



## 2010 Annual Radiation Therapy Services Survey

### Part A : General Information

#### 1. Identification

UID:

Facility Name:

County:

Street Address:

City:

Zip:

Mailing Address:

Mailing City:

Mailing Zip:

Medicaid Provider Number:

Medicare Provider Number:

#### 2. Report Period

Report Data for the full twelve month period- January 1, 2010 through December 31, 2010.  
***Do not use a different report period.***

Check the box to the right if your facility was **not** operational for the entire year.

If your facility was **not** operational for the entire year, provide the dates the facility was operational.

### Part B : Survey Contact Information

*Person authorized to respond to inquiries about the responses to this survey.*

Contact Name:

Contact Title:

Phone:

Fax:

E-mail:

## Part C : Ownership, Operation and Management

### 1. Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

#### A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

#### B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

#### C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

#### D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

#### E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

#### F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

### 2. Changes in Ownership, Operation or Management

Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period.

If checked, please explain in the box below and include effective dates.

## Part D : Services/Volume by Technology or Type

### 1a. Conventional Radiation Therapy

Please report the following utilization numbers for conventional radiation therapy machines (units) and the services provided with those machines (Linear Accelerator and/or Cobalt). Report only conventional radiation therapy treatments. Do not report treatments using technologies combining conventional radiation therapy and stereotactic radiosurgery.

Type of Machine/Therapy	Number of Machines/Units	Number of Visits	Number of Patients
Linear Accelerator/Radiation Therapy			
Cobalt Therapy			

### 1b. Other Radiation Therapy

Type of Therapy	Number of Visits	Number of Patients
Radium Therapy		
Cesium Therapy		
Superficial Radiation Therapy		
Other Radiation Therapy		

### 2. Linear Accelerator Treatment Visits by Type

Please report the following utilization numbers for linear accelerator treatments by type and the number of patients receiving those treatments. Patients can be duplicated across treatment categories.

Treatment Type	Number of Visits	Number of Patients
Simple Treatment		
Intermediate Treatment		
Complex Treatment		
Intensity Modulated Radiation Therapy (IMRT)		
Stereotactic Radiosurgery on Machines also performing radiation therapy		

### 3. Combined Radiation Therapy/Stereotactic Radiosurgery

Please provide the information requested in the table below for technologies which were able to provide both conventional and stereotactic radiosurgery treatments.

Equipment	Number of Machines	Conventional Visits	Conventional Patients	Stereotactic Radiosurgery Visits	Stereotactic Radiosurgery Patients
Trilogy					
Synergy					
Other Technology					

#### **4. Stereotactic Radiosurgery Only**

Provide the information requested in the table below for stereotactic radiosurgery only technologies. Provide for units where conventional radiation therapy could not also be performed.

Equipment	Number of Machines	Number of Visits	Number of Patients
Gamma Knife			
Cyber Knife			
Other Technology			

#### **5. Inventory of Radiation Therapy and Stereotactic Radiosurgery Technology**

Provide the brand name, model number, date purchased, technology type (Conventional Radiation Therapy Only, Combined Radiation Therapy/Stereotactic Radiosurgery, or SRS-only), and number of treatment visits for all radiation therapy and stereotactic radiosurgery machines that were in operation during the report year. For linear accelerators also indicate if the unit is operating at greater than or equal to 1 million electron volts or less than 1 million electron volts.

Brand Name	Model #	Type of Unit	Visits	Electron Volts	Date Purchased
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#### **6. Inventory of Other Technology**

Provide the brand name, model number, type of machine and date purchased for all other types of technology/machines that were in operation during the report year.

Brand Name	Model #	Type of Machine	Date Purchased
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### **Part E : Financial and Utilization Information for Radiation Therapy Services**

#### **1. Radiation Therapy Patients and Treatment Visits by Primary Payment Source**

Please report the total radiation therapy patients and treatment visits by primary payment source. Please unduplicate the number of patients by primary payment source. Please report Peachcare For Kids under Third-Party.

Primary Payment Source	Number of Radiation Therapy Patients (unduplicated)	Number of Treatment Visits
Medicare		
Medicaid		
Third-Party		
Self-Pay		
<b>Total</b>		

**2a. Total Charges**

Please report the total charges for radiation therapy services provided during the report period.

Total Charges

**2b. Reimbursement**

Please report the actual reimbursement received for charges for radiation therapy services provided during the report period.

Reimbursement

**2c. Adjusted Gross Revenue**

Please report the adjusted gross revenue for radiation therapy services provided during the report period.

Adjusted Gross Revenue

**3a. Total Uncompensated Charges**

Please report the total uncompensated charges.

Total Uncompensated Charges

**3b. Total Patients with Uncompensated Charges**

Please report the total number of patients for radiation therapy services for patients that are indigent or covered by charity care services.

Total Patients with Uncompensated Charges

**4. Average Treatment Charge**

What is your average treatment charge for radiation therapy service treatment?

### **5. Patients and Visits by Race/Ethnicity**

Please report the number of radiation therapy services patients (unduplicated) and treatment visits during the report period by the following race and ethnicity categories.

<b>Race/Ethnicity</b>	<b>Number of Patients</b>	<b>Number of Treatment Visits</b>
American Indian/Alaska Native		
Asian		
Black/African American		
Hispanic/Latino		
Pacific Islander/Hawaiian		
White		
Multi-Racial		
<b>Total</b>		

### **6. Patients and Visits by Gender**

Please report the number of radiation therapy services patients and treatment visits during the report period by gender.

<b>Gender</b>	<b>Number of Patients</b>	<b>Number of Visits</b>
Male		
Female		
<b>Total</b>		

### **7 Patients and Visits by Age Group**

Please report the number of radiation therapy services patients and treatment visits during the report period by the following age groupings.

<b>Age of Patient</b>	<b>Number of Patients</b>	<b>Number of Treatment Visits</b>
Ages 0-14		
Ages 15-29		
Ages 30-64		
Ages 65-84		
Ages 85 and Up		
<b>Total</b>		

### **8. Participation in Reporting**

Please check the box to the right if your facility participates in reporting to the Georgia Comprehensive Cancer Registry.

### 9. Patients by Principle Diagnosis

Report the number of patients, total visits, and total gross charges during the report period by the patient's principle diagnosis as indicated below.

Principle Diagnosis	Number of Patients	Number of Treatment Visits	Gross Treatment Charges
Malignant Neoplasms of Female Breast (ICD10=C50; ICD9=174)			
Colon and Rectum (ICD10=C18-C21; ICD9=153-154)			
Prostate Cancer (ICD10=C61; ICD9=185)			
Lung and Bronchus (ICD10=C33-C34; ICD9=162)			
All Other			
<b>Total</b>			

### 10. Estimated Patients and Treatments in the Next Calendar Year

Please provide the number of patients and treatments estimated, expected, or scheduled in the next calendar year (CY2011) for conventional radiation therapy.

Number of Patients	Number of Treatments

### Part F : Patient Origin for Radiation Services

#### 1. Patient Origin

By the patient's county of origin report the total number of radiation therapy services treatment visits and patients at your facility. Also report the number of visits and patients treated using the linear accelerator(s).

County	Total Patients	Total Visits	Linear Accelerator Patients	Linear Accelerator Visits
Alabama				
Appling				
Atkinson				
Bacon				
Baker				
Baldwin				
Banks				
Barrow				
Bartow				
Ben Hill				
Berrien				
Bibb				
Bleckley				
Brantley				
Brooks				

Bryan				
Bulloch				
Burke				
Butts				
Calhoun				
Camden				
Candler				
Carroll				
Catoosa				
Charlton				
Chatham				
Chattahoochee				
Chattooga				
Cherokee				
Clarke				
Clay				
Clayton				
Clinch				
Cobb				
Coffee				
Colquitt				
Columbia				
Cook				
Coweta				
Crawford				
Crisp				
Dade				
Dawson				
Decatur				
DeKalb				
Dodge				
Dooly				
Dougherty				
Douglas				
Early				
Echols				
Effingham				
Elbert				
Emanuel				
Evans				
Fannin				
Fayette				
Florida				
Floyd				

Forsyth				
Franklin				
Fulton				
Gilmer				
Glascocock				
Glynn				
Gordon				
Grady				
Greene				
Gwinnett				
Habersham				
Hall				
Hancock				
Haralson				
Harris				
Hart				
Heard				
Henry				
Houston				
Irwin				
Jackson				
Jasper				
Jeff Davis				
Jefferson				
Jenkins				
Johnson				
Jones				
Lamar				
Lanier				
Laurens				
Lee				
Liberty				
Lincoln				
Long				
Lowndes				
Lumpkin				
Macon				
Madison				
Marion				
McDuffie				
McIntosh				
Meriwether				
Miller				
Mitchell				

Monroe				
Montgomery				
Morgan				
Murray				
Muscogee				
Newton				
North Carolina				
Oconee				
Oglethorpe				
Other Out of State				
Paulding				
Peach				
Pickens				
Pierce				
Pike				
Polk				
Pulaski				
Putnam				
Quitman				
Rabun				
Randolph				
Richmond				
Rockdale				
Schley				
Screven				
Seminole				
South Carolina				
Spalding				
Stephens				
Stewart				
Sumter				
Talbot				
Taliaferro				
Tattnall				
Taylor				
Telfair				
Tennessee				
Terrell				
Thomas				
Tift				
Toombs				
Towns				
Treutlen				
Troup				

Turner				
Twiggs				
Union				
Upson				
Walker				
Walton				
Ware				
Warren				
Washington				
Wayne				
Webster				
Wheeler				
White				
Whitfield				
Wilcox				
Wilkes				
Wilkinson				
Worth				
<b>Total</b>				

## Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

*I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or inaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.*

**Authorized Signature:**

**Date:** //

**Title:**

**Comments:**