



**TENNESSEE DEPARTMENT OF HEALTH**  
**Health Statistics**  
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**710 James Robertson Parkway**  
**Nashville, TN 37243**

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**JOINT ANNUAL REPORT OF HOME HEALTH AGENCIES**  
**2014**

**Schedule A – Identification**

**Schedule B – Organization Structure**

**Schedule C – Licensure, Accreditations & Memberships**

**Schedule D – Finances**

**Schedule E – Utilization**

**Schedule F – Personnel**

**Schedule G – Branch Offices**

**Schedule A – Identification**

According to the Department of Health rules and regulations section 1200-8-26-.11, "a yearly statistical report, the 'Joint Annual Report of Home Care Organizations,' shall be submitted to the Department." Report data for the year specified above. Please read all information carefully before completing your Joint Annual Report. Please complete all items on the Joint Annual Report. Use 0 (zero) when appropriate. Check all computations, especially where a total is required. Please check all checkboxes. Any items which appear to be inconsistent will be queried. **Agencies will be reported to the Board for Licensing Health Care Facilities for both failure to file forms and failure to respond to queries.** Comments relating to unique aspects of your agency may be submitted with the Report.

Agency	State ID			
	Legal Name			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the agency's name change during the reporting period?		
	If Yes, Prior Name			
	Street			
	City		County	
	State		Zip	
	Area Code		Phone	
Preparer	Name			
	Title			
	Phone Number			
	Email Address			
Administration	Name of Administrator			
	Name of Medical Director			
Reporting Period	Is the reporting period July 1 through June 30 of the year specified above?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If unable to report based on above dates, provide beginning and ending dates (used for all utilization and financial data):	Beginning (mm/dd/yyyy)		
		Ending (mm/dd/yyyy)		

**Schedule B – Organization Structure**

Owner	Type	The type of legal entity, except proprietorship, general partnerships and government entities, can be confirmed by entering the legal entity's name into a search at the Secretary of State web site: <a href="http://www.tennesseeanytime.org/soscorp/">http://www.tennesseeanytime.org/soscorp/</a> .
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Schedule A – Identification  
 Schedule B – Organization Structure

<b>Owner (cont.)</b>	<b>Type (cont.) (Check one type and one sub-type)</b>	<input type="checkbox"/> <b>For-Profit</b>		<input type="checkbox"/>	Proprietorship - a business owned by one person.			
		<input type="checkbox"/>	General Partnership - an association of two or more persons to carry on as co-owners of a business or other undertaking for profit formed under TCA § 61-1-202, predecessor law, or comparable law of another jurisdiction.					
		<input type="checkbox"/>	Limited Partnership (LP) - a partnership formed by two or more persons under the laws of the state of Tennessee, and having one or more general partners and one or more limited partners. TCA Title 61 Chapter 2.					
		<input type="checkbox"/>	Limited Liability Partnership (LLP) - governed by TCA § 61-1-106 (c). The law of this state governs relations among the partners and between the partners and the partnership and the liability of partners for an obligation of a limited liability partnership that has filed an application as a limited liability partnership in this state.					
		<input type="checkbox"/>	Limited Liability Company (LLC) - established by the "The Tennessee Limited Liability Company Act" found in the TCA § 48-201-101 through § 48-248-606.					
		<input type="checkbox"/>	Corporation - defined by the "Tennessee Business Corporation Act" codified in TCA Title 48 Chapters 11-27.					
		<input type="checkbox"/> <b>Non profit</b>		<input type="checkbox"/>	Non-Religious Corporation or Association - defined by the "Tennessee Nonprofit Corporation Act" codified in TCA Title 48 Chapters 51-68.			
		<input type="checkbox"/>	Religious Corporation or Association - either a corporation or association that is organized and operated primarily or exclusively for religious purposes. Most of the provisions of the Tennessee Nonprofit Corporation Act apply to a religious corporation. Exceptions are specified in TCA § 48-67-102.					
		<input type="checkbox"/>	Limited Liability Company (LLC) - a company that is disregarded as an entity for federal income tax purposes, and whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in TCA § 67-4-1004(15).					
		<input type="checkbox"/> <b>Govern-ment</b>		<input type="checkbox"/>	City			
		<input type="checkbox"/>	County					
		<input type="checkbox"/>	State					
		<input type="checkbox"/>	Federal					
		<input type="checkbox"/>	Other Government (specify) _____					
		Name of Legal Entity _____						
	Street _____							
	City _____							
	State _____				Zip _____			
	List name(s) and address(es) of individual owner, partners, directors of the corporation, or head of the governmental entity:							
	Name		Address		City	State	Zip	
1.								
2.								
3.								
4.								
<b>Race of Owner</b>	If owned by an individual		<input type="checkbox"/> White		<input type="checkbox"/> Black		<input type="checkbox"/> Other	
	If owned by corporation or partnership, give race of members		Race			Number		
			White					
			Black					
			Other					

Structure	Check one of the following types of organizations and specify the name of the parent facility where applicable. A hospital based organization is a department of a hospital. A hospital affiliated organization is typically owned or leased by a hospital; not a department of the hospital.	
	Type	
	<input type="checkbox"/>	Free Standing
	<input type="checkbox"/>	Hospital Affiliated
	<input type="checkbox"/>	Hospital Based
	<input type="checkbox"/>	Nursing Home Based
	<input type="checkbox"/>	Public Health Department
<input type="checkbox"/>	Rural Health Clinic Based	

**Schedule C – Licensure, Accreditations, Memberships, and Participations**

On the following items, please report the status of your agency as of June 30.

Licensure	License Number		
	Most recent survey date (yyyy)		
Accreditation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Commission on Accreditation of Healthcare Organizations	Approval Date (yyyy) Expiration Date (yyyy)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Community Health Accreditation Program (CHAP)	Approval Date (yyyy) Expiration Date (yyyy)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (specify)	Approval Date (yyyy) Expiration Date (yyyy)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (specify)	Approval Date (yyyy) Expiration Date (yyyy)
Memberships	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tennessee Association for Home Care	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	THA Home Care Alliance	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (specify)	
Participations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	TennCare	
	If yes, indicate the <b>MCOs</b> with whom you have contracts.		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	AmeriChoiceEast (John Deere)	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	AmeriChoice (Middle)	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	AmeriGroup	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	BlueCare	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	TLC Family Care Healthplan	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	UAHC (OmniCare Health)	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	PHP TennCare	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	TennCare Select	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unison Health Plan	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Windsor Health Plan of TN	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (specify one)	
If yes, indicate the <b>BHOs</b> with whom you have contracts.			
<input type="checkbox"/> Yes <input type="checkbox"/> No	TBH		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Premier		

**Schedule D – Finances**

Gross Revenue by Revenue Source	Enter the amount of gross revenue (your total charges) that your organization received from each of the sources listed during the reporting period. Please note: this reporting period should be consistent with the reporting period listed in Schedule A of this report.
	<p>TennCare - Tennessee's Medicaid program that is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources.<sup>1</sup></p> <p>Medicare - the federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).<sup>1</sup></p> <p>Medicare HMO – a Health Management Organization (HMO) that has contracted with the federal government under the Medicare+ Choice program to provide health benefits to persons eligible for Medicare that choose to enroll in the HMO, instead of receiving their benefits and care through the traditional fee for service Medicare program.<sup>2</sup></p>

Gross Revenue by Revenue Source (cont.)	Private Pay – payment coming from consumers. Commercial – payment coming from all insurance companies, including BlueCross. TRICARE - the health care program for active duty members of the military, military retirees, and their eligible dependents. TRICARE was called CHAMPUS in the past. <sup>1</sup> Home and Community Based Waiver Programs – the Medicaid program alternative to providing long-term care in institutional settings. <sup>3</sup> Other Pay Source - payment coming from sources not included in this specific list of sources.			
	Payment Source		Gross Revenue	Percentage of Total
	TennCare			
	Medicare			
	Medicare HMO			
	Private Pay			
	Commercial			
	TRICARE			
	Home and Community Based Waiver Programs			
	Other Pay Source (specify):			
Total				

Charity Care	Charity Care (Report as a positive number.) Do not include other adjustments to gross revenue such as contractual allowances (e.g. discounts) or bad debt (e.g. not receiving expected payments).	
	Charity Care – services provided to medically needy persons for which the agency does not expect payment. These persons have insufficient income and/or assets with which to pay for their care. "Insufficient income" is defined as an amount not to exceed one hundred percent (100%) of the federal poverty guidelines. They are not eligible for Medicaid or other state or federal programs, or benefits of these programs have been exhausted. The patient has no insurance or has a very limited insurance policy.	

Average Charges by Discipline	Provide actual cost per visit for Medicare Certified and/or charge per visit or charge per hour for Private Duty for the end of your cost reporting year for the following disciplines. For Medicare Certified Home Care Organizations, indicate the average cost per visit from your cost report for each of the disciplines listed as well as Medicare reimbursement. For Private Duty Company, provide the amount your organization charges per visit <u>OR</u> per hour for the services listed.				
	Discipline	Medicare Certified Home Care Organization		Private Duty Company	
		Cost Per Visit	Reimbursement Per Visit	Average Charge Per Visit	Average Charge Per Hour
	Home Health Aide Services				
	Homemaker Services				
	Medical Social Services				
	Occupational Therapy				
	Physical Therapy				
	Skilled Nursing Care				
	Speech Therapy				
Other (specify):					

**Schedule E – Utilization**

Discharges	List the number of discharges by reason during the 12 month reporting period. Total Discharges by Number of Days (Length of Stay) should be calculated from date of admission to date of discharge.	
	Reason for Discharge	Total Number Discharged
	Physician order (Unplanned)	
	No further care needed; reached maximum functional potential (Goals met)	
	Death	
	Patient request	

Discharges (cont.)	Reason for Discharge		Total # Discharged	
	Transfer to hospital from home health agency			
	Transfer to nursing home from home health agency			
	Transfer out of service area			
	Transfer to hospice services from home health agency			
	Patient no longer met payor's home care qualifications for eligibility/ coverage criteria			
	Other (specify):			
	Unknown			
	Total Discharges			
Total Discharges by Number of Days (Length of Stay)				
Patients Served	Category		Number	
	Unduplicated	Unduplicated patient census on the <b>first day</b> of the current reporting period		
	Gender (entire reporting period)	Male		
		Female		
		Total (should match race/ethnicity total and patient origin total)		
	Race/Ethnicity (entire reporting period)	The following race/ethnicity definitions were taken from the "OASIS Implementation Manual" of the Centers on Medicare and Medicaid Services, December 2002:  American Indian or Alaska Native refers to "a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment."  Asian refers to "a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam."  Black or African American refers to "a person having origins in any of the black racial groups of Africa. Terms such as 'Haitian' or 'Negro' can be used in addition to 'Black or African American.'"  Hispanic or Latino refers to "a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, 'Spanish origin,' can be used in addition to 'Hispanic or Latino.'"  Native Hawaiian or Other Pacific Islander refers to "a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands."  White refers to "a person having origins in any of the original peoples of Europe, the Middle East, or North Africa."		
		Race/Ethnicity		Number
		American Indian or Alaska Native		
		Asian		
		Black or African-American		
		Hispanic or Latino		
		Native Hawaiian or Pacific Islander		
		White		
		Multi-Race/Ethnicity (or Other)		
Unknown				
Total				
Revenue Source	Please specify the total number of patients served who received the services below and the number of visits/hours provided to those patients by revenue source. For Medicare Certified Home Care Organizations, report the number of visits. For Private Duty companies, report the number of hours.			

Patients Served (cont.)	Revenue Source (cont.)	Discipline	TennCare		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	Medicare		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	Medicare HMO		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	Private Pay		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	Commercial		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			

Patients Served (cont.)	Revenue Source (cont.)	Discipline	Commercial (cont.)		
			Patients	Visits	Hours
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	TRICARE		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	Home and Community Based Waiver Programs		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	Other Pay Source		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			
		Discipline	Charity Care		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Total			

Patients Served (cont.)	Revenue Source (cont.)	Discipline	Total All Revenue Sources		
			Patients	Visits	Hours
		Home Health Aide Services			
		Homemaker Services			
		Medical Social Services			
		Occupational Therapy			
		Physical Therapy			
		Skilled Nursing Care			
		Speech Therapy			
		Other			
		Grand Total			

Patient Origin	List total patients served by age (0-17 years, 18-64 years, 65-74 years, 75+ years and total) and by race (B=Black, W=White, O=Other, including American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander). <b>First</b> , check the box beside each county this home health agency is licensed to operate in regardless of whether any residents from that county received services. <b>Second</b> , indicate by resident county the number of patients who received home health services.							
	Check the counties your agency is licensed to serve.	Number of Patients Served						
		Age (in years)				Total	Race	
0-17	18-64	65-74	75 +	White	Black		Other	
<input type="checkbox"/> 1 Anderson								
<input type="checkbox"/> 2 Bedford								
<input type="checkbox"/> 3 Benton								
<input type="checkbox"/> 4 Bledsoe								
<input type="checkbox"/> 5 Blount								
<input type="checkbox"/> 6 Bradley								
<input type="checkbox"/> 7 Campbell								
<input type="checkbox"/> 8 Cannon								
<input type="checkbox"/> 9 Carroll								
<input type="checkbox"/> 10 Carter								
<input type="checkbox"/> 11 Cheatham								
<input type="checkbox"/> 12 Chester								
<input type="checkbox"/> 13 Claiborne								
<input type="checkbox"/> 14 Clay								
<input type="checkbox"/> 15 Cocke								
<input type="checkbox"/> 16 Coffee								
<input type="checkbox"/> 17 Crockett								
<input type="checkbox"/> 18 Cumberland								
<input type="checkbox"/> 19 Davidson								
<input type="checkbox"/> 20 Decatur								
<input type="checkbox"/> 21 DeKalb								
<input type="checkbox"/> 22 Dickson								
<input type="checkbox"/> 23 Dyer								
<input type="checkbox"/> 24 Fayette								
<input type="checkbox"/> 25 Fentress								
<input type="checkbox"/> 26 Franklin								
<input type="checkbox"/> 27 Gibson								
<input type="checkbox"/> 28 Giles								
<input type="checkbox"/> 29 Grainger								
<input type="checkbox"/> 30 Greene								
<input type="checkbox"/> 31 Grundy								
<input type="checkbox"/> 32 Hamblen								
<input type="checkbox"/> 33 Hamilton								
<input type="checkbox"/> 34 Hancock								

Patient Origin (cont.)	Check the counties your agency is licensed to serve.	Number of Patients Served							
		Age (in years)				Total	Race		
		0-17	18-64	65-74	75 +		White	Black	Other
<input type="checkbox"/> 35 Hardeman									
<input type="checkbox"/> 36 Hardin									
<input type="checkbox"/> 37 Hawkins									
<input type="checkbox"/> 38 Haywood									
<input type="checkbox"/> 39 Henderson									
<input type="checkbox"/> 40 Henry									
<input type="checkbox"/> 41 Hickman									
<input type="checkbox"/> 42 Houston									
<input type="checkbox"/> 43 Humphreys									
<input type="checkbox"/> 44 Jackson									
<input type="checkbox"/> 45 Jefferson									
<input type="checkbox"/> 46 Johnson									
<input type="checkbox"/> 47 Knox									
<input type="checkbox"/> 48 Lake									
<input type="checkbox"/> 49 Lauderdale									
<input type="checkbox"/> 50 Lawrence									
<input type="checkbox"/> 51 Lewis									
<input type="checkbox"/> 52 Lincoln									
<input type="checkbox"/> 53 Loudon									
<input type="checkbox"/> 54 McMinn									
<input type="checkbox"/> 55 McNairy									
<input type="checkbox"/> 56 Macon									
<input type="checkbox"/> 57 Madison									
<input type="checkbox"/> 58 Marion									
<input type="checkbox"/> 59 Marshall									
<input type="checkbox"/> 60 Maury									
<input type="checkbox"/> 61 Meigs									
<input type="checkbox"/> 62 Monroe									
<input type="checkbox"/> 63 Montgomery									
<input type="checkbox"/> 64 Moore									
<input type="checkbox"/> 65 Morgan									
<input type="checkbox"/> 66 Obion									
<input type="checkbox"/> 67 Overton									
<input type="checkbox"/> 68 Perry									
<input type="checkbox"/> 69 Pickett									
<input type="checkbox"/> 70 Polk									
<input type="checkbox"/> 71 Putnam									
<input type="checkbox"/> 72 Rhea									
<input type="checkbox"/> 73 Roane									
<input type="checkbox"/> 74 Robertson									
<input type="checkbox"/> 75 Rutherford									
<input type="checkbox"/> 76 Scott									
<input type="checkbox"/> 77 Sequatchie									
<input type="checkbox"/> 78 Sevier									
<input type="checkbox"/> 79 Shelby									
<input type="checkbox"/> 80 Smith									
<input type="checkbox"/> 81 Stewart									
<input type="checkbox"/> 82 Sullivan									
<input type="checkbox"/> 83 Sumner									
<input type="checkbox"/> 84 Tipton									
<input type="checkbox"/> 85 Trousdale									

Patient Origin (cont.)	Check the counties your agency is licensed to serve.	Number of Patients Served							
		Age (in years)				Total	Race		
		0-17	18-64	65-74	75 +		White	Black	Other
<input type="checkbox"/> 86 Unicoi									
<input type="checkbox"/> 87 Union									
<input type="checkbox"/> 88 Van Buren									
<input type="checkbox"/> 89 Warren									
<input type="checkbox"/> 90 Washington									
<input type="checkbox"/> 91 Wayne									
<input type="checkbox"/> 92 Weakley									
<input type="checkbox"/> 93 White									
<input type="checkbox"/> 94 Williamson									
<input type="checkbox"/> 95 Wilson									
96 Unknown									
97 Other States									
Total									

**Schedule F – Personnel**

Type of Employee by Service	Please indicate the number of personnel as of 06/30 (or the last day of the reporting period). Do not include a type of employee for which you do not provide that type of service. For example, do not include Physical Therapists unless you provide Physical Therapy services. Record zero where appropriate. Leave the item blank if the value is unknown. Full Time Equivalent (FTE) = Number of Hours worked by part-time employees per week/40 hours per week. For example, three Registered nurses, each working 20 hours a week, the FTE would be (3x20)/40=1.5. For the purposes of this calculation, if your agency reimburses employees per visit rather than per hour worked, one visit equals one hour in FTE.				
	Type	Number of Employees			
		Full-Time	Part-Time in FTE	Contract in FTE	Total in FTE
<b>Office Staff:</b>	Administrator				
	Assistant Administrator				
	Clinical Director/In-office Clinical Staff				
	Office Personnel (Clerical)				
	Financial/Billing Personnel				
	Other Administrative Personnel (Marketing / Community Education, etc.)				
	<b>Field Staff:</b>	Registered Nurses			
Licensed Practical Nurses					
Certified Nurses Aides					
Physical Therapy Services					
Occupational Therapy					
Speech/Language Pathology Services					
Medical Social Services					
Respiratory Therapists					
Home Health Aides					
Homemakers					
Nutritionists/Dieticians					
Other Health					
Other Non-Health					
Total (Office and Field Staff)					

Personnel	Please indicate the number of personnel as of June 30 (or the last day of the reporting period):							
	Registered Nurses	Highest Education Level	Number Currently Employed	Number of Budgeted Vacancies	Average Time Required to Recruit Staff	Number Added in the Past 12 Months	Number Eliminated in the Past 12 Months	
						Clinical	Admin	
		Associate						
		Diploma						
		Bachelors						
		Masters						
	Doctorate							
	Total							
Advanced Practice Nurses	Category	Number Currently Employed	Number of Budgeted Vacancies	Average Time Required to Recruit Staff	Number Added in the Past 12 Months	Number Eliminated in the Past 12 Months		
						Clinical	Admin	
	Nurse Practitioner							
	Clinical Nurse Specialist							
	Total							
Licensed Practical Nurses	Number Currently Employed	Number of Budgeted Vacancies	Average Time Required to Recruit Staff	Number Added in the Past 12 Months	Number Eliminated in the Past 12 Months			
Certified Nurses Aides								
Occupational Therapists								
Physical Therapists								
Speech Therapists								
Occupational Therapist Assistants								
Physical Therapists Assistants								
Employee Benefits	Does your agency offer the following benefits to any of your employees?							
	<input type="checkbox"/> Yes <input type="checkbox"/> No	401K Plan						
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retirement Plan						
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Health Insurance						
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Life Insurance						
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child Day Care Center for Employees						
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Education						
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paid Holiday	If Yes, Number of Paid Holidays					
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paid Vacation						
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (specify)						

<b>Schedule G – Branch Offices</b>					
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have branch offices?				
If yes, please provide names and addresses of up to 12 branch offices:					
Name					
Street					
City		State		Zip	
County					

Administrator's Declaration	<input type="checkbox"/>	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.
Date		(mm/dd/yyyy)

**References**

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- <sup>1</sup> Centers for Medicare and Medicaid Services <http://www.cms.hhs.gov/glossary>
  - <sup>2</sup> Managed Care On-Line <http://www.medicarehmo.com>
  - <sup>3</sup> Bureau of TennCare, Home and Community Based Services <http://tennessee.gov/tenncare/ltcare/ltc3.htm>