



State ID _____

TENNESSEE DEPARTMENT OF HEALTH
 Division of Health Statistics
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**JOINT ANNUAL REPORT OF OUTPATIENT DIAGNOSTIC CENTERS
 2011**

- Schedule A – Identification
- Schedule B – Organization Structure
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- Schedule D – Availability and Utilization of Services/Equipment
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Schedule A – Identification			
According to the Department of Health Rules and Regulations Section 1200-8-35-.11 “the Joint Annual Report of Outpatient Diagnostic Centers shall be filed with the department.” Please read all information carefully before completing your Joint Annual Report with data for the calendar year indicated above. Please complete all items, using 0 (zero) when appropriate and checking all appropriate check boxes including all Yes/No choices. (Leave the item blank only if the value is not able to be determined). Check all computations, especially where a total is required. Any items, which appear to be inconsistent, will be queried. (Some items that will be checked are indicated by asterisks). Facilities will be reported to the Board for Licensing Health Care Facilities for failure to timely file a report or respond to queries.			
Facility	State ID (as assigned by Health Statistics)		
	Facility Name		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		Did the facility’s name change during the reporting period?
	If Yes, Prior Name		
	Street		
	City		County
	State		Zip Code
	Telephone		()
Preparer	Name		
	Title		
	Telephone		()
	Email Address		
Administration	Name of Administrator		
	Name of Medical Director		
Reporting Period	The reporting period is January 1 through December 31.		
	If reporting less than a full year of data, the different reporting period is:	Beginning (mm/dd/yyyy)	
		Ending (mm/dd/yyyy)	
Schedule B – Organization Structure			
Owner	Name		
	Street		
	City		Telephone ()
	State		Zip Code

Type of Legal Entity	The type of legal entity, except proprietorship, general partnerships and government entities, can be confirmed at the Secretary of State web site: http://www.tennesseeanytime.org/soscorp/						
	<input type="checkbox"/>	For-Profit	<input type="checkbox"/>	Proprietorship – a business owned by one person.			
			<input type="checkbox"/>	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.			
			<input type="checkbox"/>	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.			
			<input type="checkbox"/>	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.			
			<input type="checkbox"/>	Limited Liability Company (LLC) – established by the “The Tennessee Limited Liability Company Act” found in the TCA § 48-201-101 through § 48-248-606.			
			<input type="checkbox"/>	Corporation – defined by the Tennessee Business Corporation Act codified in TCA Title 48 Chapters 11-27.			
	<input type="checkbox"/>	Not-For-Profit	<input type="checkbox"/>	Non-Religious Corporation or Association – defined by the “Tennessee Nonprofit Corporation Act” codified in TCA Title 48 Chapters 51-68.			
			<input type="checkbox"/>	Religious Corporation or Association – either a corporation or association that is organized and operated primarily or exclusively for religious purposes. Most of the provisions of the Tennessee Nonprofit Corporation Act apply to a religious corporation. Exceptions are specified in TCA § 48-67.			
			<input type="checkbox"/>	Limited Liability Company (LLC) – a company that is disregarded as an entity for federal income tax purposes, and whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in TCA § 67-4-1004(15).			
	<input type="checkbox"/>	Government	<input type="checkbox"/>	City			
			<input type="checkbox"/>	County			
<input type="checkbox"/>			State				
<input type="checkbox"/>			Federal				
<input type="checkbox"/>			Other Government, specify				
Managed by (choose one)	Management is provided by:		If managed by contract or other, provide information below:				
	<input type="checkbox"/>	Owner	Name				
	<input type="checkbox"/>	Contract with Firm	Street				
	<input type="checkbox"/>	Other, specify below	City	Telephone	()		
		State	Zip Code				
Building Owner	Name						
	Street						
	City	Telephone	()				
	State	Zip Code					
Building	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you know the year of the original construction date? If Yes:		Year			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the building had a major renovation? A major renovation is any project that includes the addition of services or medical equipment. If Yes:		Year			
Please check one of the four types to describe your facility and include the information requested for that type.							
Type of Facility	<input type="checkbox"/>	Free-Standing					
	<input type="checkbox"/>	Hospital-Based	Name				
			Street				
			City				
			State	Zip Code			

Type of Facility (continued)	<input type="checkbox"/>	Doctor's office	Name			
			Street			
			City			
			State		Zip Code	
	<input type="checkbox"/>	Other, specify	Name			
			Street			
			City			
			State		Zip Code	

Type of Service	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multi-Specialty	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Limited-Purpose	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer Treatment and Radiation Clinic	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other, specify	

Schedule C – Licensure, Certifications and Accreditation

Check "Yes" or "No" for each. If "Yes," provide information requested.

Certifications	<input type="checkbox"/> Yes <input type="checkbox"/> No	Participation in TennCare	Provider Number:	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Participation in Medicare	Medicare Number:	

Accreditation and Audits	Type of accreditation or audit	Year Accreditation/Audit	
		Was most recently updated	Will expire
<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Commission on Accreditation of Healthcare Organizations (JCAHO)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Clinical Laboratory Improvement Amendments (CLIA)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Laboratory Proficiency Testing		
<input type="checkbox"/> Yes <input type="checkbox"/> No	American Association of Blood Banks (AABB)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	American Osteopathic Association (AOA)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	College of American Pathologists (CAP)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	American College of Radiology (ACR)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other #1, specify		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other #2, specify		

Schedule D – Availability and Utilization of Services/Equipment

Check "Yes" or "No" for each. If "Yes" provide information requested and indicate the number of patients and diagnostic procedures for those services during the reporting period. Number of patients may include duplicates because the same patient may receive several of the services listed. Mobile units are units regularly transported to your facility that are not installed for daily use.

Service/Equipment Provided		Number of Patients	Number of Diagnostic Procedures
Cardiopulmonary	<input type="checkbox"/> Yes <input type="checkbox"/> No	Electroencephalogram (EEG)	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Electrocardiogram (EKG)	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Holter Monitoring	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Exercise Tolerance Testing	

Service/Equipment Provided			Number of Patients	Number of Diagnostic Procedures
Cardiopulmonary (continued)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac Catheterization		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Percutaneous Transluminal Coronary Angioplasty		
Radiology	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiography (Diagnostic and Special Procedures- e.g. Angiography)		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ultrasound (General/Vascular/Cardiac)		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nuclear Medicine		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Positron Emission Tomography (PET scan)	# of fixed units	
			# of mobile units	
			# of days per week for mobile	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Computed Tomography (CT scan)	# of fixed units	
			# of mobile units	
			# of days per week for mobile	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ultrafast CT	# of fixed units	
			# of mobile units	
			# of days per week for mobile	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Magnetic Resonance Imaging (MRI)	# of fixed units	
			# of mobile units	
			# of days per week for mobile	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hi Field MRI and Open MRI	# of fixed units	
			# of mobile units	
# of days per week for mobile				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Megavoltage Radiation Therapy	# of fixed units		
		# of mobile units		
		# of days per week for mobile		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Therapeutic Radiology			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Stereotactic Procedure (including breast biopsy)			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Mammography			
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vascular Embolization		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anesthesia		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ultrasound (ACR Accredited Breast/Pelvic/OB)		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lithotripsy	# of fixed units	
			# of mobile units	
			# of days per week for mobile	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bone Densitometry	# of fixed units	
# of mobile units				
# of days per week for mobile				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other, specify _____			
Total number of patients and diagnostic procedures during this reporting period:				
Total Unduplicated Patients: The number of actual individuals served during the reporting period. This may be less than the number of patients and diagnostic procedures reported. * Total should match total patients by age/gender/race in Schedule E.				*
Rooms	Number of diagnostic procedure rooms			

Schedule E – Patient Characteristics							
Number of Patients Served By Age, Gender and Race	Age	Gender		Total Patients Served	Race		
		Male	Female		White	Black	Other
	17 and Under						
	18 – 64						
	65 – 84						
	85 and Older						
Total Patients				*			
* Total Patients Served should match Total Unduplicated Patients in Schedule D.							
Number of Patients Served by Patient Origin	Please record the number of Tennessee and Non-Tennessee patients who received services during the reporting period.						
Tennessee patients	County	Number of Patients	County	Number of Patients	County	Number of Patients	
	1 Anderson		33 Hamilton		65 Morgan		
	2 Bedford		34 Hancock		66 Obion		
	3 Benton		35 Hardeman		67 Overton		
	4 Bledsoe		36 Hardin		68 Perry		
	5 Blount		37 Hawkins		69 Pickett		
	6 Bradley		38 Haywood		70 Polk		
	7 Campbell		39 Henderson		71 Putnam		
	8 Cannon		40 Henry		72 Rhea		
	9 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 Cocks		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		
	Total Tennessee Patients						

Number of Patients Served by Patient Origin (continued)	Out-of- state patients	State	Number of Patients	State	Number of Patients
		<input type="checkbox"/> 01 Alabama		<input type="checkbox"/> 25 Mississippi	
		<input type="checkbox"/> 04 Arkansas		<input type="checkbox"/> 26 Missouri	
		<input type="checkbox"/> 11 Georgia		<input type="checkbox"/> 34 North Carolina	
		<input type="checkbox"/> 18 Kentucky		<input type="checkbox"/> 47 Virginia	
				<input type="checkbox"/> 55 Other State or Country	
Total Non-Tennessee Patients					
Total of Tennessee and Non-Tennessee Patients. *Total should match Total Patients by age/gender/race in Schedule E and Total Unduplicated Patients in Schedule D.					*

Schedule F – Financial Data

Round all figures to the nearest dollar.					Amount		
Expenses	Payroll – Include salaries for all full-time and part-time personnel who are included in Schedule G.						
	Fringe Benefits – Social security, group insurance, retirement benefit, etc.						
	Other Operating Expenses – Expenses for all contract staff, professional fees, energy expense (oil, natural gas, electricity, etc.), and all other operating expenses.						
	Depreciation Expense						
	Non-Operating Expense – Include all other expenses for interest, taxes, real estate lease expenses, and other non-operating expenses.						
Total							
Patient Revenue	<p>Gross Patient Charges – The sum of the facility’s established rate for all services rendered to patients during the reporting year.</p> <p>Adjustments to Charges – The difference between the gross patient charges and the actual amount of payment received by the facility during the reporting period. Adjustments to previous years revenue, such as Medicare or TennCare prior adjustments, should be reported as non-operating revenue, <u>not as current year adjustments</u>.</p> <p>Net Patient Revenue – The difference obtained by subtracting adjustments to charges from gross patient charges. This difference represents the actual amount of revenue that the facility received.</p>						
	Government	Revenue Source	Gross Patient Charges	Minus	Adjustment to Charges	Equals	Net Patient Revenue
		Medicare		-		=	
		TennCare		-		=	
		Other Government		-		=	
	Total Government			-		=	
	Non-Government	Self-Pay		-		=	
		Insurance		-		=	
		Other Non-Government		-		=	
		Total Non-Government		-		=	
	Total Patient Revenue: (Total Government plus Total Non-Government)			-		=	
	Revenue	All Non-Patient Revenue					
		Total Net Revenue: Net Total Patient Revenue plus All Non-Patient Revenue					

Non-Government Adjustment to Charges Subcategories	Bad Debt – Uncompensated care for which the facility directly billed the patient and for which the patient should reasonably be expected to pay.	
	Charity Care – Services provided to medically needy persons for which the facility does not expect payment.	
	Other – Any other adjustments that are not appropriately reported in either Bad Debt or Charity.	
	Total Non-Government Adjustment to Charges Subcategories	

Schedule G – Personnel

Type of Employee by Service	Please indicate the number of personnel during a normal week. Record zero where appropriate. Leave the item blank if the value is unknown. Full-Time employees are those whose regularly scheduled workweek 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, for three Registered Nurses, each working 20 hours a week, the FTE would be (3x20)/40=1.5. For two registered technologists, one working 10 hours per week and the other working 15 hours per week, the FTE would be (10+15)/40=.63. (Use two decimal places.)				
	Type	Number of Employees			
	Employee:	Full-Time	Part-Time in FTE	Contract in FTE	Total in FTE
	Administrators				
	Medical Director				
	Physicians (MD and DO)				
	Dentists				
	Financial/Billing Personnel				
	Nursing (RN, LPN, and Ancillary)				
	Medical Records				
	Registered Technologist				
	Technical				
	Maintenance/Services				
	Other, specify				
Total					

Nursing Personnel	Please indicate the number of personnel as of the last day of the reporting period.							
	Registered Nurses	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
		Associate						
		Diploma						
		Bachelors						
		Masters						
	Doctorate							
	Total							
	Advanced Practice Nurses	Category	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
		Nurse Practitioner						
		Clinical Nurse Specialist						
		Certified Registered Nurse Anesthetist						
		Total						

Nursing Personnel (continued)	Other Nursing Staff	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
	Licensed Practical Nurses					
	Certified Nurses Aides					
	Other #1, specify					
	Other #2, specify					
Contract Nursing Personnel	Does your organization use contract nursing personnel? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	If yes, indicate the number of contract personnel in the following categories:					
		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					

Schedule H – Medical Staff

Medical Staff	Include all physicians, whether considered active or associate. Active: Employed and practicing at the facility Associate: Has privileges to practice at the facility but is not employed at the facility					
	Specialty			Total Number of Medical Staff	Number of Medical Staff who are Board Certified	
	Pathologist					
	Radiologist					
	Other #1, specify					
	Other #2, specify					

Administrator's Declaration	<input type="checkbox"/>	I, the administrator, declare that I have examined this report and to the best of my knowledge and belief, it is true, correct, and complete.
Date (mm/dd/yyyy)		