



2013 Annual Radiation Therapy Services Survey

Part A : General Information

1. Identification

UID:DTRC167

Facility Name: Atlanta Oncology Associates at South Fulton Medical Center

County: Fulton

Street Address: 1136 Cleveland Avenue Suite 119

City: East Point

Zip: 30344

Mailing Address: 3330 Preston Ridge Road, Suite 300

Mailing City: Alpharetta

Mailing Zip: 30005

Medicaid Provider Number: 846182022A

Medicare Provider Number: 7898

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: JENNIE PALMER

Contact Title: DIRECTOR OF OPERATIONS

Phone: 4046950186

Fax: 7703940380

E-mail: JPALMER@ATLANTAONCOLOGY.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 |
|-------------------------------------|-------------------|----------------|
| ATLANTA ONCOLOGY ASSOCIATES | For Profit | 6/30/2012 |

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 |
|-------------------------------------|-------------------|----------------|
| ATLANTA ONCOLOGY ASSOCIATES | For Profit | 6/30/2012 |

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.

Part D : Services/Volume by Technology or Type

1. Conventional Radiation Therapy

Report conventional, non-special purpose megavoltage radiation therapy linear accelerators and cobalt therapy units, visits, and patients. All such units should be reported here including those units that were approved under the utilization exception to the MegaVoltage Radiation Therapy rules. Do not report units capable of providing stereotactic radiosurgery treatment visits in Question 1.

| Type of Machine/Therapy | Number of Machines | Number of Visits | Number of Patients |
|--------------------------------------|--------------------|------------------|--------------------|
| Linear Accelerator/Radiation Therapy | 1 | 341 | 18 |
| Cobalt Therapy | 0 | 0 | 0 |

2a. Combined Radiation Therapy

For Question 2 (a & b) provide the number of machines with which both conventional, non-special purpose radiation therapy and stereotactic radiosurgery could be performed. Provide the number of visits and patients treated under each specific modality and for each type of treatment category for the report year and report any treatments performed on other machines that were capable of providing both conventional radiation therapy and stereotactic radiosurgery.

| Equipment | Number of Machines | Conventional Visits | Conventional Patients |
|------------------|--------------------|---------------------|-----------------------|
| Trilogy | 0 | 0 | 0 |
| Synergy | 0 | 0 | 0 |
| Other Technology | 0 | 0 | 0 |

2b. Combined Radiation Therapy/Stereotactic Radiosurgery- Intracranial and Extracranial/Body Utilization

| Equipment | Intracranial | Intracranial | Stereotactic Body | Stereotactic Body |
|------------------|----------------------------------|------------------------------------|----------------------------|------------------------------|
| | Stereotactic Radiosurgery Visits | Stereotactic Radiosurgery Patients | Radiotherapy (SBRT) Visits | Radiotherapy (SBRT) Patients |
| Trilogy | 0 | 0 | 0 | 0 |
| Synergy | 0 | 0 | 0 | 0 |
| Other Technology | 0 | 0 | 0 | 0 |

3. Special Purpose MRT Units and Volume

Provide the number of SRS-only machines and the number of visits and patients treated on each by the treatment categories provided. For purposes of the survey, stereotactic radiosurgery consists of procedures utilizing accurately targeted doses of radiation in multiple treatments over a short period of time (usually 1 week).

| Equipment | Number of Machines | Intracranial Stereotactic Radiosurgery Visits | Intracranial Stereotactic Radiosurgery Patients | Stereotactic Body Radiotherapy (SBRT) Visits | Stereotactic Body Radiotherapy (SBRT) Patients |
|------------------|--------------------|---|---|--|--|
| Gamma Knife | 0 | 0 | 0 | 0 | 0 |
| Cyber Knife | 0 | 0 | 0 | 0 | 0 |
| Other Technology | 0 | 0 | 0 | 0 | 0 |

Grand Total of Special Purpose and Non-Special Purpose Visits

The grand total here should match the reported visit totals in Parts E and F.

| Special Purpose Visits | Non-Special Purpose Visits | Grand Total Visits |
|------------------------|----------------------------|--------------------|
| 0 | 341 | 341 |

4. Non-Special MRT Treatment Visits by Type

Please report the following utilization numbers for non-special MRT treatments by type and the number of patients receiving those treatments. Note that any non-special purpose unit and its associated volumes that were approved under the high utilization rule exception should be listed separately. Volumes should reflect only those units reported in Part D, Questions 1 and 2 above. Patients can be duplicated across treatment categories.

| Treatment Type | Non-Rule Exception Units | Non-Rule Exception Units | 90% Utilization Exception Units | 90% Utilization Exception Units |
|---|--------------------------|--------------------------|---------------------------------|---------------------------------|
| | Visits | Patients | Visits | Patients |
| Simple Treatment | 329 | 17 | 0 | 0 |
| Intermediate Treatment | 12 | 3 | 0 | 0 |
| Complex Treatment | 0 | 0 | 0 | 0 |
| Intensity Modulated Radiation Therapy (IMRT) | 0 | 0 | 0 | 0 |
| Stereotactic Radiosurgery on Machines also performing radiation therapy | 0 | 0 | 0 | 0 |
| Total | 341 | 20 | 0 | 0 |

5. Other Radiation Therapy

Report visits and patients receiving non-linear accelerator/penetrating ray radiation therapy.

| Type of Therapy | Number of Visits | Number of Patients |
|-------------------------------|------------------|--------------------|
| Radium Therapy | 0 | 0 |
| Cesium Therapy | 0 | 0 |
| Superficial Radiation Therapy | 0 | 0 |
| Brachytherapy | 0 | 0 |
| Other Radiation Therapy | 0 | 0 |

6. 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 |
|------------|---------|--------------|--------|----------------|----------------|
|------------|---------|--------------|--------|----------------|----------------|

7. 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 |
|------------|---------|-----------------|----------------|
|------------|---------|-----------------|----------------|

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 | 12 | 281 |
| Medicaid | 1 | 1 |
| Third-Party | 2 | 34 |
| Self-Pay | 3 | 25 |
| Total | 18 | 341 |

2a. Total Charges

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

| Total Charges |
|---------------|
| 236,445 |

2b. Reimbursement

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

| Reimbursement |
|---------------|
| 52,680 |

2c. Adjusted Gross Revenue

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

| Adjusted Gross Revenue |
|------------------------|
| 85,340 |

3a. Total Uncompensated Charges

Please report the total uncompensated charges.

| Total Uncompensated Charges |
|-----------------------------|
| 0 |

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 |
|---|
| 0 |

4. Average Patient Charge

Report the average charge per patient for Non-Special Purpose MRT treatment visits and for Special Purpose MRT treatment visits.

| Average Patient Charge- Non Special Purpose MRT | Average Patient Charge- Special Purpose MRT |
|---|---|
| 13,136 | 0 |
| 0 | 0 |

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.

| Race/Ethnicity | Number of Patients | Number of Treatment Visits |
|-------------------------------|--------------------|----------------------------|
| American Indian/Alaska Native | 0 | 0 |
| Asian | 0 | 0 |
| Black/African American | 16 | 332 |
| Hispanic/Latino | 0 | 0 |
| Pacific Islander/Hawaiian | 0 | 0 |
| White | 2 | 9 |
| Multi-Racial | 0 | 0 |
| Total | 18 | 341 |

6. Patients and Visits by Gender

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

| Gender | Number of Patients | Number of Visits |
|--------------|--------------------|------------------|
| Male | 6 | 96 |
| Female | 12 | 245 |
| Total | 18 | 341 |

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.

| Age of Patient | Number of Patients | Number of Treatment Visits |
|----------------|--------------------|----------------------------|
| Ages 0-14 | 0 | 0 |
| Ages 15-29 | 1 | 1 |
| Ages 30-64 | 7 | 134 |
| Ages 65-84 | 9 | 174 |
| Ages 85 and Up | 1 | 32 |
| Total | 18 | 341 |

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) | 5 | 135 | 95,293 |
| Colon and Rectum (ICD10=C18-C21; ICD9=153-154) | 1 | 28 | 20,020 |
| Prostate Cancer (ICD10=C61; ICD9=185) | 0 | 0 | 0 |
| Lung and Bronchus (ICD10=C33-C34; ICD9=162) | 7 | 137 | 91,734 |
| All Other | 5 | 41 | 29,398 |
| Total | 18 | 341 | 236,445 |

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 (CY2013) for conventional radiation therapy.

| Number of Patients | Number of Treatments |
|--------------------|----------------------|
| 20 | 375 |

Part F : Patient Origin for Radiation Services

1. Patient Origin

Please complete the Patient Origin Table to reflect the county (or out-of-state) residence for each Non-Special Purpose and/or Special Purpose MegaVoltage radiation therapy patient treated at your facility during the reporting period. The county column has a pull-down menu listing all 159 Georgia counties in alphabetical order with out-of-state listings for AL, FL, NC, SC, TN, and all other out-of-state. Please select patient origin location from this menu and provide total number of patients and treatment visits for each location by category of treatment for the report period.

| County | Total | | Non-Special | | Special | |
|--------------|-------------------------|--------------|----------------------|--------------------|----------------------|--------------------|
| | Non-Duplicated Patients | Total Visits | Purpose MRT Patients | Purpose MRT Visits | Purpose MRT Patients | Purpose MRT Visits |
| Clayton | 1 | 33 | 1 | 33 | 0 | 0 |
| Fulton | 16 | 307 | 16 | 307 | 0 | 0 |
| Lowndes | 1 | 1 | 1 | 1 | 0 | 0 |
| Total | 18 | 341 | 18 | 341 | 0 | 0 |

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: DALE MCCORD

Date: 20/4/5/12

Title: Chief Executive Officer

Comments: