency</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e <u>Skilled nursing facility-- dedicated unit</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f <u>Skilled nursing facility-- swing bed program</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g <u>Home health care</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. 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. 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. If the service is not available, please check column 3.

Column Number	Description
1	Service is made available by the hospital (staffed or contracted)
2	Service is not maintained in the hospital but is available through a <u>FORMAL CONTRACTUAL</u> arrangement with another hospital or provider
3	Service is not available at the hospital nor by formal contract with another hospital or provider

	(1) Provided by the Hospital	(2) Provided at Another Hospital or Provider	(3) Not Available
1 Medical/surgical acute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Pediatric acute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Psychiatric acute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Obstetrics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Physical medicine and rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 <u>Alcoholism/chemical dependency acute inpatient services</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 <u>Alcoholism/chemical dependency subacute inpatient services</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Medical/surgical intensive care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Cardiac intensive care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Pediatric intensive care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Neonatal intensive care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 Burn care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 Other special care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 Skilled nursing long-term care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 Psychiatric long-term care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16 Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17 Other long-term care (include ICF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 Sheltered care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19 Self-care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 Chronic obstructive pulmonary disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 Newborn nursery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22 Abortion services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23 Alcoholism/chemical dependency outpatient services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. FACILITIES AND SERVICES (Continued)

	(1) Provided by the Hospital	(2) Provided at Another Hospital or Provider	(3) Not Available
24 Cardiac catheterization laboratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25 Chaplaincy services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26 Day hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27 Dental services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28 Emergency department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29 Trauma center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30 Electrocardiography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31 Family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32 Genetic counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33 Comprehensive geriatric assessment service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34 Health promotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35 Hemodialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36 Home care program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37 Hospice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38 Hospital auxiliary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39 Laboratory services:			
a General laboratory services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b Histopathology laboratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c Blood bank	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40 Optometric services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41 Organized outpatient department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42 Premature nursery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43 Podiatric services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44 Therapy services:			
a Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c Recreational therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d Respiratory therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e Speech pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f Rehabilitation outpatient services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. FACILITIES AND SERVICES (Continued)

	(1) Provided by the Hospital	(2) Provided at Another Hospital or Provider	(3) Not Available
45 Psychiatric acute services:			
a. Psychiatric services, pediatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Psychiatric emergency services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Clinical psychology services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Psychiatric consultation and education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Psychiatric foster and/or home care program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Psychiatric outpatient services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Psychiatric liaison services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Psychiatric partial hospitalization program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46 Pharmacy services:			
a. Pharmacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Intravenous admixture service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pharmacy unit dose system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. Radiology, diagnostic:			
a. CT scanner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Diagnostic radioisotope facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Nuclear magnetic resonance (Magnetic resonance imaging)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48 Radiation therapy:			
a. Megavoltage radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Radioactive implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Therapeutic radioisotope facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. X-ray radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49 Social work services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50 Patient representative services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 Surgical services:			
a. General surgical services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Ambulatory surgical services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Kidney transplant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Organ transplant (other than kidney)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Open-heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52 Volunteer services department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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. Do not include normal newborn bassinets. 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

	(1) Beds Set Up and Staffed Last Day of the Reporting Period 1983	(2) Beds Set Up and Staffed Last Day of the Reporting Period 1984	(3) Total Inpatient Days for Reporting Period 1983	(4) Total Inpatient Days for Reporting Period 1984
1 General medical/surgical (adult, include gynecology)				
2 General medical/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 Other special care				
14 Other intensive care (specify type: _____)				
15 TOTAL INTENSIVE CARE (add lines 7-14)				
16 Skilled nursing long-term care				
17 Psychiatric long-term care				
18 Other long-term care (include ICF)				
19 Mental retardation				
20 Sheltered care				
21 Self care				
22 Other subacute care (specify type: _____)				
23 TOTAL SUBACUTE CARE (add lines 16-22)				
24 Rehabilitation				
25 Chronic obstructive pulmonary disease				
26 Chronic disease				
27 Hospice				
28 Alcoholism/chemical dependency, acute care				
29 Alcoholism/chemical dependency, subacute care				
30 Other (specify type: _____)				
31 TOTAL OTHER (add lines 24-30)				
32 TOTAL FACILITY (add lines 6, 15, 23, 31)				

E. TOTAL FACILITY BEDS AND UTILIZATION

All statistics reported in D, 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.

	1983 <u>reported</u>	1984
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	1983 <u>reported</u>	1984
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	_____	_____
d Number of birthing rooms	_____	_____
3 SURGICAL OPERATIONS, whether major or minor	1983 <u>reported</u>	1984
a Inpatient	_____	_____
b Ambulatory	_____	_____
c Total	_____	_____
d Number of operating rooms/suites	_____	_____
4 OUTPATIENT VISITS Please record the number of outpatient visits for each of the categories below. Do not report occasions of service in any category	1983 <u>reported</u>	1984 <u>Visits</u>
a Emergency	_____	_____
b <u>Clinic</u>	_____	_____
c <u>Other</u>	_____	_____
d Total	_____	_____

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

a Was there a significant temporary or a permanent 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

E. 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 opposite page.) YES NO

If NO, report total facility statistics only in column (4) below.
If YES, report data for both the hospital and nursing home units in columns (5) and (6) below, in addition to total facility statistics in column (4)

	(1) 1983 Reported Total Facility Statistics	(2) 1983 Reported Hospital	(3) 1983 Reported Nursing Home- Type Unit	(4) 1984 Total Facility Statistics	(5) 1984 Hospital	(6) 1984 Nursing Home- Type Unit
c Beds set up and staffed for use at the end of the reporting period (if number differs from 1983, answer E5a on page 13) (include neonatal beds)						
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) discharges-inpatient*						
b Total Medicare (Title XVIII) inpatient days						
c Total Medicare (Title XVIII) visits-outpatient						
d Total Medicaid (Title XIX) discharges-inpatient*						
e Total Medicaid (Title XIX) inpatient days						
f Total Medicaid (Title XIX) visits-outpatient						
8. 65 AND OLDER UTILIZATION						
a Age 65 and older admissions*						
(1) Age 65-69 admissions*						
(2) Age 70-74 admissions*						
b Age 65 and older inpatient days						
(1) Age 65-69 inpatient days						
(2) Age 70-74 inpatient days						
9. SWING-BEDS						
a Does your hospital utilize swing-beds as defined on the opposite page? YES <input type="checkbox"/> NO <input type="checkbox"/>						
b If YES, please report the total number of acute care beds designated as swing beds						
c Please report the number of admissions and inpatient days for the reporting period that the swing-beds were used in the provision of acute and subacute care services.						
	(1) Admissions	(2) Inpatient Days				
(1) Total for swing beds						
(2) Skilled nursing swing beds						
(3) Intermediate care swing beds						

*Because of unit transfers, column 4 may be less than the sum of columns 5 and 6

F. FINANCIAL DATA

All institutions fill out:

Fill out only if hospital has separate units for nursing home type of long-term care:

	(1) 1983 Reported Total Facility Statistics	(2) 1984 Total Facility Statistics	(3) 1984 Hospital	(4) 1984 Nursing Home- Type Unit
1 REVENUE** (for reporting period only. Do not include revenue related losses; if actual figures are not available, please estimate; round to the nearest dollar)				
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) Government				
(a) Medicare inpatient				
(b) Medicare outpatient				
(c) Medicaid inpatient				
(d) Medicaid outpatient				
(e) Other				
(f) Total government sources (add (1a) through (1e))				
(2) Nongovernment				
(a) Self-pay				
(b) Blue Cross/Blue Shield				
(c) Commercial insurers				
(d) Other				
(e) Total nongovernment sources (add (2a) through (2d))				
(3) Total sources of gross patient revenue ((1f) + (2e)) (total should equal line 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) through e(4))				
f TOTAL NET revenue from service to PATIENTS (1c - e(5))				
g Sources of net patient revenue:				
(1) Government				
(a) Medicare inpatient				
(b) Medicare outpatient				
(c) Medicaid inpatient				
(d) Medicaid outpatient				
(e) Other				
(f) Total government sources (add (1a) through (1e))				
(2) Nongovernment				
(a) Self-pay				
(b) Blue Cross/Blue Shield				
(c) Commercial insurers				
(d) Other				
(e) Total nongovernment sources (add (2a) through (2d))				
(3) Total sources of net patient revenue ((1f)+(2e)) (total should equal line F1f)				
h OTHER OPERATING REVENUE:				
(1) Tax appropriations				
(2) Other (include cafeteria gift shop educational programs, and so forth)				
(3) TOTAL OTHER OPERATING REVENUE (h(1) + h(2))				
i NONOPERATING REVENUE (Do not report negative numbers. Losses or expenses should be reported in F2B(7))				
(1) Contributions				
(2) Grants				
(3) Interest income				
(4) Other				
(5) TOTAL NONOPERATING REVENUE (add i(1) through i(4))				
j TOTAL REVENUE (f + h(3) + i(5))				

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

F. FINANCIAL DATA (Continued)

	(1) 1983 Reported Total Facility Statistics	(2) 1984 Total Facility Statistics	(3) 1984 Hospital	(4) 1984 Nursing Home- Type Unit
2. EXPENSES (for the reporting period only; if actual figures are not available please estimate; round to the nearest dollar)				
a. PAYROLL EXPENSES for all categories of personnel specified below: (see definitions page 18)				
(1) Physicians and dentists (include only salaries)				
(2) Medical and dental residents (include medical and dental interns)				
(3) 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) through (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) Contracted nursing services (include staff from nursing registries, service contracts, and temporary help agencies)				
(4) Depreciation expense (FOR REPORTING PERIOD ONLY)				
(5) Interest expense				
(6) Energy expense				
(7) All other expenses (supplies, purchased services, nonoperating expenses, and so forth)				
(8) TOTAL NONPAYROLL EXPENSES (add 2b(1) through (7))				
c. TOTAL EXPENSES (2a(6) + b(8)) (compare to total revenue)				
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				
(2) (a) Current receivables				
(b) Uncollectibles				
(c) Net receivables (2a - 2b)				
(3) Other current assets				
(4) (a) Gross plant and equipment assets (include land, buildings, and equipment; include actual or estimated value of plant/equipment that is leased)				
(b) LESS: Deduction for accumulated depreciation				
(c) NET plant and equipment assets (4a - 4b; if zero, please explain)				
(5) Long-term investments (at lower of cost or market value)				
(6) Other unrestricted assets				
(7) Total unrestricted assets ((1) + (2c) + (3) + (4c) + (5) + (6))				
b. LIABILITIES AND FUND BALANCE**				
(1) Current liabilities				
(2) Long-term debt				
(3) Other liabilities				
(4) Unrestricted fund balance				
(5) Total unrestricted liabilities and fund balance (add b(1) through b(4); should equal 3a(7))				
4. RESTRICTED FUNDS** (report fund balances only)				
a. Specific purpose (specify: _____)				
b. Plant replacement and expansion				
c. Endowment funds				

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

F. FINANCIAL DATA (Continued)

5 CAPITAL EXPENDITURES (for reporting period only)

a Report only the actual expenditures made during the reporting period on completed or incomplete capital acquisition projects

Asset Account	Capital Expenditures
(1) Land	_____
(2) Buildings and improvements	_____
(3) (a) Fixed equipment	_____
(b) Movable equipment	_____
(c) TOTAL EQUIPMENT ((a) + (b))	_____
(4) Construction in progress	_____
(5) TOTAL	_____

b Did your facility make any debt principal payments during the reporting period? ** YES NO
 If yes, please indicate amount of principal reduction _____

c 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

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

d During the reporting period, did the hospital acquire any debt for capital projects or acquisitions? ** (Do not include capital leases) YES NO
 If YES, give the amount and repayment period for each of the following sources:

	Amount	Repayment Period in Years
(1) Direct loans from banks	_____	_____
(2) Bond issues:		
(a) Tax exempt	_____	_____
(b) Taxable	_____	_____
(3) Section 242 federally insured loans	_____	_____
(4) Other (please specify: _____)	_____	_____
(5) TOTAL	_____	_____

e 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 (to the nearest full year) for the refinancing
 Amount _____
 Repayment period _____ years

6 Is the information generally reported in this section based on your externally audited financial statements? ** YES NO

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

G. PERSONNEL ON PAYROLL AS OF SEPTEMBER 30, 1984

1. HOSPITAL PERSONNEL BY OCCUPATIONAL CATEGORY

Report full-time and part-time personnel including trainees who were on the payroll as of SEPTEMBER 30, 1984, and whose payroll expenses are reported in F2a. If full-time and part-time are not available, please report full-time equivalent (FTE) personnel in column (3) and zero in column (4). 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 who dollar equivalents were reported. For each occupational category, please report the number of budgeted staff vacancies as of SEPTEMBER 30, 1984. Under CONTRACTED PERSONNEL, please report the number of persons who provided services within the hospital on September 30, 1984, and who were not on the hospital payroll. Include staff from contractual arrangements, nursing registries, temporary agencies and so forth. DO NOT INCLUDE physicians or dentists providing clinical services or consulting services.

	(1) 1983 Full-Time (35 hr/wk or more)	(2) 1983 Part-Time (less than 35 hr/wk)	(3) 1984 Full-Time (35 hr/wk or more) On Payroll	(4) 1984 Part-Time (less than 35 hr/wk) On Payroll	(5) 1984 Contracted Personnel (as of 9/30/84)	(6) 1984 Budgeted Vacancies (as of 9/30/84)
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 nursing personnel						
d Physician's 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, 1984 (Continued)

	(1) 1983 Full-Time (35 hr/wk or more)	(3) 1983 Part-Time (less than 35 hr/wk)	(2) 1984 Full-Time (35 hr/wk or more) On Payroll	(4) 1984 Part-Time (less than 35 hr/wk) On Payroll	(5) 1984 Contracted Personnel (as of 9/30/84)	(6) 1984 Budgeted Vacancies (as of 9/30/84)
j Radiological services:						
(1) Radiographers (radiologic technologists)						
(2) Radiation therapy technologists						
(3) Nuclear medicine technologists						
(4) Other radiologic personnel						
k Therapeutic services:						
(1) Occupational therapists						
(2) Occupational therapy assistants and aides						
(3) Physical therapists						
(4) Physical therapy assistants and aides						
(5) Recreational therapists						
l Speech and hearing services:						
(1) Speech pathologists						
(2) Audiologists						
m Respiratory therapy services:						
(1) Respiratory therapists						
(2) Respiratory therapy technicians						
n Psychologists						
o Medical social workers						
p All other professional and technical personnel						
q All other personnel						
r Total hospital personnel						

2 TRAINEES ON PAYROLL

Report full-time and part-time trainees (personnel who have not met the minimum qualifications or completed the necessary requirements for certification) who were on the payroll as of SEPTEMBER 30, 1984, whose payroll expenses are reported in line F2a(3), and who were included in TOTAL HOSPITAL PERSONNEL (line G1r) and NURSING HOME PERSONNEL (line G2). Please do not include medical and dental residents.

	1983 Full-Time (35 hr/wk or more)	1983 Part-Time (less than 35 hr/wk)	1984 Full-Time (35 hr/wk or more)	1984 Part-Time (less than 35 hr/wk)
TOTAL OTHER TRAINEES (exclude medical and dental residents)				

3 NURSING HOME PERSONNEL ON PAYROLL

Complete only if hospital has a separate nursing home-type unit as reported in E5b. Report full-time and part-time nursing home personnel who were on the payroll as of September 30, 1984, and whose payroll expenses are reported in line F2a, column 4. If nursing home staff is shared with the hospital, please report these staff as part-time employees.

	1983 Full-Time (35 hr/wk or more)	1983 Part-Time (less than 35 hr/wk)	1984 Full-Time (35 hr/wk or more)	1984 Part-Time (less than 35 hr/wk)
TOTAL NURSING HOME PERSONNEL				

4 TOTAL FACILITY PERSONNEL ON PAYROLL

Complete only if hospital has a separate nursing home-type unit as reported in E5b. Report full-time and part-time hospital plus nursing home personnel who were on the payroll as of September 30, 1984, and whose payroll expenses are reported in line F2a, column 2.

	1983 Full-Time (35 hr/wk or more)	1983 Part-Time (less than 35 hr/wk)	1984 Full-Time (35 hr/wk or more)	1984 Part-Time (less than 35 hr/wk)
TOTAL FACILITY PERSONNEL (Hospital plus Nursing Home)				

H. MEDICAL STAFF

Please indicate the number of practitioners on the ACTIVE and ASSOCIATE (do not include courtesy, consulting, honorary, provisional, or other) medical staff and the number of house staff in each of the following specialty groups as of September 30, 1984. Under house staff please report the number of individuals as of September 30, 1984. 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.

	(1) Number of Active and Associate Medical Staff (Include Board Certified)	(2) Number of Active and Associate Medical Staff Who Are Board Certified	(3) Number of House Staff (Include Staff in Approved Training Positions)	(4) 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	_____	_____	_____	_____
1984 TOTAL	_____	_____	_____	_____
1983 TOTAL	_____	_____	_____	_____

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