



2020 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 Highway, Suite 250

City: Decatur

Zip: 30033

Mailing Address: 2545 Lawrenceville Highway, 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, 2020 through December 31, 2020.

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

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	60	75	57
Colon and Rectal Cancers	60	75	62
Lymphoma Cancers	131	191	158
Melanoma Cancers	32	43	29
Esophageal Cancers	71	86	57
Head and Neck Cancers	25	29	21
Breast Cancers	108	148	116
Other Cancers	195	235	205
Total	682	882	705

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	186	208
Total	186	208

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	401
Medicaid	26
Third-Party	317
Self-Pay	95
Total	839

2. Total Charges and Adjusted Gross Revenue

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

Total Charges	Adjusted Gross Revenue
15,253,442	7,360,668

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
1,997,325	231

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)?

13,994

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	1
Asian	18
Black/African American	296
Hispanic/Latino	36
Pacific Islander/Hawaiian	0
White	418
Multi-Racial	70
Total	839

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	234
Ages 65-74	128	112
Ages 75-85	97	67
Ages 85 and Up	17	17
Total	409	430

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: 8:00AM until 4:00PM

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 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
Northside/Decatur Imaging	DeKalb	5	Alabama
Northside/Decatur Imaging	DeKalb	2	Barrow
Northside/Decatur Imaging	DeKalb	3	Bartow
Northside/Decatur Imaging	DeKalb	2	Bibb
Northside/Decatur Imaging	DeKalb	2	Butts
Northside/Decatur Imaging	DeKalb	13	Cherokee
Northside/Decatur Imaging	DeKalb	6	Clarke
Northside/Decatur Imaging	DeKalb	13	Clayton
Northside/Decatur Imaging	DeKalb	41	Cobb
Northside/Decatur Imaging	DeKalb	1	Coweta
Northside/Decatur Imaging	DeKalb	4	Dawson
Northside/Decatur Imaging	DeKalb	287	DeKalb
Northside/Decatur Imaging	DeKalb	3	Douglas
Northside/Decatur Imaging	DeKalb	4	Fannin
Northside/Decatur Imaging	DeKalb	2	Fayette
Northside/Decatur Imaging	DeKalb	3	Florida
Northside/Decatur Imaging	DeKalb	1	Floyd
Northside/Decatur Imaging	DeKalb	12	Forsyth
Northside/Decatur Imaging	DeKalb	130	Fulton
Northside/Decatur Imaging	DeKalb	1	Glynn
Northside/Decatur Imaging	DeKalb	1	Gordon
Northside/Decatur Imaging	DeKalb	3	Greene
Northside/Decatur Imaging	DeKalb	67	Gwinnett
Northside/Decatur Imaging	DeKalb	1	Habersham
Northside/Decatur Imaging	DeKalb	6	Hall
Northside/Decatur Imaging	DeKalb	2	Haralson
Northside/Decatur Imaging	DeKalb	1	Harris
Northside/Decatur Imaging	DeKalb	17	Henry
Northside/Decatur Imaging	DeKalb	2	Houston
Northside/Decatur Imaging	DeKalb	3	Jackson
Northside/Decatur Imaging	DeKalb	4	Jasper
Northside/Decatur Imaging	DeKalb	1	Madison
Northside/Decatur Imaging	DeKalb	3	Morgan
Northside/Decatur Imaging	DeKalb	1	Muscogee
Northside/Decatur Imaging	DeKalb	3	North Carolina
Northside/Decatur Imaging	DeKalb	81	Newton
Northside/Decatur Imaging	DeKalb	1	Oglethorpe

Northside/Decatur Imaging	DeKalb	3	Other Out of State
Northside/Decatur Imaging	DeKalb	1	Paulding
Northside/Decatur Imaging	DeKalb	3	Pickens
Northside/Decatur Imaging	DeKalb	1	Pike
Northside/Decatur Imaging	DeKalb	1	Pulaski
Northside/Decatur Imaging	DeKalb	1	Putnam
Northside/Decatur Imaging	DeKalb	1	Quitman
Northside/Decatur Imaging	DeKalb	1	Rabun
Northside/Decatur Imaging	DeKalb	67	Rockdale
Northside/Decatur Imaging	DeKalb	2	South Carolina
Northside/Decatur Imaging	DeKalb	2	Spalding
Northside/Decatur Imaging	DeKalb	3	Tennessee
Northside/Decatur Imaging	DeKalb	1	Troup
Northside/Decatur Imaging	DeKalb	1	Union
Northside/Decatur Imaging	DeKalb	1	Upson
Northside/Decatur Imaging	DeKalb	17	Walton
Northside/Decatur Imaging	DeKalb	1	Wilkes
Total		839	

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: 05/07/2021

Title: CEO

Comments: