



## 2019 Positron Emission Tomography (PET) Services Survey

### Part A : General Information

#### 1. Identification

UID:HOSP366

**Facility Name:** Northside Hospital Gwinnett

**County:** Gwinnett

**Street Address:** 1000 Medical Center Boulevard

**City:** Lawrenceville

**Zip:** 30046

**Mailing Address:** PO Box 348

**Mailing City:** Lawrenceville

**Mailing Zip:** 30046

**Medicaid Provider Number:** 00000294

**Medicare Provider Number:** 110087

#### 2. Report Period

Report Data for the full twelve month period- January 1, 2019 through December 31, 2019.  
***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
Hospital Authority of Gwinnett County	Hospital Authority	01/01/1957

#### B. Owner's Parent Organization

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

#### C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northside Hospital, Inc.	Not for Profit	08/28/2019

#### 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.

Change in operation and management became effective on 08/28/2019.

#### 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-2009-009

**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 64 Slice 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	149	169	99
Colon and Rectal Cancers	100	113	59
Lymphoma Cancers	140	161	106
Melanoma Cancers	18	19	11
Esophageal Cancers	23	26	16
Head and Neck Cancers	72	78	42
Breast Cancers	138	158	86
Other Cancers	339	363	140
<b>Total</b>	<b>979</b>	<b>1,087</b>	<b>559</b>

Cardiovascular Patients	Number of Patients	Number of Scans
All Cardiovascular Patients	9	9
<b>Total</b>	<b>9</b>	<b>9</b>

Neurology Patients	Number of Patients	Number of Scans
Dementias (including Alzheimer's)	0	0
Other Neurological Use	2	2
<b>Total</b>	<b>2</b>	<b>2</b>

Other Diagnostic Areas	Number of Patients	Number of Scans
All Other Patients	303	305
<b>Total</b>	<b>303</b>	<b>305</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	595
Medicaid	107
Third-Party	527
Self-Pay	35
<b>Total</b>	<b>1,264</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
16,881,707	9,238,912

### **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
677,244	198

### **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)?

12,033

### **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	92
Black/African American	241
Hispanic/Latino	103
Pacific Islander/Hawaiian	0
White	778
Multi-Racial	50
<b>Total</b>	<b>1,264</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	235	327
Ages 65-74	201	211
Ages 75-85	117	130
Ages 85 and Up	9	34
<b>Total</b>	<b>562</b>	<b>702</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:** 7:00 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
250

**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
Gwinnett Medical Center	Gwinnett	1	Alabama
Gwinnett Medical Center	Gwinnett	1	Banks
Gwinnett Medical Center	Gwinnett	65	Barrow
Gwinnett Medical Center	Gwinnett	1	Cherokee
Gwinnett Medical Center	Gwinnett	1	Clarke
Gwinnett Medical Center	Gwinnett	2	Cobb
Gwinnett Medical Center	Gwinnett	1	Dawson
Gwinnett Medical Center	Gwinnett	42	DeKalb
Gwinnett Medical Center	Gwinnett	1	Douglas
Gwinnett Medical Center	Gwinnett	1	Elbert
Gwinnett Medical Center	Gwinnett	1	Fayette
Gwinnett Medical Center	Gwinnett	7	Forsyth
Gwinnett Medical Center	Gwinnett	47	Fulton
Gwinnett Medical Center	Gwinnett	3	Greene
Gwinnett Medical Center	Gwinnett	899	Gwinnett
Gwinnett Medical Center	Gwinnett	1	Habersham
Gwinnett Medical Center	Gwinnett	20	Hall
Gwinnett Medical Center	Gwinnett	1	Hart
Gwinnett Medical Center	Gwinnett	1	Henry
Gwinnett Medical Center	Gwinnett	31	Jackson
Gwinnett Medical Center	Gwinnett	1	Madison
Gwinnett Medical Center	Gwinnett	1	Monroe
Gwinnett Medical Center	Gwinnett	2	North Carolina
Gwinnett Medical Center	Gwinnett	3	Newton
Gwinnett Medical Center	Gwinnett	1	Oconee
Gwinnett Medical Center	Gwinnett	4	Other Out of State
Gwinnett Medical Center	Gwinnett	1	Pickens
Gwinnett Medical Center	Gwinnett	1	Putnam
Gwinnett Medical Center	Gwinnett	1	Rabun
Gwinnett Medical Center	Gwinnett	5	Rockdale
Gwinnett Medical Center	Gwinnett	2	Stephens
Gwinnett Medical Center	Gwinnett	1	Towns
Gwinnett Medical Center	Gwinnett	1	Upson
Gwinnett Medical Center	Gwinnett	109	Walton
Gwinnett Medical Center	Gwinnett	3	White
Gwinnett Medical Center	Gwinnett	1	Whitfield
<b>Total</b>		<b>1,264</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:** Deborah Mitcham

**Date:** 05/08/2020

**Title:** CEO

**Comments:**