GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2014 Annual Radiation Therapy Services Survey

Part A : General Information

1. Identification

UID:DTRC167

Facility Name: Atlanta Oncology 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: GRP7898

2. Report Period

Report Data for the full twelve month period- January 1, 2014 through December 31, 2014.
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	170	21
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 Stereotactic Radiosurgery Visits	Intracranial Stereotactic Radiosurgery Patients	Stereotactic Body Radiotherapy (SBRT) Visits	Stereotactic Body 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	170	170

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 hat 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 Visits	Non-Rule Exception Units Patients	90% Utilization Exception Units Visits	90% Utilization Exception Units Patients
Simple Treatment	0	0	0	0
Intermediate Treatment	0	0	0	0
Complex Treatment	150	14	0	0
Intensity Modulated Radiation Therapy (IMRT)	17	10	0	0
Stereotactic Radiosurgery on Machines also performing radiation therapy	0	0	0	0
Total	**167**	**24**	**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	3	1
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
VARIAN	21EX	Conventional Linear Accelerator	167	Greater than or Equal t	2010-01-01 00:00:00

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	8	116
Medicaid	7	44
Third-Party	5	9
Self-Pay	1	1
Total	**21**	**170**

2a. Total Charges

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

Total Charges
142,870

2b. Reimbursement

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

Reimbursement
35,035

2c. Adjusted Gross Revenue

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

Adjusted Gross Revenue
80,749

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
6,803	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	1	1
Black/African American	16	148
Hispanic/Latino	1	11
Pacific Islander/Hawaiian	0	0
White	3	10
Multi-Racial	0	0
Total	**21**	**170**

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	12	63
Female	9	107
Total	**21**	**170**

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	0	0
Ages 30-64	8	10
Ages 65-84	11	121
Ages 85 and Up	2	39
Total	**21**	**170**

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	71	56,523
Colon and Rectum (ICD10=C18-C21; ICD9=153-154)	0	0	0
Prostate Cancer (ICD10=C61; ICD9=185)	6	10	18,288
Lung and Bronchus (ICD10=C33-C34; ICD9=162)	4	37	26,455
All Other	6	52	41,604
Total	**21**	**170**	**142,870**

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 (CY2014) for conventional radiation therapy.

Number of Patients	Number of Treatments
25	187

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-Duplicated Patients	Total Visits	Non-Special Purpose MRT Patients	Non-Special Purpose MRT Visits	Special Purpose MRT Patients	Special Purpose MRT Visits
Barrow	2	3	2	3	0	0
Clayton	2	29	2	29	0	0
DeKalb	3	6	3	6	0	0
Fulton	14	132	14	132	0	0
Total	21	170	21	170	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 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: JENNIE PALMER

Date: 5/15/2015

Title: DIRECTOR OF OPERATIONS

Comments: