GA DSH Payment Results for SFY 2024 - Pool 2 4/8/2024 8:03

DSH Uncompensated Care Cost & Allocation Factor Summary
Preliminary Results

Provider Name	NORTHSIDE HOSPITAL-CHEROKEE
Mcaid Provider Number	000001108A
Mcare Provider Number	110008

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	$ 52,838,319	$ -	$ 52,838,319

Less: 2022 Net UPL Payments	$ 2,179,905
Less: 2024 Net DPP Payments	$ 3,210,809
Plus: 2023 Net DPP Recoupments	$ -
Less: GME Payments	$ -
Add: Net OP Settlement (Difference between provider submitted and estimated)	$ 78,309
Add: Provider tax excluded from the cost report (Medicaid primary & uninsured portion)	$ 354,824
Uncompensated Care Allocation Factor	$ 47,880,738
Hospital Specific DSH Limit	$ 45,090,068
2024 Eligibility	Eligible

DSH Year Low Income Utilization Ratio (LIUR):	14.22%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):	23.08%

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 #:		Reviewer:
Examiner:		
Date:		
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-CHEROKEE

	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):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	2/28/2023		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	NORTHSIDE HOSPITAL-CHEROKEE	Yes	
5. Medicaid Provider Number:	000001108A	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:	110008	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)

	Amount
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)	$ 778,316	$ 4,994,781	$5,773,097
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 4,193,556	$ 19,536,922	$23,730,478
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$4,971,872	$24,531,703	$29,503,575
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	15.65%	20.36%	19.57%

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.

	Amount
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)	90,697

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	88,904,414
8.	Outpatient Hospital Charity Care Charges	98,959,997
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 187,864,411

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	$ 227,647,544	$ -	$ -	$ 180,584,632	$ -	$ -	$ 47,062,912
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	$ 701,854,283	$ 1,053,910,174	$ -	$ 556,755,832	$ 836,029,144	$ -	$ 362,979,481
20. Outpatient Services		$ 820,580,175	$ -		$ 650,936,824	$ -	$ 169,643,351
21. Home Health Agency			$ -			$ -	
22. Ambulance	$ -	$ -	$ -	$ -	$ -	$ -	
23. Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24. ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25. Hospice			$ -			$ -	
26. Other	$ 20,369,047	$ 191,620,273	$ -	$ 16,158,034	$ 152,005,490	$ -	$ 43,825,795
27. Total	$ 949,870,874	$ 2,066,110,622	$ -	$ 753,498,499	$ 1,638,971,459	$ -	$ 623,511,538
28. Total Hospital and Non Hospital		Total from Above	$ 3,015,981,496		Total from Above	$ 2,392,469,958	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 3,015,981,496	Total Contractual Adj. (G-3 Line 2)	$ 2,392,469,958
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				2,392,469,958
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-CHEROKEE

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	$ 94,881,847	$ -	$ -	-	**$ 94,881,847**	81,780	$ 145,037,173		**$ 1,160.21**
2	03100 INTENSIVE CARE UNIT	$ 16,146,212	$ -	$ -		**$ 16,146,212**	6,333	$ 41,840,337		**$ 2,549.54**
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
6	03500 OTHER SPECIAL CARE UNIT	$ 8,845,066	$ -	$ -		**$ 8,845,066**	4,071	$ 26,686,362		**$ 2,172.70**
7	04000 SUBPROVIDER I	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
8	04100 SUBPROVIDER II	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
10	04300 NURSERY	$ 10,036,315	$ -	$ -		**$ 10,036,315**	4,931	$ 14,083,672		**$ 2,035.35**
18	Total Routine	$ 129,909,440	$ -	$ -	$ -	$ 129,909,440	97,115	$ 227,647,544		
19	Weighted Average									$ 1,337.69

Line #	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)		6,418	-	-	**$ 7,446,228**	978,741	15,188,078	$ 16,166,819	**0.460587**

Line #	Cost Center Description	*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	$ 51,460,213	$ -	$ -		**$ 51,460,213**	$ 75,094,328	$ 176,291,425	$ 251,385,753	**0.204706**
22	5100 RECOVERY ROOM	$ 10,582,112	$ -	$ -		**$ 10,582,112**	$ 14,458,153	$ 16,363,799	$ 30,821,952	**0.343330**
23	5200 DELIVERY ROOM & LABOR ROOM	$ 14,091,858	$ -	$ -		**$ 14,091,858**	$ 35,299,862	$ 12,373,462	$ 47,673,324	**0.295592**
24	5300 ANESTHESIOLOGY	$ 661,910	$ -	$ -		**$ 661,910**	$ 17,242,633	$ 42,240,956	$ 59,483,589	**0.011128**
25	5400 RADIOLOGY-DIAGNOSTIC	$ 25,039,428	$ -	$ -		**$ 25,039,428**	$ 29,891,042	$ 114,247,475	$ 144,138,517	**0.173718**
26	5500 RADIOLOGY-THERAPEUTIC	$ 7,418,315	$ -	$ -		**$ 7,418,315**	$ 4,683,040	$ 74,058,849	$ 78,741,889	**0.094211**
27	5600 RADIOISOTOPE	$ 2,626,217	$ -	$ -		**$ 2,626,217**	$ 2,391,962	$ 19,026,598	$ 21,418,560	**0.122614**
28	5700 CT SCAN	$ 7,567,266	$ -	$ -		**$ 7,567,266**	$ 70,075,344	$ 168,162,932	$ 238,238,276	**0.031763**
29	5800 MRI	$ 6,097,818	$ -	$ -		**$ 6,097,818**	$ 19,969,945	$ 72,115,209	$ 92,085,154	**0.066219**
30	5900 CARDIAC CATHETERIZATION	$ 5,241,969	$ -	$ -		**$ 5,241,969**	$ 32,080,483	$ 41,932,791	$ 74,013,274	**0.070825**
31	6000 LABORATORY	$ 19,521,509	$ -	$ -		**$ 19,521,509**	$ 198,972,933	$ 137,278,894	$ 336,251,827	**0.058056**
32	6500 RESPIRATORY THERAPY	$ 12,364,127	$ -	$ -		**$ 12,364,127**	$ 43,086,679	$ 3,522,496	$ 46,609,175	**0.265272**
33	6600 PHYSICAL THERAPY	$ 8,001,064	$ -	$ -		**$ 8,001,064**	$ 17,168,569	$ 12,454,367	$ 29,622,936	**0.270097**
34	6700 OCCUPATIONAL THERAPY	$ 2,081,614	$ -	$ -		**$ 2,081,614**	$ 12,117,162	$ 1,086,548	$ 13,203,710	**0.157654**
35	6800 SPEECH PATHOLOGY	$ 901,919	$ -	$ -		**$ 901,919**	$ 5,953,662	$ 552,942	$ 6,506,604	**0.138616**
36	6900 ELECTROCARDIOLOGY	$ 3,284,682	$ -	$ -		**$ 3,284,682**	$ 29,321,400	$ 20,882,727	$ 50,204,127	**0.065427**
37	7000 ELECTROENCEPHALOGRAPHY	$ 544,644	$ -	$ -		**$ 544,644**	$ 1,555,277	$ 446,080	$ 2,001,357	**0.272137**
38	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 58,652,818	$ -	$ -		**$ 58,652,818**	$ 30,240,378	$ 39,207,903	$ 69,448,281	**0.844554**

G. Cost Report - Cost / Days / Charges

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

	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
39	7200	IMPL. DEV. CHARGED TO PATIENTS	$ 41,570,204	$ -	$ -		$ 41,570,204	$ 62,251,431	$ 101,664,721	$ 163,916,152	0.253607
40	7300	DRUGS CHARGED TO PATIENTS	$ 82,509,275	$ -	$ -		$ 82,509,275	$ 251,939,370	$ 277,064,300	$ 529,003,670	0.155971
41	7400	RENAL DIALYSIS	$ 2,303,026	$ -	$ -		$ 2,303,026	$ 6,963,089	$ -	$ 6,963,089	0.330748
42	7500	ASC (NON-DISTINCT PART)	$ 5,650,764	$ -	$ -		$ 5,650,764	$ 11,414,394	$ 38,368,583	$ 49,782,977	0.113508
43	7600	MISC ANCILLARY SERVICES	$ 531,983	$ -	$ -		$ 531,983	$ -	$ 2,969,698	$ 2,969,698	0.179137
44	9000	CLINIC	$ 456,659	$ -	$ -		$ 456,659	$ 530	$ 155,689	$ 156,219	2.923198
45	9001	MENTAL HEALTH OP CLINIC	$ 721,555	$ -	$ -		$ 721,555	$ 69,615	$ 701,093	$ 770,708	0.936224
46	9002	CANCER CENTER	$ 6,532,849	$ -	$ -		$ 6,532,849	$ 126,867	$ 19,318,373	$ 19,445,240	0.335961
47	9100	EMERGENCY	$ 23,900,885	$ -	$ -		$ 23,900,885	$ 51,059,784	$ 144,261,971	$ 195,321,755	0.122367
126		**Total Ancillary**	$ 400,316,683	$ -	$ -		$ 400,316,683	$ 1,024,406,673	$ 1,551,937,959	$ 2,576,344,632	
127		**Weighted Average**									0.158272
128		**Sub Totals**	$ 530,226,123	$ -	$ -		$ 530,226,123	$ 1,252,054,217	$ 1,551,937,959	$ 2,803,992,176	

Line	Description	Amount
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**	**$ 530,226,123**
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-CHEROKEE

Line #		Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	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	$ 1,160.21		3,293		3,028		3,670		4,136		5,258		**14,127**		25.77%
2	03100	INTENSIVE CARE UNIT	$ 2,549.54		587		199		729		405		592		**1,920**		39.68%
3	03200	CORONARY CARE UNIT	$ -		-		-		-		-		-		**-**		
4	03300	BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-		**-**		
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-		**-**		
6	03500	OTHER SPECIAL CARE UNIT	$ 2,172.70		28		1,544		-		533		55		**2,105**		53.06%
7	04000	SUBPROVIDER I	$ -		-		-		-		-		-		**-**		
8	04100	SUBPROVIDER II	$ -		-		-		-		-		-		**-**		
9	04200	OTHER SUBPROVIDER	$ -		-		-		-		-		-		**-**		
10	04300	NURSERY	$ 2,035.35		932		1,587		-		227		103		**2,746**		57.78%
18				**Total Days**	4,840		6,358		4,399		5,301		6,008		20,898		29.71%
19	Total Days per PS&R or Exhibit Detail				4,840		6,358		4,399		5,301		6,008				
20		Unreconciled Days (Explain Variance			-		-		-		-		-				
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21		Routine Charges			$ 11,832,321		$ 15,990,251		$ 10,801,854		$ 14,270,143		$ 14,792,307		$ 52,894,569		29.77%
21.01		Calculated Routine Charge Per Dien			$ 2,444.69		$ 2,514.98		$ 2,455.52		$ 2,691.97		$ 2,462.10		$ 2,531.08		
	Ancillary Cost Centers (from W/S C) (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**	
22	09200	Observation (Non-Distinct		0.460587	$ 33,386	$ 139,105	$ 25,034	$ 375,872	$ 54,608	$ 400,618	$ 4,332	$ 664,608	$ 2,176	$ 1,078,447	$ 117,360	$ 1,580,203	17.26%
23	5000	OPERATING ROOM		0.204706	$ 3,144,181	$ 2,380,619	$ 2,659,562	$ 5,753,401	$ 3,772,922	$ 2,970,918	$ 3,916,997	$ 2,841,308	$ 5,057,657	$ 7,168,104	$ 13,493,662	$ 13,946,247	15.84%
24	5100	RECOVERY ROOM		0.343330	$ 315,176	$ 484,717	$ 721,715	$ 1,610,398	$ 351,100	$ 699,098	$ 515,462	$ 711,542	$ 489,550	$ 1,590,818	$ 1,903,453	$ 3,505,755	24.34%
25	5200	DELIVERY ROOM & LABOR ROOM		0.295592	$ 1,644,713	$ 67,179	$ 5,714,507	$ 999,152	$ 40,288	$ 1,439	$ 1,636,862	$ 197,597	$ 292,727	$ 108,657	$ 9,036,370	$ 1,265,367	22.45%
26	5300	ANESTHESIOLOGY		0.011128	$ 545,076	$ 618,002	$ 598,858	$ 1,969,359	$ 889,266	$ 966,704	$ 872,828	$ 929,119	$ 1,236,325	$ 2,258,094	$ 2,906,028	$ 4,483,184	18.37%
27	5400	RADIOLOGY-DIAGNOSTIC		0.173718	$ 770,831	$ 1,289,474	$ 1,302,217	$ 12,416,919	$ 1,680,993	$ 7,887,510	$ 1,909,629	$ 8,140,548	$ 2,543,362	$ 21,837,447	$ 5,663,669	$ 29,734,451	41.73%
28	5500	RADIOLOGY-THERAPEUTIC		0.094211	$ 529,757	$ 1,175,718	$ 52,642	$ 890,953	$ 214,631	$ 1,482,134	$ 177,070	$ 685,366	$ 778,121	$ 2,579,883	$ 974,100	$ 4,234,171	10.88%
29	5600	RADIOISOTOPE		0.122614	$ 348,655	$ 79,645	$ 63,882	$ 274,550	$ 283,961	$ 599,354	$ 237,379	$ 684,151	$ 577,544	$ 1,251,336	$ 933,877	$ 1,637,700	20.79%
30	5700	CT SCAN		0.031763	$ 2,555,985	$ 2,543,077	$ 1,281,772	$ 1,443,177	$ 3,510,175	$ 1,395,668	$ 2,972,215	$ 1,269,962	$ 5,522,113	$ 3,737,612	$ 10,320,147	$ 6,651,884	11.05%
31	5800	MRI		0.066219	$ 746,638	$ 1,160,673	$ 556,470	$ 1,676,975	$ 1,119,250	$ 2,335,618	$ 954,857	$ 1,592,828	$ 1,887,986	$ 3,295,025	$ 3,377,215	$ 6,766,094	16.71%
32	5900	CARDIAC CATHETERIZATION		0.070825	$ 1,332,403	$ 319,073	$ 133,312	$ 305,251	$ 1,162,252	$ 1,378,322	$ 853,586	$ 924,200	$ 2,654,031	$ 1,378,085	$ 3,481,553	$ 2,926,846	14.22%
33	6000	LABORATORY		0.058056	$ 10,294,899	$ 3,064,531	$ 8,137,040	$ 5,555,195	$ 11,431,617	$ 2,512,420	$ 11,427,704	$ 2,996,057	$ 16,766,555	$ 14,232,259	$ 41,291,260	$ 14,128,203	25.76%
34	6500	RESPIRATORY THERAPY		0.265272	$ 1,645,174	$ 82,913	$ 1,139,928	$ 671,399	$ 2,174,242	$ 429,625	$ 2,733,263	$ 564,003	$ 1,856,775	$ 3,068,921	$ 7,692,607	$ 1,747,940	30.85%
35	6600	PHYSICAL THERAPY		0.270097	$ 536,610	$ 169,355	$ 114,764	$ 236,383	$ 937,023	$ 225,259	$ 798,573	$ 330,868	$ 835,735	$ 1,322,222	$ 2,386,970	$ 961,865	18.60%
36	6700	OCCUPATIONAL THERAPY		0.157654	$ 444,545	$ 21,374	$ 349,856	$ 57,067	$ 701,853	$ 59,052	$ 664,552	$ 103,281	$ 541,974	$ 337,814	$ 2,160,806	$ 240,774	24.91%
37	6800	SPEECH PATHOLOGY		0.138616	$ 303,307	$ 14,163	$ 366,763	$ 13,602	$ 312,648	$ 45,072	$ 278,395	$ 71,402	$ 274,965	$ 52,476	$ 1,261,113	$ 144,239	26.63%
38	6900	ELECTROCARDIOLOGY		0.065427	$ 372,247	$ 231,389	$ 540,092	$ 201,150	$ 1,348,776	$ 233,147	$ 1,110,632	$ 176,487	$ 2,185,708	$ 570,982	$ 3,371,747	$ 842,173	13.94%
39	7000	ELECTROENCEPHALOGRAPHY		0.272137	$ -	$ -	$ 89,768	$ 31,306	$ 63,504	$ 31,664	$ 125,572	$ 33,706	$ 149,376	$ 33,484	$ 278,844	$ 96,676	27.90%
40	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.844554	$ 777,435	$ 509,648	$ 777,271	$ 1,321,557	$ 1,252,893	$ 1,094,180	$ 1,203,323	$ 864,582	$ 2,022,687	$ 2,488,823	$ 4,010,922	$ 3,789,967	17.78%
41	7200	IMPL. DEV. CHARGED TO PATIENTS		0.253607	$ 680,777	$ 927,452	$ 1,074,018	$ 1,457,204	$ 2,903,756	$ 3,139,396	$ 2,568,084	$ 2,556,253	$ 2,164,496	$ 3,910,459	$ 7,226,635	$ 8,080,305	13.08%
42	7300	DRUGS CHARGED TO PATIENTS		0.155971	$ 10,240,445	$ 4,728,332	$ 9,750,331	$ 5,447,240	$ 12,158,917	$ 12,006,100	$ 12,409,195	$ 7,188,742	$ 18,393,347	$ 21,497,594	$ 44,558,887	$ 29,370,413	21.56%
43	7400	RENAL DIALYSIS		0.330748	$ -	$ -	$ 197,140	$ 9,384	$ 1,099,202	$ 134,504	$ 958,274	$ 134,504	$ 515,708	$ 1,160,956	$ 2,254,616	$ 278,392	60.55%
44	7500	ASC (NON-DISTINCT PART)		0.113508	$ 9,569	$ -	$ 300,878	$ 1,707,814	$ 526,594	$ 845,374	$ 546,616	$ 816,206	$ 630,753	$ 2,070,844	$ 1,383,657	$ 3,369,394	15.02%
45	7600	MISC ANCILLARY SERVICES		0.179137	$ -	$ -	$ 790	$ 107,988	$ 423	$ 158,676	$ -	$ 149,703	$ -	$ 170,714	$ 1,213	$ 416,367	19.81%
46	9000	CLINIC		2.923198	$ -	$ -	$ 2,708	$ -	$ 4,214	$ -	$ 3,482	$ -	$ 112	$ 18,304	$ 10,403	$ -	18.45%
47	9001	MENTAL HEALTH OP CLINIC		0.936224	$ 534	$ 14,952	$ 2,670	$ 29,904	$ -	$ 3,204	$ 3,204	$ 16,020	$ 27,173	$ 298,431	$ 6,408	$ 64,080	51.46%
48	9002	CANCER CENTER		0.335961	$ 3,159	$ 93,675	$ 129,755	$ 3,645,864	$ 18,892	$ 2,687,901	$ 29,461	$ 2,737,547	$ 289,614	$ 2,450,748	$ 181,267	$ 9,164,987	62.50%
49	9100	EMERGENCY		0.122367	$ 1,789,305	$ 3,789,229	$ 859,829	$ 13,805,112	$ 2,316,988	$ 4,153,664	$ 2,014,309	$ 4,851,658	$ 3,926,598	$ 21,627,144	$ 6,980,431	$ 26,599,663	30.37%
					39,064,807	23,904,294	36,943,571	62,014,175	50,330,988	47,876,621	50,925,855	42,232,249	71,623,168	121,595,683			

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

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

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		% Survey
128	**Total Charges *(includes organ acquisition from Section J)***	**$ 50,897,128**	**$ 23,904,294**	**$ 52,933,822**	**$ 62,014,175**	**$ 61,132,842**	**$ 47,876,621**	**$ 65,195,998**	**$ 42,232,249**	**$ 86,415,475**	**$ 121,595,683**	**$ 230,159,789**	**$ 176,027,340**	**21.97%**
										(Agrees to Exhibit A)	**(Agrees to Exhibit A)**			
129	Total Charges per PS&R or Exhibit Detail	$ 50,897,128	$ 23,904,294	$ 52,933,822	$ 62,014,175	$ 61,132,842	$ 47,876,621	$ 65,195,998	$ 42,232,249	$ 86,415,475	$ 121,595,683			
130	Unreconciled Charges (Explain Variance)	-	0	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**											$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**	**$ 12,949,509**	**$ 3,447,704**	**$ 17,110,677**	**$ 10,764,955**	**$ 13,841,033**	**$ 8,459,964**	**$ 15,627,216**	**$ 7,626,534**	**$ 18,288,530**	**$ 20,195,546**	$ 59,528,435	$ 30,299,157	24.26%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 7,048,073	$ 2,873,529	$ -	$ 779	$ 100,077	$ 488,383	$ 74,141	$ 262,876			$ 7,222,291	$ 3,625,567	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 8,862,991	$ 5,388,474	$ -	$ -	$ 114,636	$ 101,748			$ 8,977,627	$ 5,490,222	
134	Private Insurance (including primary and third party liability)	$ 43,665	$ 493	$ 32,311	$ 16,945	$ -	$ -	$ 6,645,329	$ 3,000,578			$ 6,721,305	$ 3,018,016	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ (1,000)	$ 8,247	$ -	$ 388	$ 6,217	$ 34,644			$ 5,217	$ 43,279	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 7,091,738	$ 2,874,022	$ 8,894,302	$ 5,414,445									
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)					$ 7,937,768	$ 4,280,160	$ 19,218	$ 13,202			$ 7,956,986	$ 4,293,362	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 5,573,025	$ 2,698,250			$ 5,573,025	$ 2,698,250	
141	Medicare Cross-Over Bad Debt Payments					$ 239,055	$ 69,999	$ -	$ -			$ 239,055	$ 69,999	
142	Other Medicare Cross-Over Payments (See Note D)					$ (194,703)	$ -	$ -	$ -	**(Agrees to Exhibit B and B-1)**	**(Agrees to Exhibit B and B-1)**	$ (194,703)	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 778,316	$ 4,994,781			
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)**	$ 5,857,771	$ 573,682	$ 8,216,375	$ 5,350,510	$ 5,758,836	$ 3,621,034	$ 3,194,650	$ 1,515,236	$ 17,510,214	$ 15,200,765	$ 23,027,632	$ 11,060,462	
146	**Calculated Payments as a Percentage of Cost**	55%	83%	52%	50%	58%	57%	80%	80%	4%	25%	61%	63%	
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**					44,361								
148	**Percent of cross-over days to total Medicare days from the cost report**					10%								

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 s
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 s
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 pa

I. Out-of-State Medicaid Data:

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

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 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	$ 1,160.21		17		-		14		4		35	
2	03100	INTENSIVE CARE UNIT	$ 2,549.54		-		-		1		-		1	
3	03200	CORONARY CARE UNIT	$ -		-		-		-		-		-	
4	03300	BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
6	03500	OTHER SPECIAL CARE UNIT	$ 2,172.70		-		-		-		-		-	
7	04000	SUBPROVIDER I	$ -		-		-		-		-		-	
8	04100	SUBPROVIDER II	$ -		-		-		-		-		-	
9	04200	OTHER SUBPROVIDER	$ -		-		-		-		-		-	
10	04300	NURSERY	$ 2,035.35		-		-		-		-		-	
18				**Total Days**	17		-		15		4		36	
19	Total Days per PS&R or Exhibit Detail				17		-		15		4			
20	Unreconciled Days (Explain Variance)				-		-		-		-			
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21		Routine Charges			$ 34,024		$ -		$ 34,246		$ 6,408		$ 74,678	
21.01		Calculated Routine Charge Per Diem			$ 2,001.41		$ -		$ 2,283.07		$ 1,602.00		$ 2,074.39	
	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)		0.460587	-	4,638	-	-	-	1,637	-	5,383	$ -	$ 11,659
23	5000	OPERATING ROOM		0.204706	12,932	17,458	-	-	60,321	35,244	30,978	7,919	$ 104,231	$ 60,621
24	5100	RECOVERY ROOM		0.343330	1,189	2,930	-	-	2,734	4,037	2,257	-	$ 6,180	$ 6,967
25	5200	DELIVERY ROOM & LABOR ROOM		0.295592	-	1,427	-	-	-	-	-	-	$ -	$ 1,427
26	5300	ANESTHESIOLOGY		0.011128	3,306	4,006	-	-	12,808	12,030	6,684	4,540	$ 22,798	$ 20,576
27	5400	RADIOLOGY-DIAGNOSTIC		0.173718	12,427	167,949	-	-	2,827	68,232	3,018	121,231	$ 18,272	$ 357,412
28	5500	RADIOLOGY-THERAPEUTIC		0.094211	-	-	-	-	-	-	-	-	$ -	$ -
29	5600	RADIOISOTOPE		0.122614	-	18,702	-	-	-	25,161	-	9,351	$ -	$ 53,214
30	5700	CT SCAN		0.031763	23,847	14,080	-	-	9,136	13,212	-	21,450	$ 32,983	$ 48,742
31	5800	MRI		0.066219	-	23,990	-	-	-	7,360	-	32,480	$ -	$ 63,830
32	5900	CARDIAC CATHETERIZATION		0.070825	982	8,425	-	-	49,947	1,445	-	24,070	$ 50,929	$ 33,940
33	6000	LABORATORY		0.058056	40,298	34,983	-	-	33,228	43,056	14,444	19,434	$ 87,970	$ 97,473
34	6500	RESPIRATORY THERAPY		0.265272	-	8,899	-	-	-	836	1,210	3,400	$ 1,210	$ 13,134
35	6600	PHYSICAL THERAPY		0.270097	2,392	-	-	-	824	-	-	-	$ 3,216	$ -
36	6700	OCCUPATIONAL THERAPY		0.157654	2,285	-	-	-	-	-	-	5,148	$ 2,285	$ 5,148
37	6800	SPEECH PATHOLOGY		0.138616	-	-	-	-	-	-	-	-	$ -	$ -
38	6900	ELECTROCARDIOLOGY		0.065427	6,999	1,766	-	-	14,847	589	4,083	981	$ 25,929	$ 3,336
39	7000	ELECTROENCEPHALOGRAPHY		0.272137	-	-	-	-	-	-	-	-	$ -	$ -
40	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.844554	579	10,213	-	-	17,794	5,257	261	3,374	$ 18,634	$ 18,844
41	7200	IMPL. DEV. CHARGED TO PATIENTS		0.253607	-	1,567	-	-	51,052	4,206	-	1,904	$ 51,052	$ 7,677
42	7300	DRUGS CHARGED TO PATIENTS		0.155971	91,798	30,654	-	-	34,604	25,002	10,718	24,582	$ 137,120	$ 80,238
43	7400	RENAL DIALYSIS		0.330748	-	-	-	-	3,128	3,128	-	-	$ 3,128	$ 3,128
44	7500	ASC (NON-DISTINCT PART)		0.113508	-	-	-	-	7,455	10,093	3,829	-	$ 11,284	$ 10,093
45	7600	MISC ANCILLARY SERVICES		0.179137	-	-	-	-	-	-	-	-	$ -	$ -
46	9000	CLINIC		2.923198	-	-	-	-	-	-	-	-	$ -	$ -
47	9001	MENTAL HEALTH OP CLINIC		0.936224	-	534	-	-	-	-	-	-	$ -	$ 534
48	9002	CANCER CENTER		0.335961	-	31,331	-	-	-	7,794	-	26,915	$ -	$ 66,040
49	9100	EMERGENCY		0.122367	3,915	112,010	-	-	9,394	18,048	3,231	31,611	$ 16,540	$ 161,669
					202,949	495,562	-	-	310,099	286,367	80,713	343,773		
	Totals / Payments													
128	**Total Charges (includes organ acquisition from Section K)**				**$ 236,973**	**$ 495,562**	**$ -**	**$ -**	**$ 344,345**	**$ 286,367**	**$ 87,121**	**$ 343,773**	**$ 668,438**	**$ 1,125,703**
129	Total Charges per PS&R or Exhibit Detail				$ 236,973	$ 495,562	$ -	$ -	$ 344,345	$ 286,367	$ 87,121	$ 343,773		
130	Unreconciled Charges (Explain Variance)				-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)												$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**				**$ 44,891**	**$ 84,327**	**$ -**	**$ -**	**$ 76,066**	**$ 44,609**	**$ 16,505**	**$ 53,877**	**$ 137,462**	**$ 182,813**
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				$ -	$ 216	$ -	$ -	$ -	$ 138	$ -	$ 4	$ -	$ 358
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

I. Out-of-State Medicaid Data:

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

#		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	
134	Private Insurance (including primary and third party liabilit	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,625	$ -	$ 1,625
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ 75	$ -	$ -	$ -	$ 75
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ 216	$ -	$ -						
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)					$ 41,567	$ 23,724	$ -	$ 313	$ 41,567	$ 24,037
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 15,145	$ 21,336	$ 15,145	$ 21,336
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)**	$ 44,891	$ 84,111	$ -	$ -	$ 34,499	$ 20,672	$ 1,360	$ 30,599	$ 80,750	$ 135,382
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	55%	54%	92%	43%	41%	26%

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-CHEROKEE

		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-CHEROKEE

		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 examinati surveys.

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

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 5,163,119		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		Expense	22-00900-00141	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 5,163,119	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	$ (2,496,715)	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		$ 2,666,404		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 2,496,715
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	407,981,270
19	Uninsured Hospital	**Charges Sec. G**	208,011,159
20	Total Hospital	**Charges Sec. G**	2,803,992,176
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		14.55%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.42%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 363,272
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 185,216
25	Provider Tax Assessment Adjustment to DSH UCC		$ 548,488

** 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-CHEROKEE**
Hospital Medicaid Number	**000001108A**
Cost Report Period	From **10/1/2021** To **9/30/2022**

		Source	As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 25,416,726	$ -	$ 25,416,726
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 25,416,726	$ -	$ 25,416,726
4	Net Hospital Patient Revenue	Survey F-3	$ 623,511,538	$ -	$ 623,511,538
5	Medicaid Fraction		4.08%	0.00%	4.08%
6	Inpatient Charity Care Charges	Survey F-2	$ 88,904,414	$ -	$ 88,904,414
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 88,904,414	$ -	$ 88,904,414
10	Inpatient Hospital Charges	Survey F-3	$ 949,870,874	$ -	$ 949,870,874
11	Inpatient Charity Fraction		9.36%	0.00%	9.36%
12	LIUR		13.44%	0.00%	13.44%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	20,898	-	20,898
14	Out-of-State Medicaid Eligible Days	Survey I	36	-	36
15	Total Medicaid Eligible Days		20,934	-	20,934
16	Total Hospital Days (excludes swing-bed)	Survey F-1	90,697	-	90,697
17	MIUR		23.08%	0.00%	23.08%

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-CHEROKEE
Hospital Medicaid Number	000001108A
Cost Report Period	From 10/1/2021 To 9/30/2022

As-Reported:

		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	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	12,949,509	7,048,073	-	43,665	-	-	-	-	-	-	-			7,091,738	5,857,771	54.76%
2 Medicaid Fee for Service	Outpatient	3,447,704	2,873,529	-	493	-	-	-	-	-	-	-			2,874,022	573,682	83.36%
3 Medicaid Managed Care	Inpatient	17,110,677	-	8,862,991	32,311	(1,000)	-	-							8,894,302	8,216,375	51.98%
4 Medicaid Managed Care	Outpatient	10,764,955	779	5,388,474	16,945	8,247	-	-							5,414,445	5,350,510	50.30%
5 Medicare Cross-over (FFS)	Inpatient	13,841,033	100,077	-	-	-		-	7,937,768	-	239,055	(194,703)			8,082,197	5,758,836	58.39%
6 Medicare Cross-over (FFS)	Outpatient	8,459,964	488,383	-	-	388		-	4,280,160	-	69,999	-			4,838,930	3,621,034	57.20%
7 Other Medicaid Eligibles	Inpatient	15,627,216	74,141	114,636	6,645,329	6,217			19,218	5,573,025	-	-			12,432,566	3,194,650	79.56%
8 Other Medicaid Eligibles	Outpatient	7,626,534	262,876	101,748	3,000,578	34,644			13,202	2,698,250	-	-			6,111,298	1,515,236	80.13%
9 Uninsured	Inpatient	18,288,530	-	-	-	-	-	-	-	-	-	-	778,316	-	778,316	17,510,214	4.26%
10 Uninsured	Outpatient	20,195,546	-	-	-	-	-	-	-	-	-	-	4,994,781	-	4,994,781	15,200,765	24.73%
11 In-State Sub-total	Inpatient	77,816,965	7,222,291	8,977,627	6,721,305	5,217	-	-	7,956,986	5,573,025	239,055	(194,703)	778,316	-	37,279,119	40,537,846	47.91%
12 In-State Sub-total	Outpatient	50,494,703	3,625,567	5,490,222	3,018,016	43,279	-	-	4,293,362	2,698,250	69,999	-	4,994,781	-	24,233,476	26,261,227	47.99%
13 Out-of-State Medicaid	Inpatient	137,462	-	-	-	-	-	-	41,567	15,145	-	-			56,712	80,750	41.26%
14 Out-of-State Medicaid	Outpatient	182,813	358	-	1,625	75	-	-	24,037	21,336	-	-			47,431	135,382	25.95%
15 Sub-Total	I/P and O/P	128,631,943	10,848,216	14,467,849	9,740,946	48,571	-	-	12,315,952	8,307,756	309,054	(194,703)	5,773,097	-	61,616,738	67,015,205	47.90%
15.01 Provider Tax Assessment Adjustment to UCC																548,488	

Adjustments:

		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	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	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-CHEROKEE
Hospital Medicaid Number	000001108A
Cost Report Period	From 10/1/2021 To 9/30/2022

As-Adjusted:

Service Type		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
		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	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	12,949,509	7,048,073	-	43,665	-	-	-	-	-	-	-			7,091,738	5,857,771	54.76%
2 Medicaid Fee for Service	Outpatient	3,447,704	2,873,529	-	493	-	-	-	-	-	-	-			2,874,022	573,682	83.36%
3 Medicaid Managed Care	Inpatient	17,110,677	-	8,862,991	32,311	(1,000)	-	-							8,894,302	8,216,375	51.98%
4 Medicaid Managed Care	Outpatient	10,764,955	779	5,388,474	16,945	8,247	-	-							5,414,445	5,350,510	50.30%
5 Medicare Cross-over (FFS)	Inpatient	13,841,033	100,077	-	-	-		-	7,937,768	-	239,055	(194,703)			8,082,197	5,758,836	58.39%
6 Medicare Cross-over (FFS)	Outpatient	8,459,964	488,383	-	-	388		-	4,280,160	-	69,999	-			4,838,930	3,621,034	57.20%
7 Other Medicaid Eligibles	Inpatient	15,627,216	74,141	114,636	6,645,329	6,217			19,218	5,573,025	-	-			12,432,566	3,194,650	79.56%
8 Other Medicaid Eligibles	Outpatient	7,626,534	262,876	101,748	3,000,578	34,644			13,202	2,698,250	-	-			6,111,298	1,515,236	80.13%
9 Uninsured	Inpatient	18,288,530	-	-	-	-	-	-	-	-	-	-	778,316	-	778,316	17,510,214	4.26%
10 Uninsured	Outpatient	20,195,546	-	-	-	-	-	-	-	-	-	-	4,994,781	-	4,994,781	15,200,765	24.73%
11 In-State Sub-total	Inpatient	77,816,965	7,222,291	8,977,627	6,721,305	5,217	-	-	7,956,986	5,573,025	239,055	(194,703)	778,316	-	37,279,119	40,537,846	47.91%
12 In-State Sub-total	Outpatient	50,494,703	3,625,567	5,490,222	3,018,016	43,279	-	-	4,293,362	2,698,250	69,999	-	4,994,781	-	24,233,476	26,261,227	47.99%
13 Out-of-State Medicaid	Inpatient	137,462	-	-	-	-	-	-	41,567	15,145	-	-			56,712	80,750	41.26%
14 Out-of-State Medicaid	Outpatient	182,813	358	-	1,625	75	-	-	24,037	21,336	-	-			47,431	135,382	25.95%
15 Cost Report Year Sub-Total	I/P and O/P	128,631,943	10,848,216	14,467,849	9,740,946	48,571	-	-	12,315,952	8,307,756	309,054	(194,703)	5,773,097	-	61,616,738	67,015,205	47.90%

Line	Description	O
15.01	Provider Tax Assessment Adjustment	548,488
16	Less: Out of State DSH Payments from Adjusted Survey	-
17	Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments	67,563,693

Medicaid DSH Survey Adjustments

PROVIDER: NORTHSIDE HOSPITAL-CHEROKEE
Mcaid Number: 000001108A
FROM: 10/1/2021 TO: 9/30/2022
Mcare Number: 110008

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.

Medicaid DSH Report Notes

PROVIDER: NORTHSIDE HOSPITAL-CHEROKEE
Mcaid Number: 000001108A
FROM: 10/1/2021 TO: 9/30/2022
Mcare Number: 110008

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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