GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2012 Positron Emission Tomography (PET) Services Survey

Part A : General Information

1. Identification

UID:hosp634

Facility Name: Northside Hospital

County: Fulton

Street Address: 1000 Johnson Ferry Road NE

City: Atlanta

Zip: 30342-1611

Mailing Address: 1000 Johnson Ferry Road NE

Mailing City: Atlanta

Mailing Zip: 30342-1611

Medicaid Provider Number: 00001405

Medicare Provider Number: 110161

2. Report Period

Report Data for the full twelve month period- January 1, 2012 through December 31, 2012.
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: Brian J. Toporek

Contact Title: Senior Planner

Phone: 404-851-6821

Fax: 404-851-6283

E-mail: brian.toporek@northside.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
Hospital Authority of Fulton County	Hospital Authority	07/01/1970

B. Owner's Parent Organization

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

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northside Hospital, Inc.	Not for Profit	11/01/1991

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northside Health Services, Inc.	Not for Profit	11/01/1991

E. Management Contractor

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

F. Management's Parent Organization

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

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.

GA 2008-067

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
Siemens Biograph M CT 40

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	146	179	98
Colon and Rectal Cancers	90	128	97
Lymphoma Cancers	295	459	407
Melanoma Cancers	20	29	19
Esophageal Cancers	20	26	16
Head and Neck Cancers	57	69	47
Breast Cancers	254	333	246
Other Cancers	316	389	218
Total	**1,198**	**1,612**	**1,148**

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)	1	1
Other Neurological Use	0	0
Total	**1**	**1**

Other Diagnostic Areas	Number of Patients	Number of Scans
All Other Patients	86	99
Total	**86**	**99**

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	491
Medicaid	43
Third-Party	663
Self-Pay	45
Total	**1,242**

2. Total Charges and Adjusted Gross Revenue

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

Total Charges	Adjusted Gross Revenue
15,036,016	8,873,595

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
915,567	135

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)?

8,783

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	11
Asian	37
Black/African American	188
Hispanic/Latino	45
Pacific Islander/Hawaiian	0
White	942
Multi-Racial	19
Total	**1,242**

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	221	551
Ages 65-74	120	172
Ages 75-85	57	85
Ages 85 and Up	16	20
Total	**414**	**828**

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: 7:30 am until 5 pm

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
Northside Hospital	Fulton	5	Alabama
Northside Hospital	Fulton	2	Barrow
Northside Hospital	Fulton	9	Bartow
Northside Hospital	Fulton	3	Bibb
Northside Hospital	Fulton	1	Butts
Northside Hospital	Fulton	2	Carroll
Northside Hospital	Fulton	51	Cherokee
Northside Hospital	Fulton	6	Clarke
Northside Hospital	Fulton	15	Clayton
Northside Hospital	Fulton	206	Cobb
Northside Hospital	Fulton	2	Columbia
Northside Hospital	Fulton	4	Coweta
Northside Hospital	Fulton	2	Dawson
Northside Hospital	Fulton	239	DeKalb
Northside Hospital	Fulton	12	Douglas
Northside Hospital	Fulton	3	Fannin
Northside Hospital	Fulton	10	Fayette
Northside Hospital	Fulton	7	Florida
Northside Hospital	Fulton	2	Floyd
Northside Hospital	Fulton	28	Forsyth
Northside Hospital	Fulton	362	Fulton
Northside Hospital	Fulton	5	Gilmer
Northside Hospital	Fulton	2	Gordon
Northside Hospital	Fulton	4	Greene
Northside Hospital	Fulton	129	Gwinnett
Northside Hospital	Fulton	2	Habersham
Northside Hospital	Fulton	6	Hall
Northside Hospital	Fulton	4	Haralson
Northside Hospital	Fulton	3	Harris
Northside Hospital	Fulton	1	Heard
Northside Hospital	Fulton	17	Henry
Northside Hospital	Fulton	1	Houston
Northside Hospital	Fulton	4	Jackson
Northside Hospital	Fulton	2	Jasper
Northside Hospital	Fulton	1	Laurens
Northside Hospital	Fulton	1	Lumpkin
Northside Hospital	Fulton	1	Monroe

Northside Hospital	Fulton	1	Morgan
Northside Hospital	Fulton	1	Murray
Northside Hospital	Fulton	3	Muscogee
Northside Hospital	Fulton	13	Newton
Northside Hospital	Fulton	3	North Carolina
Northside Hospital	Fulton	8	Other Out of State
Northside Hospital	Fulton	4	Paulding
Northside Hospital	Fulton	9	Pickens
Northside Hospital	Fulton	1	Pike
Northside Hospital	Fulton	2	Polk
Northside Hospital	Fulton	1	Putnam
Northside Hospital	Fulton	1	Rabun
Northside Hospital	Fulton	6	Rockdale
Northside Hospital	Fulton	1	South Carolina
Northside Hospital	Fulton	1	Spalding
Northside Hospital	Fulton	4	Tennessee
Northside Hospital	Fulton	2	Tift
Northside Hospital	Fulton	2	Towns
Northside Hospital	Fulton	5	Troup
Northside Hospital	Fulton	4	Union
Northside Hospital	Fulton	13	Walton
Northside Hospital	Fulton	2	Whitfield
Northside Hospital	Fulton	1	Wilkes
Total		**1,242**	

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: Robert Quattrocchi

Date: 05/17/2013

Title: President & CEO

Comments: