

**OHIO DEPARTMENT OF HEALTH  
ANNUAL HOSPITAL REGISTRATION AND PLANNING REPORT  
STATISTICAL INFORMATION  
JANUARY 1, 20\_\_\_\_ - DECEMBER 31, 20\_\_\_\_**

Please return to: Ohio Department of Health  
Office of Health Assurance and Licensing  
246 N. High Street  
Columbus, OH 43215-2412

**This report must be returned by March 1**

Completion of this report is required pursuant to section 3701.07 of the Ohio Revised Code.

**SCHEDULE A. IDENTIFICATION**

Name of Hospital

Hospital Registration Number

Medicare Name (if different from registration)

Medicare Provider Number

National Provider Identifier

Hospital Address/Location: (street name and number, city, county and zip code)

Telephone Number:

County:

Mailing address: (if different from above)

Hospital E-mail Address:

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Name of Chief Executive Officer

Title

Name of person submitting report

Title

Telephone Number

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Accreditation/certification status:

Joint Commission (JC)

Date of last accreditation survey:\_\_\_\_\_

Healthcare Facilities Accreditation Program (HFAP)

Date of last accreditation survey:\_\_\_\_\_

Det Norske Veritas (DNV)

Date of last accreditation survey:\_\_\_\_\_

Medicare Certification (if not accredited by other entities prior)

Date of last certification survey:\_\_\_\_\_

**Satellite Units:**

Indicate name, address, county and zip code of each satellite unit owned and operated by the hospital (i.e. emergency medical center, surgery center, ambulatory care center, hospice) which is a separate and distinct entity by is not independently registered. *(satellite unit is defined in OAC 3701-59-01 (OO))*

**Additional information required: types of services provided and total number of patients treated (on an outpatient basis) for each type of service.**

1. Name of Satellite Unit:

County:

Address (street address, city)

Zip Code:

TYPES OF SERVICES PROVIDED:

TOTAL PATIENTS TREATED FOR  
EACH SERVICE TYPE

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2. Name of Satellite Unit:

County:

Address (street address, city)

Zip Code:

TYPES OF SERVICES PROVIDED:

TOTAL PATIENTS TREATED FOR  
EACH SERVICE TYPE

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3. Name of Satellite Unit:

County:

Address (street address, city)

Zip Code:

TYPES OF SERVICES PROVIDED:

TOTAL PATIENTS TREATED FOR  
EACH SERVICE TYPE

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4. Name of Satellite Unit:

County:

Address (street address, city)

Zip Code:

TYPES OF SERVICES PROVIDED:

TOTAL PATIENTS TREATED FOR  
EACH SERVICE TYPE

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5. Name of Satellite Unit:

County:

Address (street address, city)

Zip Code:

TYPES OF SERVICES PROVIDED:

TOTAL PATIENTS TREATED FOR  
EACH SERVICE TYPE

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6. Name of Satellite Unit:

County:

Address (street address, city)

Zip Code:

TYPES OF SERVICES PROVIDED:

TOTAL PATIENTS TREATED FOR  
EACH SERVICE TYPE

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7. Name of Satellite Unit:

County:

Address (street address, city)

Zip Code:

TYPES OF SERVICES PROVIDED:

TOTAL PATIENTS TREATED FOR  
EACH SERVICE TYPE

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8. Name of Satellite Unit:

County:

Address (street address, city)

Zip Code:

TYPES OF SERVICES PROVIDED:

TOTAL PATIENTS TREATED FOR  
EACH SERVICE TYPE

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## SCHEDULE B. CLASSIFICATION

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

Government Non-Federal	Non-Government Not-For-Profit	Investor-Owned For-Profit
State	Church-Operated	Individual
County	Other Not-For-Profit	Partnership
City		Corporation
City-County		
Hospital District or Authority		

2. Is this hospital part of a multi-hospital system?

Name of System:

3. Medicare Hospital Classification:

Short-term acute care	Psychiatric
Rehabilitation	Critical Access
Long-term acute care	Children's

4. Hospital's primary or specialty classification (if different from Medicare):

General	Heart Alcohol
and drug	Children's
Burn care	Rehabilitation
Cancer	Psychiatric
	Other: _____

5. Business name and Medicare certification number or state licensure number, if entities below are contained within hospital:

Distinct-part psychiatric unit	_____
Distinct-part rehabilitation unit	_____
Transplant center	_____
Maternity unit	_____

## SCHEDULE C. FACILITIES AND SERVICES

### HOSPITAL SERVICES

Inpatient

Outpatient

Not available	In House	Contracted	Shared

#### **Surgical Services**

Number of Surgical Cases \_\_\_\_\_

Number of Surgical Operating Rooms: \_\_\_\_\_

Dual-Purpose Operating Rooms

(Total number of Inpatient + Outpatient) \_\_\_\_\_

Total Operating Rooms Onsite \_\_\_\_\_

Total Operating Rooms Offsite \_\_\_\_\_

#### **Emergency Services**

Number of Patients:

Treated and admitted to hospital \_\_\_\_\_

Treated in ER and released \_\_\_\_\_

### **CARDIAC SERVICES**

Number of cardiac catheterizations performed:

Pediatric \_\_\_\_\_

Adult \_\_\_\_\_

Number of adult open-heart surgical procedures: \_\_\_\_\_

Number of pediatric cardiovascular surgery procedures: \_\_\_\_\_

### **OBSTETRIC AND NEWBORN DESIGNATION**

Level designation of obstetric services: \_\_\_\_\_

Level designation of newborn: \_\_\_\_\_

### **TRAUMA LEVEL DESIGNATION**

(As verified by American College of Surgeons)

Adult Trauma Level Designation: \_\_\_\_\_

Pediatric Trauma Level Designation: \_\_\_\_\_

SCHEDULE D. BEDS AND UTILIZATION

1. Inpatient Services

Bed Category	Number of Admissions (including transfers)	Patients Days of Care	Beds in Use
Adult medical/surgical			
Adult special care(ICU/CCU)			
Alcohol or drug abuse rehabilitation			
Burn			
Hospice			
Long-Term Care			
LTAC – LTA less than 30 days stay			
Newborn care– level I			
Newborn care – level II			
Newborn Care – level III			
Obstetrics – level I			
Obstetrics – level II			
Obstetrics – level III			
Pediatric - general			
Pediatric intensive care (PICU)			
Physical rehabilitation			
Psychiatric			
Special skilled nursing			
Swing beds			
<b>TOTAL HOSPITAL Total of all bed categories</b>			



**SCHEDULE D. BEDS AND UTILIZATION (CONTINUED)**

2. Inpatient Discharges (indicate the number of inpatients discharged by category)

Home without referral to home care or hospice service	_____
Home with referral to home care	_____
Home with referral to hospice care program	_____
To inpatient service of a hospice care program	_____
Transfers to other hospitals	_____
Transfers to a nursing home	_____
Expired	_____

<b>TOTAL DISCHARGES</b>	_____
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SCHEDULE E. HOSPITAL PERSONNEL

1. Licensed or Certified Professional Employees

	Total Number of Employees	Total F.T.E.'s (includes part-time & full-time)
All other licensed health professionals/tech staff		
Certified Nurse Practitioner		
Certified Nurse-Midwife		
Certified RN Anesthetists (CRNA)		
Clinical Nurse Specialists		
Contracted Physicians		
Dental/Dental Residents		
Dietetic Technicians		
Dietitians (registered, eligible)		
Interns		
Licensed Practical Nurses		
Medical Technicians		
Medical Technologists		
Nursing Assistants		
Occupational Therapists		
Other licensed/certified laboratory personnel		
Other licensed/certified radiological personnel		
Pharmacists, licensed		
Pharmacy Technicians		
Physical Therapists		
Physician Assistants		
Psychiatric Social Workers		
Psychologists		
Radiological Personnel		
Radiological Technologists-Technicians		
Registered Nurses		
Residents		
Respiratory Therapists		
Salaried Physicians		
Totals		

**SCHEDULE E. HOSPITAL PERSONNEL (CONTINUED)**

2. Medical Staff (count specialization only once)	Number of Active/Associate Medical Staff	Number of Board Certified Active/Associate Medical Staff	Number of House Staff	Number of House Staff in ACGME or AOA approved training positions	Number of House Staff in ADA approved training positions
Allergy/Immunology					
Anesthesiology					
Cardiology					
Dentistry					
Dermatology					
Emergency medicine					
Family medicine					
Family practice					
Gastroenterology					
General internal medicine					
General medicine rotation program					
General practice					
Hematology					
Neonatology					
Neurology					
Nuclear medicine					
Obstetrics and gynecology					
Oncology					
Ophthalmology					
Other medical specialties					
Otorhinolaryngology					
Pathology					
Pediatrics					
Physical medicine					
Podiatry					
Psychiatry					
Radiology					
Rheumatology					
Surgery: cardiovascular vascular					
Surgery: colon and rectal					
Surgery: general					
Surgery: neurological					
Surgery: orthopedic					
Surgery: other surgery specialties					
Surgery: plastic					
Surgery: rotation program					
Surgery: thoracic					
Urology					
Totals:					

PATIENT'S COUNTY (OR STATE IF OTHER THAN OHIO) OF RESIDENCE AT TIME OF ADMISSION (REPORTED IN THE AGGREGATE)

ADAMS	GEAUGA	MIAMI	VINTON
ALLEN	GREENE	MONROE	WARREN
ASHLAND	GUERNSEY	MONTGOMERY	WASHINGTON
ASHTABULA	HAMILTON	MORGAN	WAYNE
ATHENS	HANCOCK	MORROW	WILLIAMS
AUGLAIZE	HARDIN	MUSKINGUM	WOOD
BELMONT	HARRISON	NOBLE	WYANDOT
BROWN	HENRY	OTTAWA	
BUTLER	HIGHLAND	PAULDING	<b>OTHER STATES:</b>
CARROLL	HOCKING	PERRY	INDIANA
CHAMPAIGN	HOLMES	PICKAWAY	KENTUCKY
CLARK	HURON	PIKE	MICHIGAN
CLERMONT	JACKSON	PORTAGE	PENNSYLVANIA
CLINTON	JEFFERSON	PREBLE	WEST VIRGINIA
COLUMBIANA	KNOX	PUTNAM	
COSHOCTON	LAKE	RICHLAND	
CRAWFORD	LAWRENCE	ROSS	
CUYAHOGA	LICKING	SANDUSKY	
DARKE	LOGAN	SCIOTO	
DEFIANCE	LORAIN	SENECA	
DELAWARE	LUCAS	SHELBY	
ERIE	MADISON	STARK	
FAIRFIELD	MAHONING	SUMMIT	
FAYETTE	MARION	TRUMBALL	
FRANKLIN	MEDINA	TUSCARAWAS	
FULTON	MEIGS	UNION	
GALLIA	MERCER	VAN WERT	