



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2014 Positron Emission Tomography (PET) Services Survey

Part A : General Information

1. Identification

UID:dtrc123

Facility Name: Northside/Fayetteville Imaging

County: Fayette

Street Address: 1275 Highway 54 West, Suite 102

City: Fayetteville

Zip: 30214

Mailing Address: 1275 Highway 54 West, Suite 102

Mailing City: Fayetteville

Mailing Zip: 30214

Medicaid Provider Number: 00001405

Medicare Provider Number: 110161

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: Brian J. Toporek

Contact Title: Senior Planner, Northside Hospital

Phone: 404-851-6821

Fax: 404-303-3820

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
Northside Hospital, Inc.	Not for Profit	05/04/2014

B. Owner's Parent Organization

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

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northside Hospital, Inc.	Not for Profit	05/04/2014

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.

Effective on 5/4/2014, Northside Hospital, Inc. acquired this facility and began operating it as a hospital-based PET service.

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.

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 40 PET/CT

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	292	327	121
Colon and Rectal Cancers	164	185	87
Lymphoma Cancers	147	174	94
Melanoma Cancers	20	20	6
Esophageal Cancers	29	35	20
Head and Neck Cancers	96	111	54
Breast Cancers	270	313	160
Other Cancers	266	295	66
Total	1,284	1,460	608

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 (including Alzheimer's)	29	32
Other Neurological Use	0	0
Total	29	32

Other Diagnostic Areas	Number of Patients	Number of Scans
All Other Patients	57	61
Total	57	61

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	710
Medicaid	103
Third-Party	452
Self-Pay	45
Total	1,310

2. Total Charges and Adjusted Gross Revenue

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

Total Charges	Adjusted Gross Revenue
13,578,890	6,371,250

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
505,252	108

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)?

8,744

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	23
Black/African American	390
Hispanic/Latino	21
Pacific Islander/Hawaiian	1
White	846
Multi-Racial	27
Total	1,310

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	236	406
Ages 65-74	188	215
Ages 75-85	111	110
Ages 85 and Up	18	26
Total	553	757

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: 8 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
252

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
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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
Northside/Fayetteville PET Imaging Center	Fayette	7	Alabama
Northside/Fayetteville PET Imaging Center	Fayette	57	Butts
Northside/Fayetteville PET Imaging Center	Fayette	4	Carroll
Northside/Fayetteville PET Imaging Center	Fayette	1	Cherokee
Northside/Fayetteville PET Imaging Center	Fayette	1	Clarke
Northside/Fayetteville PET Imaging Center	Fayette	160	Clayton
Northside/Fayetteville PET Imaging Center	Fayette	4	Cobb
Northside/Fayetteville PET Imaging Center	Fayette	102	Coweta
Northside/Fayetteville PET Imaging Center	Fayette	22	DeKalb
Northside/Fayetteville PET Imaging Center	Fayette	1	Dougherty
Northside/Fayetteville PET Imaging Center	Fayette	215	Fayette
Northside/Fayetteville PET Imaging Center	Fayette	92	Fulton
Northside/Fayetteville PET Imaging Center	Fayette	3	Gilmer
Northside/Fayetteville PET Imaging Center	Fayette	3	Gwinnett
Northside/Fayetteville PET Imaging Center	Fayette	1	Haralson
Northside/Fayetteville PET Imaging Center	Fayette	5	Harris
Northside/Fayetteville PET Imaging Center	Fayette	1	Heard
Northside/Fayetteville PET Imaging Center	Fayette	276	Henry
Northside/Fayetteville PET Imaging Center	Fayette	2	Jasper
Northside/Fayetteville PET Imaging Center	Fayette	45	Lamar
Northside/Fayetteville PET Imaging Center	Fayette	1	Lee
Northside/Fayetteville PET Imaging Center	Fayette	12	Meriwether
Northside/Fayetteville PET Imaging Center	Fayette	3	Monroe
Northside/Fayetteville PET Imaging Center	Fayette	7	Muscogee
Northside/Fayetteville PET Imaging Center	Fayette	2	Newton
Northside/Fayetteville PET Imaging Center	Fayette	3	Other Out of State
Northside/Fayetteville PET Imaging Center	Fayette	1	Peach
Northside/Fayetteville PET Imaging Center	Fayette	40	Pike
Northside/Fayetteville PET Imaging Center	Fayette	2	Rockdale
Northside/Fayetteville PET Imaging Center	Fayette	199	Spalding
Northside/Fayetteville PET Imaging Center	Fayette	2	Talbot
Northside/Fayetteville PET Imaging Center	Fayette	5	Troup
Northside/Fayetteville PET Imaging Center	Fayette	29	Upson
Northside/Fayetteville PET Imaging Center	Fayette	2	Whitfield
Total		1,310	

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: Robert Quattrocchi

Date: 05/15/2015

Title: CEO, Northside Hospital, Inc.

Comments: