



## 2014 Positron Emission Tomography (PET) Services Survey

### Part A : General Information

#### 1. Identification

UID:hosp615

**Facility Name:** WellStar Kennestone Hospital

**County:** Cobb

**Street Address:** 677 Church Street

**City:** Marietta

**Zip:** Georgia

**Mailing Address:** 30060

**Mailing City:** 677 Church Street

**Mailing Zip:** 30060

**Medicaid Provider Number:** 000001119

**Medicare Provider Number:** 110035

#### 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:** April Austin

**Contact Title:** Regulatory Planning Coordinator

**Phone:** 470-644-0057

**Fax:** 770-509-4270

**E-mail:** April.Austin@WellStar.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
Cobb County Kennestone Hospital Authority	Hospital Authority	01/01/1948

#### B. Owner's Parent Organization

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

#### C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Kennestone Hospital Inc.	Not for Profit	02/16/1993

#### D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
WellStar Health System	Not for Profit	02/16/1993

#### E. Management Contractor

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

#### F. Management's Parent Organization

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

### 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 124-88

**3c. Name of Mobile Vendor (If selected PET CON (Mobile Contract) at 3A. above.)**

N/A

**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  
Phillips PET/CT Gemini

**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	591	685	308
Colon and Rectal Cancers	175	241	177
Lymphoma Cancers	243	328	228
Melanoma Cancers	62	80	52
Esophageal Cancers	58	86	58
Head and Neck Cancers	148	170	109
Breast Cancers	283	385	296
Other Cancers	323	409	266
<b>Total</b>	<b>1,883</b>	<b>2,384</b>	<b>1,494</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)	0	0
Other Neurological Use	1	1
<b>Total</b>	<b>1</b>	<b>1</b>

Other Diagnostic Areas	Number of Patients	Number of Scans
All Other Patients	91	135
<b>Total</b>	<b>91</b>	<b>135</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	1,084
Medicaid	91
Third-Party	661
Self-Pay	81
<b>Total</b>	<b>1,917</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
23,699,987	10,965,562

### **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
552,496	121

### **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)?

9,431

### **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	3
Asian	25
Black/African American	229
Hispanic/Latino	79
Pacific Islander/Hawaiian	1
White	1,473
Multi-Racial	107
<b>Total</b>	<b>1,917</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	351	514
Ages 65-74	287	308
Ages 75-85	187	197
Ages 85 and Up	31	42
<b>Total</b>	<b>856</b>	<b>1,061</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: 7 until 5

**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
260

**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
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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
WellStar Kennestone Hospital	Cobb	4	Alabama
WellStar Kennestone Hospital	Cobb	41	Bartow
WellStar Kennestone Hospital	Cobb	10	Carroll
WellStar Kennestone Hospital	Cobb	3	Chattooga
WellStar Kennestone Hospital	Cobb	263	Cherokee
WellStar Kennestone Hospital	Cobb	5	Clayton
WellStar Kennestone Hospital	Cobb	1,094	Cobb
WellStar Kennestone Hospital	Cobb	2	Dawson
WellStar Kennestone Hospital	Cobb	7	DeKalb
WellStar Kennestone Hospital	Cobb	70	Douglas
WellStar Kennestone Hospital	Cobb	5	Fannin
WellStar Kennestone Hospital	Cobb	1	Fayette
WellStar Kennestone Hospital	Cobb	7	Florida
WellStar Kennestone Hospital	Cobb	1	Floyd
WellStar Kennestone Hospital	Cobb	7	Forsyth
WellStar Kennestone Hospital	Cobb	50	Fulton
WellStar Kennestone Hospital	Cobb	9	Gilmer
WellStar Kennestone Hospital	Cobb	2	Gordon
WellStar Kennestone Hospital	Cobb	13	Gwinnett
WellStar Kennestone Hospital	Cobb	1	Habersham
WellStar Kennestone Hospital	Cobb	1	Hall
WellStar Kennestone Hospital	Cobb	3	Haralson
WellStar Kennestone Hospital	Cobb	1	Hart
WellStar Kennestone Hospital	Cobb	4	Henry
WellStar Kennestone Hospital	Cobb	1	Jackson
WellStar Kennestone Hospital	Cobb	1	Monroe
WellStar Kennestone Hospital	Cobb	1	Murray
WellStar Kennestone Hospital	Cobb	1	Muscogee
WellStar Kennestone Hospital	Cobb	2	North Carolina
WellStar Kennestone Hospital	Cobb	11	Other Out of State
WellStar Kennestone Hospital	Cobb	253	Paulding
WellStar Kennestone Hospital	Cobb	14	Pickens
WellStar Kennestone Hospital	Cobb	11	Polk
WellStar Kennestone Hospital	Cobb	2	Rabun
WellStar Kennestone Hospital	Cobb	1	Richmond
WellStar Kennestone Hospital	Cobb	2	Rockdale
WellStar Kennestone Hospital	Cobb	1	Spalding

WellStar Kennestone Hospital	Cobb	2	Stephens
WellStar Kennestone Hospital	Cobb	1	Sumter
WellStar Kennestone Hospital	Cobb	1	Tennessee
WellStar Kennestone Hospital	Cobb	1	Towns
WellStar Kennestone Hospital	Cobb	1	Troup
WellStar Kennestone Hospital	Cobb	4	Union
WellStar Kennestone Hospital	Cobb	2	White
<b>Total</b>		<b>1,917</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:** Reynold J. Jennings

**Date:** 06/15/2015

**Title:** President and C.E.O.

**Comments:**

Part E.3. Following a conversion to the EPIC electronic medical records system in 2014, the number of indigent and charity care patients and their related charges were not being fully captured in the patient record. As a result, the numbers presented in this survey were manually counted and may not reflect the total amount of uncompensated services provided.