GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2013 Positron Emission Tomography (PET) Services Survey

Part A : General Information

1. Identification

UID:HOSP704

Facility Name: Midtown Medical Center F/K/A The Medical Center

County: Muscogee

Street Address: 710 Center Street

City: Columbus

Zip: 31902

Mailing Address: P O Box 951

Mailing City: Columbus

Mailing Zip: 31902-0951

Medicaid Provider Number: 00001196

Medicare Provider Number: 110064

2. Report Period

Report Data for the full twelve month period- January 1, 2013 through December 31, 2013.
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: Laura Flatt

Contact Title: Decision Support Analyst, II

Phone: 706-571-1381

Fax: 706-660-6515

E-mail: laura.flatt@columbusregional.com

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
The Medical Center Hospital Authority	Hospital Authority	12/31/1975

B. Owner's Parent Organization

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

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
The Medical Center, Inc.	Not for Profit	07/01/1986

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Columbus Regional Healthcare System, Inc.	Not for Profit	07/01/1986

E. Management Contractor

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

F. Management's Parent Organization

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

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.

3a. Type of PET Authorization (Select one only.)

Fixed-Based PET CON

3b. Certificate of Need Project Number

Please enter the Certificate of Need project number.

GA 2009-0012

3c. Name of Mobile Vendor (If selected PET CON (Mobile Contract) at 3A. above.)

Not Applicable

Part D : PET Imaging Services Technology and volume by Diagnostic Type

1. Manufacturer and Model

Please document the manufacturer and model of PET equipment and select PET only or PET/CT Hybrid Unit. NOTE: IF you have more than one scanner, please complete one survey for each machine.

PET / CT Hybrid Unit

2. Patients and Scans for PET Imaging Services

Please report the patients and scans for PET imaging services during the reporting period by the patient's primary diagnostic area. Please provide unduplicated patient counts within each of the three subgroups. The sum total of all patients for all three diagnostic areas (automatically calculated by the web page) may include some duplication.

Oncology Patients	Number of Patients	Total Number of Scans	Follow Up Scans
Lung and Bronchus Cancers	111	143	37
Colon and Rectal Cancers	72	86	14
Lymphoma Cancers	90	138	40
Melanoma Cancers	22	27	5
Esophageal Cancers	21	27	5
Head and Neck Cancers	37	48	11
Breast Cancers	122	165	31
Other Cancers	147	182	40
Total	**622**	**816**	**183**

Cardiovascular Patients	Number of Patients	Number of Scans
All Cardiovascular Patients	3	6
Total	**3**	**6**

Neurology Patients	Number of Patients	Number of Scans
Dementias (incuding Alzheimer's)	5	5
Other Neurological Use	1	1
Total	**6**	**6**

Other Diagnostic Areas	Number of Patients	Number of Scans
All Other Patients	146	159
Total	**146**	**159**

Part E : PET Services Financial Summary and Patient Demographics

1. Patients by Primary Payment Source

Please report the total number of patients (unduplicated) receiving PET services by primary payment source.

Primary Payment Source	Number of Patients (unduplicated)
Medicare	445
Medicaid	50
Third-Party	258
Self-Pay	24
Total	**777**

2. Total Charges and Adjusted Gross Revenue

Please report the total charges and adjusted gross revenues for PET services.

Total Charges	Adjusted Gross Revenue
5,717,311	1,901,821

3. Total Uncompensated Charges and I/C Patients

Please report the total amount of uncompensated PET services charges that can be attributed to persons who are indigent or eligible for charity care. Also provide the number of I/C patients in the PET program.

Total Uncompensated Charges	I/C Patients
207,545	62

4. Average Treatment Charge

What is your program's average treatment charge for a PET scan or study (one patient visit regardless of number of images)?

5,787

5. Patients by Race/Ethnicity

Please report the number of patient served during the entire report period by the following race and ethnicity categories.

Race/Ethnicity	Number of Patients
American Indian/Alaska Native	1
Asian	4
Black/African American	272
Hispanic/Latino	9
Pacific Islander/Hawaiian	0
White	483
Multi-Racial	8
Total	**777**

6. Patients by Age Group and Gender

Please report the number of patients served during the entire report period by the gender and age

grouping below.

Age Group	Male	Female
Ages 0-14	0	1
Ages 15-64	165	217
Ages 65-74	102	112
Ages 75-85	66	81
Ages 85 and Up	13	20
Total	**346**	**431**

7. Participation in Reporting

Does your facility/service participate in and report to the Georgia Comprehensive Cancer Registry? (check box for YES, leave unchecked for NO) ☑

8. Days and Hours of Operation

Please indicate the days and hours of operation for your program's PET services.

Mon	Tue	Wed	Thurs	Fri	Sat	Sun
☑	☑	☑	☑	☑	☐	☐

Hours of Operation: 8:00 a.m. until 4:30 p.m.

9. Total Number of Days that PET Scans Were Offered

Please report the total number of days that PET scans were offered during the report period.

Total Days PET Scans Offered
260

Part F : Mobile PET Services

1. Mobile PET Services- (For mobile vendors holding a CON to provide PET services.)

Please report each location served during the reporting period and the number of days of services provided at each loacation for each month. If your PET service is fixed-based, or your facility holds a CON for mobile PET services under contract, continue with Part G.

Site Name	Site County	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Part G : Patient Origin Table (Must be completed by all providers)

1. Patient Origin by County

Please report the county of origin for patients served by your PET program during the report period. Note to Mobile PET Providers who hold a CON: You must complete this section for every site visit location. Please select from the list of site visit ocations(s) provided above.

Name	County	Patients Served	Patient County
Midtown Medical Center F/K/A The Medical Center	Muscogee	9	Chattahoochee
Midtown Medical Center F/K/A The Medical Center	Muscogee	1	Clay
Midtown Medical Center F/K/A The Medical Center	Muscogee	1	Coweta
Midtown Medical Center F/K/A The Medical Center	Muscogee	1	Dougherty
Midtown Medical Center F/K/A The Medical Center	Muscogee	2	Fulton
Midtown Medical Center F/K/A The Medical Center	Muscogee	48	Harris
Midtown Medical Center F/K/A The Medical Center	Muscogee	1	Houston
Midtown Medical Center F/K/A The Medical Center	Muscogee	12	Marion
Midtown Medical Center F/K/A The Medical Center	Muscogee	15	Meriwether
Midtown Medical Center F/K/A The Medical Center	Muscogee	1	Mitchell
Midtown Medical Center F/K/A The Medical Center	Muscogee	1	Monroe
Midtown Medical Center F/K/A The Medical Center	Muscogee	428	Muscogee
Midtown Medical Center F/K/A The Medical Center	Muscogee	1	Newton
Midtown Medical Center F/K/A The Medical Center	Muscogee	1	Pike
Midtown Medical Center F/K/A The Medical Center	Muscogee	1	Polk
Midtown Medical Center F/K/A The Medical Center	Muscogee	3	Quitman
Midtown Medical Center F/K/A The Medical Center	Muscogee	1	Schley
Midtown Medical Center F/K/A The Medical Center	Muscogee	13	Stewart
Midtown Medical Center F/K/A The Medical Center	Muscogee	1	Sumter
Midtown Medical Center F/K/A The Medical Center	Muscogee	19	Talbot
Midtown Medical Center F/K/A The Medical Center	Muscogee	1	Taylor
Midtown Medical Center F/K/A The Medical Center	Muscogee	8	Troup
Midtown Medical Center F/K/A The Medical Center	Muscogee	2	Upson
Midtown Medical Center F/K/A The Medical Center	Muscogee	2	Webster
Midtown Medical Center F/K/A The Medical Center	Muscogee	201	Alabama
Midtown Medical Center F/K/A The Medical Center	Muscogee	3	Other Out of State
Total		**777**	

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 incaccurate 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: Ryan R. Chandler

Date: 05/23/2014

Title: President and Chief Executive Officer

Comments: