

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2018	06/30/2019

2. Select Your Facility from the Drop-Down Menu Provided:

NORTHSIDE HOSPITAL GWINNETT

Identification of cost reports needed to cover the DSH Year:

- 3. Cost Report Year 1
- 4. Cost Report Year 2 (if applicable)
- 5. Cost Report Year 3 (if applicable)

Cost Report Begin Date(s)	Cost Report End Date(s)
07/01/2018	06/30/2019
07/01/2019	08/27/2019
08/28/2019	09/30/2019

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
 Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
 Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

- 6. Medicaid Provider Number:
- 7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):
- 8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):
- 9. Medicare Provider Number:

Data
000000294A
0
0
110087

B. DSH OB Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the DSH Examination Year:

- 1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)
- 2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
- 3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?
- 3a. Was the hospital open as of December 22, 1987?
- 3b. What date did the hospital open?

DSH Examination
 Year (07/01/18 -
 06/30/19)
 Yes

No

No

Yes

2/1/1966

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019 \$ 5,574,177
(Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2018 - 06/30/2019 \$ -
*(Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.*

3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2018 - 06/30/2019 \$ 5,574,177

Certification:

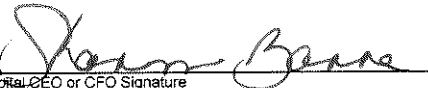
1. Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year?
Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.

Answer
Yes

Explanation for "No" answers:

The following certification is to be completed by the hospital's CEO or CFO:

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. All Medicaid eligible patients, including those who have private insurance coverage, have been reported on the DSH survey regardless of whether the hospital received payment on the claim. I understand that this information will be used to determine the Medicaid program's compliance with federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

 Hospital CEO or CFO Signature	Vice President, Finance/CFO Title	10/26/2020 Date
Shannon Banna Hospital CEO or CFO Printed Name	404-303-3621 Hospital CEO or CFO Telephone Number	Shannon.Banna@northside.com Hospital CEO or CFO E-Mail

Contact Information for individuals authorized to respond to inquiries related to this survey:

Hospital Contact:	
Name	Susan Samson
Title	Manager, Medicare Cost Reporting & Gov Reimb
Telephone Number	404-300-2275
E-Mail Address	Susan.Samson@Northside.com
Mailing Street Address	1000 Johnson Ferry Road CP Suite 520
Mailing City, State, Zip	Atlanta, GA 30342

Outside Preparer:	
Name	NA
Title	
Firm Name	
Telephone Number	
E-Mail Address	

EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		

DSH Version 8.00 3/31/2020

D. General Cost Report Year Information 7/1/2018 - 6/30/2019

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided: **NORTHSIDE HOSPITAL GWINNETT**

7/1/2018 through 6/30/2019	7/1/2019 through 8/27/2019	8/28/2019 through 9/30/2019
X		

2. Select Cost Report Year Covered by this Survey:

3. Status of Cost Report Used for this Survey (Should be audited if available): **1 - As Submitted**

3a. Date CMS processed the HCRIS file into the HCRIS database: **5/13/2020**

Data	Correct?	If Incorrect, Proper Information
NORTHSIDE HOSPITAL GWINNETT	Yes	
000000294A	Yes	
0	Yes	
0	Yes	
110087	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal): Non-State Govt.	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban): Urban	Yes	

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year:

State Name	Provider No.
Alabama	1952340994
Arizona	633223
Colorado	95014940
Florida	903467600
Idaho	1952340994-001

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2018 - 06/30/2019)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	\$ -															
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$ -															
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$ -															
4. Total Section 1011 Payments Related to Hospital Services (See Note 1)	\$ -															
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	\$ -															
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$ -															
7. Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)	\$ -															
8. Out-of-State DSH Payments (See Note 2)	\$ -															
	<table border="1"> <thead> <tr> <th style="background-color: #ccccff;">Inpatient</th> <th style="background-color: #ccccff;">Outpatient</th> <th style="background-color: #ccccff;">Total</th> </tr> </thead> <tbody> <tr> <td style="text-align: right;">\$ 1,342,129</td> <td style="text-align: right;">\$ 4,246,018</td> <td style="text-align: right;">\$5,588,147</td> </tr> <tr> <td style="text-align: right;">\$ 7,076,753</td> <td style="text-align: right;">\$ 26,623,297</td> <td style="text-align: right;">\$33,700,050</td> </tr> <tr> <td style="text-align: right;">\$8,418,882</td> <td style="text-align: right;">\$30,869,315</td> <td style="text-align: right;">\$39,288,197</td> </tr> <tr> <td style="text-align: right;">15.94%</td> <td style="text-align: right;">13.75%</td> <td style="text-align: right;">14.22%</td> </tr> </tbody> </table>	Inpatient	Outpatient	Total	\$ 1,342,129	\$ 4,246,018	\$5,588,147	\$ 7,076,753	\$ 26,623,297	\$33,700,050	\$8,418,882	\$30,869,315	\$39,288,197	15.94%	13.75%	14.22%
Inpatient	Outpatient	Total														
\$ 1,342,129	\$ 4,246,018	\$5,588,147														
\$ 7,076,753	\$ 26,623,297	\$33,700,050														
\$8,418,882	\$30,869,315	\$39,288,197														
15.94%	13.75%	14.22%														
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)																
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)																
11. Total Cash Basis Patient Payments Reported on Exhibit B(Agrees to Column (N) on Exhibit B)																
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:																

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	\$ -
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	\$ -

16. Total Medicaid managed care non-claims payments (see question 13 above) received

\$-

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2018 - 06/30/2019)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6) 149,457

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2. Inpatient Hospital Subsidies	-
3. Outpatient Hospital Subsidies	-
4. Unspecified I/P and O/P Hospital Subsidies	417,379
5. Non-Hospital Subsidies	-
6. Total Hospital Subsidies	\$ 417,379
7. Inpatient Hospital Charity Care Charges	64,542,349
8. Outpatient Hospital Charity Care Charges	85,950,074
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 150,492,423

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

	Total Patient Revenues (Charges)			Contractual Adjustments			
11. Hospital	\$ 385,455,068	\$ -	\$ -	\$ 291,357,805	\$ -	\$ -	\$ 94,097,263
12. Psych Subprovider	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
13. Rehab. Subprovider	\$ 18,864,918	\$ -	\$ -	\$ 14,259,616	\$ -	\$ -	\$ 4,605,302
14. Swing Bed - SNF	-	-	-	-	-	-	-
15. Swing Bed - NF	-	-	-	-	-	-	-
16. Skilled Nursing Facility	-	-	\$ 9,513,413	-	\$ 7,190,999	-	-
17. Nursing Facility	-	-	-	-	-	-	-
18. Other Long-Term Care	-	-	-	-	-	-	-
19. Ancillary Services	\$ 813,246,579	\$ 1,380,644,803	\$ -	\$ 614,716,883	\$ 1,043,601,894	\$ -	\$ 535,572,605
20. Outpatient Services	-	\$ 308,645,560	\$ -	-	\$ 233,299,028	\$ -	\$ 75,346,532
21. Home Health Agency	-	-	-	-	-	-	-
22. Ambulance	-	-	-	-	-	-	-
23. Outpatient Rehab Providers	-	-	-	-	-	-	-
24. ASC	-	-	-	-	-	-	-
25. Hospice	-	-	-	-	-	-	-
28. Total Hospital and Non Hospital	Total from Above	\$ 2,916,370,341	Total from Above	\$ 2,204,426,225	Total from Above	\$ 2,204,426,225	
29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	\$ 2,916,370,341	Total Contractual Adj. (G-3 Line 2)	\$ 2,204,426,225	Total Contractual Adj. (G-3 Line 2)	\$ 2,204,426,225	
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	\$ -	\$ -	
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	\$ -	\$ -	
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	\$ -	\$ -	
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)				-	\$ -	\$ -	
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"				-	\$ -	\$ -	
35. Adjusted Contractual Adjustments					2,204,426,225	2,204,426,225	
36. Unreconciled Difference	Unreconciled Difference (Should be \$0)	\$ -	Unreconciled Difference (Should be \$0)	\$ -	\$ -	\$ -	

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2018-06/30/2019) NORTHSIDE HOSPITAL GWINNETT

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*	Cost Report Worksheet C, Part I, Col.2 and Col. 4	Swing-Bed Curve Out - Cost Report Worksheet D-1, Part I, Line 26	Calculated	Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)	Calculated Per Diem

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 155,890,644	\$ 4,326,466	\$ -	\$ -	\$ 160,217,110	133,710	\$ 291,910,002.00	\$ 1,198.24
2	03100	INTENSIVE CARE UNIT	\$ 19,460,318	\$ 701,620	\$ -	\$ -	\$ 20,161,938	10,636	\$ 58,613,358	\$ 1,895.63
3	03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ 14,729,366	\$ -	\$ -	\$ -	\$ 14,729,366	10,851	\$ 32,568,937	\$ 1,357.42
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
10	04300	NURSERY	\$ 10,768,301	\$ -	\$ -	\$ -	\$ 10,768,301	7,988	\$ 7,628,000	\$ 1,348.06
18	Total Routine		\$ 200,848,629	\$ 5,028,086	\$ -	\$ -	\$ 205,876,715	163,185	\$ 390,720,297	
19	Weighted Average									\$ 1,261.61

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
09200 Observation (Non-Distinct)	13,728	-	-	\$ 16,449,439	\$ 4,062,435	\$ 19,999,474	\$ 24,061,909	0.683630

Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*	Cost Report Worksheet C, Part I, Col.2 and Col. 4	Net Cost	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
			Calculated				

Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5000	OPERATING ROOM	\$ 51,870,724	\$ 592,491	\$ -	\$ -	\$ 52,463,215	\$ 144,791,505	\$ 111,148,840	\$ 255,940,345	0.204982
22	5200	DELIVERY ROOM & LABOR ROOM	\$ 14,949,430	\$ 592,491	\$ -	\$ -	\$ 15,541,921	\$ 37,100,019	\$ 1,502,500	\$ 38,602,519	0.402614
23	5300	ANESTHESIOLOGY	\$ 3,037,352	\$ -	\$ -	\$ -	\$ 3,037,352	\$ 45,773,308	\$ 64,926,075	\$ 110,699,383	0.027438
24	5400	RADIOLOGY-DIAGNOSTIC	\$ 41,746,429	\$ -	\$ -	\$ -	\$ 41,746,429	\$ 156,844,959	\$ 467,287,042	\$ 624,132,001	0.066887
25	5600	RADIOISOTOPE	\$ 7,792,706	\$ -	\$ -	\$ -	\$ 7,792,706	\$ 20,316,255	\$ 40,324,035	\$ 60,640,290	0.128507
26	5900	CARDIAC CATHETERIZATION	\$ 7,817,114	\$ -	\$ -	\$ -	\$ 7,817,114	\$ 42,022,793	\$ 55,200,678	\$ 97,223,471	0.080404
27	6000	LABORATORY	\$ 32,277,718	\$ -	\$ -	\$ -	\$ 32,277,718	\$ 88,409,614	\$ 99,992,449	\$ 188,402,063	0.171324
28	6500	RESPIRATORY THERAPY	\$ 12,874,292	\$ -	\$ -	\$ -	\$ 12,874,292	\$ 34,988,395	\$ 6,754,184	\$ 41,742,579	0.308421
29	6600	PHYSICAL THERAPY	\$ 17,443,618	\$ -	\$ -	\$ -	\$ 17,443,618	\$ 21,708,500	\$ 11,970,662	\$ 33,679,162	0.517935
30	6601	PHYSICAL THERAPY - GECC	\$ 2,088,315	\$ -	\$ -	\$ -	\$ 2,088,315	\$ 10,786,146	\$ -	\$ 10,786,146	0.193611
31	6900	ELECTROCARDIOLOGY	\$ 8,340,227	\$ -	\$ -	\$ -	\$ 8,340,227	\$ 13,062,692	\$ 28,003,598	\$ 41,066,290	0.203092
32	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 18,292,171	\$ -	\$ -	\$ -	\$ 18,292,171	\$ 15,251,338	\$ 17,900,721	\$ 33,152,059	0.551766
33	7200	IMPL. DEV. CHARGED TO PATIENTS	\$ 55,664,735	\$ -	\$ -	\$ -	\$ 55,664,735	\$ 41,905,906	\$ 31,062,304	\$ 72,968,210	0.762863
34	7300	DRUGS CHARGED TO PATIENTS	\$ 83,277,030	\$ -	\$ -	\$ -	\$ 83,277,030	\$ 107,474,424	\$ 266,461,962	\$ 373,936,386	0.222704
35	7500	ASC (NON-DISTINCT PART)	\$ 35,290,227	\$ -	\$ -	\$ -	\$ 35,290,227	\$ 31,699,485	\$ 176,630,475	\$ 208,329,960	0.169396
36	9000	CLINIC	\$ 2,091,561	\$ -	\$ -	\$ -	\$ 2,091,561	\$ 17,241	\$ 1,042,683	\$ 1,059,924	1.973312

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2018-06/30/2019) NORTHSIDE HOSPITAL GWINNETT

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
37	9001 WOUND TREATMENT CLINIC	\$ 1,521,838	\$ -	\$ -	\$ 1,521,838	\$ 13,386	\$ 1,426,526	\$ 1,439,912	1.056897
38	9002 CENTER FOR CANCER CARE CLINICS	\$ 15,433,861	\$ -	\$ -	\$ 15,433,861	\$ 377,644	\$ 19,758,291	\$ 20,135,935	0.766483
39	9003 STRICKLAND FMC	\$ 1,230,538	\$ 3,016,926	\$ -	\$ 4,247,464	\$ 1,787	\$ 1,853,330	\$ 1,855,117	2.289594
40	9004 ACADEMIC INTERNAL MED	\$ 2,813,640	\$ 1,987,922	\$ -	\$ 4,801,562	\$ 29,395	\$ 1,472,884	\$ 1,502,279	3.196185
41	9005 DIAB & NUTR EDUCATION CENTER	\$ 2,252,778	\$ -	\$ -	\$ 2,252,778	\$ 188,220	\$ 464,128	\$ 652,348	3.453338
42	9006 SUWANEE CLINIC	\$ 387,042	\$ -	\$ -	\$ 387,042	\$ -	\$ 20,923	\$ 20,923	18.498399
43	9007 DULUTH CLINIC	\$ 918,585	\$ -	\$ -	\$ 918,585	\$ 1,029	\$ 620,353	\$ 621,382	1.478294
44	9008 PEACHTREE CORNERS CLINIC	\$ 19,668	\$ -	\$ -	\$ 19,668	\$ -	\$ 1	\$ 1	19,668.000000
45	9100 EMERGENCY	\$ 53,464,798	\$ 943,301	\$ -	\$ 54,408,099	\$ 68,183,469	\$ 182,799,765	\$ 250,983,234	0.216780
126	Total Ancillary	\$ 472,896,397	\$ 7,133,131	\$ -	\$ 480,029,528	\$ 885,009,945	\$ 1,608,623,883	\$ 2,493,633,828	
127	Weighted Average								0.199099
128	Sub Totals	\$ 673,745,026	\$ 12,161,217	\$ -	\$ 685,906,243	\$ 1,275,730,242	\$ 1,608,623,883	\$ 2,884,354,125	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)				\$ -				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)				\$ 496,526				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)				\$ -				
131.01	Other Cost Adjustments (support must be submitted)				\$ -				
132	Grand Total				\$ 685,409,717				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost								1.81%

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (07/01/2018-06/30/2019) NORTHSIDE HOSPITAL GWINNETT

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost <i>From Section G</i>	Medicaid Cost to Charge Ratio for Ancillary Cost <i>From Section G</i>	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient		
				<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From PS&R Summary (Note A)</i>	<i>From Hospital's Own Internal Analysis</i>	<i>From Hospital's Own Internal Analysis</i>				
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days			
03000	ADULTS & PEDIATRICS	\$ 1,198.24		8,995		5,575		4,977		5,436		7,461		24,983		27.30%	
03100	INTENSIVE CARE UNIT	\$ 1,895.63		2,164		71		903		123		240		3,261		32.94%	
03200	CORONARY CARE UNIT	\$ -		-		-		-		-		-		-			
03300	BURN INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-			
03400	SURGICAL INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-			
03500	OTHER SPECIAL CARE UNIT	\$ 1,357.42		2,154		1,851		-		-		36		4,005		37.24%	
04000	SUBPROVIDER I	\$ -		-		-		-		-		-		-			
04100	SUBPROVIDER II	\$ -		-		-		-		-		-		-			
04200	OTHER SUBPROVIDER	\$ -		-		-		-		-		-		-			
04300	NURSERY	\$ 1,348.06		1,585		5,173		-		-		298		6,758		88.55%	
Total Days				14,898	12,670	5,880	5,559	8,035	39,007							31.70%	
Total Days per PS&R or Exhibit Detail				14,898	12,670	5,880	5,559	8,035	39,007								
Unreconciled Days (Explain Variance)				-	-	-	-	-	-								
Routine Charges				\$ 30,270,226	\$ 27,211,673	\$ 15,150,947	\$ 14,316,243	\$ 19,852,148	\$ 86,949,083								27.57%
Calculated Routine Charge Per Dien				2,031.83	2,147.72	2,576.69	2,576.33	2,463.15	2,229.06								
Ancillary Cost Centers (from W/S G) (from Section G):				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
09200	Observation (Non-Distinct)	0.683630	\$ 785,438	\$ 427,902	\$ 154,201	\$ 514,098	\$ 3,056,714	\$ 109,646	\$ 518,535	\$ 461,482	\$ 1,797,849	\$ 1,049,285	\$ 4,517,249		32.76%		
23	5000 OPERATING ROOM	0.204982	\$ 9,849,814	\$ 674,036	\$ 5,951,178	\$ 9,061,858	\$ 7,231,411	\$ 5,926,486	\$ 5,213,363	\$ 3,220,263	\$ 11,706,371	\$ 8,971,084	\$ 28,245,766	\$ 18,882,643	26.65%		
24	5200 DELIVERY ROOM & LABOR ROOM	0.402614	\$ 4,252,778	\$ 251,402	\$ 5,913,342	\$ 2,324,557	\$ 857,314	\$ 1,021,164	\$ 625,648	\$ 573,247	\$ 1,796,508	\$ 1,895,208	\$ 11,649,062	\$ 4,170,370	50.77%		
25	5300 ANESTHESIOLOGY	0.027438	\$ 3,167,782	\$ 682,243	\$ 3,049,627	\$ 2,272,247	\$ 1,682,878	\$ 1,651,953	\$ 1,303,699	\$ 904,499	\$ 3,014,803	\$ 2,227,682	\$ 9,203,986	\$ 5,510,942	18.13%		
26	5400 RADIOLOGY-DIAGNOSTIC	0.066887	\$ 9,758,399	\$ 7,604,572	\$ 3,541,059	\$ 14,462,570	\$ 7,409,190	\$ 13,310,931	\$ 6,794,223	\$ 9,373,074	\$ 13,537,638	\$ 35,740,154	\$ 27,502,871	\$ 44,751,147	19.67%		
27	5600 RADIOISOTOPE	0.123507	\$ 1,790,511	\$ 685,055	\$ 129,898	\$ 320,018	\$ 3,493,140	\$ 13,707,595	\$ 750,003	\$ 774,323	\$ 1,423,116	\$ 1,169,552	\$ 15,386,310	\$ 8,199,532	39.40%		
28	5800 CARDIAC CATHETERIZATION	0.080404	\$ 3,434,120	\$ 110,947	\$ 927,949	\$ 962,384	\$ 1,720,321	\$ 3,216,209	\$ 2,543,982	\$ 1,766,898	\$ 4,469,689	\$ 2,235,484	\$ 8,626,352	\$ 6,056,328	22.30%		
29	6000 LABORATORY	0.171324	\$ 8,747,591	\$ 2,905,382	\$ 4,090,611	\$ 4,734,440	\$ 4,168,692	\$ 3,737,887	\$ 3,676,931	\$ 1,465,793	\$ 6,073,073	\$ 9,649,307	\$ 20,683,825	\$ 12,843,502	26.41%		
30	6500 RESPIRATORY THERAPY	0.308421	\$ 3,144,689	\$ 172,094	\$ 1,657,286	\$ 366,930	\$ 1,567,069	\$ 186,798	\$ 1,658,150	\$ 109,777	\$ 1,465,012	\$ 307,586	\$ 8,027,194	\$ 835,599	25.73%		
31	6600 PHYSICAL THERAPY	0.517935	\$ 786,567	\$ 200,657	\$ 149,965	\$ 281,259	\$ 579,081	\$ 278,869	\$ 977,691	\$ 144,103	\$ 561,378	\$ 994,635	\$ 2,493,304	\$ 904,888	14.76%		
32	6601 PHYSICAL THERAPY - GECC	0.193611	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0.00%		
33	6900 ELECTROCARDIOLOGY	0.203092	\$ 1,056,317	\$ 753,396	\$ 190,314	\$ 711,069	\$ 1,758,889	\$ 2,032,801	\$ 670,895	\$ 450,891	\$ 800,050	\$ 2,456,550	\$ 3,676,415	\$ 3,948,157	26.76%		
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.551766	\$ 795,623	\$ 313,812	\$ 379,517	\$ 350,100	\$ 545,975	\$ 746,236	\$ 477,471	\$ 288,031	\$ 736,911	\$ 404,607	\$ 2,196,488	\$ 1,498,169	14.88%		
35	7200 IMPL. DEV. CHARGED TO PATIENTS	0.782863	\$ 1,207,598	\$ 118,848	\$ 324,188	\$ 567,745	\$ 2,183,916	\$ 1,308,659	\$ 1,457,190	\$ 438,473	\$ 1,752,368	\$ 637,607	\$ 5,172,872	\$ 2,431,725	13.91%		
36	7300 DRUGS CHARGED TO PATIENTS	0.222704	\$ 10,157,293	\$ 6,282,233	\$ 5,386,431	\$ 2,230,795	\$ 2,307,022	\$ 542,446	\$ 4,127,617	\$ 1,964,602	\$ 7,493,539	\$ 5,320,492	\$ 21,978,363	\$ 11,020,076	12.31%		
37	7500 ASC (NON-DISTINCT PART)	0.169396	\$ 429,951	\$ 1,631,849	\$ 41,029	\$ 133,071	\$ 243,579	\$ 522,368	\$ 188,749	\$ 176,365	\$ 354,531	\$ 160,960	\$ 903,308	\$ 2,463,653	1.87%		
38	9000 CLINIC	1.973312	\$ -	\$ 113,333	\$ -	\$ -	\$ 374	\$ 86,159	\$ -	\$ 176	\$ -	\$ 631	\$ 374	\$ 199,668	19.54%		
39	9001 WOUND TREATMENT CLINIC	1.056897	\$ -	\$ 82,903	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 82,903	\$ -	5.87%		
40	9002 CENTER FOR CANCER CARE CLINICS	0.766483	\$ 3,372	\$ 2,077,588	\$ 604,300	\$ 602,762	\$ -	\$ 974	\$ 101,728	\$ 31,835	\$ 588,928	\$ 608,646	\$ 2,782,078	\$ -	19.92%		
41	9003 STRICKLAND FMC	2.289594	\$ -	\$ 60,968	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 60,968	\$ -	3.29%		
42	9004 ACADEMIC INTERNAL MED	3.198185	\$ -	\$ 34,054	\$ 834	\$ 43,787	\$ -	\$ -	\$ 3,367	\$ 4,950	\$ 11,220	\$ 90,387	\$ 4,191	\$ 82,791	12.55%		
43	9005 DIAB & NUTR EDUCATION CENTER	3.453338	\$ 20,814	\$ -	\$ 12,592	\$ 68,509	\$ 6,506	\$ 2,833	\$ 6,913	\$ 29,610	\$ 35,021	\$ 46,825	\$ 75,768	\$ -	28.70%		
44	9006 SUWANEE CLINIC	18.498399	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0.00%		
45	9007 DULUTH CLINIC	1.478294	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0.00%		
46	9008 PEACHTREE CORNERS CLINIC	19,668,000,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0.00%		
47	9100 EMERGENCY	0.216780	\$ 5,114,802	\$ 5,864,982	\$ 1,376,213	\$ 18,501,723	\$ 2,617,636	\$ 4,202,587	\$ 2,677,158	\$ 2,634,988	\$ 6,604,006	\$ 33,367,101	\$ 11,785,809	\$ 31,204,280	33.55%		
Totals / Payments				64,503,459	30,848,257	33,880,514	58,509,922	38,372,893	55,538,776	33,269,640	24,812,259	61,674,245	108,304,389				
128	Total Charges (includes organ acquisition from Section J)		\$ 94,773,685	\$ 30,848,257	\$ 61,092,187	\$ 58,509,922	\$ 53,523,840	\$ 55,538,776	\$ 47,585,883	\$ 24,812,259	\$ 81,626,393	\$ 108,304,389	\$ 256,975,595	\$ 169,709,214	21.57%		
129	Total Charges per PS&R or Exhibit Detail		\$ 94,773,685	\$ 30,848,257	\$ 61,092,187	\$ 58,509,922	\$ 53,523,840	\$ 55,538,776	\$ 47,585,883	\$ 24,812,259	\$ 81,626,393	\$ 108,304,389					
130	Unreconciled Charges (Explain Variance)		-	-	-	-	-	-	-	-	-	-	-	-			
131.01	Sampling Cost Adjustment (if applicable)																
131.02	Total Calculated Cost (includes organ acquisition from Section J)		\$ 33,423,780	\$ 7,216,519	\$ 24,217,988	\$ 11,502,436	\$ 15,599,418	\$ 10,636,883	\$ 13,660,196	\$ 4,216,876	\$ 21,743,022	\$ 19,425,012	\$ 86,901,382	\$ 33,572,714	23.77%		
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		\$ 24,200,609	\$ 5,428,207	\$ -	\$ -	\$ 533,056	\$ 974,748	\$ 9,658,536	\$ 2,963,577	\$ -	\$ -	\$ 34,392,201	\$ 9,366,532			
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)		\$ -	\$ -	\$ 16,147,823	\$ 7,059,783	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 16,147,823	\$ 7,059,783			
134	Private Insurance (including primary and third party liability)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
135	Self-Pay (including Co-Pay and Spend-Down)		\$ 809,983	\$ 263,486	\$ 13,556	\$ 21,681	\$ 675	\$ 11,767	\$ 96,019	\$ 64,878	\$ -	\$ -	\$ 920,233	\$ 361,812			
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		\$ 25,010,592	\$ 5,691,693	\$ 16,161,379	\$ 7,081,464	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 35,312,434	\$ 9,728,344			
137	Medicaid Cost Settlement Payments (See Note B)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)		\$ -	\$ -	\$ -	\$ -	\$ 12,133,204	\$ 7,467,673	\$ -	\$ -	\$ -	\$ -	\$ 12,133,204	\$ 7,467,673			
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (07/01/2018-06/30/2019) NORTHSIDE HOSPITAL GWINNETT

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey
141 Medicare Cross-Over Bad Debt Payments					\$ -	\$ -	\$ -	\$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	\$ -	\$ -	
142 Other Medicare Cross-Over Payments (See Note D)					\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)					\$ -	\$ -	\$ -	\$ -	\$ 1,342,129	\$ 4,246,018	\$ -	\$ -	
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									\$ -	\$ -			
145 Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ 8,413,188	\$ 1,524,826	\$ 8,056,609	\$ 4,420,972	\$ 2,932,483	\$ 2,182,695	\$ 3,905,641	\$ 1,188,421	\$ 20,400,893	\$ 15,178,994	\$ 23,307,921	\$ 9,316,914	
146 Calculated Payments as a Percentage of Cost	75%	79%	67%	62%	61%	79%	71%	72%	6%	22%	73%	72%	
147 Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					67,040								
148 Percent of cross-over days to total Medicare days from the cost report					9%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with :
 Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or P:
 Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the si
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education pay
 Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation pay

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) NORTHSIDE HOSPITAL GWINNETT

Line #	Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)
Routine Cost Centers (list below):				Days		Days		Days		Days		Days	
03000	ADULTS & PEDIATRICS	\$ 1,198.24		310		-		-		-		310	
03100	INTENSIVE CARE UNIT	\$ 1,895.63		3		-		-		-		3	
03200	CORONARY CARE UNIT	\$ -		-		-		-		-		-	
03300	BURN INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
03400	SURGICAL INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
03500	OTHER SPECIAL CARE UNIT	\$ 1,357.42		-		-		-		-		-	
04000	SUBPROVIDER I	\$ -		-		-		-		-		-	
04100	SUBPROVIDER II	\$ -		-		-		-		-		-	
04200	OTHER SUBPROVIDER	\$ -		-		-		-		-		-	
04300	NURSERY	\$ 1,348.06		17		-		-		-		17	
Total Days				330		-		-		-		330	
Total Days per PS&R or Exhibit Detail				330		-		-		-		-	
Unreconciled Days (Explain Variance)				-		-		-		-		-	
Routine Charges				\$ 800,929		\$ -		\$ -		\$ -		\$ 800,929	
Calculated Routine Charge Per Diem				\$ 2,427.06		\$ -		\$ -		\$ -		\$ 2,427.06	
Ancillary Cost Centers (from W/S C) (list below):				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
09200	Observation (Non-Distinct)		0.683630	13,213	42,778	-	-	-	-	-	-	13,213	42,778
5000	OPERATING ROOM		0.204982	323,136	78,132	-	-	-	-	-	-	323,136	78,132
5200	DELIVERY ROOM & LABOR ROOM		0.402614	62,836	24,340	-	-	-	-	-	-	62,836	24,340
5300	ANESTHESIOLOGY		0.027438	90,320	25,179	-	-	-	-	-	-	90,320	25,179
5400	RADIOLOGY-DIAGNOSTIC		0.066887	401,409	834,140	-	-	-	-	-	-	401,409	834,140
5600	RADIOISOTOPE		0.128507	101,547	34,936	-	-	-	-	-	-	101,547	34,936
5900	CARDIAC CATHETERIZATION		0.080404	179,250	109,842	-	-	-	-	-	-	179,250	109,842
6000	LABORATORY		0.171324	254,545	256,782	-	-	-	-	-	-	254,545	256,782
6500	RESPIRATORY THERAPY		0.308421	78,272	26,298	-	-	-	-	-	-	78,272	26,298
6600	PHYSICAL THERAPY		0.517935	15,169	1,523	-	-	-	-	-	-	15,169	1,523
6601	PHYSICAL THERAPY - GECC		0.193611	-	-	-	-	-	-	-	-	-	-
6900	ELECTROCARDIOLOGY		0.203092	46,314	63,774	-	-	-	-	-	-	46,314	63,774
7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.551766	15,154	11,867	-	-	-	-	-	-	15,154	11,867
7200	IMPL. DEV. CHARGED TO PATIENTS		0.762863	75,439	9,156	-	-	-	-	-	-	75,439	9,156
7300	DRUGS CHARGED TO PATIENTS		0.222704	334,561	97,833	-	-	-	-	-	-	334,561	97,833
7500	ASC (NON-DISTINCT PART)		0.169396	16,022	-	-	-	-	-	-	-	16,022	-
9000	CLINIC		1.973312	2,243	4,193	-	-	-	-	-	-	2,243	4,193
9001	WOUND TREATMENT CLINIC		1.056897	923	726	-	-	-	-	-	-	923	726
9002	CENTER FOR CANCER CARE CLINICS		0.766483	-	-	-	-	-	-	-	-	-	-
9003	STRICKLAND FMC		2.289594	-	-	-	-	-	-	-	-	-	-
9004	ACADEMIC INTERNAL MED		3.196185	-	-	-	-	-	-	-	-	-	-
9005	DIAB & NUTR EDUCATION CENTER		3.453338	-	-	-	-	-	-	-	-	-	-
9006	SUWANEE CLINIC		18.498399	-	-	-	-	-	-	-	-	-	-
9007	DULUTH CLINIC		1.478294	-	-	-	-	-	-	-	-	-	-
9008	PEACHTREE CORNERS CLINIC		19,668.000000	-	-	-	-	-	-	-	-	-	-
9100	EMERGENCY		0.216780	199,951	1,047,871	-	-	-	-	-	-	199,951	1,047,871
				2,210,304	2,669,370	-	-	-	-	-	-	-	-
Totals / Payments				\$ 3,011,233	\$ 2,669,370	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,011,233	\$ 2,669,370
Total Charges per PS&R or Exhibit Detail				\$ 3,011,233	\$ 2,669,370	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Unreconciled Charges (Explain Variance)				-	-	-	-	-	-	-	-	-	-
Sampling Cost Adjustment (if applicable)				-	-	-	-	-	-	-	-	-	-
Total Calculated Cost (includes organ acquisition from Section K)				\$ 834,309	\$ 462,229	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 834,309	\$ 462,229
Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				\$ 409,626	\$ 158,253	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 409,626	\$ 158,253
Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Private Insurance (including primary and third party liability)				\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Self-Pay (including Co-Pay and Spend-Down)				\$ 20	\$ 2,016	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 20	\$ 2,016

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) **NORTHSIDE HOSPITAL GWINNETT**

	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 409,646	\$ 160,269	\$ -	\$ -					\$ -	\$ -
137 Medicaid Cost Settlement Payments (See Note B)	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
141 Medicare Cross-Over Bad Debt Payments					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
142 Other Medicare Cross-Over Payments (See Note D)					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
143 Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ 424,663	\$ 301,960	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 424,663	\$ 301,960
144 Calculated Payments as a Percentage of Cost	49%	35%	0%	0%	0%	0%	0%	0%	49%	35%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
 Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
 Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
 Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year (07/01/2018-06/30/2019) NORTHSIDE HOSPITAL GWINNETT

	Total Organ Acquisition Cost			Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		
	Organ Acquisition Cost	Additional Add-Intern/Resident Cost	Total Adjusted Organ Acquisition Cost			Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges
	<i>Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61</i>	<i>Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost</i>	<i>Sum of Cost Report Organ Acquisition Cost and the Add-On Cost</i>	<i>Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.</i>	<i>Cost Report Worksheet D-4, Pt. III, Line 62</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Hospital's Own Internal Analysis</i>	<i>From Hospital's Own Internal Analysis</i>	
Organ Acquisition Cost Centers (list below)																
1	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
2	Kidney Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
3	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
4	Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
5	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
6	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
7	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
8		\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
9	Totals	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-
10	Total Cost															

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey)

Note B: Enter Organ Acquisition Payments in Section D as part of your In-State Medicaid total payments

Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (07/01/2018-06/30/2019) NORTHSIDE HOSPITAL GWINNETT

	Total Organ Acquisition Cost			Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		
	Organ Acquisition Cost	Additional Add-Intern/Resident Cost	Total Adjusted Organ Acquisition Cost			Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	
	<i>Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61</i>	<i>Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost</i>	<i>Sum of Cost Report Organ Acquisition Cost and the Add-On Cost</i>	<i>Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.</i>	<i>Cost Report Worksheet D-4, Pt. III, Line 62</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	
Organ Acquisition Cost Centers (list below)														
11	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
12	Kidney Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
13	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
14	Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
15	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
16	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
17	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
18		\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
19	Totals	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-
20	Total Cost													

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey)

Note B: Enter Organ Acquisition Payments in Section E as part of your Out-of-State Medicaid total payments

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (07/01/2018-06/30/2019) NORTHSIDE HOSPITAL GWINNETT

Worksheet A Provider Tax Assessment Reconciliation:

		Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 7,338,700		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	01-04-9400-000975	(WTB Account #)
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 7,338,700	5.00	(Where is the cost included on w/s A?)
3	Difference (Explain Here ----->)	\$ -		
Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	Reclassification Code	\$ -	-	(Reclassified to / (from))
5	Reclassification Code	\$ -	-	(Reclassified to / (from))
6	Reclassification Code	\$ -	-	(Reclassified to / (from))
7	Reclassification Code	\$ -	-	(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	Reason for adjustment	\$ (5,523,333)	5.02	(Adjusted to / (from))
9	Reason for adjustment	\$ -	5.02	(Adjusted to / (from))
10	Reason for adjustment	\$ -	-	(Adjusted to / (from))
11	Reason for adjustment	\$ -	-	(Adjusted to / (from))
DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	Reason for adjustment	\$ -	-	
13	Reason for adjustment	\$ -	-	
14	Reason for adjustment	\$ -	-	
15	Reason for adjustment	\$ -	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ 1,815,367		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	\$ 5,523,333
Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital Charges Sec. G	432,365,413
19	Uninsured Hospital Charges Sec. G	189,930,782
20	Total Hospital Charges Sec. G	2,365,471,371
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	18.28%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	8.03%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ 1,009,565
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 443,485
25	Provider Tax Assessment Adjustment to DSH UCC	\$ 1,453,050

* Assessment must exclude any non-hospital assessment such as Nursing Facility.

** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and Uninsured based on Charges Sec. G unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.

DSH Examination Eligibility Summary

Hospital Name	NORTHSIDE HOSPITAL GWINNETT			
Hospital Medicaid Number	00000294A			
Cost Report Period	From	7/1/2018	To	6/30/2019

		As-Reported	Adjustments	As-Adjusted
LIUR				
1 Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	\$ 68,644,960	\$ -	\$ 68,644,960
2 Hospital Cash Subsidies	Survey F-2	\$ 417,379	\$ -	\$ 417,379
3 Total		\$ 69,062,339	\$ -	\$ 69,062,339
4 Net Hospital Patient Revenue	Survey F-3	\$ 709,621,702	\$ -	\$ 709,621,702
5 Medicaid Fraction		9.73%	0.00%	9.73%
6 Inpatient Charity Care Charges	Survey F-2	\$ 64,542,349	\$ -	\$ 64,542,349
7 Inpatient Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
8 Unspecified Hospital Cash Subsidies	Survey F-2	\$ 417,379	\$ -	\$ 417,379
9 Adjusted Inpatient Charity Care		\$ 64,367,526	\$ -	\$ 64,367,526
10 Inpatient Hospital Charges	Survey F-3	\$ 1,217,566,565	\$ -	\$ 1,217,566,565
11 Inpatient Charity Fraction		5.29%	0.00%	5.29%
12 LIUR		15.02%	0.00%	15.02%
MIUR				
13 In-State Medicaid Eligible Days	Survey H	38,269	738	39,007
14 Out-of-State Medicaid Eligible Days	Survey I	330	-	330
15 Total Medicaid Eligible Days		38,599	738	39,337
16 Total Hospital Days (excludes swing-bed)	Survey F-1	149,457	-	149,457
17 MIUR		25.83%	0.49%	26.32%

NOTE: LIUR calculated above does not include other Medicaid or supplemental payments reported on DSH Survey Part I and may not reconcile to DSH results letter as a result.