



## 2020 Service Specific I/C Care Survey

### Part A : General Information

#### 1. Identification

UID:DTRC109

**Facility Name:** Northside Gainesville Imaging

**County:** Hall

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 Services

**CON #:** 2006-100

#### 2. Report Period

Please report data for the hospital fiscal year ending in calendar 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 calendar 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 Services

Type of Care	Amount	Number of Patients
Uncompensated Indigent Care	410611	217
Uncompensated Charity Care	583698	628
<b>Total</b>	<b>994309</b>	<b>845</b>

AGR: 10840107

## 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:** Robert Putnam

**Date:** 7/23/2021

**Title:** CEO, Northside Hospital Forsyth