GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2019 Positron Emission Tomography (PET) Services Survey

Part A : General Information

1. Identification

UID:HOSP901

Facility Name: Emory Johns Creek Hospital

County: Fulton

Street Address: 6325 Hospital Parkway

City: Johns Creek

Zip: 30097

Mailing Address: 6325 Hospital Parkway

Mailing City: Johns Creek

Mailing Zip: 30097

Medicaid Provider Number: 344886600

Medicare Provider Number: 110230

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: Patty Pharo

Contact Title: Senior Financial Analyst

Phone: 678-474-7045

Fax: 678-474-7053

E-mail: patty.pharo@emoryhealthcare.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
EHCA Johns Creek, LLC	Not for Profit	02/15/2005

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Emory/Saint Joseph's, Inc.	Not for Profit	01/01/2012

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Emory Healthcare, Inc.	Not for Profit	03/01/2011

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Emory University	Not for Profit	03/01/2011

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.)

PET CON (Mobile Contract)

3b. Certificate of Need Project Number

Please enter the Certificate of Need project number.

GA 2009-062

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

Alliance Healthcare Services

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 4 Slice

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	39	63	24
Colon and Rectal Cancers	34	51	17
Lymphoma Cancers	106	143	37
Melanoma Cancers	30	55	25
Esophageal Cancers	15	19	4
Head and Neck Cancers	26	36	10
Breast Cancers	114	157	43
Other Cancers	128	176	48
Total	**492**	**700**	**208**

Cardiovascular Patients	Number of Patients	Number of Scans
All Cardiovascular Patients	1	1
Total	**1**	**1**

Neurology Patients	Number of Patients	Number of Scans
Dementias (incuding Alzheimer's)	0	0
Other Neurological Use	1	1
Total	**1**	**1**

Other Diagnostic Areas	Number of Patients	Number of Scans
All Other Patients	94	102
Total	**94**	**102**

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	311
Medicaid	13
Third-Party	255
Self-Pay	9
Total	**588**

2. Total Charges and Adjusted Gross Revenue

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

Total Charges	Adjusted Gross Revenue
6,966,644	3,341,799

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
83,956	19

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)?

8,665

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	55
Black/African American	83
Hispanic/Latino	0
Pacific Islander/Hawaiian	1
White	412
Multi-Racial	34
Total	**588**

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	102	181
Ages 65-74	82	87
Ages 75-85	67	56
Ages 85 and Up	1	12
Total	**252**	**336**

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: 7am until 4pm

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
151

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 ocations(s) provided above.

Name	County	Patients Served	Patient County
Emory Johns Creek Hospital	Fulton	7	Barrow
Emory Johns Creek Hospital	Fulton	2	Bartow
Emory Johns Creek Hospital	Fulton	1	Berrien
Emory Johns Creek Hospital	Fulton	1	Bibb
Emory Johns Creek Hospital	Fulton	1	Butts
Emory Johns Creek Hospital	Fulton	3	Carroll
Emory Johns Creek Hospital	Fulton	20	Cherokee
Emory Johns Creek Hospital	Fulton	2	Clarke
Emory Johns Creek Hospital	Fulton	2	Clayton
Emory Johns Creek Hospital	Fulton	11	Cobb
Emory Johns Creek Hospital	Fulton	1	Coweta
Emory Johns Creek Hospital	Fulton	10	Dawson
Emory Johns Creek Hospital	Fulton	15	DeKalb
Emory Johns Creek Hospital	Fulton	1	Dougherty
Emory Johns Creek Hospital	Fulton	2	Douglas
Emory Johns Creek Hospital	Fulton	1	Fannin
Emory Johns Creek Hospital	Fulton	3	Florida
Emory Johns Creek Hospital	Fulton	55	Forsyth
Emory Johns Creek Hospital	Fulton	139	Fulton
Emory Johns Creek Hospital	Fulton	1	Gilmer
Emory Johns Creek Hospital	Fulton	1	Gordon
Emory Johns Creek Hospital	Fulton	208	Gwinnett
Emory Johns Creek Hospital	Fulton	4	Habersham
Emory Johns Creek Hospital	Fulton	25	Hall
Emory Johns Creek Hospital	Fulton	7	Henry
Emory Johns Creek Hospital	Fulton	24	Jackson
Emory Johns Creek Hospital	Fulton	4	Lumpkin
Emory Johns Creek Hospital	Fulton	1	Madison
Emory Johns Creek Hospital	Fulton	2	Newton
Emory Johns Creek Hospital	Fulton	3	North Carolina
Emory Johns Creek Hospital	Fulton	1	Oconee
Emory Johns Creek Hospital	Fulton	6	Other Out of State
Emory Johns Creek Hospital	Fulton	3	Pickens
Emory Johns Creek Hospital	Fulton	6	South Carolina
Emory Johns Creek Hospital	Fulton	1	Stephens
Emory Johns Creek Hospital	Fulton	2	Tennessee
Emory Johns Creek Hospital	Fulton	1	Thomas

Emory Johns Creek Hospital	Fulton	1	Toombs
Emory Johns Creek Hospital	Fulton	9	Walton
Emory Johns Creek Hospital	Fulton	1	Whitfield
Total		**588**	

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 incaccurate 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: Marilyn Margolis

Date: 05/26/2020

Title: Chief Executive Officer

Comments: