



2019 Positron Emission Tomography (PET) Services Survey

Part A : General Information

1. Identification

UID:DTRC122

Facility Name: Northside/Lawrenceville Imaging

County: Gwinnett

Street Address: 555 Old Norcross Road

City: Lawrenceville

Zip: 30046

Mailing Address: 555 Old Norcross Road

Mailing City: Lawrenceville

Mailing Zip: 30046

Medicaid Provider Number: 00001405

Medicare Provider Number: 110161

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
Northside Hospital, Inc.	Not for Profit	06/02/2014

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	06/02/2014

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northside Health System, 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-2007-001

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
GE Discovery ST 16 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	45	52	15
Colon and Rectal Cancers	38	42	13
Lymphoma Cancers	56	73	28
Melanoma Cancers	23	26	17
Esophageal Cancers	10	10	1
Head and Neck Cancers	29	33	8
Breast Cancers	64	72	19
Other Cancers	291	326	117
Total	556	634	218

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	135	137
Total	135	137

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	314
Medicaid	15
Third-Party	280
Self-Pay	65
Total	674

2. Total Charges and Adjusted Gross Revenue

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

Total Charges	Adjusted Gross Revenue
10,322,520	5,491,509

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
1,517,715	358

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)?

13,388

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	30
Black/African American	95
Hispanic/Latino	52
Pacific Islander/Hawaiian	0
White	434
Multi-Racial	62
Total	674

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	139	204
Ages 65-74	115	99
Ages 75-85	64	36
Ages 85 and Up	12	5
Total	330	344

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: 8:30 AM until 5:00 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
255

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/Lawrenceville Imaging	Gwinnett	1	Banks
Northside/Lawrenceville Imaging	Gwinnett	12	Barrow
Northside/Lawrenceville Imaging	Gwinnett	1	Chatham
Northside/Lawrenceville Imaging	Gwinnett	18	Cherokee
Northside/Lawrenceville Imaging	Gwinnett	10	Clarke
Northside/Lawrenceville Imaging	Gwinnett	1	Clayton
Northside/Lawrenceville Imaging	Gwinnett	21	Cobb
Northside/Lawrenceville Imaging	Gwinnett	13	Dawson
Northside/Lawrenceville Imaging	Gwinnett	33	DeKalb
Northside/Lawrenceville Imaging	Gwinnett	2	Dodge
Northside/Lawrenceville Imaging	Gwinnett	4	Douglas
Northside/Lawrenceville Imaging	Gwinnett	2	Elbert
Northside/Lawrenceville Imaging	Gwinnett	2	Fannin
Northside/Lawrenceville Imaging	Gwinnett	1	Florida
Northside/Lawrenceville Imaging	Gwinnett	1	Floyd
Northside/Lawrenceville Imaging	Gwinnett	40	Forsyth
Northside/Lawrenceville Imaging	Gwinnett	1	Franklin
Northside/Lawrenceville Imaging	Gwinnett	109	Fulton
Northside/Lawrenceville Imaging	Gwinnett	4	Gilmer
Northside/Lawrenceville Imaging	Gwinnett	6	Greene
Northside/Lawrenceville Imaging	Gwinnett	270	Gwinnett
Northside/Lawrenceville Imaging	Gwinnett	5	Habersham
Northside/Lawrenceville Imaging	Gwinnett	19	Hall
Northside/Lawrenceville Imaging	Gwinnett	1	Hancock
Northside/Lawrenceville Imaging	Gwinnett	3	Hart
Northside/Lawrenceville Imaging	Gwinnett	1	Henry
Northside/Lawrenceville Imaging	Gwinnett	8	Jackson
Northside/Lawrenceville Imaging	Gwinnett	1	Jasper
Northside/Lawrenceville Imaging	Gwinnett	4	Lumpkin
Northside/Lawrenceville Imaging	Gwinnett	1	Madison
Northside/Lawrenceville Imaging	Gwinnett	4	Morgan
Northside/Lawrenceville Imaging	Gwinnett	4	North Carolina
Northside/Lawrenceville Imaging	Gwinnett	7	Newton
Northside/Lawrenceville Imaging	Gwinnett	3	Oconee
Northside/Lawrenceville Imaging	Gwinnett	2	Other Out of State
Northside/Lawrenceville Imaging	Gwinnett	3	Paulding
Northside/Lawrenceville Imaging	Gwinnett	1	Peach

Northside/Lawrenceville Imaging	Gwinnett	3	Pickens
Northside/Lawrenceville Imaging	Gwinnett	2	Putnam
Northside/Lawrenceville Imaging	Gwinnett	4	Rockdale
Northside/Lawrenceville Imaging	Gwinnett	1	Spalding
Northside/Lawrenceville Imaging	Gwinnett	2	Stephens
Northside/Lawrenceville Imaging	Gwinnett	1	Towns
Northside/Lawrenceville Imaging	Gwinnett	2	Union
Northside/Lawrenceville Imaging	Gwinnett	37	Walton
Northside/Lawrenceville Imaging	Gwinnett	2	Whitfield
Northside/Lawrenceville Imaging	Gwinnett	1	Wilkes
Total		674	

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: 05/08/2020

Title: CEO

Comments: