

Annual Radiation Therapy Services Survey for 1/1/2006-12/31/2006

UID:

Part A: General Information

Georgia Department of Community Health

1. Identification:

Due Date: July 20, 2007

Year:

UID:

Facility UID			
a. Facility Name			b. County
c. Street Address	d. City	e. Street Zip	
f. Mail Address	g. City	h. Mail Zip	
i. Medicaid Provider Number			j. Medicare Provider Number

2. Report Period:

Report data for the full 12-month period, January 1, 2006 through December 31, 2006 (365 days). 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 below:

Part B: Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey:

Name Title

Telephone: Fax E-mail

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.

Category	Full Legal Name (or "Not Applicable")	Organization Type	Effective Date
a. Facility Owner:			
b. Owner's Parent Org:			
c. Facility Operator:			
d. Operator's Parent Org:			
e. Mgmt. Contractor:			
f. Mgmt's Parent Org:			

2. 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

Conventional Radiation Therapy:

1. Please report the following utilization numbers for conventional radiation therapy machines and the services provided with those machines (Linear Accelerator and/or Cobalt). Report only conventional radiation therapy treatments. Do not report treatments using technologies combining conventional radiation therapy and stereotactic radiosurgery.

Type of Machine/Therapy	Number of Machines	Number of Visits	Number of Patients
1. Linear Accelerator/Radiation Therapy			
2. Cobalt Therapy			

	Number of Visits	Number of Patients
3. Radium Therapy		
4. Cesium Therapy		
5. Superficial Radiation Therapy		
6. Other Radiation Therapy		

Linear Accelerator Treatment Visits By Type:

2. Please report the following utilization numbers for linear accelerator treatments by type and the number of patients receiving those treatments. Patients can be duplicated across treatment categories.

	Number of Visits	Number of Patients
1. Simple Treatment		
2. Intermediate Treatment		
3. Complex Treatment		
4. Intensity Modulated Radiation Therapy (IMRT)		
5. Stereotactic Radiosurgery on Machines also performing radiation therapy		

Combined Radiation Therapy / Stereotactic Radiosurgery:

3. Please provide the information requested in the table below for technologies which were able to provide both conventional and stereotactic radiosurgery treatments.

Equipment	Number of Machines	Conventional		Stereotactic Radiosurgery	
		Visits	Patients	Visits	Patients
1. Trilogy TM					
2. Synergy TM					
3. Other Technology					

Stereotactic Radiosurgery Only:

4. Provide the information requested in the table below for stereotactic radiosurgery only technologies. Provide for units where conventional radiation therapy could not also be performed.

Equipment	Number of Machines	Number of Visits	Number of Patients
1. Gamma Knife			
2. Cyber Knife TM			
3. Other Technology			

Inventory:

5. Provide the brand name, model number, and date purchased for all radiation therapy and stereotactic radiosurgery machines that were in operation during the report year.

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Part E: Financial and Utilization Information for Radiation Therapy Services

1. 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			
		Medicare	Medicaid	Third-Party	Self-Pay
Number of Radiation Therapy Patients (unduplicated)					
Number of Treatment Visits					

Total Charges

Reimbursement

Adj Gross Revenue

2a. Please report the total charges for radiation therapy services provided during the report period.

2b. Please provide the actual reimbursement received for charges for radiation therapy services provided during the report period.

2c. Please report the adjusted gross revenue for radiation therapy services provided during the report period.

3a. Total Uncompensated Charges

3a. Please report the total uncompensated charges and the number of patients for radiation therapy services for patients that are indigent or covered by charity care services.

4. What is your average treatment charge for radiation therapy service treatment ?

3b. Total Patients With Uncompensated Charges

5. Please report the number of radiation therapy services patients (unduplicated) and treatment visits during the report period by the following race and ethnicity categories.

		Patients by Race/Ethnicity							
		American Indian/Alaska Native	Asian	Black African American	Hispanic OR Latino	Pacific Hawaiian Pacific Islander	White	Multi-Racial	Total
Number of Patients									
Number of Treatment Visits									

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

		Male	Female	Total
Number of Patients				
Treatment Visits				

Part E: Financial and Utilization Information (continued)

7. Please report the total number of radiation therapy services patients and treatment visits by age groupin

		Age of Patient					
		Ages 0-14	Ages 15-29	Ages 30-64	Ages 65-84	Ages 85 and Up	Total
Number of Patients							
Number of Treatment Visits							

8. Please check the box to the right if your facility participates in reporting to the State Cancer Registry?

Part F: Patient Origin for Radiation Services

By the patients' county of origin report the total number of radiation therapy services treatment visits and patients at your facility. Also report the number of visits and patients treated using the linear accerlerator(s).

To delete a row, press Esc to clear data entry errors. Then click in the margin to the left of the county name and press the delete key. (Please see the instructions for further information.)

Grand Total Patients

Grand Total Visits

Total Linear Accelerator Patients

Total Linear Accelerator Visits

NOTE: You must go to the Signature Form and sign your survey before submitting it. The survey will not be deemed complete without an authorized signature.

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for 1/1/2006-12/31/2006

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Signature Form

Georgia Department of Community Health

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 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:

Date:

Title:

Data
Comments:

Data Summary:

Utilization of Linear Accelerator/Radiation Therapy Machine:

Number of Units

Utilization Rate
(6,000 Optimal):

Number of Patients

Number of Visits

Financial Summary:

Uncompensated
Charges as % of AGR:

Unresolved Data Issues

Please explain any unresolved data issues in the comments box.