



## 2014 Positron Emission Tomography (PET) Services Survey

### Part A : General Information

#### 1. Identification

UID:DTRC097

**Facility Name:** Georgia Institute for Lung Cancer Research, Inc. (c/o Alliance Imaging)

**County:** Fulton

**Street Address:** 245 Boulevard, NE

**City:** Atlanta

**Zip:** 30312

**Mailing Address:** 2495 Cedar Canyon Place

**Mailing City:** Marietta

**Mailing Zip:** 30067

**Medicaid Provider Number:** 000000

**Medicare Provider Number:** 000000

#### 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:** Jenny Sommerville

**Contact Title:** Manager of Operation

**Phone:** 770-714-5940

**Fax:** 480-212-8584

**E-mail:** jsommerville@allianceimaging.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
Georgia Institute for Lung Cancer Research	For Profit	10/01/2006

#### B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Alliance Imaging	For Profit	10/01/2006

#### 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.)

Mobile Vendor CON Holder

#### 3b. Certificate of Need Project Number

Please enter the Certificate of Need project number.

2000-033

**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

**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	33	33	5
Colon and Rectal Cancers	17	17	0
Lymphoma Cancers	14	14	2
Melanoma Cancers	0	0	0
Esophageal Cancers	1	1	0
Head and Neck Cancers	15	15	0
Breast Cancers	12	12	2
Other Cancers	19	19	3
<b>Total</b>	<b>111</b>	<b>111</b>	<b>12</b>

Cardiovascular Patients	Number of Patients	Number of Scans
All Cardiovascular Patients	0	0
<b>Total</b>	<b>0</b>	<b>0</b>

Neurology Patients	Number of Patients	Number of Scans
Dementias (including Alzheimer's)	1	1
Other Neurological Use	0	0
<b>Total</b>	<b>1</b>	<b>1</b>

Other Diagnostic Areas	Number of Patients	Number of Scans
All Other Patients	0	0
<b>Total</b>	<b>0</b>	<b>0</b>

## 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	27
Medicaid	15
Third-Party	66
Self-Pay	4
<b>Total</b>	<b>112</b>

### **2. Total Charges and Adjusted Gross Revenue**

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

Total Charges	Adjusted Gross Revenue
0	0

### **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
0	0

### **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)?

0

### **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	0
Asian	0
Black/African American	63
Hispanic/Latino	2
Pacific Islander/Hawaiian	0
White	47
Multi-Racial	0
<b>Total</b>	<b>112</b>

### **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	28	30
Ages 65-74	20	21
Ages 75-85	6	6
Ages 85 and Up	0	1
<b>Total</b>	<b>54</b>	<b>58</b>

**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:** 7am until 5pm

**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
56

**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 location 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
Atlanta Medical Center	Fulton	4.00	4.00	5.00	4.00	4.00	5.00	4.00	4.00	5.00	4.00	4.00	5.00
West Georgia Medical Center	Troup	4.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

**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 locations(s) provided above.

Name	County	Patients Served	Patient County
Atlanta Medical Center	Fulton	1	Butts
Atlanta Medical Center	Fulton	1	Cherokee
Atlanta Medical Center	Fulton	8	Clayton
Atlanta Medical Center	Fulton	1	Cobb
Atlanta Medical Center	Fulton	15	DeKalb
Atlanta Medical Center	Fulton	50	Fulton
Atlanta Medical Center	Fulton	1	Gwinnett
Atlanta Medical Center	Fulton	3	Habersham
Atlanta Medical Center	Fulton	2	Hart
Atlanta Medical Center	Fulton	3	Henry
Atlanta Medical Center	Fulton	2	Newton
Atlanta Medical Center	Fulton	1	Peach
Atlanta Medical Center	Fulton	2	Spalding
Atlanta Medical Center	Fulton	1	Whitfield
West Georgia Medical Center	Troup	1	Heard
West Georgia Medical Center	Troup	3	Meriwether
West Georgia Medical Center	Troup	4	Other Out of State
West Georgia Medical Center	Troup	13	Troup
<b>Total</b>		<b>112</b>	

## 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 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:** Jenny Sommerville

**Date:** 04/21/2015

**Title:** Manager of Operations

**Comments:**