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-FORSYTH
Mcaid Provider Number	000000767A
Mcare Provider Number	110005

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	$ 38,887,678	$ -	$ 38,887,678

Less: 2023 Net UPL Payments	$ 3,430,007
Less: 2025 Net DPP Payments	$ 3,864,358
Plus: 2024 Net DPP Recoupments	$ -
Less: GME Payments	$ -
Add: Net OP Settlement (Difference between provider submitted and estimated)	$ 226,294
Add: Provider tax excluded from the cost report (Medicaid primary & uninsured portion)	$ 221,826
Uncompensated Care Allocation Factor	$ 32,041,433
Hospital Specific DSH Limit	$ 28,290,423
2025 Eligibility	**Eligible**
DSH Year Low Income Utilization Ratio (LIUR):	11.83%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):	17.69%

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-FORSYTH			
	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):	1 - As Submitted			
3a. Date CMS processed the HCRIS file into the HCRIS database:	3/4/2024			

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	NORTHSIDE HOSPITAL-FORSYTH	Yes	
5. Medicaid Provider Number:	000000767A	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:	110005	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)	$ 1,605,769	$ 4,528,521	$6,134,290
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 8,346,029	$ 32,133,274	$40,479,303
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$9,951,798	$36,661,795	$46,613,593
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	16.14%	12.35%	13.16%

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

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

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

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2022 - 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)	116,958

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	91,023,791
8.	Outpatient Hospital Charity Care Charges	83,688,071
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 174,711,862

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	$ 342,519,247	$ -	$ -	$ 273,602,064	$ -	$ -	$ 68,917,183
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	$ 813,510,496	$ 1,351,578,120	$ -	$ 649,826,695	$ 1,079,631,483	$ -	$ 435,630,437
20.	Outpatient Services		$ 798,591,915	$ -		$ 637,909,834	$ -	$ 160,682,081
21.	Home Health Agency			$ -			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ 22,729,966	$ 263,995,631	$ -	$ 18,156,543	$ 210,877,929	$ -	$ 57,691,125
27.	Total	$ 1,178,759,709	$ 2,414,165,666	$ -	$ 941,585,302	$ 1,928,419,246	$ -	$ 722,920,827
28.	Total Hospital and Non Hospital		Total from Above	$ 3,592,925,375		Total from Above	$ 2,870,004,548	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 3,592,925,375	Total Contractual Adj. (G-3 Line 2)	$ 2,870,004,548
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				2,870,004,548
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-FORSYTH

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	$ 123,002,553	$ -	$ -	-	**$ 123,002,553**	102,627	$ 237,481,792		**$ 1,198.54**
2	03100 INTENSIVE CARE UNIT	$ 18,693,009	$ -	$ -		**$ 18,693,009**	6,296	$ 40,131,596		**$ 2,969.03**
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
6	03500 OTHER SPECIAL CARE UNIT	$ 12,330,389	$ -	$ -		**$ 12,330,389**	6,711	$ 41,329,459		**$ 1,837.34**
7	04000 SUBPROVIDER I	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
8	04100 SUBPROVIDER II	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
10	04300 NURSERY	$ 16,309,675	$ -	$ -		**$ 16,309,675**	8,314	$ 23,576,400		**$ 1,961.71**
11	3301 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
18	Total Routine	$ 170,335,626	$ -	$ -	$ -	$ 170,335,626	123,948	$ 342,519,247		
19	Weighted Average									$ 1,374.25

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)	6,990	-	-	**$ 8,377,795**	1,047,051	14,863,510	$ 15,910,561	**0.526556**

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	$ 62,230,769	$ -	$ -		**$ 62,230,769**	$ 91,248,764	$ 239,086,026	$ 330,334,790	**0.188387**
22	5100	RECOVERY ROOM	$ 10,827,230	$ -	$ -		**$ 10,827,230**	$ 7,796,211	$ 28,203,974	$ 36,000,185	**0.300755**
23	5200	DELIVERY ROOM & LABOR ROOM	$ 26,442,582	$ -	$ -		**$ 26,442,582**	$ 42,544,087	$ 10,609,460	$ 53,153,547	**0.497475**
24	5300	ANESTHESIOLOGY	$ 1,349,059	$ -	$ -		**$ 1,349,059**	$ 21,766,654	$ 55,013,859	$ 76,780,513	**0.017570**
25	5400	RADIOLOGY-DIAGNOSTIC	$ 33,922,263	$ -	$ -		**$ 33,922,263**	$ 39,658,023	$ 281,374,474	$ 321,032,497	**0.105666**
26	5500	RADIOLOGY-THERAPEUTIC	$ 8,988,779	$ -	$ -		**$ 8,988,779**	$ 8,671,369	$ 115,878,789	$ 124,550,158	**0.072170**
27	5600	RADIOISOTOPE	$ 2,446,578	$ -	$ -		**$ 2,446,578**	$ 6,730,916	$ 27,006,634	$ 33,737,550	**0.072518**
28	5700	CT SCAN	$ 6,229,720	$ -	$ -		**$ 6,229,720**	$ 67,233,462	$ 106,042,860	$ 173,276,322	**0.035953**
29	5800	MRI	$ 4,960,819	$ -	$ -		**$ 4,960,819**	$ 20,344,757	$ 30,132,610	$ 50,477,367	**0.098278**
30	5900	CARDIAC CATHETERIZATION	$ 6,595,419	$ -	$ -		**$ 6,595,419**	$ 38,894,439	$ 51,933,073	$ 90,827,512	**0.072615**
31	6000	LABORATORY	$ 22,492,340	$ -	$ -		**$ 22,492,340**	$ 210,378,271	$ 134,575,593	$ 344,953,864	**0.065204**
32	6500	RESPIRATORY THERAPY	$ 15,284,004	$ -	$ -		**$ 15,284,004**	$ 41,341,305	$ 5,298,282	$ 46,639,587	**0.327705**
33	6600	PHYSICAL THERAPY	$ 11,063,650	$ -	$ -		**$ 11,063,650**	$ 21,680,770	$ 35,992,159	$ 57,672,929	**0.191834**
34	6700	OCCUPATIONAL THERAPY	$ 3,359,157	$ -	$ -		**$ 3,359,157**	$ 16,809,532	$ 1,248,732	$ 18,058,264	**0.186018**
35	6800	SPEECH PATHOLOGY	$ 1,465,321	$ -	$ -		**$ 1,465,321**	$ 8,504,437	$ 482,733	$ 8,987,170	**0.163046**
36	6900	ELECTROCARDIOLOGY	$ 10,599,058	$ -	$ -		**$ 10,599,058**	$ 26,528,381	$ 17,807,355	$ 44,335,736	**0.239064**
37	7000	ELECTROENCEPHALOGRAPHY	$ 480,252	$ -	$ -		**$ 480,252**	$ 1,774,416	$ 776,804	$ 2,551,220	**0.188244**
38	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$ 57,798,847	$ -	$ -		**$ 57,798,847**	$ 38,010,120	$ 59,092,935	$ 97,103,055	**0.595232**
39	7200	IMPL. DEV. CHARGED TO PATIENTS	$ 59,220,870	$ -	$ -		**$ 59,220,870**	$ 103,594,582	$ 151,021,768	$ 254,616,350	**0.232589**
40	7300	DRUGS CHARGED TO PATIENTS	$ 73,064,098	$ -	$ -		**$ 73,064,098**	$ 275,697,708	$ 226,872,353	$ 502,570,061	**0.145381**
41	7400	RENAL DIALYSIS	$ 2,782,142	$ -	$ -		**$ 2,782,142**	$ 7,949,498	$ -	$ 7,949,498	**0.349977**
42	7500	ASC (NON-DISTINCT PART)	$ 4,240,458	$ -	$ -		**$ 4,240,458**	$ 14,624,404	$ 29,956,291	$ 44,580,695	**0.095119**
43	7600	OTHER ANC CENTER	$ 827,377	$ -	$ -		**$ 827,377**	$ 847	$ 4,034,393	$ 4,035,240	**0.205038**
44	9000	CLINIC	$ 1,914,426	$ -	$ -		**$ 1,914,426**	$ 318	$ 255,987	$ 256,305	**7.469328**
45	9001	MENTAL HEALTH OP CLINIC	$ 1,705,199	$ -	$ -		**$ 1,705,199**	$ 83,766	$ 511,567	$ 595,333	**2.864278**
46	9002	CANCER CENTER	$ 5,063,054	$ -	$ -		**$ 5,063,054**	$ 245,839	$ 11,085,902	$ 11,331,741	**0.446803**
47	9100	EMERGENCY	$ 23,991,188	$ -	$ -		**$ 23,991,188**	$ 52,415,396	$ 158,947,086	$ 211,362,482	**0.113507**
126		**Total Ancillary**	$ 459,344,659	$ -	$ -		$ 459,344,659	$ 1,165,575,323	$ 1,798,105,209	$ 2,963,680,532	
127		**Weighted Average**									**0.157818**
128		**Sub Totals**	$ 629,680,285	$ -	$ -		$ 629,680,285	$ 1,508,094,570	$ 1,798,105,209	$ 3,306,199,779	
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**					**$ 629,680,285**				
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-FORSYTH

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	$ 1,198.54		3,166		2,312		4,256		4,894		86		5,489		**14,714**		21.15%
2	03100 INTENSIVE CARE UNIT	$ 2,969.03		477		66		252		256		2		432		**1,053**		23.60%
3	03200 CORONARY CARE UNIT	$ -		-		-		-		-		-		-		-		
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		-		
6	03500 OTHER SPECIAL CARE UNIT	$ 1,837.34		129		1,035		-		970		23		100		**2,157**		33.63%
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-		-		-		
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-		-		-		
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-		-		-		
10	04300 NURSERY	$ 1,961.71		1,188		1,209		-		227		113		170		**2,737**		34.99%
11	3301 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		-		
18			**Total Days**	4,960		4,622		4,508		6,347		224		6,191		20,661		**22.99%**
19	Total Days per PS&R or Exhibit Detail			4,960		4,622		4,508		6,347		224		6,191				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 13,832,308		$ 12,508,985		$ 12,200,569		$ 19,910,733		$ 454,932		$ 17,039,666		**$ 88,452,695**		22.08%
21.01	Calculated Routine Charge Per Diem			$ 2,788.77		$ 2,706.40		$ 2,706.45		$ 3,137.03		$ 2,030.95		$ 2,752.33		$ 2,829.13		
	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)		0.526556	$ 112,616	$ 73,414	$ 15,774	$ 359,100	$ 66,411	$ 165,190	$ 4,746	$ 583,897	$ -	$ 23,352	$ -	$ 636,247	$ 199,547	$ 1,181,601	12.84%
23	5000 OPERATING ROOM		0.188387	$ 3,067,457	$ 2,287,388	$ 1,763,438	$ 5,912,794	$ 2,856,579	$ 3,578,300	$ 6,174,457	$ 83,381	$ 631,328	$ 4,068,170	$ 8,840,760	$ 10,846,426	$ 17,922,938	
24	5100 RECOVERY ROOM		0.300755	$ 412,236	$ 390,812	$ 170,570	$ 514,222	$ 100,377	$ 313,348	$ 160,807	$ 560,764	$ 10,031	$ 41,529	$ 144,226	$ 714,785	$ 843,989	$ 1,779,146	
25	5200 DELIVERY ROOM & LABOR ROOM		0.497475	$ 1,082,686	$ 7,469	$ 4,622,293	$ 1,592,232	$ 1,321,418	$ 149,201	$ 3,008,212	$ 428,388	$ 138,439	$ 73,613	$ 2,352,483	$ 951,251	$ 10,034,609	$ 2,177,280	
26	5300 ANESTHESIOLOGY		0.017570	$ 575,169	$ 512,863	$ 414,531	$ 1,312,188	$ 527,628	$ 692,634	$ 689,470	$ 1,311,872	$ 10,068	$ 112,921	$ 949,917	$ 1,796,506	$ 2,206,798	$ 3,829,554	2.67%
27	5400 RADIOLOGY-DIAGNOSTIC		0.109566	$ 833,281	$ 1,133,460	$ 1,007,662	$ 6,814,519	$ 1,797,896	$ 4,547,650	$ 2,318,695	$ 7,307,173	$ 51,508	$ 509,890	$ 2,632,648	$ 12,861,276	$ 5,957,534	$ 20,052,803	116.99%
28	5500 RADIOLOGY-THERAPEUTIC		0.072170	$ 165,292	$ 1,707,216	$ 5,720	$ 1,067,502	$ 340,369	$ 2,714,006	$ 287,667	$ 2,881,721	$ 2,329	$ 233,666	$ 694,020	$ 5,935,187	$ 799,048	$ 8,370,445	30.17%
29	5600 RADIOISOTOPE		0.072518	$ 478,758	$ 55,925	$ 57,040	$ 173,364	$ 294,118	$ 522,858	$ 284,075	$ 768,872	$ -	$ 14,339	$ 626,451	$ 892,710	$ 1,123,991	$ 1,521,039	5.44%
30	5700 CT SCAN		0.035953	$ 1,919,762	$ 1,997,311	$ 982,463	$ 3,243,593	$ 3,113,550	$ 2,851,940	$ 3,008,583	$ 3,900,464	$ 27,236	$ 227,876	$ 4,860,691	$ 9,673,457	$ 9,024,408	$ 12,013,208	11.16%
31	5800 MRI		0.098278	$ 526,057	$ 1,067,027	$ 329,927	$ 618,148	$ 968,527	$ 1,014,391	$ 857,156	$ 722,314	$ 5,373	$ 67,179	$ 1,724,368	$ 1,169,029	$ 2,681,667	$ 3,421,880	7.29%
32	5900 CARDIAC CATHETERIZATION		0.072615	$ 1,300,358	$ 285,978	$ 870,000	$ 423,233	$ 1,674,305	$ 1,053,790	$ 1,949,248	$ 1,690,859	$ 31,200	$ 40,272	$ 1,883,056	$ 1,883,056	$ 5,793,916	$ 3,453,798	48.57%
33	6000 LABORATORY		0.065204	$ 8,220,028	$ 2,153,552	$ 5,806,713	$ 6,314,138	$ 10,904,728	$ 3,686,297	$ 12,376,534	$ 4,454,097	$ 243,211	$ 347,413	$ 14,707,959	$ 11,507,237	$ 37,307,999	$ 16,562,082	46.65%
34	6500 RESPIRATORY THERAPY		0.327705	$ 1,541,172	$ 101,376	$ 428,295	$ 108,095	$ 974,534	$ 73,149	$ 2,800,517	$ 212,747	$ 16,298	$ 2,585	$ 1,136,905	$ 127,362	$ 5,744,518	$ 495,367	14.91%
35	6600 PHYSICAL THERAPY		0.191834	$ 613,760	$ 394,231	$ 142,793	$ 290,337	$ 903,184	$ 682,710	$ 983,575	$ 765,048	$ 1,496	$ 46,864	$ 847,287	$ 2,078,036	$ 2,643,312	$ 2,132,326	8.54%
36	6700 OCCUPATIONAL THERAPY		0.186018	$ 512,022	$ 76,772	$ 165,319	$ 106,517	$ 769,095	$ 182,487	$ 895,119	$ 186,354	$ 3,409	$ 2,703	$ 649,300	$ 285,111	$ 2,341,555	$ 552,130	1.11%
37	6800 SPEECH PATHOLOGY		0.163046	$ 316,517	$ 13,927	$ 237,962	$ 7,888	$ 353,035	$ 74,362	$ 430,200	$ 55,246	$ 20,068	$ 1,124	$ 334,583	$ 61,796	$ 1,337,734	$ 151,423	4.10%
38	6900 ELECTROCARDIOLOGY		0.239064	$ 224,167	$ 85,041	$ 78,202	$ 141,873	$ 293,735	$ 194,313	$ 299,819	$ 237,311	$ 1,872	$ 6,575	$ 424,764	$ 365,281	$ 895,923	$ 658,538	4.13%
39	7000 ELECTROENCEPHALOGRAPHY		0.188244	$ -	$ -	$ 46,096	$ 42,580	$ 94,939	$ 26,780	$ 124,417	$ 27,290	$ -	$ -	$ 166,230	$ 34,393	$ 265,454	$ 96,650	3.12%
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.595232	$ 926,388	$ 415,877	$ 42,050	$ 47,375	$ 16,877	$ 11,838	$ 38,641	$ 27,190	$ 2,429	$ 6,907	$ 33,481	$ 955,223	$ 1,023,956	$ 502,280	28.10%
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.232589	$ 1,639,491	$ 1,155,453	$ 316,193	$ 2,202,399	$ 2,969,920	$ 2,066,597	$ 3,838,317	$ 3,497,381	$ 5,095	$ 96,159	$ 2,613,895	$ 3,718,250	$ 8,793,921	$ 8,920,830	54.51%
42	7300 DRUGS CHARGED TO PATIENTS		0.145381	$ 8,710,989	$ 2,111,709	$ 6,808,290	$ 3,873,222	$ 13,782,868	$ 2,537,615	$ 15,612,024	$ 4,278,021	$ 232,259	$ 278,351	$ 16,179,550	$ 18,391,082	$ 44,914,170	$ 12,800,567	3643.49%
43	7400 RENAL DIALYSIS		0.349977	$ -	$ -	$ 117,576	$ -	$ 791,120	$ -	$ 863,044	$ -	$ -	$ -	$ 257,816	$ -	$ 1,771,740	$ -	2.09%
44	7500 ASC (NON-DISTINCT PART)		0.095119	$ 40,188	$ 5,865	$ 342,770	$ 672,135	$ 575,473	$ 384,785	$ 661,522	$ 684,494	$ 16,563	$ 70,999	$ 772,363	$ 956,212	$ 1,619,953	$ 1,747,276	2.05%
45	7600 OTHER ANC CENTER		0.205038	$ -	$ -	$ 2,490	$ 125,499	$ -	$ 124,168	$ 444	$ 259,502	$ -	$ 16,867	$ -	$ 172,582	$ 2,934	$ 509,160	0.14%
46	9000 CLINIC		7.469328	$ -	$ -	$ 3,720	$ 53,788	$ -	$ -	$ 1,277	$ 12,636	$ -	$ 3,075	$ 106	$ 33,834	$ 4,997	$ 66,424	1.36%
47	9001 MENTAL HEALTH OP CLINIC		2.864278	$ 561	$ 4,488	$ 2,478	$ 14,025	$ -	$ 1,683	$ 1,683	$ 20,103	$ -	$ 1,683	$ 31,557	$ 141,894	$ 4,722	$ 40,299	0.40%
48	9002 CANCER CENTER		0.446803	$ 2,090	$ 65,299	$ 38,711	$ 438,459	$ 15,978	$ 356,910	$ 39,838	$ 653,789	$ 3,184	$ 35,017	$ 57,628	$ 2,009,165	$ 96,617	$ 1,514,448	92.16%
49	9100 EMERGENCY		0.113507	$ 1,481,880	$ 2,550,527	$ 686,299	$ 11,789,236	$ 2,151,172	$ 2,588,553	$ 2,123,051	$ 5,064,228	$ 31,404	$ 585,601	$ 3,575,005	$ 19,257,526	$ 6,442,402	$ 21,992,543	20324.14%
				34,702,922	18,532,969	25,505,400	48,258,458	47,487,875	30,598,396	57,027,641	47,026,215	936,832	3,478,088	64,932,157	105,469,202			
	Totals / Payments																	
128	**Total Charges** *(includes organ acquisition from Section J)*			$ 48,535,230	$ 18,532,969	$ 38,014,385	$ 48,258,458	$ 59,688,544	$ 30,598,396	$ 76,938,374	$ 47,026,215	$ 1,391,764	$ 3,478,088	$ 81,971,823 (Agrees to Exhibit A)	$ 105,469,202 (Agrees to Exhibit A)	$ 223,176,533	$ 144,416,037	16.81%
129	Total Charges per PS&R or Exhibit Detail			$ 48,535,230	$ 18,532,969	$ 38,014,385	$ 48,258,458	$ 59,688,544	$ 30,598,396	$ 76,938,374	$ 47,026,215	$ 1,391,764	$ 3,478,088	$ 81,971,823	$ 105,469,202			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**															$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			**$ 13,170,975**	**$ 2,475,488**	**$ 12,116,861**	**$ 7,025,625**	**$ 12,432,883**	**$ 3,804,476**	**$ 17,735,385**	**$ 6,469,847**	**$ 538,890**	**$ 493,746**	**$ 16,937,296**	**$ 14,492,709**	$ 55,456,104	$ 19,775,436	16.96%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 7,721,563	$ 2,418,969	$ -	$ 105	$ 344,044	$ 332,750	$ 414,147	$ 348,858					$ 8,479,753	$ 3,100,682	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 7,031,651	$ 5,026,594	$ -	$ -	$ 72,789	$ 82,205					$ 7,104,440	$ 5,108,798	
134	Private Insurance (including primary and third party liability)			$ 163,289	$ 2,535	$ 1,474	$ 4,375	$ -	$ -	$ 7,539,387	$ 2,821,507					$ 7,704,150	$ 2,828,417	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ -	$ 5,801	$ 1,358	$ 4	$ 25,796	$ 29,228	$ 7,882	$ 12,718			$ 27,154	$ 45,033	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 7,884,852	$ 2,421,504	$ 7,033,125	$ 5,046,875											
137	Medicaid Cost Settlement Payments (See Note B)			$ -	$ (123,699)	$ -	$ -									$ -	$ (123,699)	
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)			$ -		$ -		$ 7,238,667	$ 2,475,360	$ 1,207,238	$ 431,236	$ -		$ -		$ 8,445,904	$ 2,906,596	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ 6,288,964	$ 3,200,813					$ 6,288,964	$ 3,200,813	
141	Medicare Cross-Over Bad Debt Payments							$ 159,305	$ 85,340	$ -	$ -			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 159,305	$ 85,340	
142	Other Medicare Cross-Over Payments (See Note D)							$ 16,701	$ -	$ -	$ -					$ 16,701	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)													$ 1,605,769	$ 4,528,521			
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)**			$ 5,286,123	$ 177,683	$ 5,083,736	$ 1,978,750	$ 4,672,808	$ 911,021	$ 2,187,066	$ (443,999)	$ 531,008	$ 481,028	$ 15,331,527	$ 9,964,188	$ 17,229,733	$ 2,623,455	
146	**Calculated Payments as a Percentage of Cost**			60%	93%	58%	72%	62%	76%	88%	107%	1%	3%	9%	31%	69%	87%	
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)**							56,197										
148	**Percent of cross-over days to total Medicare days from the cost report**							8%										

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 su
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&
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 sur
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 payme
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 payr

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 cl
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-FORSYTH

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	$ 1,198.54		4		-		16		8		28	
2	03100 INTENSIVE CARE UNIT	$ 2,969.03		-		-		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	$ 1,837.34		-		-		-		-		-	
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-	
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-	
10	04300 NURSERY	$ 1,961.71		2		-		-		-		2	
11	3301 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
18			**Total Days**	6		-		17		8		31	
19	Total Days per PS&R or Exhibit Detail			6		-		17		8			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 12,216		$ -		$ 89,140		$ 41,648		$ 143,004	
21.01	Calculated Routine Charge Per Diem			$ 2,036.00		$ -		$ 5,243.53		$ 5,206.00		$ 4,613.03	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**		**Ancillary Charges**		**Ancillary Charges**		**Ancillary Charges**		**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.526556	-	-	-	-	-	-	-	2,883	$ -	$ 2,883
23	5000 OPERATING ROOM		0.188387	-	-	-	-	-	-	-	-	$ -	$ -
24	5100 RECOVERY ROOM		0.300755	-	-	-	-	-	-	-	-	$ -	$ -
25	5200 DELIVERY ROOM & LABOR ROOM		0.497475	17,029	-	-	-	-	-	-	-	$ 17,029	$ -
26	5300 ANESTHESIOLOGY		0.017570	-	-	-	-	-	3,020	-	3,020	$ -	$ 6,040
27	5400 RADIOLOGY-DIAGNOSTIC		0.105666	-	53,515	-	-	5,649	40,518	1,146	677	$ 6,795	$ 94,710
28	5500 RADIOLOGY-THERAPEUTIC		0.072170	-	-	-	-	-	-	-	-	$ -	$ -
29	5600 RADIOISOTOPE		0.072518	-	-	-	-	-	-	-	-	$ -	$ -
30	5700 CT SCAN		0.035953	-	-	-	-	3,447	-	12,369	-	$ 15,816	$ -
31	5800 MRI		0.098278	-	-	-	-	5,373	-	-	-	$ 5,373	$ -
32	5900 CARDIAC CATHETERIZATION		0.072615	8,370	-	-	-	3,837	-	-	-	$ 12,207	$ -
33	6000 LABORATORY		0.065204	12,916	41,459	-	-	59,859	12,075	25,039	8,132	$ 97,814	$ 61,666
34	6500 RESPIRATORY THERAPY		0.327705	-	-	-	-	-	1,272	-	-	$ -	$ 1,272
35	6600 PHYSICAL THERAPY		0.191834	-	-	-	-	3,021	-	2,674	1,114	$ 5,695	$ 1,114
36	6700 OCCUPATIONAL THERAPY		0.186018	-	-	-	-	2,782	-	2,390	878	$ 5,172	$ 878
37	6800 SPEECH PATHOLOGY		0.163046	274	-	-	-	3,243	3,115	-	1,047	$ 3,517	$ 4,162
38	6900 ELECTROCARDIOLOGY		0.239064	-	959	-	-	2,808	468	1,872	468	$ 4,680	$ 1,895
39	7000 ELECTROENCEPHALOGRAPHY		0.188244	-	-	-	-	-	-	-	-	$ -	$ -
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.595232	200	497	-	-	-	-	-	414	$ 200	$ 911
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.232589	-	-	-	-	-	18,708	1,569	-	$ 1,569	$ 18,708
42	7300 DRUGS CHARGED TO PATIENTS		0.145381	6,890	60,475	-	-	54,564	5,340	22,847	7,323	$ 84,301	$ 73,138
43	7400 RENAL DIALYSIS		0.349977	-	-	-	-	-	-	-	-	$ -	$ -
44	7500 ASC (NON-DISTINCT PART)		0.095119	-	-	-	-	-	-	-	-	$ -	$ -
45	7600 OTHER ANC CENTER		0.205038	-	-	-	-	-	-	-	-	$ -	$ -
46	9000 CLINIC		7.469328	-	-	-	-	-	-	-	-	$ -	$ -
47	9001 MENTAL HEALTH OP CLINIC		2.864278	-	234	-	-	-	-	-	-	$ -	$ 234
48	9002 CANCER CENTER		0.446803	-	2,278	-	-	-	516	-	-	$ -	$ 2,794
49	9100 EMERGENCY		0.113507	-	126,838	-	-	8,445	9,981	5,200	54,844	$ 13,645	$ 193,663
				45,679	288,255	-	-	153,028	95,013	75,106	80,800		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			**$ 57,895**	**$ 288,255**	**$ -**	**$ -**	**$ 242,168**	**$ 95,013**	**$ 116,754**	**$ 80,800**	**$ 416,817**	**$ 464,068**
129	Total Charges per PS&R or Exhibit Detail			$ 57,895	$ 288,255	$ -	$ -	$ 242,168	$ 95,013	$ 116,754	$ 80,800		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)											$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			**$ 19,804**	**$ 33,987**	**$ -**	**$ -**	**$ 38,764**	**$ 12,649**	**$ 17,469**	**$ 10,369**	**$ 76,037**	**$ 57,005**
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ -	$ 156	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 156
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)			$ -	$ -	$ -	$ -	$ -	$ -	$ 5,868	$ 1,940	$ 5,868	$ 1,940
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ -	$ 156	$ -	$ -						
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)			$ -		$ -		$ 12,796	$ 14,225	$ 443	$ -	$ 13,239	$ 14,225
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ 6,288	$ 7,426	$ 6,288	$ 7,426
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)**			$ 19,804	$ 33,831	$ -	$ -	$ 25,968	$ (1,576)	$ 4,870	$ 1,003	$ 50,642	$ 33,258
144	**Calculated Payments as a Percentage of Cost**			0%	0%	0%	0%	33%	112%	72%	90%	33%	42%

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-FORSYTH

		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-FORSYTH

		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-FORSYTH

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 8,256,316		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		Expense	06-00900-00141	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 8,256,316	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	$ (2,119,669)	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		$ 6,136,647		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 2,119,669
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	373,343,306
19	Uninsured Hospital	**Charges Sec. G**	187,441,026
20	Total Hospital	**Charges Sec. G**	3,306,199,779
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		11.29%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		5.67%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ 239,358
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 120,172
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$ 359,530**
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	153,687,192
27	Uninsured Hospital	**Charges Sec. G**	192,310,877
28	Total Hospital	**Charges Sec. G**	3,306,199,779
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		4.65%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		5.82%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ 98,532
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 123,294
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$ 221,826**

** 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-FORSYTH**
Hospital Medicaid Number	**000000767A**
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)	$ 23,857,605	$ -	$ 23,857,605
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 23,857,605	$ -	$ 23,857,605
4	Net Hospital Patient Revenue	Survey F-3	$ 722,920,827	$ -	$ 722,920,827
5	Medicaid Fraction		3.30%	0.00%	3.30%
6	Inpatient Charity Care Charges	Survey F-2	$ 91,023,791	$ -	$ 91,023,791
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 91,023,791	$ -	$ 91,023,791
10	Inpatient Hospital Charges	Survey F-3	$ 1,178,759,709	$ -	$ 1,178,759,709
11	Inpatient Charity Fraction		7.72%	0.00%	7.72%
12	LIUR		11.02%	0.00%	11.02%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	20,661	-	20,661
14	Out-of-State Medicaid Eligible Days	Survey I	31	-	31
15	Total Medicaid Eligible Days		20,692	-	20,692
16	Total Hospital Days (excludes swing-bed)	Survey F-1	116,958	-	116,958
17	MIUR		17.69%	0.00%	17.69%

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-FORSYTH
Hospital Medicaid Number: 000000767A
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	13,170,975	7,721,563	-	163,289	-	-	-	-	-	-	-			7,884,852	5,286,123	59.87%
2 Medicaid Fee for Service	Outpatient	2,475,488	2,418,969	-	2,535	-	(123,699)	-	-	-	-	-			2,297,805	177,683	92.82%
3 Medicaid Managed Care	Inpatient	12,116,861	-	7,031,651	1,474	-	-	-	-						7,033,125	5,083,736	58.04%
4 Medicaid Managed Care	Outpatient	7,025,625	105	5,026,594	4,375	15,801	-	-							5,046,875	1,978,750	71.84%
5 Medicare Cross-over (FFS)	Inpatient	12,432,883	344,044	-	-	1,358		-	7,238,667	-	159,305	16,701			7,760,075	4,672,808	62.42%
6 Medicare Cross-over (FFS)	Outpatient	3,804,476	332,750	-	-	4		-	2,475,360	-	85,340	-			2,893,455	911,021	76.05%
7 Other Medicaid Eligibles	Inpatient	17,735,385	414,147	72,789	7,539,387	25,796			1,207,238	6,288,964	-	-			15,548,319	2,187,066	87.67%
8 Other Medicaid Eligibles	Outpatient	6,469,847	348,858	82,205	2,821,507	29,228			431,236	3,200,813	-	-			6,913,846	(443,999)	106.86%
9 Uninsured	Inpatient	17,476,186	-	-	-	7,882	-	-	-	-	-	-	1,605,769	-	1,613,651	15,862,535	9.23%
10 Uninsured	Outpatient	14,986,455	-	-	-	12,718	-	-	-	-	-	-	4,528,521	-	4,541,239	10,445,216	30.30%
11 In-State Sub-total	Inpatient	72,932,290	8,479,753	7,104,440	7,704,150	35,036	-	-	8,445,904	6,288,964	159,305	16,701	1,605,769	-	39,840,022	33,092,268	54.63%
12 In-State Sub-total	Outpatient	34,761,891	3,100,682	5,108,798	2,828,417	57,751	(123,699)	-	2,906,596	3,200,813	85,340	-	4,528,521	-	21,693,220	13,068,671	62.41%
13 Out-of-State Medicaid	Inpatient	76,037	-	-	5,868	-	-	-	13,239	6,288	-	-			25,395	50,642	33.40%
14 Out-of-State Medicaid	Outpatient	57,005	156	-	1,940	-	-	-	14,225	7,426	-	-			23,747	33,258	41.66%
15 Sub-Total	I/P and O/P	107,827,223	11,580,591	12,213,238	10,540,375	92,786	(123,699)	-	11,379,965	9,503,490	244,645	16,701	6,134,290	-	61,582,383	46,244,840	57.11%
15.01 Provider Tax Assessment Adjustment to UCC																359,530	

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-FORSYTH**
Hospital Medicaid Number: **000000767A**
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	13,170,975	7,721,563	-	163,289	-	-	-	-	-	-	-			7,884,852	5,286,123	59.87%
2	Medicaid Fee for Service	Outpatient	2,475,488	2,418,969	-	2,535	-	(123,699)	-	-	-	-	-			2,297,805	177,683	92.82%
3	Medicaid Managed Care	Inpatient	12,116,861	-	7,031,651	1,474	-	-	-	-						7,033,125	5,083,736	58.04%
4	Medicaid Managed Care	Outpatient	7,025,625	105	5,026,594	4,375	15,801	-	-							5,046,875	1,978,750	71.84%
5	Medicare Cross-over (FFS)	Inpatient	12,432,883	344,044	-	-	1,358		-	7,238,667	-	159,305	16,701			7,760,075	4,672,808	62.42%
6	Medicare Cross-over (FFS)	Outpatient	3,804,476	332,750	-	-	4		-	2,475,360	-	85,340	-			2,893,455	911,021	76.05%
7	Other Medicaid Eligibles	Inpatient	17,735,385	414,147	72,789	7,539,387	25,796			1,207,238	6,288,964	-	-			15,548,319	2,187,066	87.67%
8	Other Medicaid Eligibles	Outpatient	6,469,847	348,858	82,205	2,821,507	29,228			431,236	3,200,813	-	-			6,913,846	(443,999)	106.86%
9	Uninsured	Inpatient	17,476,186	-	-	-	7,882	-	-	-	-	-	-	1,605,769	-	1,613,651	15,862,535	9.23%
10	Uninsured	Outpatient	14,986,455	-	-	-	12,718	-	-	-	-	-	-	4,528,521	-	4,541,239	10,445,216	30.30%
11	In-State Sub-total	Inpatient	72,932,290	8,479,753	7,104,440	7,704,150	35,036	-	-	8,445,904	6,288,964	159,305	16,701	1,605,769	-	39,840,022	33,092,268	54.63%
12	In-State Sub-total	Outpatient	34,761,891	3,100,682	5,108,798	2,828,417	57,751	(123,699)	-	2,906,596	3,200,813	85,340	-	4,528,521	-	21,693,220	13,068,671	62.41%
13	Out-of-State Medicaid	Inpatient	76,037	-	-	5,868	-	-	-	13,239	6,288	-	-			25,395	50,642	33.40%
14	Out-of-State Medicaid	Outpatient	57,005	156	-	1,940	-	-	-	14,225	7,426	-	-			23,747	33,258	41.66%
15	Cost Report Year Sub-Total	I/P and O/P	107,827,223	11,580,591	12,213,238	10,540,375	92,786	(123,699)	-	11,379,965	9,503,490	244,645	16,701	6,134,290	-	61,582,383	46,244,840	57.11%
15.01																		
															Provider Tax Assessment Adjustment to UCC Including all Medicaid Eligibles		359,530	
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		46,604,370	
18															Less: Non-Medicaid Primary Provider Tax Assessment Adjustment to UCC		137,704	
19															Less: Non-Medicaid Primary UCC Prior to Supplemental Medicaid Payments		7,357,162	
20															Adjusted Sub-Total UCC Including Only Medicaid-Primary Payors and Uninsured Prior to Supplemental Medicaid Payments		39,109,504	

Medicaid DSH Survey Adjustments

PROVIDER: NORTHSIDE HOSPITAL-FORSYTH
Mcaid Number: 000000767A
FROM: 10/1/2022
TO: 9/30/2023
Mcare Number: 110005

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-FORSYTH Mcaid Number: 000000767A
FROM: 10/1/2022 TO: 9/30/2023 Mcare Number: 110005

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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