

**TENNESSEE DEPARTMENT OF HEALTH
INSTRUCTIONS FOR COMPLETING THE JOINT ANNUAL REPORT OF HOSPITALS
2015**

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GENERAL INSTRUCTIONS

All licensed hospitals are required to complete a Joint Annual Report. The report must cover a full year of operation, even if there has been a change of ownership during the year. A separate report is required for parent and each satellite hospital. Please read all instructions and definitions carefully before completing your Joint Annual Report.

- Please complete all items. For example, if a question asks for patients and patient days, provide both.
- Use 0 (zero) for all fields with no applicable data unless otherwise instructed. (e.g., if the hospital provides cardiac services for adults but not for pediatric patients, enter 0 (zero) for pediatric).
- Please check the appropriate answer to all yes or no questions.
- If “yes” is indicated, please answer all associated questions (e.g., if the hospital offers PET scanning, answer all associated questions about the number of units and the number procedures for inpatients and outpatients).
- Check all computations, especially where a total is required.
- Please be aware of differences in requested counts. e.g., when asked for the number of patients, a count of the medical records for the year might be appropriate; when asked for the number of treatments, a count of dates of service for each patient may be necessary.
- Services provided by a separately licensed facility (e.g., home health agency, hospice, nursing home, assisted-care living facility, ambulatory surgical treatment center, outpatient diagnostic center) will be reported on that facility’s Joint Annual Report. Do not duplicate this reporting on the hospital’s Joint Annual Report.

- Note that data collected may not be consistent with the most current standards. Please complete all sections using the most applicable answers possible. For levels of care, indicate the highest level provided by your facility.

All items are required to be completed. DO NOT LEAVE ITEMS BLANK UNLESS OTHERWISE SPECIFIED. Any items which are missing or which appear to be inconsistent will be queried. Hospitals will be reported to the Board for Licensing Health Care Facilities and deficiencies may be issued for both failure to file forms and the submission of incomplete forms.

If your facility needs more than the space allowed on the JAR to report complete data, provide additional data on a separate sheet labeled with the Schedule and item number and submit it with the printed copy of the JAR. If there is space available on the JAR form, indicate, “See attached page.”

The numbers within the definitions are not consecutive. The definitions are numbered according to the Joint Annual Report. Items/questions that are considered self-explanatory are not included.

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SCHEDULE A - IDENTIFICATION

1. Name of Hospital: The legal hospital name recorded on the license by the Board for Licensing Health Care Facilities. If you indicated your hospital had a name change, list previous legal hospital name recorded.

4. Chief Executive Officer: Please have the chief executive officer sign the completed final printout below his or her name to indicate approval.

6. Reporting Period: Record the beginning and ending dates of the reporting period in an eight-digit number; for example, October 1, 2015 should be shown as 10/01/2015. Reporting for fewer than 365 days is not allowed except for new or closing hospitals. If there has been a change of ownership, the new owner must obtain data generated by the previous owner and submit a report covering a complete year.

7. Satellite Hospital: A satellite hospital is a hospital that is licensed with a parent hospital when two (or more) hospitals are located on separate premises and are operated under the same management. Designation of a hospital as a satellite requires approval by the Board for Licensing Health Care Facilities. **Only parent facilities that have satellites should respond yes to this question.** Satellite hospitals are expected to complete their own joint annual report separate from their parent hospital. See Attachment A for five-digit State ID.

Please use the following guidelines for questions that relate to ownership and/or operation of a facility.

- Own - If you own the facility but do not operate it, please mark "own".
- Operate - If you operate the facility but do not own it, please mark "operate".
- Own and Operate - If you own and operate the facility, please mark "own and operate".

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SCHEDULE B - CLASSIFICATION

1. CONTROL: Check the line/box to the left of the type of organization that is responsible for establishing policy for overall operation of the hospital.

1.A.1. Government Non-Federal:

- State: Controlled by an agency of state government
- County: Controlled by an agency of county government
- City: Controlled by an agency of municipal government
- City-County: Controlled by an agency of municipal and county governments
- Hospital district or authority: Controlled by a political subdivision of the state created solely for the purpose of establishing and maintaining medical care or health related care institutions

1.A.2. Government-Federal: Hospitals controlled by an agency or department of federal government.

1.A.3. Nongovernmental Not-for-Profit: Hospitals controlled by not-for-profit organizations, including religious organizations (for example, Catholic hospitals), community hospitals, cooperative hospitals operated by fraternal societies, and so forth.

1.A.4. Investor-owned, For-Profit: Hospitals controlled on a for-profit basis by an individual, a partnership, or a profit-making corporation.

1.B. Health system: A corporate body that may own and/or manage health facilities or health-related subsidiaries as well as non-health-related facilities including free-standing facilities and/or subsidiary corporations.

1.E. Holding Company: A company, incorporated or unincorporated, that is in a position to control or materially influence the management of one or more other companies by virtue of its ownership securities and/or its rights to appoint directors in the other company or companies.

1.F. Subsidiary: A company wholly controlled by another that owns more than half of its voting stock.

1.G. Contract Managed: General day-to-day management of an entire organization by another organization, under a formal contract. Managing organization reports directly to the board of trustees for owners of the managed organization; managed organization retains total legal responsibility and ownership of the facility's assets and liabilities.

1.H. Clinical Unit/Area Contract Managed: General day-to-day management of a particular clinical, patient care unit/area within the organization by another organization, under formal contract. Managing organization reports directly to the board of trustees for owners of the managed unit/area; managed unit/area retains total legal responsibility and ownership of the unit/area's assets and liabilities.

1.I. Network: A group of hospitals, physicians, and other providers, insurers and/or community agencies that work together to coordinate and deliver a broad spectrum of services to their community. Examples of Networks are Highland Wellmont Health Network, Inc., Mountain States Healthcare Network, Tennessee Healthcare Network, Baptist Health Services Group, St. Francis Physician Hospital Organization and Vanderbilt Health Affiliated Network (VHAN).

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2.A. SERVICE: Please check the one category that best describes your hospital.

2.A.01. General Medical and Surgical (acute care): Provides diagnostic and therapeutic services to patients for a variety of medical conditions, both surgical and nonsurgical. Acute care general hospitals that provide many of the listed services should select this category.

2.A.02. Pediatric: Provides diagnosis and treatment of pediatric patients.

2.A.03. Psychiatric: (also may be known as Behavioral Health) Provides diagnostic, treatment, and supportive services to patients with mental or emotional disorders.

2.A.04. Tuberculosis and Other Respiratory Diseases: Provides medical care and rehabilitative service to patients for whom the primary diagnosis is tuberculosis or other respiratory diseases.

2.A.05. Obstetrics and Gynecology: Provides medical and surgical treatment to pregnant women and to mothers following delivery. Also provides diagnostic and therapeutic services to women with diseases or disorders of the reproductive organs.

2.A.06. Eye, Ear, Nose, and Throat: Provides diagnosis and treatment of diseases and injuries of the eyes, ears, nose, and throat.

2.A.07. Rehabilitation: Provides a comprehensive array of restoration services for the disabled and all support services necessary to help them attain their maximum functional capacity.

2.A.08. Orthopedic: Provides corrective treatment of deformities, diseases, and ailments of the locomotive apparatus, especially affecting the limbs, bones, muscles, and joints.

2.A.09. Chronic Disease: Provides medical and skilled nursing services to patients with long-term illnesses who are not in an acute phase, but who require an intensity of services not available in nursing homes.

2.A.10. Alcoholism and Other Chemical Dependency: Provides diagnostic, treatment, and supportive services to patients who are alcoholic or have substance abuse problems.

2.A.11. Long Term Acute Care: Provides the same services as a general medical and surgical facility, but has an average length of stay comparable to chronic disease, rehabilitation or psychiatric hospitals.

2.A.12. Other: None of the previous categories is the best description of the hospital. If 12 are selected, provide a category not listed in 1-11 that best describes the hospital.

2.B.1. Independent Practice Association (IPA): An Independent Practice Association is a legal entity that holds managed care contracts. The IPA then contracts with physicians, usually in solo practice, to provide care either on a fee for service or capitates basis. The purpose of an IPA is to assist solo physicians in obtaining managed care contracts.

2.B.2. Open Panel Physician-Hospital Organization (PHO): A joint venture between the hospital and all members of the medical staff who wish to participate. The PHO can act as a unified agent in managed care contracting or own a managed care plan, own and operate ambulatory care centers or ancillary services projects, or provide administrative services to physician members.

2.B.3. Closed Panel Physician-Hospital Organization: A PHO that restricts physician membership to those practitioners who meet criteria for cost effectiveness and/or high quality.

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2.B.4. Management Services Organization (MSO): A corporation, owned by the hospital or a physician/hospital joint venture, that provides management services to one or more medical group practices. The MSO purchases the tangible assets of the practices and leases them back as part of a full-service management agreement, under which the MSO employs all non-physician staff and provides all supplies/administrative systems for a fee.

2.B.5. Integrated Salary Model: Physicians are salaried by the hospital or another entity of a health system to provide medical services for primary care and specialty care. Include all intensivists, hospitalists, salaried ER physicians, whom the hospital pays to provide medical services to its patients. Exclude all other types of physicians who may provide an ancillary service or an administrative function, but not direct patient care (i.e., radiologists, anesthesiologists, pathologists). Do not include independent group contracts that are not owned by the hospital/system.

2.B.6. Foundation: A corporation organized either as a hospital affiliate or subsidiary, which purchases both the tangible and intangible assets of one or more medical group practices. Physicians remain in a separate corporate entity but sign a professional services agreement with the foundation.

3. Of all physician arrangements listed in question 2.B. (1-6), indicate 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). Joint contracting does not include contracting between physicians participating in an independent practice.

7. Shared Risk Payments: A payment arrangement in which a hospital and a managed care organization share the risk of adverse claims experience. Methods for sharing risk could include: capitation with partial funds or supplements if billed hospital charges or costs differ from capitated payments, and service or discharge-based payments with withholds and bonus payouts that depend on expenditure targets.

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SCHEDULE C - ACCREDITATIONS AND APPROVALS

1. ACCREDITATIONS:

1.A.1. Comprehensive Accreditation Manual for Hospitals (CAMH) for The Joint Commission

1.A.2. Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC) for The Joint Commission

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SCHEDULE D - SERVICES

1. CERTIFICATE OF NEED (CON): If services were listed last year for an approved but not completed Certificate of Need (CON) and the CON is still outstanding and has not expired, the service or activity should be reported again this year. If the CON has expired and the service was not built, acquired or initiated, do not list the service or activity.

Services which require a Certificate of Need:

Health Care Institutions

- Hospital
- Nursing Home
- Recuperation Center
- Ambulatory Surgical Treatment Center (ASTC)
- Mental Health Hospital
- Mental Retardation Institutional Habilitation Facility
- Home Care Organization (Home Health and Hospice)
- Outpatient Diagnostic Center (ODC)
- Rehabilitation Facility
- Residential Hospice
- Non-residential Methadone Treatment Facility
- Birthing Center

Health Care Services

- Burn Unit
- Neonatal Intensive Care Unit (NICU)
- Open Heart Surgery
- Positron Emission Tomography (PET)
- Swing Beds
- Home Health
- Psychiatric (inpatient)
- Rehabilitation (inpatient)
- Hospital-Based Alcohol and Drug Treatment for Adolescents provided under a program of care longer than 28 days
- Extracorporeal Lithotripsy
- Magnetic Resonance Imaging (MRI)
- Cardiac Catheterization
- Linear Accelerator
- Hospice
- Methadone Treatment provided through a facility licensed as a non-residential methadone treatment facility

Other

- Modification, renovation, or addition to a hospital in excess of \$5 million and other health care institutions in excess of \$2 million
- Any change in the bed complement of a health care institution which:
 - a) Increases by one or more the total number of licensed beds;
 - b) Redistributes beds from acute to long-term care;
 - c) Redistributes beds from any category to acute, rehabilitation, child and adolescent psychiatric, or adult psychiatric; and/or
 - d) Relocates beds to another facility or site
- Closure of a Critical Access Hospital (CAH)
- Discontinuation of a CON-covered service by a Critical Access Hospital (CAH)

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Other CON (continued)

- Change in location or replacement of existing or certified facilities providing health care services, major medical equipment, or health care institutions
- Change of parent office of a home health or hospice agency from one county to another county
- Acquisition of major medical equipment in which the cost exceeds \$1.5 million
- Discontinuation of obstetrics

2. Primary Care Clinic: Provides organized diagnostic preventative, curative, rehabilitative, and educational services on a scheduled basis to ambulatory patients at locations which may or may not be on the hospital grounds.

3. Physician/Specialty Clinic: Clinic that operates primarily for the provision of a specialty service (e.g., orthopedic clinic, eye clinic, dermatology clinic)

4. Blood Bank: A medical facility with the responsibility for blood procurement, drawing, processing, and distribution. If yes, please indicate yes or no to each:

- A. Distributes blood within the hospital
- B. Collects blood within the hospital (including pre-surgery autologous donations)
- C. Distributes blood outside the hospital
- D. Collects blood from outside the hospital (drawing blood for patients not admitted/treated at the hospital)

5 - 16, 18 Ownership: For all ownership, operate, and joint venture questions, please use the following guidelines. If you own the facility but do not operate it, please mark the “own” line. If you operate the facility but do not own it, please mark the “operate” line. If you own AND operate a given facility, please mark the “own and operate” line. If you own the facility in a joint venture, please mark the “own in joint venture” line.

If your hospital has a helicopter pad, but does not own or operate a helicopter, report NO in .5.B. and report YES in Schedule I.7.B.

Schedule D, 6-14: If there are more than 2 clinics or centers, report additional facilities on a separate sheet and provide it to the Tennessee Department of Health with the paper copy of your JAR submission.

6. Outpatient/Ambulatory Clinic: An off-site medical service with an organized professional staff that typically provides non-surgical medical services to patients who do not require an inpatient bed.

7. Ambulatory Surgical Treatment Center (ASTC): An off-site medical service with an organized professional staff that provides surgical services to patients who do not require an inpatient bed. If the hospital has an ambulatory surgery treatment center (ASTC), complete this question but do not include any of the ASTC information in the subsequent pages of the hospital report. (If the ASTC patient becomes hospitalized, the patient’s information pertaining to hospital care is included on the hospital report.) Licensed ASTCs are required to submit a separate Joint Annual Report.

9. Outpatient Diagnostic Center (ODC): Any off-site agency, institution, facility or place which primarily performs diagnostic procedures on an outpatient basis only. If the hospital has a separately licensed outpatient diagnostic center (ODC), complete this question but do not include any of the ODC information in the subsequent pages of the hospital report. (If the ODC patient becomes hospitalized, the patient’s information pertaining to hospital care is included on the hospital report.) Licensed ODCs are required to submit a separate Joint Annual Report.

11. Hospice: A program providing palliative care, chiefly medical relief of pain and supportive services to terminally ill patients, and assistance to their families in adjusting to the patient's illness and death. If the hospital has a hospice, complete this question but do not include any of the hospice information in the

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subsequent pages of the hospital report. (If the Hospice patient becomes hospitalized, the patient's information pertaining to hospital care is included on the hospital report.) Licensed Hospice agencies are required to submit a separate Joint Annual Report.

12. Assisted-Care Living Facility (ACLF): A health care facility which accepts primarily aged persons for domiciliary care and provides to its residents on-site room, board, and non-medical living assistance services as prescribed by each resident's respective needs, and medical services as prescribed by each resident's treating physician, limited to the extent not covered by a physician's order to a home care organization and not actually provided by a home care organization. An ACLF may directly provide such medical services as medication procedures and administration that are typically self-administered, limited to oral medications, topicals, suppositories and injections (excluding intravenous) pursuant to a physician's order, and emergency response. All other skilled nursing services (part-time or intermittent nursing care, physical, occupational and speech therapy, medical social services, medical supplies other than drugs and biologicals, and durable medical equipment) that a home care organization is licensed to provide may be provided in the facility only by a licensed home care organization, except for home health aide services. If the hospital has an ACLF, complete this question but do not include any of the ACLF information in the subsequent pages of the hospital report. (If the ACLF patient becomes hospitalized, the patient's information pertaining to hospital care is included on the hospital report.) Licensed ACLF facilities are required to submit a separate Joint Annual Report.

13. Home for the Aged: A home represented and held out to the general public as a home which accepts aged persons for relatively permanent, domiciliary care. It provides room, board and personal services to one or more non-related persons.

14. Urgent Care Center: A facility that is designed, organized, equipped, and staffed to provide intermediate medical care for minor injuries and illnesses. The facility may or may not operate 24 hours per day, and may have established arrangements for transporting critical patients or patients requiring hospitalization once stabilized. The facility does not provide continuity of care, but treats episodic, emergency and primary care cases.

15. Home Health Agency (HHA): A home care organization which provides home health services to patients on an outpatient basis in either regular or temporary place of residence. Please record the number of visits for each HHA agency that you own or operate. If the hospital has a Home Health agency (HHA), complete this question but do not include any of the HHA information in the subsequent pages of the hospital report. (If the HHA patient becomes hospitalized, the patient's information pertaining to hospital care is included on the hospital report.) Licensed HHAs are required to submit a separate Joint Annual Report.

16. Nursing Home (NH): A health care facility typically for the aged where nursing care is provided around the clock. If the hospital has a nursing home (NH), complete this question but do not include any of the NH information in the subsequent pages of the hospital report. (If the NH patient becomes hospitalized, the patient's information pertaining to hospital care is included on the hospital report.) Licensed NHs are required to submit a separate Joint Annual Report. In completing this section, please note the relationship:

Total = Medicare only beds (SNF)
+ Medicaid only beds (NF)
+ Medicare/Medicaid beds (dually certified SNF/NF)
+ Not Certified beds

17. Skilled Nursing Unit (subacute unit): If the hospital has a skilled nursing unit licensed as a nursing home (SNF), complete this question but do not include any of the SNF information in the subsequent pages of the hospital report. (If the skilled nursing unit patient becomes hospitalized, the patient's information pertaining to hospital care is included on the hospital report.) The number of SNF beds, admissions, and

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patient days reported on the hospital report in question D.17 should match the numbers reported on the Joint Annual Report for Nursing Homes that is submitted separately.

18. Mobile Unit: A movable facility in which preventive, diagnostic, and therapeutic ambulatory services are provided to the community. If the hospital provides services to the community through a contract for mobile units owned and operated by a contractor, indicate as “contract.”

19. Hospital Based Services: Inpatient services are services provided to patients admitted to the hospital. Outpatient services are services provided to patients who have not been admitted but who receive services on-site at the hospital through an emergency department or outpatient department/clinic, or through other hospital departments by physician referral.

19.A. Miscellaneous:

- Percutaneous Lithotripsy: A surgical procedure that allows surgeons to remove stones from the kidney, renal pelvis, and upper urinary tract through a percutaneous channel called a nephrostomy, established through the patient's skin.
- Extracorporeal Shock Wave Lithotripsy (ESWL): A medical device used for treating stones in the kidney or ureter. The device disintegrates kidney stones noninvasively through the transmission of acoustic shock waves directed at the stones.

For the number of fixed units, please indicate the number that is located inside the hospital with the associated number of procedures for inpatients and outpatients. Also indicate the number of fixed units owned or operated by the hospital located off site. Indicate the number of procedures if the figure will not be reported on another JAR (e.g. licensed Ambulatory Surgical Treatment Center JAR)

Mobile units may provide services on the hospital campus or elsewhere.

“Number of days per week” applies to mobile units only.

- Renal Dialysis: Provision of equipment and personnel for the treatment of renal insufficiency on an inpatient or outpatient basis.

Dedicated stations: stations used only for renal dialysis.

- Hemo Dialysis: Removal of certain elements from the blood by diffusion through a semi-permeable membrane.
- Peritoneal Dialysis: Provision of hemodialysis through the peritoneum.

19.B. Oncology/Therapies: The information provided in this section does not require a diagnosis of cancer even though most of the patients receiving these treatments/therapies will be cancer patients.

- Chemotherapy: Treatment of disease by use of drugs and chemicals.
- Hyperthermia: Abnormally high body temperatures induced for therapeutic purposes.
- Radiation Therapy - Megavoltage: The use of specialized equipment (above 1 million volts) in the supervoltage and megavoltage ranges for deep therapy treatment of cancer. Includes cobalt units, linear accelerators with or without electron beam therapy capability, betatrons, and Van de Graaff machines.

For the number of fixed units, please indicate the number that is located inside the hospital. Also indicate the number of fixed units owned or operated by the hospital located off site. Indicate the number of procedures if the figure will not be reported on another JAR (e.g. licensed Outpatient Diagnostic Center JAR). Indicate the number of patients and procedures for all units, fixed plus mobile, for both inpatient and outpatient usage.

19.C. Radiology: Be sure to count only the specific test/procedure. DO NOT COUNT DYE INJECTIONS AS A SEPARATE PROCEDURE.

- CT Scanner: Computerized tomographic scanner. For the number of fixed units, please indicate the number that are located inside the hospital with the associated number of procedures for inpatients and outpatients. Also indicate the number of fixed units owned or operated by the hospital located off site. Indicate the

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number of procedures if the figure will not be reported on another JAR (e.g. licensed Outpatient Diagnostic Center JAR)

- Mobile units may provide services on the hospital campus or elsewhere.
“Number of days per week” applies to mobile units only.

- Ultrafast CT Scanner: Ultrafast computerized tomographic scanner which provides a minimum of 16 slices. For the number of fixed units, please indicate the number that is located inside the hospital with the associated number of procedures for inpatients and outpatients. Also indicate the number of fixed units owned or operated by the hospital located off site. Indicate the number of procedures if the figure will not be reported on another JAR (e.g. licensed Outpatient Diagnostic Center JAR)
Mobile units may provide services on the hospital campus or elsewhere.
“Number of days per week” applies to mobile units only.

- Magnetic Resonance Imaging (Nuclear Magnetic Resonance): The use of a uniform field and radio frequencies to study tissue and structure of the body. This procedure enables the visualization of biochemical activity of the cell in vivo without the use of ionizing radiation, radioisotopic substances, or high-frequency sound. For the number of fixed units, please indicate the number that is located inside the hospital with the associated number of procedures for inpatients and outpatients. Also indicate the number of fixed units owned or operated by the hospital located off site. Indicate the number of procedures if the figure will not be reported on another JAR (e.g. licensed Outpatient Diagnostic Center JAR)
Mobile units may provide services on the hospital campus or elsewhere.
“Number of days per week” applies to mobile units only.

- Nuclear Medicine: A service providing diagnosis and treatment through the use of radioisotopes. Please give the total number of procedures performed.

- Radium Therapy: The treatment of disease through the use of radium. Please give the number of procedures performed.

- Isotope Therapy: The treatment of disease through the use of isotopes. Please give the number of procedures performed.

- Positron Emission Tomography (PET): A procedure used to measure or follow positrons through blood flow or other body processes. For the number of fixed units, please indicate the number that is located inside the hospital with the associated number of procedures for inpatients and outpatients. Also indicate the number of fixed units owned or operated by the hospital located off site. Indicate the number of procedures if the figure will not be reported on another JAR (e.g. licensed Outpatient Diagnostic Center JAR)
Mobile units may provide services on the hospital campus or elsewhere.
“Number of days per week” applies to mobile units only.

- Mammography: Use of radiography of the breast to diagnose breast cancer. Please give the total number of fixed American College of Radiation (ACR) approved units, other fixed units, number of mobile units, and the number of days per week the units are used.
For the number of fixed units, please indicate the number that is located inside the hospital and the number located offsite. Provide the number of total procedures for fixed plus mobile, whether onsite or offsite, for both inpatients and outpatients.
“Number of days per week” applies to mobile units only.

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- Bone Densitometry: a method of measuring bone density and strength; a bone density test commonly used to diagnose osteoporosis. Please give the total number of units and the number of procedures provided to inpatients and outpatients.

19.D. Cardiac and Other Cath Lab Procedures: Note: Pediatric patients should be defined as patients 14 years old and younger.

The number and type of cardiac services provided by each hospital regardless of where in the hospital the services are provided (cardiac catheterization lab, operating room, or other site) is important information for public health and the state's hospitals to be able to access. HOWEVER since cardiac catheterization services require a CON, it is also very important to know how many services (cardiac and non-cardiac) are provided in the cardiac cath labs within each hospital.

When counting procedures **DO NOT include** injections, insertion of IV, or supervision and interpretation activities that may also be billed for. These activities are done in support of the actual procedure and they should not be included in any of the counts. If the same patient has more than one cardiac procedure performed, each cardiac procedure should be counted. Count procedures, not necessarily patients.

Intra-cardiac or coronary artery procedures generally should include right or left heart catheterizations as well as combined right and left heart catheterizations (Note: a combined right and left heart catheterization would be counted as only 1 procedure).

- Cardiac Catheterization Laboratory: Facilities for special diagnostic procedures necessary for the care of patients with cardiac conditions. Available procedures must include, but need not be limited to, introduction of a catheter into the interior of the heart by way of a vein or artery or by direct needle puncture. Procedures must be performed in a laboratory or a special procedure room. Provide the number of adult procedures and the number of pediatric procedures performed IN a cath lab setting. Provide the number of adult procedures and the number of pediatric procedures performed anywhere OUTSIDE a cath lab setting.
- Percutaneous Transluminal Coronary Angioplasty (PTCA): Procedures in which a deflated balloon on a catheter tip is passed across a blockage and then inflated to dilate the vessel. PTCA should include balloon angioplasty of coronary artery, coronary atherectomy, percutaneous coronary angioplasty, or coronary angioplasty.
- Stents: Should include non-drug eluting coronary stents, drug-eluting coronary stents, and intracoronary stents.
- All other Heart Procedures such as angiograms, internal cardiac defibrillators, permanent pacemakers, cardioversions, and pericardiocentesis.
- All other Non-Cardiac Procedures such as peripheral vascular IVUS, atherectomy renal, and venogram balloon catheterization, and electrophysiology lab procedures.
- Thrombolytic Therapy (is not performed in a cardiac cath lab): Procedures in which a blood clot that obstructs a blood vessel or cavity of the heart is treated.
- Open Heart Surgery (is not performed in a cardiac cath lab): Note that the headings for this category and the Surgery category to follow refer to Inpatients and Outpatients rather than to procedures done in the cath lab setting or outside the cath lab setting.

19.E. Surgery

Each visit during the reporting year counts as one surgical "encounter" regardless of the number of surgical procedures that were performed during the visit. INCLUDE: cesarean deliveries. EXCLUDE: procedures performed in areas other than a surgical suite, operating room, and/or ambulatory surgery area. The number of "encounters" includes each time a patient receives the service even if the same patient received the service multiple times. For 3 patients each having two surgeries, the number of encounters would be 6 (3 patients x 2 surgeries = 6 encounters).

The number of "procedures" counts each major procedure that is performed and should not include support procedures or activities done in support of the major procedure such as injections, IV insertions, or

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supervision and interpretations that may be a part of the process of providing the procedure. When counting procedures, if the same patient has more than one procedure, each procedure should be counted.

- Inpatient Surgery: Facilities staffed, equipped, and used in the performance of surgical and related procedures and encounters. Count rooms that are used for surgeries or procedures for inpatients using an overnight stay in the facility.

For inpatient surgery “encounters” and “procedures,” use the definitions above.

- Outpatient Surgery: Scheduled surgical services provided to patients who do not remain in the hospital overnight. Count rooms used exclusively by outpatients, that is operating rooms dedicated to outpatient use only. If your facility uses a room for both inpatient and outpatient surgery or procedures, include these rooms only as inpatient operating rooms. If all outpatient surgery is performed in the inpatient operating rooms, report zero (0) in the outpatient section for the number of dedicated operating rooms.

For outpatient surgery “encounters” and “procedures,” use the definitions above. Outpatient surgery may be performed in operating suites also used for inpatient surgery, in specially designated surgical suites for outpatient surgery, or in procedure rooms within an outpatient care facility. **INCLUDE:** each appearance of an outpatient in each organized outpatient program or emergency service area. **EXCLUDE:** the number of diagnostic and/or therapeutic treatments the patient received in the ancillary departments.

“Episodes of care” are important with types of services where patients have a series or multiple visits such as physical therapy or rehabilitation therapy reported in Schedule D, Sections F and G. For example, if Mary Smith was seen 3 times in March for physical therapy (PT) on her leg; Sue Jones was seen 2 times in May for PT on her back; and Mary Smith returned 5 times in November for PT on her arm, this would be 3 episodes of care. Episodes of care focus on each unique treatment ‘package’ provided to a patient for a unique problem. In this example, there were 2 patients, 10 visits, and 3 episodes of care.

19.F. Rehabilitation

- Cardiac: Treatment to enable attainment of maximum functional capacity by patients who have experienced a myocardial infarction or any other cardiac event.
- Chemical Dependency: Treatment or rehabilitation of patient to restore, maintain, or increase adaptive functioning. This includes treatment for alcohol or drug dependency.
- Nutritional Counseling: Dietary assessments, counseling, training and education by registered or trained dietitians in the unique nutritional problems of persons with complex and often prolonged debilitating illnesses.
- Pulmonary: Treatment designed to return patients with pulmonary disease to optimal function.

19.G. Physical Rehabilitation

- Occupational Therapy: Services that provide for goal-directed, purposeful activity to aid in the development of adaptive skills and performance capacities by individuals of all ages who have physical disabilities and related psychological impairment(s). Occupational therapy focuses on the active involvement of a patient in specially designed therapeutic tasks and activities to improve function, performance capacity, and the ability to cope with demands of daily living. Such therapy is designed to maximize independence, prevent further disability, and maintain health, and is provided by a qualified individual.
- Orthotic Services: The design, fabrication, fitting and training by licensed orthotists in the use of artificial devices that support or align movable parts of the body, prevent or correct deformities, or improve functioning.

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- Physical Therapy: Evaluation and treatment by a registered physical therapist to identify and treat specific problems interrupting the ability to move normally and carry out usual daily activities, including use of therapeutic exercise, functional mobility training and physical agents (heat, cold, and electricity) aimed at achieving the highest functional level possible.
- Prosthetic Services: Services necessary to design prosthetic devices (excluding dental devices and renal dialysis machine); to measure, fit and align the device; and to instruct the patient in its use. Prosthetic devices replace all or part of an internal body organ or external body member including contiguous tissue or replace all or part of the function of a permanently inoperative or malfunctioning external body member or internal body organ.
- Speech/Language Therapy: Evaluation and treatment by a licensed speech pathologist of speech and language disorders that create difficulties in communication. The therapy is designed to improve the individual's swallowing through evaluation and/or therapy or the individual's overall communication skills including listening, reading, speaking, and writing.
- Therapeutic Recreational Service: Techniques employed by a recreational therapist and related personnel to teach and use interactive social and leisure skills designed to boost morale, alleviate mental stress and prevent mental and physical deterioration.
- Inpatient Rehabilitation: Patients served in this unit will typically be classified as DRG 462 through September, 2007. Starting in October 2007, MS-DRG 945 or 946 would apply. Please specify the total number of assigned beds, admissions and patient days. Please specify if you have a dedicated outpatient rehabilitation unit.

19.H. Pain Management: treatment in which pain is frequently managed separately from the underlying condition of which it is a symptom, or the goal of treatment is to manage the pain with no treatment of any underlying condition (e.g., if the underlying condition has resolved or if no identifiable source of the pain can be found). Please provide the number of inpatients and outpatients who received pain management care.

19.I. Obstetrics

- Obstetric Level of Care: A system which requires designation of hospitals for provision of care according to their capability. Definitions were developed by the state Perinatal Advisory Committee.
 - Level I Unit - Provides basic care for uncomplicated maternity and neonatal patients. All high-risk mothers and neonates must be promptly identified for referral and/or consultation for more specialized care. The Level I unit shall provide equipment and staff to care for maternity patients whose onset of labor occurs on or after the first day of the 35th week of gestation, for neonates whose birth-weight is over 2500 grams, or for sick patients pending transfer to another hospital. The Level I unit can also provide care for convalescing neonates who are transferred from other institutions to be closer to home.
 - Level II Units - Obstetric - Have the capability to provide a broad range of maternal-fetal services for normal patients and for those with mild or moderate obstetric illnesses or complications. These units provide planned delivery services for women whose infants are expected to be >32 completed weeks of gestation and have a birthweight of at least 1500 grams. Additionally, a need for immediate pediatric subspecialty care for these newborns should not be anticipated. Level II obstetric units also provide emergency care for unplanned births of younger, smaller, or sicker babies before transfer to a facility at which newborn intensive care is provided.
 - Level III Units - Obstetric - Have the capability to provide a broad range of maternal-fetal services for normal patients as well as for those with mild, moderate, and severe obstetric illnesses or complications. These units provide planned delivery services for women whose infants are expected to be >28 completed weeks of gestation and have a birthweight of at least 1000 grams. Additionally, a need for advanced respiratory support such as high-frequency ventilation and inhaled nitric oxide should not be anticipated (Level III-A nursery). Level III obstetric units located in facilities with Level III-B or Level III-C nurseries may provide planned delivery services for younger, smaller, or sicker newborns.

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- Cesarean Section: Delivery of a fetus by incision through the abdominal and uterine walls. Include fetal deaths delivered by C-Section.
- Non C-Section Deliveries: All other deliveries not included in the count of Cesarean Section Deliveries. Include fetal deaths. The sum of Cesarean Section Deliveries plus Non C-Section Deliveries equals the total number of deliveries. Include deliveries in any setting under hospital control.
- Birthing Room/Labor Delivery Recovery Postpartum (LDRP) room/Labor Delivery Recovery (LDR): An in-hospital combination labor and delivery unit with a home like setting for mothers and fathers/families who have completed specified childbirth courses and wish to jointly participate in the birth. The newborn may remain at the bedside throughout the stay.
Indicate for all deliveries the number performed in a Birthing Room setting.
- Postpartum Service: Provision of medical, nursing, and other health-related services to patients following childbirth. Outpatient Postpartum Services include any visit by a woman to a hospital as an outpatient for a service directly related to her pregnancy or delivery.
- Newborn Nursery: A unit staffed and equipped for the care of a newborn.
- Premature Nursery: A separate nursery used exclusively for the care of infants whose birth weight is 2500 grams (5.8 lbs.) or less and/or who shows signs of incomplete prenatal development or immature organ systems.
- Isolation Nursery: A nursery which affords total isolation for infants suspected of contagious, infectious or communicable disease.

For Schedule D, question 19 Section I. when counting patients and patient days for babies transferred to various parts of the hospital, please use this example as a guide: After birth the newborn stays overnight in the newborn nursery. The baby is transferred to NICU for one night, then back to the regular newborn nursery for a night before being discharged. The newborn would be counted as a case or patient in both the Newborn Nursery category (Section I) and in the Neonatal Intensive Care Unit (Section L) since resources were required from both nurseries. The days counted should reflect the days in each of the categories. In this example the days in newborn nursery would be 2 and the days in NICU would be 1.

19.J. Transplants

- Organ or tissue harvested means a count of any organ or tissue donated for transplantation. It does not mean those organs which were removed. For example, if a cornea is removed from a person and a healthy, donated cornea is transplanted as a replacement, you should not count the cornea which was removed. Only in the area of autografts should the removal be counted, as in the case of skin and bone grafts.
- Organ and tissue transplants should be counted only if they are performed in your facility. For example, if an organ or tissue is removed from a donor in your facility but is transplanted into a donee in another facility, you would count the donation as a removal, but the transplant would be counted in the facility which performed the transplant. Be sure to specify the transplant and donation units for the indicated organs and tissues. Lung transplants and other organs not listed should be included and listed in “Any Other.”

19.K. Other

- Hyperbaric Oxygen Therapy - A medical treatment in which the patient is entirely enclosed in a pressure chamber breathing 100% oxygen at greater than one atmosphere pressure. Either a mono-place chamber pressurized with pure oxygen or a larger multi-place chamber pressurized with compressed air where the patient receives pure oxygen by mask, head tent, or endotracheal tube may be used.
- Gamma Knife: Radiosurgery in which an intracranial target can be destroyed by ionizing beams of radiation that is directed with stereotaxic precision. Used to treat brain tumors and vascular lesions.

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- Cyberknife: Radiosurgery in which an intracranial or extracranial target can be destroyed by ionizing beams of radiation that is directed with stereotaxic precision. Cyberknife is used to treat tumors and vascular lesions anywhere in the body.

19.L. Intensive/Intermediate

- Burn Care: Provides care to severely burned patients. Severely burned patients are those with any of the following: 1) second-degree burns of more than 25% total body surface area for adults or 20% total body surface for children; 2) third degree burns of more than 10% total body surface area; 3) any severe burns of the hands, face, eyes, ears or feet; or 4) all inhalation injuries, electrical burns, complicated burn injuries involving fractures and major traumas, and all other poor risk factors.
- Cardiac Care: Provides patient care of a more specialized nature than the usual medical and surgical care, on the basis of physicians' orders and approved nursing care plans. The unit is staffed with specially trained nursing personnel and contains monitoring and specialized support or treatment equipment for patients who, because of heart seizure, open-heart surgery, or other life-threatening conditions, require intensified, comprehensive observation and care. May include myocardial infarction, pulmonary care, and heart transplant units.
- Medical Intensive Care: Intensive care unit for non-surgical patients.
- Mixed Intensive Care: Provides patient care of a more intensive nature than the usual medical and surgical care, on the basis of physicians' orders and approved nursing care plans. These units are staffed with specially trained nursing personnel and contain monitoring and specialized support equipment for patients who, because of shock, trauma, or other life-threatening conditions, require intensified, comprehensive observation and care.
- Newborn/Neonatal Level of Care:
 - *Note: The revised Neonatal Levels of Care, as defined by the Guidelines of Perinatal Care 7th Edition, will be updated on the 2016 Joint Annual Report for Hospitals. Until that time, please indicate your facility's highest level of care.
 - Level I Units - Provides basic care for uncomplicated maternity and neonatal patients. All high-risk mothers and neonates must be promptly identified for referral and/or consultation for more specialized care. The Level I unit shall provide equipment and staff to care for maternity patients whose onset of labor occurs on or after the first day of the 35th week of gestation, for neonates whose birth-weight is over 2500 grams, or for sick patients pending transfer to another hospital. The Level I unit can also provide care for convalescing neonates who are transferred from other institutions to be closer to home.
 - Level II-A Unit - Neonatal - Level II-A nurseries provide specialty neonatal services. They provide care for infants born at >32 weeks gestation and weighing \geq 1500 grams who have physiologic immaturity or who are moderately ill with problems that are anticipated to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis. These units also resuscitate and stabilize preterm and/or ill infants before transfer to a facility at which newborn intensive care is provided. In addition, Level-A units provide care for infants who are convalescing after intensive care.
 - Level II-B Unit - Neonatal - Level II-B nurseries provide specialty neonatal services. They provide care for infants born at >32 weeks gestation and weighing \geq 1500 grams who have physiologic immaturity or who are moderately ill with problems that are anticipated to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis. Level II-B units also have the capability to provide mechanical ventilation for brief durations (<24 hours) or continuous positive airway pressure.
 - Level III-A Unit - Neonatal - Level III-A nurseries provide subspecialty care for patients with severe and complicated neonatal disorders, as well as those who require normal or intermediate care. They provide care for infants born >28 weeks gestation and weighing >1000 grams. Level III-A units also have the capability to provide sustained conventional mechanical ventilation and perform minor surgical procedures.

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- Level III-B Unit – Neonatal - Level III-B nurseries provide subspecialty care for patients with severe and complicated neonatal disorders, as well as those who require normal or intermediate care. They provide comprehensive care for extremely low birth weight infants (≤ 1000 grams and ≤ 28 weeks gestation). Level III-B units have the capability to provide advanced respiratory support such as high-frequency ventilation and inhaled nitric oxide for as long as required. These units also offer access to a full range of pediatric medical subspecialists on site or at a closely related institution, advanced imaging, and pediatric surgical specialists and pediatric anesthesiologists on site or at a closely related institution to perform major surgery.
- Level III-C Unit – Neonatal - Level III-C nurseries provide subspecialty care for patients with severe and complicated neonatal disorders, as well as those who require normal or intermediate care. They provide comprehensive care for extremely low birth weight infants (≤ 1000 grams and ≤ 28 weeks gestation). Level III-C units have the capability to provide advanced respiratory support such as high-frequency ventilation and inhaled nitric oxide for as long as required. These units also offer prompt and on-site access to a full range of pediatric medical subspecialists, advanced imaging, and pediatric surgical specialists and pediatric anesthesiologists on site or at a closely related institution to perform major surgery. In addition, Level III-C units are located within institutions that have the capability to provide ECMO and surgical repair of complex cardiac malformations that require cardiopulmonary bypass.
- Pediatric Care: Provides care to pediatric patients that are of a more intensive nature than usually provided to pediatric patients. The unit is staffed with specially trained personnel and contains monitoring and specialized support equipment for treatment of patients who, because of shock, trauma, or other life-threatening conditions, require intensified, comprehensive observation and care.
- Stepdown ICU: Provides care to patients requiring care more intensive than provided in the acute area, yet not sufficiently intensive to remain in an intensive care unit. Patients admitted to this area are usually transferred here from an intensive care unit once their condition has improved. The unit has specially trained nursing personnel and contains monitoring and observation equipment for intensified comprehensive observation and care.
- Stepdown CCU: Provides care to patients requiring care more intensive than provided in the acute area, yet not sufficiently intensive to remain in a critical care unit. Patients admitted to this area are usually transferred here from a critical care unit once their condition has improved. The unit has specially trained nursing personnel and contains monitoring and observation equipment for intensified comprehensive observation and care.
- Surgical Intensive Care: Intensive care unit for post-operative high risk inpatients.
- Other Intensive/Intermediate Care: Provides care to patients requiring care more intensive than provided in the acute area. Please specify the type of unit and number of beds.

19.M. Psychiatric partial hospitalization: A non-residential medically directed treatment program that offers intensive, coordinated, and structured services for adults and/or children within a stable therapeutic milieu. Partial hospitalization embraces day, evening, night, and weekend treatment programs which employ an integrated, comprehensive and complementary schedule of recognized mental health service approaches. Partial hospitalization must be a separate, identifiable, organized program representing a significant link within the continuum of comprehensive mental health services. If yes, provide the number of patients served, whether or not they stayed overnight.

19.N. Psychiatric intensive outpatient care: A treatment option providing therapy, individualized treatment planning, and psychoeducational opportunities for individuals who are able to function at home, work, or school, but who still need a structured outpatient program 3 - 5 days per week. If yes, provide the number of Outpatients served.

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19.O. Electroconvulsive Treatment: Electrically induced seizures primarily used in the treatment of severe affective disorders, depression and schizophrenia.

19.P. Other Convulsive Treatment: The use of stimuli other than electrical to produce a generalized seizure primarily used in the treatment of severe affective disorders, depression and schizophrenia.

19.Q. Negative pressure ventilated room: Condition that exists when less air is supplied to a space than is exhausted from the space, so the air pressure within that space is less than that in surrounding areas. Under this condition, if an opening exists, air will flow from surrounding areas into the negatively pressurized space. Often used as a part of airborne precautions for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei of evaporated droplets containing microorganisms that remain suspended in the air and that can be dispersed widely by air currents within a room or over a long distance. If yes, please provide the number of beds in such rooms.

19.R. 23 Hour Observations: Please record the total number of 23 hour observation patients.

19.S. Cancer Patients:

Please use the new definitions below for the questions (1, 2, and 3). Please refer any question to the appropriate personnel at your facility that deals with your cancer registry or cancer treatments.

Please report numbers for the cancer cases with date of first contact with your institution within the reporting period, January 1, 2015 through December 31, 2015.

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

These reporting questions omit the cases which were diagnosed and had the entire first course of treatment elsewhere, and came to your institution for treatment of recurrence or progression of the cancer. (Class of Case)

This information should be counted consistently with the data that is reported to the Tennessee Cancer Reporting System.

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SCHEDULE E - FINANCIAL DATA

Round all amounts to the nearest whole dollar. Use the accounting method required by the Centers for Medicare & Medicaid Services.

A. CHARGES: Enter charges and adjustments that were earned or relate to earnings of the current reporting period only. Do not include charges and adjustments that were earned in a prior period. **Adjustments relating to amounts earned in a prior period should be entered as nonoperating revenue in item A.8.d) Other nonoperating revenue.** Do not include gains or losses. Gains are increases and losses are decreases in net assets that are not related to the central operations of the hospital.

Gross Patient Charges: These charges are the hospital's full established rate for all hospital services rendered to patients during the reporting year. This does not include hospital owned or operated services that are licensed separately such as skilled nursing units or facilities, home health agencies or ambulatory surgical treatment centers. The total gross patient charges for government in A.1.f) plus total Cover Tennessee charges in A.2.d) plus total gross patient charges for nongovernment in A.3.f) must equal the grand total of gross patient charges in A.4.e).

Adjustments to Charges: Adjustments are decreases or increases in revenue during the current reporting period due to contracts with third party payers, legislation, regulation, or hospital policy. Payers may reimburse at a rate lower than the hospital's full established rate; therefore, revenue should be adjusted to its net realizable value. Adjustments due to legislation or regulation may be in the form of worker's compensation or no-fault insurance. Hospital policy may allow for discounts to employees. Please specify adjustments included in the other categories.

Adjustments to a previous year's revenue, such as Medicare or TennCare prior adjustments, should be reported as non-operating revenue, not as current year adjustments. Because adjustments are subtracted from gross charges (revenues), adjustments are reported as positive numbers.

Net Patient Revenue: Net patient revenue is the realizable increase in assets earned during the current reporting period from the patient services. Net Patient Revenue should include the total amount paid by the specified payer for services provided to patients covered by that payer that correspond to the billed charges included in the charges column of this section. The net patient revenue should equal the difference obtained by subtracting adjustments to charges from gross patient charges.

A.1. Government Charges: Programs funded by federal, state or other governments should be included in the government category even if administered by Blue Cross/Blue Shield or another commercial insurer. Do NOT include Cover Tennessee program revenues.

A.1.a) & b) Medicare-Total: This amount should include both traditional Medicare and Medicare Managed Care revenues and adjustments. Be aware that there are categories for inpatient and outpatient.

A.1.a)1) & A.1.b)1) Medicare-Managed Care: This amount should include only managed Medicare revenues and adjustments. Be aware that there are categories for inpatient and outpatient.

A.1.c) & d) Medicaid/TennCare: Medicaid and TennCare refer to programs funded through Title XIX of the Social Security Act. Both venues are included here to obtain complete reporting from this source. Do NOT include Cover Tennessee.

A.1.e) Other: All other government sources of revenue. Include TRICARE/CHAMPUS.

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A.2. Cover Tennessee: Voluntary health insurance created by the State of Tennessee. Do NOT include in either the government or the nongovernment financial data sections.

A.2.a. CoverTN partners the state, private employers, and individuals to offer basic health coverage for employees of Tennessee's small businesses. Be sure to report Blue Cross InReach under CoverTN and not in nongovernment Blue Cross.

A.2.b. CoverKids offers health coverage to uninsured children in Tennessee, age 18 and under, and pregnant women.

A.2.c. AccessTN provides health insurance for seriously ill adults who have been turned down by insurance companies.

A.3. Nongovernment Charges: Exclude all revenue from Medicare, Medicaid, TennCare, TRICARE/CHAMPUS, and other government payers. Exclude Cover Tennessee.

A.3.b) & c) Blue Cross/Blue Shield and Commercial Insurers: Be sure to distinguish between insurance coverage options. It is no longer necessary to differentiate among indemnity, HMO/POS and PPO coverage. Exclude Workers Compensation.

A.3.d) Workers Compensation: Payments required by law to be made for an employee who suffers an occupational disease, accidental personal injury, or disability arising out of and in the course of employment.

A.3.e) Other: All other Nongovernment sources of revenue. Exclude Cover Tennessee.

A.4. Totals: The Grand Total must equal the sum of A.1.f. Total Government Sources, A.2.d. Total Cover Tennessee and A.3.f. Total Nongovernment Sources. (The Totals in the Adjustment to Charges column include all adjustments in A.5 Bad Debt and A.6 Nongovernment and Cover Tennessee Adjustments to Charges, but may include other adjustments not included in A.5. and A.6.; there is not necessarily any direct comparison between figures submitted in these sections.)

A.5. Bad Debt: "Bad debts are amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future.

(A) To constitute a "bad debt", the debt must meet the following criteria:

(i) The provider must be able to establish that reasonable collection efforts were made;

(ii) The debt was actually uncollectible when claimed as worthless; and

(iii) Sound business judgment established that there was no likelihood of recovery at any time in the future.

Accounts turned over to a collection agency should be classified as bad debt.

(B) If, after reasonable and customary attempts to collect a bill, the debt remains unpaid more than one hundred twenty (120) days from the date the first bill is mailed to the patient, then the debt may be deemed uncollectible. Bankrupt accounts shall be considered bad debts, unless there is documented evidence that the medical bill caused bankruptcy. Such accounts would then be counted as charity." TCA 68-1-109 (1)

(1) (amended 5/30/07)

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This number may be different from the amount shown on your financial statements as bad debt expense if you are using the allowance method to account for bad debts. The amount entered on the report should be bad debts that were actually written off during the current reporting period.

Please divide bad debt according to:

- A.5.a. Medicare Enrollees (Inpatient and Outpatient)
- A.5.b. Other Government (includes TennCare, Medicaid, Tri-Care, and all other government programs; excludes Cover Tennessee)
- A.5.c. Cover Tennessee (Do NOT include in Government or commercial insurance.)
- A.5.d. Blue Cross and Commercially Insured Patients
- A.5.e. All other bad debt (Do NOT include discounts provided to uninsured patients. See NOTE below.)
- A.5.f. Total Bad Debt

Because bad debt figures are subtracted from Gross Charges, Bad Debt is reported as a positive number. Only the portion of the patient's account for which the patient is responsible is included in bad debt. This includes unpaid copays and deductibles.

A.6. Nongovernment and Cover Tennessee Adjustments to Charges: If you cannot provide the full break out of the corresponding adjustments please provide the subtotals that represent the most detailed level of data. (Do not include Bad Debt.)

- A.6.a) Nongovernment Contractual Adjustments
- A.6.b) Cover Tennessee Contractual Adjustments
- A.6.c) Charity Care Inpatient and A.6.d) Charity Care Outpatient Include all adjustments to charges for indigent patients in Charity Care, as defined by law: (2) "Charity care" is reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. The provider should apply the following guidelines for making a determination of indigence or medical indigence:
 - (A) The patient's indigence must be determined by the provider, not by the patient, (i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence);
 - (B) The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash and unnecessary for the patient's daily living), liabilities, and income and expenses. Indigence income means an amount not be exceed one hundred percent (100%) of the federal poverty guidelines. Medical indigence is a status reached when a person uses or commits all available current and expected resources to pay for medical bills and is not limited to a defined percent of the federal poverty guidelines. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;
 - (C) The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill, (e.g., title XIX, local welfare agency, and guardian); and
 - (D) The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.
 - (E) Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the bad debt collection criteria." TCA 68-1-109 (1) (2) (amended 5/30/07)

Because charity care figures are adjustments subtracted from Gross Charges, Charity Care-Inpatient and Charity Care-Outpatient figures are reported as positive numbers.

- A.6.e) Other Adjustments: Any other adjustments that are not appropriately reported in any of the other specific categories, including other discounts such as prompt pay discounts, the amount of discount given for services provided to employees and professionals (e.g., ministers), risk management and/or public relations and administrative expenses which include the amount of services discounted as a result of turning

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accounts over to a collection agency and/or discounts given on credit cards. These should not be reported as bad debt. (Do not include discounts provided to uninsured patients. See NOTE below)

Total Charity: Total charity is the sum of inpatient and outpatient charity care provided. A.6.c) + A.6.d)

Total Charity plus Bad Debt: the sum of charity care and bad debt. A.6.c) + A.6.d) + A.5.f.

NOTE: Amount of discounts provided to uninsured patients: The total dollar amount of adjustment to charges provided to patients with no insurance coverage for any portion of the bill. Because the law mandates a discount to the uninsured, this amount can no longer be included in charity care or bad debt. This figure may be used for the calculation of the Essential Access hospital payments.

A.7. Other Operating Revenue: Revenue from non-patient care services, non-patient revenue received from state or local governments, other contributions that may be used to pay for uncompensated health care, and revenue generated from activities or service to persons other than patients that are normally part of the day-to-day operation of a hospital. Includes, but is not limited to, revenue from educational or physical fitness programs, cafeteria sales, and gift shop sales.

A.7.a) Tax Appropriations: Report any amounts of money that are funded by local government tax appropriations and provided to the hospital by local governments during the reporting period.

A.7.b)2) Essential Access Hospital (EAH) Payments are supplemental payments made to hospitals by the TennCare program. Report all special TennCare payments including the actual amount of EAH payments, charity pool payments, medical equipment pool payments and any other special pool payments made directly by the TennCare bureau to your hospital during the reporting period. Include any amounts that are Medicaid Disproportionate Share Hospital (DSH) payments in this item.

A.7.b)3) Critical Access Hospital (CAH) Payments are made to hospitals designated as Critical Access Hospitals (CAH) under the Medicare Rural Hospital Flexibility Program (MRHFP). The cost-based reimbursement that is reimbursed by the TennCare Bureau for care provided by the CAH to TennCare enrollees is to be recorded in Section A.1. Government: Charges, Adjustments and Revenues. Report the amount of actual cost based reimbursements received by the hospital during the reporting period. Also report any CAH charity care pool payments in this item.

A.7.b)4) State and Local government contributions - Amount used for other:

- Disproportionate Share Payment (included in EAH payments A.7.b)2)
- Capital Payment
- Indirect Education
- Supplemental payments received from states other than Tennessee (special pool payments, etc.)
- Other Tennessee State government special payments (trauma pool)
- TennCare State Payments
- Cost Settlements and Operating Rate Adjustments
- Certified Public Expenditure

A.8. Nonoperating Revenue: Includes but is not limited to restricted contributions that cannot be used to offset bad debt, such as grants and interest income, and adjustments to prior years' revenues. **Include payments received for Electronic Health Records (EHR) incentive program.** Do not include losses or expenses.

B. EXPENSES: Include all expired costs for goods and services that have been used or consumed in carrying on some activity during the reporting period and from which no benefit will extend beyond the present.

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B.1. Payroll Expenses: Report salaries for all full-time and part-time personnel who are included in Schedule J, Personnel. Payroll expenses should be reported for each category of employees included in that schedule.

B.1.a) Physicians and Dentists: Include only the salaries of physicians and dentists engaged in clinical practice. The payroll for physicians and dentists who hold administrative positions should be included under "All other personnel" line B.1.e). Payroll for physicians and dentists whose clinical work is totally financed by outside research grants or fellowships should be excluded. Exclude professional fees, as provision for these expenses is made in line B.2.b). If you list physicians or dentists on page 39 4.2.a) or 4.2.c), this line should report their payroll.

B.1.b) Medical and Dental Residents: If you list personnel on page 39 4.2.b) or 4.2.d), this line should report their payroll.

B.1.c) Trainees: Include persons who have not completed the necessary requirements for certification or have not met the qualifications required for full salary under the related title.

B.1.d) Registered and licensed practical nurses: Report payroll expenses for only those nurses, including advanced practice nurses that are involved in the delivery of care to patients in the registered and other licensed nurse category. Nurses whose roles are purely administrative should be included in all other personnel.

B.2.c) Contracted Nursing Services: Report expenses for all nursing staff who provided patient care services within the hospital but who were not on the hospital payroll. Include staff from contractual arrangements, nursing registries, temporary help agencies, and so forth. Do not include nurses who do not provide nursing services (such as CRNAs); these types of services should be reported in professional fees.

B.2.d) Depreciation expense: Report only depreciation expenses applicable to the reporting period. This amount also should be included in accumulated depreciation reported on page 20, item D.2.

B.2.e) Interest expense: Report interest expense for the reporting period only.

B.2.f) Energy expense: Report expenses for oil, natural gas, electricity, purchase of steam, coal, propane gas, and any other energy expenses.

B.2.g) All other expenses: Include non operating expenses, expenses for supplies, expenses for purchased services, all appropriate taxes, and any other expenses not included in the above categories.

C. CURRENT ASSETS: Current assets are the value of cash, accounts receivable, inventories, marketable securities and other assets that could be converted to cash in less than one (1) year. **DO NOT** include funds from inter-corporate accounts.

D. FIXED ASSETS: These are assets required for the normal conduct of a business, which normally are not converted into cash during the period after they were declared fixed. Fixed Assets would include, but are not limited to, movable equipment, buildings, land, and construction in progress. Include all fixed assets that are carried on the hospital's balance sheet. Actual or estimated value of the plant and/or equipment that is leased should be included. Depreciation applicable to the reporting period and included in expenses page 19 item B.2.d) also should be included here within accumulated depreciation. Depreciation should be calculated in the same way as required by the Centers for Medicare and Medicaid Services.

E. OTHER ASSETS: Those assets not included in current and fixed assets.

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F. TOTAL ASSETS: Total assets are future benefits or service potential that is recognized in accounting only after a transaction has occurred. Assets may be tangible or intangible, current or long term. The sum of current, fixed and other assets. C.1. + D.3. + E.

G. CURRENT LIABILITIES: Current Liabilities are the amounts owed for salaries, interest, accounts payable and other debts due within one (1) year.

H. LONG TERM LIABILITIES: Long Term Liabilities are the amounts owed for leases, bond repayment and other items due in excess of one (1) year.

J. CAPITAL ACCOUNT: The excess of assets of an enterprise or a fund over its liabilities and reserves. This includes Fund Balance or Stockholder's Equity.

K.2. Local Property Taxes: Taxes paid on the inpatient facility should include only taxes paid during the reporting period on the address of the inpatient facility. Taxes on all other property should include taxes paid during the reporting period on all other property owned by the hospital.

M. TennCare Utilization and Revenue: Please record the number of admissions, patient days, gross revenue and net revenue for TennCare patients by Managed Care Organization (MCO) and Behavioral Health Organizations (BHO). **Exclude normal newborns designated as DRG 390 - 391, and primary diagnosis code of V30 – V39 for all utilization through September, 2007. Starting in October 2007, MS-DRG 794 and 795 identify the excluded newborns.**

- Patient Day: A patient day is a period of service between census-taking hours on two (2) successive calendar days, the day of discharge being counted only when the patient was admitted the same day. Sometimes referred to as a census day.
- Gross Revenue: Gross revenue is the facility's full established rate for all services rendered to patients during the reporting period.
- Net Revenue: Net revenue is the difference obtained by subtracting the adjustments to charges from gross revenue. This difference represents the actual amount that the facility received.

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SCHEDULE F - BEDS AND BASSINETS

1.A. Licensed Beds: The maximum number of beds authorized by a state licensing (certifying) agency or regulated by a federal agency as of the last day of the reporting period. This figure includes adult and pediatric beds (excludes beds in a sub-acute unit that are licensed as nursing home beds).

1.B. Number of Staffed Beds: The number of adult and pediatric beds set up, staffed and in use as of the last day of the hospital's reporting period. (NOTE: this definition matches the wording on the form. This is not the average staffed beds but staffed beds on a normal day.)

Staffed Beds: The number of beds that are available in the facility that have nursing staff available or could have nursing staff available if needed for admission of a patient.

1.C. Non-Licensed Bassinets: A bassinet or crib for normal routine newborn infants born in the hospital and located in the newborn nursery as of the last day of the reporting period. The nursery bassinet or crib is not available for admission of a patient and is not included in the licensed bed capacity for the hospital.

1D. Licensed Beds NOT Staffed at any time at all during the reporting period: The intent of this question is to determine where there is unused licensed bed capacity.

1.E. Licensed beds that could NOT be put into use within 24-48 hours: Beds in a completely or partially closed wing of the facility are considered available only if the hospital can put the beds into use when they are needed. If a bed can be staffed for inpatient care within 24 to 48 hours, the unoccupied bed is determined available (exclude normal newborn bassinets, include neonatal care units).

2. Temporary Changes: A temporary change occurs when beds are temporarily out of use and not included in the bed count; it is not considered a permanent change. Report as an eight-digit number, the date(s) when bed change(s) occurred; for example, January 7, 2015 should be written as 01/07/2015. The number of beds added or withdrawn should account for the difference between beds reported in item 1.B. (Staffed Beds) and beds shown in last year's statistics. If there have been more than four changes during the reporting period, please report all changes on a separate sheet of paper.

3. SWING BEDS: A licensed acute bed that has been designated by a hospital to provide either acute or long-term care services and has met the following conditions necessary for reimbursement under the rules and regulations of the Omnibus Reconciliation Act of 1980.

- A hospital must be located in a "rural" area. Rural means any area that has not been designated as urban by the U.S. Bureau of the Census.
- A hospital must have less than 100 acute care beds, excluding beds for newborns and beds in intensive care units.
- When applicable, a hospital must receive a Certificate of Need (CON) for the provision of long-term services from its state health planning and development agency.

3.A. Swing Beds: Please specify if your facility has swing beds and the number of acute care beds designated as swing beds. (Do not report swing bed "units" in 3A. This is for number of acute care swing beds.)

3.B. Intermediate or Skilled: Please provide the number of admissions and patient days for each of the specified categories in the provision of intermediate and skilled care. A patient day is a period of service between census-taking hours on two successive calendar days, the day of discharge being counted only when the patient was admitted the same day. A patient day is sometimes referred to as a census day.

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4.A. Beds Set Up and Staffed on a Typical Day: Because it is recognized that September 30 or the end of a fiscal year (e.g. December 31) may not be a typical day for hospital usage, the hospital may choose its own typical day during the reporting period.

Account for all adult and pediatric inpatient beds set up and staffed for use on the chosen typical day. List beds for a particular service area only if a unit is specifically designated for the service area. DO NOT include normal newborn bassinets.

- **Note: Neonatal Care:** Provides care to newborn infants of a more intensive nature than the usual nursing care provided in newborn acute care units, on the basis of physicians' orders and approved nursing care plans. A unit that must be separate from the newborn nursery and that provides intermediate, recovery, and intensive care. Includes capabilities for prolonged respiratory support and intravenous therapy.

4.B. Number of Patients: This is a census of patients in the hospital on the chosen typical day. Include babies in neonatal intensive care or neonatal intermediate care; exclude long term skilled or intermediate patients and newborns designated as DRG 390 - 391, and primary diagnosis code of V30 – V39 for all utilization through September, 2007. Starting in October 2007, MS-DRG 794 and 795 identify the excluded newborns.

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SCHEDULE G - UTILIZATION

2. UTILIZATION BY MAJOR DIAGNOSTIC CATEGORIES: **Indicate whether reporting is done using Admissions and Inpatient Days or using Discharges and Discharge Patient Days.

- Column 2
 - Admissions - This figure must include all patients admitted to a facility during the reporting period including normal newborns.
 - Discharges - The number of discharges from the facility should include normal newborn and patients who died during their stay, and all other discharges.
- Column 3
 - Inpatient Day - An Inpatient Day of Care (also commonly referred to as a patient day or a census day, or by some federal hospitals as an occupied bed day) is a period of service between the census-taking hours on two successive calendar days; the day of discharge being counted only when the patient was admitted on the same day.
 - Discharge Patient Day - The total number of patient days of care rendered to patients discharged or dying during the reporting period. This figure must include days of care rendered to those patients admitted prior to the beginning of the reporting period.

3. UTILIZATION BY REVENUE SOURCE: Report admissions/discharges and inpatient days/discharge patient days or outpatient visits according to the primary payment source. Indicate whether reporting is done using Admissions and Inpatient Days or using Discharges and Discharge Patient Days. Exclude normal newborns, designated as DRG 390 – 391, and primary diagnosis code of V30 – V39 for all utilization through September, 2007. Starting in October 2007, MS-DRG 794 and 795 identify the excluded newborns. Charges for normal newborns will be included in the obstetrics charges.

- Column 2 and Column 3: See information in 2. UTILIZATION BY MAJOR DIAGNOSTIC CATEGORIES
- Column 4: Outpatient Visits includes all visits to an outpatient service or department or to the emergency department. Observations should generally be counted in outpatient visits. If the patient is in observation and then admitted, the observation portion would be counted as outpatient visit, the admission would count as 1 and the length of stay after admission would be counted as inpatient days. Under PPS the from-and-through date of the claim would start after the observation period.

4. NUMBER OF PATIENTS BY AGE GROUP: See above (3. UTILIZATION BY REVENUE SOURCE).

5. PATIENT ORIGIN: **Indicate whether reporting is done using Admissions and Inpatient Days or using Discharges and Discharge Patient Days. Exclude normal newborns designated as DRG 390 – 391, and primary diagnosis code of V30 – V39 for all utilization through September, 2007. Starting in October 2007, MS-DRG 794 and 795 identify the excluded newborns. Patients whose state of residence is unknown should be recorded in Residence Unknown. Tennessee residents with Unknown County of residence should be recorded in TN County Unknown.

- **NOTE:** The “Tennessee Total” at the end of the county list should equal all individual county data entered. The other state/counties “Grand Total” should equal all individual state/county data entered.

6.C. DELIVERY STATUS: A reportable fetal death means death prior to the complete expulsion or extraction from its mother of a product of human conception. By law, a fetal death must be reported to the Department of Health if the weight of the fetus is 350 grams or more, or in absence of weight, if the completed weeks of gestation are 20 weeks or more. Do not include induced termination of pregnancy.

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SCHEDULE H - PSYCHIATRIC AND CHEMICAL DEPENDENCY

1. TYPE OF UNIT: Psychiatric unit data should be entered on pages 35 and 36. Chemical dependency unit data should be entered on pages 37 and 38.

1.B Gero-Psychiatric Unit: (Psychiatric data only) provides services to the geriatric patient who needs inpatient psychiatric care in a structured, therapeutic environment.

3. UTILIZATION BY AGE GROUPS

- Inpatient Service: 24 hour care in a hospital setting.
- Partial Care or Day Hospital: A planned program of mental health or chemical dependency treatment services generally provided in visits of 3 or more hours to groups of patients/clients.
- Outpatient Care: Mental health or chemical dependency services to ambulatory clients generally provided for less than 3 hours at a single visit to an individual, group, or family, usually in a clinic or similar setting. Include emergency care on a walk-in basis as well as services provided by mobile teams. Exclude all 'hotline' services.
- Residential Care (Chemical Dependency only): Mental health or chemical dependency services offered to clients placed in a residential care facility.

6. Seclusion and Restraints

6.A. Seclusion: The confinement of a patient alone in a room or an area where the patient is physically prevented from leaving. This definition is not limited to instances in which a patient is confined by a locked or closed door.

6.B. Mechanical Restraints: The application of a mechanical device, material, or equipment attached or adjacent to the patient's body, including ambulatory restraints, that the patient cannot easily remove and that restricts freedom of movement or normal access to the patient's body.

6.C. Physical Holding Restraints: The use of staff body contact with a patient to restrict freedom of movement or normal access to his or her body.

6.D. Chemical Restraints: The use of a medication to restrict the patient's freedom of movement for the emergency control of behavior. Chemical restraints are medications used in addition to, or in replacement of, the patient's regular drug regimen to control extreme behavior during an emergency. The medications that comprise the patient's regular medical regimen, including PRN medications, are not considered chemical restraints, even if their purpose is to control ongoing behavior.

If Seclusion or Restraint has been used, please provide the number of patients under age 18 and those over age 18, as well as the number of times Seclusion or Restraints were initiated for patients of each age group.

7. Financial Data

Gross Patient Charges: These charges are the hospital's full established rate for all hospital services rendered to patients, both inpatient and outpatient as well as the total, during the reporting year.

Adjustments to Charges: Adjustments are decreases in revenue during the current reporting period due to contracts with third party payers, legislation, regulation, or hospital policy. Payers may reimburse at a rate lower than the hospital's full established rate; therefore, revenue should be adjusted to its net realizable value. Adjustments due to legislation or regulation may be in the form of worker's compensation or no-fault insurance. Hospital policy may allow for discounts to employees. Because adjustments are subtracted from charges (gross revenue) to obtain net revenue, report adjustments as positive numbers.

Adjustments to a previous year's revenue, such as Medicare or TennCare prior adjustments, are reported as non-operating revenue, not as current year adjustments.

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Net Patient Revenue: Net patient revenue is the realizable increase in assets earned during the current reporting period from the patient services. The difference obtained by subtracting adjustments to charges from gross patient charges.

7.A.1) Self Pay (includes uninsured patients)

7.A.2) Blue Cross/Blue Shield and 7.A.4) Commercial Insurance (excludes Workers Comp). Be sure to distinguish between insurance coverage options.

7.A.5) CoverTN partners the state, private employers and individuals to offer basic health coverage for employees of Tennessee's small businesses. Be sure to report Blue Cross InReach under CoverTN and not in nongovernment Blue Cross.

7.A.6) Cover Kids offers health coverage to uninsured children in Tennessee, age 18 and under, and pregnant women.

7.A.7) Access TN provides health insurance for seriously ill adults who have been turned down by insurance companies.

7.A.9) Medicare – Total This amount should include both traditional Medicare and Medicare Managed Care revenues and adjustments.

Medicare Managed Care (included in Medicare Total) This amount should include only managed Medicare revenues and adjustments.

7.B.1. Bad Debt: "Bad debts are amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future.

(A) To constitute a "bad debt", the debt must meet the following criteria:

(i) The provider must be able to establish that reasonable collection efforts were made;

(ii) The debt was actually uncollectible when claimed as worthless; and

(iii) Sound business judgment established that there was no likelihood of recovery at any time in the future.

Accounts turned over to a collection agency should be classified as bad debt.

(B) If, after reasonable and customary attempts to collect a bill, the debt remains unpaid more than one hundred twenty (120) days from the date the first bill is mailed to the patient, then the debt may be deemed uncollectible. Bankrupt accounts shall be considered bad debts, unless there is documented evidence that the medical bill caused bankruptcy. Such accounts would then be counted as charity." TCA 68-1-109 (1) (1) (amended 5/30/07)

This number may be different from the amount shown on your financial statements as bad debt expense if you are using the allowance method to account for bad debts. The amount entered on the report should be bad debts that were actually written off during the current reporting period.

Because bad debt figures are subtracted from Gross Charges, Bad Debt is reported as a positive number. Only the portion of the patient's account for which the patient is responsible is included in bad debt. This includes unpaid copays and deductibles.

(Do not include discounts provided to uninsured patients. See NOTE below)

7.B.2. Charity Care: "Charity care" is reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. The provider should apply the following guidelines for making a determination of indigence or medical indigence:

(A) The patient's indigence must be determined by the provider, not by the patient, (i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence);

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(B) The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash and unnecessary for the patient's daily living), liabilities, and income and expenses. Indigence income means an amount not be exceed one hundred percent (100%) of the federal poverty guidelines. Medical indigence is a status reached when a person uses or commits all available current and expected resources to pay for medical bills and is not limited to a defined percent of the federal poverty guidelines. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;

(C) The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill, (e.g., title XIX, local welfare agency and guardian); and

(D) The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

(E) Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the bad debt collection criteria." TCA 68-1-109 (1) (2) (amended 5/30/07)

Because charity care figures are adjustments subtracted from Gross Charges, Charity Care-Inpatient and Charity Care-Outpatient figures are reported as positive numbers.

(Do not include discounts provided to uninsured patients. See NOTE below)

7.B.3. Contractual Adjustment: A contractual adjustment is the total amount of discount given to insurance companies, Blue Cross, and/or employers because of the volume of business and promptness of payment which the provider expects as a result of a contractual agreement.

7.B.4. Total: Total of lines 7.B.1, 2 and 3.

7.B.5 NOTE: Amount of discounts provided to uninsured patients: The total dollar amount of adjustment to charges provided to patients with no insurance coverage for any portion of the bill. Because the law mandates a discount to the uninsured, this amount can no longer be included in charity care or bad debt.

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SCHEDULE I - EMERGENCY DEPARTMENT

3. Number of Visits by Payer: Make sure all visits are indicated in the Grand Total. Be sure to distinguish between insurance coverage options. Emergency patients seen and treated should be included as well as emergency patients who are admitted.

4. Staffed Hours: Please specify the hours of operation for your Emergency Department.

5. Personnel: Provide personnel numbers for a “normal day”. On-Hospital Campus personnel are personnel who are in the hospital and available to the emergency room but are not actually assigned to the emergency department. In Emergency Department personnel are staffs who are directly assigned to the emergency department during their shifts.

7.B. Burn Center: If you have specialized emergency care for burns, please specify if you have a designation by a government agency as a Burn Center.

8. Triage: The 3 questions are related as defined below: $a = b + c$:

- a. Total number of patients who presented in your ER. If a patient leaves the ER without being seen at all do NOT count.
- b. Total number of patients treated in your ER.
- c. Total number screened and not treated in your ER but referred to physician or clinic for treatment.

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SCHEDULE J - PERSONNEL

General Instructions: The data in Schedule J should reflect the staff providing services indicated in Schedule D.

Full-Time Equivalent: Full-time equivalent employees equal the sum of full-time employees plus part-time employees specified in full-time equivalents. Please compute the part-time employees in full-time equivalent as number of hours worked by part-time employees per week divided by 40 hours per week. Please report full-time equivalent for all employees who were on the hospital payroll as of the last day of the reporting period. Exclude private-duty nurses, volunteers, and all personnel whose salaries are financed entirely by outside research grants. Personnel who work in more than one area should be included in the category of their primary responsibility and should be counted only once. Include trainees if they are on the hospital payroll. Include members of religious orders for whom dollar equivalents were reported.

Full-Time Equivalent Budgeted Vacancies: Please report the number of vacancies which are included in the facility's budget on the last day of the hospital's reporting period.

Contract Staff: Includes staff from nursing registries, pools, contract services, and temporary help agencies. Check the box only if you use contract staff for that type of employee.

1.A. Administrators and Assistant Administrators: The administrator is the top-level position in the facility, the person in charge of policy development, activity coordination, procedural development and planning for the institution. Assistant Administrators include persons who work under the supervision of the facility administrator as department administration assistants for the areas of finance, organization, personnel, purchasing, accounting, and voluntary services.

1.B. Director, Health Services Research and Assistants: The director is the hospital employee in charge of health services research function, especially in terms of the design and conduct of clinical trials, and health services and organizational studies which rely on the analysis of large data bases. Assistants include persons who work under the supervision of the Director, and who have administrative authority for the conduct of any health services research activities.

1.C. Marketing & Planning Officer(s) & Assistants: The top-level marketing and/or planning positions in the facility, if different than the Chief Executive Officer. The people in charge of marketing and/or planning, activity coordination and plan development in the institution. Also includes persons who work directly under the supervision of the top-level marketing and/or planning officer(s), and who have administrative authority for the conduct of marketing and/or planning activities.

1.D. Financial and Accounting Officer(s) & Assistants: The top-level financial and/or accounting positions in the facility, if different than the Chief Executive Officer. The people in charge of financial and/or accounting policy, activity coordination, and procedural development of the institution. Also includes persons who work directly under the supervision of the top-level financial and/or accounting officer(s), and who have administrative authority for the conduct of financial and/or accounting activities.

2. Physician and Dental Services: Include only those physicians and dentists engaged in clinical practice and on the payroll. Those who hold administrative positions should be reported under "Administration" (1.A.). Exclude physicians and dentists who are paid on a fee basis. "Hospitalists" and "Intensivists" should be included under Physicians (2A.).

3.A. Registered Nurses – Administrative: Nurses who have graduated from approved schools of nursing and who are currently registered by the state but do not have direct patient care responsibilities. Do not include any

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registered nurses more appropriately reported in other occupational categories, such as facility administrators.

3.B. Registered Nurses – Patient Care, Clinical: Nurses who have graduated from approved schools of nursing and who are currently registered by the state. They are responsible for the nature and quality of all nursing care that patients receive.

3.C. Licensed Practical or Vocational Nurses: Nurses who have graduated from an approved school of practical (vocational) nursing who work under the supervision of registered nurses and/or physicians.

3.D. Ancillary Nursing Personnel: Persons who assist the nursing staff by performing routine duties in caring for the patients under the direct supervision of a nurse, including nursing aides, orderlies, attendants, operating room technicians, and so forth.

4. Certified Nurse Midwives: A registered nurse qualified by advance training in obstetric and neonatal care and certified by the American College of Nurse Midwives who manages the perinatal care of women having normal pregnancy, labor, and childbirth.

5. Nurse Anesthetists: A registered nurse who has usually completed an accredited educational program in anesthesia, who is usually certified by the Council on Certification/Council of Recertification of Nurse Anesthetists, and who, in collaboration with appropriate health care professionals, provides pre-, intra-, and post-operative care to patients in intensive care, coronary care, and emergency situations.

6. Physicians Assistants: Persons who provide health care services customarily performed by a physician under responsible supervision of that qualified licensed physician and who have successfully completed an accredited education program for physician's assistants that is approved by the Committee of Allied Health Education and Accreditation or other recognized accrediting agencies or who have been certified, licensed, or registered by recognized agencies or commissions.

7. Nurse Practitioners: Registered nurses who have successfully completed a formal program of study designed to prepare registered nurses to provide primary health care through diagnosis, clinical judgment, and management abilities to restore, maintain, and improve the health status of patients.

8.A. Medical Record Administrators: Registered Health Information Administrators (RHIA) Medical Record Administrators: Qualified professionals in the planning and management of health medical information management systems and analysis of data generated by those systems, having graduated from approved schools of Health Information Medical Records Administration and passed the national registration examination.

8.B. Medical Record Technicians (Certified or Accredited): Registered Health Information Medical Record Technicians (RHIT) and Certified Coding Specialists (CCS, CCS, CCS-P, CPC, CPC-H) (Certified or Accredited): Persons who are knowledgeable and skilled in health information management systems medical record keeping systems, coding and classification systems, and procedures who have graduated from accredited Health Information Technology programs and/or have successfully passed the national registration or certification examinations. Count each person only once regardless of the number of credentials held by each person, completed an accredited educational program, and who have successfully passed a national accreditation examination.

8.C. Other Medical Record Technicians: Other Health Information Management Medical Record Technicians: Persons who are knowledgeable and skilled in HIM medical record keeping systems and procedures, but

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have not yet completed an accredited educational program or successfully passed a national accreditation examination.

9.A. Pharmacists, Licensed: Persons licensed within the state who are concerned with the preparation and distribution of medicinal products.

9.B. Pharmacy Technicians: Persons who assist the pharmacist with selected activities, including medication profile reviews for drug incompatibilities, typing labels and prescription packaging, handling of purchase records, and inventory control.

9.C. Clinical Pharm.D.: Persons with Clinical Pharm.D. degree and licensed within the state who are involved directly in patient care, rather than the distribution function of pharmacy practice.

10.A. Medical Technologists (Biochemistry Technologist, Blood Technologist, Microbiology Technologist): Persons who perform a wide range of complex and specialized procedures in all general areas of the clinical laboratory, making independent and correlated judgments and working in conjunction with pathologists, physicians, and qualified scientists. They may supervise and/or teach laboratory assistants, and other laboratory personnel performing specified tasks requiring special training or experience.

11.A. Dietitians: Persons who apply the principles of nutrition and management in administering institutional food service programs, planning special diets at the physician's request, and instructing individuals and groups in the application of nutrition principles to the selection of food.

11.B. Dietetic Technicians: Persons who function as service personnel in the nutritional care of patients in health care facilities, assist with the planning, implementation, and evaluation of food programs, and work with both the food service supervisor and the dietitian.

12.A. Radiographers (Radiologic Technologists): Persons who accurately demonstrate anatomical structures on a radiograph by applying knowledge of anatomy, positioning, and radiographic technique. They recognize emergency patient conditions and initiate life-saving first aid. They may maintain equipment, process film, keep patient records, and perform various office tasks. Radiographers must be graduates of at least a two-year education program.

12.B. Radiation Therapy Technologists: Persons who assist the radiologist in all aspects of radiation therapy treatment. They may expose specific areas of patient's body to prescribed doses of ionizing radiation and operate a variety of laboratory equipment, including high energy linear accelerators, radioactive isotopes, and particle generators. They must be graduates of a 12-month or 2-year program in radiation therapy.

12.C. Nuclear Medicine Technologists: Persons who work under the supervision of a physician in administering and measuring radioactive nucleotides in diagnostic and therapeutic applications. They must be graduates of a 12-month or longer educational program, in nuclear medicine technology.

12.D. Other Radiologic Personnel: Persons with the following titles: ultrasound technologists technicians, radiation monitors, health physics technicians, personnel monitors, radiation protectors, radiologic assistants, and x-ray assistants. Also included under this category are radiologic technicians, radiation therapy technicians, and nuclear medicine technicians. A technician is one who has not completed education requirements specified above for the technologist level of the respective occupational area.

13.A. Occupational Therapists: Persons who evaluate the self-care, work, leisure time, and task performance skills of well and disabled patients of all age ranges. They plan and implement programs and social and interpersonal activities designed to restore, develop, and/or maintain a patient's ability to satisfactorily

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accomplish those daily living tasks required for the patient's specific age and necessary to the patient's particular occupational role adjustment.

13.B. Occupational Therapy Assistants: Persons who work under the supervision of an occupational therapist in evaluating patients and planning and implementing programs and who are prepared to function independently when working with patients.

13.B. Occupational Therapy Assistants and Aides: Persons who assist occupational therapists in administering medically oriented occupational programs to assist in rehabilitating patients in hospitals and similar institutions.

13.C. Physical Therapists: Therapists who use physical agents, biomechanical and neurophysiological principles, and assistive devices in relieving pain, restoring maximum function, and preventing disability following disease, injury, or loss of bodily part.

13.D. Physical Therapy Assistants and Aides: Persons who assist the physical therapist by assembling equipment, carrying out specified treatment programs, and helping with complex treatment procedures. Other duties include responsibility for the personal care of patients, safety precautions, and routine clerical and maintenance work.

13.E. Recreational Therapists: Persons who plan, organize and direct medically approved recreation programs such as sports, trips, dramatics, and arts and crafts, either to help patients in recovery from illness or in coping with a temporary or permanent disability. In pediatric settings, recreational therapists may be classified as child-life workers.

14.A. Speech Pathologists: Persons who diagnose and evaluate speech and language abilities and plan, direct, and conduct rehabilitative treatment programs to restore or develop communication skills.

14.B. Audiologists: Persons who assess type and degree of hearing impairment and participate in aural rehabilitation programs that meet the needs of the individual patient.

15.A. Respiratory Therapists: Persons who specialize in the application of scientific knowledge and theory to practical, clinical problems of respiratory care. Knowledge and skills for performing these functions are usually achieved through two or more years of academic and clinical responsibility for all respiratory care modalities, including supervision of respiratory technician functions.

15.B. Respiratory Therapy Technicians: Persons who specialize in the technical details of general respiratory therapeutics. The knowledge and skills of the technician are usually acquired through formal education programs of at least one year in length. They may assume clinical responsibility for specified respiratory care modalities involving the application of well-defined therapeutics under the direct supervision of a therapist or physician.

16.A. Clinical Psychologists: Person with a doctorate (Ph.D.) in clinical psychology conferred from an accredited university and licensure as a psychologist in the State of Tennessee.

16.B. Psychiatric Social Workers: Person with a Master's degree in social work from an accredited college or university.

16.C. Psychiatric Registered Nurses: Person with a Master's degree in psychiatric nursing from an accredited college or university and licensure as a registered nurse in the State of Tennessee.

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- 16.D. Other Mental Health Professionals: Other mental health staff not previously mentioned such as Psychologist (Ed.D.), R.N.'s with a Master's degree in an area other than psychiatry or with other degrees and certified as R.N.'s, and other health technicians or workers with a Bachelor's degree or above.
- 17.D. Other Specialists in Addiction and/or Chemical Dependency: Other staff not previously mentioned such as Certified Substance Abuse Counselors (CSAC) and other substance abuse/addiction workers with a Bachelor's (B.A.) degree.
18. Medical Social Workers (Caseworkers): Persons prepared to identify and understand the social and emotional factors underlying a patient's illness and to communicate these factors to the health team. They assist patients and their families in understanding and accepting the treatment necessary to maximize medical benefits and in their adjustments to permanent and temporary effects of illness. They utilize resources, such as family and community agencies, in assisting patients to recovery.
19. Surgical Technicians: Persons who specialize in the technical details of general surgery. The knowledge and skills of the technician are usually acquired through formal education programs of at least one year in length. They perform technical work in assisting in an operating room team by using aseptic techniques in preparation for and during operations.
20. All Other Certified Professional and Technical Personnel: Persons not previously included who work in occupations requiring special education and training to allow them to function in a health setting. The knowledge and skills of the personnel are usually ensured through a certification or accreditation process. Professional IT staff should be included in this category.
21. All Other Non-Certified Professional and Technical Personnel: Persons not previously included who work in occupations requiring special education and training to allow them to function in a health setting.
22. All Other Personnel: These include accounting, data processing, secretarial, clerical, kitchen, laundry, housekeeping, and maintenance and any other types of personnel who were not specified in the previous list.

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SCHEDULE K - MEDICAL STAFF

1. Privileged Physicians: Report the total number of physicians (by type) on the medical staff with privileges except those with courtesy, honorary and provisional privileges.

Employed by your hospital: Physicians that are either direct hospital employees or employees of a hospital subsidiary corporation. Physicians that are employed for non-clinical services (administrative services, medical director services, etc.) should be excluded.

Individual Contract: An independent physician under a formal contract to provide services at your hospital including outpatient facilities, clinics and offices. Physicians that are contracted only for non-clinical services (administrative services, medical director services, etc.) should be excluded.

Group Contract: A physician that is part of a group (group practice, faculty practice plan or medical foundation) under a formal contract to provide services at your hospital including at inpatient and outpatient facilities, clinics and offices. Physicians that are contracted only for non-clinical services (administrative services, medical director services, etc.) should be excluded.

Not Employed or Under Contract: Other physicians with privileges that have no employment or contractual relationship with the hospital to provide services.

Total Privileged: The sum of the physicians reported in each category, across items 1-4 should equal the total number privileged in item 6.

Residents: Physicians who are engaged in specialized practice under supervision in your organization. (Do NOT include the total number of residents in item 5, Total Privileged.

The sum of the physicians reported in 1a-i should equal the total number of privileged physicians in the hospital.

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SCHEDULE L - PERINATAL

2.A. Number of Births: Provide total number of live births at facility during the reporting period.

2.B. Number of Births Below 2500 Grams: Of the total number of births in 2.A., provide the number of births less than 2,500 grams birth weight. Note that these births will also include those births with weights less than 1,500 grams.

2.C. Number of Births Below 1500 Grams: Of the total number of births in 2.A., provide the number of births less than 1,500 grams birth weight.

4. Neonatal Management: Provide number of babies NOT born at your hospital who were sent to your facility for high risk neonatal care.

7. Subspecialty Consultants: Mark 'yes' or 'no' for each subspecialty consultant type listed in both 'a. OBSTETRICS:' and 'b. NEONATAL:'. Note that each consultant for which 'yes' is marked, the consultant should be spending more than 2/3 full-time effort at your facility.

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SCHEDULE M – SURVEY ON NURSING PERSONNEL

Data in Schedule M should reflect numbers as of the last day of the hospital's reporting period.

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SCHEDULE N – HEALTH CARE PLANS ACCEPTED

Information should ONLY include the plans you have a contract with as of the last day of the hospital's reporting period. Also if there are more plans than this form allows, report remainder of plans on a separate sheet, but provide data entry into the electronic form for as many plans as can be accommodated on the form. Submit any separate sheets with the paper copy of your JAR submission.

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ATTACHMENT A

County	Hospital Name	State ID
Anderson	Methodist Medical Center of Oak Ridge	01202
Anderson	Ridgeview Psychiatric Hospital and Center	01452
Bedford	Heritage Medical Center	02214
Benton	Camden General Hospital, Inc.	03225
Bledsoe	Erlanger Bledsoe	04213
Blount	Blount Memorial Hospital	05202
Blount	Peninsula Hospital	05402
Bradley	Skyridge Medical Center	06223
Bradley	Skyridge Medical Center Westside	06233
Campbell	Jellico Community Hospital, Inc.	07252
Campbell	Tennova Healthcare - LaFollette Medical Center	07242
Cannon	Stones River Hospital	08214
Carroll	Baptist Memorial Hospital - Huntingdon	09245
Carroll	McKenzie Regional Hospital	09255
Carter	Sycamore Shoals Hospital	10221
Cheatham	TriStar Ashland City Medical Center	11204
Claiborne	Claiborne Medical Center	13202
Clay	Cumberland River Hospital	14204
Cocke	Tennova Healthcare - Newport Medical Center	15222
Coffee	Harton Regional Medical Center	16234
Coffee	Medical Center of Manchester	16244
Coffee	United Regional Medical Center	16214
Cumberland	Cumberland Medical Center, Inc.	18224
Davidson	Kindred Hospital - Nashville	19754
Davidson	Metropolitan Nashville General Hospital	19244
Davidson	Middle Tennessee Mental Health Institute	19404
Davidson	Saint Thomas Hospital for Speciality Surgery	19354
Davidson	Saint Thomas Midtown Hospital	19254
Davidson	Saint Thomas West Hospital	19274
Davidson	Select Specialty Hospital - Nashville	19784
Davidson	Skyline Medical Center Campus	19234
Davidson	TriStar Centennial Medical Center	19324
Davidson	TriStar Skyline Medical Center	19334

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Davidson	TriStar Southern Hills Medical Center	19214
Davidson	TriStar Summit Medical Center	19344
Davidson	Vanderbilt Stallworth Rehabilitation Hospital	19764
Davidson	Vanderbilt University Hospitals	19284
Decatur	Decatur County General Hospital	20205
DeKalb	DeKalb Community Hospital	21234
Dickson	TriStar Horizon Medical Center	22204
Dyer	Dyersburg Regional Medical Center	23215
Fentress	Jamestown Regional Medical Center	25204
Franklin	Southern Tennessee Regional Health System - Sewanee	26204
Franklin	Southern Tennessee Regional Health System- Winchester	26224
Gibson	Milan General Hospital	27205
Giles	Southern Tennessee Regional Health System Pulaski	28214
Greene	Laughlin Memorial Hospital, Inc.	30221
Greene	Takoma Regional Hospital	30231
Hamblen	Lakeway Regional Hospital	32252
Hamblen	Morristown - Hamblen Healthcare System	32242
Hamilton	Erlanger East	33233
Hamilton	Erlanger Medical Center	33203
Hamilton	Erlanger North	33213
Hamilton	HealthSouth Chattanooga Rehabilitation Hospital	33763
Hamilton	Kindred Hospital - Chattanooga	33773
Hamilton	Memorial Healthcare System, Inc.	33323
Hamilton	Memorial North Park	33223
Hamilton	Moccasin Bend Mental Health Institute	33423
Hamilton	Parkridge East Hospital	33393
Hamilton	Parkridge Medical Center, Inc.	33383
Hamilton	Parkridge Valley Adult and Seniors Services	33453
Hamilton	Parkridge Valley Child and Adolescents Hospital	33433
Hamilton	Siskin Hospital for Physical Rehabilitation	33753
Hancock	Wellmont Hancock County Hospital	34201
Hardeman	Bolivar General Hospital	35215
Hardeman	Western Mental Health Institute	35405
Hardin	Hardin Medical Center	36205
Hawkins	Wellmont Hawkins County Memorial Hospital	37221
Henderson	Henderson County Community Hospital	39215

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Henry	Henry County Medical Center	40225
Hickman	Saint Thomas Hickman Hospital	41214
Houston	Houston County Community Hospital	42204
Humphreys	Three Rivers Hospital	43204
Jefferson	Tennova Healthcare - Jefferson Memorial Hospital	45242
Johnson	Johnson County Community Hospital	46201
Knox	East Tennessee Children's Hospital	47292
Knox	Fort Sanders Regional Medical Center	47212
Knox	North Knoxville Medical Center	47352
Knox	Parkwest Medical Center	47322
Knox	Select Specialty Hospital - Knoxville	47752
Knox	Select Specialty Hospital - North Knoxville	47762
Knox	Tennova Healthcare	47242
Knox	The University of Tennessee Medical Center	47282
Knox	Turkey Creek Medical Center	47332
Lauderdale	Lauderdale Community Hospital	49206
Lawrence	Southern Tennessee Regional Health System Lawrenceburg	50234
Lincoln	Lincoln Medical Center	52214
Loudon	Fort Loudon Medical Center	53202
McMinn	Starr Regional Medical Center	54243
McMinn	Starr Regional Medical Center Etowah	54233
McNairy	McNairy Regional Hospital	55225
Macon	Macon County General Hospital	56204
Madison	Jackson - Madison County General Hospital	57245
Madison	Pathways of Tennessee	57405
Madison	Regional Hospital of Jackson	57265
Marion	Parkridge West Hospital	58233
Marshall	Marshall Medical Center	59244
Maury	Behavioral Healthcare Center at Columbia	60404
Maury	Maury Regional Hospital	60224
Monroe	Sweetwater Hospital Association	62202
Montgomery	Behavioral Healthcare Center at Clarksville	63404
Montgomery	Gateway Medical Center	63204
Obion	Baptist Memorial Hospital - Union City	66205
Overton	Livingston Regional Hospital	67214
Perry	Perry Community Hospital	68204

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Polk	Copper Basin Medical Center	70223
Putnam	Cookeville Regional Medical Center	71204
Putnam	PremierCare Tennessee, Inc.	71404
Rhea	Rhea Medical Center	72223
Roane	Roane Medical Center	73212
Robertson	NorthCrest Medical Center	74214
Rutherford	Saint Thomas Rutherford Hospital	75214
Rutherford	TriStar StoneCrest Medical Center	75234
Rutherford	Trustpoint Hospital	75254
Scott	Pioneer Community Hospital of Scott	76212
Sevier	LeConte Medical Center	78232
Shelby	Baptist Memorial Hospital	79216
Shelby	Baptist Memorial Hospital - Collierville	79326
Shelby	Baptist Memorial Hospital for Women	79506
Shelby	Baptist Memorial Rehabilitation Hospital	79826
Shelby	Baptist Memorial Restorative Care Hospital	79776
Shelby	Baptist Rehabilitation - Germantown	79766
Shelby	Community Behavioral Health	79476
Shelby	Delta Medical Center	79386
Shelby	Healthsouth Rehabilitation Hospital - North	79806
Shelby	HealthSouth Rehabilitation Hospital of Memphis	79756
Shelby	Lakeside Behavioral Health System	79456
Shelby	Lebonheur Children's Medical Center	79306
Shelby	Memphis Mental Health Institute	79446
Shelby	Methodist Extended Care Hospital, Inc.	79796
Shelby	Methodist Healthcare - Memphis Hospitals	79276
Shelby	Methodist Hospital - Germantown	79236
Shelby	Methodist Hospital - North	79296
Shelby	Methodist Hospital - South	79266
Shelby	Regional Med Extended Care Hospital	79816
Shelby	Regional One Health	79246
Shelby	Saint Francis Hospital	79396
Shelby	Saint Francis Hospital - Bartlett, Inc.	79516
Shelby	Saint Jude Children's Research Hospital	79256
Shelby	Select Specialty Hospital - Memphis	79786
Smith	Riverview Regional Medical Center North	80204

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Smith	Riverview Regional Medical Center South	80214
Sullivan	HealthSouth Rehabilitation Hospital	82751
Sullivan	Indian Path Medical Center	82251
Sullivan	Select Specialty Hospitals - Tricities, Inc.	82761
Sullivan	Wellmont Bristol Regional Medical Center	82201
Sullivan	Wellmont Holston Valley Medical Center, Inc.	82211
Sumner	Portland Medical Center	83204
Sumner	Sumner Regional Medical Center	83244
Sumner	TriStar Hendersonville Medical Center	83254
Tipton	Baptist Memorial Hospital - Tipton	84256
Trousdale	Trousdale Medical Center	85214
Unicoi	Unicoi County Memorial Hospital, Inc.	86211
Warren	River Park Hospital	89234
Washington	Franklin Woods Community Hospital	90231
Washington	James H. & Cecile Quillen Rehabilitation Hospital	90751
Washington	Johnson City Medical Center	90281
Washington	Quillen Rehabilitation Hospital	90752
Washington	Woodridge Psychiatric Hospital	90411
Wayne	Wayne Medical Center	91214
Weakley	Behavioral Healthcare Center at Martin	92405
Weakley	Healthsouth Cane Creek Rehabilitation Hospital	92795
Weakley	Volunteer Community Hospital	92225
White	Highlands Medical Center	93204
Williamson	Rolling Hills Hospital	94404
Williamson	Williamson Medical Center	94234
Wilson	McFarland Hospital	95204
Wilson	University Medical Center	95224