GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2011 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP541

Facility Name: Northside Hospital Cherokee

County: Cherokee

Street Address: 201 Hospital Road

City: Canton

Zip: 30114

Mailing Address: 201 Hospital Road

Mailing City: Canton

Mailing Zip: 30114

2. Report Period

Please report data for the hospital fiscal year ending during calender 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	170,096,888
Total Inpatient Admissions accounting for Inpatient Revenue	5,643
Outpatient Gross Patient Revenue	214,351,849
Total Outpatient Visits accounting for Outpatient Revenue	72,964
Medicare Contractual Adjustments	126,380,293
Medicaid Contractual Adjustments	33,133,286
Other Contractual Adjustments:	84,676,112
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	19,149,300
Uncompensated Indigent Care (net):	10,397,119
Uncompensated Charity Care (net):	13,834,195
Other Free Care:	845,944
Other Revenue/Gains:	1,020,890
Total Expenses:	93,092,693

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
Total	**0**

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	5,284,021	7,047,980	12,332,001
Outpatient	5,113,098	7,157,776	12,270,874
Total	**10,397,119**	**14,205,756**	**24,602,875**

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	371,561
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
Total	**371,561**

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	5,284,021	6,676,419	11,960,440
Outpatient	5,113,098	7,157,776	12,270,874
Total	**10,397,119**	**13,834,195**	**24,231,314**

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	1,488	0	0	6	30,119
Baldwin	0	0	0	0	1	22,142	0	0
Barrow	0	0	0	0	0	0	1	482
Bartow	3	39,914	66	142,277	3	23,061	107	158,929
Brantley	0	0	1	1,061	0	0	0	0
Bulloch	0	0	1	488	0	0	0	0
Butts	0	0	0	0	0	0	1	1,564
Chatham	0	0	0	0	0	0	1	409
Cherokee	177	4,074,430	1,758	3,693,490	455	5,810,900	4,117	5,496,854
Clinch	0	0	0	0	0	0	1	1,671
Cobb	7	354,794	96	190,453	26	556,590	195	288,680
Colquitt	0	0	1	978	0	0	0	0
Dawson	2	52,793	9	13,164	0	0	12	10,404
Decatur	0	0	1	2,125	0	0	0	0
DeKalb	0	0	6	28,486	0	0	24	18,040
Douglas	0	0	3	5,046	0	0	42	103,386
Fannin	2	34,193	19	99,375	5	7,305	32	24,194
Florida	0	0	5	5,342	0	0	20	41,680
Floyd	0	0	2	917	0	0	0	0
Forsyth	1	250	8	8,764	4	36,700	56	84,642
Franklin	0	0	1	737	0	0	0	0
Fulton	4	124,316	18	83,305	4	18,454	61	91,883
Gilmer	5	96,674	42	337,626	8	83,757	50	74,443
Glynn	0	0	1	1,133	0	0	0	0
Gordon	1	261	9	4,059	4	3,821	29	149,858
Gwinnett	0	0	3	1,536	1	23,144	14	12,811
Hall	0	0	3	1,734	0	0	17	26,675
Haralson	0	0	1	1,115	0	0	2	1,256
Henry	0	0	0	0	0	0	2	470
Houston	0	0	0	0	0	0	1	240
Jackson	0	0	3	931	1	16,933	9	27,787
Jasper	1	33,833	1	1,486	0	0	0	0

Lumpkin	0	0	0	0	0	0	5	22,380
Madison	0	0	0	0	0	0	1	1,253
Murray	0	0	0	0	1	741	1	1,109
Muscogee	0	0	1	2,484	0	0	0	0
Newton	0	0	0	0	0	0	1	326
North Carolina	0	0	3	4,305	1	12,440	8	11,212
Other Out of State	1	59,185	14	30,407	2	130,020	28	42,774
Paulding	3	69,552	6	6,115	1	3,900	14	13,297
Pickens	9	298,150	148	430,155	30	218,592	335	378,024
Pike	0	0	0	0	0	0	1	4,303
Polk	0	0	2	3,244	0	0	2	967
Rockdale	0	0	1	1,077	0	0	0	0
South Carolina	0	0	0	0	5	77,608	4	3,932
Stephens	0	0	1	851	0	0	0	0
Sumter	0	0	1	1,064	0	0	0	0
Tennessee	0	0	2	1,691	1	1,872	4	6,777
Toombs	0	0	0	0	0	0	1	513
Towns	1	45,676	2	1,478	0	0	6	1,381
Troup	0	0	3	2,385	0	0	1	912
Union	0	0	0	0	0	0	1	15,942
Walker	0	0	0	0	0	0	2	3,277
Wayne	0	0	0	0	0	0	1	213
White	0	0	0	0	0	0	1	645
Whitfield	0	0	1	726	0	0	2	2,062
Total	**217**	**5,284,021**	**2,245**	**5,113,098**	**553**	**7,047,980**	**5,219**	**7,157,776**

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 7/1/09-6/30/10	SFY2011 7/1/10-6/30/11	SFY2012 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 7/1/09-6/30/10	SFY2011 7/1/10-6/30/11	SFY2012 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 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.

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: