

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0
-----------	--------	----------------	---



TENNESSEE DEPARTMENT OF HEALTH
Health Statistics
6th Floor, Cordell Hull Building
425 5th Avenue North
Nashville, TN 37243
Telephone: (615) 741-1954 Fax: (615) 253-1688

JOINT ANNUAL REPORT OF NURSING HOMES 2011

[Schedule A – Identification](#)

[Schedule B – Organization Structure](#)

[Schedule C – Licensure, Accreditations, and Memberships](#)

[Schedule D – Facilities and Services – Part 1](#)

[Schedule D – Facilities and Services – Part 2](#)

[Schedule D – Facilities and Services – Part 3](#)

[Schedule E – Beds](#)

[Schedule F – Utilization – Part 1](#)

[Schedule F – Utilization – Part 2](#)

[Schedule G – Personnel](#)

[Schedule H – Financial Data](#)

[Administrator’s Declaration](#)

[Appendix A: Commonly Prescribed Medications by Category by Brand \(Generic\)](#)

[Appendix B: Definitions](#)

[Error Listing - Facility Comments Required](#)

[Find Your State ID](#)

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0	
Schedule A - Identification				
<p>According to the Department of Health rules and regulations section 1200-8-6-.11(4), "a yearly statistical report, the 'Joint Annual Report of Nursing Homes', shall be submitted to the Department." Report data for the year indicated above. Please read all information carefully before completing your Joint Annual Report. Please complete all applicable items on the Joint Annual Report. Check all computations. Please check all checkboxes. Any items which appear to be inconsistent will be queried. Facilities will be reported to the Board for Licensing Health Care Facilities for failure to timely file a report or respond to queries.</p>				
Facility	State ID			
	Nursing Home Name			
	Did the facility name change during the reporting period?	Yes/No	-	
	If Yes, Prior Name			
	Street Address			
	City	County		
	State	Zip Code (5 digit)		
	Phone			
	Mailing Address same as Street Address? If Yes, proceed to next section.	Yes/No	-	
	Mailing Address			
	City			
	State	Zip Code (5 digit)		
Preparer	Preparer Name	Preparer Phone		
	Preparer Title			
	Preparer Email			
Reporting Period	<p>In the event that a reporting period other than January 1 through December 31 is used for statistical information, please report data for the last day of your reporting period when information is requested for December 31. If you are reporting for less than a full year, utilization and financial data should be presented for days reported only. The reporting period for the nursing home JAR report does not need to match the reporting period for an affiliated hospital.</p>			
	Is the reporting period from January 1 through December 31?	Yes/No	-	
	If unable to report based on above dates, provide the beginning and ending dates (used for all utilization and financial data)	Beginning (mm/dd/yyyy)		
		Ending (mm/dd/yyyy)		
Administration	<p>TCA 63-16-111 (b) No nursing home in the state may operate unless it is under the supervision of an administrator who holds a currently valid nursing home administrator license and registration, or provisional license issued pursuant to this chapter.</p>			
	Name of Administrator			
	Administrator License			

Provisional Provisional Provisional

State ID:		000000		Facility Name:		0		
Schedule B - Organization Structure								
Owner	Name							
	Street							
	City		Phone					
	State		Zip Code					
The type of legal entity, except proprietorship, general partnerships and government entities, can be confirmed at the Secretary of State website: http://www.tennesseeanytime.org/soscorp/								
Type of Owner (Choose one)	For Profit	-	Proprietorship – a business owned by one person.					
		-	Partnership – an association of two or more persons to carry on as co-owners of a business or other undertaking for profit formed under 61-1-202, predecessor law, or comparable law of another jurisdiction. TCA Title 61 Chapter 1.					
		-	Limited Partnership (LP) – a partnership formed by two or more persons under the law of the state of Tennessee, and having one or more general partners and one or more limited partners. TCA Title 61 Chapter 2.					
		-	Limited Liability Partnership (LLP) – is governed by TCA § 61-1-106(C). The law of this state governs relations among the partners and between the partners and the partnership and the liability of partners for an obligation of a limited liability partnership that has filed an application as a limited liability partnership in this state.					
		-	Limited Liability Company (LLC) – established by the “The Tennessee Limited Liability Company Act” found in the TCA § 48-201-101 through § 48-248-606.					
		-	Corporation – defined by the Tennessee Business Corporation Act codified in TCA Title 48 Chapters 11-27.					
	Not for Profit	-	Non-Religious Corporation or Association – defined by the “Tennessee Nonprofit Corporation Act” codified in TCA Title 48 Chapters 51-68.					
		-	Religious Corporation or Association – either a corporation or association that is organized and operated primarily or exclusively for religious purposes. Most of the provisions of the Tennessee Nonprofit Corporation Act apply to a religious corporation. Exceptions are specified in TCA § 48-67.					
		-	Limited Liability Company (LLC) – a company that is disregarded as an entity for federal income tax purposes, and whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in TCA § 67-4-1004(15).					
	Government	-	City					
		-	County					
		-	State					
		-	Federal					
		-	Other Government, specify					

Provisional Provisional Provisional

State ID:		000000		Facility Name:		0				
Schedule B - Organization Structure										
Managed By				Management Information						
				Name						
				- Owner	Street					
				- Contract with Firm	City		Phone			
- Other	State		Zip Code							
Building Owner		Name								
		Street								
		City		Phone						
		State		Zip Code						
Building		Yes/No	-	Do you know the year of the original construction date?		Year				
		Yes/No	-	Has the building had a major renovation? A major renovation is any project that includes the addition of beds, services, or medical equipment.		Year				
		Yes/No	-	Has there been new construction that increased licensed bed count?		Year Cost				
Organization Structure		Yes/No	-	Hospital Based, specify:						
		Yes/No	-	Chain	Name					
					Street					
					City					
					State		Zip Code			
		Yes/No	-	Holding Company/ Parent Corporation	Name					
					Street					
City										
State					Zip Code					

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0		
Schedule C - Licensure, Accreditations, and Memberships					
Licensure	License Number for reporting year				
	Most recent survey date				
Accreditation	Yes/No		Joint Commission on Accreditation of Healthcare Organizations	Approval Year	
				Expiration Year	
	Yes/No	-	Other Accreditation, specify:		
Membership	Yes/No	-	National Hospice Organization		
	Yes/No	-	Tennessee Association for Home Care		
	Yes/No	-	Tennessee Association of Homes and Services for the Aging		
	Yes/No	-	Tennessee Health Care Association		
	Yes/No	-	Tennessee Hospice Organization		
	Yes/No	-	American Health Care Association		
	Yes/No	-	THA Home Care Alliance		
	Yes/No	-	Other memberships, specify		

Provisional Provisional Provisional

State ID:		000000	Facility Name:		0
Schedule D - Facilities and Services - Part 1					
Certificate of Need Projects	Yes/No	-	Do you have an approved, but not completed, Certificate of Need?		
	Date of Approval		Name of Service or Activity		Number of Beds (if applicable)
Services	Indicate 'Yes' or 'No' for the services that the facility provides or makes available. The services to be provided to these persons may include case management, personal care services, respite care services, adult day health services, homemaker/home health aide, habilitation, and other services requested by the State and approved by CMS (previously HCFA).				
	Yes/No	-	Continuing Care Retirement Community		
			Type of Continuing Care		Number of Units
			Independent Apartment Living		
			Assisted Care Living		
			Home for the Aged		
	Yes/No	-	Home Health Care Services: Usually furnished on a visiting basis in a place of residence used as the individual's home. However, outpatient services in a hospital, SNF, or rehabilitation center are covered home health services, if arranged for by a home health agency, when equipment is required that cannot be made available in the patient's home.		
			Number of former nursing home residents discharged from this facility that received home health care services from this facility.		
			Number of individuals who were not former nursing home residents from this facility who received home health care services from this facility.		
	Yes/No	-	Home Health Care Services Referrals: Residents referred to a home health care agency at the time of discharge.		
Number of former nursing home residents discharged from this facility that were referred to a home health care agency.					
Yes/No	-	Adult Day Care: Minimal medical and social supervision for the older person who has help at home during the evening, but whose family or spouse is employed during the day. Services can include general assistance with the needs of daily living, socialization and lunches. In some instances, restorative and therapeutic programs may be included.			
Yes/No	-	Outpatient/Rehabilitation Services: Services that may be obtained at the facility without the need for an overnight stay. Examples of outpatient services include physician's' services, physical, occupational, and respiratory therapies as well as speech and pathology services; testing, fitting or training in the use of prosthetic and orthotic devices; social and psychological services; nursing care; drugs and biologicals that cannot be self-administered; and other items and services that are medically necessary for the rehabilitation of the patient. Nursing homes may provide one, some or all of these services.			

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0			
Schedule D - Facilities and Services - Part 1 (Continued)						
Services (continued)	Yes/No	-	Respite Care Services: The resident's care program involves a short-term stay in the facility for the purpose of providing relief to a nursing facility-eligible resident's primary home based caregiver(s). Following this planned short stay, it is anticipated that the resident will return to his or her home in the community.			
	Yes/No	-	Case Management Services: Services that assist individuals in obtaining home and community based services. Case managers develop an individual's plan of care and monitor the provision of services to that individual.			
	Yes/No	-	Homemaker Services: Assistance with general household activities and ongoing monitoring of the well being of the individual.			
	Yes/No	-	Personal Care Services: Direct supervision and assistance in daily living skills and activities (e.g., assisting the individual in bathing and grooming).			
	Yes/No	-	Home Delivered Meals			
	Yes/No	-	Transportation Services			
	Yes/No	-	Licensed / Approved Specialized Unit for Alzheimer's Patients: Structurally distinct parts of a nursing home designated as special care units for ambulatory residents with dementia or Alzheimer's Disease and related disorders.	Number of Beds		
	Yes/No	-	Specialized Programs for Alzheimer's Patients			
	Yes/No	-	Secured Unit: A facility or distinct part of a facility where residents are intentionally denied egress by any means.	Number of Beds		
	Yes/No	-	Behavioral Health Unit: Structurally distinct parts of a nursing home designated as special care units for patients with dementia, cognitive disorders, psychiatric disorders, post-traumatic stress disorders, mania, schizophrenia, major depression, and mood disorders.	Number of Beds		
	Yes/No	-	Hospice Care: a program where the resident is identified as being in a program for terminally ill persons where services are necessary for the palliation and management of terminal illness and related conditions whether provided by the nursing home or by contracted services.			
	Yes/No	-	Are hospice services provided by a separately licensed hospice agency that also reports service utilization via a separated Joint Annual Report?			
			Specify Facility: _____			
	Yes/No	-	Training in Skills Required to Return to the Community: The resident is regularly involved in individual or group activities with a licensed skilled professional to attain goals necessary for community living (e.g., medication management, housework, shopping, using transportation, activities of daily living). May include training family or other caregivers.			

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0	
Schedule D - Facilities and Services - Part 2				
Skilled Care Procedures	Special Treatments	Yes/No	-	Chemotherapy: includes any type of anticancer drug given by any route.
		Yes/No	-	Dialysis: includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility.
		Yes/No	-	IV Medication: includes any drug or biological given by intravenous push or drip through a central or peripheral port.
		Yes/No	-	Intake / Output: the measurement and evaluation of all fluids the resident received and/or excreted for at least three consecutive shifts.
		Yes/No	-	Ostomy Care: care that requires nursing assistance. Includes both ostomies used for intake and excretion.
		Yes/No	-	Oxygen Therapy: continuous or intermittent oxygen via mask, cannula, etc. (does not include hyperbaric oxygen for wound therapy).
		Yes/No	-	Radiation: includes radiation therapy or having a radiation implant.
		Yes/No	-	Suctioning: includes nasopharyngeal or tracheal aspiration only.
		Yes/No	-	Tracheotomy Care: includes cleansing of tracheotomy and cannula.
		Yes/No	-	Transfusions: includes transfusions of blood or any blood products (e.g., platelets), which are administered directly into the bloodstream. Do not include transfusions that were administered during dialysis or chemotherapy.
		Yes/No	-	Ventilator / Respirator: a ventilator or respirator assures adequate ventilation in residents who are, or who may become, unable to support their own respiration.

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0
-----------	--------	----------------	---

Schedule D - Facilities and Services - Part 2

Skilled Care Procedures (continued)	Indicate therapies that occurred after admission/readmission to the nursing facility, were ordered by a physician, and were performed by a qualified therapist (i.e., one who meets state credentialing requirement or in some instances, under such a person's direct supervision). Includes only medically necessary therapies furnished after admission to the nursing facility. Also includes only therapies ordered by a physician, based on a therapist's assessment and treatment plan that is documented in the resident's clinical record. The therapy treatment may occur either inside or outside the facility. For groups of four or fewer residents per supervising therapist (or assistant), each resident has received the full time in the therapy session.			
	Therapies	Yes/No	-	Occupational therapy: services are provided or directly supervised by a licensed occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a licensed occupational therapist.
		Yes/No	-	Physical therapy: services are provided or directly supervised by a licensed physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified physical therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a licensed physical therapist.
		Yes/No	-	Respiratory therapy: services are provided by a qualified professional (respiratory therapist, trained nurse). A trained nurse refers to a nurse who received specific training on the administration of respiratory treatments and procedures. Therapies may have been provided at the facility during a previous work experience or as part of an academic program. Nurses do not necessarily learn these procedures as part of their formal nurse training programs. Included treatments are coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds, and mechanical ventilation, etc., which must be provided by a qualified professional (i.e., trained nurse, respiratory therapist). It does not include hand held medication dispensers. Count only the time that the qualified professional spends with the resident.
		Yes/No	-	Psychological therapy: provided only by any licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker. Psychiatric nurses usually have a Masters degree and/or certification from the American Nurses Association. Psychiatric technicians are not considered to be licensed mental health professionals and their services may not be counted in this item. If the state does not license a certain category of professionals working in your facility, you may not count the services of those unlicensed therapists in this item.
	Yes/No	-	Speech therapies: language pathology and audiology services that are provided by a licensed speech-language pathologist.	

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0		
Schedule D - Facilities and Services - Part 2					
Skilled Care Procedures (continued)	Enterostomy Care	Yes/No	-	Colostomy Irrigation: care for a colostomy, the surgical creation of an opening between the colon and the surface of the body; also used to refer to the opening, or stoma, so created.	
		Yes/No	-	Ileostomy: care for an ileostomy, the surgical creation of an opening into the ileum, usually by establishing an ileal stoma on the abdominal wall.	
Levels of Resident Care	Activities of Daily Living (ADL)	Number of residents on the last day of the reporting period who received assistance with these activities of daily living. Residents will be duplicated and should be counted in every category that applies.			
		Bathing		Toileting	
		Dressing		Eating	
		Transferring			
		Number of residents on the last day of the reporting period			
		No ADL's		One ADL's	
		Two ADL's		Three ADL's	
		Four ADL's		Five or more ADL's	
	Medication	Number of residents on the last day of reporting period that received medication(s). Include any of these medications given to the resident by any route in any setting (e.g., at the nursing facility, in a hospital emergency room). A list of commonly prescribed medications by category by brand is in Appendix A.			
		Antianxiety		Antidepressants	
		Antipsychotics		Hypnotics	
		Diuretic		Nine or More Medications	
	Immunization Activity	Number of residents given influenza vaccine by this facility or any other source during the calendar year:			
		Number given by this facility		Number given by any other source	
		Number of staff given influenza vaccine during the calendar year:			
		Number given by this facility		Number given by any other source	
		Number of new admissions without documentation of ever having pneumococcal vaccine:			
		Number of new admissions given pneumococcal vaccine during the calendar year:			
		Number given by this facility		Number given by any other source	
	Mobility	Number of residents as of the last day of the reporting period whose mobility can be described as:		Bedfast	
Chair bound					
Ambulatory					

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0
Schedule D - Facilities & Services - Part 3			
HCBS Waiver Program	Elderly and Disabled Home and Community Based Services (HCBS) Statewide Medicaid Waiver Program		
	Yes/No	-	Did the facility participate in the Home and Community Based Services (HCBS) Medicaid Waiver Program during the reporting period?
	If yes, which services were provided to patients during the reporting period as part of the HCBS waiver:		
	Yes/No	-	Adult Day Care: A place where a patient can go for more than 3 hours but less than 24 hours during the day to spend time with others
	Yes/No	-	Case Management: A Case Manager to visit a patient at least once a month to be sure the patient gets needed care.
	Yes/No	-	Homemaker: Someone to help a patient with household chores or errands like laundry, sweeping or grocery shopping
	Yes/No	-	Personal Care Services: Someone to help a patient with activities of daily living like bathing, toileting or transfers
	Yes/No	-	Home Delivered Meals: Up to one healthy meal per day delivered to a patient's home
	Yes/No	-	Personal Emergency Response System (PERS): A call button so a patient can call for help in an emergency when the patient's caregiver is not around
	Yes/No	-	Inpatient Respite: Short stay in a nursing home or assisted care living facility so a patient's caregiver can get some rest
	Yes/No	-	In-home Respite: Someone to come and stay with a patient in the patient's home for a short time so the patient's caregiver can get some rest
	Yes/No	-	Assistive Technology: Certain devices that help a patient with activities of daily living like grabbers or big handled eating utensils
	Yes/No	-	Personal Care Assistance/Attendant: Someone to help a patient with activities of daily living for longer periods of time or go with a patient to doctor visits or other appointments
	Yes/No	-	Pest Control: Someone to come to a patient's home a few times a year to spray for bugs or get rid of mice and rats
	Yes/No	-	Assisted Care Living Facility: A place where a patient can live that will help the patient with personal care needs, homemaker services, and being sure the patient takes needed medicines—Medicaid can not pay for room and board
Yes/No	-	Minor Home Modifications: Certain devices or changes to a patient home to make it easier and safer for the patient to be in the patient's home like ramps or grab-bars	

Provisional Provisional Provisional

State ID:		000000		Facility Name:		0			
Schedule E - Beds									
Beds	Licensed Beds	Type					Number of Beds on the last day of the reporting period		
		Yes/No	-	Medicare Certified Only					
		Yes/No	-	Medicaid/TennCare Certified Only					
		Yes/No	-	Medicare and Medicaid/TennCare Certified					
		Yes/No	-	Non-Certified (licensed only) Beds					
		(System Calculation)					Total Licensed Beds		0
		Yes/No	-	Were there changes in the number of licensed beds between the first and last day of the reporting period? If yes, complete the 'Opened' and/or 'Discontinued' and 'Date' fields below.					
		Licensed Beds Opened and Discontinued		Enter as many rows as needed to explain changes to licensed bed count.					
				Licensed Beds Opened		Licensed Beds Discontinued		Date	
		<p>Levels of care (Level I and Level II): The intensity of care provided to nursing home patients depends on their medical needs. Most patients need a less intensive level of care that the Medicaid program calls Level I (formerly called intermediate care), while others need a more intensive level of care Level II or skilled nursing care. The cost of Level II is higher than that of Level I, both to private pay patients and to the Medicaid program. The Medicare program does not cover Level I care and covers skilled care only in certain circumstances and in certified facilities.</p>							
		Medicare Provider Number							
		Medicaid/TennCare Provider Number Level II							
Medicaid/TennCare Provider Number Level I									
Yes/No	-	Did you enter the Medicaid/TennCare program during this reporting period?							
If Yes, Medicaid/TennCare approval date									
Yes/No	-	Did you withdraw from the Medicaid/TennCare program during this reporting period?							
If Yes, Medicaid/TennCare withdrawal date									

Provisional Provisional Provisional

State ID:		000000		Facility Name:		0	
Schedule E - Beds (Continued)							
Beds	Beds Set Up and Staffed	Type					Number of Beds on the last day of the reporting period
		Yes/No	-	Number of Beds in Private Rooms. A private room contains one bed.			
		Yes/No	-	Number of Beds in Semi-Private Rooms. A semi-private room contains two beds.			
		Yes/No	-	Number of Beds in Wards. A ward is a room that contains three or more beds.			
		(System Calculation) Total Beds Set up and Staffed					0
		Yes/No	-	Were there changes in the number of beds set up and staffed between the first and last day of the reporting period? If yes, Enter as many rows as needed to explain changes.			
		Staffed Beds Opened and Discontinued		Staffed Beds Opened	Staffed Beds Discontinued	Date	

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0
------------------	---------------	-----------------------	----------

Schedule F - Utilization - Part 1

Admissions are the number of all residents admitted to the facility during the reporting period. Discharges include all residents discharged from the facility during the reporting period, including those who died during their stay. Transferring a resident from one level of care to another level of care within the facility is counted as a discharge and admission. Discharge resident days are the total number of resident days of care rendered to residents who were discharged or died during the reporting period. (e.g. admitted 1/11 and discharged in the same year, on 6/30 = 171 days, the number of days that resident had been at the facility at the time of discharge; another resident admitted one year earlier on 1/11 and discharged on 6/30 the next year would be counted as 536 days). Do not include the day of discharge in the calculation unless the resident was discharged the same day as admitted. To make the calculations of the number of days a resident has stayed, you may wish to use the website, <http://www.timeanddate.com/date/duration.html>

Level of Care in the Facility	Level (See definition in Licensed Beds section above.)	Admissions	Discharges (including deaths)	Deaths	Discharge Resident Days (including deaths)	(System Calculation) Average Length of Stay
	Level II/Skilled Care					0
	Level I/Intermediate Care					0
	(System Calculation) Total:	0	0	0	0	0

Source of Admissions	Number of admissions from sources	
	Home (private residence): Any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities, and independent housing for the elderly.	
	Private Home with Home Health Services: Includes skilled nursing, therapy (e.g., physical, occupational, speech), nutritional, medical, psychiatric and home health aide services delivered in the home. Does not include the following services unless provided in conjunction with the services previously named: homemaker/personal care services, home delivered meals, telephone reassurance, transportation, respite services or adult day care.	
	Home and Community Based Services (HCBS) Waiver Program: statewide Medicaid program, available through application.	
	Home for the Aged	
	Assisted Care Living Facility: A non-institutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.	
	Other Nursing Home: An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for injured, disabled or sick persons.	

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0	
Schedule F - Utilization - Part 1				
Source of Admissions (Continued)	Hospital: Includes acute care hospitals, psychiatric hospitals, MR/DD facilities, and rehabilitation hospitals. An acute care hospital is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled or sick persons. A psychiatric hospital is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients. An MR/DD facility is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are mentally retarded or who have developmental disabilities. An Inpatient Rehabilitations Hospital (IRF) is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons.			
	Transfers Within Facility	To Medicaid/TennCare Level I from Medicaid/TennCare Level II		
		To Medicaid/TennCare Level I from Medicare SNF		
		To Medicaid/TennCare Level II from TennCare Level I		
		To Medicaid/TennCare Level II from Medicare SNF		
		To Medicare SNF from Medicaid/TennCare Level I		
		To Medicare SNF from Medicaid/TennCare Level II		
	Other (please specify)			
(System Calculation)			Source of Admissions Total 0	
Discharge Destination (Do not include deaths)	Home (private residence)			
	Private Home with Home Health Services from Other Source			
	Private Home with Home Health Services from this Facility			
	Home and Community Based Services (HCBS) Waiver Program			
	Home for the Aged			
	Assisted Care Living Facility			
	Other Nursing Home			
	Hospital (bed held for return)			
	Hospital (did not return)			
	Residential Hospice			
	Transfers Within Facility	To Medicaid/TennCare Level I from Medicaid/TennCare Level II		
		To Medicaid/TennCare Level I from Medicare SNF		
		To Medicaid/TennCare Level II from TennCare Level I		
		To Medicaid/TennCare Level II from Medicare SNF		
		To Medicare SNF from Medicaid/TennCare Level I		
To Medicare SNF from Medicaid/TennCare Level II				
Other (please specify)				
(System Calculation)			Discharge Destination Total (not including deaths) 0	

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0
------------------	---------------	-----------------------	----------

Schedule F - Utilization - Part 2

Do not enter zero. Blank fields will represent zero residents.

Resident Days of Care	A resident day of care, also commonly referred to as an inpatient day, patient day, census day, or 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 resident was admitted the same day. Report resident days of care for the reporting period and according to the primary payment source. Include Medicare/TennCare dually entitled residents in Medicare SNF. (Rule 1240-3-1-.02) July, 1997 (Revised) 2 (f) Level I care is health care in a nursing facility, which is more than room and board, but is less than skilled nursing care (Level I care was formerly called I.C.F. - Intermediate Care Facility). (m) Level II care is health care in a nursing facility which is a higher level of care than Level I, but less than inpatient hospitalization. (Level II care was formerly called Skilled Nursing Care.)								
	Payer Source	Level I Care/ Intermediate Care		Level II Care/ Skilled Nursing Care		(System Calculation) Total			
	Medicare Advantage					0			
	All Other Medicare					0			
	TennCare MCO					0			
	All Other Medicaid/ TennCare					0			
	VA Contract					0			
	Other Government					0			
	Access TN					0			
	Private (Self Pay)					0			
	Long-Term Care Insurance					0			
	Other non-government					0			
	(System Calculation) Total	0		0		0			
Age, Race and Gender on the last day of the reporting period	Number of residents served during the reporting period by age, race, and gender								
	Age	White		Black		Other		(System Calculation) Total	
		Male	Female	Male	Female	Male	Female	Male	Female
	Under 21						0	0	
	21-59						0	0	
	60-64						0	0	
	65-69						0	0	
	70-74						0	0	
	75-79						0	0	
	80-84						0	0	
	85-89						0	0	
	90-94						0	0	
	95-99						0	0	
	100 & Over						0	0	
	(System Calculation) Total	0	0	0	0	0	0	0	
(System Calculation)	Total Male and Female							0	

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0
Schedule F - Utilization - Part 2			
Do not enter zero. Blank fields will represent zero residents.			
Number of residents on the last day of reporting period with a diagnosis of mental illness			
Number of residents on the last day of reporting period with a diagnosis of mental retardation			
Length of Stay	Enter the number of residents whose length of stay correspond to the following categories and were not discharged as of the last day of reporting period.		Number of Residents
	Less Than 100 Days		
	100 Days to 180 Days		
	181 Days to 364 Days		
	1 Year to Less Than 2 Years		
	2 Years to Less Than 3 Years		
	3 Years to Less Than 4 Years		
	4 or More Years		
	(System Calculation)		Total

Provisional Provisional Provisional

State ID:		000000		Facility Name:		0		
Schedule F - Utilization - Part 2								
Do not enter zero. Blank fields will represent zero residents.								
Please enter the number of residents from each county who received services on the last day of reporting period								
Patient Origin Tennessee Counties	County	Number of Residents	County	Number of Residents	County	Number of Residents		
	01 Anderson		33 Hamilton		65 Morgan			
	02 Bedford		34 Hancock		66 Obion			
	03 Benton		35 Hardeman		67 Overton			
	04 Bledsoe		36 Hardin		68 Perry			
	05 Blount		37 Hawkins		69 Pickett			
	06 Bradley		38 Haywood		70 Polk			
	07 Campbell		39 Henderson		71 Putnam			
	08 Cannon		40 Henry		72 Rhea			
	09 Carroll		41 Hickman		73 Roane			
	10 Carter		42 Houston		74 Robertson			
	11 Cheatham		43 Humphreys		75 Rutherford			
	12 Chester		44 Jackson		76 Scott			
	13 Claiborne		45 Jefferson		77 Sequatchie			
	14 Clay		46 Johnson		78 Sevier			
	15 Cocke		47 Knox		79 Shelby			
	16 Coffee		48 Lake		80 Smith			
	17 Crockett		49 Lauderdale		81 Stewart			
	18 Cumberland		50 Lawrence		82 Sullivan			
	19 Davidson		51 Lewis		83 Sumner			
	20 Decatur		52 Lincoln		84 Tipton			
	21 DeKalb		53 Loudon		85 Trousdale			
	22 Dickson		54 McMinn		86 Unicoi			
	23 Dyer		55 McNairy		87 Union			
	24 Fayette		56 Macon		88 Van Buren			
	25 Fentress		57 Madison		89 Warren			
	26 Franklin		58 Marion		90 Washington			
	27 Gibson		59 Marshall		91 Wayne			
	28 Giles		60 Maury		92 Weakley			
	29 Grainger		61 Meigs		93 White			
	30 Greene		62 Monroe		94 Williamson			
	31 Grundy		63 Montgomery		95 Wilson			
	32 Hamblen		64 Moore		96 Unknown			
(System Calculation)						Total Tennessee Residents	0	
Patient Origin Out of State	01 Alabama		18 Kentucky		34 North Carolina			
	04 Arkansas		25 Mississippi		47 Virginia			
	11 Georgia		26 Missouri		55 Other States/ Countries			
	(System Calculation)						Total Non-Tennessee Residents	0
	(System Calculation)						Total Residents	0

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0		
Schedule G - Personnel					
<p>Please indicate the number of personnel as of September 30. Do not include a type of employee for which you do not provide that type of service. For example, do not include Physical Therapists unless you provide Physical Therapy services. If you have additional types of employees that are not listed in the following table, please include them in either the 'Other Health' or 'Other Non-Health' categories as applicable. For example, you may list Non-Certified Nurse Aides in the 'Other Health' category. Leave the item blank if the value is unknown or not applicable. Full-Time - employees whose regularly scheduled work week is 40 hours or more. Full Time Equivalent (FTE) = Number of Hours worked by part-time employees per week /40 hours per week. For example, three Registered nurses, each working 20 hours a week, the FTE would be (3 x 20) / 40 = 1.5.</p>					
Do not enter zero. Blank fields will represent zero employees.					
Type of Employee by Service	Type of Employee	Employee		Employee Pool/ Consultant/Contract	
		Full-Time	Part-Time In FTE	Full-Time	Part-Time In FTE
	Administrator				
	Assistant Administrator				
	Physicians (M.D. or D.O.)				
	Registered Nurses				
	Licensed Practical Nurses				
	Certified Nurses Aides				
	Licensed Pharmacists				
	Dietary Managers				
	Registered Dieticians				
	Dietetic Technicians				
	Medical Social Workers				
	Social Workers				
	Registered Respiratory Therapists				
	Licensed Physical Therapists				
	Physical Therapists Assistants and Aides				
	Registered Occupational Therapists				
	Other Occupational Therapists Assistants				
	Recreational Therapists				
	Activity Coordinators				
	Medical Records Technicians				
	Maintenance				
	Housekeeping				
Other Health					
Other Non-Health					
	Total	0	0.00	0	0.00

Provisional Provisional Provisional

State ID:		000000		Facility Name:		0			
Schedule G - Personnel									
	Nurse Type	Highest Education Level	Number Currently Employed	Number of Budgeted Vacancies	Average # Weeks Required to Recruit Staff	Number Added in the Past 12 Months	Number Eliminated in the Past 12 Months		
							Clinical	Admin.	
Nurses	Registered	Associate							
		Diploma							
		Bachelors							
		Masters							
		Doctorate							
		(System Calc) Total	0	0		0	0	0	
	Advanced Practice	Nurse Practitioner							
		Clinical Nurse							
		Certified Registered Nurse Anesthetist							
		(System Calc) Total	0	0		0	0	0	
Licensed Practical Nurses									
Certified Nurse Aides									
Other Nurses (specify)									
Yes/No		No	Does your organization use contract nursing personnel? If yes, indicate the number of contract personnel in the following categories.						
Contract Nursing Personnel	Type		Number Currently Contracted	Number of Budgeted Vacancies	Average # Weeks Required to Recruit Staff	Number Added in the Past 12 Months	Number Eliminated in the Past 12 Months		
	Registered Nurses								
	Licensed Practical Nurses								
	Certified Nurse Aides								

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0
------------------	---------------	-----------------------	----------

Schedule G - Personnel

Please indicate the number of nursing personnel on duty, on the premises and routinely serving the patients on September 30 for each shift. DO NOT include personnel who are on call. Use the section for the three-shift pattern or for the two shift pattern depending on your facility, or both if your facility uses a mix of 8 and 12 hour shifts.

Nursing Three Shifts per Day Patterns	Three Shifts	Shift # 1 (day)	Shift # 2 (evening)	Shift # 3 (night)	(System Calculation) Total
	Registered Nurses				0
	Licensed Practical Nurses				0
	Aides				0
	(System Calculation) Total	0	0	0	0
Nursing Two Shifts per Day Patterns	Two Shifts	Shift # 1 (day)	Shift # 2 (evening)		(System Calculation) Total
	Registered Nurses				0
	Licensed Practical Nurses				0
	Aides				0
	(System Calculation) Total	0	0		0

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0
-----------	--------	----------------	---

Schedule H - Financial Data

Round to the nearest dollar. Use the same reporting period as used for the other sections of the Joint Annual Report. If you are reporting for less than a full year, financial data should be presented for days reported only.

Reporting Period	Yes/No	-	Is the financial data reporting period different from the Joint Annual Report statistical data reporting period entered on Schedule A?
	If yes, the different reporting period is (Enter dates even if less than 12 months.)		Beginning date of Financial reporting period.
			Ending date of Financial reporting period.

Revenues

Generally Accepted Accounting Principles require that accounting records be on the accrual basis. Under the accrual basis, revenues are recognized when realizable and earned. The assumption is that Adjustments to Revenue have a normal debit balance. The receipt of cash is not required for the recognition of revenues. Revenues and adjustments should be included for the reporting period only. Gross Patient Revenue is the full established rate charged to patients for services rendered during the accounting period. Adjustments to Revenue are classified as 1) contractual adjustments when the nursing home agrees through a contractual arrangement to accept less than 100% of the amount charged for patient services, 2) Bad Debt (see definition to follow), and 3) as Charity Care (see definition to follow). Do not include losses in adjustments. Revenues and adjustments that are not appropriately reported in any of the specific categories should be reported in the "other" category.

Adjustments to revenue that decrease revenue should be entered as a positive number.

Patient Revenue	Source		Gross Patient Charges	minus	Adjustments to Revenue	equals	(System Calculation) Net Patient Revenue
	Government	Medicare Advantage			-		=
All Other Medicare			-		=	\$0	
TennCare MCO			-		=	\$0	
All other Medicaid/ TennCare			-		=	\$0	
VA Contract			-		=	\$0	
Other Government			-		=	\$0	
(System Calculation) Total Government		\$0	-	\$0	=	\$0	
Cover Tennessee	Access Tennessee			-		=	\$0
	(System Calculation) Total Cover Tennessee		\$0	-	\$0	=	\$0
Non-government	Private (Self-Pay)			-		=	\$0
	Long Term Care Insurance			-		=	\$0
	Other Non-government			-		=	\$0
	(System Calculation) Total Non-government		\$0	-	\$0	=	\$0

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0			
Patient Revenue (Continued)	(System Calculation) Total Patient Revenue: Total Government + Cover Tennessee + Total Non-government	\$0	-	\$0	=	\$0
Non-Patient Revenue	All Other Revenue					
Total Revenue	(System Calculation)	Grand Total Revenue: Total Patient Revenue + Non Patient Revenue				\$0
Adjustment to Charges	Bad Debts - (See Appendix B: Definitions)					
	Charity Care – (See Appendix B: Definitions)					
	Other – Any other adjustments that are not appropriately reported in either Bad Debt or Charity					
	(System Calculation)	Total Adjustments				\$0
Expenses (exclude depreciation)	Expenses are recognized when assets are used in the production of revenue. The disbursement of cash is not required for the recognition of expenses.					Amount
	Payroll (for full-time and part-time personnel included in Schedule G)					
	Benefits (social security, group insurance, retirement benefits, etc.)					
	Other Operating (contract staff, professional fees, energy expense, etc.)					
	Non-Operating (interest, taxes, real estate lease expenses, etc.)					
	(System Calculation)	Total Expenses				\$0

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0				
Capital Assets	Report capital assets recorded on the balance sheet at the end of the reporting period. Capital assets are property, buildings and equipment. Indicate if you lease or own your facility and equipment. Record the estimated fair market and net book value.						
	Category	Cost	Depreciation		(System Calculation) Net Book Value (cost minus accumulated)	Fair Market Value	
			Annual	Accumulated			
	Building						
	Own or Lease	-				\$0	
	Equipment						
	Own or Lease	-				\$0	
	Other, Specify						
					\$0		
(System Calculation) Total Capital Assets		\$0	\$0	\$0	\$0	\$0	
Daily Charge	Please indicate your daily charge for each category. The daily charge should be based on charges for all services not just the room and board charge. Levels of care (Level I and Level II): The intensity of care provided to nursing home patients depends on their medical needs. Most patients need a less intensive level of care that the Medicaid program calls Level I (formerly called intermediate care), while others need a more intensive level called Level II or skilled nursing care. The cost of Level II care is higher than that of Level I, both to private pay patients and to the Medicaid program. The Medicare program does not cover Level I care and covers skilled care only in certain circumstances and in certified facilities.						
	Type					Daily Charge on the last day of reporting period	
	Federal and State	Yes/No	-	Medicare/Skilled Care (Average Daily Charge)			
		Yes/No	-	Medicaid/TennCare Level II			
		Yes/No	-	Medicaid/TennCare Level I			
	Private Pay	Yes/No	-	Private Level II (one resident per room)			
		Yes/No	-	Private Level I (one resident per room)			
		Yes/No	-	Semi Private Level II (two residents per room)			
		Yes/No	-	Semi Private Level I (two residents per room)			
		Yes/No	-	Ward Level II (more than two residents per room)			
Yes/No	-	Ward Level I (more than two residents per room)					

Provisional Provisional Provisional

State ID:	000000	Facility Name:	0
Administrator's Declaration			
Administrator's Declaration	-	I, the administrator, declare that I have examined this report and to the best of my knowledge and belief, it is true, correct, and complete.	
Date (mm/dd/yyyy) (use slashes)			