

NEW HOSPITAL REGISTRATION ONLY

**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: _____

Name of Chief Executive Officer _____ Title _____

Name of person submitting report _____ Title _____ Telephone Number _____

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: _____

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 D. BEDS AND UTILIZATION

1. Inpatient Services

Bed Category	Number of Registered Beds
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	
TOTAL HOSPITAL Total of all bed categories	