



## 2009 Hospital Financial Survey

### Part A : General Information

#### 1. Identification

UID:HOSP634

**Facility Name:** Northside Hospital

**County:** Fulton

**Street Address:** 1000 Johnson Ferry Road NE

**City:** Atlanta

**Zip:** 30342-1611

**Mailing Address:** 1000 Johnson Ferry Road NE

**Mailing City:** Atlanta

**Mailing Zip:** 30342-1611

#### 2. Report Period

Please report data for the hospital fiscal year ending during calendar year 2009 only.

***Do not use a different report period.***

**Please indicate your hospital fiscal year.**

From: 10/1/2008 To:9/30/2009

**Please indicate your cost report year.**

From: 10/01/2008 To:09/30/2009

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:** Shannon Asbury

**Contact Title:** Director of Finance

**Phone:** 404-303-3621

**Fax:** 404-303-3820

**E-mail:** shannon.asbury@northside.com

## Part C : Financial Data and Indigent and Charity Care

### 1. Financial Table

Please report the following data elements. Data reported here must balance in other parts of the HFS.

Revenue or Expense	Amount
Inpatient Gross Patient Revenue	1,001,942,417
Total Inpatient Admissions accounting for Inpatient Revenue	46,025
Outpatient Gross Patient Revenue	794,092,245
Total Outpatient Visits accounting for Outpatient Revenue	311,567
Medicare Contractual Adjustments	230,303,589
Medicaid Contractual Adjustments	159,622,662
Other Contractual Adjustments:	670,123,839
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	26,522,787
Uncompensated Indigent Care (net):	16,619,502
Uncompensated Charity Care (net):	44,264,547
Other Free Care:	0
Other Revenue/Gains:	32,851,440
Total Expenses:	629,874,252

### 2. Types of Other Free Care

Please enter the amount for each type of other free care. The amounts entered here must equal the total "Other Free Care" reported in Part C. Question 1. Use the blank line to indicate the type description and amount for other free care that is not included in the types listed.

Other Free Care Type	Other Free Care Amount
Self-Pay/Uninsured Discounts	0
Admin Discounts	0
Employee Discounts	0
	0
<b>Total</b>	<b>0</b>

## Part D : Indigent/Charity Care Policies and Agreements

### 1. Formal Written Policy

Did the hospital have a formal written policy or written policies concerning the provision of indigent and/or charity care during 2009? (Check box if yes.)

### 2. Effective Date

What was the effective date of the policy or policies in effect during 2009?

01/22/2010

### 3. Person Responsible

Please indicate the title or position held by the person most responsible for adherence to or interpretation of the policy or policies you will provide the department.?

Director of Business Office

#### **4. Charity Care Provisions**

Did the policy or policies include provisions for the care that is defined as charity pursuant to HFMA guidelines and the definitions contained in the Glossary that accompanies this survey (i.e., a sliding fee scale or the accomodation to provide care without the expectation of compensation for patients whose individual or family income exceeds 125% of federal poverty level guidelines)? (Check box if yes.)

#### **5. Maximum Income Level**

If you had a provision for charity care in your policy, as reflected by responding yes to item 4, what was the maximum income level, expressed as a percentage of the federal poverty guidelines, for a patient to be considered for charity care (e.g., 185%, 200%, 235%, etc.)?

125%

## 6. Agreements Concerning the Receipt of Government Funds

Did the hospital have an agreement or agreements with any city or county concerning the receipt of government funds for indigent and/or charity care during 2009? (Check box if yes.)

### Part E : Indigent And Charity Care

#### 1. Gross Indigent and Charity Care Charges

Please indicate the totals for indigent and charity care for the categories provided below. If the hospital used a sliding fee scale for certain charity patients, only the net charges to charity should be reported (i.e., gross patient charges less any payments received from or billed to the patient.) Total Uncompensated I/C Care must balance to totals reported in Part C.

Patient Type	Indigent Care	Charity Care	Total
Inpatient	9,254,616	24,781,258	34,035,874
Outpatient	7,364,886	22,739,276	30,104,162
<b>Total</b>	<b>16,619,502</b>	<b>47,520,534</b>	<b>64,140,036</b>

#### 2. Sources of Indigent and Charity Care Funding

Please indicate the source of funding for indigent and/or charity care in the table below.

Source of Funding	Amount
Home County	365,004
Other Counties	0
City Or Cities	0
Hospital Authority	0
State Programs And Any Other State Funds (Do Not Include Indigent Care Trust Funds)	2,890,983
Federal Government	0
Non-Government Sources	0
Charitable Contributions	0
Trust Fund From Sale Of Public Hospital	0
All Other	0
<b>Total</b>	<b>3,255,987</b>

#### 3. Net Uncompensated Indigent and Charity Care Charges

Total net indigent care must balance to Part C net indigent care and total net charity care must balance to Part C net charity care.

Patient Type	Indigent Care	Charity Care	Total
Inpatient	9,254,616	24,781,258	34,035,874
Outpatient	7,364,886	19,483,289	26,848,175
<b>Total</b>	<b>16,619,502</b>	<b>44,264,547</b>	<b>60,884,049</b>

## Part F : Patient Origin

### 1. Total Gross Indigent/Charity Care By Charges County

Please report Indigent/Charity Care by County in the following categories. For non Georgia use Alabama, Florida, North Carolina, South Carolina, Tennessee, or Other-Out-of-State.

To add a row press the button. To delete a row press the minus button at the end of the row.

(You may enter the data on the web form or upload the data to the web form using the .csv file.)

Inp Ad-I = Inpatient Admissions (Indigent Care)

Inp Ch-I = Inpatient Charges (Indigent Care)

Out Vis-I = Outpatient Visits (Indigent Care)

Out Ch-I = Outpatient Charges (Indigent Care)

Inp Ad-C = Inpatient Admissions (Charity Care)

Inp Ch-C = Inpatient Charges (Charity Care)

Out Vis-C = Outpatient Visits (Charity Care)

Out Ch-C = Outpatient Charges (Charity Care)

County	Inp Ad-I	Inp Ch-I	Out Vis-I	Out Ch-I	Inp Ad-C	Inp Ch-C	Out Vis-C	Out Ch-C
Alabama	1	30,330	2	18,175	6	231,133	41	79,463
Banks	0	0	0	0	2	3,275	0	0
Barrow	0	0	20	29,665	12	77,196	24	58,095
Bartow	0	0	7	6,060	14	172,651	45	196,724
Berrien	0	0	0	0	1	24,339	4	1,896
Bibb	0	0	0	0	0	0	4	7,730
Bleckley	0	0	0	0	1	100	0	0
Bulloch	0	0	0	0	2	1,304	4	4,495
Butts	0	0	0	0	0	0	1	123
Camden	0	0	0	0	1	35,219	0	0
Carroll	3	1,272	16	98,037	6	17,203	30	62,067
Catoosa	0	0	0	0	0	0	6	1,966
Chatham	0	0	1	697	0	0	4	1,968
Cherokee	29	164,878	155	519,554	85	394,967	466	506,473
Clarke	0	0	0	0	3	82,035	6	19,286
Clayton	5	2,211	11	1,910	17	129,753	141	188,988
Cobb	71	2,663,883	210	1,203,203	208	1,558,937	1,197	1,896,421
Colquitt	0	0	1	1,808	0	0	2	120
Columbia	0	0	0	0	0	0	3	4,921
Coweta	1	29,589	10	29,080	10	122,864	24	50,210
Dawson	1	22,586	3	186	10	10,452	30	52,130
Decatur	0	0	0	0	2	158,511	0	0
DeKalb	74	2,292,069	346	1,624,778	362	5,328,905	2,344	4,736,445
Dougherty	0	0	0	0	0	0	6	5,827
Douglas	3	41,472	18	57,506	23	137,550	113	162,633
Elbert	0	0	0	0	1	52,970	0	0
Fannin	0	0	9	86,001	8	636,136	15	288,739
Fayette	1	2,137	5	12,300	0	0	54	78,736
Florida	3	39,077	5	14,412	15	163,481	90	228,789
Floyd	0	0	0	0	1	110	4	15,584
Forsyth	16	10,733	68	299,660	74	941,932	353	478,156
Franklin	0	0	1	1,866	0	0	0	0

Fulton	104	2,694,468	370	1,196,640	494	5,957,754	7,596	8,474,388
Gilmer	2	45,091	4	21,824	4	88,610	5	4,288
Gordon	0	0	0	0	1	26,530	6	18,269
Grady	0	0	0	0	0	0	1	3,664
Greene	1	716	9	5,457	0	0	2	583
Gwinnett	87	911,842	317	1,569,486	316	4,340,990	1,775	3,150,101
Habersham	0	0	2	16,200	1	32,736	1	16,721
Hall	1	1,800	4	6,060	21	270,176	94	175,949
Haralson	0	0	1	209	2	17,380	4	4,402
Harris	0	0	0	0	0	0	1	1,474
Hart	0	0	0	0	0	0	1	545
Heard	0	0	0	0	1	550	0	0
Henry	1	46,575	1	228	12	75,303	60	87,798
Houston	0	0	3	2,565	1	1,852	10	14,801
Jackson	0	0	0	0	6	1,707,094	10	25,322
Jasper	0	0	0	0	0	0	2	7,620
Lamar	0	0	0	0	0	0	1	8,302
Laurens	0	0	0	0	0	0	4	8,655
Lee	0	0	0	0	1	1,534	3	2,484
Lowndes	0	0	0	0	3	91,787	1	5,213
Lumpkin	0	0	4	2,565	1	300	24	34,104
Meriwether	0	0	0	0	0	0	2	1,312
Monroe	2	3,115	6	1,435	0	0	0	0
Murray	0	0	0	0	1	40	0	0
Muscogee	0	0	0	0	1	18,974	8	7,980
Newton	3	52,166	6	1,857	3	168,179	27	97,259
North Carolina	0	0	8	12,400	8	23,777	42	60,261
Oconee	0	0	0	0	0	0	5	34,577
Oglethorpe	0	0	0	0	0	0	1	5,102
Other Out of State	7	106,169	17	44,420	49	710,270	377	727,967
Paulding	0	0	12	28,825	16	104,593	47	97,918
Peach	0	0	0	0	0	0	1	1,440
Pickens	2	0	51	311,853	13	94,958	37	95,808
Pike	0	0	0	0	1	750	2	4,210
Polk	3	31,906	4	16,523	4	46,917	9	11,104
Putnam	0	0	1	1,216	0	0	1	4,705
Rabun	0	0	0	0	6	208,185	2	2,510
Richmond	2	1,066	3	1,316	4	22,225	24	42,709
Rockdale	3	33,871	10	61,980	15	220,722	39	72,513
South Carolina	0	0	4	10,150	2	17,249	38	70,981
Spalding	0	0	2	480	1	342	5	16,975
Stephens	0	0	0	0	0	0	1	3,422
Sumter	0	0	0	0	1	1,329	0	0
Taylor	0	0	0	0	0	0	2	8,083

Tennessee	0	0	1	2,495	11	228,046	34	70,587
Thomas	0	0	0	0	3	750	0	0
Towns	0	0	0	0	0	0	4	13,933
Treutlen	0	0	0	0	1	712	2	1,103
Troup	0	0	0	0	2	1,470	0	0
Union	1	25,594	5	23,808	1	9,344	3	16,706
Upson	0	0	0	0	0	0	2	5,609
Walton	0	0	2	7,095	5	5,299	22	70,079
White	0	0	0	0	1	969	6	3,661
Whitfield	0	0	5	12,901	1	2,539	16	18,094
<b>Total</b>	<b>427</b>	<b>9,254,616</b>	<b>1,740</b>	<b>7,364,886</b>	<b>1,878</b>	<b>24,781,258</b>	<b>15,371</b>	<b>22,739,276</b>

## Indigent Care Trust Fund Addendum

### 1. Indigent Care Trust Fund

Did your hospital receive funds from the Indigent Care Trust Fund during its Fiscal Year 2009?  
(Check box if yes.)

### 2. Amount Charged to ICTF

Indicate the amount charged to the ICTF by each State Fiscal Year (SFY) and for each of the patient categories indicated below during Hospital Fiscal Year 2009.

Patient Category		SFY 2008	SFY2009	SFY2010
		7/1/07-6/30/08	7/1/08-6/30/09	7/1/09-6/30/10
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	0	0
B.	Medically Indigent Patients with incomes between 125% and 200% of the Federal Poverty Level Guidelines where adjustments were made to patient amounts due in accordance with an established sliding scale.	0	0	0
C.	Other Patients in accordance with the department approved policy.	0	0	0

### 3. Patients Served

Indicate the number of patients served by SFY.

SFY 2008	SFY2009	SFY2010
7/1/07-6/30/08	7/1/08-6/30/09	7/1/09-6/30/10
0	0	0

## Reconciliation Addendum

This section is printed in landscape format on a separate PDF file.



## 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.

**Signature of Chief Executive:** Robert Quattrocchi

**Date:** 7/28/2010

**Title:** President & CEO

I hereby certify that I am the financial officer authorized to sign this form and that the information is true and accurate. 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.

**Signature of Financial Officer:** Deborah S. Mitcham

**Date:** 7/28/2010

**Title:** CFO

**Comments:**