



2021 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP226

Facility Name: Northside Hospital Duluth

County: Gwinnett

Street Address: 3620 Howell Ferry Road

City: Duluth

Zip: 30096

Mailing Address: 3620 Howell Ferry Road

Mailing City: Duluth

Mailing Zip: 30096

2. Report Period

Please report data for the hospital fiscal year ending during calendar year 2021 only.

Do not use a different report period.

Please indicate your hospital fiscal year.

From: 10/1/2020 To:9/30/2021

Please indicate your cost report year.

From: 10/01/2020 To:09/30/2021

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.

3. Trauma Center Designation Change During the Report Period

Check the box to the right if your facility experienced a change in trauma center designation during the report period.

If your facility's trauma center designation changed, provide the date and type of change.

Part B : Survey Contact Information

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

Contact Name: Anne Eiswirth

Contact Title: Director of Finance / System Controller

Phone: 404-303-3798

Fax: 404-303-3820

E-mail: Anne.Eiswirth@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	337,203,544
Total Inpatient Admissions accounting for Inpatient Revenue	5,091
Outpatient Gross Patient Revenue	601,279,405
Total Outpatient Visits accounting for Outpatient Revenue	90,270
Medicare Contractual Adjustments	288,517,831
Medicaid Contractual Adjustments	71,070,353
Other Contractual Adjustments:	251,339,255
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	64,613,436
Gross Indigent Care:	17,941,969
Gross Charity Care:	29,030,070
Uncompensated Indigent Care (net):	17,941,969
Uncompensated Charity Care (net):	29,030,070
Other Free Care:	44,743,749
Other Revenue/Gains:	5,179,423
Total Expenses:	169,970,372

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	38,841,486
Admin Discounts	5,902,263
Employee Discounts	0
	0
Total	44,743,749

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 2021? (Check box if yes.)

2. Effective Date

What was the effective date of the policy or policies in effect during 2021?

02/12/2020

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.?

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.)?

300%

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 2021? (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	5,588,109	12,309,022	17,897,131
Outpatient	12,353,860	16,721,048	29,074,908
Total	17,941,969	29,030,070	46,972,039

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
Total	0

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	5,588,109	12,309,022	17,897,131
Outpatient	12,353,860	16,721,048	29,074,908
Total	17,941,969	29,030,070	46,972,039

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	2,123	0	0	32	139,682
BALDWIN	0	0	0	0	0	0	1	517
BANKS	0	0	2	146,605	0	0	0	0
BARROW	0	0	34	39,752	4	17,352	49	128,962
BARTOW	0	0	1	879	0	0	0	0
BIBB	0	0	1	202	0	0	1	520
BUTTS	0	0	0	0	0	0	1	11,101
CARROLL	3	170,198	3	4,789	0	0	2	1,528
CHATHAM	0	0	0	0	0	0	1	327
CHEROKEE	0	0	4	55,533	0	0	16	101,322
CLARKE	0	0	3	3,538	1	2,086	8	34,188
CLAYTON	0	0	5	22,835	0	0	25	34,580
COBB	0	0	9	47,218	3	111,698	49	306,134
COFFEE	0	0	0	0	0	0	3	2,141
COLQUITT	0	0	1	67	0	0	0	0
COLUMBIA	0	0	0	0	0	0	1	2,353
COWETA	0	0	2	70,619	0	0	0	0
DAWSON	0	0	4	13,151	1	43	3	35,645
DEKALB	10	111,636	204	1,002,885	28	376,372	437	1,448,329
DOUGHERTY	0	0	1	495	0	0	1	565
DOUGLAS	0	0	1	3,241	0	0	21	108,059
EARLY	0	0	0	0	0	0	1	231
EMANUEL	0	0	0	0	0	0	3	105
FAYETTE	0	0	0	0	0	0	1	69
FLORIDA	4	113,414	12	290,773	3	4,934	47	97,244
FLOYD	0	0	1	1,099	0	0	1	5,173
FORSYTH	0	0	6	37,331	4	89,067	25	93,724
FRANKLIN	0	0	0	0	0	0	2	606
FULTON	11	627,444	168	497,391	38	1,344,550	322	898,678
GWINNETT	157	4,044,238	2,064	9,213,199	304	9,060,946	3,227	11,221,242
HABERSHAM	0	0	0	0	0	0	3	4,446
HALL	1	134,946	34	259,899	5	19,017	30	65,776

HART	0	0	0	0	0	0	2	5,817
HENRY	1	1,484	5	36,777	1	74,243	12	17,785
JACKSON	3	104,796	40	261,490	1	22,528	39	72,156
JASPER	0	0	1	1,000	0	0	0	0
JOHNSON	1	1,300	0	0	0	0	0	0
LOWNDES	0	0	0	0	1	33,405	13	96,314
MADISON	0	0	0	0	1	120,979	8	17,362
MORGAN	0	0	1	728	0	0	2	4,162
MURRAY	1	193,295	0	0	0	0	0	0
MUSCOGEE	0	0	1	1,042	0	0	1	1,389
NEWTON	0	0	0	0	0	0	12	23,588
NORTH CAROLINA	0	0	0	0	2	2,850	32	36,849
OCONEE	0	0	2	1,059	0	0	1	2,080
OGLETHORPE	0	0	0	0	0	0	1	1,634
OTHER OUT OF STAT	1	1,788	16	122,495	17	709,733	237	1,183,535
PAULDING	0	0	0	0	0	0	1	41,657
PICKENS	0	0	1	1,934	1	2,086	1	3,990
PIKE	0	0	0	0	0	0	1	1,356
POLK	0	0	0	0	2	48,424	6	37,277
RABUN	0	0	1	4,324	0	0	1	15,346
RANDOLPH	0	0	0	0	0	0	1	1,863
ROCKDALE	1	41,155	7	8,074	3	157,027	14	90,680
SOUTH CAROLINA	0	0	0	0	0	0	14	57,564
TAYLOR	1	1,408	1	201	0	0	0	0
TENNESSEE	1	38,360	1	4,897	1	107,432	16	40,637
UPSON	0	0	0	0	0	0	1	3,758
WALTON	2	2,647	57	196,215	3	4,250	66	218,793
WHITE	0	0	0	0	0	0	2	2,209
Total	198	5,588,109	2,696	12,353,860	424	12,309,022	4,797	16,721,048

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 2021?
(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 2021.

Patient Category	SFY 2020	SFY2021	SFY2022
	7/1/19-6/30/20	7/1/20-6/30/21	7/1/21-6/30/22
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 2020	SFY2021	SFY2022
7/1/19-6/30/20	7/1/20-6/30/21	7/1/21-6/30/22
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: 7/22/2022

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: SHANNON A BANNA

Date: 7/22/2022

Title: VP FINANCE / CFO

Comments: