#### DTRC177 2017 Fulton Service Specific I/C Care Survey - Adjusted Gross Revenue MRI and Imaging of Johns Creek

Part A: General l	nformation	Georgi	a Department of	Community Health
1		Year: 2017		
,,	TRC177	Northside/McGi	nois	Fullan
Facility Name M	RL and Imaging of	Johns Craek Ferry Ima	Sing County:	Fulton
		e following Certificate-of-Need (Co ated indigent/charity care:	ON) service for which the	e hospital has a
Service: In	naging Center			
CON: 20	010-088			
Please report data f  Report Period:	or the hospital fiscal	year ending in calender year 2017	only. Do not use a differ	rent report period.
`			Ending: 12 12	<del></del> _
Beginning:	11/2017		Ending. 12/31	2017
3. Was the service id	entified above ope	erational for the full report period?		Yes
If "No," explain:			<del></del>	
have reviewed the re nformation submitted	esponses to this so in this survey is su	urvey and certify that the informat bject to compliance review by the	ion is true and accurate. Department.	I understand that the
Authorized Signature:	Bi J	Title Sen	or Planner	Date: 7/27 2018
Person authorized to i	respond to inquirie	s about the responses to this surv	rey	
Contact's Name:	Brian J T	Contact's Title:	Senior Plan	nes
Telephone: ฯษ	1-851-6821	Contact's Title:  Fax: Yoy. 303 - 3820	E-mail: brian.	toporele Cnorthside.co
Part C: Service-S	Specific Data 1	for Specified Service		
Data for service:	Imaging C	enter		
		Amount	Number of Pati	ents
Uncompensated I	ndigent Care	\$87, 139	62	
Uncompensated (	Charity Care	\$ 338,463	367	
Totals		\$ 425 602	420	

\$87, 139	62	
\$ 338 463	367	
\$ 425,602	420	
# 1 a - 1 a		·

\$7,249,746 Service-Specific-AGR

Adjusted Gross Revenue

# Service Specific I/C Care Survey - Adjusted Gross Revenue DTRC112 2017 Forsyth MRI & Imaging of Cumming

Part A: Genera	Part A: General Information		Georgia Department of Community Health				
1.		Year: 2017					
Facility UID	DTRC112						
Facility Name	MRI & Imaging of Cumr	ning Northside/Omn	ring Imaging County:	Forsyth			
This Addendu	m reports data for the fo provide uncompensated	llowing Certificate-of-Need (C	• -	e hospital has a			
Service:	Imaging Center						
CON:	2009-107						
2. Please report da	ata for the hospital fiscal yea	ar ending in calender year 201	7 only. Do not use a diffe	rent report period.			
Report Period:							
Beginning:	1/1/2017		Ending: 12/31	2017			
3. Was the servic	e identified above operat	ional for the full report period	?	Yes			
If "No," explain:	:						
I have reviewed the information submitted	e responses to this surve ted in this survey is subje	ey and certify that the informa ct to compliance review by th	ation is true and accurate. se Department.	I understand that the			
Authorized Signate	ure: 3: 15	Title Ser	nior Planner	Date: 7/27/2018			
Person authorized	to respond to inquiries a	bout the responses to this su					
Contact's Name:	Brian J. Ti	porek Contact's Title	e: Senior Plan	ine			
Telephone: 4	74-851-6821	Fax: 404-303-3820	E-mail: brign.	toporek @ northside.			
Part C: Servic	e-Specific Data for	Specified Service		_			
ait o. oeivio							
Data for service	ce: Imaging Cen	ter					
		Amount	Number of Pat	ients			
Uncompensat	ed Indigent Care	\$163,773	72				
	ed Charity Care	\$ 229 588	296				
Totals		\$393,361	364				
Adjusted Gros	s Revenue	\$ 1 852 201		<del></del>			

# Service Specific I/C Care Survey - Adjusted Gross Revenue MRI & Imaging of Snellville DTRC113 2017 Gwinnett

Part A: General Information		Ge	Georgia Department of Community Health			
1.		Year: 2017				
Facility UID	DTRC113					
Facility Name		nellville Northside/Snel	Iville Imaging	County: Gwir	nnett	
This Addendur	m reports data for the provide uncompensa	e following Certificate-of-Ne ated indigent/charity care:	ed (CON) service fo	r which the hospi	tal has a	
Service:	Imaging Center				] .	
CON:	2006-098					
2. Please report da	ta for the hospital fiscal	year ending in calender yea	r 2017 only. Do not	use a different rep	port period.	
Report Period:						
Beginning:	1/1/2017		Ending:	12/31/201-	7	
			:- 40	1 931 /201		
<ol><li>Was the service</li></ol>	e identified above ope	erational for the full report pe	eriod ? 		Yes	
If "No," explain:						
I have reviewed the information submitt	e responses to this so ed in this survey is so	urvey and certify that the in- ubject to compliance review	formation is true and by the Department.	accurate. I und	erstand that the	
Authorized Signatu	~ ~		ienior Plann	er	Date: 7/27/2018	
Person authorized	to respond to inquirie	s about the responses to th	is survey			
Contact's Name:	Brian J.	Contact's	s Title: Senior	Planner		
Telephone: 40	4-851-6821	Fax: 401-303-38	S20 E-mail:	brian. topo	nek@northside	
Part C: Servic	e-Specific Data	for Specified Service	•			
Data for service	e: Imaging (	Center				
		Amount	Num	per of Patients	,	
Uncompensate	ed Indigent Care	\$300,928	199			
Uncompensate	ed Charity Care	\$ 117,770	164			
Totals		9 418, 698	360	7		
Adjusted Gros	s Revenue	\$ 7,576,760				
					Service-Specific-AGR	

# Service Specific I/C Care Survey - Adjusted Gross Revenue DTRC109 2017 Hall MRI & Imaging of Gainesville

art A: General Information			Georgia Department of Community Health			
1.		Year	: 2017			
Facility UID	DTRC109					
Facility Name	MRI & Imaging of G	ainesville Northsid	le/Gainesri		County: Hal	1
		e following Certificate ated indigent/charity		مروه می N) service for	) which the hosp	ital has a
Service:	Imaging Center Ser	vices				
CON:	2006-100					
2. Please report da	ta for the hospital fisca	al year ending in calenc	der year 2017 o	nly. Do not ເ	use a different re	eport period.
Report Period:						
Beginning:	1/1/2017			Ending:	12/31/201	7
Was the service		erational for the full re	eport period?			Yes
						<u></u>
If "No," explain:						
I have reviewed the information submitt	e responses to this s ed in this survey is s	survey and certify tha ubject to compliance	t the informatio review by the D	n is true and Department.	accurate. I uno	derstand that the
Authorized Signatu	ire: Loci Jy	TI	itle Senior	Planne	<u>.</u>	Date: 7/27/2018
Person authorized	to respond to inquiri	es about the respons	es to this surve	у		
Contact's Name:	Brian J.	Topore 4 C	ontact's Title:	Senie	r Planner	
Telephone: 40	t-851-6821	Fax: 404-30	<u> (1588-5</u>	E-mail:	brian-topo	oreh @ north side.
Part C: Servic	e-Specific Data	for Specified Se	ervice			
Data for servic	e: Imaging	Center Services				
		Amour	nt	Numb	er of Patients	
	ed Indigent Care	\$476,17	0	37	3	
•	ed Charity Care	\$ 809,6	26	1,193	3	·
Totals		\$1, 285, 79	iL	1,51	5	
Adjusted Gross	s Revenue	\$13,450,19	2			

# Service Specific I/C Care Survey - Adjusted Gross Revenue DTRC047 2017 Fulton MRI & Imaging of North Fulton

	I Information	Georgia Department of Community Health				
l.		Year: 2017				
Facility UID	DTRC047	Northside/He	mbree			
	MRI & Imaging of Nor	th-Fulton /	سرا اس	County:	Fulton	
		following Certificate-of-Need ed indigent/charity care:	(CON) service t	for which the	e hospital has a	
Service:	Imaging Center					
CON:	2011-062					
Please report dat	ta for the hospital fiscal y	rear ending in calender year 20	)17 only. Do no	t use a diffe	rent report period.	
Report Period:	•				·	
Beginning:	1/1/2017		Ending:	12/31	2017	
. Was the service	identified above oper	ational for the full report perio	id?		Tes	
If "No," explain:						
•	e responses to this sur	vey and certify that the inforr ject to compliance review by	nation is true ar the Department	nd accurate.	I understand that the	
have reviewed the nformation submitte	ed iii tiiis survey is sub					
nformation submitte Authorized Signatu	re: Bi 15	Title Se a	nior Plann survey	) e C	Date: 7 21 20 18	
nformation submitte Authorized Signatu	re: Bi 15	about the responses to this s	survey			
Authorized Signatu Person authorized Contact's Name:	re: Si Jf	about the responses to this s	survey			
Authorized Signatu Person authorized Contact's Name:	to respond to inquiries  Brian J. To	about the responses to this s	survey		Date: 7/21/2018 er t uponek@north	
Authorized Signatu Person authorized Contact's Name:	to respond to inquiries  Brian J. To  OH- 851 - 6821  e-Specific Data for	about the responses to this so Contact's Ti	survey			
Authorized Signatu Person authorized Contact's Name: Telephone:  Vart C: Service	to respond to inquiries  Brian J. To  OH- 851 - 6821  e-Specific Data for	about the responses to this so Contact's Ti	tle: Se Ote		er toporele@nortl	

Uncompensated Indigent Care
Uncompensated Charity Care
Totals
Adjusted Gross Revenue

Amount	Number of Patients
\$143,696	69
9 28,975	31
\$172,671	99
\$ 4.824, 422	

#### DTRC115 2017 Fulton Service Specific I/C Care Survey - Adjusted Gross Revenue MRI & Imaging of Hapeville

Part A: Gener	al Information	Geor	gia Department of	Community Health
1.		Year: 2017		
Facility UID	DTRC115			
Facility Name		apeville Northside/Hopevill	(e, MANINA County:	Fulton
This Addendu commitment to	m reports data for th	e following Certificate-of-Need ( ated indigent/charity care:	7 )	e hospital has a
Service:	Imaging Center			
CON:	2013-005			
2. Please report da	ata for the hospital fisca	l year ending in calender year 20	17 only. Do not use a diffe	rent report period.
Report Period:				
Beginning:	1/1/2017		Ending: 12 3	1/2017
3. Was the service	e identified above op	erational for the full report period	d?	Yes
If "No," explain	:			
Part B: Signa	ture and Contac	t		
I have reviewed th information submit	e responses to this s ted in this survey is s	urvey and certify that the inforn ubject to compliance review by t	nation is true and accurate the Department.	I understand that the
Authorized Signat	ure: Bi J.	Title Se-	nior Planner	Date: 1/27/2018
Person authorized	I to respond to inquiri	es about the responses to this s	urvey	
Contact's Name:	Brian J.	Toporek Contact's Tit	le: Senior Pla	nnec
Telephone:	04-851-6821	Fax: 404-303-382	E-mail: brign.	toporek @northside com
Part C: Service	e-Specific Data	for Specified Service		
Data for servi	ce: Imaging	Center		
		Amount	Number of Pat	ients
•	ed Indigent Care	<i>₹33,874</i>	17	
•	ed Charity Care	\$ 75 130	51	· · ·
Totals	_	\$109,005	67	
Adjusted Gros	ss Revenue	<b>\$ 972, 356</b>		

### Service Specific I/C Care Survey - Adjusted Gross Revenue DTRC110 2017 Fulton

OC: 1.	oc opec.		 	
Duluth	Diagnostic	Imaging		

Part A: Gener	ral Information	Georgi	a Department o	f Community Health
1.		Year: 2017		
Facility UID	DTRC110			
Facility Name		aging Northside / Duluth 1	magina County:	Fulton
This Addendo	um reports data for the to provide uncompensat	following Certificate-of-Need (Co ted indigent/charity care:	ON) service for which t	he hospital has a
Service:	Imaging Center			
CON:	2013-006			
2. Please report d	ata for the hospital fiscal	year ending in calender year 2017	only. Do not use a diff	erent report period.
Report Period	: 			
Beginning:	1/1/2017		Ending: 12 3	31/2017
3. Was the servi	ce identified above ope	rational for the full report period?		Yes
If "No," explai	n:			
I have reviewed t	ature and Contact he responses to this su itted in this survey is sul	rvey and certify that the informatible to compliance review by the	tion is true and accurat Department.	e. I understand that the
Authorized Signa	ture: Si th	Title Sen	ior Planner	Date: אוט 27   27   20   א
Person authorize	d to respond to inquiries	s about the responses to this sur	vey	
Contact's Name:	Brian 1:	Toporek Contact's Title	Senior Pla	226
Telephone:	404-851-6821	Fax: 404-303-3820	E-mail: brigh	. toporek p northside. co
		or Specified Service		
Data for serv	rice: Imaging C	enter		
		Amount	Number of Pa	atients
Uncompensa	ated Indigent Care	\$4,087	1	
Uncompensa	ated Charity Care	\$ 0	O	
Totals		84,087	1	
Adjusted Gro	oss Revenue	84000		

#### DTRC108 2017 Douglas

# Service Specific I/C Care Survey - Adjusted Gross Revenue MRI and Imaging of Douglasville

Part A: Genera	I Information		Georgia De <sub>l</sub>	partment o	f Community H	ieaith
l.		Year:	2017			
Facility UID	DTRC108	Monthsil	e/medical			
Facility Name	MRI and Imaging of	Douglasville Cen	ter Imaging	County:	Douglas	
This Addendur	m reports data for the provide uncompensa	following Certificate ted indigent/charity o	of-Need (CON) serare:	rvice for which t	he hospital has a	
Service:	Imaging Center					
CON:	2013-001					
					·	
2. Please report da	ita for the hospital fiscal	year ending in calend	er year 2017 only.	Do not use a diff	ferent report period.	
Report Period:				ading.		
Beginning:	1/1/2007		Er	nding: 12/	31/2017	
3. Was the service	e identified above ope	erational for the full re	port period?		Yes	
If "No," explain				<del></del>		
ii ito, oxpiani						
nformation submit	te responses to this sted in this survey is si	ubject to compliance	the information is review by the Depa	rument. 	e. I understand that	t the
Authorized Signat		m		14nnes		121/2010
	I to respond to inquirie		_			
Contact's Name:	Rusu 7:	Topore4	britact's true.	Senior Plan		
Telephone: प्	04-851-6821	Fax: 404-3	03-3820 E	-mail: brian	. toporek eno	orthside
					,	
Part C: Servi	e-Specific Data	for Specified Se	rvice			
Data for servi	ce: Imaging	Center				
		Amou	nt	Number of P	atients	
Uncompensa	ted Indigent Care	\$62.09	9	21		
Uncompensa	ted Charity Care	\$ 11, 235		3		
Totals		\$ 72 27	2	24		
lotais		- 1 4 · 44	)	- 1		
Adjusted Gro	ss Revenue	\$1.061,7	26			

## Service Specific I/C Care Survey - Adjusted Gross Revenue Northside Marble Mill Imaging

DTRC164 2017 Cobb

ait A. Geliciai	Information	Geor	gia Departm	ent of	Commu	nity Health
1.		Year: 2017				
	TRC164				[ a . i .	
Facility Name	orthside Marble Mill	Imaging	(	County:	Cobb	
This Addendum commitment to p	reports data for the rovide uncompensat	following Certificate-of-Need ( ted indigent/charity care:	(CON) service for	which the	e hospital h	as a
Service:	naging Center					
CON: 2	011-025					
2. Please report data	for the hospital fiscal y	year ending in calender year 20	17 only. Do not u	se a diffe	rent report p	period.
Report Period:	•					
Beginning:	.1.10-		Ending:	12/2	1/2017	
	1/1/2017		_	<u> </u>	100, 1	
3. Was the service i	dentified above oper	rational for the full report perio	d?		[>	res
ICUNA II . Latina	<u> </u>	<del>_</del>				
If "No," explain:						
Part B: Signatu	re and Contact					
_			nation is true and	accurate	. I understa	and that the
have reviewed the	esponses to this su	rvey and certify that the inforn bject to compliance review by t	nation is true and the Department.	accurate	. I understa	and that the
have reviewed the	esponses to this su	rvey and certify that the inform	nation is true and the Department.	accurate	. I understa	and that the
have reviewed the notering the notering in the conference of the c	esponses to this su in this survey is sub	rvey and certify that the inforn bject to compliance review by t	the Department.			
have reviewed the information submitted	esponses to this su in this survey is sub	rivey and certify that the inform bject to compliance review by the second of the seco	nior Plans			and that the
have reviewed the information submitted	esponses to this su in this survey is sub	rvey and certify that the inforn bject to compliance review by t	nior Plans			
have reviewed the information submitted	esponses to this su in this survey is suf	Title Se sabout the responses to this s	nior Plane urvey	).r	Da	
have reviewed the information submitted  Authorized Signature  Person authorized to  Contact's Name:	esponses to this su in this survey is substituted in the survey is substituted in the survey in the	Title Se Contact's Title	urvey	res	Da	ate: 1 21 2018
have reviewed the information submitted  Authorized Signature  Person authorized to  Contact's Name:	esponses to this su in this survey is suf	Title Se sabout the responses to this s	urvey	res	Da	
have reviewed the information submitted  Authorized Signature  Person authorized to  Contact's Name:	esponses to this su in this survey is substituted in the survey is substituted in the survey in the	Title Se Contact's Title	urvey	res	Da	ate: 1 21 2018
have reviewed the information submitted  Authorized Signature Person authorized to Contact's Name: Telephone:	esponses to this su in this survey is substituted in the survey is substituted in the survey in the survey in the survey is substituted in the survey in the	Title Se Contact's Title	urvey	res	Da	ate: 1 21 2018
have reviewed the information submitted  Authorized Signature Person authorized to Contact's Name: Telephone:	responses to this suring this survey is sufficient to inquiries  Brian J  4-851-6821  Specific Data for	Title Se about the responses to this s  Contact's Title Fax: YOY - 303 - 38 3	urvey	res	Da	ate: 1 21 2018
have reviewed the information submitted  Authorized Signature Person authorized to Contact's Name: Telephone:	esponses to this su in this survey is substituted in the survey is substituted in the survey in the survey in the survey is substituted in the survey in the	Title Se about the responses to this s  Contact's Title Fax: YOY - 303 - 38 3	urvey	res	Da	ate: 1 21 2018
have reviewed the information submitted  Authorized Signature Person authorized to Contact's Name: Telephone:	responses to this suring this survey is sufficient to inquiries  Brian J  4-851-6821  Specific Data for	Title Se Contact's Title Fax: 404-303-383	the Department.  Or Plance  or Pl	Pla- brian	Danes	ate: 1 21 2018
have reviewed the information submitted  Authorized Signature Person authorized to Contact's Name: Telephone:  Part C: Service  Data for service:	responses to this suring this survey is sufficient to inquiries  Brian J  4-851-6821  Specific Data for Imaging Comments	Title Se about the responses to this se about the responses to this se are Contact's Title Fax: 404-303-38 and Cor Specified Service center	the Department.  Or Plance  urvey  tle: Server  E-mail: Numb	res	Danes	ate: 1 21 2018
have reviewed the information submitted.  Authorized Signature Person authorized to Contact's Name:  Telephone:  Part C: Service:  Uncompensated	responses to this suring this survey is sufficient to inquiries  Brian J  H-8SI-G8 ZI  Specific Data for Imaging Collindigent Care	Title Se Contact's Title Fax: 404-303-383	the Department.  Or Plance urvey tle: Senson  E-mail: Numb	Pla- brian	Danes	ate: 1 21 2018
have reviewed the information submitted  Authorized Signature Person authorized to Contact's Name: Telephone:  Part C: Service  Data for service:	responses to this suring this survey is sufficient to inquiries  Brian J  H-8SI-G8 ZI  Specific Data for Imaging Collindigent Care	Title Se about the responses to this se about the responses to this se are Contact's Title Fax: 404-303-38 and Cor Specified Service center	Numb	Pla- brian	Danes	ate: 1 21 2018
have reviewed the information submitted.  Authorized Signature Person authorized to Contact's Name:  Telephone:  Part C: Service:  Uncompensated	responses to this suring this survey is sufficient to inquiries  Brian J  H-8SI-G8 ZI  Specific Data for Imaging Collindigent Care	Title Se Contact's Title Fax: 404-303-383  Fax: 404-303-383  Fax: 404-303-383  Fax: 404-303-383	the Department.  Or Plance urvey tle: Senson  E-mail: Numb	Pla- brian	Danes	ate: 1 21 2018

# Service Specific I/C Care Survey - Adjusted Gross Revenue OMI Diagnostics-Douglasville DTRC163 2017 Douglas

Pa	rt A: Genera	al Information	Georg	ia Department of	Community Health
1.	Facility UID Facility Name	DTRC163  GMI Diagnostics-Deu	Year: 2017 Nunthside/ Iglasville Douglasville	mania County:	Douglas
	This Addendu	m reports data for the	following Certificate-of-Need (Control indigent/charity care:	0 1	
	Service:	Imaging Center			
	CON:	2011-017			
2.	Please report da	ita for the hospital fiscal	year ending in calender year 2017	only. Do not use a diffe	erent report period.
	Report Period:				
	Beginning:	1/1/2017		Ending: 12	31/2017
3.	Was the servic	e identified above ope	rational for the full report period?	ı	Yes
	If "No," explain	:			
l ha	ave reviewed th	ture and Contact e responses to this su ted in this survey is su	rvey and certify that the informa bject to compliance review by the	tion is true and accurate Department.	. I understand that the
		ure: Bin Ja		nior Planner	Date: 7 27 20 8
			s about the responses to this sur	•	
	ntact's Name:	Brigh J.	loporele	Senior Pla.	-toporel@northside.com
Те	lephone:	04-851-6821	Fax: 404-303-3820	b E-mail.   brigh	-toporela northside.com
Pa	rt C: Servic	e-Specific Data f	or Specified Service		
	Data for service	ce: Imaging C	enter		
				1	· · · · · ·
	Uncomponent	ed Indigent Care	Amount	Number of Pat	gents
	•	ed Indigent Care ed Charity Care	\$ 214, 341	133	
	Totals	on one of the other	\$ 164, 450 \$ 378,792	2912	<del></del>
	Adjusted Gros	s Revenue	4 518, 172 4 4, 139, 487		
	•		<u> </u>	_	

