Georgia Department of Community Health

2013 Positron Emission Tomography (PET) Services Survey

Part A : General Information

1. Identification

UID:HOSP617

Facility Name: Piedmont Hospital

County: Fulton

Street Address: 1968 Peachtree Road NW

City: Atlanta

Zip: 30309-1285

Mailing Address: 1968 Peachtree Road NW

Mailing City: Atlanta

Mailing Zip: 30309-1285

Medicaid Provider Number: 00001504

Medicare Provider Number: 110083

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: Ross Sloop

Contact Title: Senior Director, Finance

Phone: 404-605-4237

Fax: 404-588-4526

E-mail: ross.sloop@piedmont.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
Piedmont Healthcare, Inc.	Not for Profit	06/13/1983

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
N/A	Not Applicable	

D. Operator's Parent Organization

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

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.

115-001

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
2009 Philips PET/CT Gemini TF

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	137	243	106
Colon and Rectal Cancers	94	146	52
Lymphoma Cancers	91	147	56
Melanoma Cancers	26	29	3
Esophageal Cancers	24	36	12
Head and Neck Cancers	45	62	17
Breast Cancers	122	204	82
Other Cancers	116	161	45
Total	**655**	**1,028**	**373**

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

Other Diagnostic Areas	Number of Patients	Number of Scans
All Other Patients	174	210
Total	**174**	**210**

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	412
Medicaid	22
Third-Party	375
Self-Pay	20
Total	**829**

2. Total Charges and Adjusted Gross Revenue

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

Total Charges	Adjusted Gross Revenue
14,271,697	7,833,682

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
101,358	28

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)?

11,708

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	2
Asian	11
Black/African American	198
Hispanic/Latino	4
Pacific Islander/Hawaiian	1
White	609
Multi-Racial	4
Total	**829**

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	167	246
Ages 65-74	110	130
Ages 75-85	71	74
Ages 85 and Up	11	20
Total	**359**	**470**

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: 8am until 4pm

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
255

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
Piedmont Hospital	Fulton	2	Florida
Piedmont Hospital	Fulton	1	Banks
Piedmont Hospital	Fulton	4	Barrow
Piedmont Hospital	Fulton	2	Bartow
Piedmont Hospital	Fulton	1	South Carolina
Piedmont Hospital	Fulton	2	Butts
Piedmont Hospital	Fulton	2	Carroll
Piedmont Hospital	Fulton	1	Chatham
Piedmont Hospital	Fulton	24	Cherokee
Piedmont Hospital	Fulton	1	Clay
Piedmont Hospital	Fulton	21	Clayton
Piedmont Hospital	Fulton	110	Cobb
Piedmont Hospital	Fulton	1	Colquitt
Piedmont Hospital	Fulton	13	Coweta
Piedmont Hospital	Fulton	2	Dawson
Piedmont Hospital	Fulton	110	DeKalb
Piedmont Hospital	Fulton	16	Douglas
Piedmont Hospital	Fulton	3	Fannin
Piedmont Hospital	Fulton	22	Fayette
Piedmont Hospital	Fulton	1	Floyd
Piedmont Hospital	Fulton	8	Forsyth
Piedmont Hospital	Fulton	1	Franklin
Piedmont Hospital	Fulton	335	Fulton
Piedmont Hospital	Fulton	2	Gilmer
Piedmont Hospital	Fulton	1	Glynn
Piedmont Hospital	Fulton	2	Gordon
Piedmont Hospital	Fulton	2	Greene
Piedmont Hospital	Fulton	40	Gwinnett
Piedmont Hospital	Fulton	1	Habersham
Piedmont Hospital	Fulton	3	Hall
Piedmont Hospital	Fulton	1	Haralson
Piedmont Hospital	Fulton	1	Heard
Piedmont Hospital	Fulton	31	Henry
Piedmont Hospital	Fulton	2	Jackson
Piedmont Hospital	Fulton	1	Jasper
Piedmont Hospital	Fulton	1	Lamar
Piedmont Hospital	Fulton	1	Lee

Piedmont Hospital	Fulton	1	Lincoln
Piedmont Hospital	Fulton	1	Mitchell
Piedmont Hospital	Fulton	1	Monroe
Piedmont Hospital	Fulton	8	Newton
Piedmont Hospital	Fulton	4	Other Out of State
Piedmont Hospital	Fulton	8	Paulding
Piedmont Hospital	Fulton	11	Pickens
Piedmont Hospital	Fulton	3	Pike
Piedmont Hospital	Fulton	1	Rabun
Piedmont Hospital	Fulton	2	Rockdale
Piedmont Hospital	Fulton	5	Spalding
Piedmont Hospital	Fulton	1	Toombs
Piedmont Hospital	Fulton	1	Towns
Piedmont Hospital	Fulton	2	Troup
Piedmont Hospital	Fulton	2	Union
Piedmont Hospital	Fulton	1	Upson
Piedmont Hospital	Fulton	1	Walker
Piedmont Hospital	Fulton	3	Walton
Piedmont Hospital	Fulton	1	Wilcox
Total		**829**	

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: Les Donahue

Date: 07/21/2014

Title: Chief Executive Officer

Comments: