GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2014 Annual Radiation Therapy Services Survey

Part A : General Information

1. Identification

UID:HOSP415

Facility Name: Hamilton Medical Center

County: Whitfield

Street Address: P O Box 1168

City: Dalton

Zip: 30722-1168

Mailing Address: P O Box 1168

Mailing City: Dalton

Mailing Zip: 30722-1168

Medicaid Provider Number: 110001

Medicare Provider Number: 00000899

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: Todd Harrison

Contact Title: Director of Business Development

Phone: 706-272-6173

Fax: 706-272-6477

E-mail: toddharrison@hhcs.org

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
Hamilton Medical Center	Not for Profit	10/7/1982

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Hamilton Health Care System, Inc	Not for Profit	5/13/1986

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Hamilton Medical Center	Not for Profit	10/7/1982

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Hamilton Health Care System, Inc.	Not for Profit	5/13/1986

E. Management Contractor

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

F. Management's Parent Organization

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

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	6,002	263
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	6,002	6,002

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	36	6	0	0
Intermediate Treatment	0	0	0	0
Complex Treatment	3,421	99	0	0
Intensity Modulated Radiation Therapy (IMRT)	2,545	178	0	0
Stereotactic Radiosurgery on Machines also performing radiation therapy	0	0	0	0
Total	**6,002**	**283**	**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	93	12
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	21 EX Silhouette	Conventional Linear Accelerator	6002	Not Applicable	2005-02-01 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
Varian	OBI/CBCT Model# 080510		02/01/2005

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	132	2,817
Medicaid	31	792
Third-Party	86	2,138
Self-Pay	14	255
Total	**263**	**6,002**

2a. Total Charges

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

Total Charges
10,579,781

2b. Reimbursement

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

Reimbursement
2,853,967

2c. Adjusted Gross Revenue

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

Adjusted Gross Revenue
4,205,418

3a. Total Uncompensated Charges

Please report the total uncompensated charges.

Total Uncompensated Charges
86,693

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
12

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
57,498	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	10	237
Hispanic/Latino	14	354
Pacific Islander/Hawaiian	1	10
White	235	5,331
Multi-Racial	3	70
Total	**263**	**6,002**

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	132	2,784
Female	131	3,218
Total	**263**	**6,002**

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	129	3,094
Ages 65-84	123	2,678
Ages 85 and Up	11	230
Total	**263**	**6,002**

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)	65	1,990	0
Colon and Rectum (ICD10=C18-C21; ICD9=153-154)	5	113	0
Prostate Cancer (ICD10=C61; ICD9=185)	15	480	0
Lung and Bronchus (ICD10=C33-C34; ICD9=162)	44	821	0
All Other	134	2,598	0
Total	**263**	**6,002**	**0**

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
263	6,002

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
Catoosa	3	61	3	61	0	0
Gilmer	3	26	3	26	0	0
Gordon	11	219	11	219	0	0
Murray	73	1,573	73	1,573	0	0
Pickens	1	45	1	45	0	0
Walker	5	139	5	139	0	0
Whitfield	165	3,930	165	3,930	0	0
Fulton	1	8	1	8	0	0
Fannin	1	1	1	1	0	0
Total	263	6,002	263	6,002	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: Jeff Myers

Date: 5/27/2015

Title: President and CEO

Comments:

Original submitted 5/14 Revised AGR submitted 5/27