GA DSH Payment Results for SFY 2024 - Pool 2 4/8/2024 7:56
DSH Uncompensated Care Cost & Allocation Factor Summary
Preliminary Results

Provider Name	NORTHSIDE HOSPITAL
Mcaid Provider Number	000001405A
Mcare Provider Number	110161

Below is the preliminary uncompensated care cost (UCC) and allocation factor used as a basis for the 2023 Georgia Disproportionate Share Hospital (DSH) Payment. An initial review of the provider submitted survey and detailed information was performed and adjustments made, as appropriate. Please review the proposed adjustments and adjusted survey included with the preliminary results and respond with concerns within 5 business days. Hospital specific preliminary results are subject to change based on revisions needed after initial results are reviewed and possible additional validation work.

NOTE: These are initial results only.

GA Medicaid DSH Payment Uncompensated Care Cost (UCC) For State Fiscal Year: 7/1/2023 - 6/30/2024

	(A)		(B)	(C)	(D)	(E)
	Cost Report Year Begin		Cost Report Year End	As-Filed DSH Uncompensated Care Cost (UCC)	Total Adjustments	Adjusted DSH Uncompensated Care Cost (UCC)
Cost Report Year UCC:	10/1/2021	-	9/30/2022	$ 210,203,657	$ -	$ 210,203,657

Less: 2022 Net UPL Payments	$ 9,501,463
Less: 2024 Net DPP Payments	$ 13,096,566
Plus: 2023 Net DPP Recoupments	$ -
Less: GME Payments	$ -
Add: Net OP Settlement (Difference between provider submitted and estimated)	$ 2,714,812
Add: Provider tax excluded from the cost report (Medicaid primary & uninsured portion)	$ 1,570,592
Uncompensated Care Allocation Factor	$ 191,891,032
Hospital Specific DSH Limit	$ 180,192,462
2024 Eligibility	Eligible
DSH Year Low Income Utilization Ratio (LIUR):	16.45%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):	35.90%

If you disagree with the findings presented above please respond within five days of receipt with additional supporting documentation.

All inquiries and additional documentation should be sent to the following:

e-mail:	gadsh@mslc.com
Fax:	816-945-5301
Web Portal Address:	https://DSH.MSLC.com
Phone Inquiries:	800-374-6858

EXAMINER ADJUSTED SURVEY

Workpaper #:	1302	Reviewer:
Examiner:	SAE	
Date:	1/12/2024	
DSH Version	8.11	2/10/2023

D. General Cost Report Year Information 10/1/2021 - 9/30/2022

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**

	10/1/2021 through 9/30/2022		
2. Select Cost Report Year Covered by this Survey:	X		
3. Status of Cost Report Used for this Survey (Should be audited if available)	5 - Amended		
3a. Date CMS processed the HCRIS file into the HCRIS database:	4/18/2023		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	NORTHSIDE HOSPITAL	Yes	
5. Medicaid Provider Number:	000001405A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110161	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	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.
9. State Name & Number	Alabama	247571
10. State Name & Number	Florida	107736700
11. State Name & Number	North Carolina	1457396079
12. State Name & Number	Tennessee	Q061341.
13. State Name & Number	South Carolina	232810
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2021 - 09/30/2022)

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)**	$ -

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 1,082,730	$ 6,436,337	$7,519,067
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 14,408,300	$ 63,108,936	$77,517,236
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$15,491,030	$69,545,273	$85,036,303
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	6.99%	9.25%	8.84%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No

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 (10/01/2021 - 09/30/2022)

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)	219,253

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	-
5. Non-Hospital Subsidies	-
6. Total Hospital Subsidies	$ -
7. Inpatient Hospital Charity Care Charges	205,448,477
8. Outpatient Hospital Charity Care Charges	351,007,283
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	$ 556,455,760

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			
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11. Hospital	$ 677,535,769	$ -	$ -	$ 502,659,039	$ -	$ -	$ 174,876,730
12. Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14. Swing Bed - SNF			$ -			$ -	
15. Swing Bed - NF			$ -			$ -	
16. Skilled Nursing Facility			$ -			$ -	
17. Nursing Facility			$ -			$ -	
18. Other Long-Term Care			$ -			$ -	
19. Ancillary Services	$ 1,143,397,382	$ 2,210,392,645	$ -	$ 848,278,505	$ 1,639,874,812	$ -	$ 865,636,710
20. Outpatient Services		$ 5,074,634,169	$ -		$ 3,764,835,526	$ -	$ 1,309,798,643
21. Home Health Agency			$ -			$ -	
22. Ambulance			$ -			$ -	
23. Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24. ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25. Hospice			$ -			$ -	
26. Other	$ 25,442,456	$ 859,089,794	$ -	$ 18,875,580	$ 637,352,698	$ -	$ 228,303,973
27. Total	$ 1,846,375,607	$ 8,144,116,608	$ -	$ 1,369,813,123	$ 6,042,063,036	$ -	$ 2,578,616,056
28. Total Hospital and Non Hospital		Total from Above	$ 9,990,492,215		Total from Above	$ 7,411,876,159	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 9,990,492,215	Total Contractual Adj. (G-3 Line 2)	$ 7,411,876,159
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)			+	$ -
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies 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. Adjusted Contractual Adjustments				7,411,876,159
36. Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2021-09/30/2022) NORTHSIDE HOSPITAL

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 Carve 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	$ 212,977,273	$ -	$ -	-	**$ 212,977,273**	137,051	$ 240,454,662		**$ 1,554.00**
2	03100 INTENSIVE CARE UNIT	$ 39,321,828	$ -	$ -		**$ 39,321,828**	23,704	$ 162,239,662		**$ 1,658.87**
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
6	03500 OTHER SPECIAL CARE UNIT	$ 50,456,660	$ -	$ -		**$ 50,456,660**	29,166	$ 176,025,345		**$ 1,729.98**
7	04000 SUBPROVIDER I	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
8	04100 SUBPROVIDER II	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
10	04300 NURSERY	$ 71,160,131	$ -	$ -		**$ 71,160,131**	35,471	$ 98,816,099		**$ 2,006.15**
18	Total Routine	$ 373,915,892	$ -	$ -	$ -	$ 373,915,892	225,392	$ 677,535,768		
19	Weighted Average									$ 1,658.96
	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*
20	09200 Observation (Non-Distinct)		6,139	-	-	**$ 9,540,006**	861,790	15,866,214	$ 16,728,004	**0.570302**
		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*		*Calculated*	*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*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000 OPERATING ROOM	$ 141,290,851	$ -	$ -		**$ 141,290,851**	$ 188,204,108	$ 511,222,923	$ 699,427,031	**0.202009**
22	5100 RECOVERY ROOM	$ 19,132,632	$ -	$ -		**$ 19,132,632**	$ 17,199,604	$ 51,867,071	$ 69,066,675	**0.277017**
23	5200 DELIVERY ROOM & LABOR ROOM	$ 91,305,229	$ -	$ -		**$ 91,305,229**	$ 157,557,853	$ 33,591,626	$ 191,149,479	**0.477664**
24	5300 ANESTHESIOLOGY	$ 2,792,403	$ -	$ -		**$ 2,792,403**	$ 38,935,219	$ 127,225,804	$ 166,161,023	**0.016805**
25	5400 RADIOLOGY-DIAGNOSTIC	$ 125,355,999	$ -	$ -		**$ 125,355,999**	$ 51,607,389	$ 377,597,647	$ 429,205,036	**0.292066**
26	5500 RADIOLOGY-THERAPEUTIC	$ 28,134,186	$ -	$ -		**$ 28,134,186**	$ 7,138,519	$ 185,933,643	$ 193,072,162	**0.145719**
27	5600 RADIOISOTOPE	$ 6,259,053	$ -	$ -		**$ 6,259,053**	$ 2,370,725	$ 43,770,667	$ 46,141,392	**0.135649**
28	5700 CT SCAN	$ 9,019,170	$ -	$ -		**$ 9,019,170**	$ 73,463,782	$ 260,075,427	$ 333,539,209	**0.027041**
29	5800 MRI	$ 10,876,287	$ -	$ -		**$ 10,876,287**	$ 20,166,795	$ 140,159,935	$ 160,326,730	**0.067838**
30	5900 CARDIAC CATHETERIZATION	$ 7,749,664	$ -	$ -		**$ 7,749,664**	$ 20,555,132	$ 44,544,595	$ 65,099,727	**0.119043**
31	6000 LABORATORY	$ 100,641,167	$ -	$ -		**$ 100,641,167**	$ 411,785,748	$ 405,258,887	$ 817,044,635	**0.123177**
32	6500 RESPIRATORY THERAPY	$ 26,324,126	$ -	$ -		**$ 26,324,126**	$ 78,357,202	$ 5,082,258	$ 83,439,460	**0.315488**
33	6600 PHYSICAL THERAPY	$ 13,109,108	$ -	$ -		**$ 13,109,108**	$ 21,079,438	$ 19,511,154	$ 40,590,592	**0.322959**
34	6700 OCCUPATIONAL THERAPY	$ 3,293,398	$ -	$ -		**$ 3,293,398**	$ 11,600,109	$ 1,073,880	$ 12,673,989	**0.259855**
35	6800 SPEECH PATHOLOGY	$ 2,108,250	$ -	$ -		**$ 2,108,250**	$ 10,935,961	$ 274,060	$ 11,210,021	**0.188068**
36	6900 ELECTROCARDIOLOGY	$ 6,305,680	$ -	$ -		**$ 6,305,680**	$ 29,790,325	$ 19,106,542	$ 48,896,867	**0.128959**

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2021-09/30/2022) NORTHSIDE HOSPITAL

	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	7000	ELECTROENCEPHALOGRAPHY	$ 965,399	$ -	$ -	**$ 965,399**	$ 2,649,474	$ 446,257	$ 3,095,731	**0.311848**
38	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$ 111,212,593	$ -	$ -	**$ 111,212,593**	$ 59,430,045	$ 97,757,844	$ 157,187,889	**0.707514**
39	7200	IMPL. DEV. CHARGED TO PATIENTS	$ 77,313,063	$ -	$ -	**$ 77,313,063**	$ 108,402,133	$ 166,540,713	$ 274,942,846	**0.281197**
40	7300	DRUGS CHARGED TO PATIENTS	$ 460,635,055	$ -	$ -	**$ 460,635,055**	$ 684,274,627	$ 3,098,982,731	$ 3,783,257,358	**0.121756**
41	7400	RENAL DIALYSIS	$ 2,253,973	$ -	$ -	**$ 2,253,973**	$ 9,610,577	$ -	$ 9,610,577	**0.234530**
42	7500	ASC (NON-DISTINCT PART)	$ 20,670,185	$ -	$ -	**$ 20,670,185**	$ 14,322,066	$ 104,821,855	$ 119,143,921	**0.173489**
43	7600	OTHER ANCILLARY SERVICES	$ 3,051,774	$ -	$ -	**$ 3,051,774**	$ 46,221	$ 6,025,593	$ 6,071,814	**0.502613**
44	7700	ALLOGENEIC HSCT ACQUISITION	$ 1,260,981	$ -	$ -	**$ 1,260,981**	$ 1,699,651	$ 4,571,897	$ 6,271,548	**0.201064**
45	9000	CLINIC	$ 1,529,846	$ -	$ -	**$ 1,529,846**	$ 302	$ 704,158	$ 704,460	**2.171658**
46	9001	MENTAL HEALTH OP CLINIC	$ 6,177,804	$ -	$ -	**$ 6,177,804**	$ 66,228	$ 3,851,426	$ 3,917,654	**1.576914**
47	9002	CANCER CENTER	$ 187,245,292	$ -	$ -	**$ 187,245,292**	$ 1,712,549	$ 504,051,892	$ 505,764,441	**0.370222**
48	9100	EMERGENCY	$ 30,101,284	$ -	$ -	**$ 30,101,284**	$ 41,974,817	$ 149,058,838	$ 191,033,655	**0.157571**
49	**112**	**Other Organ Acquisition Costs**	**$ 15,716,219**	$ -	$ -	**$ 15,716,219**	$ -	$ -	$ -	-
50			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
51			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
52			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
53			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
54			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
55			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
56			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
57			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
58			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
59			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
60			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
61			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
62			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
63			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
64			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
65			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
66			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
67			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
68			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
69			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
70			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
71			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
72			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
73			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
74			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
75			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
76			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
77			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
78			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
79			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
80			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
81			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
82			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
83			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
84			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
85			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
86			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
87			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
88			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
89			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
90			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
91			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
92			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
93			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
94			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
95			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2021-09/30/2022) NORTHSIDE HOSPITAL

	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
96			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
97			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
98			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
99			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
100			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
101			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
102			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
103			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
104			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
105			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
106			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
107			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
108			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
109			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
110			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
111			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
112			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
113			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
114			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
115			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
116			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
117			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
118			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
119			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
120			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
121			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
122			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
123			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
124			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
125			$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
126		**Total Ancillary**	$ 1,511,830,671	$ -	$ -	$ 1,511,830,671	$ 2,065,798,389	$ 6,378,975,537	$ 8,444,773,926	
127		**Weighted Average**								**0.178294**
128		**Sub Totals**	$ 1,885,746,563	$ -	$ -	$ 1,885,746,563	$ 2,743,334,157	$ 6,378,975,537	$ 9,122,309,694	
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)				$ -				
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**				**$ 1,885,746,563**				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost				**0.00%**				

* 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 (10/01/2021-09/30/2022) NORTHSIDE HOSPITAL

Line #	Code	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	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	
			From Section G	From Section G	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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
		Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000	ADULTS & PEDIATRICS	$ 1,554.00		13,112		14,872		4,317		8,588		10,154		40,889		39.02%
2	03100	INTENSIVE CARE UNIT	$ 1,658.87		3,238		372		1,422		871		1,998		5,903		33.33%
3	03200	CORONARY CARE UNIT	$ -		-		-		-		-		-		-		
4	03300	BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		
6	03500	OTHER SPECIAL CARE UNIT	$ 1,729.98		779		8,590		-		2,093		679		11,462		41.63%
7	04000	SUBPROVIDER I	$ -		-		-		-		-		-		-		
8	04100	SUBPROVIDER II	$ -		-		-		-		-		-		-		
9	04200	OTHER SUBPROVIDER	$ -		-		-		-		-		-		-		
10	04300	NURSERY	$ 2,006.15		10,989		8,124		-		1,302		538		20,415		59.08%
18				Total Days	28,118		31,958		5,739		12,854		13,369		78,669		42.00%
19		Total Days per PS&R or Exhibit Detail			28,118		31,958		5,739		12,854		13,369				
20		Unreconciled Days (Explain Variance)			-		-		-		-		-				
					Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21		Routine Charges			$ 71,554,787		$ 91,502,598		$ 14,956,135		$ 37,237,011		$ 35,724,185		$ 215,250,531		37.06%
21.01		Calculated Routine Charge Per Diem			$ 2,544.80		$ 2,863.21		$ 2,606.05		$ 2,896.92		$ 2,672.17		$ 2,736.15		

Line #	Code	Ancillary Cost Centers (from W/S C) (from Section G):	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Medicaid FFS Primary Inpatient Ancillary Charges	Medicaid FFS Primary Outpatient Ancillary Charges	Managed Care Primary Inpatient Ancillary Charges	Managed Care Primary Outpatient Ancillary Charges	Medicare FFS Cross-Overs Inpatient Ancillary Charges	Medicare FFS Cross-Overs Outpatient Ancillary Charges	Other Medicaid Eligibles Inpatient Ancillary Charges	Other Medicaid Eligibles Outpatient Ancillary Charges	Uninsured Inpatient Ancillary Charges	Uninsured Outpatient Ancillary Charges	Total In-State Medicaid Inpatient Ancillary Charges	Total In-State Medicaid Outpatient Ancillary Charges	% Survey to Cost Report Totals
22	09200	Observation (Non-Distinct)		0.570302	$ 66,188	$ 880,522	$ 151,689	$ 1,097,989	$ 80,528	$ 599,551	$ 37,420	$ 934,927	$ 2,176	$ 1,003,869	$ 335,825	$ 3,512,989	29.10%
23	5000	OPERATING ROOM		0.202009	$ 13,686,369	$ 3,840,210	$ 12,472,447	$ 10,127,781	$ 9,052,748	$ 7,038,089	$ 9,702,840	$ 8,498,181	$ 13,573,633	$ 19,216,843	$ 44,914,405	$ 29,504,260	15.34%
24	5100	RECOVERY ROOM		0.277017	$ 1,868,847	$ 603,555	$ 2,414,073	$ 2,491,400	$ 700,732	$ 1,603,184	$ 1,340,394	$ 1,910,166	$ 1,615,729	$ 4,582,860	$ 6,324,046	$ 6,608,305	27.72%
25	5200	DELIVERY ROOM & LABOR ROOM		0.477664	$ 11,554,668	$ 38,869	$ 19,062,089	$ 164,563	$ 19,456	$ 2,828	$ 4,757,990	$ 59,602	$ 1,163,208	$ 77,698	$ 35,394,203	$ 265,862	19.31%
26	5300	ANESTHESIOLOGY		0.016805	$ 2,074,668	$ 852,247	$ 2,526,434	$ 3,290,625	$ 1,564,024	$ 2,319,605	$ 1,989,833	$ 2,745,600	$ 3,164,269	$ 6,174,116	$ 8,154,959	$ 9,208,077	16.08%
27	5400	RADIOLOGY-DIAGNOSTIC		0.292066	$ 3,053,285	$ 2,662,695	$ 6,133,090	$ 24,049,068	$ 2,289,613	$ 15,065,504	$ 3,315,744	$ 15,953,501	$ 5,492,294	$ 46,689,940	$ 14,791,732	$ 57,730,768	29.09%
28	5500	RADIOLOGY-THERAPEUTIC		0.145719	$ 328,697	$ 1,947,022	$ 7,051	$ 1,477,359	$ 215,351	$ 5,563,913	$ 178,169	$ 4,223,464	$ 843,657	$ 9,839,078	$ 729,268	$ 13,211,758	12.75%
29	5600	RADIOISOTOPE		0.135649	$ 324,693	$ 148,871	$ 94,611	$ 528,874	$ 283,983	$ 2,112,879	$ 303,799	$ 2,159,419	$ 942,626	$ 2,356,647	$ 1,007,085	$ 4,950,043	20.09%
30	5700	CT SCAN		0.027041	$ 4,139,586	$ 4,120,467	$ 2,454,635	$ 1,872,361	$ 3,283,078	$ 2,242,278	$ 3,715,781	$ 1,794,016	$ 9,394,545	$ 6,820,207	$ 13,593,081	$ 10,029,122	11.96%
31	5800	MRI		0.067838	$ 1,082,732	$ 2,375,263	$ 909,650	$ 4,729,890	$ 711,724	$ 6,260,042	$ 938,922	$ 5,402,326	$ 2,508,234	$ 7,915,920	$ 3,643,028	$ 18,767,521	20.50%
32	5900	CARDIAC CATHETERIZATION		0.119043	$ 3,263,166	$ 175,667	$ 479,129	$ 581,375	$ 371,895	$ 905,853	$ 501,670	$ 774,862	$ 3,112,421	$ 1,597,358	$ 4,615,860	$ 2,437,757	18.07%
33	6000	LABORATORY		0.123177	$ 41,651,142	$ 14,878,483	$ 33,825,800	$ 15,017,192	$ 14,844,212	$ 12,846,927	$ 22,803,505	$ 12,372,261	$ 41,525,667	$ 43,431,385	$ 113,124,659	$ 55,114,863	31.05%
34	6500	RESPIRATORY THERAPY		0.315488	$ 5,291,380	$ 79,482	$ 6,294,068	$ 1,456,896	$ 1,618,666	$ 1,482,747	$ 4,032,206	$ 1,611,706	$ 3,904,117	$ 6,067,747	$ 17,236,320	$ 4,630,832	38.21%
35	6600	PHYSICAL THERAPY		0.322959	$ 962,903	$ 32,422	$ 653,436	$ 264,853	$ 828,014	$ 331,694	$ 934,605	$ 324,581	$ 1,119,900	$ 1,547,374	$ 3,378,958	$ 953,550	17.26%
36	6700	OCCUPATIONAL THERAPY		0.259855	$ 1,156,245	$ 7,081	$ 983,183	$ 94,603	$ 576,667	$ 215,968	$ 856,441	$ 183,086	$ 769,233	$ 477,941	$ 3,572,536	$ 500,738	42.04%
37	6800	SPEECH PATHOLOGY		0.188068	$ 1,607,246	$ 5,512	$ 1,718,856	$ 38,177	$ 317,250	$ 86,992	$ 651,511	$ 74,605	$ 444,900	$ 109,963	$ 4,294,863	$ 205,286	45.11%
38	6900	ELECTROCARDIOLOGY		0.128959	$ 841,696	$ 278,857	$ 3,626,954	$ 238,343	$ 1,373,833	$ 293,776	$ 1,885,271	$ 176,689	$ 3,196,047	$ 835,474	$ 7,727,754	$ 987,665	26.10%
39	7000	ELECTROENCEPHALOGRAPHY		0.311848	$ -	$ -	$ 136,020	$ 16,251	$ 83,992	$ 48,780	$ 98,286	$ 18,677	$ 320,191	$ 37,508	$ 318,298	$ 83,708	24.60%
40	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.707514	$ 2,398,386	$ 984,683	$ 3,203,636	$ 2,238,099	$ 2,091,702	$ 2,262,902	$ 2,877,610	$ 2,049,145	$ 3,843,499	$ 5,502,700	$ 10,571,334	$ 7,534,829	17.47%
41	7200	IMPL. DEV. CHARGED TO PATIENTS		0.281197	$ 2,046,556	$ 1,782,482	$ 1,843,202	$ 2,537,144	$ 4,352,980	$ 4,590,247	$ 3,517,200	$ 4,690,265	$ 4,033,744	$ 6,108,865	$ 11,759,938	$ 13,600,138	12.91%
42	7300	DRUGS CHARGED TO PATIENTS		0.121756	$ 50,173,753	$ 60,893,704	$ 41,584,269	$ 45,836,729	$ 23,026,083	$ 170,048,461	$ 36,541,343	$ 130,851,110	$ 51,302,122	$ 171,384,526	$ 151,325,448	$ 407,630,004	20.80%
43	7400	RENAL DIALYSIS		0.234530	$ 545,364	$ -	$ 175,168	$ 6,256	$ 1,107,312	$ 109,480	$ 904,772	$ 125,120	$ 848,928	$ 153,428	$ 2,732,616	$ 240,856	41.40%
44	7500	ASC (NON-DISTINCT PART)		0.173489	$ 9,569	$ 24,492	$ 1,442,235	$ 3,133,394	$ 879,430	$ 2,132,668	$ 1,136,893	$ 2,613,730	$ 1,649,053	$ 5,669,503	$ 3,468,127	$ 7,904,283	15.70%
45	7600	OTHER ANCILLARY SERVICES		0.502613	$ -	$ -	$ 430,327	$ 202,809	$ 9,973	$ 110,733	$ 116,170	$ 128,552	$ 30,709	$ 298,586	$ 556,470	$ 442,094	21.87%
46	7700	ALLOGENEIC HSCT ACQUISITION		0.201064	$ -	$ -	$ 18,199	$ 114,711	$ 25,168	$ 59,281	$ 32,308	$ 83,240	$ 155,236	$ 185,705	$ 75,675	$ 257,232	10.74%
47	9000	CLINIC		2.171658	$ -	$ -	$ 35,836	$ -	$ 20,960	$ 9,066	$ 14,638	$ 7,469	$ 561	$ 43,433	$ 71,434	$ 16,535	18.73%
48	9001	MENTAL HEALTH OP CLINIC		1.576914	$ 534	$ 67,880	$ 7,503	$ 293,087	$ -	$ 149,399	$ 1,602	$ 262,188	$ 35,690	$ 794,131	$ 9,639	$ 772,554	41.17%
49	9002	CANCER CENTER		0.370222	$ 26,925	$ 1,140,123	$ 531,399	$ 15,854,469	$ 30,356	$ 21,723,960	$ 97,328	$ 20,122,859	$ 237,897	$ 15,471,851	$ 686,008	$ 58,841,411	15.00%
50	9100	EMERGENCY		0.157571	$ 3,049,605	$ 10,297,577	$ 1,634,679	$ 14,234,562	$ 1,851,372	$ 4,078,734	$ 1,918,704	$ 4,682,582	$ 5,700,471	$ 41,604,235	$ 8,454,360	$ 33,293,455	46.75%
					151,204,204	108,118,166	144,849,668	151,988,858	71,611,102	264,295,543	105,202,955	224,833,929	160,930,756	405,998,891			

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

Cost Report Year (10/01/2021-09/30/2022) NORTHSIDE HOSPITAL

Line	Totals / Payments	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		%
128	**Total Charges** *(includes organ acquisition from Section J)*	**$ 222,758,991**	**$ 108,118,166**	**$ 236,352,266**	**$ 151,988,858**	**$ 86,567,237**	**$ 264,295,543**	**$ 142,439,966**	**$ 224,833,929**	**$ 196,654,941** (Agrees to Exhibit A)	**$ 405,998,891** (Agrees to Exhibit A)	**$ 688,118,460**	**$ 749,236,496**	22.44%
129	Total Charges per PS&R or Exhibit Detail	$ 222,758,991	$ 108,118,166	$ 236,352,266	$ 151,988,858	$ 86,567,237	$ 264,295,543	$ 142,439,966	$ 224,833,929	$ 196,654,941	$ 405,998,891			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**											$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**	**$ 76,396,903**	**$ 15,528,204**	**$ 85,654,907**	**$ 30,833,000**	**$ 21,389,599**	**$ 43,621,817**	**$ 40,264,611**	**$ 39,038,400**	**$ 46,976,490**	**$ 71,509,883**	$ 223,706,020	$ 129,021,421	25.05%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 38,575,059	$ 12,201,533	$ 10,234	$ 15,255	$ 46,771	$ 4,213,583	$ 140,004	$ 2,705,365			$ 38,772,068	$ 19,135,736	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 40,656,611	$ 17,506,007	$ -	$ -	$ 530,112	$ 373,020			$ 41,186,723	$ 17,879,027	
134	Private Insurance (including primary and third party liability)	$ 228,657	$ 11,705	$ 78,684	$ 46,577	$ -	$ -	$ 27,723,278	$ 13,784,618			$ 28,030,619	$ 13,842,900	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ 7,993	$ 57,344	$ -	$ 62	$ 46,584	$ 54,002			$ 54,577	$ 111,408	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 38,803,716	$ 12,213,238	$ 40,753,522	$ 17,625,183									
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)					$ 14,290,975	$ 24,980,765	$ 39,318	$ 75,820			$ 14,330,293	$ 25,056,585	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 10,077,559	$ 16,786,518			$ 10,077,559	$ 16,786,518	
141	Medicare Cross-Over Bad Debt Payments					$ 357,242	$ 172,907	$ -	$ -			$ 357,242	$ 172,907	
142	Other Medicare Cross-Over Payments (See Note D)					$ 252,930	$ -	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 252,930	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 1,082,730	$ 6,436,337			
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)**	$ 37,593,187	$ 3,314,966	$ 44,901,385	$ 13,207,817	$ 6,441,681	$ 14,254,500	$ 1,707,756	$ 5,259,057	$ 45,893,760	$ 65,073,546	$ 90,644,009	$ 36,036,340	
146	**Calculated Payments as a Percentage of Cost**	51%	79%	48%	57%	70%	67%	96%	87%	2%	9%	59%	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)**					45,186								
148	**Percent of cross-over days to total Medicare days from the cost report**					13%								

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.

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2021-09/30/2022) NORTHSIDE HOSPITAL

Line #	Cost Center Description		Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to 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 Section G	*From Section G*	*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**	
1	03000	ADULTS & PEDIATRICS	$ 1,554.00		19		-		16		8		43	
2	03100	INTENSIVE CARE UNIT	$ 1,658.87		-		-		-		-		-	
3	03200	CORONARY CARE UNIT	$ -		-		-		-		-		-	
4	03300	BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
6	03500	OTHER SPECIAL CARE UNIT	$ 1,729.98		-		-		-		-		-	
7	04000	SUBPROVIDER I	$ -		-		-		-		-		-	
8	04100	SUBPROVIDER II	$ -		-		-		-		-		-	
9	04200	OTHER SUBPROVIDER	$ -		-		-		-		-		-	
10	04300	NURSERY	$ 2,006.15		3		-		-		-		3	
18				**Total Days**	22		-		16		8		46	
19	Total Days per PS&R or Exhibit Detail				22		-		16		8			
20	Unreconciled Days (Explain Variance)				-		-		-		-			
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21		Routine Charges			$ 47,209		$ -		$ 29,997		$ 16,211		$ 93,417	
21.01		Calculated Routine Charge Per Diem			$ 2,145.86		$ -		$ 1,874.81		$ 2,026.38		$ 2,030.80	
	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**
22	09200	Observation (Non-Distinct)		0.570302	-	2,552	-	-	-	-	-	10,065	$ -	$ 12,617
23	5000	OPERATING ROOM		0.202009	45,810	-	-	-	-	7,677	-	31,688	$ 45,810	$ 39,365
24	5100	RECOVERY ROOM		0.277017	4,870	-	-	-	-	3,550	-	4,919	$ 4,870	$ 8,469
25	5200	DELIVERY ROOM & LABOR ROOM		0.477664	743	-	-	-	-	-	-	-	$ 743	$ -
26	5300	ANESTHESIOLOGY		0.016805	8,193	-	-	-	-	2,454	-	8,715	$ 8,193	$ 11,169
27	5400	RADIOLOGY-DIAGNOSTIC		0.292066	1,176	126,280	-	-	3,429	17,530	3,262	13,269	$ 7,867	$ 157,079
28	5500	RADIOLOGY-THERAPEUTIC		0.145719	-	-	-	-	-	-	-	-	$ -	$ -
29	5600	RADIOISOTOPE		0.135649	-	-	-	-	-	12,150	-	-	$ -	$ 12,150
30	5700	CT SCAN		0.027041	6,566	25,240	-	-	16,610	712	8,497	879	$ 31,673	$ 26,830
31	5800	MRI		0.067838	-	4,002	-	-	-	-	-	28,475	$ -	$ 32,477
32	5900	CARDIAC CATHETERIZATION		0.119043	-	-	-	-	-	-	-	1,833	$ -	$ 1,833
33	6000	LABORATORY		0.123177	57,240	117,078	-	-	10,346	146,701	29,021	107,660	$ 96,607	$ 371,439
34	6500	RESPIRATORY THERAPY		0.315488	2,420	10,444	-	-	-	15,483	-	11,488	$ 2,420	$ 37,415
35	6600	PHYSICAL THERAPY		0.322959	2,157	-	-	-	-	-	1,909	2,041	$ 4,066	$ 2,041
36	6700	OCCUPATIONAL THERAPY		0.259855	2,054	-	-	-	-	-	2,401	2,752	$ 4,455	$ 2,752
37	6800	SPEECH PATHOLOGY		0.188068	261	-	-	-	-	-	1,315	-	$ 1,576	$ -
38	6900	ELECTROCARDIOLOGY		0.128959	4,546	3,925	-	-	254	-	3,908	392	$ 8,708	$ 4,317
39	7000	ELECTROENCEPHALOGRAPHY		0.311848	1,752	-	-	-	-	-	-	-	$ 1,752	$ -
40	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.707514	6,346	-	-	-	-	-	-	630	$ 6,346	$ 630
41	7200	IMPL. DEV. CHARGED TO PATIENTS		0.281197	-	419	-	-	-	-	-	419	$ -	$ 838
42	7300	DRUGS CHARGED TO PATIENTS		0.121756	53,801	72,535	-	-	6,937	2,531,810	13,692	2,441,560	$ 74,430	$ 5,045,905
43	7400	RENAL DIALYSIS		0.234530	-	3,128	-	-	-	-	-	-	$ -	$ 3,128
44	7500	ASC (NON-DISTINCT PART)		0.173489	-	-	-	-	-	2,413	-	9,905	$ -	$ 12,318
45	7600	OTHER ANCILLARY SERVICES		0.502613	-	-	-	-	-	-	-	-	$ -	$ -
46	7700	ALLOGENEIC HSCT ACQUISITION		0.201064	-	-	-	-	-	-	-	-	$ -	$ -
47	9000	CLINIC		2.171658	-	-	-	-	-	-	-	-	$ -	$ -
48	9001	MENTAL HEALTH OP CLINIC		1.576914	534	-	-	-	-	534	-	-	$ 534	$ 534
49	9002	CANCER CENTER		0.370222	-	132,468	-	-	-	235,683	-	251,012	$ -	$ 619,163
50	9100	EMERGENCY		0.157571	9,693	212,746	-	-	3,423	14,728	6,654	17,058	$ 19,770	$ 244,532
					208,162	710,816	-	-	40,999	2,991,424	70,659	2,944,760		
	Totals / Payments													
128	**Total Charges (includes organ acquisition from Section K)**				$ 255,371	$ 710,816	$ -	$ -	$ 70,996	$ 2,991,424	$ 86,870	$ 2,944,760	$ 413,237	$ 6,647,001
129	Total Charges per PS&R or Exhibit Detail				$ 255,371	$ 710,816	$ -	$ -	$ 70,996	$ 2,991,424	$ 86,870	$ 2,944,760		
130	Unreconciled Charges (Explain Variance)				-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)												$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**				$ 70,797	$ 149,762	$ -	$ -	$ 29,006	$ 431,417	$ 21,897	$ 433,185	$ 121,700	$ 1,014,364

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2021-09/30/2022) NORTHSIDE HOSPITAL

		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	
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ -	$ 1,563	$ -	$ -	$ -	$ 566	$ -	$ 148	$ -	$ 2,277
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
134	Private Insurance (including primary and third party liability)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 25,848	$ -	$ 25,848
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ 377	$ -	$ 2,344	$ -	$ 2,721
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ 1,563	$ -	$ -						
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)					$ 19,280	$ 386,367	$ -	$ -	$ 19,280	$ 386,367
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 19,250	$ 240,380	$ 19,250	$ 240,380
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)**	$ 70,797	$ 148,199	$ -	$ -	$ 9,726	$ 44,107	$ 2,647	$ 164,465	$ 83,170	$ 356,771
144	**Calculated Payments as a Percentage of Cost**	0%	1%	0%	0%	66%	90%	88%	62%	32%	65%

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 (10/01/2021-09/30/2022) NORTHSIDE HOSPITAL

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted 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	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*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.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	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 (10/01/2021-09/30/2022) NORTHSIDE HOSPITAL

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted 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 Primar		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*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.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	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 (10/01/2021-09/30/2022) NORTHSIDE HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 28,786,064		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		Expense	10-00900-00141	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 28,786,064	5.00	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	0	$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	Lessor of Expense or benefit of add on fee	$ (10,830,821)	5.00	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ -	-	*(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*	0	$ -	-	
13	*Reason for adjustment*	0	$ -	-	
14	*Reason for adjustment*	0	$ -	-	
15	*Reason for adjustment*	0	$ -	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 17,955,243		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 10,830,821
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	1,444,415,194
19	Uninsured Hospital	**Charges Sec. G**	602,653,832
20	Total Hospital	**Charges Sec. G**	9,122,309,694
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		15.83%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.61%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 1,714,939
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 715,524
25	Provider Tax Assessment Adjustment to DSH UCC		$ 2,430,463

** 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**
Hospital Medicaid Number	**000001405A**
Cost Report Period	From **10/1/2021** To **9/30/2022**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 117,406,791	$ -	$ 117,406,791
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 117,406,791	$ -	$ 117,406,791
4	Net Hospital Patient Revenue	Survey F-3	$ 2,578,616,056	$ -	$ 2,578,616,056
5	Medicaid Fraction		4.55%	0.00%	4.55%
6	Inpatient Charity Care Charges	Survey F-2	$ 205,448,477	$ -	$ 205,448,477
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 205,448,477	$ -	$ 205,448,477
10	Inpatient Hospital Charges	Survey F-3	$ 1,846,375,607	$ -	$ 1,846,375,607
11	Inpatient Charity Fraction		11.13%	0.00%	11.13%
12	LIUR		15.68%	0.00%	15.68%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	78,669	-	78,669
14	Out-of-State Medicaid Eligible Days	Survey I	46	-	46
15	Total Medicaid Eligible Days		78,715	-	78,715
16	Total Hospital Days (excludes swing-bed)	Survey F-1	219,253	-	219,253
17	MIUR		35.90%	0.00%	35.90%

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.

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name	NORTHSIDE HOSPITAL			
Hospital Medicaid Number	000001405A			
Cost Report Period	From	10/1/2021	To	9/30/2022

As-Reported:

	Service Type		A Total Costs	B Medicaid Basic Rate Payments	C Medicaid Managed Care Payments	D Private Insurance Payments	E Self-Pay Payments (Includes Co-Pay and Spenddown)	F Medicaid Cost Settlement Payments	G Other Medicaid Payments (Outliers, etc..) **	H Medicare Traditional (non-HMO) Payments	I Medicare Managed Care (HMO) Payments	J Medicare Cross-over Bad Debt	K Other Medicare Cross-over Payments (GME, etc.)	L Uninsured Payments	M Uninsured Payments Not On Exhibit B (1011 Payments)	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
			Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1	Medicaid Fee for Service	Inpatient	76,396,903	38,575,059	-	228,657	-	-	-	-	-	-	-			38,803,716	37,593,187	50.79%
2	Medicaid Fee for Service	Outpatient	15,528,204	12,201,533	-	11,705	-	-	-	-	-	-	-			12,213,238	3,314,966	78.65%
3	Medicaid Managed Care	Inpatient	85,654,907	10,234	40,656,611	78,684	7,993	-	-							40,753,522	44,901,385	47.58%
4	Medicaid Managed Care	Outpatient	30,833,000	15,255	17,506,007	46,577	57,344	-	-							17,625,183	13,207,817	57.16%
5	Medicare Cross-over (FFS)	Inpatient	21,389,599	46,771	-	-	-		-	14,290,975	-	357,242	252,930			14,947,918	6,441,681	69.88%
6	Medicare Cross-over (FFS)	Outpatient	43,621,817	4,213,583	-	-	62		-	24,980,765	-	172,907	-			29,367,317	14,254,500	67.32%
7	Other Medicaid Eligibles	Inpatient	40,264,611	140,004	530,112	27,723,278	46,584			39,318	10,077,559	-	-			38,556,855	1,707,756	95.76%
8	Other Medicaid Eligibles	Outpatient	39,038,400	2,705,365	373,020	13,784,618	54,002			75,820	16,786,518	-	-			33,779,343	5,259,057	86.53%
9	Uninsured	Inpatient	46,976,490	-	-	-	-	-	-	-	-	-	-	1,082,730	-	1,082,730	45,893,760	2.30%
10	Uninsured	Outpatient	71,509,883	-	-	-	-	-	-	-	-	-	-	6,436,337	-	6,436,337	65,073,546	9.00%
11	In-State Sub-total	Inpatient	270,682,510	38,772,068	41,186,723	28,030,619	54,577	-	-	14,330,293	10,077,559	357,242	252,930	1,082,730	-	134,144,741	136,537,769	49.56%
12	In-State Sub-total	Outpatient	200,531,304	19,135,736	17,879,027	13,842,900	111,408	-	-	25,056,585	16,786,518	172,907	-	6,436,337	-	99,421,418	101,109,886	49.58%
13	Out-of-State Medicaid	Inpatient	121,700	-	-	-	-	-	-	19,280	19,250	-	-			38,530	83,170	31.66%
14	Out-of-State Medicaid	Outpatient	1,014,364	2,277	-	25,848	2,721	-	-	386,367	240,380	-	-			657,593	356,771	64.83%
15	Sub-Total	I/P and O/P	472,349,878	57,910,081	59,065,750	41,899,367	168,706	-	-	39,792,525	27,123,707	530,149	252,930	7,519,067	-	234,262,282	238,087,596	49.60%
15.01	Provider Tax Assessment Adjustment to UCC																2,430,463	

Adjustments:

	Service Type		A Total Costs	B Medicaid Basic Rate Payments	C Medicaid Managed Care Payments	D Private Insurance Payments	E Self-Pay Payments (Includes Co-Pay and Spenddown)	F Medicaid Cost Settlement Payments	G Other Medicaid Payments (Outliers, etc..) **	H Medicare Traditional (non-HMO) Payments	I Medicare Managed Care (HMO) Payments	J Medicare Cross-over Bad Debt	K Other Medicare Cross-over Payments (GME, etc.)	L Uninsured Payments	M Uninsured Payments Not On Exhibit B (1011 Payments)	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
2	Medicaid Fee for Service	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
3	Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-							-	-	0.00%
4	Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-							-	-	0.00%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
7	Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
8	Other Medicaid Eligibles	Outpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
9	Uninsured	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
10	Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
11	In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
12	In-State Sub-total	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15	Sub-Total	I/P and O/P	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
15.01	Provider Tax Assessment Adjustment to UCC																	

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name	NORTHSIDE HOSPITAL
Hospital Medicaid Number	000001405A
Cost Report Period	From 10/1/2021 To 9/30/2022

As-Adjusted:

		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1 Medicaid Fee for Service	Inpatient	76,396,903	38,575,059	-	228,657	-	-	-	-	-	-	-			38,803,716	37,593,187	50.79%
2 Medicaid Fee for Service	Outpatient	15,528,204	12,201,533	-	11,705	-	-	-	-	-	-	-			12,213,238	3,314,966	78.65%
3 Medicaid Managed Care	Inpatient	85,654,907	10,234	40,656,611	78,684	7,993	-	-							40,753,522	44,901,385	47.58%
4 Medicaid Managed Care	Outpatient	30,833,000	15,255	17,506,007	46,577	57,344	-	-							17,625,183	13,207,817	57.16%
5 Medicare Cross-over (FFS)	Inpatient	21,389,599	46,771	-	-	-		-	14,290,975	-	357,242	252,930			14,947,918	6,441,681	69.88%
6 Medicare Cross-over (FFS)	Outpatient	43,621,817	4,213,583	-	-	62		-	24,980,765	-	172,907	-			29,367,317	14,254,500	67.32%
7 Other Medicaid Eligibles	Inpatient	40,264,611	140,004	530,112	27,723,278	46,584			39,318	10,077,559	-	-			38,556,855	1,707,756	95.76%
8 Other Medicaid Eligibles	Outpatient	39,038,400	2,705,365	373,020	13,784,618	54,002			75,820	16,786,518	-	-			33,779,343	5,259,057	86.53%
9 Uninsured	Inpatient	46,976,490	-	-	-	-	-	-	-	-	-	-	1,082,730	-	1,082,730	45,893,760	2.30%
10 Uninsured	Outpatient	71,509,883	-	-	-	-	-	-	-	-	-	-	6,436,337	-	6,436,337	65,073,546	9.00%
11 In-State Sub-total	Inpatient	270,682,510	38,772,068	41,186,723	28,030,619	54,577	-	-	14,330,293	10,077,559	357,242	252,930	1,082,730	-	134,144,741	136,537,769	49.56%
12 In-State Sub-total	Outpatient	200,531,304	19,135,736	17,879,027	13,842,900	111,408	-	-	25,056,585	16,786,518	172,907	-	6,436,337	-	99,421,418	101,109,886	49.58%
13 Out-of-State Medicaid	Inpatient	121,700	-	-	-	-	-	-	19,280	19,250	-	-			38,530	83,170	31.66%
14 Out-of-State Medicaid	Outpatient	1,014,364	2,277	-	25,848	2,721	-	-	386,367	240,380	-	-			657,593	356,771	64.83%
15 Cost Report Year Sub-Total	I/P and O/P	472,349,878	57,910,081	59,065,750	41,899,367	168,706	-	-	39,792,525	27,123,707	530,149	252,930	7,519,067	-	234,262,282	238,087,596	49.60%
15.01	Provider Tax Assessment Adjustment															2,430,463	
16	Less: Out of State DSH Payments from Adjusted Survey															-	
17	Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments															240,518,059	

Medicaid DSH Survey Adjustments

PROVIDER: NORTHSIDE HOSPITAL
FROM: 10/1/2021 TO: 9/30/2022
Mcaid Number: 000001405A
Mcare Number: 110161

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
	G - CR Data	49	Other Organ Acquisition Costs	3.00	Total Allowable Cost	Adjust to cost report.	$ -	$ 15,716,219	$ 15,716,219.00	

Medicaid DSH Report Notes

PROVIDER: NORTHSIDE HOSPITAL
Mcaid Number: 000001405A
FROM: 10/1/2021 TO: 9/30/2022
Mcare Number: 110161

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		