

**OHIO DEPARTMENT OF HEALTH  
ANNUAL HOSPITAL REGISTRATION AND PLANNING REPORT  
STATISTICAL INFORMATION  
JANUARY 1, 2019 - DECEMBER 31, 2019**

Please Return to: Ohio Department of Health  
OHAL/LICENSURE  
246 N. High St - 3rd Floor  
Columbus, OH. 43215-2412

This report must be returned by **March 1, 2020**

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
Arrowhead Behavioral Health	1543
Medicare Name (if different from registration)	National Provider Identifier
Arrowhead Behavioral Health, LLC	1336370196
Hospital Address/Location: (street name and number, city and zip code)	Medicare Provider Number
1725 Timberline Road, Maumee, OH 43537	364036

Telephone Number: (419)891-9333

County:  
**LUCAS**

Mailing address: (if different from above):  
1725 Timberline Road, Maumee, OH 43537  
Hospital E-Mail Address: Theresa.Contreras@uhsinc.com

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Name of Chief Executive Officer	Title	
Mrs. Theresa Contreras	CEO/Managing Director	
Name of person submitting report	Title	Telephone Number:
Jodi VanCamp	Director of Risk Management/PI/Compliance	(419)740-6815

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Accreditation/certification status: (Check One)

Joint Commission (JC)  
Date of last accreditation survey: 9/15/2017

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 but 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.**

**Name of Satellite Unit:**

**County:**

**Address (street address, city, state)**

**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
- County
- City
- City-County
- Hospital District or Authority

- Church-Operated
- Other Not-For Profit

- Individual
- Partnership
- Corporation

2. Is this hospital part of a multi-hospital system?  Yes  No

Name of System: Universal Health Services, Inc

3. Medicare Hospital Classification:

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

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

- General
- Alcohol and drug
- Burn Care
- Cancer
- Heart
- Children's
- Rehabilitation
- 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 Service** **Inpatient**      **Outpatient**

Not Available	In House	Contracted	Shared
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Surgical Services**

Number of Surgical Cases	<u>0</u>	<u>0</u>
Number of Surgical Operating Rooms	<u>0</u>	<u>0</u>
Dual-Purpose Operating Rooms		
(Total Number of Inpatient + Outpatient)	<u>0</u>	
Total Operating Rooms Onsite	<u>0</u>	
Total Operating Rooms Offsite	<u>0</u>	

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**Emergency Services**

Number of Patients:		
Treated and admitted to hospital	<u>0</u>	
Treated in ER and released	<u>0</u>	

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**CARDIAC SERVICES**

Number of cardiac catheterizations performed:		
Pediatric	<u>0</u>	
Adult	<u>0</u>	
Number of adult open-heart surgical procedures: <span style="float: right;"><u>0</u></span>		
Number of pediatric cardiovascular surgery procedures: <span style="float: right;"><u>0</u></span>		

**OBSTETRIC AND NEWBORN DESIGNATION**

Level designation of obstetric services	<b>0</b>
Level designation of newborn	<b>0</b>

**TRAUMA LEVEL DESIGNATION  
(As verified by American College of Surgeons)**

Adult Trauma Level Designation	<b>Not available</b>
Pediatric Trauma Level Designation	<b>Not available</b>

## 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/chemical dependency	1309	6957	34
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 (PICU)			
Physical rehabilitation			
Psychiatric	315	2049	14
Special skilled nursing			
Swing Beds			
<b>TOTAL HOSPITAL (Total of all Bed Categories)</b>	<b>1624</b>	<b>9006</b>	<b>48</b>

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**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	1536
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	42
Transfers to A Nursing Home	3
Expired	
<b>TOTAL DISCHARGES</b>	<b>1581</b>

**SCHEDULE E. HOSPITAL PERSONNEL**

1. Licensed or Certified Professional Employees

Total Number of Employees      Total F.T.E's  
(Includes part-time & full-time staff)

All other licensed professional/tech staff	31	
Certified Nurse Practitioner		
Certified Nurse-Midwife		
Certified RN Anesthetists(CRNA)		
Clinical Nurse Specialist		
Contracted physicians	7	
Dentists/Dental residents		
Dietetic technicians		
Dietitians (registered, eligible)		
Interns	7	
Licensed practical nurses	4	
Medical social workers (exclude psych.)		
Medical Technician		
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	16	
Psychologists		
Radiological Personnel		
Radiological Technologist - technicians		
Registered nurses	28	
Residents		
Respiratory therapists		
Salaried physicians		
Speech/audiology therapists		
<b>TOTALS:</b>	<b>93</b>	<b>0.00</b>

## 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	3				
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	4				
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					
<b>TOTAL:</b>	7	0	0	0	0



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

ADAMS	GEAUGA	MIAMI	VINTON
ALLEN 24	GREENE	MONROE	WARREN
ASHLAND	GUERNSEY	MONTGOMERY 3	WASHINGTON
ASHTABULA	HAMILTON	MORGAN	WAYNE
ATHENS	HANCOCK 47	MORROW 1	WILLIAMS 51
AUGLAIZE 3	HARDIN 6	MUSKINGUM	WOOD 120
BELMONT	HARRISON	NOBLE	WYANDOT 12
BROWN	HENRY 31	OTTAWA 43	OTHER STATES
BUTLER	HIGHLAND	PAULDING 11	INDIANA 3
CARROLL	HOCKING	PERRY	KENTUCKY
CHAMPAIGN	HOLMES	PICKAWAY 1	MICHIGAN 111
CLARK 2	HURON 40	PIKE	PENNSYLVANIA
CLERMONT 1	JACKSON	PORTAGE	WEST VIRGINIA
CLINTON	JEFFERSON	PREBLE	OTHER STATE 5
COLUMBIANA	KNOX	PUTNAM 4	
COSHOCTON 1	LAKE	RICHLAND 2	
CRAWFORD 4	LAWRENCE	ROSS	
CUYAHOGA 6	LICKING	SANDUSKY 30	
DARKE	LOGAN	SCIOTO	
DEFIANCE 35	LORAIN 25	SENECA 51	
DELAWARE 1	LUCAS 848	SHELBY 6	
ERIE 50	MADISON	STARK	
FAIRFIELD	MAHONING	SUMMIT 1	
FAYETTE	MARION	TRUMBULL	
FRANKLIN 5	MEDINA	TUSCARAWAS	
FULTON 55	MEIGS	UNION	
GALLIA	MERCER	VAN WERT 6	

**AFFIDAVIT**

**CERTIFICATION BY THE CHIEF EXECUTIVE OFFICER OF THE HOSPITAL**

Report period FROM: 1/1/2019 TO 12/31/2019 INCLUSIVE

I hereby certify that the statements made in the foregoing report are true to the best of my knowledge and belief.

(AHR Online Submission)

\_\_\_\_\_  
(Signature)

Jodi VanCamp

\_\_\_\_\_  
(Name)

Director of Risk  
Management/PI/Compliance

\_\_\_\_\_  
(Title)

(419)740-6815

\_\_\_\_\_  
(Phone)

1/29/2020

\_\_\_\_\_  
(Date Report Signed)