

**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
Access Hospital Dayton, LLC	1499
Medicare Name (if different from registration)	National Provider Identifier
	1063737765
Hospital Address/Location: (street name and number, city and zip code)	Medicare Provider Number
2611 Wayne Avenue, Dayton, OH 45420	364050

Telephone Number: (937)256-7801

County:

MONTGOMERY

Mailing address: (if different from above):

Hospital E-Mail Address: angela.nickell@accesshospital.net

Name of Chief Executive Officer	Title	
Dr. John A. Johnson	CEO	
Name of person submitting report	Title	Telephone Number:
Angela Nickell	CEO	(614)531-1758

Accreditation/certification status: (Check One)

Joint Commission (JC)

Date of last accreditation survey: 12/5/2017

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

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:

3. Medicare Hospital Classification:

- | | |
|------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Short-term acute care | <input checked="" type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Critical Access |
| <input type="checkbox"/> Long-term acute care | <input type="checkbox"/> Children's |

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

- | | |
|-------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> General | <input type="checkbox"/> Heart |
| <input type="checkbox"/> Alcohol and drug | <input type="checkbox"/> Children's |
| <input type="checkbox"/> Burn Care | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Cancer | <input checked="" type="checkbox"/> Psychiatric |
| | <input type="checkbox"/> 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 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>	

Emergency Services

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

CARDIAC SERVICES

Number of cardiac catheterizations performed:	
Pediatric	<u>0</u>
Adult	<u>0</u>
Number of adult open-heart surgical procedures:	<u>0</u>
Number of pediatric cardiovascular surgery procedures:	<u>0</u>

OBSTETRIC AND NEWBORN DESIGNATION

Level designation of obstetric services	0
Level designation of newborn	0

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

Adult Trauma Level Designation	Not available
Pediatric Trauma Level Designation	Not available

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			
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	1738	5304	54
Special skilled nursing			
Swing Beds			
TOTAL HOSPITAL (Total of all Bed Categories)	1738	5304	54

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	1675
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	61
Transfers to A Nursing Home	_____
Expired	2

TOTAL DISCHARGES	1738
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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 staff)

All other licensed professional/tech staff		
Certified Nurse Practitioner		
Certified Nurse-Midwife		
Certified RN Anesthetists(CRNA)		
Clinical Nurse Specialist		
Contracted physicians	4	4.00
Dentists/Dental residents		
Dietetic technicians		
Dietitians (registered, eligible)		
Interns		
Licensed practical nurses	10	9.00
Medical social workers (exclude psych.)		
Medical Technician		
Medical technologists		
Nursing assistants	30	26.00
Occupational therapists	1	1.00
Other licensed/certified laboratory personnel		
Other licensed/certified radiological personnel		
Pharmacists, licensed	1	1.00
Pharmacy technicians	3	3.00
Physical therapists		
Physician assistants		
Psychiatric social workers	8	7.00
Psychologists		
Radiological Personnel		
Radiological Technologist - technicians		
Registered nurses	11	10.50
Residents		
Respiratory therapists		
Salaried physicians		
Speech/audiology therapists		
TOTALS:	68	61.50

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	2	2			
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					
TOTAL:	2	2	0	0	0

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

ADAMS 4	GEAUGA	MIAMI 91	VINTON
ALLEN 5	GREENE 77	MONROE 1	WARREN 16
ASHLAND	GUERNSEY	MONTGOMERY 1027	WASHINGTON
ASHTABULA	HAMILTON 35	MORGAN	WAYNE
ATHENS	HANCOCK 1	MORROW	WILLIAMS
AUGLAIZE	HARDIN 1	MUSKINGUM 2	WOOD
BELMONT	HARRISON	NOBLE 1	WYANDOT
BROWN 2	HENRY	OTTAWA	OTHER STATES
BUTLER 81	HIGHLAND 5	PAULDING	INDIANA
CARROLL	HOCKING 2	PERRY	KENTUCKY
CHAMPAIGN 10	HOLMES	PICKAWAY	MICHIGAN
CLARK 117	HURON	PIKE	PENNSYLVANIA
CLERMONT 6	JACKSON 2	PORTAGE	WEST VIRGINIA
CLINTON 14	JEFFERSON	PREBLE 19	OTHER STATE
COLUMBIANA	KNOX	PUTNAM	
COSHOCTON	LAKE	RICHLAND	
CRAWFORD	LAWRENCE	ROSS 9	
CUYAHOGA 2	LICKING 3	SANDUSKY	
DARKE 22	LOGAN 6	SCIOTO 3	
DEFIANCE	LORAIN	SENECA	
DELAWARE 3	LUCAS	SHELBY 25	
ERIE	MADISON	STARK	
FAIRFIELD 2	MAHONING	SUMMIT	
FAYETTE 3	MARION 4	TRUMBULL	
FRANKLIN 103	MEDINA	TUSCARAWAS	
FULTON	MEIGS	UNION	
GALLIA 2	MERCER 2	VAN WERT 4	

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)

Angela Nickell

(Name)

CEO

(Title)

(614)531-1758

(Phone)

2/27/2020

(Date Report Signed)