

**Service Specific I/C Care Survey - Adjusted Gross Revenue** **HOSP541 2017 Cherokee**  
 Northside Hospital Cherokee

**Part A: General Information**

**Georgia Department of Community Health**

1. Year: 2017

Facility UID:   
 Facility Name:  County:

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:   
 CON:

2. Please report data for the hospital fiscal year ending in calendar year 2017 only. Do not use a different report period.

Report Period:

Beginning:  Ending:

3. Was the service identified above operational for the full report period?

If "No," explain:

**Part B: Signature and Contact**

I have reviewed the responses to this survey and certify that the information is true and accurate. I understand that the information submitted in this survey is subject to compliance review by the Department.

Authorized Signature:  Title:  Date:

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

Contact's Name:  Contact's Title:

Telephone:  Fax:  E-mail:

**Part C: Service-Specific Data for Specified Service**

Data for service:

|                             | Amount       | Number of Patients |
|-----------------------------|--------------|--------------------|
| Uncompensated Indigent Care | 9,577,040    | 75                 |
| Uncompensated Charity Care  | \$ 248,001   | 40                 |
| Totals                      | \$1,825,041  | 105                |
| Adjusted Gross Revenue      | \$11,211,947 |                    |

Service-Specific-AGR