GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2020 Service Specific I/C Care Survey

Part A : General Information

1. Identification

UID:DTRC047

Facility Name: Northside Hembree Imaging

County: Fulton

This Addendum reports data for the following Certificate-of-Need (CON) service for which the hospital has a commitment to provide uncompensated indigent/charity care:

Service: Imaging Center

CON #: 2011-062

2. Report Period

Please report data for the hospital fiscal year ending in calender year 2020 only. Do not use a different report period.

Beginning: 1/1/2020

Ending: 12/31/2020

Please report data for the hospital fiscal year ending in calender year 2020 only. Do not use a different report period.

3. Operational Status

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, please explain.

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: Brian J. Toporek

Contact Title: Senior Planner

Phone: 404-851-6821

Fax: 404-250-3102

E-mail: brian.toporek@northside.com

Part C : Service-Specific Data for Specified Service

Data for Service: Imaging Center

Type of Care	Amount	Number of Patients
Uncompensated Indigent Care	39474	19
Uncompensated Charity Care	76994	49
Total	**116468**	**68**

AGR: 3487683

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: Robert Quattrocchi

Date: 7/23/2021

Title: CEO and President, Northside Hospital, Inc.