****

**TENNESSEE DEPARTMENT OF HEALTH**

**DIVISION OF HEALTH PLANNING**

**Joint Annual Report**

**Manual for**

**Outpatient Diagnostic Center**

**Facilities**

**2019**

**JOINT ANNUAL REPORT**

**MANUAL**

**For**

**Outpatient Diagnostic Center**

**Facilities**

**2019**

##### **STATE OF TENNESSEE**

#### Department of Health

#### Health Planning - Facilities

#### Andrew Johnson Tower

#### 2nd Floor

#### 710 James Robertson Parkway

#### Nashville, TN 37243

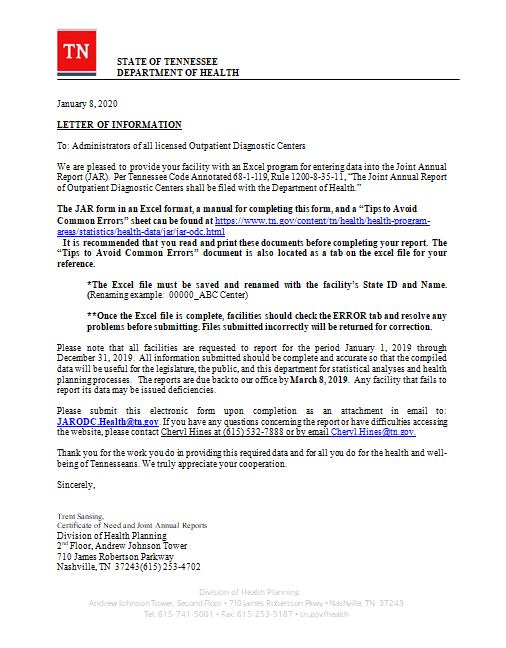
#### 615-741-1954

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| ***Before beginning your report go to the*** <https://www.tn.gov/content/tn/health/health-program-areas/statistics/health-data/jar/jar-odc.html>  ***website to first download your form and save it with your State ID Number, and Facility Name.***  ***Example: 00000 John Doe Imaging ODC*** | | | | | | | | | | | | | | | | | | | | |
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**SECTION I**

Letter of Information



**SECTION II**

**Rules and Regulations for Reporting**

**General Reporting Requirements**

**Per T. C. A. 1200-8-35-11 The Joint Annual Report of Outpatient Diagnostic Centers shall be filed with the department. The forms are furnished online to each Outpatient Diagnostic Center by the department each year and the forms must be completed and returned to the department as required.**

All facilities are requested to report for the calendar year beginning January 1st through December 31st. Information should be complete and accurate as possible so that the compiled data will be useful for the legislature, the public and the department’s statistical analyses and health planning process.

**Forty-five days after the facility gets the form from the department it needs to be completed. Any facility that fails to report its data could be issued deficiencies.**

**Data Editing and Quality Contro**l

The department will review data submitted. Incomplete reports or inaccuracies will be queried. The facility will be asked to investigate these errors and to supply correct information **within 15 working days** of the date that the error is reported to the facility.

**Data System Summary**

**Data Set Name:**  Outpatient Patient Diagnosis **(**ODC)

**Location/Owner of Data Set:** Tennessee Department of Health, Office of Health Statistics

**Contact Person: Cheryl Hines** (615) 532-7888 Email Address: [Cheryl.Hines@tn.gov](mailto:Cheryl.Hines@tn.gov)

**Purpose for Which Data Collected:** This system collects and compiles data that will be useful for the legislature, the public and the department’s statistical analysis and health planning process.

**Process for Accessing Data:** Requests for data are handled by Statistical Services. Contact Statistical Services at (615) 741-4939 or [HealthStatistics.Health@tn.](mailto:HealthStatistics.Health@tn.)gov.

**Description:**

**Method of Data Collection:**  JAR for ODC forms

**Percent Return:** 95% - 99%

**Frequency of Updating:** Annually

**Years of Data:** One

**Types of Data Output Available:** Excel format files

**Cost for Data Output:** No

**Standard Reports Generated:** ODC Joint Annual Reports

**Timing and Frequency of Data Submission**

All data submitted must be approved by the Department of Health. The Department of Health must receive all required data from the facility 45 days following the close of the calendar year.

|  |  |  |
| --- | --- | --- |
| **Date Sent to Facility** | **Date Due to TDOH** | **Reporting Period** |
| January 8, 2020 | March 9, 2020 | January 1st, 2019  through  December 31, 2019 |

**Data reported to the Department of Health should be e-mailed to:**

##### **Facilities**

##### **Office of Health Statistics**

##### **Andrew Johnson Tower**

##### **2nd Floor**

**710 James Robertson Boulevard**

##### **Nashville, Tennessee 37243**

**JARODC.Health@tn.gov**

**ODC JAR Contacts**

Technical questions regarding the Tennessee Outpatient Diagnostic Center Joint Annual Reports should be directed to:

**Cheryl Hines\***

**Division of Health Planning**

**Health Facilities**

**(615) 532-7888**

[**Cheryl.Hines@ tn.gov**](mailto:Cheryl.Hines@%20tn.gov)

**All other JAR inquiries should be referred to:**

**Trent Sansing**

**Division of Health Planning**

**Health Facilities**

**(615) 253-4702**

**Email to** [**trent.sansing@tn.gov**](mailto:trent.sansing@tn.gov)

**SECTION III**

**Schedules**

|  |  |  |
| --- | --- | --- |
| Schedule A – Identification | Facility | Required Fields - Yes |

*The State Identification number for all ODC facilities is found on the “State ID” sheet of the computer form. This information is protected and cannot be accessed. If the facility had a name change that is not reflected on this data base, please contact Facilities, TN Department of Health.* ***See page 11 for all contact information.***

**Facility** – **State ID**

The **State ID** is accessed from the “drop” box on the computer form. Once the State ID is selected, *the Street Address, City, State, County, and Zip Code* fields will automatically populate the form. This ID will automatically populate Schedule A through Administration Declaration.

**DO NOT KEY in this field.** Select the **State ID** from the “drop” box for this field.

**Facility – Did the facility’s name change during the reporting period?**

This is a Required Field and must be answered with “Yes” or “No”.

**DO NOT KEY in this field.** Make the selection from the “drop” box for this field.

If **“Yes”**, key in the facility’s Prior Name.

If **“No”**, leave blank.

**Facility – Telephone**

This is a 10 digit field. Key the telephone number starting with the area code, i.e. 1234567890. **DO NOT** use brackets or dashes. This field will automatically place the number in the telephone format (123) 456-7890.

**Facility – Mailing Address same as Street Address?**

This is a Required Field and must be answered with “Yes” or “No”. **DO NOT KEY in this field.** Make the selection from the “drop” box for this field.

If “**Yes**”, the Mailing Address, City, State and Zip Code will be automatically populated.

If “**No**”, manually key in the following information

Mailing Address – Put in the Mailing Address for the facility (P. O. Box, Street, etc.)

Mailing City – Put in the City for the facility

Mailing State – **DO NOT KEY in this field**. Make the selection from the “drop” box.

Mailing Zip Code – Put in the facility’s zip code. The 4 digit extension may also be added if available.

|  |  |  |
| --- | --- | --- |
| Schedule A – Identification **(cont.)** | Preparer | Required Fields - Yes |

*The person that prepared this form information should go here.*

**Preparer – Name**

Enter in the name of the person who prepared the form.

**Preparer – Title**

Enter in the work title of the person who prepared the form i.e. Supervisor, etc.

**Preparer – Phone**

This is a 10 digit field. Enter the telephone number starting with the area code, i.e. 1234567890. **DO NOT** use brackets or dashes. This field will automatically place the number in the telephone format (123)456-7890.

**Preparer – E-Mail Address**

Enter in a valid work e-mail address of the person who prepared the “JAR” form.

|  |  |  |
| --- | --- | --- |
| Schedule A – Identification **(cont.)** | **Reporting Period** | Required Fields - Yes |

*In the event your organizations’ reporting period is different from that of our January 1st through December 31st,, 2019 requested reporting period, due to your facility having newly opened or your facility having closed prior to December 31st; please provide the data including the actual beginning and ending dates for the period of time you are reporting for your facility.*

**Reporting Period – Is the Reporting Period from January 1st through December 31st of the year specified above?**

This is a Required Field and must be answered with “Yes” or “No”. **DO NOT KEY in this field.** Make the selection from the **“drop”** box for this field.

If **“Yes”,** the Beginning and Ending date fields will be automatically populated.

If **“No”**, then key in the dates. The format for the Beginning and Ending date is MMDDYYYY.

\*If the reporting year is contained within a Leap Year, please use 366 reporting days. Example the year 2012 was a Leap Year.

|  |  |  |
| --- | --- | --- |
| Schedule A – Identification **(cont.)** | **Administration** | Required Fields - Yes |

**Administration – Administrator’s Name**

Put in Administrator’s Name of facility along with any title if present or applicable, i.e. RN, Dr., etc.

**Administration – Medical Director’s Name**

Enter in the Medical Director’s Name of facility along with any title if present or applicable, i.e. RN, Dr., etc.

|  |  |  |
| --- | --- | --- |
| Schedule B – Organization Structure | **Owner** | Required Fields – Yes |

**Owner – Name**

Put in the owners’ complete Name (along with suffix if applicable).

**Owner – Street**

Put in the owner’s Street address. This may also include Apt. No., P. O. Box, etc.

**Owner – City**

Put in the owner’s City.

**Owner –State**

**DO NOT KEY in this field.** Make the selection from the **“drop”** box for this field.

**Owner – Zip Code**

Put in the owner’s zip code. The 4 digit extension may be added if available.

**Owner – Telephone**

This is a 10 digit field. Key the telephone number starting with the area code, i.e. 1234567890. Do not use brackets or dashes. This field will automatically place the number in the telephone format (123)456-7890.

|  |  |  |
| --- | --- | --- |
| Schedule B – Organization Structure **(cont.)** | **Managed By** | Required Fields – Yes |

***Select only one from this group.*** *A “drop box” is provided to place an* ***“X”*** *beside the selection. If you choose one from this group DO NOT choose one from another group.*

**Management Provided By – Owner**

Please give Management Name. No other information is required.

**Management Provided By – Contract with Firm**

**Name** – Put in Firm Name

**Street** – Put in Firm Street

**City** --– Put in Firm City

**State** – **DO NOT KEY in this field.** Make the selection from the **“drop”** box for this field.

**Zip Code** – Put in Firm 5 digit Zip Code. The 4 digit extension may also be given if available

**Phone Number** – This is a 10 digit field. Key the telephone number starting with the area code, i.e. 1234567890. This field will automatically place the number in the telephone format (123)456-7890.

**Management Provided By – Other (Specify**)

**Name** – Put in Other Name

**Street** – Put in Other Street

**City** --– Put in Other City

**State** – **DO NOT KEY in this field.** Make the selection from the **“drop”** box for this field.

**Zip Code** – Put in Other 5 digit Zip Code. The 4 digit extension may also be given if available

**Phone Number** – This is a 10 digit field. Key the telephone number starting with the area code, i.e. 1234567890. This field will automatically place the number in the telephone format (123)456-7890.

|  |  |  |
| --- | --- | --- |
| Schedule B – Organization Structure **(cont.)** | Building Owner | Required Fields – Yes |

**Building Owner – Name**

Put in the building owners’ Name.

**Building Owner – Street**

Put in the building owner’s Street.

**Building Owner – City**

Put in the building owner’s City.

**Building Owner – State**

**DO NOT KEY in this field.** Make the selection from the **“drop”** box for this field.

**Building Owner – Zip Code**

Put in the owner’s zip code. The 4 digit extension may also be added if available.

**Building Owner – Telephone**

This is a 10 digit field. Key the telephone number starting with the area code, i.e. 1234567890. Do not use brackets or dashes. This field will automatically place the number in the telephone format (123)456-7890.

|  |  |  |
| --- | --- | --- |
| Schedule B – Organization Structure **(cont.)** | Building | Required Fields – Yes |

**Building –** **Do you know the year of the original Construction Date?**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box.

If **“Yes”**, the **Year** must be keyed in. The format for Year is **“YYYY”.**

If **“No”**, leave blank.

**Building – Has the building had a major renovation?**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box.

If **“Yes”**, the **Year** must be keyed in. The format for Year is **“YYYY”.**

If **“No”**, leave blank.

|  |  |  |
| --- | --- | --- |
| Schedule B – Organization Structure **(cont.)** | **Type of Facility** | Required Fields – Yes |

*Please check Yes or No in* ***each*** *of the four types to describe your facility and include the information requested for that type.*

**Type of Facility – Free-Standing**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. No other information is required.

**Type of Facility – Hospital Based**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

If ***“Yes”,*** providethe Name, Street, City, State and Zip Code***.***

***State:* DO NOT KEY in this field.** Make the selection from the **“drop”** box for this field.

If “**No”**, leave blank.

**Type of Facility – Doctor’s Office**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

If ***“Yes”,*** providethe Name, Street, City, State and Zip Code***.***

***State:* DO NOT KEY in this field.** Make the selection from the **“drop”** box for this field.

If “**No”**, leave blank.

**Type of Facility – Other**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

If ***“Yes”,*** providethe Name, Street, City, State and Zip Code***.***

***State:* DO NOT KEY in this field.** Make the selection from the **“drop”** box for this field.

If “**No”**, leave blank.

|  |  |  |
| --- | --- | --- |
| Schedule B – Organization Structure **(cont.)** | **Type of Service** | Required Fields – Yes |

**Type of Service – Multi-Specialty**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. . No other information is required.

**Type of Service – Limited-Purpose**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. No other information is required.

**Type of Service – Cancer Treatment and Radiation Clinic**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. No other information is required.

**Type of Service – Other, Specify**\*

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

\*If **“Yes”,** please providedescription of Type of Service.

\*If **“No”**, leave blank.

|  |  |  |
| --- | --- | --- |
| Schedule C – Licensure, Certifications, Accreditation | **Certifications** | Required Fields – Yes |

**Certifications – Participation in TennCare**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

If **“Yes”**, enter the Provider Number.

If **“No”**, leave blank.

**Certifications – Participation in Medicare**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

If **“Yes”**, enter the Provider Number.

If **“No”**, leave blank.

|  |  |  |
| --- | --- | --- |
| Schedule C – Licensure, Certifications, Accreditation (cont.) | **Accreditation and Audits** | Required Fields – Yes |

**Accreditation and Audits – Joint Commission on Accreditation of Healthcare Organizations (JCAHO)**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

If **“Yes”**, provide the Approval Year and Expiration Year. The format for Year is “YYYY”.

If **“No”**, leave blank.

**Accreditation and Audits – Clinical Laboratory Improvement Amendments (CLIA)**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

If **“Yes”**, provide the Approval Year and Expiration Year. The format for Year is “YYYY”.

If **“No”**, leave blank.

**Accreditation and Audits – Laboratory Proficiency Testing**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

If **“Yes”**, provide the Approval Year and Expiration Year. The format for Year is “YYYY”.

If **“No”**, leave blank.

**Accreditation and Audits – American Association of Blood Banks (AABB)**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

If **“Yes”**, provide the Approval Year and Expiration Year. The format for Year is “YYYY”.

If **“No”**, leave blank.

**Accreditation and Audits – American Osteopathic Association (AOA)**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

If **“Yes”**, provide the Approval Year and Expiration Year. The format for Year is “YYYY”.

If **“No”**, leave blank.

|  |  |  |
| --- | --- | --- |
| **Schedule C – Licensure, Certifications, Accreditations (cont.)** | **Accreditation and Audits** | **Required Fields – Yes** |

**Accreditation and Audits – College of American Pathologist (CAP)**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

If **“Yes”**, provide the Approval Year and Expiration Year. The format for Year is “YYYY”.

If **“No”**, leave blank.

**Accreditation and Audits – American College of Radiology (ACR)**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

If **“Yes”**, provide the Approval Year and Expiration Year. The format for Year is “YYYY”.

If **“No”**, leave blank.

**Accreditation and Audits – Other, Specify 1, 2, and 3.**\*

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

\*If **“Yes”**, must specify other services in corresponding cell. Provide the Approval Year and Expiration Year. The format for Year is “YYYY”.

\*If **“No”**, leave blank.

|  |  |  |
| --- | --- | --- |
| Schedule D –  Availability and Utilization of Svcs/Equip | **Cardiopulmonary** | Required Fields – Yes |

*Please provide information requested and indicate the number of patients and diagnostic procedures for those services during the reporting period. Number of patients may include duplicates because the same patient may receive several of the services listed. Mobile units are units regularly transported to your facility that are not installed for daily use. Do not report equipment, patients or procedures already reported on a hospital Joint Annual Report.*

**Cardiopulmonary Type of Service – Electroencephalogram (EEG)**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. Enter number of Patients and Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Cardiopulmonary Type of Service – Electrocardiogram (EKG)**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. Enter number of Patients and Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Cardiopulmonary Type of Service – Holter Monitoring**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. Enter number of Patients and Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Cardiopulmonary Type of Service – Exercise Tolerance Testing**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. Enter number of Patients and Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Cardiopulmonary Type of Service – Cardiac Catheterization**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. Enter number of Patients and Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

|  |  |  |
| --- | --- | --- |
| Schedule D –  Availability and Utilization of Svcs/Equip (cont.) | **Cardiopulmonary** | Required Fields – Yes |

**Cardiopulmonary Type of Service – Percutaneous Transiuminal Coronary Angioplasty**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. Enter number of Patients and Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

|  |  |  |
| --- | --- | --- |
| Schedule D –  Availability and Utilization of Services/Equip (cont.) | **Radiology**  ***Type of Service*** | Required Fields – Yes |

**Radiology Type of Service – Radiography (Diagnostic and Special Procedures-e.g. Angiography)**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. Enter number of Patients and Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Service – Ultrasound (General/Vascular/Cardiac)**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. Enter number of Patients and Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Service – Nuclear Medicine**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. Enter number of Patients and Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

|  |  |  |
| --- | --- | --- |
| Schedule D –  Availability and Utilization of Services/Equip (cont.) | Radiology  *Type Equipment* | Required Fields – Yes |

*Mobile units are units regularly transported to your facility that are not installed for daily use. Do not report equipment, patients or procedures already reported on a hospital Joint Annual Report.*

**Radiology Type of Equipment on Site –Position Emission Tomography (PET scan)**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Equipment on Site – Computed Tomography (CT Scan)**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Equipment on Site – Ultrafast CT**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Equipment on Site – Magnetic Resonance Imaging (MRI)**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Equipment on Site – Hi Field MRI and Open MRI**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

|  |  |  |
| --- | --- | --- |
| Schedule D –  Availability and Utilization of Services/Equip (cont.) | Radiology  *Type Equipment* | Required Fields – Yes |

*Mobile units are units regularly transported to your facility that are not installed for daily use. Do not report equipment, patients or procedures already reported on a hospital Joint Annual Report. \*\**

**Radiology Type of Equipment on Site –Megavoltage Radiation Therapy**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Equipment on Site –Stereotactic Procedure (including Breast Biopsy)\*\***

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

Enter number of Fixed plus Mobile Patients and/or Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Radiology Type of Equipment on Site – Mammography\*\***

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

Enter number of Fixed plus Mobile Patients and/or Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

|  |  |  |
| --- | --- | --- |
| Schedule D –  Availability and Utilization of Services/Equip (cont.) | Other  *Type of Service* | Required Fields – Yes |

**Other Type of Service – Vascular Embolization**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. Enter number of Patients and Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Other Type of Service – Anesthesia**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. Enter number of Patients and Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Other Type of Service – Ultrasound (ACR Accredited Breast/Pelvic/OB)**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

Enter number of Patients and Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Other Type of Service – Chemotherapy**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field. Enter number of Patients and Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

|  |  |  |
| --- | --- | --- |
| Schedule D –  Availability and Utilization of Svcs/Equip (cont.) | Other  *Type Equipment* | Required Fields – Yes |

*Mobile units are units regularly transported to your facility that are not installed for daily use. Do not report equipment, patients or procedures already reported on a hospital Joint Annual Report.*

**Other Type of Equipment on Site – Lithotripsy**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and /or Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Other Type of Equipment on Site – Bone, Densitometry**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

If “**Yes”**, enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and /or Procedures.\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

**Other Type of Equipment on Site – Other, Specify**

**DO NOT KEY in this field.** This is a Required Field and must be answered with “Yes” or “No”. Make the selection from the “drop” box for this field.

If “**Yes**”, provide Other description for Type of Service. Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and /or Procedures. ***Procedures must equal or exceed number of Patients*.**\*

**\*DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

|  |  |  |
| --- | --- | --- |
| Schedule D –  Availability and Utilization of Svcs/Equip (cont.) | **Total and Rooms** | Required Fields – Yes |

**Total – Number of patients and diagnostic procedures during this reporting period.**

**DO NOT KEY in this field.** This field is cumulative of the Cardiopulmonary, Radiology, and Other field of patients and diagnostic procedures.

**Total – Unduplicated patients\*\*\***

This is a Required Field. The number of actual individuals served during the reporting period. This may be less than the number of patients and diagnostic procedures reported. **DO NOT ENTER ZERO** in this field. Blank fields represent zero patients and/or procedures.

**\*\*\*This count must MATCH Total Patients Served. See page 34.**

**Rooms – Number of Diagnostic Procedure rooms**

This is a Required Field and must be answered.

|  |  |  |
| --- | --- | --- |
| Schedule E –Patient Characteristics | **Number of Patients Served** | Required Fields – Yes |

**Number of Patients Served By Age – Gender**

**DO NOT ENTER ZERO** in these fields. Provide Age by Gender information.Blank fields represent zero patients.

**Number of Patients Served By Age – Race**

**DO NOT ENTER ZERO** in these fields. Provide Age by Race information.Blank fields represent zero patients.

**Number of Patients Served - Total Patients Served**\*\*\*

This is a calculated field of Patient Age by Gender and Race. Patients by Gender must equal to Patients by Race for each Age group represented.

|  |  |  |
| --- | --- | --- |
| Schedule E –  Patient Characteristics (cont.) | **Number of Patients TN Origin** | Required Fields – Yes |

**Number of Patients Served – Tennessee Patients**

**DO NOT ENTER ZERO** in these fields. Please record the number of Tennessee patients who received services during the reporting period in the corresponding county cells. Blank fields represent zero patients.

**Number of Patients Served – Total Tennessee Patients**

This is a calculated field. The number “0” will automatically appear in the corresponding cell until data is placed in the patient county cells.

|  |  |  |
| --- | --- | --- |
| Schedule E –  Patient Characteristics (cont.) | **Number of Patients Out of State Origin** | Required Fields – Yes |

**Number of Patients Served – Out-of-state & Other State or Country Patients**

**DO NOT ENTER ZERO** in these fields. Please record the number of Out-of-state and or Other State/Country patients who received services during the reporting period in the corresponding cells. Blank fields will represent zero patients.

**Number of Patients Served – Total Non-Tennessee Patients**

This is a calculated field. The number “0” will automatically appear in the corresponding cell until data is placed in the Out-of-state and or Other State/Country fields.

**Number of Patients Served – Total Tennessee and Non-Tennessee Patients**\*\*\*\*

This is a cumulative calculated field. The number “0” will automatically appear in the corresponding cell until data is placed in the County, Out-of-state, and Other State or Country fields.

***\*\*\*\*This total must equal the Total Patients Served field in Schedule E***

|  |  |  |
| --- | --- | --- |
| Schedule F –Financial Data | Expenses | Required Fields – Yes |

**Expenses – Payroll**

Include salaries for all full-time and part-time personnel who are included in Schedule G.

This is a required field. Data must be placed in this field. This field will accept zero (0).

**Expenses – Fringe Benefits**

Social Security, group insurance, retirement benefits, etc.

This is a required field. Data must be placed in this field. This field will accept zero (0).

**Expenses – Other Operating Expenses**

These are expenses for all contract staff, professional fees, energy expense (oil, natural gas, electricity, etc.) and all other operating expenses.

This is a required field. Data must be placed in this field. This field will accept zero (0).

**Expenses – Depreciation Expense**

This is a required field. Data must be placed in this field. This field will accept zero (0).

**Expenses – Non-Operating Expenses**

Include all other expenses for interest, taxes, real estate ease expenses, and other non-operating expenses.

This is a required field. Data must be placed in this field. This field will accept zero (0).

|  |  |  |
| --- | --- | --- |
| Schedule F –Financial Data | Patient Revenue | Required Fields – Yes |

**Government – Gross Patient Charges**

This is the sum of the facility’s established rate for all services rendered to patients during the reporting year. *Show the revenue source from Medicare, TennCare, and Other Government.*

This is a required field. If there are no transactions enter zero (0).

**Government –** **Adjustment to Charges**

The difference between the gross patient charges and the actual amount of payment received by the facility during the reporting period should be reported here. Adjustments to previous year’s revenue (Medicare or TennCare) should be reported as non-operating revenue, **not as current year adjustments**.

*Show the revenue source from Medicare, TennCare, and Other Government.*

This is a required field. If there are no transactions enter zero (0).

**Government – Total Government Gross Patient Charges and Adjustment to Charges**

This is a cumulative calculated field of Gross Patient Charges and Adjustment to Charges field. The number “0” will automatically appear in this cell until an amount is placed in these fields.

**Non-Government – Gross Patient Charges**

This is the sum of the facility’s established rate for all services rendered to patients during the reporting year. *Show the* *charges are from “Self-Pay”, Insurance, Other Non-Government.*

This is a required field. If there are no transactions enter zero (0).

**Non-Government Revenue Source –** **Adjustment to Charges**

The difference between the gross patient charges and the actual amount of payment received by the facility during the reporting period should be reported here. Adjustments to previous year’s revenue (Medicare or TennCare) should be reported as non-operating revenue, not as current year adjustments.

*Show the charges are from “Self-Pay”, Insurance, Other Non-Government.*

This is a required field. If there are no transactions enter zero (0).

**Non-Government Revenue Source – Total Non-Government**

This is a cumulative calculated field of the Non-Government Gross Patient Charges and Non-Government Adjustment to Charges fields. The number “0” will automatically appear in this cell until an amount is placed in these fields.

**Patient Revenue – Total Patient Revenue**

This is a cumulative calculated field. The number “0” will automatically appear in this cell and sums the amounts in the *Total Government plus Total Non-Government* cells.

|  |  |  |
| --- | --- | --- |
| Schedule F –Financial Data (cont.) | Patient Revenue | Required Fields – Yes |

**Patient Revenue – All Non-Patient Revenue**

This is a required field. Data must be placed in this field. If there are no transactions enter zero (0).

**Patient Revenue – Net Patient Revenue**

This is a calculated field. The difference obtained by subtracting Adjustments to Charges from Gross Patient Charges. This difference represents the actual amount of revenue that the facility received.

**Patient Revenue – Total Net Revenue: Net Total Patient Revenue plus All Non-Patient Revenue**

This is a calculated field. This is the sum of the Total patient Revenue plus All Non-Patient Revenue.

|  |  |  |
| --- | --- | --- |
| Schedule F –Financial Data (cont.) | Non-Government Adjustment | Required Fields – Yes |

**Non-Government Adjustment – Bad Debt**

Uncompensated care for which the facility directly billed the patient and for which the patient should reasonably be expected to pay.

This is a required field. If there are no transactions enter zero (0).

**Non-Government Adjustment – Charity Care**

Services provided to medically needy persons for which the facility does not expect payment.

This is a required field. If there are no transactions enter zero (0).

**Non-Government Adjustment – Other**

Any other adjustments that are not appropriately reported in either Bad Debt or Charity

This is a required field. If there are no transactions enter zero (0).

**Non-Government Adjustment –Total Non-Government Adjustment to Charges Subcategories**

This is a cumulative calculated field. The number “0” will automatically appear in this cell and sums the amounts in the Bad Debt, Charity Care, and Other cells.

|  |  |  |
| --- | --- | --- |
| Schedule G – Personnel | Type of Personnel by Service | Required Fields – Yes |

*Please indicate the number of paid personnel as of the last day of reporting period. Do not include a type of personnel for which you do not provide that type of service. For example, do not include Physical Therapist unless you provide Physical Therapy Services.*

**Full Time Equivalent (FTE)**

Part-time is the Number of hours worked by part-time employees per week/40.

Example: Three Registered Nurses, each working 20 hours a week, the FTE would be (3X20)/40=1.5.

**Additional Example of FTE**

40 Hours = 1.00

30 Hours = .75

20 Hours = .50

10 Hours = .25

For the purpose of this calculation if your agency reimburses employees per visit rather than per hour worked, one visit equals one hour in FTE.

*The sum of full-time personnel plus part time personnel (in full-time equivalents) added together equals the total number of full-time equivalents.*

**Type Administrators – Employee and Contract – Full-Time / Part-Time**

Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Medical Director – Employee and Contract – Full-Time / Part-Time**

Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Physicians (M.D. and D. O.) – Employee and Contract – Full-Time / Part-Time**

Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Dentist – Employee and Contract – Full-Time / Part-Time**

Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

|  |  |  |
| --- | --- | --- |
| Schedule G – Personnel (cont.) | Type of Personnel by Service | Required Fields – Yes |

**Type Financial/Billing Personnel – Employee and Contract – Full-Time / Part-Time**

Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Nursing (R.N., L.P.N., and Ancillary) – Employee and Contract – Full-Time / Part-Time**

Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Medical Records – Employee and Contract – Full-Time / Part-Time**

Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Registered Technologist – Employee and Contract – Full-Time / Part-Time**

Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Technical – Employee and Contract – Full-Time / Part-Time**

Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type Maintenance/Services – Employee and Contract – Full-Time / Part-Time**

Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

|  |  |  |
| --- | --- | --- |
| Schedule G – Personnel (cont.) | **Type of Personnel by Service** | Required Fields – Yes |

**Type Other 1, 2, and 3 Specify – Employee and Contract – Full-Time / Part-Time**

*Supply name of other service if indicated.* Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

**Type – Total Number of Personnel by Type**

This is a cumulative calculated field. The number “0” will automatically appear in this cell and sums the amounts in the *Employee Full-Time, Employee Part-Time, Contract Full-Time, and Contract Part-Time cells separately.*

|  |  |  |
| --- | --- | --- |
| Schedule G – Personnel (cont.) | **Nursing Personnel – RN** | Required Fields – Yes |

*Please indicate the number of personnel as of the last day of the reporting period.*

**Registered Nurses – Highest Education Level – Number Currently Employed**

Associate, Diploma, Bachelors, Masters, and Doctorate: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Registered Nurses – Highest Education Level – Number of Budgeted Vacancies**

Associate, Diploma, Bachelors, Masters, and Doctorate: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Registered Nurses – Highest Education Level – Average Number of Weeks Required to Recruit Staff**

Associate, Diploma, Bachelors, Masters, and Doctorate: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Registered Nurses – Highest Education Level – Number Added in Past 12 Months**

Associate, Diploma, Bachelors, Masters, and Doctorate: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Registered Nurses – Highest Education Level – Number Eliminated in Past 12 Months**

Associate, Diploma, Bachelors, Masters, and Doctorate employed in Clinical and Administration: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Registered Nurses – Highest Education Level – Total**

This is a cumulative calculated field. The number “0” will automatically appear in this cell and sums the amounts in the *Number Currently Employed, Number Budgeted Vacancies, Number Added in Past 12 Months, and Number Eliminated in Past 12 Months (Clinical and Administrative) cells separately.*

|  |  |  |
| --- | --- | --- |
| Schedule G – Personnel (cont.) | **Nursing Personnel – Advanced** | Required Fields – Yes |

*Please indicate the number of personnel as of the last day of the reporting period.*

**Advanced Practical Nurses – Category – Number Currently Employed**

*Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Advanced Practical Nurses – Category – Number of Budgeted Vacancies**

*Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Advanced Practical Nurses – Category – Average Number of Weeks Required to Recruit Staff**

*Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Advanced Practical Nurses – Category – Number Added in Past 12 Months**

*Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Advanced Practical Nurses – Category – Number Eliminated in Past 12 Months**

*Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist employed in Clinical and Administration*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Advanced Practical Nurses – Category – Total**

This is a cumulative calculated field. The number “0” will automatically appear in this cell and sums the amounts in the *Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist employed in Number Added in Past 12 Months and Number Eliminated in Past 12 Months (Clinical and Administrative) cells separately.*

|  |  |  |
| --- | --- | --- |
| Schedule G – Personnel (cont.) | **Nursing Personnel – Other** | Required Fields – Yes |

*Please indicate the number of personnel as of the last day of the reporting period.*

**Other Nurses – Other Nursing Staff – Number Currently Employed**

*Licensed Practical Nurses, Certified Nurses’ Aides, Other 1, Specify, Other 2, Specify*: Indicate number of personnel as of the last day of reporting period. If data is given for ***Other 1 or 2***, please describe the Other Nursing Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Other Nurses – Other Nursing Staff – Number of Budgeted Vacancies**

*Licensed Practical Nurses, Certified Nurses’ Aides, Other 1, Specify, Other 2, Specify*: Indicate number of personnel as of the last day of reporting period. If data is given for ***Other 1 or 2***, please describe the Other Nursing Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Other Nurses – Other Nursing Staff – Average Number of Weeks Required to Recruit Staff**

*Licensed Practical Nurses, Certified Nurses’ Aides, Other 1, Specify, Other 2,Specify*: Indicate number of personnel as of the last day of reporting period. If data is given for ***Other 1 or 2***, please describe the Other Nursing Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Other Nurses – Other Nursing Staff – Number Added in Past 12 Months**

*Licensed Practical Nurses, Certified Nurses’ Aides, Other 1, Specify, Other 2, Specify*: Indicate number of personnel as of the last day of reporting period. If data is given for ***Other 1 or 2***, please describe the Other Nursing Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Other Nurses – Other Nursing Staff – Number Eliminated in Past 12 Months**

*Licensed Practical Nurses, Certified Nurses’ Aides, Other 1, Specify, Other 2, Specify*: Indicate number of personnel as of the last day of reporting period. If data is given for ***Other 1 or 2***, please describe the Other Nursing Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

|  |  |  |
| --- | --- | --- |
| Schedule G – Personnel (cont.) | **Nursing Personnel – Contract** | Required Fields – Yes |

*Please indicate the number of personnel as of the last day of the reporting period.*

**Contract Nursing – Does your organization use contract nursing personnel?**

This is a Required Field and must be answered with “Yes” or “No”. **DO NOT KEY in this field.** Make the selection from the “drop” box for this field.

If **“Yes”**, indicate the number of contract personnel in the categories below.

If **“No”**, continue to the next schedule. Leave fields blank.

**Contract Nursing – Number Currently Employed**

*Registered Nurses, Licensed Practical Nurses, and Certified Nurses’ Aides*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Contract Nursing – Number of Budgeted Vacancies**

*Registered Nurses, Licensed Practical Nurses, and Certified Nurses’ Aides*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Contract Nursing – Average Number of Weeks Required to Recruit Staff**

*Registered Nurses, Licensed Practical Nurses, and Certified Nurses’ Aides*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Contract Nursing – Number Added in Past 12 Months**

*Registered Nurses, Licensed Practical Nurses, and Certified Nurses’ Aides*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Contract Nursing – Number Eliminated in Past 12 Months**

*Registered Nurses, Licensed Practical Nurses, and Certified Nurses’ Aides*: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

|  |  |  |
| --- | --- | --- |
| Schedule H – Personnel | **Medical Staff** | Required Fields – Yes |

*Please include all physicians, whether considered active or associate.*

*Active: Employed and practicing at the facility.*

*Associate: Has privileges to practice at the facility but is not employed at the facility.*

**Medical Staff – Specialty – Total number of Medical Staff**

*Cardiologist, Neurologist, Pathologist, Radiologist, Technician, Other 1 (specify), Other 2 (specify)*: Indicate number of medical staff as of the last day of reporting. If data is given for ***Other 1 or 2***, please describe the Other Medical Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

**Medical Staff – Specialty – Number of Medical Staff who are Board Certified**

*Cardiologist, Neurologist, Pathologist, Radiologist, Technician, Other 1 (specify), Other 2 (specify)*: Indicate number of medical staff as of the last day of reporting. If data is given for ***Other 1 or 2***, please describe the Other Medical Staff for that field. Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

|  |  |  |
| --- | --- | --- |
| Schedule Adm. Dec. – Administrator’s Declaration | Administrator’s Declaration | Required Fields – Yes |

**Administrator Declaration – “I, the administrator, declare that I have examined this report and to the best of my knowledge and belief, it is true, correct, and complete.”**

This is a Required Field and must be answered with “Yes” or “No”. **DO NOT KEY in this field.** Make the selection from the “drop” box for this field.

**If the answer is “Yes”, then key the date acknowledged. The format is MM/DD/YYYY.**

Appendix

**“Saving your Joint Annual Report Form”**

Go to the JAR ODC Website: <https://www.tn.gov/content/tn/health/health-program-areas/statistics/health-data/jar/jar-odc.html>





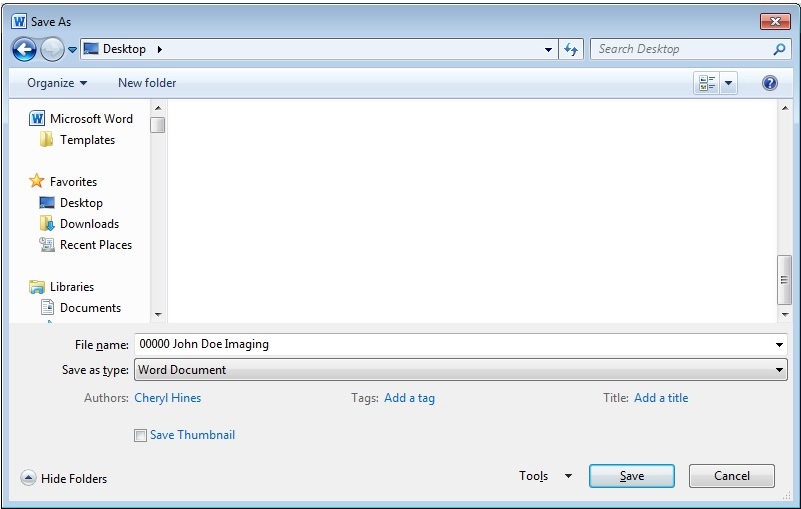
**“Saving your Joint Annual Report Form”**

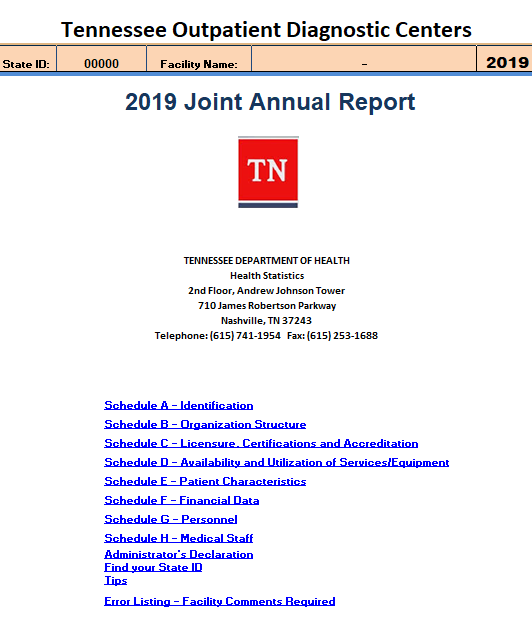
1. Select: **Click here to save the Blank “JAR” data entry form to your computer.**



**“Saving your Joint Annual Report Form”**

1. Select File**: SAVE AS** from your menu bar:



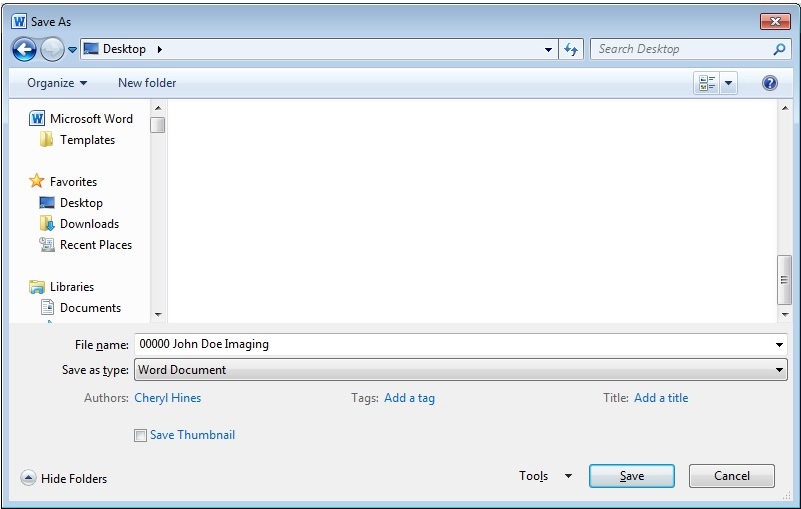


**“Saving your Joint Annual Report Form”**

1. **NAME** your Joint Annual Report “JAR” Files as:

***Example:***  00000 John Doe Imaging

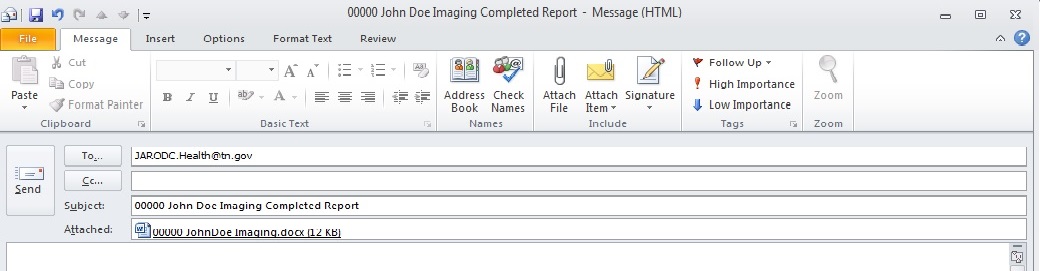
State ID Number Your Facility Name



**“Saving your Joint Annual Report Form”**

1. After having downloaded, saved and completed your facility’s ODC Joint Annual Report “JAR” Form. It is time to EMAIL an attached copy of the completed form to the below email address:

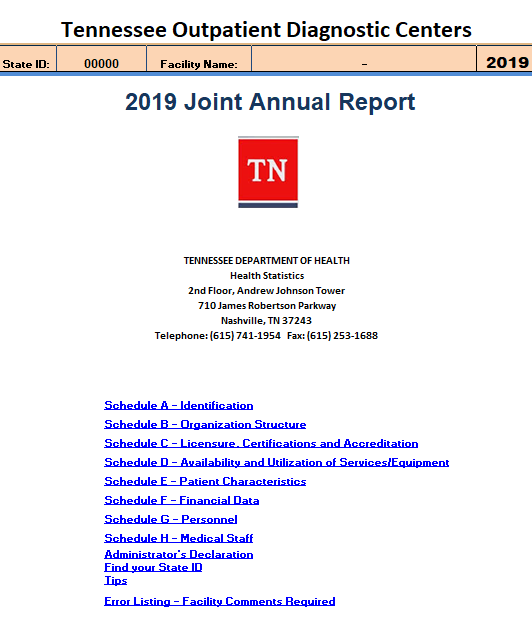
EMAIL TO: [JARODC.health@tn.gov](mailto:JARODC.health@tn.gov)

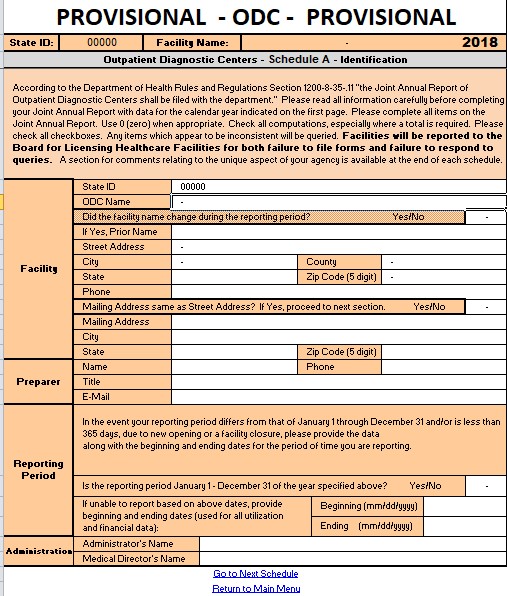
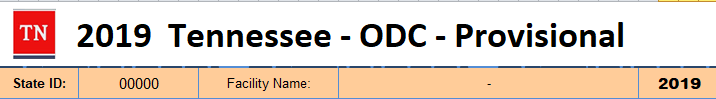


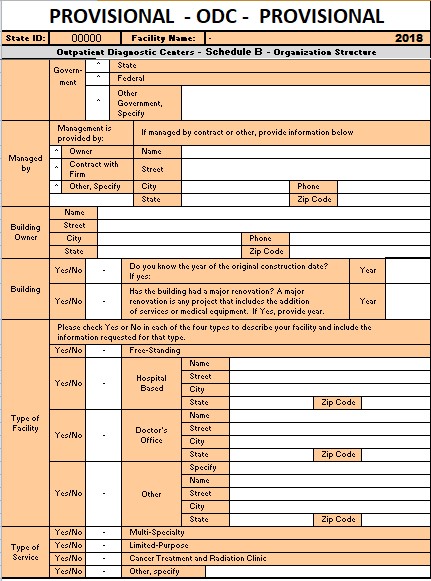
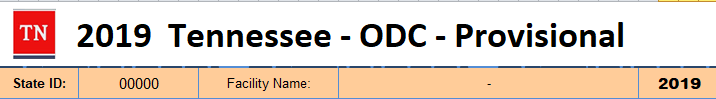
**Please include your saved attached file named as:**

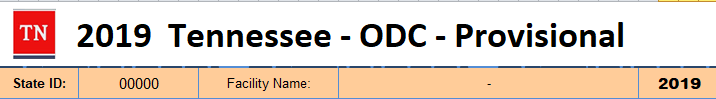
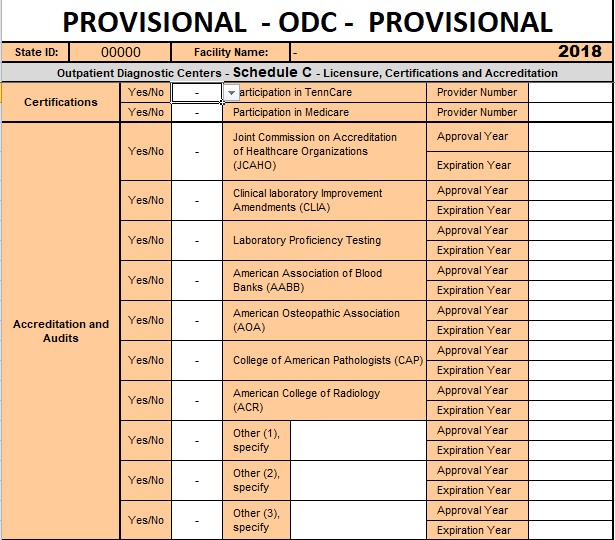
***Example:***  00000 John Doe Imaging

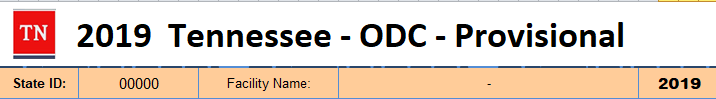
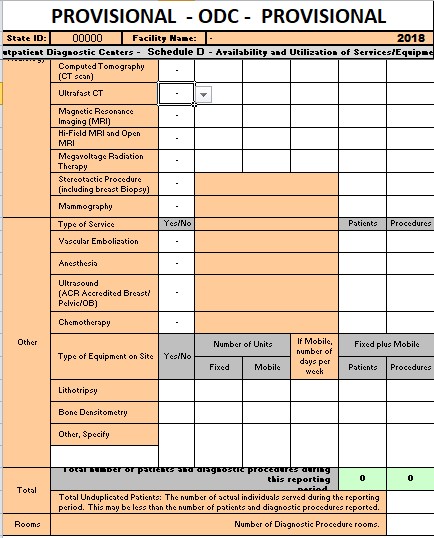
State ID Number Your Facility Name

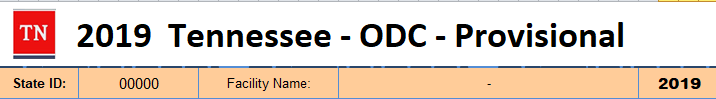
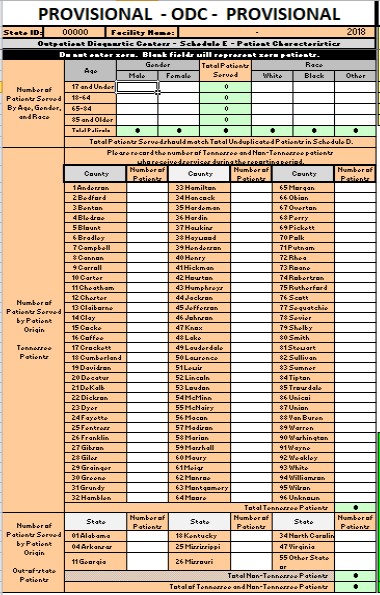


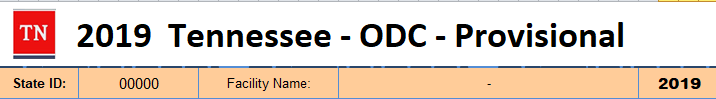
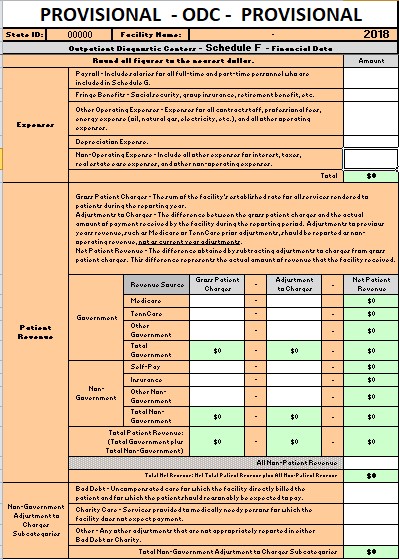


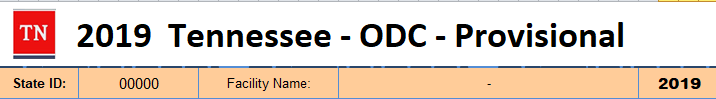
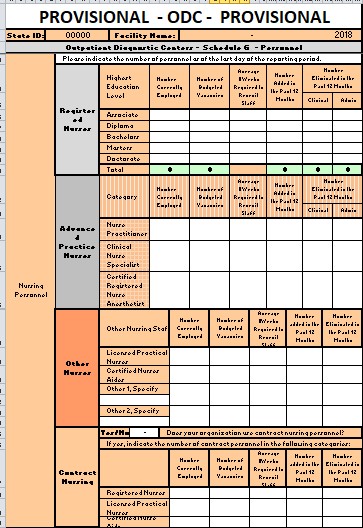
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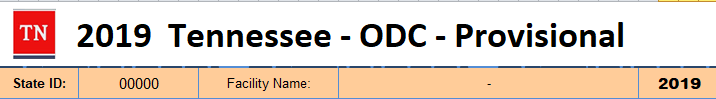
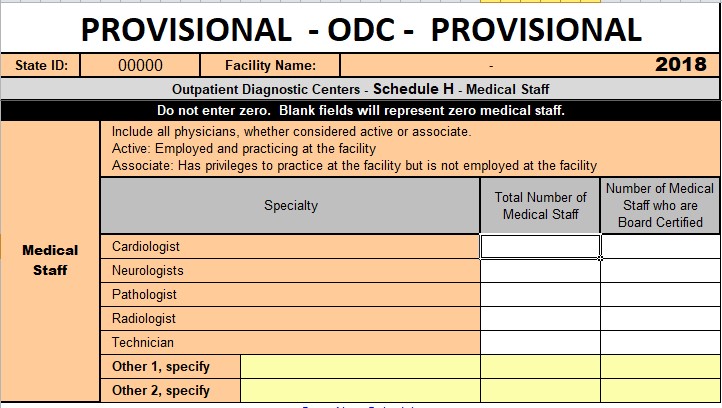
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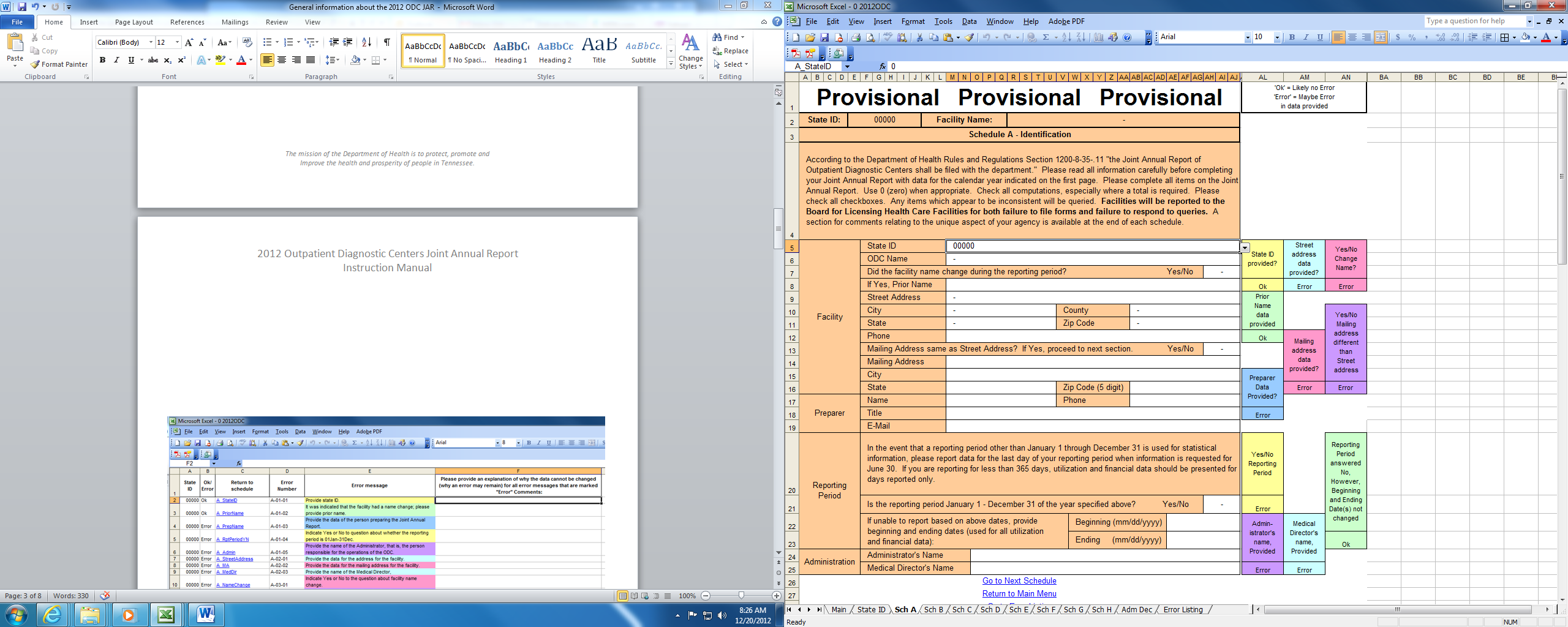
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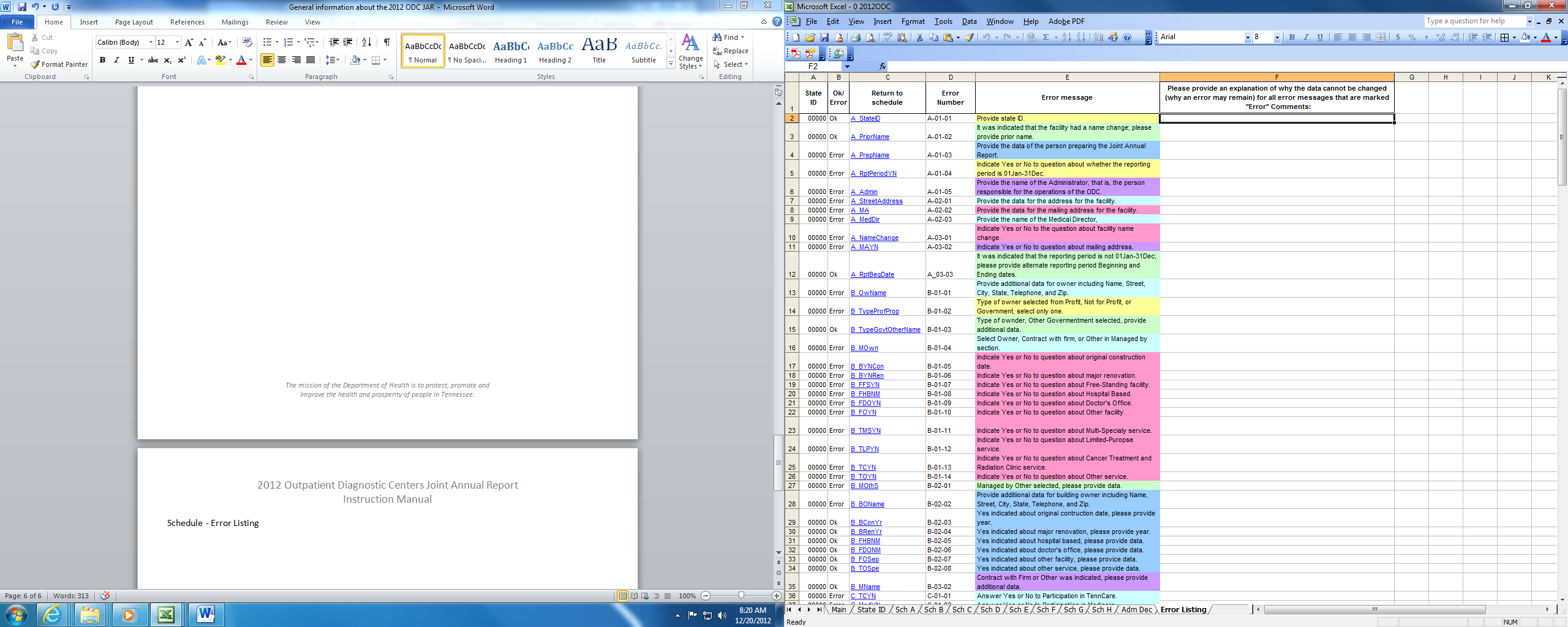
1

Error Listing

2

3

Worksheet



6

4

5

1. **State ID** from Schedule A will be populated by the system in column A of the Error Listing worksheet for each error question in the JAR.
2. Error message **(Ok or Error)** will be populated by the system from each error in all schedules.
3. Error **message color** will match on the schedule and in the Error Listing worksheet. A more detailed explanation of the error is in the Error Listing worksheet.

**Printing** continued

1. This is a **hyperlink** which should return you to the schedule containing the actual error. The cell you are returned to will be the first possible cell where the error may reside; however, this cell may not contain actual the error in question but only reference the error relating cell.
2. **Error Number** is an address/location of each individual error.

The format for the error number A-01-02, A represents the schedule in this example A. 01 represents the first column of errors starting in column “AL”. 02 represent the error number for the column in order from top to bottom.

1. **Error Comment** is used to provide an explanation of why the data of each individual listed error should not be considered a justifiable error.

**Joint Annual Report of Outpatient Diagnostic Centers**

**2019 Tips to Avoid Common Errors**

The following guidelines are written to assist you to complete the Joint Annual Report for the Outpatient Diagnostic Center 2019 reporting year.

A User Manual can be found on the website

[https://www.tn.gov/content/tn/health/health-program-areas/statistics/health-data/jar/jar-odc.html](%20https://www.tn.gov/content/tn/health/health-program-areas/statistics/health-data/jar/jar-odc.html)

Please read all information carefully before completing your Joint Annual Report. Keep the manual and these tips handy as you will need them to fill out the form and export the data. For your reference, this Tips document is also included as a Tab on the Excel data entry form.

B. Please complete all items on the report form.

(1) Use 0 (zero) when appropriate rather than leaving the item blank.

(2) Please select the appropriate answer to all (Yes / No) questions.

(3) Check all computations, especially where a total is required.

(4) Corporate offices that do data entry for several facilities must close out

between each facility to avoid system generated errors. It is requested that

you work on one (1) facility at a time.

(5) In the event that a reporting period other than January1 through December 31

is used by your facility for statistical information, please report that data

including the actual beginning and ending dates of your facilities’ reporting period.

C. Any item which appears to be inconsistent will be queried. Report forms with items left blank

will not be acceptable. ***The Tennessee Department of Health’s Bureau of Health***

***Licensure and Regulation may issue deficiencies for either failing to file forms***

***or submission of incomplete forms.***

**SCHEDULE A – IDENTIFICATION**

**Facility**

State ID: Select your State ID from the drop down list first. Facility name and address are filled in automatically, unless there is a name change in which case your facility’s new name and your facility’s

new address has to be typed in manually.

Reporting Period: All facilities are requested to report data based on the twelve month period for the calendar year. If reporting period is January 1, 2019 through December 31, 2019 leave date lines blank.

Use Proper Case and **not ALL CAPS** in Schedule A; such as facility name, address, and city.

Please fill in the e-mail address of the preparer of your facility’s report, so that we may use this address as a means of initial contact.

###### SCHEDULE B – ORGANIZATION STRUCTURE

**Owner Type**

Please place an “X” in only **one block** of the For Profit, Not for Profit or Government Section.

###### SCHEDULE C – LICENSURE, CERTIFICATIONS AND ACCREDITATION

Please fill in provider numbers. The data field for year of accreditation/audit takes only the four digit year. Do not put in a complete date. Answer all Yes/No questions.

**SCHEDULE D – AVAILABILITY AND UTILIZATION OF SERVICES/EQUIPMENT**

Fill in the number of patients and diagnostic procedures and number of fixed and mobile units as well as number of days per week for mobile. The total unduplicated patients on this schedule should match the total patients by age, gender, and race in Schedule E.