GA DSH Payment Results for SFY 2025 - Pool 2

3/25/2025 9:49

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 2025 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: 7/1/2024 - 6/30/2025

	(A) Cost Report Year Begin		(B) Cost Report Year End	(C) As-Filed DSH Uncompensated Care Cost (UCC)	(D) Total Adjustments	(E) Adjusted DSH Uncompensated Care Cost (UCC)
Cost Report Year UCC:	10/1/2022	-	9/30/2023	$ 201,477,843	$ -	$ 201,477,843

Less: 2023 Net UPL Payments	$ 11,690,190
Less: 2025 Net DPP Payments	$ 20,658,099
Plus: 2024 Net DPP Recoupments	$ -
Less: GME Payments	$ -
Add: Net OP Settlement (Difference between provider submitted and estimated)	$ 1,522,214
Add: Provider tax excluded from the cost report (Medicaid primary & uninsured portion)	$ 1,520,621
Uncompensated Care Allocation Factor	$ 172,172,389
Hospital Specific DSH Limit	$ 155,537,805
2025 Eligibility	**Eligible**
DSH Year Low Income Utilization Ratio (LIUR):	17.69%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):	37.68%

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	9.00	9/11/2024

D. General Cost Report Year Information 10/1/2022 - 9/30/2023

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			
	10/1/2022 through 9/30/2023			
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:	1/17/2024			

	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: (10/01/2022 - 09/30/2023)

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)	$ 2,836,017	$ 10,168,790	$13,004,807
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 16,111,361	$ 81,049,941	$97,161,302
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$18,947,378	$91,218,731	$110,166,109
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	14.97%	11.15%	11.80%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** Yes

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 (10/01/2022 - 09/30/2023)

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)	227,906

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	222,586,709
8.	Outpatient Hospital Charity Care Charges	352,907,333
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 575,494,042

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	$ 720,744,313	$ -	$ -	$ 541,310,555	$ -	$ -	$ 179,433,758
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	$ 1,216,365,827	$ 2,513,999,865	$ -	$ 913,544,025	$ 1,888,124,038	$ -	$ 928,697,629
20.	Outpatient Services		$ 5,705,530,403	$ -		$ 4,285,103,293	$ -	$ 1,420,427,110
21.	Home Health Agency			$ -			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ -	$ -	$ 1,068,436,424	$ -	$ -	$ 802,442,563	$ -
27.	Total	$ 1,937,110,140	$ 8,219,530,268	$ 1,068,436,424	$ 1,454,854,580	$ 6,173,227,331	$ 802,442,563	$ 2,528,558,497
28.	Total Hospital and Non Hospital		Total from Above	$ 11,225,076,832		Total from Above	$ 8,430,524,474	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 11,225,076,832	Total Contractual Adj. (G-3 Line 2)	$ 8,430,524,474
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.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	$ -
36.	Adjusted Contractual Adjustments				8,430,524,474
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2022-09/30/2023 | 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	$ 217,018,358	$ -	$ -	-	**$ 217,018,358**	146,562	$ 301,704,283		**$ 1,480.73**
2	03100 INTENSIVE CARE UNIT	$ 28,877,520	$ -	$ -		**$ 28,877,520**	20,414	$ 130,023,529		**$ 1,414.59**
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
6	03500 OTHER SPECIAL CARE UNIT	$ 52,856,343	$ -	$ -		**$ 52,856,343**	30,687	$ 184,088,349		**$ 1,722.43**
7	04000 SUBPROVIDER I	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
8	04100 SUBPROVIDER II	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
10	04300 NURSERY	$ 71,926,040	$ -	$ -		**$ 71,926,040**	37,096	$ 104,928,152		**$ 1,938.92**
18	Total Routine	$ 370,678,261	$ -	$ -	$ -	$ 370,678,261	234,759	$ 720,744,313		
19	Weighted Average									$ 1,578.97

Line #		*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*
	Observation Data (Non-Distinct)								
20	09200 Observation (Non-Distinct)	6,853	-	-	**$ 10,147,443**	737,805	19,704,021	$ 20,441,826	**0.496406**

Line #		*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	$ 141,878,602	$ -	$ -		**$ 141,878,602**	$ 200,781,999	$ 557,029,092	$ 757,811,091	**0.187222**
22	5100 RECOVERY ROOM	$ 18,290,023	$ -	$ -		**$ 18,290,023**	$ 17,592,932	$ 51,489,026	$ 69,081,958	**0.264758**
23	5200 DELIVERY ROOM & LABOR ROOM	$ 96,437,840	$ -	$ -		**$ 96,437,840**	$ 178,197,458	$ 37,601,863	$ 215,799,321	**0.446887**
24	5300 ANESTHESIOLOGY	$ 2,890,379	$ -	$ -		**$ 2,890,379**	$ 40,909,825	$ 138,221,160	$ 179,130,985	**0.016136**
25	5400 RADIOLOGY-DIAGNOSTIC	$ 131,272,949	$ -	$ -		**$ 131,272,949**	$ 57,128,249	$ 422,046,872	$ 479,175,121	**0.273956**
26	5500 RADIOLOGY-THERAPEUTIC	$ 33,034,875	$ -	$ -		**$ 33,034,875**	$ 10,903,758	$ 261,666,398	$ 272,570,156	**0.121198**
27	5600 RADIOISOTOPE	$ 10,018,456	$ -	$ -		**$ 10,018,456**	$ 3,201,511	$ 55,757,610	$ 58,959,121	**0.169922**
28	5700 CT SCAN	$ 9,033,382	$ -	$ -		**$ 9,033,382**	$ 85,694,351	$ 289,433,526	$ 375,127,877	**0.024081**
29	5800 MRI	$ 10,954,223	$ -	$ -		**$ 10,954,223**	$ 24,509,342	$ 159,288,958	$ 183,798,300	**0.059599**
30	5900 CARDIAC CATHETERIZATION	$ 7,925,481	$ -	$ -		**$ 7,925,481**	$ 23,662,458	$ 48,993,994	$ 72,656,452	**0.109082**
31	6000 LABORATORY	$ 96,594,114	$ -	$ -		**$ 96,594,114**	$ 425,006,035	$ 437,644,874	$ 862,650,909	**0.111974**
32	6500 RESPIRATORY THERAPY	$ 21,209,885	$ -	$ -		**$ 21,209,885**	$ 59,586,616	$ 5,034,528	$ 64,621,144	**0.328219**
33	6600 PHYSICAL THERAPY	$ 13,167,762	$ -	$ -		**$ 13,167,762**	$ 24,502,872	$ 21,997,021	$ 46,499,893	**0.283178**
34	6700 OCCUPATIONAL THERAPY	$ 3,644,289	$ -	$ -		**$ 3,644,289**	$ 15,613,552	$ 1,324,223	$ 16,937,775	**0.215157**
35	6800 SPEECH PATHOLOGY	$ 2,048,278	$ -	$ -		**$ 2,048,278**	$ 11,782,568	$ 378,099	$ 12,160,667	**0.168435**
36	6900 ELECTROCARDIOLOGY	$ 6,554,864	$ -	$ -		**$ 6,554,864**	$ 33,975,565	$ 25,533,101	$ 59,508,666	**0.110150**
37	7000 ELECTROENCEPHALOGRAPHY	$ 1,029,942	$ -	$ -		**$ 1,029,942**	$ 3,316,736	$ 559,519	$ 3,876,255	**0.265705**
38	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 122,137,787	$ -	$ -		**$ 122,137,787**	$ 68,246,197	$ 114,976,173	$ 183,222,370	**0.666610**
39	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 82,149,336	$ -	$ -		**$ 82,149,336**	$ 111,841,204	$ 187,819,936	$ 299,661,140	**0.274141**
40	7300 DRUGS CHARGED TO PATIENTS	$ 531,465,053	$ -	$ -		**$ 531,465,053**	$ 680,814,678	$ 3,540,404,617	$ 4,221,219,295	**0.125903**
41	7400 RENAL DIALYSIS	$ 3,118,093	$ -	$ -		**$ 3,118,093**	$ 10,705,260	$ -	$ 10,705,260	**0.291267**
42	7500 ASC (NON-DISTINCT PART)	$ 20,620,065	$ -	$ -		**$ 20,620,065**	$ 14,850,787	$ 119,252,296	$ 134,103,083	**0.153763**
43	7600 OTHER ANCILLARY SERVICES	$ 3,023,878	$ -	$ -		**$ 3,023,878**	$ 41,376	$ 6,390,214	$ 6,431,590	**0.470160**
44	7700 ALLOGENEIC HSCT ACQUISITION	$ 3,042,800	$ -	$ -		**$ 3,042,800**	$ 1,627,494	$ 5,262,343	$ 6,889,837	**0.441636**
45	9000 CLINIC	$ 1,914,483	$ -	$ -		**$ 1,914,483**	$ 468	$ 725,652	$ 726,120	**2.636593**
46	9001 MENTAL HEALTH OP CLINIC	$ 6,353,169	$ -	$ -		**$ 6,353,169**	$ 114,624	$ 3,864,677	$ 3,979,301	**1.596554**
47	9002 CANCER CENTER	$ 190,413,487	$ -	$ -		**$ 190,413,487**	$ 2,088,138	$ 589,485,035	$ 591,573,173	**0.321876**
48	9100 EMERGENCY	$ 31,125,615	$ -	$ -		**$ 31,125,615**	$ 49,276,906	$ 163,526,559	$ 212,803,465	**0.146265**
126	**Total Ancillary**	$ 1,601,349,110	$ -	$ -		$ 1,601,349,110	$ 2,156,710,764	$ 7,265,411,387	$ 9,422,122,151	
127	**Weighted Average**									**0.171033**
128	**Sub Totals**	$ 1,972,027,371	$ -	$ -		$ 1,972,027,371	$ 2,877,455,077	$ 7,265,411,387	$ 10,142,866,464	
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**					**$ 1,972,027,371**				
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 (10/01/2022-09/30/2023) NORTHSIDE HOSPITAL

Line #	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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)
				Inpatient	Outpatient	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 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		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,480.73		14,293		12,857		5,174		10,742		1,209		11,541		**44,275**		**40.06%**
2	03100 INTENSIVE CARE UNIT	$ 1,414.59		3,367		317		785		1,193		98		1,774		**5,760**		37.01%
3	03200 CORONARY CARE UNIT	$ -		-		-		-		-		-		-		-		
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		-		
6	03500 OTHER SPECIAL CARE UNIT	$ 1,722.43		443		8,408		-		-		439		59		**13,056**		42.74%
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-		-		-		
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-		-		-		
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-		-		-		
10	04300 NURSERY	$ 1,938.92		12,803		8,274		-		880		540		583		**22,597**		62.51%
18			**Total Days**	30,906		29,856		5,959		16,681		2,286		13,957		85,688		**43.99%**
19	Total Days per PS&R or Exhibit Detail			30,906		29,856		5,959		16,681		2,286		13,957				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 81,372,943		$ 90,190,570		$ 15,966,655		$ 56,139,108		$ 6,734,510		$ 38,026,883		**$ 242,665,438**		39.17%
21.01	Calculated Routine Charge Per Diem			$ 2,632.89		$ 3,020.85		$ 2,679.42		$ 3,365.46		$ 2,945.98		$ 2,724.72		$ 2,843.67		
	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**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.496406	$ 182,351	$ 1,347,448	$ 91,056	$ 1,233,546	$ 62,546	$ 222,737	$ 45,009	$ 1,015,433	$ 1,404	$ 197,172	$ 6,363	$ 1,009,950	$ 381,365	$ 3,819,164	26.60%
23	5000 OPERATING ROOM		0.187222	$ 15,587,699	$ 4,565,738	$ 9,854,470	$ 14,630,517	$ 5,947,102	$ 6,439,893	$ 9,246,664	$ 14,512,827	$ 1,092,593	$ 2,038,465	$ 10,622,603	$ 23,697,275	$ 40,635,927	$ 40,148,976	
24	5100 RECOVERY ROOM		0.264738	$ 3,021,248	$ 658,370	$ 1,193,570	$ 1,548,669	$ 235,074	$ 683,717	$ 609,006	$ 1,506,801	$ 93,921	$ 231,932	$ 576,116	$ 2,379,602	$ 5,061,903	$ 4,497,556	
25	5200 DELIVERY ROOM & LABOR ROOM		0.446887	$ 14,457,516	$ 70,063	$ 29,249,135	$ 5,918,137	$ 3,749,624	$ 264,246	$ 11,971,200	$ 1,840,346	$ 1,736,339	$ 531,469	$ 8,906,066	$ 2,974,078	$ 59,427,469	$ 8,092,793	
26	5300 ANESTHESIOLOGY		0.016136	$ 2,304,750	$ 978,808	$ 1,719,249	$ 3,540,009	$ 1,144,774	$ 1,599,391	$ 1,710,498	$ 3,521,784	$ 186,498	$ 446,623	$ 2,315,745	$ 5,499,505	$ 6,879,271	$ 9,639,992	3.30%
27	5400 RADIOLOGY-DIAGNOSTIC		0.273956	$ 3,713,891	$ 2,926,113	$ 5,413,756	$ 14,451,170	$ 2,345,132	$ 7,841,828	$ 5,017,297	$ 14,307,539	$ 496,399	$ 1,407,316	$ 5,182,702	$ 28,838,007	$ 16,490,078	$ 39,526,650	132.93%
28	5500 RADIOLOGY-THERAPEUTIC		0.121198	$ 600,713	$ 3,554,664	$ 447,866	$ 4,598,736	$ 844,877	$ 9,225,086	$ 879,372	$ 16,356,807	$ 28,762	$ 1,476,431	$ 843,051	$ 16,746,013	$ 2,772,827	$ 33,735,293	25.90%
29	5600 RADIOISOTOPE		0.169922	$ 405,362	$ 141,598	$ 138,713	$ 470,253	$ 301,635	$ 1,229,340	$ 444,089	$ 2,239,390	$ 30,861	$ 52,695	$ 1,179,175	$ 2,862,897	$ 1,289,799	$ 4,080,581	5.73%
30	5700 CT SCAN		0.024081	$ 5,208,363	$ 4,485,416	$ 3,072,347	$ 5,091,908	$ 3,789,441	$ 4,909,467	$ 6,223,675	$ 7,377,882	$ 490,723	$ 567,304	$ 11,148,771	$ 18,929,864	$ 18,293,857	$ 21,851,669	14.91%
31	5800 MRI		0.059599	$ 1,626,757	$ 2,481,697	$ 1,094,878	$ 5,022,488	$ 985,579	$ 5,102,251	$ 1,714,415	$ 9,125,815	$ 125,873	$ 1,079,390	$ 3,423,508	$ 10,716,931	$ 5,424,429	$ 22,732,250	15.98%
32	5900 CARDIAC CATHETERIZATION		0.109082	$ 3,670,191	$ 103,986	$ 3,613,187	$ 699,053	$ 1,995,118	$ 858,362	$ 3,391,012	$ 1,741,132	$ 267,840	$ 101,323	$ 5,766,092	$ 1,788,776	$ 12,669,508	$ 3,402,533	40.80%
33	6000 LABORATORY		0.111974	$ 44,824,158	$ 15,092,164	$ 33,797,718	$ 15,929,448	$ 15,465,437	$ 10,753,769	$ 30,885,970	$ 20,512,220	$ 3,260,202	$ 2,574,334	$ 40,312,545	$ 30,440,490	$ 124,973,284	$ 62,287,601	70.88%
34	6500 RESPIRATORY THERAPY		0.328219	$ 4,390,021	$ 97,027	$ 5,465,960	$ 102,303	$ 880,418	$ 69,224	$ 5,195,223	$ 265,305	$ 322,344	$ 13,607	$ 2,505,212	$ 315,627	$ 15,931,622	$ 533,859	10.72%
35	6600 PHYSICAL THERAPY		0.283178	$ 1,148,462	$ 100,122	$ 510,593	$ 187,450	$ 974,324	$ 334,643	$ 1,476,003	$ 404,582	$ 79,277	$ 79,907	$ 1,380,713	$ 1,979,167	$ 4,109,382	$ 1,026,797	11.94%
36	6700 OCCUPATIONAL THERAPY		0.215157	$ 1,522,290	$ 45,495	$ 1,142,559	$ 37,622	$ 807,122	$ 199,811	$ 1,520,306	$ 240,381	$ 110,872	$ 90,674	$ 1,111,474	$ 361,348	$ 4,992,277	$ 523,309	0.94%
37	6800 SPEECH PATHOLOGY		0.168435	$ 1,960,179	$ 2,805	$ 1,799,458	$ 48,821	$ 345,533	$ 88,686	$ 865,541	$ 112,223	$ 136,068	$ 18,079	$ 924,926	$ 173,348	$ 4,930,711	$ 252,535	9.33%
38	6900 ELECTROCARDIOLOGY		0.110150	$ 1,066,983	$ 308,845	$ 260,365	$ 282,327	$ 339,763	$ 188,433	$ 539,546	$ 542,255	$ 37,236	$ 23,354	$ 807,563	$ 633,429	$ 2,206,658	$ 1,321,860	10.82%
39	7000 ELECTROENCEPHALOGRAPHY		0.265705	$ -	$ -	$ 613,019	$ 8,768	$ 136,616	$ 60,668	$ 415,504	$ 18,469	$ 108,191	$ 738	$ 357,808	$ 46,230	$ 1,165,140	$ 87,906	10.44%
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.666610	$ 2,980,393	$ 1,299,839	$ 483,093	$ 103,138	$ 76,540	$ 22,221	$ 193,408	$ 140,223	$ 31,156	$ 50,353	$ 156,739	$ 1,208,679	$ 3,733,434	$ 1,565,421	55.48%
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.274141	$ 3,838,949	$ 1,885,157	$ 3,090,615	$ 2,758,634	$ 4,817,363	$ 3,186,640	$ 4,376,901	$ 4,700,675	$ 526,768	$ 87,485	$ 3,229,506	$ 5,920,828	$ 16,123,828	$ 12,531,106	64.61%
42	7300 DRUGS CHARGED TO PATIENTS		0.125903	$ 46,531,982	$ 84,994,804	$ 36,789,613	$ 58,003,941	$ 19,667,168	$ 112,476,320	$ 37,545,978	$ 167,027,457	$ 3,714,669	$ 5,900,174	$ 48,856,974	$ 164,100,043	$ 140,535,741	$ 422,502,522	20561.03%
43	7400 RENAL DIALYSIS		0.291267	$ 928,876	$ -	$ 205,188	$ -	$ 1,309,328	$ -	$ 1,948,524	$ -	$ 127,428	$ -	$ 955,012	$ -	$ 4,391,916	$ -	2.99%
44	7500 ASC (NON-DISTINCT PART)		0.153763	$ -	$ 50,213	$ 1,263,116	$ 3,369,913	$ 752,106	$ 1,500,165	$ 1,343,156	$ 3,677,186	$ 132,628	$ 441,933	$ 1,400,736	$ 4,972,836	$ 3,358,378	$ 8,597,477	6.31%
45	7600 OTHER ANCILLARY SERVICES		0.470160	$ -	$ -	$ -	$ 177,685	$ -	$ 35,040	$ -	$ 127,546	$ -	$ 61,968	$ -	$ 237,062	$ -	$ 340,241	0.02%
46	7700 ALLOGENEIC HSCT ACQUISITION		0.441636	$ 4,162,689	$ -	$ 34,873	$ 144,871	$ 2,114,308	$ 12,564	$ 56,995	$ 81,554	$ 3,745	$ 18,251	$ 87,969	$ 110,524	$ 6,368,856	$ 238,989	63.78%
47	9000 CLINIC		2.636593	$ -	$ -	$ 28,271	$ 127,346	$ -	$ 3,207	$ 7,440	$ 38,352	$ 1,969	$ 12,876	$ 954	$ 71,274	$ 35,711	$ 168,905	0.22%
48	9001 MENTAL HEALTH OP CLINIC		1.596554	$ 6,730	$ 73,909	$ 2,479	$ 125,212	$ -	$ 64,784	$ 7,293	$ 396,690	$ 1,122	$ 294,419	$ 42,309	$ 786,882	$ 16,502	$ 660,601	28.02%
49	9002 CANCER CENTER		0.321876	$ 19,365	$ 1,301,345	$ 395,526	$ 14,413,705	$ 106,304	$ 13,133,290	$ 362,197	$ 21,903,861	$ 32,472	$ 1,374,112	$ 353,158	$ 23,401,804	$ 883,392	$ 50,752,201	1121.48%
50	9100 EMERGENCY		0.146265	$ 3,702,905	$ 11,393,230	$ 2,489,961	$ 15,090,664	$ 2,306,163	$ 3,123,030	$ 4,734,182	$ 7,473,269	$ 429,017	$ 1,529,768	$ 8,295,210	$ 42,727,732	$ 13,233,211	$ 37,080,193	14283.67%
				167,865,829	137,958,856	144,220,443	169,206,300	71,502,797	183,625,812	132,727,405	301,208,010	13,606,379	20,702,152	160,529,091	392,730,801			
	Totals / Payments																	
128	**Total Charges** *(includes organ acquisition from Section J)*			**$ 249,237,874**	**$ 137,958,856**	**$ 234,411,013**	**$ 169,206,300**	**$ 87,469,452**	**$ 183,625,812**	**$ 188,866,573**	**$ 301,208,010**	**$ 20,340,889**	**$ 20,702,152**	**$ 198,557,984** (Agrees to Exhibit A)	**$ 392,730,801** (Agrees to Exhibit A)	**$ 759,984,912**	**$ 791,998,978**	**21.30%**
129	Total Charges per PS&R or Exhibit Detail			$ 249,237,874	$ 137,958,856	$ 234,411,013	$ 169,206,300	$ 87,469,452	$ 183,625,812	$ 188,866,573	$ 301,208,010	$ 20,340,889	$ 20,702,152	$ 198,557,984	$ 392,730,801			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**															$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			**$ 82,728,586**	**$ 19,358,686**	**$ 80,507,754**	**$ 29,739,638**	**$ 21,089,620**	**$ 27,146,915**	**$ 49,370,973**	**$ 46,277,822**	**$ 6,279,473**	**$ 3,864,395**	**$ 45,159,674**	**$ 62,139,622**	$ 233,696,933	$ 122,523,061	23.63%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 43,654,114	$ 12,681,510	$ 1,617	$ 1,352	$ 75,698	$ 3,047,724	$ 2,534,217	$ 2,782,414					$ 46,265,646	$ 18,513,000	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 47,054,782	$ 17,561,781	$ -	$ -	$ -	$ 761,582	$ 416,741				$ 41,816,364	$ 17,978,523	
134	Private Insurance (including primary and third party liability)			$ 1,245,318	$ 15,114	$ 44,698	$ 46,308	$ -	$ 2,460	$ 29,380,103	$ 15,716,329					$ 30,670,119	$ 15,780,261	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ 1,243	$ 22,583	$ -	$ -	$ 29,914	$ 93,257	$ 10,156	$ 39,329			$ 31,157	$ 115,850	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 44,899,432	$ 12,696,624	$ 41,102,340	$ 17,632,086											
137	Medicaid Cost Settlement Payments (See Note B)			$ -	$ (633,825)	$ -	$ -									$ -	$ (633,825)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)			$ -	$ -	$ -	$ -									$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)			$ -		$ -		$ 14,097,374	$ 18,150,113	$ 2,519,262	$ 1,246,584	$ -		$ -		$ 16,616,636	$ 19,396,697	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ 37,505,978	$ 24,602,203					$ 10,707,297	$ 24,602,203	
141	Medicare Cross-Over Bad Debt Payments							$ 285,938	$ 277,156	$ -	$ -			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 285,938	$ 277,156	
142	Other Medicare Cross-Over Payments (See Note D)							$ -	$ -	$ -	$ -					$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)													$ 2,836,017	$ 10,168,790			
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)**			$ 37,829,154	$ 7,295,887	$ 39,405,414	$ 12,107,553	$ 6,630,610	$ 5,669,462	$ 3,438,599	$ 1,420,293	$ 6,269,315	$ 3,825,066	$ 42,323,657	$ 51,970,732	$ 87,303,776	$ 26,493,195	
146	**Calculated Payments as a Percentage of Cost**			54%	62%	51%	59%	69%	79%	93%	97%	0%	1%	6%	16%	63%	78%	
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)**							46,298										
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.

Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2022-09/30/2023) 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 & with Medicaid Secondary)		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	$ 1,480.73		77		-		48		22		147	
2	03100 INTENSIVE CARE UNIT	$ 1,414.59		21		-		-		1		22	
3	03200 CORONARY CARE UNIT	$ -		-		-		-		-		-	
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
6	03500 OTHER SPECIAL CARE UNIT	$ 1,722.43		-		-		-		-		-	
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-	
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-	
10	04300 NURSERY	$ 1,938.92		9		-		-		-		9	
18			**Total Days**	107		-		48		23		178	
19	Total Days per PS&R or Exhibit Detail			107		-		48		23			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 476,170		$ -		$ 111,470		$ 56,898		$ 644,538	
21.01	Calculated Routine Charge Per Diem			$ 4,450.19		$ -		$ 2,322.29		$ 2,473.83		$ 3,621.00	
	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)		0.496406	5,817	1,659	-	-	4,821	2,679	-	8,061	$ 10,638	$ 12,399
23	5000 OPERATING ROOM		0.187222	95,317	-	-	-	39,507	-	162,041	-	$ 296,865	$ -
24	5100 RECOVERY ROOM		0.264758	-	-	-	-	-	-	-	-	$ -	$ -
25	5200 DELIVERY ROOM & LABOR ROOM		0.446887	21,330	-	-	-	-	-	-	-	$ 21,330	$ -
26	5300 ANESTHESIOLOGY		0.016136	2,685	15,276	-	-	-	-	-	10,036	$ 2,685	$ 25,312
27	5400 RADIOLOGY-DIAGNOSTIC		0.273956	19,920	30,346	-	-	14,238	2,360	4,896	16,491	$ 39,054	$ 49,197
28	5500 RADIOLOGY-THERAPEUTIC		0.121198	765	3,165	-	-	-	162,231	-	118,622	$ 765	$ 284,018
29	5600 RADIOISOTOPE		0.169922	-	-	-	-	-	-	-	762,456	$ -	$ 762,456
30	5700 CT SCAN		0.024081	69,276	-	-	-	54,430	-	20,169	-	$ 143,875	$ -
31	5800 MRI		0.059599	-	12,752	-	-	5,373	13,212	5,373	13,212	$ 10,746	$ 39,176
32	5900 CARDIAC CATHETERIZATION		0.109082	32,634	-	-	-	17,363	3,837	3,837	1,259	$ 53,834	$ 5,096
33	6000 LABORATORY		0.111974	278,147	475,468	-	-	106,532	699,526	76,148	394,683	$ 460,827	$ 1,569,677
34	6500 RESPIRATORY THERAPY		0.328219	79,351	1,905	-	-	-	-	1,270	-	$ 80,621	$ 1,905
35	6600 PHYSICAL THERAPY		0.283178	10,575	1,114	-	-	4,522	1,138	1,527	618	$ 16,624	$ 2,870
36	6700 OCCUPATIONAL THERAPY		0.215157	13,011	-	-	-	3,885	854	1,771	-	$ 18,667	$ 854
37	6800 SPEECH PATHOLOGY		0.168435	6,551	-	-	-	1,843	1,331	1,736	-	$ 10,130	$ 1,331
38	6900 ELECTROCARDIOLOGY		0.110150	-	-	-	-	-	-	-	-	$ -	$ -
39	7000 ELECTROENCEPHALOGRAPHY		0.265705	-	-	-	-	3,015	-	-	-	$ 3,015	$ -
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.666610	-	-	-	-	-	-	1,325	172	$ 1,325	$ 172
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.274141	-	22,144	-	-	-	-	4,475	204	$ 4,475	$ 22,348
42	7300 DRUGS CHARGED TO PATIENTS		0.125903	407,478	242,452	-	-	198,106	6,682,603	72,581	3,784,678	$ 678,165	$ 10,709,734
43	7400 RENAL DIALYSIS		0.291267	-	-	-	-	-	-	-	-	$ -	$ -
44	7500 ASC (NON-DISTINCT PART)		0.153763	-	-	-	-	-	1,140	-	4,370	$ -	$ 5,510
45	7600 OTHER ANCILLARY SERVICES		0.470160	-	-	-	-	-	-	-	-	$ -	$ -
46	7700 ALLOGENEIC HSCT ACQUISITION		0.441636	-	-	-	-	-	-	-	-	$ -	$ -
47	9000 CLINIC		2.636593	-	-	-	-	-	-	-	-	$ -	$ -
48	9001 MENTAL HEALTH OP CLINIC		1.596554	-	561	-	-	-	-	-	-	$ -	$ 561
49	9002 CANCER CENTER		0.321876	226	13,894	-	-	-	242,606	-	213,975	$ 226	$ 470,475
50	9100 EMERGENCY		0.146265	29,265	281,117	-	-	17,113	36,201	16,965	40,777	$ 63,343	$ 358,095
44				1,072,348	1,101,854	-	-	470,748	7,849,718	374,114	5,369,614		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			**$ 1,548,518**	**$ 1,101,854**	**$ -**	**$ -**	**$ 582,218**	**$ 7,849,718**	**$ 431,012**	**$ 5,369,614**	**$ 2,561,747**	**$ 14,321,185**
129	Total Charges per PS&R or Exhibit Detail			$ 1,548,518	$ 1,101,854	$ -	$ -	$ 582,218	$ 7,849,718	$ 431,012	$ 5,369,614		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)											$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			**$ 322,002**	**$ 147,789**	**$ -**	**$ -**	**$ 130,892**	**$ 1,026,822**	**$ 90,673**	**$ 750,093**	**$ 543,567**	**$ 1,924,704**
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 15,925	$ 2,801	$ -	$ -	$ -	$ 53,449	$ -	$ 29,994	$ 15,925	$ 86,244
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)			$ -	$ -	$ -	$ -	$ -	$ (245)	$ 10,712	$ 53,997	$ 10,712	$ 53,752
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 944	$ -	$ 944
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 15,925	$ 2,801	$ -	$ -						
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) (See Note F)			$ -		$ -		$ 69,495	$ 682,348	$ -	$ -	$ 69,495	$ 682,348
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 20,289	$ 79,595	$ 56,165	$ 736,445	$ 76,454	$ 816,040
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)**			$ 306,077	$ 144,988	$ -	$ -	$ 41,108	$ 211,675	$ 23,795	$ (71,287)	$ 370,981	$ 285,376
144	**Calculated Payments as a Percentage of Cost**			5%	2%	0%	0%	69%	79%	74%	110%	32%	85%

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.
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

Cost Report Year (10/01/2022-09/30/2023) 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	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 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	$ -	0
2	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
3	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
4	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
5	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
6	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
7	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
8		$ -	$ -	$ -	$ -	0	$ -	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 (10/01/2022-09/30/2023) 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 Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Included Elsewhere & with Medicaid Secondary)	
							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 (10/01/2022-09/30/2023) 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)*		$ 29,924,702		
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)		$ 29,924,702	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	$ (10,817,440)	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		$ 19,107,262		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 10,817,440
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	1,609,909,863
19	Uninsured Hospital	**Charges Sec. G**	591,288,786
20	Total Hospital	**Charges Sec. G**	10,142,866,464
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		15.87%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		5.83%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ 1,716,980
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 630,614
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$ 2,347,594**
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	793,464,414
27	Uninsured Hospital	**Charges Sec. G**	632,331,826
28	Total Hospital	**Charges Sec. G**	10,142,866,464
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		7.82%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.23%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ 846,235
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 674,386
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$ 1,520,621**

** 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.*

****For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.*

DSH Examination Eligibility Summary

Hospital Name	**NORTHSIDE HOSPITAL**
Hospital Medicaid Number	**000001405A**
Cost Report Period	From **10/1/2022** To **9/30/2023**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 125,417,202	$ -	$ 125,417,202
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 125,417,202	$ -	$ 125,417,202
4	Net Hospital Patient Revenue	Survey F-3	$ 2,794,552,358	$ (265,993,861)	$ 2,528,558,497
5	Medicaid Fraction		4.49%	0.47%	4.96%
6	Inpatient Charity Care Charges	Survey F-2	$ 222,586,709	$ -	$ 222,586,709
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 222,586,709	$ -	$ 222,586,709
10	Inpatient Hospital Charges	Survey F-3	$ 1,963,641,177	$ (26,531,037)	$ 1,937,110,140
11	Inpatient Charity Fraction		11.34%	0.15%	11.49%
12	LIUR		15.83%	0.62%	16.45%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	85,688	-	85,688
14	Out-of-State Medicaid Eligible Days	Survey I	178	-	178
15	Total Medicaid Eligible Days		85,866	-	85,866
16	Total Hospital Days (excludes swing-bed)	Survey F-1	227,906	-	227,906
17	MIUR		37.68%	0.00%	37.68%

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 10/1/2022 To 9/30/2023

As-Reported:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	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	82,728,586	43,654,114	-	1,245,318	-	-	-	-	-	-	-			44,899,432	37,829,154	54.27%
2	Medicaid Fee for Service	Outpatient	19,358,686	12,681,510	-	15,114	-	(633,825)	-	-	-	-	-			12,062,799	7,295,887	62.31%
3	Medicaid Managed Care	Inpatient	80,507,754	1,617	41,054,782	44,698	1,243	-	-	-						41,102,340	39,405,414	51.05%
4	Medicaid Managed Care	Outpatient	29,739,638	1,352	17,561,781	46,358	22,593	-	-							17,632,085	12,107,553	59.29%
5	Medicare Cross-over (FFS)	Inpatient	21,089,620	75,698	-	-	-		-	14,097,374	-	285,938	-			14,459,010	6,630,610	68.56%
6	Medicare Cross-over (FFS)	Outpatient	27,146,915	3,047,724	-	2,460	-		-	18,150,113	-	277,156	-			21,477,453	5,669,462	79.12%
7	Other Medicaid Eligibles	Inpatient	49,370,973	2,534,217	761,582	29,380,103	29,914			2,519,262	10,707,297	-	-			45,932,374	3,438,599	93.04%
8	Other Medicaid Eligibles	Outpatient	46,277,822	2,782,414	416,741	15,716,329	93,257			1,246,584	24,602,203	-	-			44,857,529	1,420,293	96.93%
9	Uninsured	Inpatient	51,439,147				10,158			-				2,836,017	-	2,846,175	48,592,972	5.53%
10	Uninsured	Outpatient	66,003,917				39,329			-				10,168,790	-	10,208,119	55,795,798	15.47%
11	In-State Sub-total	Inpatient	285,136,080	46,265,646	41,816,364	30,670,119	41,315	-	-	16,616,636	10,707,297	285,938	-	2,836,017	-	149,239,331	135,896,749	52.34%
12	In-State Sub-total	Outpatient	188,526,978	18,513,000	17,978,523	15,780,261	155,179	(633,825)	-	19,396,697	24,602,203	277,156	-	10,168,790	-	106,237,985	82,288,993	56.35%
13	Out-of-State Medicaid	Inpatient	543,567	15,925	-	10,712	-	-	-	69,495	76,454	-	-			172,586	370,981	31.75%
14	Out-of-State Medicaid	Outpatient	1,924,704	86,244	-	53,752	944	-	-	682,348	816,040	-	-			1,639,328	285,376	85.17%
15	Sub-Total	I/P and O/P	476,131,329	64,880,816	59,794,887	46,514,844	197,438	(633,825)	-	36,765,176	36,201,994	563,094	-	13,004,807	-	257,289,231	218,842,098	54.04%
15.01	Provider Tax Assessment Adjustment to UCC																2,347,594	

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 **10/1/2022** To **9/30/2023**
As-Adjusted:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	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	82,728,586	43,654,114	-	1,245,318	-	-	-	-	-	-	-			44,899,432	37,829,154	54.27%
2	Medicaid Fee for Service	Outpatient	19,358,686	12,681,510	-	15,114	-	(633,825)	-	-	-	-	-			12,062,799	7,295,887	62.31%
3	Medicaid Managed Care	Inpatient	80,507,754	1,617	41,054,782	44,698	1,243	-	-	-						41,102,340	39,405,414	51.05%
4	Medicaid Managed Care	Outpatient	29,739,638	1,352	17,561,781	46,358	22,593	-	-							17,632,085	12,107,553	59.29%
5	Medicare Cross-over (FFS)	Inpatient	21,089,620	75,698	-	-	-			14,097,374	-	285,938	-			14,459,010	6,630,610	68.56%
6	Medicare Cross-over (FFS)	Outpatient	27,146,915	3,047,724	-	2,460	-			18,150,113	-	277,156	-			21,477,453	5,669,462	79.12%
7	Other Medicaid Eligibles	Inpatient	49,370,973	2,534,217	761,582	29,380,103	29,914			2,519,262	10,707,297	-	-			45,932,374	3,438,599	93.04%
8	Other Medicaid Eligibles	Outpatient	46,277,822	2,782,414	416,741	15,716,329	93,257			1,246,584	24,602,203	-	-			44,857,529	1,420,293	96.93%
9	Uninsured	Inpatient	51,439,147	-	-	-	10,158	-	-	-	-	-	-	2,836,017	-	2,846,175	48,592,972	5.53%
10	Uninsured	Outpatient	66,003,917	-	-	-	39,329	-	-	-	-	-	-	10,168,790	-	10,208,119	55,795,798	15.47%
11	In-State Sub-total	Inpatient	285,136,080	46,265,646	41,816,364	30,670,119	41,315	-	-	16,616,636	10,707,297	285,938	-	2,836,017	-	149,239,331	135,896,749	52.34%
12	In-State Sub-total	Outpatient	188,526,978	18,513,000	17,978,523	15,780,261	155,179	(633,825)	-	19,396,697	24,602,203	277,156	-	10,168,790	-	106,237,985	82,288,993	56.35%
13	Out-of-State Medicaid	Inpatient	543,567	15,925	-	10,712	-	-	-	69,495	76,454	-	-			172,586	370,981	31.75%
14	Out-of-State Medicaid	Outpatient	1,924,704	86,244	-	53,752	944	-	-	682,348	816,040	-	-			1,639,328	285,376	85.17%
15	Cost Report Year Sub-Total	I/P and O/P	476,131,329	64,880,816	59,794,887	46,514,844	197,438	(633,825)	-	36,765,176	36,201,994	563,094	-	13,004,807	-	257,289,231	218,842,098	54.04%
15.01															Provider Tax Assessment Adjustment to UCC Including all Medicaid Eligibles		2,347,594	
16															Less: Out of State DSH Payments from Adjusted Survey		-	
17															Adjusted Sub-Total UCC Including All Medicaid Eligibles and Uninsured Prior to Supplemental Medicaid Payments		221,189,692	
18															Less: Non-Medicaid Primary Provider Tax Assessment Adjustment to UCC		826,973	
19															Less: Non-Medicaid Primary UCC Prior to Supplemental Medicaid Payments		17,364,255	
20															Adjusted Sub-Total UCC Including Only Medicaid-Primary Payors and Uninsured Prior to Supplemental Medicaid Payments		202,998,464	

Medicaid DSH Survey Adjustments

PROVIDER: NORTHSIDE HOSPITAL
Mcaid Number: 000001405A
FROM: 10/1/2022 TO: 9/30/2023
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.
1	E - Disclosure of Medicaid / Uninsured Payments	13	Did your hospital receive any Medicaid managed care payments not paid at the claim leve	2.00	Amount - Outpatient	Adjust based on provider's correspondence.	$ -	Yes	Yes	1101
2	F - MIUR/LIUR Data	26	Other	1.00	Inpatient Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	$ 26,531,037	$ (26,531,037)	$ -	2002
2	F - MIUR/LIUR Data	26	Other	2.00	Outpatient Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	$ 1,041,905,387	$ (1,041,905,387)	$ -	2002
2	F - MIUR/LIUR Data	26	Other	3.00	Non-Hospital Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	$ -	$ 1,068,436,424	$ 1,068,436,424	2002
2	F - MIUR/LIUR Data	26	Other	4.00	Inpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ 19,925,971	$ (19,925,971)	$ -	2002
2	F - MIUR/LIUR Data	26	Other	5.00	Outpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ 782,516,592	$ (782,516,592)	$ -	2002
2	F - MIUR/LIUR Data	26	Other	6.00	Non-Hospital Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ -	$ 802,442,563	$ 802,442,563	2002

Medicaid DSH Report Notes

PROVIDER: NORTHSIDE HOSPITAL
Mcaid Number: 000001405A
FROM: 10/1/2022 TO: 9/30/2023
Mcare Number: 110161

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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