American
Hospital
Association

AHA

1986 Annual Survey of Hospitals

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

Please return by:

AMERICAN HOSPITAL ASSOCIATION
PLEASE REFER TO THE INSTRUCTIONS AND DEFINITIONS

A. REPORTING PERIOD

Report data for a full 12-month period, preferably October 1, 1985 through September 30, 1986 (365 days) (Use the same reporting period 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. ORGANIZATIONAL STRUCTURE

CONTROL

1. Indicate the type of organization that is responsible for establishing policy for overall operation of your 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

SERVICE

2. 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 _____

3. Does your hospital restrict admissions primarily to children? YES ☐ NO ☐

OTHER

4. Does your hospital have a formal written contract with:
   - a. Health maintenance organization (HMO) that specify the obligations of each party YES ☐ NO ☐
   - b. Preferred provider organization (PPO) that specify the obligations of each party YES ☐ NO ☐

5. Is the hospital a member of a multihospital system? YES ☐ NO ☐
   If yes, please provide the name, city and state of the system headquarters

   Name: _____
   City: _____
   State: _____

6. Is the hospital a division or subsidiary of a holding company? YES ☐ NO ☐
7. Does the hospital itself operate subsidiary corporations? YES ☐ NO ☐
8. Is the hospital contract managed? YES ☐ NO ☐
   If yes, please provide the name, city and state of the organization that manages the hospital

   Name: _____
   City: _____
   State: _____

9. Is the hospital a member of an alliance? YES ☐ NO ☐
   If yes, please provide the name(s), city, and state of the alliance headquarters.

   Name: _____
   City: _____
   State: _____

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C. FACILITIES AND SERVICES

For each service or facility listed below, please check all those provided by your hospital as of the last day of the reporting period. If a service is not maintained in the hospital but is available through a FORMAL CONTRACTUAL arrangement with another hospital or provider (include joint ventures), please check column (2)

	(1) Provided by the Hospital	(2) Provided at Another Hospital or Provider
DIAGNOSTIC AND TREATMENT SERVICES		
1. Acquired immune-deficiency syndrome (AIDS) services	☐	☐
2. Birthing room	☐	☐
3. Chronic obstructive pulmonary disease services	☐	☐
4. Day hospital	☐	☐
5. Extra corporeal shock wave lithotripter (ESWL)	☐	☐
6. Geriatric Services:		
a. Comprehensive geriatric assessment	☐	☐
b. Geriatric acute care unit	☐	☐
c. Satellite geriatric clinics	☐	☐
d. Respite care	☐	☐
e. Adult day care	☐	☐
7. Hemodialysis	☐	☐
8. Laboratory Services:		
a. Histopathology	☐	☐
b. Blood bank	☐	☐
9. 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 liaison services	☐	☐
g. Psychiatric partial hospitalization program	☐	☐
h. Psychiatric outpatient services	☐	☐
10. Radiology Diagnostic:		
a. CT scanner	☐	☐
b. Diagnostic radioistope facility	☐	☐
c. Diagnostic x-ray	☐	☐
d. Magnetic resonance imaging (Nuclear magnetic resonance)	☐	☐
e. Ultrasound	☐	☐
11. Radiation Therapy:		
a. Megavoltage radiation therapy	☐	☐
b. Radioactive implants	☐	☐
c. Therapeutic radiosotope facility	☐	☐
d. X-ray radiation therapy	☐	☐

C. FACILITIES AND SERVICES (continued)

	(1) Provided by the Hospital	(2) Provided at Another Hospital or Provider
12. Surgical Services:		
a. Ambulatory surgery	☐	☐
b. Cardiac catheterization laboratory	☐	☐
c. Organ transplant (include kidney)	☐	☐
d. Open-heart surgery	☐	☐
13. Therapy Services:		
a. Occupational therapy	☐	☐
b. Physical therapy	☐	☐
c. Recreational therapy	☐	☐
d. Respiratory therapy	☐	☐
e. Speech therapy	☐	☐
AMBULATORY AND OUTREACH SERVICES		
14. Organized outpatient services	☐	☐
15. Emergency Services:		
a. Emergency department	☐	☐
b. Trauma Center	☐	☐
16. Alcoholism/chemical dependency outpatient services	☐	☐
17. Continuing care case management	☐	☐
18. Fitness center	☐	☐
19. Genetic counseling	☐	☐
20. Genetic screening	☐	☐
21. Health Promotion:		
a. Patient education	☐	☐
b. Community health promotion	☐	☐
c. Worksite health promotion	☐	☐
22. Home care program	☐	☐
23. Hospice	☐	☐
24. Occupational health services	☐	☐
25. Rehabilitation outpatient services	☐	☐
26. Reproductive Health:		
a. Contraceptive care	☐	☐
b. Fertility counseling	☐	☐
c. Sterilization	☐	☐
27. Sports medicine clinic/service	☐	☐
28. Women's center	☐	☐

D. BED

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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. 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 sections E and F should list the beds contained in those units under the appropriate categories in this section

		Beds Set Up and Staffed Last Day of the Reporting Period 1986	Total Inpatient Days for Reporting Period 1986
1	General medical/surgical (adult, include gynecology)		
2	General medical/surgical (pediatric)		
3	Obstetrics (indicate level of unit _____) (see instructions section D)		
4	Psychiatric acute care		
5	Alcoholism/chemical dependency, acute care		
6	Other acute (Specify type: _____)		
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	Rehabilitation		
16	Chronic disease		
17	Hospice		
18	Skilled nursing long-term care		
19	Psychiatric long-term care		
20	Alcoholism/chemical dependency, subacute care		
21	Other long-term care (include ICF)		
22	Mental retardation		
23	Sheltered care		
24	Self care		
25	Other (specify type: _____)		
26	TOTAL FACILITY (excluding swing bed utilization add lines 1 to 25)		

27 SWING-BEDS

a Is your hospital certified by Medicare to provide swing bed services as defined on page 10? YES ☐ NO ☐

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 (Medicare and non-Medicare) were used in the provision of acute and subacute care services

	(1) Admissions	(2) Inpatient Days
(1) Skilled nursing swing beds		
(2) Intermediate care swing beds		

28 TOTAL FACILITY INPATIENT DAY TOTAL (including swing bed utilization)

E. TOTAL FACILITY BEDS AND UTILIZATION

All statistics reported in D, E, 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 BED CHANGES

a Was there a significant temporary or permanent change in the total number of adult, pediatric and neonatal beds set up and staffed during the reporting period? YES ☐ NO ☐

b 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 ☐☐

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

a Does your hospital maintain a separate nursing home type of long-term care unit? (Please refer to the instructions and definitions for section E) 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).
***Because of unit transfers, column (1) may be less than the sum of columns (2) and (3)**

		(1) Total Facility	(2) Hospital	(3) Nursing Home–Type Unit
b	Beds set up and staffed for use at the end of the reporting period (include neonatal & swing beds)			
c	Admissions (exclude newborns, include neonatal & swing admissions)*			
d	Inpatient days (exclude newborns, include neonatal & swing days)			
e	Discharges (exclude newborns, include neonatal, swing discharges & deaths)*			
f	Discharge days (exclude newborns, include neonatal, swing days & deaths)			
g	Census (number of inpatients occupying beds on the last day of reporting period. Exclude newborn & include neonatal.)			

4 MEDICARE/MEDICAID UTILIZATION

a	Total Medicare (Title XVIII) inpatient discharges*			
b	Total Medicare (Title XVIII) inpatient days			
c	Total Medicaid (Title XIX) inpatient discharges*			
d	Total Medicaid (Title XIX) inpatient days			

5 NEWBORN NURSERY

a Number of bassinets set up and staffed for use at the end of the reporting period (exclude pediatric and neonatal beds listed on page 9) _____

b Total births (exclude fetal deaths) _____

c Newborn days (exclude neonatal listed on page 9) _____

6 SURGICAL OPERATIONS, whether major or minor

a Inpatient _____

b Outpatient _____

c Total _____

7 OUTPATIENT VISITS

Please record the number of outpatient visits for each of the categories below. Do not report occasions of service in any category

		Visits
a	Emergency	
b	Clinic/Other	
c	Total	

FINANCIAL DATA

	All institutions fill out: (1) Total Facility Statistics	(2) Hospital	Fill out only if hospital has separate units for nursing home type of long-term care: (3) 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)	.00	.00	
b. GROSS REVENUE from service to OUTPATIENTS (based on full established rates)	.00	.00	
c. TOTAL GROSS revenue from service to PATIENTS (add 1a+1b)	.00	.00	.00
d. DEDUCTIONS FROM REVENUE:			
(1) Government contractual adjustments	.00	.00	
(2) Nongovernment contractual adjustments	.00	.00	
(3) Bad debts	.00	.00	
(4) Charity	.00	.00	
(5) Other deductions	.00	.00	
(6) Total deductions (add 1d(1) through 1d(5))	.00	.00	
e. TOTAL NET revenue from service to PATIENTS (subtract 1d(6) from 1c)	.00	.00	.00
f. OTHER OPERATING REVENUE:			
(1) Tax appropriations	.00	.00	
(2) Other (include cafeteria, gift shop, etc.)	.00	.00	
(3) TOTAL OTHER OPERATING REVENUE (1f(1) + 1f(2))	.00	.00	
g. TOTAL NONOPERATING REVENUE (No negative numbers! Losses or expenses should be reported in F2b(5).)	.00	.00	
h. TOTAL REVENUE (add 1e + 1f(3) + g))	.00	.00	.00
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 14)			
(1) Medical and dental residents (include medical and dental interns) and trainees (medical technology, x-ray therapy and so forth)	.00	.00	
(2) All other personnel	.00	.00	
(3) TOTAL PAYROLL EXPENSES (add 2a(1) + 2a(2))	.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) Depreciation expense (FOR REPORTING PERIOD ONLY)	.00	.00	
(4) Interest expense	.00	.00	
(5) All other expenses (supplies, purchased services, utilities, nonoperating expenses, and so forth)	.00	.00	
(6) TOTAL NONPAYROLL EXPENSES (add 2b(1) through 2b(5)	.00	.00	.00
c. TOTAL EXPENSES (add 2a(3) + 2b(6)) (compare to total revenue)	.00	.00	.00
3. NET INCOME (Excess of Revenue over expenses)**	.00	.00	.00

****These data will be treated as confidential and not released without written permission. AHA will however share this data with your respective state hospital association. The state association may not release this data without written permission from the hospital.**

F. FINANCIAL DATA (Continued)

	Total Facility Gross	Total Facility Net
4. SOURCES OF PATIENT REVENUE:**		
(1) Government		
(a) Medicare	.00	.00
(b) Medicaid	.00	.00
(c) Other	.00	.00
(d) Total government sources	.00	.00
(2) Nongovernment		
(a) Self-pay	.00	.00
(b) Third party payors	.00	.00
(c) Other	.00	.00
(d) Total nongovernment sources	.00	.00
(3) Total sources of patient revenue 4(1d) + 4(2d) (total should equal line 1c and 1e column 1 on page 13)	.00	.00

		1986 Unrestricted Funds
5. 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) Uncollectibles	.00	
(c) Net receivables (subtract 5a(2b) from 5a(2a))		.00
(3) Other current assets		.00
(4) (a) Gross plant and equipment assets (include land buildings, and equipment; Include actual or estimated value of plant/equipment that is leased)	.00	
(b) LESS: Deduction for accumulated depreciation	.00	
(c) NET plant and equipment assets (subtract 5a(4b) from 5a(4a); 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 (5a(1)+5a(2c)+5a(3)+5a(4c)+5a(5)+5a(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 5b(1) through 5b(4); should equal 5a(7))		.00
6. RESTRICTED FUNDS** (report fund balances only)		
a. Specific purpose (specify: _____)		.00
b. Plant replacement and expansion		.00
c. Endowment funds		.00

7. CAPITAL EXPENDITURES**

a. During the reporting period did the hospital acquire any new debt? YES ☐ NO ☐

If yes please indicate total amount of new debt and the proportion for refinancing of existing debt?

Total New debt _____.00
Percent of total for refinancing _____%

b. During the reporting period did the hospital begin a construction project? YES ☐ NO ☐

If yes please indicate total cost for the new project and the percentage of the total that is related to modernization of existing facilities?

Total Construction _____.00
Percent of total for modernization _____%

****These data will be treated as confidential and not released without written permission. AHA will however share this data with your respective state hospital association. The state association may not release this data without written permission from the hospital.**

PERSONNEL ON PAYROLL AS OF SEPTEMBER 30, 1986

1 HOSPITAL PERSONNEL BY OCCUPATIONAL CATEGORY

Report full-time and part-time personnel including trainees who were on the payroll as of SEPTEMBER 30, 1986, 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 (1) and zero in column (2). For those hospitals that operate a nursing home-type unit as reported in E3a, 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 in each area. This means that one full-time employee would be counted as a part-time employee under the appropriate hospital occupational category and also as one part-time employee in total nursing home personnel. Include members of religious orders for who dollar equivalents were reported.

	(1) 1986 Full-Time (35 hr/wk or more) On Payroll	(2) 1986 Part-Time (less than 35 hr/wk) On Payroll
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, 1986 (Continued)

	(1) 1986 Full-Time (35 hr/wk or more) On Payroll	(2) 1986 Part-Time (less than 35 hr/wk) On Payroll
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 th necessary requirements for certification) who were on the payroll as of SEPTEMBER 30, 1986, whose payroll expenses ar reported in line F2a(1), and who were included in TOTAL HOSPITAL PERSONNEL (line G1r) and NURSING HOME PERSONNE (line G2). Please do not include medical and dental residents.

	1986 Full-Time (35 hr/wk or more)	1986 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 E3a. Report full-time and part-time nursin home personnel who were on the payroll as of September 30, 1986, and whose payroll expenses are reported in line F2a column 3. If nursing home staff is shared with the hospital, please report these staff as part-time employees.

	1986 Full-Time (35 hr/wk or more)	1986 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 E3a. Report full-time and part-time hospita plus nursing home personnel who were on the payroll as of September 30, 1986, and whose payroll expenses are reporte in line F2a, column 1.

	1986 Full-Time (35 hr/wk or more)	1986 Part-Time (less than 35 hr/wk)
TOTAL FACILITY PERSONNEL (Hospital plus Nursing Home)		

5 SUPPLEMENTAL ASSISTANTS

Does your facility have any of the following:

a	Hospital auxiliary	YES ☐	NO ☐	
b	Patient representative services	YES ☐	NO ☐	
c	Volunteer services	YES ☐	NO ☐	

MEDICAL STAFF

Please indicate the number of practitioners on the ACTIVE and ASSOCIATE (do not include courtesy, consulting, honorary, provisional, or other) medical staff in each of the following specialty groups as of September 30, 1986. 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.

Active and Associate Medical Staff

		(1) Total (Include Board Certified)	(2) Board Certified
1	MEDICAL SPECIALITIES		
a	General & family practice		
b	General internal medicine		
c	Pediatrics		
d	Other medical specialties		
2	SURGICAL SPECIALITIES		
a	Obstetrics & gynecology		
b	Ophthalmology		
c	Orthopedic surgery		
d	Plastic surgery		
e	General surgery		
f	Thoracic surgery		
g	Other surgical specialties		
3	OTHER		
a	Anesthesiology		
b	Dermatology		
c	Emergency medicine		
d	Nuclear medicine		
e	Pathology		
f	Psychiatry		
g	Radiology		
h	Other specialties		
1986 TOTAL			

4 Does your hospital have a contractual arrangement with a physician who serves in a paid capacity (i.e., medical director or vice president for medical affairs) as liaison between hospital management and the medical staff? YES ☐ NO ☐