



2022 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 2022 only.

Do not use a different report period.

Please indicate your hospital fiscal year.

From: 10/1/2021 To:9/30/2022

Please indicate your cost report year.

From: 10/01/2021 To:09/30/2022

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	378,610,599
Total Inpatient Admissions accounting for Inpatient Revenue	5,497
Outpatient Gross Patient Revenue	646,193,977
Total Outpatient Visits accounting for Outpatient Revenue	83,307
Medicare Contractual Adjustments	295,611,882
Medicaid Contractual Adjustments	94,795,839
Other Contractual Adjustments:	262,563,461
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	77,348,962
Gross Indigent Care:	17,978,198
Gross Charity Care:	47,755,161
Uncompensated Indigent Care (net):	17,978,198
Uncompensated Charity Care (net):	47,755,161
Other Free Care:	35,876,960
Other Revenue/Gains:	5,485,185
Total Expenses:	169,685,269

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	33,369,423
Admin Discounts	2,507,537
Employee Discounts	0
	0
Total	35,876,960

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 2022? (Check box if yes.)

2. Effective Date

What was the effective date of the policy or policies in effect during 2022?

06/24/2022

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 2022? (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	6,520,087	28,812,938	35,333,025
Outpatient	11,458,111	18,942,223	30,400,334
Total	17,978,198	47,755,161	65,733,359

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	6,520,087	28,812,938	35,333,025
Outpatient	11,458,111	18,942,223	30,400,334
Total	17,978,198	47,755,161	65,733,359

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	1	2,518	2	1,180	15	38,094
BANKS	0	0	1	862	0	0	2	7,634
BARROW	5	66,866	36	68,419	13	462,184	66	270,617
BARTOW	0	0	1	1,090	0	0	4	4,798
BIBB	0	0	0	0	0	0	1	923
CARROLL	0	0	0	0	0	0	2	38,056
CHEROKEE	0	0	8	109,029	3	147,714	12	75,804
CLARKE	0	0	0	0	0	0	4	151,015
CLAYTON	1	181,027	11	49,216	3	187,982	15	109,754
COBB	1	45,749	12	111,849	10	1,017,107	31	99,472
COLUMBIA	0	0	1	6,382	0	0	0	0
COWETA	0	0	0	0	0	0	2	97,032
CRISP	0	0	0	0	1	320,141	0	0
DAWSON	1	10,315	1	282	1	2,086	3	31,569
DEKALB	16	639,328	203	1,329,976	62	3,645,605	280	1,676,546
DOUGHERTY	0	0	0	0	1	73,590	0	0
DOUGLAS	0	0	11	6,953	0	0	0	0
ELBERT	0	0	3	1,506	0	0	3	255
FAYETTE	0	0	0	0	0	0	2	2,784
FLORIDA	1	3,109	5	39,550	9	425,516	50	160,345
FLOYD	0	0	0	0	0	0	5	20,708
FORSYTH	1	275	14	126,809	5	67,016	25	29,965
FRANKLIN	0	0	0	0	0	0	1	150
FULTON	12	669,805	158	828,686	47	2,548,222	298	1,277,784
GLYNN	0	0	1	923	0	0	0	0
GORDON	0	0	1	2,403	0	0	0	0
GWINNETT	179	4,586,960	1,744	8,011,657	375	18,220,854	2,844	12,541,770
HABERSHAM	0	0	0	0	0	0	5	5,573
HALL	1	1,400	18	88,282	1	153,566	40	114,100
HART	0	0	0	0	0	0	4	2,525
HENRY	1	2,471	9	104,677	3	287,805	14	90,271
HOUSTON	0	0	2	270	0	0	0	0

JACKSON	1	296	18	93,829	2	86,847	29	44,380
JASPER	0	0	0	0	0	0	1	356
LAMAR	0	0	0	0	0	0	1	1,039
LIBERTY	0	0	1	112	0	0	1	82
LUMPKIN	0	0	1	6,644	0	0	1	64,659
MADISON	0	0	2	2,122	0	0	1	6,202
MARION	0	0	1	2,349	0	0	0	0
MUSCOGEE	0	0	0	0	2	187,970	4	15,953
NEWTON	0	0	5	4,229	0	0	14	38,850
NORTH CAROLINA	0	0	3	11,037	2	52,344	13	59,232
OCONEE	1	2,499	0	0	0	0	4	2,551
OGLETHORPE	0	0	1	2,513	0	0	0	0
OTHER OUT OF STAT	1	1,484	12	7,037	15	502,055	203	1,348,905
PAULDING	0	0	3	2,421	0	0	2	23,626
PICKENS	0	0	0	0	0	0	1	76,924
RICHMOND	0	0	5	3,342	0	0	2	2,884
ROCKDALE	0	0	11	21,939	1	1,250	20	50,418
SOUTH CAROLINA	1	229,862	2	38,810	4	121,865	7	39,400
SPALDING	0	0	1	300	1	37,698	12	11,896
TENNESSEE	0	0	1	19,152	2	99,029	15	68,204
TOWNS	1	1,192	1	275	0	0	0	0
TROUP	0	0	0	0	0	0	1	660
WALTON	3	77,449	69	277,542	7	163,312	96	235,675
WHITE	0	0	3	73,119	0	0	1	2,783
Total	227	6,520,087	2,381	11,458,111	572	28,812,938	4,157	18,942,223

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 2022?
(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 2022.

Patient Category		SFY 2021	SFY2022	SFY2023
		7/1/20-6/30/21	7/1/21-6/30/22	7/1/22-6/30/23
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 2021	SFY2022	SFY2023
7/1/20-6/30/21	7/1/21-6/30/22	7/1/22-6/30/23
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: 7/19/2023

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: 7/19/2023

Title: VP FINANCE / CFO

Comments: