

**2011 ANNUAL SURVEY OF HOSPITALS**  
**WHA Information Center, LLC / American Hospital Association**

---

**INSTRUCTIONS:** All blank data items must be completed. See Instructions on page two for details.

Instructions and definitions are available at the end of the survey, unless otherwise noted.  
 Additional information may be reported in **SUPPLEMENTAL INFORMATION** on the last page of the survey.

Fill out the survey using **hospital data only**, except when the hospital owns and operates a nursing home **AND** a common Board of Directors governs both the hospital and nursing home. For further information on such facilities, refer to page six of the survey.

**If information for a category is zero, fill in 0. If information for a category is Not Applicable, fill in 0. Do NOT use dashes, N/A, N/AV, M, or decimals on any line in this survey.**

**Return To:**                    **WHA Information Center**  
                                       **5510 Research Park Drive**  
                                       **P.O. Box 259038**  
                                       **Madison, WI 53725-9038 or Fax to: 608-274-8554**

**I. GENERAL INFORMATION**

*Type or print clearly all information*

WHA Information Center Hospital ID _____	AHA Hospital ID _____
<b>Hospital Mailing Label</b>	
Hospital Name _____	
Address _____	P.O. Box _____
City, State _____	ZIP Code _____
FY 2011 Beginning Date	FY 2011 Ending Date
_____ / _____ / _____ Mo.                    Day                    Yr.	_____ / _____ / _____ Mo.                    Day                    Yr.

**II. CLASSIFICATION**

Type or print all information

**1 Public Contact** (provide First and Last Name of individual you want listed in the public data sets)

First Name	Last Name
------------	-----------

**Control**

**2** Indicate the type of organization responsible for establishing policy concerning overall hospital operation.

**CHECK ONLY ONE CODE**

- |                                    |  |   |  |
|------------------------------------|--|---|--|
| Government,<br>Nonfederal          | Non-government,<br>Not-for-profit                  | Investor-owned<br>For-profit            | Government,<br>Federal                       |
| <input type="checkbox"/> 12 State  | <input type="checkbox"/> 21 Religious organization | <input type="checkbox"/> 31 Individual  | <input type="checkbox"/> 45 Veterans Affairs |
| <input type="checkbox"/> 13 County | <input type="checkbox"/> 23 Other not-for-profit   | <input type="checkbox"/> 32 Partnership |  |
| <input type="checkbox"/> 14 City   |  | <input type="checkbox"/> 33 Corporation |  |

**3** Is the hospital part of a health care system? .....  Yes  No  
If YES, give name, city, and state of the system headquarters.

<i>(Name)</i>	<i>(City)</i>	<i>(State)</i>
---------------	---------------	----------------

**4** Is the hospital a division or subsidiary of a holding company? .....  Yes  No

**5** Does the hospital itself operate subsidiary corporations? .....  Yes  No

**6** Is the hospital contract managed? .....  Yes  No  
If YES, give name, city, and state of organization that manages the hospital.

<i>(Name)</i>	<i>(City)</i>	<i>(State)</i>
---------------	---------------	----------------

**7** Is the hospital a member of an alliance? .....  Yes  No  
If YES, give name, city, and state of the alliance headquarters. **If more than one, list in Section XIV.**

<i>(Name)</i>	<i>(City)</i>	<i>(State)</i>
---------------	---------------	----------------

**8** Is the hospital a participant in a health care network? .....  Yes  No  
If YES, give name, city, and state of the network headquarters. **If more than one, list in Section XIV.**

<i>(Name)</i>	<i>(City)</i>	<i>(State)</i>
---------------	---------------	----------------

**9** Does the hospital participate in a group purchasing arrangement? .....  Yes  No  
If YES, give name, city, and state of the group purchasing organization.

<i>(Name)</i>	<i>(City)</i>	<i>(State)</i>
---------------	---------------	----------------

**10** Does the hospital own or operate a primary group practice? .....  Yes  No

**Service**

**11** Indicate the ONE category that BEST describes the type of service that the hospital provides to the MAJORITY of admissions.

- |  |   |
|--|---|
| <input type="checkbox"/> 10 General medical and surgical   | <input type="checkbox"/> 22 Psychiatric                     |
| <input type="checkbox"/> 15 GMS – Critical Access Hospital | <input type="checkbox"/> 46 Rehabilitation                  |
| <input type="checkbox"/> 20 GMS – Long-Term Acute Care     | <input type="checkbox"/> 82 Alcoholism and other drug abuse |

**12** Does the hospital restrict admissions primarily to children? .....  Yes  No

**II. CLASSIFICATION (continued) Type or print any information**

**Accreditation/Licensure Status** (Check all that apply). \*Note for "Other," do not specify State of Wisconsin

- 13  JCAHO  AOA  Title 18 certified and HFS 124 licensed  
 Date of last survey \_\_\_/\_\_\_ (mm/yy)  HFS 124 licensed only  
 Other (specify) \_\_\_\_\_

**Certification Status**  
**If more than one provider number, list in Section XIV.**

- 14 Medicare (Title 18) .....  Yes  No  
 If YES, **Provider Number** 52 - \_\_\_\_\_
- 15 Medicaid (Title 19) .....  Yes  No  
 If YES, **Provider Number** \_\_\_\_\_ - \_\_\_\_\_

**Managed Care Information**

Does the hospital have a formal written contract that specifies the obligations of each party with

- 16 Health Maintenance Organization (HMO)? .....  Yes  No **If Yes**, how many contracts?
- 17 Preferred Provider Organization (PPO)? .....  Yes  No **If Yes**, how many contracts?
- 18 Other managed care or prepaid plan? .....  Yes  No **If Yes**, how many contracts?

19 Indicate whether any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer (check all that apply):

	(1) Hospital	(2) Health Care System	(3) Network	(4) Joint Venture With Insurer
Health Maintenance Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preferred Provider Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indemnity Fee-for-Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20 What percentage of the hospital's NET patient revenue is paid on a capitated basis?  %  
 (If the hospital does not participate in capitated arrangements, enter "0.") (Round; do not use decimals.)

- 21 Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared-risk basis? .....  Yes  No
- 22 If your hospital has arrangements to care for a specific group of enrollees in exchange for a capitated premium, how many lives are covered?

**Criteria to Determine If Nursing Home Data Should Be Submitted**

23 Does the hospital own and operate a nursing home facility under HFS 132? .....  Yes  No  
**If YES**, answer the question on line 24.

24 Are the hospital and nursing home governed by a common Board of Directors? .....  Yes  No

25 If answers to both 23 and 24 are YES, check the appropriate box regarding the location of the nursing home facility.

- Attached/within hospital  Freestanding on hospital campus  Freestanding off campus

**III. SELECTED INPATIENT UNITS**

**If information for a category is zero, fill in 0. If information for a category is Not Applicable, fill in 0. Do NOT use dashes, NA, N/AV, or M.**

Account for all adult and pediatric inpatient beds set-up-and-staffed on the last day of the fiscal year (*excluding weekends or holidays*). Do not include "normal newborn" bassinets. List beds for a line only if a unit is specifically designated for the service area. The number of discharges should include deaths and unit transfers. For each service listed, circle the code number (see codes 1-5 below) that best describes the status of the service as of the last day of the fiscal year.

**NOTE: Service Code numbering changed as of the 1999 Annual Survey of Hospitals.**

<b>Code</b>	<b>Description</b>
1	Service is provided in or by the hospital in a <b>DISTINCT AND SEPARATE UNIT</b> . The number of beds and utilization information <b>MUST</b> be provided for inpatient units.
2	Service is provided in or by the hospital but <b>NOT IN A DISTINCT AND SEPARATE UNIT</b> .
3	Service is provided by the hospital's Health Care System in the community.
4	Service <b>IS NOT MAINTAINED</b> by the hospital but is available, in the hospital or another facility, through a <b>FORMAL CONTRACTUAL</b> arrangement with another hospital or provider, including networks and joint ventures.
5	<b>SERVICE NOT AVAILABLE</b> either by the hospital or through a formal contractual arrangement with another hospital or provider.
<b>Code</b>	<b>Description</b>
O	Service is provided by the hospital <b>IN BUILDINGS OTHER THAN THE MAIN HOSPITAL BUILDING</b> and is billed under <b>the hospital's Medicare provider number</b> .
B	Service is provided by the hospital <b>IN BOTH THE MAIN HOSPITAL BUILDING AND IN BUILDINGS OTHER THAN THE MAIN HOSPITAL BUILDING</b> ( <b>which is billed under the hospital's Medicare provider number</b> ).
<b>NOTE:</b>	If the hospital has beds of more than one type in a mixed unit, all bed and utilization data for all bed types found in that unit should be reported on the line corresponding to the mixed unit. Code the "mixed unit" with a "1," and code each individual bed type line for that unit with a "2."  Example: If "Mixed intensive care" is the main unit for intensive care beds, code it "1" and the types of beds that may be found there "2." All bed and utilization data should be reported on line 40, "Mixed intensive care."  <b>For a unit coded "2," utilization may be reported only if beds, discharges, and inpatient days are all available.</b>

**26** Are any patient services provided by the hospital in buildings other than the main hospital bldg **and is billed under the hospital's Medicare's provider number?**  Yes  No

If YES, in addition to circling code numbers 1-5, circle O or B, if applicable. See Instructions.

Selected Inpatient Units	Beds-set-up-&-staffed last day of fiscal year	Number of discharges / transfers for fiscal year	Inpatient days for fiscal year	Circle one for each line	O or B
<b>GENERAL MEDICAL/SURGICAL</b>					
27 Adult medical / surgical, acute (include gynecology) .....	_____	_____	_____	1 2 3 4 5	_____
28 Orthopedic .....	_____	_____	_____	1 2 3 4 5	_____
29 Rehabilitation and physical medicine ....	_____	_____	_____	1 2 3 4 5	_____
30 Hospice .....	_____	_____	_____	1 2 3 4 5	_____
31 Acute Long-Term Care (Hospital Only) .....	_____	_____	_____	1 2 3 4 5	_____
32 All Other Acute (Specify types) [ _____ ] .....	_____	_____	_____	1 2 3 4 5	_____

Selected Inpatient Units	Beds-set-up-&-staffed last day of fiscal year	Number of discharges / transfers for fiscal year	Inpatient days for fiscal year	Circle one for each line	O or B
<b>33 Pediatrics</b>					
General medical/surgical				1 2 3 4 5	
Level of care					
<b>34 Obstetrics</b>	(1, 2 or 3)				
(include LDRP, exclude gynecology)				1 2 3 4 5	
<b>35 Psychiatric</b>					
Inpatient care				1 2 3 4 5	
<b>36 Alcoholism / Chemical Dependency</b>					
Inpatient care				1 2 3 4 5	
<b>ICU/CCU</b>					
<b>37 Medical / Surgical Intensive Care</b>				1 2 3 4 5	
<b>38 Cardiac Intensive Care</b>				1 2 3 4 5	
<b>39 Pediatric Intensive Care</b>				1 2 3 4 5	
<b>40 Burn Care</b>				1 2 3 4 5	
<b>41 Mixed Intensive Care</b>				1 2 3 4 5	
<b>42 Step-down (special care)</b>				1 2 3 4 5	
<b>43 Neonatal Intensive / Intermediate Care</b>					
(exclude normal newborns)				1 2 3 4 5	
<b>44 All Other Intensive Care</b>					
[specify type(s)]				1 2 3 4 5	
<b>45 Subacute Care</b>					
Inpatient care				1 2 3 4 5	
<b>46 ALL OTHER INPATIENT UNITS</b>					
[specify treatment area(s)]				1 2 3 4 5	
<b>47 TOTAL HOSPITAL FACILITY</b>					
(Exclude Medicare-certified swing bed inpatient days and Non-Medicare-certified, swing-bed inpatient days).					
	(add lines 27-46)	(add lines 27-46)	(add lines 27-46)		
<b>48 MEDICARE-CERTIFIED SWING UNIT</b>					
(Medicare patients only)				1 2 3 4 5	
(Report <b>average</b> number of beds used, rounded to whole number)	(average # beds used)	(discharges and transfers)	(inpatient days)		

Selected Inpatient Units	Beds-set-up-&-staffed last day of fiscal year	Number of discharges / transfers for fiscal year	Inpatient days for fiscal year	Circle one for each line	O or B
<b>49 NON- MEDICARE-CERTIFIED SWING UNIT</b> (Non-Medicare patients only) (Report <b>average</b> number of beds used, rounded to whole number)	_____	_____	_____	1 2 3 4 5	_____
<b>50 Newborn nursery</b> (Bassinets and utilization should be reported on lines 148-150)				1 2 3 4 5	_____

**IV. SELECTED ANCILLARY AND OTHER SERVICES**

Circle One

O or B

For each service, circle the code number that best describes the status of the service as of the last day of the fiscal year, except weekends and holidays.

- 51 AIDS/HIV – Specialized outpatient program for AIDS/HIV 1 2 3 4 5
- 52 Alcoholism/chemical dependency outpatient services (*psych/social*) 1 2 3 4 5
- Ambulance/transportation services- Non-emergency**
- 53 - **Non-emergency** inter-facility transports by ground ambulance 1 2 3 4 5
- 54 - **Non-emergency** inter-facility transports by air ambulance 1 2 3 4 5
- 55 Arthritis treatment center 1 2 3 4 5
- 56 Assisted living 1 2 3 4 5
- 57 Auxiliary 1 2 3 4 5
- 58 Bariatric Services: Bariatric/Weight Control Issues 1 2 3 4 5
- 59 Birthing Room/Labor, delivery, recovery, post-partum room (LDR or LDRP room) 1 2 3 4 5
- Cardiac services**
- 60 - Cardiac angioplasty (*percutaneous transluminal*) 1 2 3 4 5
- 61 - Cardiac catheterization laboratory 1 2 3 4 5
- 62 - Cardiac rehabilitation program 1 2 3 4 5
- 63 - Non-invasive cardiac assessment services 1 2 3 4 5
- 64 - Open-heart surgery 1 2 3 4 5
- 65 Case management 1 2 3 4 5
- 66 Crisis prevention 1 2 3 4 5
- 67 Complementary Services 1 2 3 4 5

**68 Dental Services**

**1 2 3 4 5**

**Dialysis services:**

**69** - Hemodialysis 1 2 3 4 5

**70** - Peritoneal dialysis 1 2 3 4 5

**Emergency/urgent care:**

**71** - Emergency department (*general medical and surgical*) 1 2 3 4 5

**72** - Trauma center [ **Self-designated level** ] 1 2 3 4 5

**73** - Urgent care center 1 2 3 4 5

**74** Ethics committee 1 2 3 4 5

**75** Extracorporeal shock wave lithotripter (*ESWL*) **CHECK ONE** Fixed Mobile 1 2 3 4 5

**76** Fitness center ..... 1 2 3 4 5

**Food service**

**77** - Meals on wheels ..... 1 2 3 4 5

**78** - Nutrition programs ..... 1 2 3 4 5

**79** Genetic counseling/screening ..... 1 2 3 4 5

**Geriatric services**

**80** - Adult day care program ..... 1 2 3 4 5

**81** - Alzheimer's diagnosis/assessment ..... 1 2 3 4 5

**82** - Comprehensive geriatric assessment ..... 1 2 3 4 5

**83** - Emergency response system ..... 1 2 3 4 5

**84** - Geriatric acute care unit ..... 1 2 3 4 5

**85** - Geriatric clinics ..... 1 2 3 4 5

**86** - Respite care ..... 1 2 3 4 5

**87** - Retirement housing ..... 1 2 3 4 5

**88** - Senior membership program ..... 1 2 3 4 5

**Health promotion**

**89** - Community health promotion ..... 1 2 3 4 5

**90** - Patient education ..... 1 2 3 4 5

**91** - Worksite health promotion ..... 1 2 3 4 5

**92** Home health services ..... 1 2 3 4 5

<b>Selected Ancillary and Other Services</b>	<b>Circle One</b>
93 Home hospice services .....	1 2 3 4 5 _____
<b>Mammography services</b>	
94 - Diagnostic mammography .....	1 2 3 4 5 _____
95 - Mammography screening .....	1 2 3 4 5 _____
96 Occupational health services .....	1 2 3 4 5 _____
<b>Occupational, physical, and/or rehabilitation services</b>	
97 - Audiology .....	1 2 3 4 5 _____
98 - Occupational therapy .....	1 2 3 4 5 _____
99 - Physical therapy .....	1 2 3 4 5 _____
<b>Occupational, physical, and/or rehabilitation services (continued)</b>	
100 - Recreational therapy .....	1 2 3 4 5 _____
101 - Rehabilitation inpatient services (service does not have beds) .....	1 2 3 4 5 _____
102 - Rehabilitation outpatient services .....	1 2 3 4 5 _____
103 - Respiratory therapy .....	1 2 3 4 5 _____
104 - Speech pathology / therapy .....	1 2 3 4 5 _____
105 Oncology services .....	1 2 3 4 5 _____
106 - Outpatient services – within the hospital .....	1 2 3 4 5 _____
107 - Outpatient services – on hospital campus, but in freestanding center .....	1 <input checked="" type="checkbox"/> 3 4 5 _____
108 - Outpatient services – freestanding off hospital campus .....	1 <input checked="" type="checkbox"/> 3 4 5 _____
109 Pain Management Program .....	1 2 3 4 5 _____
110 Patient representative services .....	1 2 3 4 5 _____
<b>Psychiatric services</b>	
111 - Psychiatric child / adolescent services .....	1 2 3 4 5 _____
112 - Psychiatric consultation – liaison services .....	1 2 3 4 5 _____
113 - Psychiatric education services .....	1 2 3 4 5 _____
114 - Psychiatric emergency services .....	1 2 3 4 5 _____
115 - Psychiatric geriatric services .....	1 2 3 4 5 _____
116 - Psychiatric outpatient services .....	1 2 3 4 5 _____

<b>Selected Ancillary and Other Services</b>		<b>Circle One</b>	<b>O or B</b>
117	- Psychiatric partial hospitalization program .....	1 2 3 4 5	_____
118	Radiation therapy .....	1 2 3 4 5	_____
<b>Radiology, diagnostic</b>			
119	- CT scanner ( <i>Computed Tomographic Scanner</i> ) Check One: <input type="checkbox"/> Fixed <input type="checkbox"/> Mobile <input type="checkbox"/> Both .....	1 2 3 4 5	_____
120	- Diagnostic radioisotope facility .....	1 2 3 4 5	_____
121	- Magnetic resonance imaging ( <i>MRI</i> ) Check One: <input type="checkbox"/> Fixed <input type="checkbox"/> Mobile <input type="checkbox"/> Both .....	1 2 3 4 5	_____
122	- Positron emission tomography scanner ( <i>PET</i> ) .....	1 2 3 4 5	_____
123	- Single photon emission computerized tomography ( <i>SPECT</i> ) Check One: <input type="checkbox"/> Fixed <input type="checkbox"/> Mobile <input type="checkbox"/> Both .....	1 2 3 4 5	_____
124	- Ultrasound .....	1 2 3 4 5	_____
<b>Reproductive health</b>			
125	- Fertility counseling .....	1 2 3 4 5	_____
126	- In vitro fertilization .....	1 2 3 4 5	_____
127	Social work services .....	1 2 3 4 5	_____
128	Sports medicine clinic/services .....	1 2 3 4 5	_____
129	Surgery, ambulatory or outpatient ( <i>day surgery</i> ) .....	1 2 3 4 5	_____
<b>Transplant services</b>			
130	- Bone marrow transplant program .....	1 2 3 4 5	_____
131	- Heart and/or lung transplant .....	1 2 3 4 5	_____
132	- Kidney transplant .....	1 2 3 4 5	_____
133	- Tissue transplant .....	1 2 3 4 5	_____
134	Women's health center/services .....	1 2 3 4 5	_____
135	Are additional non-listed <b>patient</b> services provided by the hospital? If YES, list and indicate with O or B if provided in other buildings (If more room is needed, go to Section XII) .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	

136 If **O** or **B** is used on lines 27-134, indicate the number of locations and the address(es) and service(s) provided. (If more room is needed, go to Section XIV.)

Number of other locations

Street address \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_

City \_\_\_\_\_

Service \_\_\_\_\_ Line \_\_\_\_\_

Service \_\_\_\_\_ Line \_\_\_\_\_

Service \_\_\_\_\_ Line \_\_\_\_\_

Service \_\_\_\_\_ Line \_\_\_\_\_

Service \_\_\_\_\_ Line \_\_\_\_\_

Service \_\_\_\_\_ Line \_\_\_\_\_

137 Does the hospital have provider-based facilities that are billed using the hospital's Medicare provider number, reported on Line 14? .....  Yes  No

If YES, indicate the number of facilities.

If YES, indicate the street address and city. (If more than one address, go to Section XII.)

Street address \_\_\_\_\_

City \_\_\_\_\_

**V. SELECTED SERVICE UTILIZATION**

**DO NOT SKIP THIS PAGE. FILL IN ALL LINES.**

If information for a category is zero, fill in 0.  
 If information for a category is Not Applicable, fill in 0.  
 Do NOT use dashes, N/A, N/AV, or M.

**Surgical Operations (whether major or minor)**

- 138 Inpatient surgical operations (not procedures) ..... \_\_\_\_\_
- 139 Outpatient surgical operations (not procedures) ..... \_\_\_\_\_
- 140 TOTAL surgical operations (not procedures) [line 138 + line 139] ..... \_\_\_\_\_

**Outpatient Visits**

- 141 Emergency visits ..... \_\_\_\_\_
- Number of emergency visits that resulted in inpatient admissions (Subset of line 141)
- 142 Other visits (all non-emergency visits, including physician referrals and outpatient surgeries) ..... \_\_\_\_\_
- 143 Observation visits ..... \_\_\_\_\_
- 144 TOTAL outpatient visits [Add Line 141 + Line 142 + Line 143] ..... \_\_\_\_\_

**Non-emergency Ambulance/Transport Services**

- 145 Non-emergency inter-facility transports by ground ambulance ..... \_\_\_\_\_
- 146 Non-emergency inter-facility transports by air ambulance ..... \_\_\_\_\_
- 147 TOTAL non-emergency transports by ambulance [Add Line 145 + Line 146] ..... \_\_\_\_\_

**Newborn Nursery**

- 148 Number of bassinets set-up-and-staffed as of the last day of the fiscal year  
 (exclude neonatal beds) ..... \_\_\_\_\_
- 149 Total births (exclude fetal deaths) ..... \_\_\_\_\_
- 150 Newborn days (exclude neonatal days) ..... \_\_\_\_\_

**VI. TOTAL FACILITY UTILIZATION AND BEDS**

**DO NOT USE DASHES, N/A, N/AV, OR M.  
 IF INFORMATION FOR A CATEGORY IS ZERO, FILL IN 0.  
 IF INFORMATION FOR A CATEGORY IS NOT APPLICABLE, FILL IN 0.  
 DO NOT MAKE ALTERATIONS TO SURVEY QUESTIONS**

**Utilization and Beds**

	(1) Hospital	(2) Nursing Home
<b>151</b> Admissions <i>(exclude newborns; include Medicare-certified and Non-Medicare swing admissions)</i>	_____	_____
<b>152</b> Inpatient days <i>(exclude newborns; include Medicare-certified and Non-Medicare swing days)</i>	_____	_____ Skilled nursing _____ Intermediate care _____ Residential / Elderly housing
<b>153</b> Discharges/deaths <i>(exclude newborns; include Medicare-certified and Non-Medicare swing discharges)</i>	_____	_____
<b>154</b> Census [ <i>The number of inpatients occupying beds at midnight on the last day (exclude weekends or holidays) of the fiscal year. Exclude newborns; include Medicare-Certified and Non-Medicare swing patients.</i> ]	_____	_____

**Utilization and Beds**

**Indicate Beds set-up-and-staffed (NOT number of licensed beds)** on the last day **excluding weekends or holidays** of the hospital's fiscal year quarter *(every 3 months)*.

	(1) Hospital	(2) Nursing Home
<b>155</b> 1 <sup>st</sup> Quarter	_____	_____ Skilled nursing _____ Residential / Elderly housing
<b>156</b> 2 <sup>nd</sup> Quarter	_____	_____ Skilled nursing _____ Residential / Elderly housing
<b>157</b> 3 <sup>rd</sup> Quarter	_____	_____ Skilled nursing _____ Residential / Elderly housing
<b>158</b> 4 <sup>th</sup> Quarter <i>(Hospital beds must equal line 47, col.1)</i>	_____	_____ Skilled nursing _____ Residential / Elderly housing

(1) Hospital (2) Nursing Home

**Medicare / Medicaid Primary Payer Utilization**

- 159 Total Medicare (Title 18) inpatient discharges \_\_\_\_\_
- 160 Total Medicare (Title 18) Outpatient Visits \_\_\_\_\_
- 161 Total Medicare inpatient days \_\_\_\_\_
- 162 Total Medicaid (Titles 19 & 21) Inpatient discharges \_\_\_\_\_
- 163 Total Medicaid (Titles 19 & 21) Outpatient visits \_\_\_\_\_
- 164 Total Medicaid inpatient days \_\_\_\_\_  
(Exclude newborns and deaths; include Medicare-certified swing bed utilization. Include T-18 and T-19 HMO utilization.)

**VII. MEDICAL STAFF – September 30, 2011**

Indicate which of the following physician arrangements the hospital, health care system, and/or network participate in:

	Hospital	Health Care System	Network
165 Independent practice association (IPA)	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
166 Group practice without walls	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
167 Open Physician Hospital Organization (PHO)	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
168 Closed Physician Hospital Organization (PHO)	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
169 Management service organization (MSO)	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
170 Integrated salary model	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
171 Equity model	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>
172 Foundation	<input type="checkbox"/> # physicians: _____	<input type="checkbox"/>	<input type="checkbox"/>

**Selected Specialty**

If information for a category is zero, fill in 0.  
If information for a category is Not Applicable, fill in 0. Do NOT use dashes, N/A, N/AV, or M.

Active/Associate Medical Staff	(1) Medical Staff as of Sept. 30, 2011 <i>(Includes Board Certified)</i>	(2) Board Certified Staff As of Sept. 30, 2011 <i>[Not to exceed column (1)]</i>
<b>Medical Specialties</b>		
173 General and family practice .....	_____	_____
174 Internal medicine (general) .....	_____	_____
175 Internal medicine subspecialties .....	_____	_____
176 Pediatrics (general) .....	_____	_____
177 Pediatric subspecialties .....	_____	_____

Selected Specialty Active/Associate Medical Staff (continued)	(1) Medical Staff as of Sept. 30, 2011 (Includes Board Certified)	(2) Board Certified Staff As of Sept. 30, 2011
<b>Surgical Specialties</b>		
178 General surgery .....	_____	_____
179 Obstetrics/Gynecology .....	_____	_____
180 All other surgical specialties .....	_____	_____
<b>Other</b>		
181 Anesthesiology .....	_____	_____
182 Emergency medicine .....	_____	_____
183 Pathology .....	_____	_____
184 Radiology .....	_____	_____
185 Addiction Medicine .....	_____	_____
186 Psychiatry .....	_____	_____
187 All other specialties (use valid specialties below) .....	_____	_____
<i>Line 188 - codes for valid specialties- circle all codes that apply:</i>		
<input type="checkbox"/> Aerospace Medicine	<input type="checkbox"/> General Preventive Medicine	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Chiropractic Services	<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> Physical Med&Rehab (includes Physiatry)
<input type="checkbox"/> Dental	<input type="checkbox"/> Occupational Medicine	<input type="checkbox"/> Public health
189 <b>TOTAL</b> Medical Staff .....	_____ (add lines 173-187)	_____ (add lines 173-187)

**VIII. PERSONNEL ON HOSPITAL PAYROLL – September 30, 2011 - DATA FOR ONE WEEK ONLY.**

Report the number of full-time and part-time personnel, **including trainees**, in the categories specified below. Report part-time hours for each category. All data must be for **the week of September 30, 2011 regardless of the hospitals' fiscal year end date**. Treat shared hospital/nursing home staff as part-time and report only hospital hours. **Do not include contracted staff or nursing home personnel.**

**DO NOT USE DASHES, N/A, N/AV, OR M.  
PLEASE ROUND TO NEAREST WHOLE NUMBER. DO NOT USE DECIMALS.**

Occupational Categories	FULL TIME		PART TIME	
	Total No. of Persons (35 Hr/Wk or more)	Total No. of Persons (less than 35 Hr/Wk)	Total No. of P-T hours (week of Sept 30, 2011)	
<b>190</b> Administrators and assistant administrators .....	_____	_____	_____	_____
<b>Physician And Dental Services</b>				
<b>191</b> Physicians / Dentists .....	_____	_____	_____	_____
<b>192</b> <b>Dental Hygienists</b> .....	_____	_____	_____	_____
<b>193</b> <b>Hospitalists</b> .....	_____	_____	_____	_____
<b>194</b> <b>Please select the category below that best describes the employment model for your hospitalists.</b>				
<input type="checkbox"/> <b>Independent provider group</b>		<input type="checkbox"/> <b>Employed by a university or school program</b>		
<input type="checkbox"/> <b>Employed by a physician group</b>		<input type="checkbox"/> <b>Other</b>		
<input type="checkbox"/> <b>Employed by your hospital</b>				
<b>195</b> <b>Intensivists</b> .....	_____	_____	_____	_____
<b>196</b> Medical and dental residents/interns .....	_____	_____	_____	_____
<b>Nursing Services</b>				
<b>197</b> Registered nurses .....	_____	_____	_____	_____
<b>198</b> Certified nurse midwives .....	_____	_____	_____	_____
<b>199</b> Licensed practical (vocational) nurses .....	_____	_____	_____	_____
<b>200</b> Paraprofessionals: Nursing Assistants .....	_____	_____	_____	_____
<b>201</b> Physician assistants .....	_____	_____	_____	_____
<b>202</b> Nurse practitioners .....	_____	_____	_____	_____
<b>203</b> Pharmacists .....	_____	_____	_____	_____
<b>204</b> Pharmacy Technician/Aides .....	_____	_____	_____	_____
<b>205</b> Medical & Clinical Laboratory Technologists .....	_____	_____	_____	_____
<b>206</b> Medical & Clinical Laboratory Technicians .....	_____	_____	_____	_____
<b>207</b> Surgical Technologists & Technicians .....	_____	_____	_____	_____
<b>208</b> Certified registered nurse anesthetists .....	_____	_____	_____	_____
<b>209</b> Clinical Nurse Specialists .....	_____	_____	_____	_____
<b>Therapeutic Services</b>				
<b>210</b> Respiratory Therapists .....	_____	_____	_____	_____
<b>211</b> Radiologic Technologists .....	_____	_____	_____	_____
<b>212</b> All other Radiologic Personnel .....	_____	_____	_____	_____

Occupational Categories (continued)	FULL TIME	PART TIME	
	Total No. of Persons (35 Hr/Wk or more)	Total No. of Persons (less than 35 Hr/Wk)	Total No. of P-T hours (week of Sept 30, 2011)
213 Occupational Therapists	_____	_____	_____
214 Occupational therapy assistants/aides	_____	_____	_____
215 Physical therapists	_____	_____	_____
216 Physical therapy assistants/aides	_____	_____	_____
217 Recreational therapists	_____	_____	_____
218 <b>Health Information Management</b> Administrators/Technicians	_____	_____	_____
219 Dieticians and Nutritionists	_____	_____	_____
<b>Psychology / Social Work Services</b>			
220 Psychologists	_____	_____	_____
221 Social Workers	_____	_____	_____
<b>Other Personnel</b>			
222 All other health professional / technical personnel	_____	_____	_____
223 All other personnel	_____	_____	_____
224 <b>TOTAL</b> hospital personnel	_____	_____	_____
	(add lines 190-223)	(add lines 190-223)	(add lines 190-223)

225 **Workweek**  
Indicate the **average or definition of WORKWEEK** (number of hours per week) of the full-time employees engaged in direct patient care (40, 38, 35, etc.) **Do not use decimals.**  (Average **full-time** hours per week)

**IX. OTHER (Lines 226-234)**

Check the appropriate box to indicate the answer to each question.

- 226 Does your hospital's mission statement include a focus on community benefit?  Yes  No
- 227 Does your hospital have a long-term plan for improving the health status of its community?  Yes  No
- 228 Does your hospital have resources for its community benefit activities?  Yes  No
- 229 Does your hospital work with other providers, public agencies, or community representatives to conduct a health status assessment of the community?  Yes  No
- 230 Does your hospital use health status indicators (such as rates of health problems or surveys of self-reported health) for defined populations to design new services or modify existing services?  Yes  No
- 231 Does your hospital work with other local providers, public agencies, or community representatives to conduct/develop a written health status assessment of the needed capacity for health services in the community?  Yes  No
- 232 **IF YES**, have you used the assessment to identify unmet health needs, excess capacity, or duplicative services in the community?  Yes  No
- 233 Does your hospital work with other providers to collect, track, and communicate clinical and health information across cooperating organizations?  Yes  No
- 234 Does your hospital either by itself or in conjunction with others disseminate reports to the community on the comparative quality and costs of health care services?  Yes  No

**X. SERVICE QUALITY / PATIENT SAFETY**

**235 Please identify the amount of resources allocated to quality and risk management functions. If a position is split between two or more roles, indicate the portion of the FTE dedicated to each function.**

	<u>Dedicated FTEs</u>
Quality management & improvement	_____
Clinical safety	_____
Case management	_____
Accreditation	_____
Infection control	_____
Risk Management	_____

**236** Does your facility provide 24-hour pharmacy services? **PHARM24**

Yes       No

**XI. eHealth**

Please indicate if you have the following features fully implemented, partially implemented, in the planning process, or not at all with your facility's electronic health record implementation.

Feature	<u>Fully Implemented</u>	<u>Partially Implemented</u>	<u>Planning</u>	<u>Not at All</u>
<b>237</b> Core MPI database with admission/discharge/transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>238</b> Lab information system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>239</b> Pharmacy system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>240</b> E-MAR (real-time enterprise medication administration record)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>241</b> Medication dispensing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>242</b> RIS (Radiology information system)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>243</b> Computerized radiography (digital x-ray)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>244</b> PACS (Picture archiving and communication system)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>245</b> Order entry/resulting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>246</b> Inpatient charting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>247</b> Bedside medication verification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>248</b> CPOE (Computerized physician order entry)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>249</b> EHR portal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>250</b> Bulk scanning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>251</b> Surgery management system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>252</b> Interface engine/expertise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Feature	Fully Implemented	Partially Implemented	Planning	Not at All
253 Physician Practice Management Systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
254 Physician Practice EMR Systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
255 Long Term Care EMR System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
256 Home Health EMR System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**XII. Health Information Technology**

**Expenditures**

257 Total Health Information Technology Expenditures - Capital \$ \_\_\_\_\_

258 Total Health Information Technology Expenditures- Operating \$ \_\_\_\_\_

**259 What type of internet connection comes into your hospital?**

- No internet service
  - Dial-up service (slower speed through a telephone line)
  - A cable model
  - A telephone company DSL line (high speed)
  - A fiber-optic connection
  - A wireless connection that requires an outside antenna (does not refer to a WiFi router)
  - Satellite dish
  - Other
- If Other, please explain:

**XIII. HIM Coding Function**

**Does your hospital outsource the HIM coding function under any of the following conditions?**

	YES	NO
260 To handle backlog due to staff vacations or shortages	<input type="checkbox"/>	<input type="checkbox"/>
261 Partially outsourced during normal operations	<input type="checkbox"/>	<input type="checkbox"/>
262 Completely outsourced during normal operations	<input type="checkbox"/>	<input type="checkbox"/>
263 To handle backlog during the ICD-10 transition / training	<input type="checkbox"/>	<input type="checkbox"/>

**XIV. SUPPLEMENTAL INFORMATION**

**264** Use this space or an additional sheet if more space is needed to elaborate on any of the information supplied on the survey. Refer to each response by page, section, and line number.