



## 2011 Hospital Financial Survey

### Part A : General Information

#### 1. Identification

UID:HOSP346

**Facility Name:** Northside Hospital Forsyth

**County:** Forsyth

**Street Address:** 1200 Northside Forsyth Drive

**City:** Cumming

**Zip:** 30041

**Mailing Address:** 1200 Northside Forsyth Drive

**Mailing City:** Cumming

**Mailing Zip:** 30041

#### 2. Report Period

Please report data for the hospital fiscal year ending during calendar year 2011 only.

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

**Please indicate your hospital fiscal year.**

From: 10/1/2010 To:9/30/2011

**Please indicate your cost report year.**

From: 10/01/2010 To:09/30/2011

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/System Controller

**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	417,150,302
Total Inpatient Admissions accounting for Inpatient Revenue	12,871
Outpatient Gross Patient Revenue	430,984,217
Total Outpatient Visits accounting for Outpatient Revenue	126,983
Medicare Contractual Adjustments	312,564,220
Medicaid Contractual Adjustments	54,929,513
Other Contractual Adjustments:	199,185,814
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	23,771,832
Uncompensated Indigent Care (net):	14,789,750
Uncompensated Charity Care (net):	21,912,091
Other Free Care:	795,234
Other Revenue/Gains:	4,157,961
Total Expenses:	221,843,807

### 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 2011? (Check box if yes.)

### 2. Effective Date

What was the effective date of the policy or policies in effect during 2011?

05/13/2011

### 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.)?

185%

## 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 2011? (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	7,026,653	10,401,026	17,427,679
Outpatient	7,763,097	11,511,065	19,274,162
<b>Total</b>	<b>14,789,750</b>	<b>21,912,091</b>	<b>36,701,841</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	0
Other Counties	0
City Or Cities	0
Hospital Authority	0
State Programs And Any Other State Funds (Do Not Include Indigent Care Trust Funds)	0
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>0</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	7,026,653	10,401,026	17,427,679
Outpatient	7,763,097	11,511,065	19,274,162
<b>Total</b>	<b>14,789,750</b>	<b>21,912,091</b>	<b>36,701,841</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	0	0	2	1,077	0	0	3	2,609
Baldwin	0	0	0	0	0	0	1	5,922
Banks	1	11,719	21	352,831	1	250	2	271
Barrow	2	79,711	8	10,873	9	8,570	33	20,676
Bartow	1	18,545	13	69,930	1	36,665	11	35,559
Brooks	0	0	0	0	0	0	1	1,155
Bulloch	0	0	0	0	0	0	1	878
Butts	0	0	1	513	0	0	0	0
Carroll	0	0	0	0	2	19,251	2	2,720
Chatham	0	0	1	1,300	3	900	0	0
Cherokee	17	280,128	79	296,868	26	291,391	229	341,506
Clarke	1	38,025	0	0	0	0	3	2,791
Clayton	0	0	0	0	1	27,743	2	9,871
Cobb	1	62,084	11	16,901	4	104,024	24	42,898
Coffee	0	0	1	2,167	0	0	0	0
Coweta	0	0	3	4,448	0	0	1	284
Dawson	27	559,999	259	534,889	85	918,144	702	1,438,093
DeKalb	3	166,630	17	64,864	8	262,165	49	133,209
Douglas	0	0	2	33,671	0	0	8	10,978
Fannin	0	0	1	4,457	3	48,209	4	20,470
Fayette	0	0	1	1,600	0	0	0	0
Florida	2	51,852	14	19,348	5	79,533	16	21,901
Forsyth	120	2,132,751	1,062	3,492,350	447	5,452,430	2,957	5,539,239
Franklin	0	0	0	0	0	0	1	20,311
Fulton	24	776,325	154	572,049	57	883,846	362	1,275,609
Gilmer	0	0	16	66,205	0	0	21	49,354
Gordon	1	1,132	9	5,244	0	0	9	7,462
Gwinnett	50	1,789,061	342	1,230,398	78	1,044,292	557	1,002,727
Habersham	0	0	4	1,854	0	0	7	8,663
Hall	13	668,667	171	294,797	69	714,761	587	960,072
Haralson	0	0	0	0	0	0	1	125
Hart	0	0	2	811	0	0	1	143

Heard	0	0	0	0	0	0	1	631
Henry	1	59,570	1	1,001	0	0	1	911
Jackson	1	41,138	10	19,118	2	22,563	15	15,278
Laurens	0	0	0	0	0	0	7	2,015
Lee	0	0	0	0	0	0	1	32,290
Lumpkin	7	95,245	48	119,813	23	212,875	126	214,371
Madison	0	0	0	0	0	0	31	52,086
Murray	0	0	0	0	0	0	1	447
Muscogee	1	49,332	0	0	0	0	0	0
Newton	0	0	0	0	0	0	3	1,327
North Carolina	1	619	3	4,398	2	31,621	10	13,345
Oconee	1	24,699	1	2,555	0	0	0	0
Other Out of State	3	116,039	19	25,690	7	95,769	23	39,414
Paulding	0	0	6	6,947	0	0	8	7,207
Pickens	2	3,382	23	357,195	6	43,927	41	72,510
Polk	0	0	0	0	0	0	1	8,017
Rabun	0	0	1	2,512	0	0	0	0
Richmond	0	0	0	0	0	0	2	2,115
Rockdale	0	0	1	1,576	0	0	3	5,861
South Carolina	0	0	1	811	0	0	1	485
Spalding	0	0	0	0	1	100,247	1	522
Stephens	0	0	0	0	0	0	2	5,965
Tennessee	0	0	3	5,630	0	0	2	4,312
Toombs	0	0	1	214	0	0	3	2,713
Towns	0	0	4	7,124	0	0	9	5,117
Troup	0	0	0	0	0	0	1	927
Union	0	0	6	125,349	0	0	7	60,288
White	0	0	5	3,719	2	1,850	17	7,415
<b>Total</b>	<b>280</b>	<b>7,026,653</b>	<b>2,327</b>	<b>7,763,097</b>	<b>842</b>	<b>10,401,026</b>	<b>5,912</b>	<b>11,511,065</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 2011?  
(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 2011.

Patient Category		SFY 2010	SFY2011	SFY2012
		7/1/09-6/30/10	7/1/10-6/30/11	7/1/11-6/30/12
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 2010	SFY2011	SFY2012
7/1/09-6/30/10	7/1/10-6/30/11	7/1/11-6/30/12
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:** 7/12/2012

**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 Mitcham

**Date:** 7/12/2012

**Title:** VP & CFO

**Comments:**