Service-Specific-AGR

# Service Specific I/C Care Survey - Adjusted Gross Revenue Northside Roswell Imaging DTRC175 2017 Fulton

Part A: Genera	al Information	Georg	gia Department of	Community Health
1.		Year: 2017		·
Facility UID	DTRC175		<del></del>	<u></u>
Facility Name	Northside Roswell Im	naging	County:	Fulton
This Addendu commitment to	m reports data for the provide uncompensa	following Certificate-of-Need (ted indigent/charity care:	CON) service for which th	e hospital has a
Service:	Imaging Center			
CON:	2012-009			
Please report da	ata for the hospital fiscal	year ending in calender year 20°	17 only. Do not use a diffe	erent report period.
Report Period:				
Beginning:	1/1/2017		Ending:	31/2017
3. Was the service		erational for the full report period	1?	Yes
remain an anal-ta-	. ———			
If "No," explain	:			
I have reviewed th	ture and Contact he responses to this su ted in this survey is su	urvey and certify that the inform	nation is true and accurate the Department.	e. I understand that the
Authorized Signat	ure: Bi Ji	Title Ser	nior Planner	Date: 7 27 2018
		Title Ser	nor Planner	Date: רב ר   2018
Authorized Signat Person authorized Contact's Name:		es about the responses to this su	urvey	
Person authorized	I to respond to inquirie	es about the responses to this su	urvey  Senior Plan  Emilion	
Person authorized Contact's Name: Telephone:	Brian J.	as about the responses to this su  Toporek  Contact's Tit	urvey  Senior Plan  Emilion	221 2018
Person authorized Contact's Name: Telephone:	Brian J.  Brian J.  Be-Specific Data f	s about the responses to this sure contact's Tit  Fax: Yoy-303-38:  for Specified Service	urvey  Senior Plan  Emilion	221 2018
Person authorized Contact's Name: Telephone:	Brian J.  Poy - 851 + 821  ce-Specific Data f	s about the responses to this sure contact's Tit  Fax: Yoy-303-38:  for Specified Service	urvey  Senior Plan  Emilion	221 2018
Person authorized Contact's Name: Telephone:  Part C: Service Data for servi	to respond to inquiries    Brian J.     Puy - 851 - 6 8 21     ce-Specific Data for the second control of the	s about the responses to this sure contact's Tit  Fax: Yoy-303-38:  for Specified Service	urvey  Senior Plan  Emilion	ner.
Person authorized Contact's Name: Telephone:  Part C: Service Data for servi	Brian J.  Poy - 851 + 821  ce-Specific Data f	s about the responses to this sure about the response to the response tof	nior Planner  urvey  le: Senior Plan  20 E-mail: brigh	ner.
Person authorized Contact's Name: Telephone:  Part C: Service Data for service Uncompensar	to respond to inquiries    Brian J.     Puy - 851 - 6 8 21     ce-Specific Data for the second control of the	s about the responses to this surface Contact's Tit  Fax: 404-303-387  for Specified Service  Center  Amount	Number of Pa	ner.
Person authorized Contact's Name: Telephone:  Part C: Service Data for service Uncompensar	ted Indigent Care	s about the responses to this sure about 100 and 1	Number of Pa	ner.

### Service Specific I/C Care Survey - Adjusted Gross Revenue DTRC171 2017 Fulton

		•			
OMI	Diagr	ostics	s - L	_ake	Hearn

	Information	Georgi	a Departi	nent of (	ommuni	ty Health
1.		Year: 2017				
Facility UID	DTRC171	Jorthside / Lake			<del></del>	
	O <del>MI Diagnostics - Lake Hea</del> rn	Hearn Imag	بخر	County:	Fulton	
This Addendun commitment to	n reports data for the following provide uncompensated indiger	Certificate-of-Need (CC nt/charity care:	ON) service fo	or which the	hospital has	a
Service:	Imaging Center					
CON:	2011-080					
2. Please report dat	a for the hospital fiscal year ending	g in calender year 2017	only. Do not	use a differe	ent report per	iod.
Report Period:						
Beginning:	1/1/2017		Ending:	12 3	1/2017	
3. Was the service	identified above operational for	r the full report period?			Ye	2
If "No," explain:		<del></del>				
Part B: Signat	ure and Contact		,			
I have reviewed the information submitte	e responses to this survey and o ed in this survey is subject to co	certify that the informat ompliance review by the	tion is true an Department.	d accurate.	I understand	that the
Authorized Signatu	(C) 7.		11 or P14.	2016	Date:	7/27/2018
•	re: Size Jight to respond to inquiries about the			201	Date:	7/27/2018
•	(C) 7.	e responses to this surv	vey	or Plan		7/27/2018
Person authorized Contact's Name:	to respond to inquiries about the	e responses to this surv	vey	or Plan	ner	21 2018  enorthside.
Person authorized Contact's Name: Telephone:	to respond to inquiries about the	Contact's Title:	vey : Seni	or Plan	ner	1121 2018
Person authorized Contact's Name: Telephone:	Brian J. Toporek  4-851-6821 Fax:	Contact's Title:	vey : Seni	or Plan	ner	1121 2018
Person authorized Contact's Name: Telephone:	Brian J. Toporek  W-851-6821 Fax:	Contact's Title:	vey : Seni	or Plan	ner	[121 2018]
Person authorized Contact's Name: Telephone:	Brian J. Toporek  W-851-6821 Fax:	Contact's Title:	Seni E-mail:	or Plan	ne C	[121 2018]
Person authorized Contact's Name: Telephone: 40  Part C: Service Data for service	Brian J. Toporek  W-85t-6821 Fax:  e-Specific Data for Specific Da	e responses to this survice Contact's Title:  You-303-38-20 cified Service	Seni E-mail:	brian	ne C	[121 2018]
Person authorized Contact's Name: Telephone: 40  Part C: Service Data for service Uncompensate	Brian J. Toporek  W-85t-6821 Fax:  e-Specific Data for Specific Da	e responses to this survive Contact's Title:  You-303-38-20 cified Service  Amount	Sent Sent D E-mail:	brian	ne C	[121 2018]
Person authorized Contact's Name: Telephone: 40  Part C: Service Data for service Uncompensate	Brian J. Toporek  Brian J. Toporek  4-851-6821 Fax:  e-Specific Data for Specific Da	Contact's Title:  404-303-38-20  cified Service  Amount	Seni E-mail:  Num  130	brian	ne C	[121 2018]

## Service Specific I/C Care Survey - Adjusted Gross Revenue \*\*DTRC157 2017 Clayton Northside Riverdale Imaging\*\*

Part A: Gen	neral Information	Geor	gia Department of	Community Health
1.		Year: 2017		
Facility UI	DTRC157			
Facility Na	me Northside Riverdale	Imaging	County:	Clayton
		e following Certificate-of-Need ated indigent/charity care:	(CON) service for which th	e hospital has a
Service:	Imaging Center			
CON:	2010-015			
2. Please repor	rt data for the hospital fisca	l year ending in calender year 20	017 only. Do not use a diffe	erent report period.
Report Peri	iod:			
Beginning:	1/1/2017		Ending: 12년3	1 2017
3. Was the se	rvice identified above op	erational for the full report perio	d?	Yes
If "No," exp	lain:			
Part B: Sig	nature and Contac	t	•	
I have reviewed information sub	d the responses to this somitted in this survey is s	urvey and certify that the inforr ubject to compliance review by	nation is true and accurate the Department.	. I understand that the
Authorized Sig	nature: Bin J	Title Se	nior Planner	Date:
Person authori	zed to respond to inquiri	es about the responses to this s	survey	
Contact's Nam	e: Boil	Toporeh Contact's Ti	tle: Securic Plan	200
		¬ <u>~</u>	= mail 1	
Telephone:	404-851-6821	Fax: 404-303-388	bolan	toporek Enorthside.c
Part C: Ser	vice-Specific Data	for Specified Service		
Data for se	ervice: Imaging	Center Center		
		Amount	Number of Pat	ients
Uncompen	nsated Indigent Care	\$247 611	232	<del></del>
Uncompen	nsated Charity Care	\$ 248 660	307	
Totals		\$ 496 284	534	
Adjusted G	Gross Revenue	\$ 4 495 924		

### ervice Specific I/C Care Survey - Adjusted Gross Revenue DTRC117 2017 Cherokee

Se.	rvice	Spec	IIIC I/C	Cale	Survey	- Aujusteu	01033
MRI	& Ima	aina of	Woodsto	ck			

	al Information	Georgia Department of Community Health
		Year: 2017
Facility UID	DTRC117	Northeide/Towne
	MRI & Imaging of We	
This Addendur commitment to	m reports data for the provide uncompensa	e following Certificate-of-Need (CON) service for which the hospital has a ated indigent/charity care:
Service:	Imaging Center	
CON:	2012-008	
Report Period:		
Beginning:	1/1/2017	Ending: 12 31 20 17
Was the service	e identified above ope	erational for the full report period?
If "No," explain:	: -	
ii No, explain.		
art B: Signat	ture and Contact	turvey and certify that the information is true and accurate. I understand that the abject to compliance review by the Department.
art B: Signat nave reviewed the formation submitt uthorized Signatu	ture and Contact e responses to this su ed in this survey is su ure:	urvey and certify that the information is true and accurate. I understand that the ubject to compliance review by the Department.  Title Senior Planner  Date:
art B: Signat have reviewed the formation submitt uthorized Signatu	ture and Contact e responses to this su ed in this survey is su ure:	Title Senior Planner  Date:
art B: Signat nave reviewed the formation submitt uthorized Signatu erson authorized	ture and Contact e responses to this su ed in this survey is su ure:	Title Senior Planner  Date:
art B: Signated are reviewed the formation submitted uthorized Signaturerson authorized contact's Name:	e responses to this sured in this survey is survey to respond to inquirie	Title Senior Planner  Date:
art B: Signate nave reviewed the formation submitted uthorized Signaturerson authorized contact's Name:	ture and Contact e responses to this su red in this survey is su  ure:  Brian 1.	Title Senior Planner  Date:
art B: Signate have reviewed the formation submitted uthorized Signaturerson authorized contact's Name:	ture and Contact e responses to this su ed in this survey is su  ure:  Brian 1:  04-851-6821  e-Specific Data 1	Title Senior Planner  Date:  Toporch  Fax: 404-303-38 20  Toporch  Toporch  Toporch  Toporch  Toporch  Temporch  Temporch  Temporch  Toporch  Temporch  Temp

Uncompensated Indigent Care Uncompensated Charity Care

Totals

Adjusted Gross Revenue

Amount	Number of Patients
\$283,788	233
\$518, 397	1,084
\$802,185	1, 285
\$13.017.902	

### Service Specific I/C Care Survey - Adjusted Gross Revenue DTRC168 2017 Cobb Northside Marietta Imaging Center

Part A:	Genera	I Information	Geo	rgia Department o	f Community Health
1.			Year: 2017		
Facili	ity UID	DTRC168		<del></del>	
Facili	ty Name	Northside Marietta I	maging Center	County:	Cobb
			e following Certificate-of-Need ated indigent/charity care:	(CON) service for which the	ne hospital has a
Servi	ce:	Imaging Center			
CON	•	2012-026			
2. Please	e report dat	a for the hospital fisca	l year ending in calender year 20	017 only. Do not use a diffe	erent report period.
Repo	rt Period:				
Begin	ning:	1/1/2017		Ending: 1-2	31 2017
3. Was t	he service	identified above op	erational for the full report perio	od?	Yes
If "No	," explain:				
Part B:	Signat	ure and Contac	t ·		•
I have revinformation	riewed the	responses to this s ed in this survey is s	urvey and certify that the inforublect to compliance review by	mation is true and accurate the Department.	e. I understand that the
	d Signatu	year J	_ <del>/</del>	enior Planner	Date: 7 27 2018
Person a	uthorized f	to respond to inquirie	es about the responses to this s	survey	
Contact's	Name:	Bris J.	Toporek Contact's Ti	itle: Senior Pl	anner
Telephon	e: 40	14-851-6821	Fax: 404-303-38	(20) E-mail: brign	toporek @ northside.co
Part C:	Service	e-Specific Data	for Specified Service		
Data	for service	e: Imaging (	Center	·	
			Amount	Number of Pa	liants
Linco	mnensate	d Indigent Care	Amount		
	-	d Charity Care	7 459, 931	286	
Total	•	a onanty oate	7 118,776	15%	
		Revenue	± 578,727	735	
Aajus	sieu Gross	nevenue	± 4,962, 869		

#### Service Specific I/C Care Survey - Adjusted Gross Revenue Northside Hospital Cherokee

HOSP541 2017 Cherokee

Part A: Genera	Information	Geo	rgia Department of	Community Health
1.		Year: 2017		
Facility UID	HOSP541			
Facility Name	Northside Hospital C	Cherokee	County:	Cherokee
This Addendum commitment to	reports data for the provide uncompensa	e following Certificate-of-Need ated indigent/charity care:	(CON) service for which the	e hospital has a
Service:	Northside Canton G	Lab		
CON:	1995-081			
2. Please report data	a for the hospital fiscal	year ending in calender year 20	ี่ วา only. Do not use a differ	rent report period.
Report Period:				
Beginning:	1/1/2017		Ending: 12 3	1 2017
3. Was the service	identified above ope	erational for the full report perio	od?	Yes
If "No," explain:				
•				
have reviewed the	responses to this st d in this survey is su	urvey and certify that the inform bject to compliance review by	mation is true and accurate. the Department.	I understand that the
Authorized Signatur		Title Se	nier Planner	Date: 7 27 2018
Contact's Name:		Contact's Ti		
		10porek	Denior 119	
Telephone: けい	4-851-6821	Fax: 401-303-38	20   E-mail:   baga-	topone & Pronthsilde
Part C: Service	-Specific Data	for Specified Service		
Data for service	Northside	Canton GI Lab		
Harry	d Indiana O	Amount	Number of Pati	ents
Uncompensated		\$20,122	22	
Uncompensated Totals	i Charity Care	\$179,595	101	
	Payanua	\$ 199,717	121	
Adjusted Gross	Revenue	\$ 2,530,425		

### Service Specific I/C Care Survey - Adjusted Gross Revenue Northside Hospital Forsyth

HOSP346 2017 Forsyth

Pa	rt A: Genera	al Information	. (	Georgia	Depart	ment of	Commun	ity Health	)
1.			Year: 20	17				•	
	Facility UID	HOSP346					/	· · ·	
	Facility Name	Northside Hospital Fo	rsyth			County:	Forsyth		
			following Certificate-of- ed indigent/charity care		l) service fo	or which the	hospital has	s a	
	Service:	Gamma Knife				<u> </u>			
	CON:	2013-010							
2.	Please report da	ta for the hospital fiscal y	rear ending in calender y	vear 2017 o	nly. Do not	use a differ	ent report pe	riod.	
	Report Period:								
	Beginning:	1/1/2011			Ending:	12/3	1/2017		
3.	Was the service	e identified above oper	ational for the full repor	t period?			40	2.5	
	If "No," explain:								
i ha	ive reviewed the	e responses to this sur ed in this survey is sub	vey and certify that the ject to compliance revi	information w by the D	n is true an epartment.	d accurate.	I understan	d that the	
	thorized Signatu	Jese 7.	Title about the responses to	Senior		e C	Date	2/27/2018	Y
	ntact's Name:			ct's Title:		<u> </u>	· <del>-</del>		1
Co	ntacts ivame.	Brien J.	Toponer	icts ride.		x P1420			
Tel	ephone:	DY-851-6821	Fax: 404-303	-3820	E-mail:	brign.	toporek	@ north	side.com
Paı	rt C: Servic	e-Specific Data fo	or Specified Servi	ce					
	Data for servic	e: Gamma Kn	fe						
			Amount		Num	ber of Patie	ents	]	
	Uncompensate	ed Indigent Care	✓		14				
		ed Charity Care	\$ 4695		7				
	Totals		\$429, 307		21				
	Adjusted Gross	s Revenue	\$4,820,014						