



GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

**2024 Annual Hospital Questionnaire**

**Part A : General Information**

**1. Identification**

**UID:hosp541**

**Facility Name:** Northside Hospital Cherokee

**County:** Cherokee

**Street Address:** 450 Northside Cherokee Boulevard

**City:** Canton

**Zip:** 30115

**Mailing Address:** 450 Northside Cherokee Boulevard

**Mailing City:** Canton

**Mailing Zip:** 30115

**Medicaid Provider Number:** 00001108

**Medicare Provider Number:** 110008

**2. Report Period**

Report Data for the full twelve month period- January 1, 2024 through December 31, 2024.

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

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:** Brian J. Toporek

**Contact Title:** Senior Planner

**Phone:** 404-851-6821

**Fax:** 404-250-3102

**E-mail:** brian.toporek@northside.com

## Part C : Ownership, Operation and Management

### 1. Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

#### A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northside Hospital, Inc.	Not for Profit	1/1/2010

#### B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northside Health Services, Inc.	Not for Profit	11/1/1991

#### C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northside Hospital, Inc.	Not for Profit	1/1/2010

#### D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northside Health Services, Inc.	Not for Profit	11/1/1991

#### E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	Not Applicable	

#### F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	Not Applicable	

### 2. Changes in Ownership, Operation or Management

Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period. ☐

If checked, please explain in the box below and include effective dates.

3. Check the box to the right if your facility is part of a health care system ☒

**Name:** Northside Hospital, Inc.

**City:** Atlanta **State:** GA

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☒

**Name:** Northside Health Services, Inc.

**City:** Atlanta **State:** GA

**5.** Check the box to the right if the hospital itself operates subsidiary corporations ☐

**Name:**

**City:**      **State:**

**6.** Check the box to the right if your hospital is a member of an alliance. ☒

**Name:** GA Alliance of Community Hospitals; VHA

**City:**      **State:**

**7.** Check the box to the right if your hospital is a participant in a health care network ☒

**Name:** Northside Health Network; NovaNet; Others

**City:**      **State:**

**8.** Check the box to the right if the hospital has a policy or policies and a peer review process related to medical errors. ☒

**9.** Check the box to the right if the hospital owns or operates a primary care physician group practice. ☒

**10a. Managed Care Information: Formal Written Contract**

Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO) ☒

2. Preferred Provider Organization(PPO) ☒

3. Physician Hospital Organization(PHO) ☐

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☒

**10b. Managed Care Information: Insurance Products**

Check the appropriate boxes to indicate if any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer:

Type of Insurance Product	Hospital	Health Care System	Network	Joint Venture with Insurer
Health Maintenance Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preferred Provider Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indemnity Fee-for-Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Another Insurance Product Not Listed Above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**11. Owner or Owner Parent Based in Another State**

If the owner or owner parent at Part C, Question 1(A&B) is an entity based in another state please report the location in which the entity is based. (City and State)

## Part D : Inpatient Services

### 1. Utilization of Beds as Set Up and Staffed(SUS):

Please indicate the following information. Do not include newborn and neonatal services. Do not include long-term care units, such as Skilled Nursing Facility beds, if not licensed as hospital beds. If your facility is approved for LTCH beds report them below.

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	24	3,111	9,621	3,115	9,629
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	268	11,114	69,801	11,094	69,931
Intensive Care	24	2,953	12,398	2,949	12,549
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	0	0	0	0	0
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	0	0	0	0	0
Swing Bed (Include All Utilization)	0	0	0	0	0
Long Term Care Hospital (LTCH)	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
<b>Total</b>	<b>316</b>	<b>17,178</b>	<b>91,820</b>	<b>17,158</b>	<b>92,109</b>

## **2. Race/Ethnicity**

Please report admissions and inpatient days for the hospital by the following race and ethnicity categories. Exclude newborn and neonatal.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	105	531
Asian	139	628
Black/African American	1,071	6,502
Hispanic/Latino	1,077	4,489
Pacific Islander/Hawaiian	9	41
White	13,804	74,325
Multi-Racial	973	5,304
<b>Total</b>	<b>17,178</b>	<b>91,820</b>

## **3. Gender**

Please report admissions and inpatient days by gender. Exclude newborn and neonatal.

Gender	Admissions	Inpatient Days
Male	6,550	39,297
Female	10,628	52,523
<b>Total</b>	<b>17,178</b>	<b>91,820</b>

## **4. Payment Source**

Please report admissions and inpatient days by primary payment source. Exclude newborn and neonatal.

Primary Payment Source	Admissions	Inpatient Days
Medicare	9,032	54,430
Medicaid	1,339	5,780
Peachare	0	0
Third-Party	5,486	24,557
Self-Pay	1,201	6,480
Other	120	573

## **5. Discharges to Death**

Report the total number of inpatient admissions discharged during the reporting period due to death.

407

## **6. Charges for Selected Services**

Please report the hospital's average charges as of 12-31-2024 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,724
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	13,234
Average Total Charge for an Inpatient Day	14,597

## Part E : Emergency Department and Outpatient Services

### **1. Emergency Visits**

Please report the number of emergency visits only.

56,517

### **2. Inpatient Admissions from ER**

Please report inpatient admissions to the Hospital from the ER for emergency cases ONLY.

12,448

### **3. Beds Available**

Please report the number of beds available in ER as of the last day of the report period.

55

### **4. Utilization by Specific type of ER bed or room for the report period.**

Type of ER Bed or Room	Beds	Visits
Beds dedicated for Trauma	0	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	0	0
Multipurpose Beds	49	68,965
Behavioral Health (seen in multipurpose room 1st)	6	2,091
	0	0
	0	0

### **5. Transfers**

Please provide the number of Transfers to another institution from the Emergency Department.

1,754

### **6. Non-Emergency Visits**

Please provide the number of Outpatient/Clinic/All Other Non-Emergency visits to the hospital.

201,541

### **7. Observation Visits/Cases**

Please provide the total number of Observation visits/cases for the entire report period.

1,995

### **8. Diverted Cases**

Please provide the number of cases your ED diverted while on Ambulance Diversion for the entire report period.

9

### **9. Ambulance Diversion Hours**

Please provide the total number of Ambulance Diversion hours for your ED for the entire report period

35.00

## 10. Untreated Cases

Please provide the number of patients who sought care in your ED but who left without or before being treated. Do not include patients who were transferred or cases that were diverted.

347

## Part F : Services and Facilities

### 1a. Services and Facilities

Please report services offered onsite for in-house and contract services as requested. Please reflect the status of the service during the report period. *(Use the blank lines to specify other services.)*

#### Site Codes

- 1 = In-House - Provided by the Hospital
- 2 = Contract - Provided by a contractor but onsite
- 3 = Not Applicable

#### Status Codes

- 1 = On-Going
- 2 = Newly Initiated
- 3 = Discontinued
- 4 = Not Applicable

Service/Facilities	Site Code	Service Status
Podiatric Services	1	1
Renal Dialysis	1	1
ESWL	2	1
Biliary Lithotripter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	3	4
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnostic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	1	1
HIV/AIDS Diagnostic Treatment/Services	3	4
Ambulance Services	3	4
Hospice	3	4
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

**1b. Report Period Workload Totals**

Please report the workload totals for in-house and contract services as requested. The number of units should equal the number of machines.

Category	Total
Number of Podiatric Patients	788
Number of Dialysis Treatments	2,355
Number of ESWL Patients	109
Number of ESWL Procedures	116
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	70,914
Number of CTS Units (machines)	9
Number of CTS Procedures	65,367
Number of Diagnostic Radioisotope Procedures	2,029
Number of PET Units (machines)	2
Number of PET Procedures	4,169
Number of Therapeutic Radioisotope Procedures	99
Number of Number of MRI Units	8
Number of Number of MRI Procedures	20,836
Number of Chemotherapy Treatments	1,591
Number of Respiratory Therapy Treatments	37,019
Number of Occupational Therapy Treatments	66,272
Number of Physical Therapy Treatments	117,786
Number of Speech Pathology Patients	3,453
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	2,963
Number of HIV/AIDS Diagnostic Procedures	0
Number of HIV/AIDS Patients	0
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	14
Number of Ultrasound/Medical Sonography Procedures	26,213
Number of Treatments, Procedures, or Patients (Other 1)	0
Number of Treatments, Procedures, or Patients (Other 2)	0
Number of Treatments, Procedures, or Patients (Other 3)	0

**2. Medical Ventilators**

Provide the number of computerized/mechanical Ventilator Machines that were in use or available



for immediate use as of the last day of the report period (12/31).

75

**3. Robotic Surgery System**

Please report the number of units, number of procedures, and type of unit(s).

# Units	# Procedures	Type of Unit(s)
5	2,056	Xi

## Part G : Facility Workforce Information

### 1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2024. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2024.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	68.80	5.60	5.32
Physician Assistants Only (not including Licensed Physicians)	29.75	2.00	0.00
Registered Nurses (RNs-Advanced Practice*)	1,065.75	43.78	9.86
Licensed Practical Nurses (LPNs)	61.30	19.40	0.03
Pharmacists	53.45	2.15	0.00
Other Health Services Professionals*	896.90	124.13	22.47
Administration and Support	662.25	57.94	0.86
All Other Hospital Personnel (not included above)	221.80	3.28	1.17

### 2. Filling Vacancies

Using the drop-down menus, please select the average time needed during the past six months to fill each type of vacant position.

Type of Vacancy	Average Time Needed to Fill Vacancies
Physician's Assistants	30 Days or Less
Registered Nurses (RNs-Advance Practice)	More than 90 Days
Licensed Practical Nurses (LPNs)	More than 90 Days
Pharmacists	31-60 Days
Other Health Services Professionals	30 Days or Less
All Other Hospital Personnel (not included above)	61-90 Days

### 3. Race/Ethnicity of Physicians

Please report the number of physicians with admitting privileges by race.

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	0
Asian	0
Black/African American	0
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	0
Multi-Racial	0

### 4. Medical Staff

Please report the number of active and associate/provisional medical staff for the following specialty categories. Keep in mind that physicians may be counted in more than one specialty. Please

indicate whether the specialty group(s) is hospital-based. Also, indicate how many of each medical specialty are enrolled as providers in Georgia Medicaid/PeachCare for Kids and/or the Public Employee Health Benefit Plans (PEHB-State Health Benefit Plan and/or Board of Regents Benefit Plan).

Medical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
General and Family Practice	189	<input checked="" type="checkbox"/>	0	0
General Internal Medicine	525	<input checked="" type="checkbox"/>	0	0
Pediatricians	176	<input checked="" type="checkbox"/>	0	0
Other Medical Specialties	702	<input checked="" type="checkbox"/>	0	0

Surgical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Obstetrics	242	<input checked="" type="checkbox"/>	0	0
Non-OB Physicians Providing OB Services	0	<input checked="" type="checkbox"/>	0	0
Gynecology	92	<input checked="" type="checkbox"/>	0	0
Ophthalmology Surgery	129	<input checked="" type="checkbox"/>	0	0
Orthopedic Surgery	180	<input checked="" type="checkbox"/>	0	0
Plastic Surgery	89	<input checked="" type="checkbox"/>	0	0
General Surgery	126	<input checked="" type="checkbox"/>	0	0
Thoracic Surgery	9	<input checked="" type="checkbox"/>	0	0
Other Surgical Specialties	367	<input checked="" type="checkbox"/>	0	0

Other Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Anesthesiology	151	<input checked="" type="checkbox"/>	0	0
Dermatology	23	<input checked="" type="checkbox"/>	0	0
Emergency Medicine	142	<input checked="" type="checkbox"/>	0	0
Nuclear Medicine	212	<input checked="" type="checkbox"/>	0	0
Pathology	35	<input checked="" type="checkbox"/>	0	0
Psychiatry	28	<input checked="" type="checkbox"/>	0	0
Radiology	107	<input checked="" type="checkbox"/>	0	0
Radiation Oncology	30	<input checked="" type="checkbox"/>	0	0
	0	<input type="checkbox"/>	0	0
	0	<input type="checkbox"/>	0	0

**5a. Non-Physicians**

Please report the number of professionals for the categories below. Exclude any hospital-based staff reported in Part G, Questions 1,2,3 and 4 above.

Profession	Number
Dentists (include oral surgeons) with Admitting Privileges	65
Podiatrists	47
Certified Nurse Midwives with Clinical Privileges in the Hospital	97
All Other Staff Affiliates with Clinical Privileges in the Hospital	1,663

**5b. Name of Other Professions**

Please provide the names of professions classified as "Other Staff Affiliates with Clinical Privileges" above.

Nurse Practitioner, Nurse Anesthetist, Physicians Assistant, Anesthesia Assistant, Optometrist, Psychologist, Dietitian

**Comments and Suggestions:**

## Part H : Physician Name and License Number

### 1. Physicians on Staff

Please report the full name and license number of each physician on staff. **(Due to the large number of entries, this section has been moved to a separate PDF file.)**

## Part I : Patient Origin Table

### 1. Patient Origin

Please report the county of origin for the inpatient admissions or discharges excluding newborns (except surgical services should include outpatients only).

Inpat=Inpatient Services

Surg=Outpatient Surgical

OB=Obstetric

P18+=Acute psychiatric adult 18 and over

P13-17=Acute psychiatric adolescent 13-17

P0-12=Acute psychiatric children 12 and under

Rehab=Inpatient Rehabilitation

S18+=Substance abuse adult 18 and over

S13-17=Substance abuse adolescent 13-17

E18+=Extended care adult 18 and over

E13-17=Extended care adolescent 13-17

E0-12=Extended care children 0-12

LTCH=Long Term Care Hospital

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH	Rehab
Alabama	27	54	2	0	0	0	0	0	0	0	0	0	0
Baldwin	1	1	0	0	0	0	0	0	0	0	0	0	0
Banks	0	2	0	0	0	0	0	0	0	0	0	0	0
Barrow	9	11	2	0	0	0	0	0	0	0	0	0	0
Bartow	482	495	174	0	0	0	0	0	0	0	0	0	0
Ben Hill	1	0	0	0	0	0	0	0	0	0	0	0	0
Bibb	1	8	0	0	0	0	0	0	0	0	0	0	0
Brantley	1	1	0	0	0	0	0	0	0	0	0	0	0
Bryan	0	1	0	0	0	0	0	0	0	0	0	0	0
Bulloch	3	2	0	0	0	0	0	0	0	0	0	0	0
Burke	1	0	0	0	0	0	0	0	0	0	0	0	0
Butts	2	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	39	29	3	0	0	0	0	0	0	0	0	0	0
Catoosa	4	5	0	0	0	0	0	0	0	0	0	0	0
Chatham	6	1	0	0	0	0	0	0	0	0	0	0	0
Chattooga	8	12	0	0	0	0	0	0	0	0	0	0	0
Cherokee	11,222	6,485	1,944	0	0	0	0	0	0	0	0	0	0
Clarke	1	5	0	0	0	0	0	0	0	0	0	0	0
Clayton	9	19	1	0	0	0	0	0	0	0	0	0	0
Cobb	1,290	1,407	245	0	0	0	0	0	0	0	0	0	0
Colquitt	0	2	0	0	0	0	0	0	0	0	0	0	0
Columbia	3	1	1	0	0	0	0	0	0	0	0	0	0
Cook	0	1	0	0	0	0	0	0	0	0	0	0	0
Coweta	8	8	2	0	0	0	0	0	0	0	0	0	0
Crawford	0	1	0	0	0	0	0	0	0	0	0	0	0
Crisp	1	1	0	0	0	0	0	0	0	0	0	0	0
Dawson	42	40	10	0	0	0	0	0	0	0	0	0	0

Decatur	0	2	0	0	0	0	0	0	0	0	0	0	0
Dekalb	52	82	5	0	0	0	0	0	0	0	0	0	0
Dougherty	2	3	0	0	0	0	0	0	0	0	0	0	0
Douglas	27	54	7	0	0	0	0	0	0	0	0	0	0
Effingham	3	0	0	0	0	0	0	0	0	0	0	0	0
Elbert	1	0	1	0	0	0	0	0	0	0	0	0	0
Fannin	437	331	87	0	0	0	0	0	0	0	0	0	0
Fayette	4	7	0	0	0	0	0	0	0	0	0	0	0
Florida	68	32	3	0	0	0	0	0	0	0	0	0	0
Floyd	51	72	12	0	0	0	0	0	0	0	0	0	0
Forsyth	169	197	28	0	0	0	0	0	0	0	0	0	0
Franklin	1	7	0	0	0	0	0	0	0	0	0	0	0
Fulton	350	439	52	0	0	0	0	0	0	0	0	0	0
Gilmer	712	633	169	0	0	0	0	0	0	0	0	0	0
Glynn	0	1	0	0	0	0	0	0	0	0	0	0	0
Gordon	147	123	42	0	0	0	0	0	0	0	0	0	0
Greene	2	0	1	0	0	0	0	0	0	0	0	0	0
Gwinnett	59	166	12	0	0	0	0	0	0	0	0	0	0
Habersham	7	3	2	0	0	0	0	0	0	0	0	0	0
Hall	25	35	2	0	0	0	0	0	0	0	0	0	0
Hancock	1	2	0	0	0	0	0	0	0	0	0	0	0
Haralson	14	9	0	0	0	0	0	0	0	0	0	0	0
Harris	1	3	0	0	0	0	0	0	0	0	0	0	0
Heard	0	1	0	0	0	0	0	0	0	0	0	0	0
Henry	15	23	2	0	0	0	0	0	0	0	0	0	0
Houston	3	5	0	0	0	0	0	0	0	0	0	0	0
Jackson	4	15	1	0	0	0	0	0	0	0	0	0	0
Jasper	3	0	0	0	0	0	0	0	0	0	0	0	0
Jefferson	0	1	0	0	0	0	0	0	0	0	0	0	0
Lamar	2	1	0	0	0	0	0	0	0	0	0	0	0
Laurens	1	1	1	0	0	0	0	0	0	0	0	0	0
Lee	1	1	0	0	0	0	0	0	0	0	0	0	0
Long	1	0	0	0	0	0	0	0	0	0	0	0	0
Lowndes	0	1	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	7	11	2	0	0	0	0	0	0	0	0	0	0
Madison	2	1	0	0	0	0	0	0	0	0	0	0	0
Marion	0	1	0	0	0	0	0	0	0	0	0	0	0
Meriwether	0	3	0	0	0	0	0	0	0	0	0	0	0
Mitchell	1	0	0	0	0	0	0	0	0	0	0	0	0
Monroe	1	0	0	0	0	0	0	0	0	0	0	0	0
Morgan	0	1	0	0	0	0	0	0	0	0	0	0	0
Murray	19	37	8	0	0	0	0	0	0	0	0	0	0
Muscogee	1	4	0	0	0	0	0	0	0	0	0	0	0
Newton	14	5	1	0	0	0	0	0	0	0	0	0	0

North Carolina	104	104	3	0	0	0	0	0	0	0	0	0	0
Oconee	0	1	0	0	0	0	0	0	0	0	0	0	0
Other Out Of State	109	47	5	0	0	0	0	0	0	0	0	0	0
Paulding	128	175	42	0	0	0	0	0	0	0	0	0	0
Peach	0	1	0	0	0	0	0	0	0	0	0	0	0
Pickens	1,195	945	200	0	0	0	0	0	0	0	0	0	0
Pike	4	4	0	0	0	0	0	0	0	0	0	0	0
Polk	26	24	5	0	0	0	0	0	0	0	0	0	0
Pulaski	0	1	0	0	0	0	0	0	0	0	0	0	0
Putnam	2	2	0	0	0	0	0	0	0	0	0	0	0
Rabun	2	6	0	0	0	0	0	0	0	0	0	0	0
Richmond	2	1	2	0	0	0	0	0	0	0	0	0	0
Rockdale	7	14	0	0	0	0	0	0	0	0	0	0	0
South Carolina	19	21	0	0	0	0	0	0	0	0	0	0	0
Spalding	3	9	0	0	0	0	0	0	0	0	0	0	0
Stephens	1	3	0	0	0	0	0	0	0	0	0	0	0
Sumter	2	0	0	0	0	0	0	0	0	0	0	0	0
Tennessee	50	68	3	0	0	0	0	0	0	0	0	0	0
Terrell	0	1	0	0	0	0	0	0	0	0	0	0	0
Thomas	0	1	0	0	0	0	0	0	0	0	0	0	0
Tift	0	2	0	0	0	0	0	0	0	0	0	0	0
Toombs	0	1	0	0	0	0	0	0	0	0	0	0	0
Towns	28	21	5	0	0	0	0	0	0	0	0	0	0
Troup	3	3	1	0	0	0	0	0	0	0	0	0	0
Union	91	114	19	0	0	0	0	0	0	0	0	0	0
Upson	0	2	0	0	0	0	0	0	0	0	0	0	0
Walker	7	6	1	0	0	0	0	0	0	0	0	0	0
Walton	3	15	0	0	0	0	0	0	0	0	0	0	0
Ware	1	0	0	0	0	0	0	0	0	0	0	0	0
White	3	11	0	0	0	0	0	0	0	0	0	0	0
Whitfield	18	29	3	0	0	0	0	0	0	0	0	0	0
Wilkes	0	1	0	0	0	0	0	0	0	0	0	0	0
Worth	1	0	0	0	0	0	0	0	0	0	0	0	0
<b>Total</b>	<b>17,178</b>	<b>12,539</b>	<b>3,111</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

## Surgical Services Addendum

### Part A : Surgical Services Utilization

#### 1. Surgery Rooms in the OR Suite

Please report the Number of Surgery Rooms, (as of the end of the report period). Report only the rooms in CON-Approved Operating Room Suites pursuant to Rule 111-2-2-.40 and 111-8-48-.28.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Rooms
General Operating	0	3	19
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	0
	0	0	0
<b>Total</b>	<b>0</b>	<b>3</b>	<b>19</b>

#### 2. Procedures by Type of Room

Please report the number of procedures by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	4,270	12,502	20,752
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
<b>Total</b>	<b>0</b>	<b>4,270</b>	<b>12,502</b>	<b>20,752</b>

#### 3. Patients by Type of Room

Please report the number of patients by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	2,222	3,193	10,625
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
<b>Total</b>	<b>0</b>	<b>2,222</b>	<b>3,193</b>	<b>10,625</b>

### Part B : Ambulatory Patient Race/Ethnicity, Age, Gender and Payment Source

#### 1. Race/Ethnicity of Ambulatory Patients

Please report the total number of ambulatory patients for both dedicated outpatient and shared room environment.



Race/Ethnicity	Number of Ambulatory Patients
American Indian/Alaska Native	53
Asian	114
Black/African American	882
Hispanic/Latino	677
Pacific Islander/Hawaiian	2
White	10,370
Multi-Racial	441
<b>Total</b>	<b>12,539</b>

## **2. Age Grouping**

Please report the total number of ambulatory patients by age grouping.

Age of Patient	Number of Ambulatory Patients
Ages 0-14	358
Ages 15-64	7,454
Ages 65-74	2,873
Ages 75-85	1,659
Ages 85 and Up	195
<b>Total</b>	<b>12,539</b>

## **3. Gender**

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,329
Female	7,210
<b>Total</b>	<b>12,539</b>

## **4. Payment Source**

Please report the total number of ambulatory patients by payment source.

Primary Payment Source	Number of Patients
Medicare	4,644
Medicaid	541
Third-Party	6,808
Self-Pay	546

## **Perinatal Services Addendum**

### **Part A : Obstetrical Services Utilization**

Please report the following obstetrical services information for the report period. Include all deliveries and births in any unit of the hospital or anywhere on its grounds.

#### **1. Number of Delivery Rooms: 2**

2. Number of Birthing Rooms: 0
3. Number of LDR Rooms: 13
4. Number of LDRP Rooms: 0
5. Number of Cesarean Sections: 981
6. Total Live Births: 2,969
7. Total Births (Live and Late Fetal Deaths): 2,987
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 3,333

## Part B : Newborn and Neonatal Nursery Services

### 1. Nursery Services

Please Report the following newborn and neonatal nursery information for the report period.

Type of Nursery	Set-Up and Staffed Beds/Station	Neonatal Admissions	Inpatient Days	Transfers within Hospital
Normal Newborn (Basic)	37	2,762	9,400	260
Specialty Care (Intermediate Neonatal Care)	4	177	2,420	132
Subspecialty Care (Intensive Neonatal Care)	4	37	293	13

## Part C : Obstetrical Charges and Utilization by Mother's Race/Ethnicity and Age

### 1. Race/Ethnicity

Please provide the number of admissions and inpatient days for mothers by the mother's race using race/ethnicity classifications.

Race/Ethnicity	Admissions by Mother's Race	Inpatient Days
American Indian/Alaska Native	25	62
Asian	66	218
Black/African American	225	891
Hispanic/Latino	551	1,598
Pacific Islander/Hawaiian	3	7
White	2,077	6,367
Multi-Racial	164	478
<b>Total</b>	<b>3,111</b>	<b>9,621</b>

## **2. Age Grouping**

Please provide the number of admissions by the following age groupings.

Age of Patient	Number of Admissions	Inpatient Days
Ages 0-14	0	0
Ages 15-44	3,103	9,592
Ages 45 and Up	8	29
<b>Total</b>	<b>3,111</b>	<b>9,621</b>

## **3. Average Charge for an Uncomplicated Delivery**

Please report the average hospital charge for an uncomplicated delivery(CPT 59400)

\$16,502.00

## **4. Average Charge for a Premature Delivery**

Please report the average hospital charge for a premature delivery.

\$53,987.00

## **LTCH Addendum**

### **Part A : General Information**

**1a. Accreditation** Check the box to the right if your Long Term Care Hospital is accredited. ☐  
If you checked the box for yes, please specify the agency that accredits your facility in the space below.

### **1b. Level/Status of Accreditation**

Please provide your organization's level/status of accreditation.

**2. Number of Licensed LTCH Beds: 0**

**3. Permit Effective Date:**

**4. Permit Designation:**

**5. Number of CON Beds: 0**

**6. Number of SUS Beds: 0**

**7. Total Patient Days: 0**

**8. Total Discharges: 0**

**9. Total LTCH Admissions: 0**

### **Part B : Utilization by Race, Age, Gender and Payment Source**

#### **1. Race/Ethnicity**

Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
<b>Total</b>	<b>0</b>	<b>0</b>

## **2. Age of LTCH Patient**

Please provide the number of admissions and inpatient days by the following age groupings.

Age of Patient	Admissions	Inpatient Days
Ages 0-64	0	0
Ages 65-74	0	0
Ages 75-84	0	0
Ages 85 and Up	0	0
<b>Total</b>	<b>0</b>	<b>0</b>

## **3. Gender**

Please provide the number of admissions and inpatient days by the following gender classifications.

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
<b>Total</b>	<b>0</b>	<b>0</b>

## **4. Payment Source**

Please indicate the number of patients by the payment source. Please note that individuals may have multiple payment sources.

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	0	0
Third-Party	0	0
Self-Pay	0	0
Other	0	0

## **Psychiatric/Substance Abuse Services Addendum**

### **Part A : Psychiatric and Substance Abuse Data by Program**

## 1. Beds

Please report the number of beds as of the last day of the report period. Report beds only for officially recognized programs. Use the blank row to report combined beds. For combined bed programs, please report each of the combined bed programs and the number of combined beds. Indicate the combined programs using letters A through H, for example, "AB"

Patient Type	Distribution of CON-Authorized Beds	Set-Up and Staffed Beds
A- General Acute Psychiatric Adults 18 and over	0	0
B- General Acute Psychiatric Adolescents 13-17	0	0
C- General Acute Psychiatric Children 12 and under	0	0
D- Acute Substance Abuse Adults 18 and over	0	0
E- Acute Substance Abuse Adolescents 13-17	0	0
F-Extended Care Adults 18 and over	0	0
G- Extended Care Adolescents 13-17	0	0
H- Extended Care Adolescents 0-12	0	0
	0	0

## 2. Admissions, Days, Discharges, Accreditation

Please report the following utilization for the report period. Report only for officially recognized programs.

Program Type	Admissions	Inpatient Days	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program is JCAHO Accredited
General Acute Psychiatric Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	<input type="checkbox"/>
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 0-12	0	0	0	0	0	<input type="checkbox"/>

## Part B : Psych/SA Utilization by Race/Ethnicity, Gender, and Payment Source

### 1. Race/Ethnicity

Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
<b>Total</b>	<b>0</b>	<b>0</b>

### 2. Gender

Please provide the number of admissions and inpatient days by the following gender classifications.

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
<b>Total</b>	<b>0</b>	<b>0</b>

### 3. Payment Source

Please indicate the number of patients by the following payment sources. Please note that individuals may have multiple payment sources.

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	0	0
Medicaid	0	0
Third Party	0	0
Self-Pay	0	0
PeachCare	0	0

## Georgia Minority Health Advisory Council Addendum

Because of Georgia's racial and ethnic diversity, and a dramatic increase in segments of the population with Limited English Proficiency, the Georgia Minority Health Advisory Council is working with the Department of Community Health to assess our health systems' ability to provide Culturally and Linguistically Appropriate Services (CLAS) to all segments of our population. We appreciate your willingness to provide information on the following questions:

1. Do you have paid medical interpreters on staff? (Check the box, if yes.) ☒

If you checked yes, how many? 5 (FTE's)

What languages do they interpret?

Spanish Only; 5 Full-time and 4 PRN Interpreters

2. When a paid medical interpreter is not available for a limited-English proficiency patient, what alternative mechanisms do you use to assure the provision of Linguistically Appropriate Services? (Check all that apply)

Bilingual Hospital Staff Member ☐

Bilingual Member of Patient's Family ☐

Community Volunteer Interpreter ☐

Telephone Interpreter Service ☒

Refer Patient to Outside Agency ☐

Other (please describe): ☒

Video on iPads; Outside agencies come to hospital

3. Please complete the following grid to show the proportion of patients you serve who prefer speaking various languages (name the 3 most common non-English languages spoken.)

Top 3 most common non-English languages spoken by your patients	Percent of patients for whom this is their preferred language	# of physicians on staff who speak this language	# of nurses on staff who speak this language	# of other employed staff who speak this language
Spanish	2.82%	0	0	0
Russian	.06%	0	0	0
Haitian Creole/Vietnamese	.04%	0	0	0

4. What **training** have you provided to your staff to assure cultural competency and the provision of **Culturally and Linguistically Appropriate Services (CLAS)** to your patients?

All staff interpreters complete annual mandatory computer-based learning (CBLs) to ensure they are

up to date on culture sensitivity, medical terminology and vocabulary. Interpreters also complete annual competencies, education and attend interpretation in-services. All new hospital staff must complete a CBL to understand the importance of using a qualified medical interpreter and attend an orientation class to receive information directly from Interpretation Services.

5. What is the most urgent tool or resource you need in order to increase your ability to provide **Culturally and Linguistically Appropriate Services (CLAS)** to your patients?

As our hospital continues to grow and provide care to an increasingly diverse patient population, we would benefit from hiring interpreters who are qualified in additional languages including American Sign Language (ASL), Russian, Arabic, Vietnamese, Mandarin, French, Haitian Creole, and Portuguese.

6. In what languages are the signs written that direct patients within your facility?

1. English

2. Spanish

3.

4.

7. If an uninsured patient visits your emergency department, is there a community health center, federally-qualified health center, free clinic, or other reduced-fee safety net clinic nearby to which you could refer that patient in order to provide him or her an affordable primary care medical home regardless of ability to pay? (*Check the box, if yes*) ☐

If you checked yes, what is the name and location of that health care center or clinic?

Bethesda Clinic, 111 Mountain Brook Dr., Canton GA 30115

Georgia Highlands, 220 Oakside Lane, Canton GA 30115

Good Samaritan Health & Wellness Center, 175 Samaritan Way, Jasper GA 30143



## Comprehensive Inpatient Physical Rehabilitation Addendum

### Part A : Rehab Utilization by Race/Ethnicity, Gender, and Payment Source

#### 1. Admissions and Days of Care by Race

Please report the number of inpatient physical rehabilitation admissions and inpatient days for the hospital by the following race and ethnicity categories.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0

#### 2. Admissions and Days of care by Gender

Please report the number of inpatient physical rehabilitation admissions and inpatient days by gender.

Gender	Admissions	Inpatient Days
Male	0	0
Female	0	0

#### 3. Admissions and Days of Care by Age Cohort

Please report the number of inpatient physical rehabilitation admissions and inpatient days by age cohort.

Gender	Admissions	Inpatient Days
0-17	0	0
18-64	0	0
65-84	0	0
85 Up	0	0

### Part B : Referral Source

#### 1. Referral Source

Please report the number of inpatient physical rehabilitation admissions during the report period from each of the following sources.

Referral Source	Admissions
Acute Care Hospital/General Hospital	0
Long Term Care Hospital	0
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0

	0
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### 1. Payers

Please report the number of inpatient physical rehabilitation admissions by each of the following payer categories.

Primary Payment Source	Admissions
Medicare	0
Third Party/Commercial	0
Self Pay	0
Other	0

### 2. Uncompensated Indigent and Charity Care

Please report the number of inpatient physical rehabilitation patients qualifying as uncompensated indigent or charity care

0

## Part D : Admissions by Diagnosis Code

### 1. Admissions by Diagnosis Code

Please report the number of inpatient physical rehabilitation admissions by the "CMS 13" diagnosis of the patient listed below.

Diagnosis	Admissions
1. Stroke	0
2. Brain Injury	0
3. Amputation	0
4. Spinal Cord	0
5. Fracture of the femur	0
6. Neurological disorders	0
7. Multiple Trauma	0
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	0
All Other	0

## 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.

**Authorized Signature:** William Hayes

**Date:** 3/7/2025

**Title:** CEO, Northside Hospital Cherokee

**Comments:**

NOTES ABOUT THIS SURVEY:

Various Areas of the AHQ and Addenda: Race/Ethnicity of Patients: The determination of a patient's race is based on the discretion of the admissions clerk. If the admissions clerk is unsure of the patient's race, the clerk must choose "Multi-racial/Unknown". In addition, "Hispanic" or "Latino" are ethnic characteristics, meaning that Hispanic patients may be of any race. As such, the figures provided should be considered only a very rough approximation of true utilization by race at Northside Hospital.

Part D, Item 1: Utilization of Beds: Critical Care Admissions and Discharges: The figures provided represent direct admissions to and direct discharges from critical care beds only. Length of stay in critical care beds cannot be accurately calculated using direct admissions and discharges because these figures do not represent all patients who spent time in a critical care bed (e.g., patients transferred from other units), while inpatient days and discharge days do reflect all occupied bed days.

Part D, Item 4: Government Payment Source: Medicare admissions and days include Medicare managed care, while Medicaid admissions and days include Medicaid managed care.

Part E, Item 1: Emergency Visits to the Hospital: Consistent with past surveys dating back to 2003, based on instructions from DCH staff, only outpatient visits to the ER are to be included in this figure. Total ER visits thus would equal the sum of Lines E.1 and E.2.

Part E, Item 4: Behavioral Health visits are seen in a multipurpose room prior to being moved to a behavioral health room. These visits are counted under both room categories since two rooms are occupied during these visits.

Part E, Item 7: Total Observation Visits: Observation patients seen in the Emergency Department are included as Emergency Room visits are not reflected in this total. Total Observation Visits includes all 23-hour patients (observation and extended recovery) served outside of the ED.

Part F, Item 1: Services & Facilities: "ESWL": Northside contracts with two different companies for this service. Each company provides a transportable unit at Northside Hospital Cherokee one or more days per week. No more than one unit is on site on any given day.

Part F - CT, MRI, and PET units and procedures: Includes the units and procedures for all hospital-based imaging centers under the license of Northside Hospital Cherokee.

Part F, Item 1: Respiratory Therapy Treatments: Beginning with the 2009 survey, Northside began using UB codes to determine the number of respiratory therapy treatments.

Part F, Item 1: PET Units: In December 2020, Northside implemented a CON for mobile PET/CT services provided at its Jasper Imaging location for one day per week. This leased unit is included in the PET/CT unit count.

Part F, Item 1: Ultrasound units and procedures: Per instructions from DCH staff, ultrasound procedures include only diagnostic ultrasounds and exclude prenatal ultrasounds.

Part F, Item 1: Robotic surgery procedures are determined by ICD-9 and ICD-10 codes.

Part F, Item 2: Medical Ventilators: The figure reported includes both adult and infant ventilators.

Part G, Item 1: Budgeted and vacant budgeted FTE figures are estimated.

Part G, Medical Staff Info.: Please note that the medical staffs of Northside Hospital, Northside

Hospital Forsyth, Northside Hospital Cherokee, Northside Hospital Gwinnett, and Northside Hospital Duluth have been merged and are thus identical. Northside Hospital does not maintain data regarding the race/ ethnicity of its medical staff. Northside does not have figures on medical staff enrolled in Medicaid or PEHB.

Part G, Item 5: Oral surgeons are included in the "Other Surgical Specialties" category.

Part G, Item 5: Other Staff Affiliates are employed by physicians on staff. None can function independently, and thus do not have "privileges" by Northside's definition. These staff have "clinical functions", not clinical privileges.

Surgical Services Addendum, Part A, Item 1: Consistent with our prior surveys, the operating rooms reported here are sterile rooms only.

Perinatal Addendum, Part A: As we have done on past surveys, we have reported the number of C-section rooms under "Number of Delivery Rooms".

Perinatal Addendum, Part C3: Northside does not assign CPT codes to inpatients. This average charge represents those patients classified under MS-DRG 775.

Minority Health Addendum, Item 3: Northside does not have information on the number of physicians, nurses, and other staff who speak the languages listed.

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