GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2013 Positron Emission Tomography (PET) Services Survey

Part A : General Information

1. Identification

UID:hosp916

Facility Name: Southeastern Regional Medical Center, Inc

County: Coweta

Street Address: 600 Parkway North

City: Newnan

Zip: 30265

Mailing Address: 600 Parkway North

Mailing City: Newnan

Mailing Zip: 30265

Medicaid Provider Number: 003139950A

Medicare Provider Number: 11-0233

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: David Kent

Contact Title: Chief Operating Officer

Phone: 770-400-6261

Fax: 770-400-6941

E-mail: david.kent@ctca-hope.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
Cancer Treatment Centers of America	For Profit	08/15/2012

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

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.

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

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
GE Discovery 600

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	117	743	0
Colon and Rectal Cancers	132	708	0
Lymphoma Cancers	17	130	0
Melanoma Cancers	10	43	0
Esophageal Cancers	17	89	0
Head and Neck Cancers	18	98	0
Breast Cancers	205	211	0
Other Cancers	246	2,247	0
Total	**762**	**4,269**	**0**

Cardiovascular Patients	Number of Patients	Number of Scans
All Cardiovascular Patients	0	0
Total	**0**	**0**

Neurology Patients	Number of Patients	Number of Scans
Dementias (incuding Alzheimer's)	0	0
Other Neurological Use	0	0
Total	**0**	**0**

Other Diagnostic Areas	Number of Patients	Number of Scans
All Other Patients	0	0
Total	**0**	**0**

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	43
Medicaid	0
Third-Party	719
Self-Pay	0
Total	**762**

2. Total Charges and Adjusted Gross Revenue

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

Total Charges	Adjusted Gross Revenue
9,872,790	5,923,674

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
3	0

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)?

2,313

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	242
Hispanic/Latino	11
Pacific Islander/Hawaiian	0
White	493
Multi-Racial	11
Total	**762**

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	0
Ages 15-64	301	396
Ages 65-74	34	25
Ages 75-85	5	1
Ages 85 and Up	0	0
Total	**340**	**422**

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: 7:30AM until 6:30PM

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
251

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
Southeastern Regional Medical Center, Inc	Coweta	3	Floyd
Southeastern Regional Medical Center, Inc	Coweta	4	Forsyth
Southeastern Regional Medical Center, Inc	Coweta	2	Franklin
Southeastern Regional Medical Center, Inc	Coweta	29	Fulton
Southeastern Regional Medical Center, Inc	Coweta	2	Gilmer
Southeastern Regional Medical Center, Inc	Coweta	2	Glynn
Southeastern Regional Medical Center, Inc	Coweta	1	Gordon
Southeastern Regional Medical Center, Inc	Coweta	16	Gwinnett
Southeastern Regional Medical Center, Inc	Coweta	1	Habersham
Southeastern Regional Medical Center, Inc	Coweta	2	Hall
Southeastern Regional Medical Center, Inc	Coweta	1	Haralson
Southeastern Regional Medical Center, Inc	Coweta	1	Harris
Southeastern Regional Medical Center, Inc	Coweta	2	Hart
Southeastern Regional Medical Center, Inc	Coweta	1	Heard
Southeastern Regional Medical Center, Inc	Coweta	7	Henry
Southeastern Regional Medical Center, Inc	Coweta	9	Houston
Southeastern Regional Medical Center, Inc	Coweta	1	Jasper
Southeastern Regional Medical Center, Inc	Coweta	1	Lamar
Southeastern Regional Medical Center, Inc	Coweta	4	Laurens
Southeastern Regional Medical Center, Inc	Coweta	1	Liberty
Southeastern Regional Medical Center, Inc	Coweta	1	Lincoln
Southeastern Regional Medical Center, Inc	Coweta	1	Lowndes
Southeastern Regional Medical Center, Inc	Coweta	1	Lumpkin
Southeastern Regional Medical Center, Inc	Coweta	1	Madison
Southeastern Regional Medical Center, Inc	Coweta	1	Meriwether
Southeastern Regional Medical Center, Inc	Coweta	2	Morgan
Southeastern Regional Medical Center, Inc	Coweta	1	Clarke
Southeastern Regional Medical Center, Inc	Coweta	1	Atkinson
Southeastern Regional Medical Center, Inc	Coweta	4	Richmond
Southeastern Regional Medical Center, Inc	Coweta	1	Barrow
Southeastern Regional Medical Center, Inc	Coweta	2	Ben Hill
Southeastern Regional Medical Center, Inc	Coweta	5	Bibb
Southeastern Regional Medical Center, Inc	Coweta	2	Bryan
Southeastern Regional Medical Center, Inc	Coweta	1	Butts
Southeastern Regional Medical Center, Inc	Coweta	1	Camden
Southeastern Regional Medical Center, Inc	Coweta	1	Bartow
Southeastern Regional Medical Center, Inc	Coweta	3	Carroll

Southeastern Regional Medical Center, Inc	Coweta	1	Catoosa
Southeastern Regional Medical Center, Inc	Coweta	3	Chatham
Southeastern Regional Medical Center, Inc	Coweta	2	Cherokee
Southeastern Regional Medical Center, Inc	Coweta	10	Clayton
Southeastern Regional Medical Center, Inc	Coweta	13	Cobb
Southeastern Regional Medical Center, Inc	Coweta	1	Coffee
Southeastern Regional Medical Center, Inc	Coweta	3	Muscogee
Southeastern Regional Medical Center, Inc	Coweta	18	Coweta
Southeastern Regional Medical Center, Inc	Coweta	1	Crisp
Southeastern Regional Medical Center, Inc	Coweta	12	DeKalb
Southeastern Regional Medical Center, Inc	Coweta	2	Dougherty
Southeastern Regional Medical Center, Inc	Coweta	7	Douglas
Southeastern Regional Medical Center, Inc	Coweta	1	Effingham
Southeastern Regional Medical Center, Inc	Coweta	9	Fayette
Southeastern Regional Medical Center, Inc	Coweta	2	Murray
Southeastern Regional Medical Center, Inc	Coweta	4	Newton
Southeastern Regional Medical Center, Inc	Coweta	1	Oconee
Southeastern Regional Medical Center, Inc	Coweta	5	Paulding
Southeastern Regional Medical Center, Inc	Coweta	1	Peach
Southeastern Regional Medical Center, Inc	Coweta	1	Pike
Southeastern Regional Medical Center, Inc	Coweta	2	Polk
Southeastern Regional Medical Center, Inc	Coweta	1	Pulaski
Southeastern Regional Medical Center, Inc	Coweta	3	Rockdale
Southeastern Regional Medical Center, Inc	Coweta	1	Spalding
Southeastern Regional Medical Center, Inc	Coweta	1	Sumter
Southeastern Regional Medical Center, Inc	Coweta	1	Taliaferro
Southeastern Regional Medical Center, Inc	Coweta	1	Taylor
Southeastern Regional Medical Center, Inc	Coweta	1	Telfair
Southeastern Regional Medical Center, Inc	Coweta	11	Troup
Southeastern Regional Medical Center, Inc	Coweta	3	Upson
Southeastern Regional Medical Center, Inc	Coweta	5	Walton
Southeastern Regional Medical Center, Inc	Coweta	1	Washington
Southeastern Regional Medical Center, Inc	Coweta	1	Whitfield
Southeastern Regional Medical Center, Inc	Coweta	85	Alabama
Southeastern Regional Medical Center, Inc	Coweta	54	Florida
Southeastern Regional Medical Center, Inc	Coweta	45	North Carolina
Southeastern Regional Medical Center, Inc	Coweta	44	South Carolina
Southeastern Regional Medical Center, Inc	Coweta	45	Tennessee
Southeastern Regional Medical Center, Inc	Coweta	241	Other Out of State
Total		**762**	

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: Scott Walker

Date: 08/18/2014

Title: CFO

Comments: