



TENNESSEE DEPARTMENT OF HEALTH

Health Statistics
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JOINT ANNUAL REPORT OF HOSPITALS

2015

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State ID _____

TENNESSEE DEPARTMENT OF HEALTH
JOINT ANNUAL REPORT OF HOSPITALS
2015

SCHEDULE A - IDENTIFICATION*

Federal Tax I.D. # _____
Medicare ID # _____
TN Medicaid ID # _____

1. Name of Hospital _____

Did your facility name change during the reporting period? ___ YES ___ NO

If yes, list former name of your facility _____

County _____

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

3. Telephone Number (____) _____
Area Code Number

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

Signature of Chief Executive Officer _____

5. Name of person(s) coordinating form completion _____

Telephone Number (____) _____
Area Code Number

Email address _____

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

7. Does your hospital own or operate other hospitals licensed as satellites of your hospital? ___ YES ___ NO

If yes, please complete the following.

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

8. Does your hospital have another independently licensed facility housed inside your hospital? ___ YES ___ NO

If yes, what type of service (e.g. psychiatric, long term acute care, rehabilitation, etc.)?

Name _____ State ID _____ Type of service _____

Name _____ State ID _____ Type of service _____

Name _____ State ID _____ Type of service _____

SCHEDULE B - CLASSIFICATION*

State ID _____

1. CONTROL:

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

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

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

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

Name _____ City _____ State _____

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

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

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

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

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

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

Name _____ City _____ State _____
 Name _____ City _____ State _____

H. Does this hospital have a particular clinical unit/area that is managed under contract? _____ YES _____ NO

If yes, please provide name, city and state of the organization that manages the unit/area.

Name _____ City _____ State _____
 Length of contract: From _____ To _____

I. Is the hospital part of a health network? _____ YES _____ NO (see definition of network)

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

Name _____ City _____ State _____
 Name _____ City _____ State _____

2. SERVICE:

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

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

SCHEDULE B - CLASSIFICATION (continued)*

State ID _____

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

	(1)	Yes	(2)	No	Specify one:		Number of Physicians	FTE Physicians
					1) Own	2) Contract		
1. Independent Practice Association	_____	_____	_____	_____	_____	_____	_____	_____
2. Open Panel Physician-Hospital Organization(PHO)	_____	_____	_____	_____	_____	_____	_____	_____
3. Closed Panel Physician-Hospital Organization(PHO)	_____	_____	_____	_____	_____	_____	_____	_____
4. Management Services Organization (MSO)	_____	_____	_____	_____	_____	_____	_____	_____
5. Integrated Salary Model	_____	_____	_____	_____	_____	_____	_____	_____
6. Foundation	_____	_____	_____	_____	_____	_____	_____	_____

3. In regard to question 2B, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payers or shared responsibility for financial risk or clinical performance between the hospital and physician? (arrangement may be at the hospital, system or network level) Number of physicians _____

4. Does Your Hospital have a formal written contract that specifies the obligations of each party with:

A. Health Maintenance Organization (HMO)? _____YES _____NO

1. How many do you contract with? _____

2. Number of different contracts _____

B. Preferred Provider Organization (PPO)? _____YES _____NO

1. How many do you contract with? _____

2. Number of different contracts _____

5. What percentage of the hospital's net patient revenue is paid on a capitated basis?

If the hospital does not participate in any capitated arrangement, please enter "0". _____ %

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

7. Does your hospital contract directly with employees or a coalition of employers to provide care on a capitated, predetermined or shared risk basis? _____YES _____NO

SCHEDULE C - ACCREDITATIONS AND APPROVALS*

State ID _____

1. ACCREDITATIONS:

A. The Joint Commission (TJC)

Date of most recent accrediting letter or survey _____ YES _____ NO

If Yes, Is the hospital accredited under either/both of the following manuals:

1. Comprehensive Accreditation Manual for Hospitals (CAMH) _____ YES _____ NO

2. Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC) _____ YES _____ NO

3. Other manuals, please specify _____

B. Commission on Accreditation of Rehabilitation Facilities (CARF)

Date of most recent accrediting letter or survey _____ YES _____ NO

C. American College of Surgeons Commission on Cancer _____ YES _____ NO

D. American College of Surgeons Metabolic and Bariatric Surgery _____ YES _____ NO

E. American College of Surgeons Nat. Accreditation Program for Breast Centers _____ YES _____ NO

F. Other, please specify _____

2. CERTIFICATIONS:

Medicare Certification _____ YES _____ NO

3. OTHER:

A. THA Membership _____ YES _____ NO

B. Hospital Alliance of Tennessee, Inc. Membership _____ YES _____ NO

C. American Hospital Association Membership _____ YES _____ NO

D. American Medical Association Approval for Residencies (and Internships) _____ YES _____ NO

E. State Approved School of Nursing:

Registered Nurses _____ YES _____ NO

Licensed Practical Nurses _____ YES _____ NO

F. Medical School Affiliation _____ YES _____ NO

G. Tennessee Association of Public and Teaching Hospitals (TNPath) _____ YES _____ NO

H. National Association of Children's Hospitals (NACH) _____ YES _____ NO

I. National Association of Public Hospitals (NAPH) _____ YES _____ NO

J. Other, please specify _____

Field is limited to 255 characters

1. CERTIFICATE OF NEED:

Do you have an approved, **outstanding**, certificate of need (CON) ? YES NO

If yes, please specify:

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

2. Does your hospital own or operate Tennessee physician primary care clinics? YES NO If yes, how many? _____
How many physicians practice in these clinics? _____

3. Does your hospital own or operate other physician/specialty clinics located in Tennessee? YES NO If yes, how many? _____
How many physicians practice in these clinics? _____

4. Does your hospital own or operate a blood bank? YES NO
If yes, please indicate:
A. Distributes blood within the hospital YES NO
B. Collects blood within the hospital YES NO
C. Distributes blood outside the hospital YES NO
D. Collects blood from outside the hospital YES NO

5. Does your hospital own or operate an ambulance service? YES NO
If yes, please specify the counties where services are located.

Please specify the type of service and ownership relationship:

- A. Land Transport YES NO If yes, own, operate, or own and operate; own in joint venture
- B. Helicopter YES NO If yes, own, operate, or own and operate; own in joint venture
- C. Special Neonatal Helicopter YES NO If yes, own, operate, or own and operate; own in joint venture
- D. Special Neonatal Land Transport YES NO If yes, own, operate, or own and operate; own in joint venture

6. Does your hospital own or operate an off-site outpatient/ambulatory clinic located in Tennessee? ___Yes ___No

If yes, please complete the following.

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

7. Does your hospital own or operate an off-site ambulatory surgical treatment center located in Tennessee? ___Yes ___No

If yes, please complete the following.

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

8. Does your hospital own or operate an off-site birthing center located in Tennessee? ___Yes ___No

If yes, please complete the following.

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

9. Does your hospital own or operate an off-site outpatient diagnostic center located in Tennessee? ___Yes ___No

If yes, please complete the following.

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

10. Does your hospital own or operate an off-site outpatient physical therapy rehab center located in Tennessee? ___Yes ___No

If yes, please complete the following.

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

SCHEDULE D - SERVICES (continued)*

State ID _____

11. Does your hospital own or operate a hospice that has a separate license located in Tennessee? ___Yes ___No

If yes, please complete the following.

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

12. Does your hospital own or operate an off-site assisted-care living facility located in Tennessee? ___Yes ___No

If yes, please complete the following.

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

13. Does your hospital own or operate a home for the aged located in Tennessee? ___Yes ___No

If yes, please complete the following.

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

14. Does your hospital own or operate an urgent care center? ___Yes ___No

If yes, please complete the following.

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

15. Does your hospital own or operate a home health agency? ___Yes ___No

If yes, please complete the following.

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

SCHEDULE D - SERVICES (continued)*

State ID _____

16. Does your hospital own or operate an off-site nursing home located in Tennessee? ___ Yes ___ No

If yes, please complete the following.

_____	_____	_____	_____ own	_____ operate	_____ own and operate	_____ own in joint venture
Name of Home	County	City				
Number of Beds - Total _____ = Medicare only (SNF) _____ + Medicaid only (NF) _____ + Medicare/Medicaid (SNF/NF) _____ + Not Certified _____						
_____	_____	_____	_____ own	_____ operate	_____ own and operate	_____ own in joint venture
Name of Home	County	City				
Number of Beds - Total _____ = Medicare only (SNF) _____ + Medicaid only (NF) _____ + Medicare/Medicaid (SNF/NF) _____ + Not Certified _____						

17. Does your hospital operate a hospital-based skilled nursing unit (subacute unit) licensed as a nursing home for skilled nursing care (exclude swing beds)? ___ Yes ___ No If yes, please complete the following.

_____	_____	_____
Name of SNF	Number of Licensed Beds	Number of Staffed Beds
	_____	_____
	Number of Admissions	Number of Patient Days

18. Does your hospital own, operate, or contract a mobile unit that operates in Tennessee? ___ Yes ___ No

If yes, specify name(s) and whether owned, operated, or contracted.

A. List mobile services:

1 _____	_____ contract	_____ own	_____ operate	_____ own and operate	_____ own in joint venture	_____ # of visits
2 _____	_____ contract	_____ own	_____ operate	_____ own and operate	_____ own in joint venture	_____ # of visits
3 _____	_____ contract	_____ own	_____ operate	_____ own and operate	_____ own in joint venture	_____ # of visits
4 _____	_____ contract	_____ own	_____ operate	_____ own and operate	_____ own in joint venture	_____ # of visits
5 _____	_____ contract	_____ own	_____ operate	_____ own and operate	_____ own in joint venture	_____ # of visits
6 _____	_____ contract	_____ own	_____ operate	_____ own and operate	_____ own in joint venture	_____ # of visits

B. List counties served (where you take the service):

List counties for service 1 in 18A on line 1, for service 2 on line 2, etc.

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

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

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

SCHEDULE D - SERVICES (continued)*

State ID _____

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

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

SCHEDULE D - SERVICES (continued)*

State ID _____

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

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

H. Pain Management: _____ Patients _____ Patients _____

SCHEDULE D - SERVICES (continued)*

State ID _____

Utilization of Selected Services

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

* Refer to Instructions for Completing JAR-H_15

SCHEDULE D - SERVICES (continued)*

State ID _____

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

SCHEDULE D - SERVICES (continued)*

State ID _____

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

R. 23 Hour Observation ___Yes ___No Outpatients _____

S. Cancer Patients:

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

SCHEDULE E - FINANCIAL DATA*

State ID _____

Dates covered from _____ to _____ Use zeros where applicable.

Do not leave blank lines in this schedule

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

	Gross Patient Charges	minus	Adjustments To Charges	equals	Net Patient Revenue	
1. Government						
a) Medicare Inpatient - Total (include managed care)	_____	-	_____	=	_____	
1) Medicare Managed Care - Inpatient	_____	-	_____	=	_____	
b) Medicare Outpatient - Total (include managed care)	_____	-	_____	=	_____	
1) Medicare Managed Care - Outpatient	_____	-	_____	=	_____	
c) Medicaid/TennCare Inpatient* (for EAH use 7.b.2.)	_____	-	_____	=	_____	
d) Medicaid/TennCare Outpatient* (for EAH use 7.b.2.)	_____	-	_____	=	_____	
e) Other	_____	-	_____	=	_____	
f) Total Government Sources	=====	-	=====	=	=====	
2. Cover Tennessee * see instructions						
a) Cover TN	_____	-	_____	=	_____	
b) Cover Kids	_____	-	_____	=	_____	
c) Access Tennessee	_____	-	_____	=	_____	
d) Total Cover Tennessee	=====	-	=====	=	=====	
3. Nongovernment						
a) Self-Pay	_____	-	_____	=	_____	
b) Blue Cross Blue Shield	_____	-	_____	=	_____	
c) Commercial Insurers (excludes Workers Comp)	_____	-	_____	=	_____	
d) Workers Compensation	_____	-	_____	=	_____	
e) Other	_____	-	_____	=	_____	
f) Total Nongovernment Sources	=====	-	=====	=	=====	
4. Totals						
a) Total Inpatient (excludes Newborn)	_____					
b) Newborns	_____					
c) Total Inpatient (includes Newborn) (A4a + A4b)	_____	-	_____	=	_____	
d) Total Outpatient	_____	-	_____	=	_____	
e) Grand Total (A1f + A2d + A3f)	=====	-	=====	=	=====	
5. Bad Debt						
a) Medicare Enrollees	_____		_____			
b) Other Government	_____		_____			
c) Cover Tennessee	_____		_____			
d) Blue Cross and Commercially Insured Patients	_____		_____			
e) All Other	_____		_____			
f) Total Bad Debt	_____		=====			
6. Nongovernment and Cover Tennessee Adjustments to Charges						
a) Nongovernment Contractual	_____		_____			Amount of discounts provided
b) Cover Tennessee Contractual	_____		_____			to uninsured patients _____
c) Charity Care-Inpatient	_____		_____			
d) Charity Care-Outpatient	_____		_____			
e) Other Adjustments, specify types _____	_____		_____			
f) Total Nongovernment Adjustments	_____		=====			
						Total Charity (A6c + A6d)
						Total Charity plus Bad Debt (A5f + A6c + A6d)

SCHEDULE E - FINANCIAL DATA (continued)*

State ID _____

A. CHARGES (continued)

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

7. Other Operating Revenue

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

8. Nonoperating Revenue (No negative numbers! Losses or expenses should be reported in B2g.)

- a) Contributions _____
- b) Grants _____
- c) Interest Income _____
- d) Other _____
- e) Total nonoperating revenue
(add A8a through A8d)
- f) TOTAL REVENUE
(Net A4e + A7e + A8e)

1. Payroll Expenses for all categories of personnel specified below; (see definitions page)

- a) Physicians and dentists (include only salaries) _____
- b) Medical and dental residents (include medical and dental interns) _____
- c) Trainees (medical technology, x-ray therapy, administrative, and so forth) _____
- d) Registered and licensed practical nurses _____
- e) All other personnel _____
- f) Total payroll expenses
(add B1a through B1e)

2. Nonpayroll Expenses

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

i) TOTAL EXPENSES (add B1f + B2h)

3. Are system overhead/management fees included in your expenses? YES NO
If yes, specify amount _____

SCHEDULE E - FINANCIAL DATA (continued)*

State ID _____

C. CURRENT ASSETS

- 1. What was the value of cash as of the last day of the reporting period? _____
- 2. What was the value of all other current assets, including net receivables, as of the last day of the reporting period? _____
- 3. What were your net receivables on the last day of your reporting period? _____

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

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

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

What were your other assets on the last day of your reporting period (specified in Schedule A6 on page 2)? _____

F. TOTAL ASSETS

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

What were your total assets on the last day of your reporting period (specified in Schedule A6 on page 2)? _____

G. CURRENT LIABILITIES

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

H. LONG TERM LIABILITIES

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

I. OTHER LIABILITIES

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

What were your total other liabilities on the last day of your reporting period (specified in Schedule A6 on page 2)? _____

J. CAPITAL ACCOUNT

Capital Account includes Fund Balance or Stockholder's Equity and all general, specific purpose, restricted or unrestricted funds.

The Capital Account is the excess of assets over its liabilities.

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

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

K. 1. Federal Income Tax:

2. Local Property Taxes Paid During the Reporting Period:

- a) Taxes on the Inpatient Facility _____
- b) Taxes on all Other Property _____

3. Other Local, State, or Federal Taxes:

(exclude sales tax) _____

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

- Radiology - ___YES ___NO Pathology - ___YES ___NO Anesthesiology - ___YES ___NO Other - Specify _____
- Surgery - ___YES ___NO Urology - ___YES ___NO Emergency Department - ___YES ___NO

SCHEDULE E - FINANCIAL DATA (continued)*

State ID _____

M. TennCare Utilization and Revenue:

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

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

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

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

SCHEDULE F - BEDS AND BASSINETS*

State ID _____

1. PLEASE GIVE THE NUMBER OF:

- A. TOTAL LICENSED ADULT AND PEDIATRIC BEDS AS OF THE LAST DAY OF THE REPORTING PERIOD
(exclude beds in a sub-acute unit that are licensed as nursing home beds) _____
- B. The number of adult and pediatric staffed beds set up, staffed and in use as of the last day of the reporting period. _____
- C. NEWBORN NURSERY BASSINETS AS OF THE LAST DAY OF THE REPORTING PERIOD _____
- D. Licensed Beds that were NOT staffed during the reporting period. _____
- E. Licensed beds that could NOT be put into use within 24-48 hours _____

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

Was there a temporary or a permanent change in the total number of beds set up and staffed during the period? ____ YES ____ NO
If yes, give beds added or withdrawn (show increase by + and decrease by -) and date of change.

Bed change (+ or -) _____
Date: _____ Date: _____ Date: _____ Date: _____
Month Day Year Month Day Year Month Day Year Month Day Year

3. SWING BEDS:

A. Does your facility utilize swing beds? ____ YES ____ NO If yes, number of Acute Care beds designated as Swing Beds. _____

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

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

INTERMEDIATE CARE	ADMISSIONS	PATIENT DAYS
Private Pay		
Medicaid/TennCare		
Other		
Total		

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

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

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

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

5. OBSERVATION BEDS

- A. Do you use inpatient staffed beds for 23-hour observation? YES NO
If yes, number of beds _____ number of patients _____ number of patient days _____
- B. Do you have beds assigned to a dedicated 23-hour observation unit? YES NO
If yes, number of beds _____ number of patients _____ number of patient days _____
- C. Do you have beds in a "same-day-surgery" unit that are used for both same-day surgery and 23-hour observation? YES NO
If yes, number of beds _____ number of patients _____ number of patient days _____

SCHEDULE G - UTILIZATION*

State ID _____

1. INPATIENT UTILIZATION (include normal newborns)

Patient Census Records:

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

2. UTILIZATION BY MAJOR DIAGNOSTIC CATEGORIES:

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

SCHEDULE G - UTILIZATION (continued)*

State ID _____

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

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

Please indicate whether you are reporting Admissions and Inpatient Days _____

or Discharges and Discharge Patient Days _____

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

* Should include emergency department visits and hospital outpatient visits

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

Please indicate whether you are reporting Admissions and Inpatient Days _____

or Discharges and Discharge Patient Days _____

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

* Should include emergency department visits and hospital outpatient visits

SCHEDULE G - UTILIZATION (continued)*

State ID _____

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

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

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

SCHEDULE G - UTILIZATION (continued)*

State ID _____

5. PATIENT ORIGIN (continued)

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

SCHEDULE G - UTILIZATION (continued)*

State ID _____

5. PATIENT ORIGIN (continued)

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

SCHEDULE G - UTILIZATION (continued)*

State ID _____

5. PATIENT ORIGIN (continued)

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

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

5. PATIENT ORIGIN (continued)

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

SCHEDULE G - UTILIZATION (continued)*

State ID _____

6. Delivery Status:

A. Number of Infants Born Alive _____

B. Number of Deaths Among Infants Born Alive _____

C. Number of Fetal Deaths (350 grams or 20 weeks or more gestation) _____

SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY UNITS*

1. TYPE OF UNIT - PSYCHIATRIC:

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

2. BEDS

- A. Number of assigned beds _____
 B. Date unit opened _____

3. UTILIZATION BY AGE GROUPS:

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

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

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

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

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

7. FINANCIAL DATA - PSYCHIATRIC

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

B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE

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

8. A. SERVICE CHARGES

	<u>INPATIENT CHARGES</u>	<u>OUTPATIENT CHARGES</u>
1. Routine Treatment	_____	_____
2. Ancillary Services	_____	_____
3. Other	_____	_____
4. Total	=====	=====

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

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

1. TYPE OF UNIT - CHEMICAL DEPENDENCY:

Do you have a dedicated chemical dependency unit? Yes No If yes, please complete items on this page and on the next page.

2. BEDS

A. Number of assigned beds _____

B. Date unit opened _____

3. UTILIZATION BY AGE GROUPS:

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

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

4. Is the chemical dependency service managed under a management contract different from the hospital itself? Yes No

If yes, please specify name of organization that manages the unit. _____

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

6. FINANCIAL DATA - CHEMICAL DEPENDENCY

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

B. NON-GOVERNMENT ADJUSTMENTS TO REVENUE

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

7. A. SERVICE CHARGES

	<u>INPATIENT CHARGES</u>	<u>OUTPATIENT CHARGES</u>
1. Routine Treatment	_____	_____
2. Ancillary Services	_____	_____
3. Other	_____	_____
4. Total	=====	=====

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

SCHEDULE I - EMERGENCY DEPARTMENT*

State ID _____

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

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

3. Emergency Department:

Number of visits by payer:

A. Self Pay	_____	H. Medicaid/TennCare	_____	L. Grand Total	_____
		United Health Care Community Plan	_____		
B. Blue Cross/Blue Shield	_____	Amerigroup	_____		
		Blue Care	_____		
C. Champus/TRICARE	_____	TennCare Select	_____		
		TennCare, MCO (Not Specified)	_____		
D. Commercial Insurance (excludes Workers Comp)	_____	TennCare Total	_____		
		I. Medicare - Total	_____		
E. Cover TN	_____	Medicare Managed Care	_____		
		J. Workers Compensation	_____		
F. Cover Kids	_____				
G. Access TN	_____	K. Other	_____		

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

SCHEDULE I - EMERGENCY DEPARTMENT (continued)*

State ID _____

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

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

SCHEDULE I - EMERGENCY DEPARTMENT (continued)*

State ID _____

6. SUPPORTIVE SERVICES:

YES NO

A. COMMUNICATIONS:

- Two-Way radio in ER with Access to:
- Central Emergency Dispatch Center
- Ambulances
- Other hospitals

_____	_____
_____	_____
_____	_____

B. HELIPORT:

_____	_____
-------	-------

C. PHARMACY IN ER:

_____	_____
-------	-------

D. BLOOD BANK (check ONLY one):

- Fully stocked
- Common blood types only

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

A. Designated Trauma Center Yes _____ No _____

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

C. Pediatrics Yes _____ No _____

D. Other, specify

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

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

	Full-Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***		Full-Time Equivalent**	Full-Time Equivalent Budgeted Vacancies	Use Contract Staff in this Employee Category***
1. Administration:				12. Radiological services:			
A. Administrators & Assistants . . .	_____	_____	<input type="checkbox"/>	A. Radiographers (radiologic technologists)	_____	_____	<input type="checkbox"/>
B. Director, Health Services Research & Assistants	_____	_____	<input type="checkbox"/>	B. Radiation therapy technologists	_____	_____	<input type="checkbox"/>
C. Marketing & Planning Officer(s) and Assistants	_____	_____	<input type="checkbox"/>	C. Nuclear medicine technologists	_____	_____	<input type="checkbox"/>
D. Financial and Accounting Officer(s) & Assistants	_____	_____	<input type="checkbox"/>	D. Other radiologic personnel	_____	_____	<input type="checkbox"/>
2. Physician and Dental Services:				13. Therapeutic services:			
A. Physicians	_____	_____	<input type="checkbox"/>	A. Occupational therapists	_____	_____	<input type="checkbox"/>
B. Medical residents	_____	_____	<input type="checkbox"/>	B. Occupational therapy assistants & aides	_____	_____	<input type="checkbox"/>
C. Dentists	_____	_____	<input type="checkbox"/>	C. Physical therapists	_____	_____	<input type="checkbox"/>
D. Dental residents	_____	_____	<input type="checkbox"/>	D. Physical therapy assistants & aides	_____	_____	<input type="checkbox"/>
3. Nursing Services:				E. Recreational therapists	_____	_____	<input type="checkbox"/>
A. RNs - Administrative	_____	_____	<input type="checkbox"/>	14. Speech and hearing services:			
B. RNs - Patient care/clinical	_____	_____	<input type="checkbox"/>	A. Speech Pathologist	_____	_____	<input type="checkbox"/>
C. LPNs	_____	_____	<input type="checkbox"/>	B. Audiologist	_____	_____	<input type="checkbox"/>
D. Ancillary nursing personnel	_____	_____	<input type="checkbox"/>	15. Respiratory therapy services:			
4. Certified Nurse Midwives	_____	_____	<input type="checkbox"/>	A. Respiratory therapists	_____	_____	<input type="checkbox"/>
5. Nurse Anesthetists	_____	_____	<input type="checkbox"/>	B. Respiratory therapy technicians	_____	_____	<input type="checkbox"/>
6. Physicians assistants	_____	_____	<input type="checkbox"/>	16. Psychiatric services:			
7. Nurse practitioners	_____	_____	<input type="checkbox"/>	A. Clinical psychologists	_____	_____	<input type="checkbox"/>
8. Medical record service:				B. Psychiatric social workers	_____	_____	<input type="checkbox"/>
A. Medical record administrators	_____	_____	<input type="checkbox"/>	C. Psychiatric registered nurses	_____	_____	<input type="checkbox"/>
B. Medical record technicians (certified or accredited)	_____	_____	<input type="checkbox"/>	D. Other mental health professionals	_____	_____	<input type="checkbox"/>
C. Other Medical record technicians	_____	_____	<input type="checkbox"/>	17. Chemical dependency services:			
9. Pharmacy:				A. Clinical psychologists	_____	_____	<input type="checkbox"/>
A. Pharmacists, licensed	_____	_____	<input type="checkbox"/>	B. Social workers	_____	_____	<input type="checkbox"/>
B. Pharmacy technicians	_____	_____	<input type="checkbox"/>	C. Registered nurses	_____	_____	<input type="checkbox"/>
C. Clinical Phar-D	_____	_____	<input type="checkbox"/>	D. Other specialists in addiction and/or in chemical dependency	_____	_____	<input type="checkbox"/>
10. Clinical laboratory services:				18. Medical Social workers	_____	_____	<input type="checkbox"/>
A. Medical Technologists	_____	_____	<input type="checkbox"/>	19. Surgical technicians	_____	_____	<input type="checkbox"/>
B. Other laboratory personnel	_____	_____	<input type="checkbox"/>	20. All other certified professional & technical	_____	_____	<input type="checkbox"/>
11. Dietary services:				21. All other non-certified professional & technical	_____	_____	<input type="checkbox"/>
A. Dietitians	_____	_____	<input type="checkbox"/>	22. All other personnel	_____	_____	<input type="checkbox"/>
B. Dietetic technicians	_____	_____	<input type="checkbox"/>				
				TOTAL	=====	=====	

** Full-time + Part-time specified in Full Time Equivalent
 *** Please check if contract staff is used.

SCHEDULE K - MEDICAL STAFF*

State ID ____

Report the total number of physicians with privileges at your hospital by type of relationship with the hospital.
 The sum of the physicians reported in a-i should equal the total number of privileged physicians (j) in the hospital.

	(1) Total Employed	(2) Total Individual Contracts	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) TOTAL PRIVILEGED (sum 1-4)	(6) Total Residents (Do not count in total privileged.)
a. Primary Care (general practitioner, general internal medicine, family practice, general pediatrics, obstetrics/gynecology, geriatrics)	_____	_____	_____	_____	_____	_____
b. Emergency Medicine	_____	_____	_____	_____	_____	_____
c. Hospitalist	_____	_____	_____	_____	_____	_____
d. Intensivist	_____	_____	_____	_____	_____	_____
e. Radiologist/Pathologist/Anesthesiologist	_____	_____	_____	_____	_____	_____
f. General Surgeons	_____	_____	_____	_____	_____	_____
g. Surgical Specialists	_____	_____	_____	_____	_____	_____
h. Other Medical Specialists (excluding primary care listed in a.)	_____	_____	_____	_____	_____	_____
i. Other	_____	_____	_____	_____	_____	_____
j. TOTAL (add a-i)	=====	=====	=====	=====	=====	=====

SCHEDULE L - PERINATAL*

State ID _____

- 1A. Name of person completing Perinatal survey _____
- 1B. Telephone number _____
- 1C. Fax number _____

Please complete the following questions.

- 2. Births
 - A. Total number of live births _____
 - B. Birth weight below 2500 grams (5 lb 8 oz) _____
 - C. Birth weight below 1500 grams (3 lb 5 oz) _____
- 3. Number of babies on Ventilator longer than 24 hours _____
- 4. Number of babies received from referring hospitals for neonatal management _____

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

SCHEDULE M - SURVEY ON NURSING PERSONNEL*
(As of the last day of the reporting period)

State ID _____

1. Registered Nurses

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

2. Advanced Practice Nurses

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

3. Licensed Practical Nurses

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

4. Recruitment of Nursing Personnel

The following are selected specialties for which hospitals commonly report recruiting difficulties.

Please specify other categories as necessary.

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

