TENNESSEE DEPARTMENT OF HEALTH

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JOINT ANNUAL REPORT OF HOSPITALS

2014

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State ID _____

TENNESSEE DEPARTMENT OF HEALTH
JOINT ANNUAL REPORT OF HOSPITALS
2014

SCHEDULE A - IDENTIFICATION*

1. Name of Hospital _____ Federal Tax I.D. # _____
   Did your facility name change during the reporting period? ____YES ____NO
   County _____

2. Address of Facility — Street _____
   City _____ State _____ Zip _____

3. Telephone Number ( ) _____
   Area Code Number

4. Name of Chief Executive Officer _____ _____
   First Name Last Name
   Signature of Chief Executive Officer _____

5. Name of person(s) coordinating form completion _____
   Telephone Number if different than above ( ) _____
   Area Code Number

6. _____ Office Use Only

7. Reporting period used for this facility:
   Beginning Date _____ Ending Date _____

8. _____ Office Use Only

9. Does your hospital own or operate or have other hospitals licensed as satellites of your hospital? ___Yes ___No
   If yes, please complete the following.

	NAME OF HOSPITAL	STATE ID	SATELLITE	OWN	OPERATE	OWN AND OPERATE
1						
2						
3						
4						
5						

* Refer to Instructions for Completing JAR-H_14

SCHEDULE B - CLASSIFICATION* State ID _____

1. CONTROL:

A. Indicate the type of organization that is responsible for establishing policy for overall operation of the hospital. CHECK ONLY ONE.

1. Government-Non-Federal	2. Government-Federal	3. Nongovernmental, not-for-profit	4. Investor-owned, for-profit
_____ 11 State	_____ 17 Armed Forces	_____ 20 Church-operated	_____ 23 Individual
_____ 12 County	_____ 18 Veterans Admin.	_____ 21 Other Nonprofit Corporation	_____ 24 Partnership
_____ 13 City	_____ 19 Other, please specify _____	_____ 22 Other not-for-profit, please specify _____	_____ 25 Corporation
_____ 14 City-County			
_____ 15 Hospital district or authority			

B. Is the hospital part of a health system? YES _____ NO _____

If yes, please provide the name and location of the health system.

Name_____ City _____ State _____

C. Does the controlling organization lease the physical property from the owner(s) of the hospital? YES _____ NO _____

D. What is the name of the legal entity that owns and has title to the land and physical plant of the hospital?

_____

E. Is the hospital a division of a holding company? YES _____ NO _____

F. Does the hospital itself operate subsidiary corporations? YES _____ NO _____

G. Is the hospital managed under contract? ___YES ___ NO If yes, length of contract From _____ To _____

If yes, please provide name, city, and state of the organization that manages the hospital.

Name_____ City _____ State _____

Name_____ City _____ State _____

H. Is the hospital part of a health care alliance? _____Yes _____No (see definition of alliance)

If yes, please provide the name, city, and state of the alliance headquarters.

Name _____ City _____ State _____

Name _____ City _____ State _____

I. Is the hospital part of a health network?_____YES _____NO (see definition of network)

If yes, please provide the name, city and state of the network

Name_____ City _____ State _____

Name_____ City _____ State _____

2. SERVICE:

A. Indicate the ONE category that BEST describes your hospital.

_____ 01 General medical & surgical	_____ 07 Rehabilitation
_____ 02 Pediatric	_____ 08 Orthopedic
_____ 03 Psychiatric	_____ 09 Chronic disease
_____ 04 Tuberculosis and other respiratory diseases	_____ 10 Alcoholism and other chemical dependency
_____ 05 Obstetrics and gynecology	_____ 11 Long term acute care
_____ 06 Eye, ear, nose and throat	_____ 12 Other-specify treatment area _____

B. Does your hospital own or have a contract with any of the following?

	(1) Yes	(2) No	Specify one: 1) Own	2) Contract	Number of Physicians	FTE Physicians
1. Independent Practice Association	____	_____	_____	_____	_____	_____
2. Group Practice Without Walls	____	_____	_____	_____	_____	_____
3. Open Panel Physician-Hospital Organization(PHO)	____	_____	_____	_____	_____	_____
4. Closed Panel Physician-Hospital Organization(PHO)	____	_____	_____	_____	_____	_____
5. Management Services Organization (MSO)	____	_____	_____	_____	_____	_____
6. Integrated Salary Model	____	_____	_____	_____	_____	_____
7. Equity Model	____	_____	_____	_____	_____	_____
8. Foundation	____	_____	_____	_____	_____	_____

3. Have any of the following insurance products been developed for use in Tennessee by your hospital, health system, health network alliance or as a joint venture with an insurer?
Check all that apply.

	Your (1) Hospital	(2) Health System	(3) Health Network	(4) Alliance	(5)Joint Venture With Insurer
A. Health Maintenance Organization	(1) _____	(2) _____	(3) _____	(4) _____	(5) _____
B. Preferred Provider Organization	(1) _____	(2) _____	(3) _____	(4) _____	(5) _____
C. Indemnity Fee For Service Plan	(1) _____	(2) _____	(3) _____	(4) _____	(5) _____

4. Does Your Hospital have a formal written contract that specifies the obligations of each party with:
   A. Health Maintenance Organization (HMO)? _____YES _____NO
      1. How many do you contract with?_____
      2. Number of different contracts _____
   B. Preferred Provider Organization (PPO)? _____YES_____NO
      1. How many do you contract with?_____
      2. Number of different contracts _____

5. What percentage of the hospital's net patient revenue is paid on a capitated basis?
   If the hospital does not participate in any capitated arrangement, please enter "0". _____ %

6. How many covered lives are in your capitation agreements? _____

SCHEDULE C - ACCREDITATIONS AND APPROVALS* State ID _____

1. ACCREDITATIONS:
   A. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
      Date of most recent accrediting letter or survey _____ _____ YES _____ NO
      If Yes, Is the hospital accredited under either/both of the following manuals:
      1. Comprehensive Accreditation Manual for Hospitals (CAMH) _____ YES _____ NO
      2. Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC) _____ YES _____ NO
      3. Other manuals, please specify _____
   B. Commission on Accreditation of Rehabilitation Facilities (CARF)
      Date of most recent accrediting letter or survey _____ _____ YES _____ NO
   C. American College of Surgeons Commission on Cancer _____ YES _____ NO
   D. American Osteopathic Association (AOA) _____ YES _____ NO
   E. TÜV Healthcare Specialists _____ YES _____ NO
   F. Community Health Accreditation Program (CHAP) _____ YES _____ NO

2. CERTIFICATIONS:
   Medicare Certification _____ YES _____ NO

3. OTHER:
   A. THA Membership _____ YES _____ NO
   B. Hospital Alliance of Tennessee, Inc. Membership _____ YES _____ NO
   C. American Hospital Association Membership _____ YES _____ NO
   D. American Medical Association Approval for Residencies (and Internships) _____ YES _____ NO
   E. State Approved School of Nursing:
      Registered Nurses _____ YES _____ NO
      Licensed Practical Nurses _____ YES _____ NO
   F. Medical School Affiliation _____ YES _____ NO
   G. Tennessee Association of Public and Teaching Hospitals (TNPath) _____ YES _____ NO
   H. National Association of Children's Hospitals and Related Institutions (NACHRI) _____ YES _____ NO
   I. National Association of Public Hospitals (NAPH) _____ YES _____ NO
   J. Other, please specify _____
      Field is limited to 255 characters

SCHEDULE D - SERVICES* State ID _____

1. CERTIFICATE OF NEED:

A. Do you have an approved, **but not completed**, certificate of need (CON) ? ___Yes ___No
If yes, please specify:

Name of Service or Activity Requiring the CON	# of Beds (if applicable)	Date of Approval
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Does your hospital own or operate Tennessee physician primary care clinics? ___Yes ___No If yes, how many? _____
How many physicians practice in these clinics? _____

3. Does your hospital own or operate other physician/specialty clinics located in Tennessee? ___Yes ___No If yes, how many? _____
How many physicians practice in these clinics? _____

4. Does your hospital own or operate a blood bank? _____Yes _____No
If yes, please indicate:
A. Distributes blood within the hospital ____Yes ____No
B. Collects blood within the hospital ____Yes ____No
C. Distributes blood outside the hospital ____Yes ____No
D. Collects blood from outside the hospital ____Yes ____No

5. Does your hospital own or operate an ambulance service? ____Yes ____No
If yes, please specify the counties where services are located.
_____ _____ _____ _____ _____ _____

Please specify the type of service and ownership relationship:

A. Land Transport ___ Yes ___No If yes, _____own, _____operate, or _____own and operate; _____ own in joint venture
B. Helicopter ___ Yes ___No If yes, _____own, _____operate, or _____own and operate; _____ own in joint venture
C. Special Neonatal Helicopter ___ Yes ___No If yes, _____own, _____operate, or _____own and operate; _____ own in joint venture
D. Special Neonatal Land Transport ___ Yes ___No If yes, _____own, _____operate, or _____own and operate; _____ own in joint venture

6. Does your hospital own or operate an off-site outpatient/ambulatory clinic located in Tennessee? ___Yes ___No
If yes, please complete the following.

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Clinic County City

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Clinic County City

7. Does your hospital own or operate an off-site ambulatory surgical treatment center located in Tennessee? ___Yes ___No
If yes, please complete the following.

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Center County City

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Center County City

8 . Does your hospital own or operate an off-site birthing center located in Tennessee? ___Yes ___No
If yes, please complete the following.

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Center County City

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Center County City

9. Does your hospital own or operate an off-site outpatient diagnostic center located in Tennessee? ___Yes ___No
If yes, please complete the following.

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Center County City

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Center County City

10. Does your hospital own or operate an off-site outpatient physical therapy rehab center located in Tennessee? ___Yes ___No
If yes, please complete the following.

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Center County City

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Center County City

11. Does your hospital own or operate a hospice that has a separate license located in Tennessee? ___Yes ___No
If yes, please complete the following.

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Hospice County City

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Hospice County City

12. Does your hospital own or operate an off-site assisted-care living facility located in Tennessee? ___Yes ___No
If yes, please complete the following.

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Facility County City

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Facility County City

13. Does your hospital own or operate a home for the aged located in Tennessee? ___Yes ___No
If yes, please complete the following.

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Home County City

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Home County City

14. Does your hospital own or operate an urgent care center? ___Yes ___No
If yes, please complete the following.

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Center County City

_____ _____ _____ ____own ___operate ____own and operate ____own in joint venture
Name of Center County City

15. Does your hospital own or operate a home health agency? ___Yes ___No
If yes, please complete the following.

Name of Agency: _____
Location of Agency: City _____ County _____
Number of Visits _____
___own ___operate ___own and operate ___own in joint venture

Name of Agency: _____
Location of Agency: City _____ County _____
Number of Visits _____
___own ___operate ___own and operate ___own in joint venture

16. Does your hospital own or operate an off-site nursing home located in Tennessee? ___Yes ___No
If yes, please complete the following.

_____ _____ _____ ____own ___operate ____own and operate ___own in joint venture
Name of Home County City

Number of Beds - Total _____ = Medicare only (SNF) _____ + Medicaid only (NF)_____ + Medicare/Medicaid (SNF/NF) _____ + Not Certified _____

_____ _____ _____ ____own ___operate ____own and operate ___own in joint venture
Name of Home County City

Number of Beds - Total _____ = Medicare only (SNF) _____ + Medicaid only (NF)_____ + Medicare/Medicaid (SNF/NF) _____ + Not Certified _____

17. Does your hospital operate a hospital-based skilled nursing unit (subacute unit) licensed as a nursing home for skilled nursing care (exclude swing beds)? ___Yes ___No If yes, please complete the following.

_____ _____ _____
Name of SNF Number of Licensed Beds Number of Staffed Beds

_____ _____
Number of Admissions Number of Patient Days

18. Does your hospital own, operate, or contract a mobile unit that operates in Tennessee? ___ Yes ___ No
If yes, specify name(s) and whether owned, operated, or contracted.

A. List mobile services:

1 _____ ____contract ____own ____operate ____own and operate _____own in joint venture ____ # of visits
2 _____ ____contract ____own ____operate ____own and operate _____own in joint venture ____ # of visits
3 _____ ____contract ____own ____operate ____own and operate _____own in joint venture ____ # of visits
4 _____ ____contract ____own ____operate ____own and operate _____own in joint venture ____ # of visits
5 _____ ____contract ____own ____operate ____own and operate _____own in joint venture ____ # of visits
6 _____ ____contract ____own ____operate ____own and operate _____own in joint venture ____ # of visits

B. List counties served (where you take the service):
List counties for service 1 in 18A on line 1, for service 2 on line 2, etc.

1 _____ _____ _____ _____ _____ _____
2 _____ _____ _____ _____ _____ _____
3 _____ _____ _____ _____ _____ _____
4 _____ _____ _____ _____ _____ _____
5 _____ _____ _____ _____ _____ _____
6 _____ _____ _____ _____ _____ _____

19. HOSPITAL-BASED DETAILED SERVICES (*See Explanation)* :

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
A. Miscellaneous:						
Lithotripsy						
Percutaneous	_____	_____	Procedures	_____	Procedures	_____
Extracorporeal Shock Wave	_____	_____				
# fixed units inside hospital _____			Procedures	_____	Procedures	_____
# fixed units off site _____					Procedures	_____
# of mobile units _____			Procedures	_____	Procedures	_____
# days per week (mobile units) ____						
Renal Dialysis						
# of dedicated stations _____						
Hemo Dialysis			Patients	_____	Patients	_____
			Treatments	_____	Treatments	_____
Peritoneal Dialysis			Patients	_____	Patients	_____
			Treatments	_____	Treatments	_____
B. Oncology/Therapies:						
Chemotherapy			Patients	_____	Patients	_____
					Encounters	_____
Hyperthermia			Treatments	_____	Treatments	_____
Radiation Therapy-Megavoltage						
# fixed units inside hospital _____			Patients	_____	Patients	_____
			Treatments	_____	Treatments	_____
# fixed units off site _____						

State ID _____

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
C. Radiology:						
Computerized Tomographic						
Scanners CT/CAT			Patients		Visits	
# fixed units inside hospital ____			Procedures		Procedures	
# fixed units off site ____					Procedures	
# of mobile units _____			Procedures		Procedures	
# days per week (mobile units) ____						
Ultrafast CT			Patients		Visits	
# fixed units inside hospital ____			Procedures		Procedures	
# fixed units off site ____					Procedures	
# of mobile units _____			Procedures		Procedures	
# days per week (mobile units) ____						
Magnetic Resonance Imaging						
# fixed units inside hospital ____			Procedures		Procedures	
# fixed units off site ____					Procedures	
# of mobile units _____			Procedures		Procedures	
# days per week (mobile units) ____						
Nuclear Medicine			Procedures		Procedures	
Radium Therapy			Procedures		Procedures	
Isotope Therapy			Procedures		Procedures	
Positron Emission Tomography						
# fixed units inside hospital ____			Procedures		Procedures	
# fixed units off site ____					Procedures	
# of mobile units _____			Procedures		Procedures	
# days per week (mobile units) ____						
Mammography			Procedures		Procedures	
# of ACR accredited units _____						
# other fixed units inside hospital ____						
# other fixed units off site ____						
# of mobile units _____						
# days per week (mobile units) ____						
Bone Densitometry			Procedures		Procedures	
# of units _____						

* Refer to Instructions for Completing JAR-H_14

SCHEDULE D - SERVICES (continued)* State ID _____

Note: Pediatric patients should be defined as patients 14 years old and younger.

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	In Cath Lab Setting Unit of Measure	Number	Outside Cath Lab Setting Unit of Measure	Number
D. Cardiac:						
Cardiac Catheterization						
Date Initiated _____						
# labs _____						
Intra-Cardiac or Coronary Artery			Adult Procedures		Adult Procedures	
			Pediatric Procedures		Pediatric Procedures	
Percutaneous Transluminal Coronary Angioplasty			Adult Procedures		Adult Procedures	
			Pediatric Procedures		Pediatric Procedures	
Stents			Adult Procedures		Adult Procedures	
			Pediatric Procedures		Pediatric Procedures	
All Other Heart Procedures			Adult Procedures		Adult Procedures	
			Pediatric Procedures		Pediatric Procedures	
All Other Non-Cardiac Procedures			Adult Procedures		Adult Procedures	
			Pediatric Procedures		Pediatric Procedures	
Thrombolytic Therapy			Adult Procedures		Adult Procedures	
			Pediatric Procedures		Pediatric Procedures	
			To Inpatients		To Outpatients	
Open Heart Surgery			Adult Operations			
# dedicated O.R.'s _____			Pediatric Operations			
E. Surgery:						
Inpatient			Encounters			
# operating rooms _____			Procedures			
Outpatient (one day)					Encounters	
# dedicated O.R.'s _____					Procedures	
F. Rehabilitation:						
Cardiac			Patients		Patients	

SCHEDULE D - SERVICES (continued)* State ID _____

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
F. Rehabilitation (continued):						
Chemical Dependency			Patients		Patients Episodes of Care	
Nutritional Counseling			Patients		Patients Episodes of Care	
Pulmonary			Patients		Patients Episodes of Care	
G. Physical Rehabilitation:						
Occupational Therapy			Patients		Patients Episodes of Care	
Orthotic Services			Patients		Patients Episodes of Care	
Physical Therapy			Patients		Patients Episodes of Care	
Prosthetic Services			Patients		Patients Episodes of Care	
Speech/Language Therapy			Patients		Patients Episodes of Care	
Therapeutic Recreational Service			Patients		Patients Episodes of Care	

Do you have a dedicated inpatient physical rehabilitation unit? ____Yes ____No
If yes, please complete the following. Number of assigned beds _____ Number of admissions _____ Number of patient days _____
Do you have a dedicated outpatient physical rehabilitation unit? ____Yes ____No

H. Pain Management:	_____	_____	Patients	_____	Patients	_____

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
I. Obstetrics/Newborn:						
Obstetrics Level of Care						
Level I						
Level II						
Level III						
Cesarean Section Deliveries			Deliveries	_____		
Non C-Section Deliveries			Deliveries	_____		
Birthing Rooms			Deliveries	_____		
# rooms _____						
# LDRP beds _____						
# LDR beds _____						
Labor Rooms						
# rooms _____						
Postpartum Services			Patients	_____	Visits	_____
# beds _____						
Newborn Nursery			Infants Discharged	_____		
# bassinets _____			Patient Days	_____		
Premature Nursery			Infants Discharged	_____		
# bassinets _____			Patient Days	_____		
Isolation Nursery			Patient Days	_____		
# bassinets _____						

SCHEDULE D - SERVICES (continued)*

State ID _____

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
J. Transplants:						
Organs						
Total Donors			Donors			
Total Harvested			Donations			
Transplants			Transplants			
Organ Bank			Organs			
Type of Organ:						
Heart			# Harvested			
			# Transplanted			
Liver			# Harvested			
			# Transplanted			
Kidneys			# Harvested			
			# Transplanted			
Pancreas			# Harvested			
			# Transplanted			
Intestine			# Harvested			
			# Transplanted			
Any Other _____			# Harvested			
			# Transplanted			
Tissues						
Total Donors			Donors			
Total Harvested			Donations			
Transplants			Transplants			
Tissue Bank			Tissues			
Type of Tissue:						
Eye			# Harvested			
			# Transplanted		# Transplanted	
Bone			# Harvested			
			# Transplanted		# Transplanted	
Bone Marrow			# Harvested			
			# Transplanted		# Transplanted	
Connective			# Harvested			
			# Transplanted		# Transplanted	
Cardiovascular			# Harvested			
			# Transplanted		# Transplanted	
Stem Cell			# Harvested			
			# Transplanted		# Transplanted	
Other _____			# Harvested			
			# Transplanted		# Transplanted	

* Refer to Instructions for Completing JAR-H_14

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
K. Other:						
Hyperbaric Oxygen Therapy			Patients			
Gamma Knife			Patients		Patients	
Cyberknife			Patients		Patients	
L. Intensive/Intermediate:						
Burn Care Unit # beds _____			Patients		Patients	
			Patient Days			
Cardiac Care Unit # beds _____			Patients			
			Patient Days			
Medical Intensive Care Unit # beds _____			Patients			
			Patient Days			
Mixed Intensive Care Unit # beds _____			Patients			
			Patient Days			
Neonatal Level of Care (Indicate highest level of care.)						
Level I # beds _____			Patients			
			Patient Days			
Level II A # beds _____			Patients			
			Patient Days			
Level II B # beds _____			Patients			
			Patient Days			
Level III A # beds _____			Patients			
			Patient Days			
Level III B # beds _____			Patients			
			Patient Days			
Level III C # beds _____			Patients			
			Patient Days			
Pediatric Care Unit # beds _____			Patients			
			Patient Days			
Stepdown ICU # beds _____			Patients			
			Patient Days			
Stepdown CCU # beds _____			Patients			
			Patient Days			
Surgical Intensive Care Unit # beds _____			Patients			
			Patient Days			

* Refer to Instructions for Completing JAR-H_14

SCHEDULE D - SERVICES (continued)* State ID _____

Utilization of Selected Services	Is This Service Provided In Your Hospital? Yes	No	To Inpatients Unit of Measure	Number	To Outpatients Unit of Measure	Number
L. Intensive/Intermediate (continued):						
Other, specify _____			Patients	_____		
Number of beds _____			Patient Days	_____		
Other, specify _____			Patients	_____		
Number of beds _____			Patient Days	_____		
M. Psychiatric Partial Hospitalization			Patients	_____		
N. Psychiatric Intensive Outpatient Care					Patients	_____
O. Electroconvulsive Treatment			Patients	_____	Patients	_____
			Treatments	_____	Treatments	_____
P. Other Convulsive Treatment			Patients	_____	Patients	_____
			Treatments	_____	Treatments	_____
Q. Negative Pressure Ventilated Room						
If yes, number of beds _____						

R. 23 Hour Observation ____Yes ____No Outpatients _____

S. Cancer Patients:

1. How many patients were diagnosed with cancer at your facility during this reporting period? _____
2. How many patients were both diagnosed and provided the first course of treatment for cancer at your facility during the reporting period? _____
3. How many patients were diagnosed elsewhere but provided the first course of treatment at your facility during this reporting period? _____

SCHEDULE E - FINANCIAL DATA*

State ID _____

Dates covered from _____ to _____ Use zeros where applicable. Do not leave blank lines in this schedule

A. CHARGES (For reporting period only. Do not include revenue related losses; round to the nearest dollar)

	Gross Patient Charges	minus	Adjustments To Charges	equals	Net Patient Revenue
1. Government					
a) Medicare Inpatient - Total (include managed care)		-		=	
1) Medicare Managed Care - Inpatient		-		=	
b) Medicare Outpatient - Total (include managed care)		-		=	
1) Medicare Managed Care - Outpatient		-		=	
c) Medicaid/TennCare Inpatient* (for EAH use 7.b.2.)		-		=	
d) Medicaid/TennCare Outpatient* (for EAH use 7.b.2.)		-		=	
e) Other		-		=	
f) Total Government Sources		-		=	
2. Cover Tennessee * see instructions					
a) Cover TN		-		=	
b) Cover Kids		-		=	
c) Access Tennessee		-		=	
d) Total Cover Tennessee		-		=	
3. Nongovernment					
a) Self-Pay		-		=	
b) Blue Cross Blue Shield		-		=	
c) Commercial Insurers (excludes Workers Comp)		-		=	
d) Workers Compensation		-		=	
e) Other		-		=	
f) Total Nongovernment Sources		-		=	
4. Totals					
a) Total Inpatient (excludes Newborn)					
b) Newborns					
c) Total Inpatient (includes Newborn) (A4a + A4b)		-		=	
d) Total Outpatient		-		=	
e) Grand Total (A1f + A2d + A3f)		-		=	
5. Bad Debt					
a) Medicare Enrollees					
b) Other Government					
c) Cover Tennessee					
d) Blue Cross and Commercially Insured Patients					
e) All Other					
f) Total Bad Debt					
6. Nongovernment and Cover Tennessee Adjustments to Charges					
a) Nongovernment Contractual					
b) Cover Tennessee Contractual					
c) Charity Care-Inpatient					
d) Charity Care-Outpatient					
e) Other Adjustments, specify types _____					
f) Total Nongovernment Adjustments					

Amount of discounts provided to uninsured patients _____

Total Charity (A6c + A6d) _____

Total Charity plus Bad Debt (A5f + A6c + A6d) _____

A. CHARGES (continued)

7. Other Operating Revenue
   a) Tax appropriations . . . . . _____
   b) State and Local government contributions:
      1) Amount designated to offset indigent care . . . _____
      2) Essential Access Hospital (EAH) payments. . . _____
      3) Critical Access Hospital (CAH) payments. . . . _____
      4) Amount used for other. . . . . _____
      5) Total . . . . . _____
   c) Other contributions:
      1) Amount designated to offset indigent care. . . _____
      2) Amount used for other . . . . . _____
      3) Total . . . . . _____
   d) Other (include cafeteria, gift shop, etc.) . . . _____
   e) Total other operating revenue . . . . . _____
      (A7a + A7b5 + A7c3 + A7d)

8. Nonoperating Revenue (No negative numbers! Losses or expenses should be reported in B2g.)
   a) Contributions . . . . . _____
   b) Grants . . . . . _____
   c) Interest Income . . . . . _____
   d) Other . . . . . _____
   e) Total nonoperating revenue . . . . . _____
      (add A8a through A8d)
   f) TOTAL REVENUE . . . . . _____
      (Net A4e + A7e + A8e)

B. EXPENSES (for the reporting period only; round to the nearest dollar)

1. Payroll Expenses for all categories of personnel specified below; (see definitions page)
   a) Physicians and dentists (include only salaries) . . . . . _____
   b) Medical and dental residents (include medical and dental interns) . . . . . _____
   c) Trainees (medical technology, x-ray therapy, administrative, and so forth) . . . . . _____
   d) Registered and licensed practical nurses . . . . . _____
   e) All other personnel . . . . . _____
   f) Total payroll expenses . . . . . _____
      (add B1a through B1e)

2. Nonpayroll Expenses
   a) Employee benefits (social security, group insurance, retirement benefits) . . . . . _____
   b) Professional fees (medical, dental, legal, auditing, consultant and so forth). . . . . _____
   c) Contracted nursing services (include staff from nursing registries, service contracts, and temporary help agencies) . . . . . _____
   d) Depreciation expense . . . . . _____
   e) Interest expense. . . . . _____
   f) Energy expense . . . . . _____
   g) All other expenses (supplies, purchased services, nonoperating expenses, and so forth) . . . . . _____
   h) Total nonpayroll expenses (add B2a through B2g) . . _____

   i) TOTAL EXPENSES (add B1f + B2h) . . . . . _____

3. Are system overhead/management fees included in your expenses? . . . . . ____YES ____NO
   If yes, specify amount . . . . . _____

C. CURRENT ASSETS

1. Current Assets is defined as the value of cash, accounts receivable, inventories, marketable securities and other assets that could be converted to cash in less than 1 year. What were your current assets on the last day of your reporting period (specified in Schedule A7 on page 2)? _____

Net receivables are defined as the collectibles as of the last day of your reporting period, whether or not they are currently due.

2. What were your net receivables on the last day of your reporting period? _____

D. FIXED ASSETS recorded on the balance sheet at the end of the reporting period (include actual or estimated value of plant/equipment that is leased).

1. Gross plant and equipment assets (including land, building, and equipment) _____
2. LESS: Deduction for accumulated depreciation _____
3. NET FIXED plant and equipment assets (D.1. Less D.2.; if zero please explain on separate sheet) _____

E. OTHER ASSETS recorded on the balance sheet at the end of the reporting period (include assets not included above as current or fixed assets).

What were your other assets on the last day of your reporting period (specified in Schedule A7 on page 2)? _____

F. TOTAL ASSETS

Total Assets is the sum of current assets, fixed assets and other assets (C.1.+D.3.+E.).

What were your total assets on the last day of your reporting period (specified in Schedule A7 on page 2)? _____

G. CURRENT LIABILITIES

Current liabilities is defined as the amount owed for salaries, interest, accounts payable, and other debts due within one (1) year. What were your current liabilities on the last day of your reporting period? _____

H. LONG TERM LIABILITIES

1. Long Term Liabilities is defined as the amount owed for leases, bond repayment and other items due after one (1) year. What were your long term liabilities on the last day of your reporting period? _____
2. Long Term Debt is defined as the value of obligations of over 1 year that require interest to be paid. What was your long term debt on the last day of your reporting period? _____

I. OTHER LIABILITIES

Other liabilities includes those liabilities not reported as current (item G.) or long term (item H.1.).

What were your total other liabilities on the last day of your reporting period (specified in Schedule A7 on page 2)? _____

J. CAPITAL ACCOUNT

Capital Account includes Fund Balance or Stockholder's Equity and all general, specific purpose, restricted or unrestricted funds. The Capital Account is the excess of assets over its liabilities.

What was your capital account on the last day of your reporting period? _____

Note: TOTAL ASSETS SHOULD EQUAL LIABILITIES PLUS CAPITAL ACCOUNT (i.e item F.=G.+H.1.+ I.+J.).

K. 1. Federal Income Tax: _____

2. Local Property Taxes Paid During the Reporting Period:
   a) Taxes on the Inpatient Facility _____
   b) Taxes on all Other Property _____

3. Other Local, State, or Federal Taxes: (exclude sales tax) _____

L. Does your hospital bill include charges incurred for the following professional services?

Radiology-Yes___ No___ Pathology-Yes___ No___ Anesthesiology-Yes___ No___ Other-Specify _____

M. TennCare Utilization and Revenue:

1. Inpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF ADMISSIONS	NUMBER OF PATIENT DAYS	GROSS REVENUE	NET REVENUE
United Health Care Community Plan				
Amerigroup				
Blue Care				
TennCare Select				
TennCare, MCO (Not Specified)				
Total MCO				

2. Outpatient Utilization and Revenue for TennCare Managed Care Organizations:

MCO	NUMBER OF PATIENTS	NUMBER OF VISITS	GROSS REVENUE	NET REVENUE
United Health Care Community Plan				
Amerigroup				
Blue Care				
TennCare Select				
TennCare, MCO (Not Specified)				
Total MCO				

SCHEDULE F - BEDS AND BASSINETS* State ID _____

1. PLEASE GIVE THE NUMBER OF:

A. TOTAL LICENSED ADULT AND PEDIATRIC BEDS AS OF THE LAST DAY OF THE REPORTING PERIOD (exclude beds in a sub-acute unit that are licensed as nursing home beds) _____
B. The number of adult and pediatric staffed beds set up, staffed and in use as of the last day of the reporting period. _____
C. NEWBORN NURSERY BASSINETS AS OF THE LAST DAY OF THE REPORTING PERIOD _____
D. Licensed Beds that were not staffed at any time during the reporting period. _____

2. STAFFED ADULT, PEDIATRIC, AND NEONATAL BEDS (exclude newborn nursery, include neonatal care units):

Was there a temporary or a permanent change in the total number of beds set up and staffed during the period? _____Yes _____No
If yes, give beds added or withdrawn (show increase by + and decrease by -) and date of change.

Bed change (+ or -) _____ Bed change (+ or -) _____ Bed change (+ or -) _____ Bed change (+ or -) _____

Date: _____ Date: _____ Date: _____ Date: _____
Month Day Year Month Day Year Month Day Year Month Day Year

3. SWING BEDS:

A. Does your facility utilize swing beds? ___ Yes ___ No If yes, number of Acute Care beds designated as Swing Beds. _____

B. PLEASE SPECIFY THE FOLLOWING FOR BEDS WHEN USED FOR LONG TERM SKILLED OR INTERMEDIATE CARE:

(How many admissions and how many days did you provide in the following categories?)

INTERMEDIATE CARE	ADMISSIONS	PATIENT DAYS
Private Pay		
Other		
Total		

SKILLED CARE	ADMISSIONS	PATIENT DAYS
Commercial		
Blue Cross		
Medicare		
Private Pay		
Other		
Total		

4. A. Number of Beds Set Up and Staffed on a typical day

SERVICE	BEDS
Medical	
Surgical	
Medical/Surgical	
Obstetrics	
Gynecological	
OB/GYN	
Pediatric	
Eye	
Neonatal Care	
Intensive Care (excluding Neonatal)	
Orthopedic	
Urology	
Rehabilitation	
Chronic/Extended Care	
Pulmonary	
Psychiatric (Total)	
Psychiatric specifically for Children and Youth under age 18	
Psychiatric specifically for Geriatric Patients	
Chemical Dependency (Total)	
Chemical Dependency specifically for Children and Youth under age 18	
Chemical Dependency specifically for Geriatric Patients	
Swing Beds (for long term skilled or intermediate care)	
Other, specify	
Unassigned	
TOTAL	

B. Number of Patients in hospital on a typical day. Exclude normal newborns (See Instructions), long term skilled or intermediate patients. _____

5. OBSERVATION BEDS

A. Do you use inpatient staffed beds for 23-hour observation? ___Yes ___No If yes, number of beds _____
B. Do you have beds assigned to a dedicated 23-hour observation unit? ___Yes ___No If yes, number of beds _____
C. Do you have beds in a "same-day-surgery" unit that are used for both same-day surgery and 23-hour observation? ___Yes ___No
If yes, number of beds _____

SCHEDULE G - UTILIZATION* State ID _____

1. INPATIENT UTILIZATION (include normal newborns)
   Patient Census Records:
   Please indicate whether you are reporting Admissions and Inpatient Days _____
   or Discharges and Discharge Patient Days _____

2. UTILIZATION BY MAJOR DIAGNOSTIC CATEGORIES:

MAJOR DIAGNOSTIC CATEGORIES	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS
01 Nervous System		
02 Eye		
03 Ear, Nose, Mouth and Throat		
04 Respiratory System		
05 Circulatory System		
06 Digestive System		
07 Hepatobiliary System & Pancreas		
08 Musculoskeletal Sys. & Connective Tissue		
09 Skin, Subcutaneous Tissue & Breast		
10 Endocrine, Nutritional & Metabolic		
11 Kidney & Urinary Tract		
12 Male Reproductive System		
13 Female Reproductive System		
14 Pregnancy, Childbirth & the Puerperium		
15 Normal Newborns & Other Neonates with Conditions Originating in the Perinatal Period		
16 Blood and Blood Forming Organs and Immunological Disorders		
17 Myeloproliferative Disorders & Poorly Differentiated Neoplasms		
18 Infectious & Parasitic Diseases		
19 Mental Diseases & Disorders		
20 Alchohol/Drug Use & Alcohol/Drug-Induced Organic Mental Disorders		
21 Injuries, Poisoning, & Toxic Effects of Drugs		
22 Burns		
23 Factors Influencing Health Status and Other Contacts with Health Services		
24 Multiple Significant Trauma		
25 Human Immunodeficiency Virus Infections		
26 Other DRGs Associated with All MDCs		
TOTAL		

* Refer to Instructions for Completing JAR-H_14

3. UTILIZATION BY REVENUE SOURCE (excluding normal newborns -- see Instructions)

Patients should be categorized according to primary payor and counted only once.

Please indicate whether you are reporting Admissions and Inpatient Days _____ or Discharges and Discharge Patient Days _____

	ADMISSIONS OR DISCHARGES	INPATIENT DAYS OR DISCHARGE PATIENT DAYS	OUTPATIENT VISITS*
a) Self Pay			
b) Blue Cross/Blue Shield			
c) Champus/TRICARE			
d) Commercial Insurance (excludes Workers Comp)			
e) Cover TN			
f) Cover Kids			
g) Access TN			
h) Medicaid/Tenncare			
i) Medicare - Total			
Medicare Managed Care			
j) Workers Compensation			
k) Other			
l) Total			

* Should include emergency department visits and hospital outpatient visits

4. NUMBER OF PATIENTS BY AGE GROUP (excluding normal newborns -- see Instructions)

Please indicate whether you are reporting Admissions and Inpatient Days _____ or Discharges and Discharge Patient Days _____

Age	Admissions or Discharges	Inpatient Days or Discharge Patient Days	Outpatient Visits*
Under 15 years			
15-17 years			
18-64 years			
65-74 years			
75-84 years			
85 years & older			
GRAND TOTAL			

* Should include emergency department visits and hospital outpatient visits

5. PATIENT ORIGIN (excluding normal newborns -- see Instructions)

Indicate usual residence of patients and number of patient days. Please indicate whether you are reporting Admissions and Inpatient Days _____ or Discharges and Discharge Patient Days _____

** List only those counties in other states that represent at least 1 percent of the total admissions or discharges to your hospital. If you have fewer than 500 total discharges or admissions annually, list only those counties that represent at least 2 percent of your total admissions or discharges.

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
1	Anderson		
2	Bedford		
3	Benton		
4	Bledsoe		
5	Blount		
6	Bradley		
7	Campbell		
8	Cannon		
9	Carroll		
10	Carter		
11	Cheatham		
12	Chester		
13	Claiborne		
14	Clay		
15	Cocke		
16	Coffee		
17	Crockett		
18	Cumberland		
19	Davidson		
20	Decatur		
21	DeKalb		
22	Dickson		
23	Dyer		
24	Fayette		
25	Fentress		
26	Franklin		
27	Gibson		
28	Giles		

5. PATIENT ORIGIN (continued)

County #	Tennessee County of Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
29	Grainger		
30	Greene		
31	Grundy		
32	Hamblen		
33	Hamilton		
34	Hancock		
35	Hardeman		
36	Hardin		
37	Hawkins		
38	Haywood		
39	Henderson		
40	Henry		
41	Hickman		
42	Houston		
43	Humphreys		
44	Jackson		
45	Jefferson		
46	Johnson		
47	Knox		
48	Lake		
49	Lauderdale		
50	Lawrence		
51	Lewis		
52	Lincoln		
53	Loudon		
54	McMinn		
55	McNairy		
56	Macon		
57	Madison		
58	Marion		
59	Marshall		
60	Maury		
61	Meigs		
62	Monroe		

5. PATIENT ORIGIN (continued)

County #	State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
63	Montgomery		
64	Moore		
65	Morgan		
66	Obion		
67	Overton		
68	Perry		
69	Pickett		
70	Polk		
71	Putnam		
72	Rhea		
73	Roane		
74	Robertson		
75	Rutherford		
76	Scott		
77	Sequatchie		
78	Sevier		
79	Shelby		
80	Smith		
81	Stewart		
82	Sullivan		
83	Sumner		
84	Tipton		
85	Trousdale		
86	Unicoi		
87	Union		
88	Van Buren		
89	Warren		
90	Washington		
91	Wayne		
92	Weakley		
93	White		
94	Williamson		
95	Wilson		
96	TN County Unknown		
	Tennessee Total		

5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
ALABAMA COUNTIES: (Specify)		
1)		
2)		
Other Alabama Counties		
Alabama Total		
GEORGIA COUNTIES: (Specify)		
1)		
2)		
Other Georgia Counties		
Georgia Total		
MISSISSIPPI COUNTIES: (Specify)		
1)		
2)		
Other Mississippi Counties		
Mississippi Total		
ARKANSAS COUNTIES: (Specify)		
1)		
2)		
Other Arkansas Counties		
Arkansas Total		
MISSOURI COUNTIES: (Specify)		
1)		
2)		
Other Missouri Counties		
Missouri Total		

5. PATIENT ORIGIN (continued)

State & County Residence	Number of Admissions or Discharges	Number of Inpatient Days or Discharge Patient Days
KENTUCKY COUNTIES: (Specify)		
1)		
2)		
Other Kentucky Counties		
Kentucky Total		
VIRGINIA COUNTIES: (Specify)		
1)		
2)		
Other Virginia Counties		
Virginia Total		
NORTH CAROLINA COUNTIES: (Specify)		
1)		
2)		
Other North Carolina Counties		
North Carolina Total		
OTHER STATES: (Specify)		
1)		
2)		
All Other States and Countries		
RESIDENCE UNKNOWN:		
GRAND TOTAL		

6. Delivery Status:

   A. Number of Infants Born Alive _____
   B. Number of Deaths Among Infants Born Alive _____
   C. Number of Fetal Deaths (350 grams or 20 weeks or more gestation) _____

State ID _____

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS*

1. TYPE OF UNIT - PSYCHIATRIC:
   A. Do you have a dedicated psychiatric unit?_____ Yes _____ No If yes, please complete items on this page and on the next page.
   B. Do you have a designated Gero-Psychiatric Unit? _____ Yes _____ No

2. BEDS
   A. Number of assigned beds _____
   B. Date unit opened _____

3. UTILIZATION BY AGE GROUPS:
   Please indicate if you are reporting Admissions and Inpatient Days _____ or Discharges and Discharge Patient Days. _____

	Inpatient			Partial Care or Day Hospital	Outpatient
AGE GROUPS	Number of Patients on September 30	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Visits
Children and/or Adolescents Ages 0 - 17					
Adults Ages 18 - 64					
Elderly Ages 65 and older					
Total					

4. Is the psychiatric service managed under a management contract different from the hospital itself? _____Yes _____ No
   If yes, please specify name of organization that manages the unit. _____

5. Do you have contracts with Behavioral Health Organizations? ____ Yes ____ No

6. Does your hospital use:

			If Yes, Number of Patients Secluded or Restrained		Number of Times Seclusion or Restraint was Initiated	
			Age 0-17	Age 18+	Age 0-17	Age 18+
A. Seclusion	_____ Yes	_____ No	_____	_____	_____	_____
B. Mechanical Restraints	_____ Yes	_____ No	_____	_____	_____	_____
C. Physical Holding Restraints	_____ Yes	_____ No	_____	_____	_____	_____
D. Chemical Restraints	_____ Yes	_____ No	_____	_____	_____	_____

7. FINANCIAL DATA - PSYCHIATRIC

	INPATIENT CHARGES	plus	OUTPATIENT CHARGES	equals	TOTAL CHARGES	minus	ADJUSTMENTS TO CHARGES	equals	NET PATIENT REVENUE
A. GROSS PATIENT REVENUE & NET PATIENT REVENUE BY PAYER:									
1) Self Pay		+		=		-		=	
2) Blue Cross/Blue Shield		+		=		-		=	
3) Champus/TRICARE		+		=		-		=	
4) Commercial Insurance (excludes Workers Comp)		+		=		-		=	
5) Cover TN		+		=		-		=	
6) Cover Kids		+		=		-		=	
7) Access TN		+		=		-		=	
8) Medicaid/Tenncare		+		=		-		=	
9) Medicare - Total		+		=		-		=	
Medicare Managed Care		+		=		-		=	
10) Workers Compensation		+		=		-		=	
11) Other		+		=		-		=	

B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE

1. Bad Debt	
2. Charity Care	
3. Contractual Adjustments	
4. Total	
5. Amount of discounts provided to uninsured patients	

8. A. SERVICE CHARGES

	INPATIENT CHARGES	OUTPATIENT CHARGES
1. Routine Treatment		
2. Ancillary Services		
3. Other		
4. Total		

B. Do these charges include physicians' fees? ___YES ___NO

State ID_____

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS (continued)*

1. TYPE OF UNIT - CHEMICAL DEPENDENCY:
   Do you have a dedicated chemical dependency unit? _____ Yes _____ No If yes, please complete items on this page and on the next page.

2. BEDS
   A. Number of assigned beds _____
   B. Date unit opened_____

3. UTILIZATION BY AGE GROUPS:
   Please indicate if you are reporting Admissions and Inpatient Days _____ or Discharges and Discharge Patient Days. _____

	Inpatient			Partial Care or Day Hospital	Outpatient	Residential Care
AGE GROUPS	Number of Patients on September 30	Number of Admissions or Discharges	Number of Inpatient or Discharge Patient Days	Number of Sessions	Number of Visits	Number of Visits
Children and/or Adolescents Ages 0 - 17						
Adults Ages 18 - 64						
Elderly Ages 65 and older						
Total						

4. Is the chemical dependency service managed under a management contract different from the hospital itself? ____Yes ____No
   If yes, please specify name of organization that manages the unit. _____

5. Do you have contracts with Behavioral Health Organizations? _____ Yes _____ No

6. FINANCIAL DATA - CHEMICAL DEPENDENCY

	INPATIENT CHARGES	plus	OUTPATIENT CHARGES	equals	TOTAL CHARGES	minus	ADJUSTMENTS TO CHARGES	equals	NET PATIENT REVENUE
A. GROSS PATIENT REVENUE & NET PATIENT REVENUE BY PAYER:									
1) Self Pay		+		=		-		=	
2) Blue Cross/Blue Shield		+		=		-		=	
3) Champus/TRICARE		+		=		-		=	
4) Commercial Insurance		+		=		-		=	
(excludes Workers Comp)		+		=		-		=	
5) Cover TN		+		=		-		=	
6) Cover Kids		+		=		-		=	
7) Access TN		+		=		-		=	
8) Medicaid/Tenncare		+		=		-		=	
9) Medicare - Total		+		=		-		=	
Medicare Managed Care		+		=		-		=	
10) Workers Compensation		+		=		-		=	
11) Other		+		=		-		=	

B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE

1. Bad Debt	
2. Charity Care	
3. Contractual Adjustments	
4. Total	
5. Amount of discounts provided to uninsured patients	

7. A. SERVICE CHARGES

	INPATIENT CHARGES	OUTPATIENT CHARGES
1. Routine Treatment		
2. Ancillary Services		
3. Other		
4. Total		

B. Do these charges include physicians' fees? ___YES ___NO

SCHEDULE I - EMERGENCY DEPARTMENT* State ID _____

1. What is the direct telephone number into your Emergency Department? _____

2. Is the Emergency Department managed under a management contract different from the hospital itself? ____ Yes ____ No
   If yes, with whom is the contract held? _____

3. Emergency Department:

   Number of visits by payer:

   A. Self Pay _____

   B. Blue Cross/Blue Shield _____

   C. Champus/TRICARE _____

   D. Commercial Insurance (excludes Workers Comp) _____

   E. Cover TN _____

   F. Cover Kids _____

   G. Access TN _____

   H. Medicaid/Tenncare
      - United Health Care Community Plan _____
      - Amerigroup _____
      - Blue Care _____
      - TennCare Select _____
      - TennCare, MCO (Not Specified) _____
      - TennCare Total _____

   I. Medicare - Total _____
      - Medicare Managed Care _____

   J. Workers Compensation _____

   K. Other _____

   L. Grand Total _____

4. Is your Emergency Department staffed 24 hours per day? ____ Yes ____ No If no, please give hours covered. _____

5. Indicate the number of the following personnel available in the hospital on a normal day and how many are available to the Emergency Department.

	ON HOSPITAL CAMPUS	IN EMERGENCY DEPARTMENT
A. PHYSICIANS:		
Board certified in Emergency Medicine	_____	_____
Board eligible in Emergency Medicine	_____	_____
Declared Specialty of Emergency Medicine	_____	_____
Board Certified Psychiatrists	_____	_____
Other Physicians Available to Emergency Department	_____	_____
B. NURSES:		
Nurse Practitioners	_____	_____
R.N.'s with formal emergency training and experience	_____	_____
Other R.N.'s	_____	_____
L.P.N.'s and other nursing support personnel	_____	_____
Clerical Staff	_____	_____
C. OTHER:		
E.M.T.	_____	_____
E.M.T. advanced	_____	_____

6. SUPPORTIVE SERVICES:

	YES	NO
A. COMMUNICATIONS:		
Two-Way radio in ER with Access to:		
Central Emergency Dispatch Center	_____	_____
Ambulances	_____	_____
Other hospitals	_____	_____
B. HELIPORT:	_____	_____
C. PHARMACY IN ER:	_____	_____
D. BLOOD BANK (check ONLY one):		
Fully stocked	_____	
Common blood types only	_____	

7. Do you have dedicated centers for the provision of specialized emergency care for the following:

A. Designated Trauma Center Yes _____ No _____

B. Burns Yes _____ No _____
If yes, do you have a designation by a government agency as a Burn Center? Yes ___ No ___

C. Pediatrics Yes _____ No _____

D. Other, specify
_____

8. Triage: A. Total number of patients who presented in your ER. _____
B. Total number treated in your ER. _____
C. Total number not treated in the ER but referred to physician or clinic for treatment. _____

State ID ____

SCHEDULE J - PERSONNEL ON PAYROLL AS OF LAST DAY OF REPORTING PERIOD AND USE OF CONTRACT EMPLOYEES*

	Full-Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***
1. Administration:			
A. Administrators & Assistants . . .			☐
B. Director, Health Services Research & Assistants			☐
C. Marketing & Planning Officer(s) and Assistants			☐
D. Financial and Accounting Officer(s) & Assistants			☐
2. Physician and Dental Services:			
A. Physicians			☐
B. Medical residents			☐
C. Dentists			☐
D. Dental residents			☐
3. Nursing Services:			
A. RNs - Administrative			☐
B. RNs - Patient care/clinical			☐
C. LPNs			☐
D. Ancillary nursing personnel . . .			☐
4. Certified Nurse Midwives			☐
5. Nurse Anesthetists			☐
6. Physicians assistants			☐
7. Nurse practitioners			☐
8. Medical record service:			
A. Medical record administrators . .			☐
B. Medical record technicians (certified or accredited)			☐
C. Other Medical record technicians .			☐
9. Pharmacy:			
A. Pharmacists, licensed			☐
B. Pharmacy technicians			☐
C. Clinical Phar-D			☐
10. Clinical laboratory services:			
A. Medical Technologists			☐
B. Other laboratory personnel . . .			☐
11. Dietary services:			
A. Dietitians			☐
B. Dietetic technicians			☐

	Full-Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***
12. Radiological services:			
A. Radiographers (radiologic technologists)			☐
B. Radiation therapy technologists			☐
C. Nuclear medicine technologists			☐
D. Other radiologic personnel			☐
13. Therapeutic services:			
A. Occupational therapists			☐
B. Occupational therapy assistants & aides			☐
C. Physical therapists			☐
D. Physical therapy assistants & aides . .			☐
E. Recreational therapists			☐
14. Speech and hearing services:			
A. Speech Pathologist			☐
B. Audiologist			☐
15. Respiratory therapy services:			
A. Respiratory therapists			☐
B. Respiratory therapy technicians			☐
16. Psychiatric services:			
A. Clinical psychologists			☐
B. Psychiatric social workers			☐
C. Psychiatric registered nurses			☐
D. Other mental health professionals . . .			☐
17. Chemical dependency services:			
A. Clinical psychologists			☐
B. Social workers			☐
C. Registered nurses			☐
D. Other specialists in addiction and/or in chemical dependency			☐
18. Medical Social workers			☐
19. Surgical technicians			☐
20. All other certified professional & technical			☐
21. All other non-certified professional & technical			☐
22. All other personnel			☐
TOTAL			

** Full-time + Part-time specified in Full Time Equivalent

*** Please check if contract staff is used.

SCHEDULE K - MEDICAL STAFF*

State ID _____

	(1) Number of Active and Associate Medical Staff (Include Board Certified)	(2) Number of Active and Associate Medical Staff Who Are Board Certified	(3) Number of House Staff Who Are Interns, Externs or Residents
1. MEDICAL SPECIALTIES:			
A. General and family practice			
B. Pediatric			
C. General internal medicine			
D. Psychiatric			
E. Neonatologists			
F. Cardiologists			
G. Neurologists			
H. Other medical specialties			
2. SURGICAL SPECIALTIES:			
A. General surgery			
B. Obstetrics and gynecology			
C. Perinatologists			
D. Gynecology			
E. Orthopedic			
F. Neurosurgeons			
G. Cardiovascular			
H. Gastroenterology			
I. Other surgical specialties			
3. OTHER SPECIALTIES:			
A. Pathology			
B. Radiology			
C. Anesthesiology			
D. Other specialties			
4. DENTAL SPECIALTIES			
TOTAL			

SCHEDULE L - PERINATAL*

State ID _____

1A. Name of person completing Perinatal survey _____

1B. Telephone number _____

1C. Fax number _____

Please complete the following questions.

2. Births
   A. Total number of live births _____
   B. Birth weight below 2500 grams (5 lb 8 oz) _____
   C. Birth weight below 1500 grams (3 lb 5 oz) _____

3. Number of babies on Ventilator longer than 24 hours _____

4. Number of babies received from referring hospitals for neonatal management _____

	YES	NO
5. Is Medical Director of Obstetrics board certified/eligible in maternal-fetal medicine?	☐	☐
6. Is Medical Director of the Nursery board certified/eligible in neonatal-perinatal?	☐	☐
7. Do the following subspecialty consultants spend more than 2/3 full-time effort at your hospital?		
A. OBSTETRICS:		
Perinatal Sonologist	☐	☐
Hematologist	☐	☐
Cardiologist	☐	☐
B. NEONATAL:		
Pediatric Radiologist	☐	☐
Pediatric Cardiologist	☐	☐
Pediatric Neurologist	☐	☐
Pathologist	☐	☐
Pediatric Surgeon	☐	☐

SCHEDULE M - SURVEY ON NURSING PERSONNEL* State ID _____

(As of the last day of the reporting period)

1. Registered Nurses

HIGHEST EDUCATION LEVEL	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS	PRIMARY ROLE (NUMBER OF POSITIONS)	
					CLINICAL	ADMINISTRATIVE
Total						
Bachelors Degree						
Associate Degree						
Diploma						
Masters Degree						
Doctorate Degree						

2. Advanced Practice Nurses

NURSING PERSONNEL CATEGORY	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS	PRIMARY ROLE (NUMBER OF POSITIONS)	
					CLINICAL	ADMINISTRATIVE
Total						
Nurse Practitioner						
Clinical Nurse Specialist						
CRNA						
Certified Nurse Midwife						

3. Licensed Practical Nurses

LPNs	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS
Total		

4. Recruitment of Nursing Personnel

The following are selected specialties for which hospitals commonly report recruiting difficulties.
Please specify other categories as necessary.

NURSING PERSONNEL CATEGORY	FTE NUMBER CURRENTLY EMPLOYED	NUMBER OF BUDGETED VACANCIES	NUMBER OF POSITIONS YOU PLAN TO ADD IN THE NEXT 12 MONTHS	NUMBER OF POSITIONS YOU PLAN TO ELIMINATE IN THE NEXT 12 MONTHS
CCU/ICU				
ER				
Other (Specify):				

SCHEDULE N - HEALTH CARE PLANS ACCEPTED* State ID _____

The Health Care Consumer Right-to-Know Act of 1998 which was signed by Governor Sundquist in May, 1998 requires hospitals to report to the Department of Health "health care plans accepted by the hospital" as well as a variety of information that is included in earlier schedules of the Joint Annual Report. In order to allow the Joint Annual Report to meet the entire reporting requirement described in this act, please list all health insurance plans with which you currently - as of the last day of this reporting period - have a valid contract. List each plan separately not just the name of the Company. For example, if you have contracts to provide services to individuals enrolled in Blue Choice and Blue Preferred, list both plans and do not only list Blue Cross & Blue Shield of Tennessee.

Plans: