



2018 Positron Emission Tomography (PET) Services Survey

Part A : General Information

1. Identification

UID:DTRC142

Facility Name: Northside/Decatur Imaging

County: DeKalb

Street Address: 2545 Lawrenceville Hwy., Suite 250

City: Decatur

Zip: 30033

Mailing Address: 2545 Lawrenceville Hwy., Suite 250

Mailing City: Decatur

Mailing Zip: 30033

Medicaid Provider Number: 00001405

Medicare Provider Number: 110161

2. Report Period

Report Data for the full twelve month period- January 1, 2018 through December 31, 2018.

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, Inc.

Phone: 404-851-6821

Fax: 404-250-3102

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	01/01/2014

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	01/01/2014

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.

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-2001-042

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
Siemens Biograph mCT 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	52	72	35
Colon and Rectal Cancers	48	65	37
Lymphoma Cancers	68	87	49
Melanoma Cancers	17	24	12
Esophageal Cancers	5	7	2
Head and Neck Cancers	29	34	11
Breast Cancers	88	97	38
Other Cancers	193	217	104
Total	500	603	288

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)	0	0
Other Neurological Use	0	0
Total	0	0

Other Diagnostic Areas	Number of Patients	Number of Scans
All Other Patients	249	278
Total	249	278

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	303
Medicaid	34
Third-Party	353
Self-Pay	46
Total	736

2. Total Charges and Adjusted Gross Revenue

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

Total Charges	Adjusted Gross Revenue
12,184,624	6,348,513

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
1,041,199	145

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)?

13,830

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	23
Black/African American	237
Hispanic/Latino	14
Pacific Islander/Hawaiian	1
White	408
Multi-Racial	53
Total	736

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	155	191
Ages 65-74	135	119
Ages 75-85	57	63
Ages 85 and Up	7	9
Total	354	382

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: 8:00 AM until 4:00 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
238

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 locations(s) provided above.

Name	County	Patients Served	Patient County
Decatur PET Imaging	DeKalb	1	Alabama
Decatur PET Imaging	DeKalb	2	Barrow
Decatur PET Imaging	DeKalb	1	Bartow
Decatur PET Imaging	DeKalb	2	Bibb
Decatur PET Imaging	DeKalb	2	Carroll
Decatur PET Imaging	DeKalb	14	Cherokee
Decatur PET Imaging	DeKalb	5	South Carolina
Decatur PET Imaging	DeKalb	3	Spalding
Decatur PET Imaging	DeKalb	1	Thomas
Decatur PET Imaging	DeKalb	2	Troup
Decatur PET Imaging	DeKalb	1	Walker
Decatur PET Imaging	DeKalb	11	Walton
Decatur PET Imaging	DeKalb	1	Wilcox
Decatur PET Imaging	DeKalb	3	Clarke
Decatur PET Imaging	DeKalb	9	Clayton
Decatur PET Imaging	DeKalb	41	Cobb
Decatur PET Imaging	DeKalb	1	Columbia
Decatur PET Imaging	DeKalb	1	Coweta
Decatur PET Imaging	DeKalb	1	Dawson
Decatur PET Imaging	DeKalb	225	DeKalb
Decatur PET Imaging	DeKalb	1	Dougherty
Decatur PET Imaging	DeKalb	10	Douglas
Decatur PET Imaging	DeKalb	2	Fannin
Decatur PET Imaging	DeKalb	2	Fayette
Decatur PET Imaging	DeKalb	4	Florida
Decatur PET Imaging	DeKalb	11	Forsyth
Decatur PET Imaging	DeKalb	116	Fulton
Decatur PET Imaging	DeKalb	2	Gilmer
Decatur PET Imaging	DeKalb	1	Gordon
Decatur PET Imaging	DeKalb	74	Gwinnett
Decatur PET Imaging	DeKalb	1	Habersham
Decatur PET Imaging	DeKalb	16	Hall
Decatur PET Imaging	DeKalb	19	Henry
Decatur PET Imaging	DeKalb	7	Jackson
Decatur PET Imaging	DeKalb	4	Jasper
Decatur PET Imaging	DeKalb	1	Lamar
Decatur PET Imaging	DeKalb	2	Laurens

Decatur PET Imaging	DeKalb	2	Lumpkin
Decatur PET Imaging	DeKalb	1	Madison
Decatur PET Imaging	DeKalb	2	Meriwether
Decatur PET Imaging	DeKalb	6	Morgan
Decatur PET Imaging	DeKalb	2	Muscogee
Decatur PET Imaging	DeKalb	5	North Carolina
Decatur PET Imaging	DeKalb	62	Newton
Decatur PET Imaging	DeKalb	5	Other Out of State
Decatur PET Imaging	DeKalb	2	Paulding
Decatur PET Imaging	DeKalb	3	Pickens
Decatur PET Imaging	DeKalb	1	Putnam
Decatur PET Imaging	DeKalb	1	Rabun
Decatur PET Imaging	DeKalb	44	Rockdale
Total		736	

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: 05/10/2019

Title: CEO and President

Comments: