DSH Uncompensated Care Cost & Allocation Factor Summary Preliminary Results

Provider Name
Mcaid Provider Number
Mcare Provider Number

NORTHSIDE HOSPITAL GWINNETT	
00000294A	
110087	

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 Payme	7/1/2024 -	6/30/2025					
	(A)	(B)	(C)	(D)	(E)		
			As-Filed DSH	_	Adjusted DSH		
	Cost Report	Cost Report	Uncompensated	Total	Uncompensated		
Cost Poport Voca LICC	Year Begin	Year End	Care Cost (UCC)	Adjustments	Care Cost (UCC)	•	
Cost Report Year UCC:	10/1/2022 -	9/30/2023	\$ 113,407,306	<del>-</del>	\$ 113,407,306		
Less: 2023 Net UPL Payments					\$ 8,119,097		
Less: 2025 Net DPP Payments					\$ 46,251,938	-	
Plus: 2024 Net DPP Recoupmen	nts				\$ -		
Less: GME Payments					\$ 1,124,572	•	
Add: Net OP Settlement (Differ	•				\$ (32,772)	1	
Add: Provider tax excluded from	•	viedicald primary &	🕱 uninsured portion)		\$ 1,064,893		
Uncompensated Care Allocatio	n ractor				\$ 58,943,820		
Hospital Specific DSH Limit					\$ 26,776,968		
2025 Eligibility					Eligible	1	
DSH Year Low Income Utiliza	16.93%	-					
DSH Year Medicaid Inpatient	• •				33.73%	<u>-</u> 	

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: <a href="https://DSH.MSLC.com">https://DSH.MSLC.com</a>

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, Inc	Gwinnett	
	10/1/2022 through 9/30/2023		
Select Cost Report Year Covered by this Survey:	Х		
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, Inc Gwinnett	Yes	
5. Medicaid Provider Number:	000000294A	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:	110087	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	247
10. State Name & Number	Florida	107736
11. State Name & Number	North Carolina	1457396

11.	State Name	&	Num	nber			
12.	State Name	&	Nun	ber			
13.	State Name	&	Nun	ber			
14.	State Name	&	Num	ber			
		_					

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 Ho	spital Services In	cluded in Exhibits F	3 & B-1 (See Note 1)	

- Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
   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)

- 9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)
- 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)
- 11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)
- 12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

\$	-
\$	-
\$	-
	\$-
\$	-
\$	-
	\$-

	Inpatient	Inpatient Outpatient			
\$	2,297,432	\$	8,082,730	\$10,380,162	
\$	7,044,026	\$	25,241,828	\$32,285,854	
	\$9,341,458		\$33,324,558	\$42,666,016	
	24 59%		24 25%	24 33%	

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

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

\$	
\$	-

Printed 3/20/2025 Property of Myers and Stauffer LC Page 1

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) 174,688 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 8. Outpatient Hospital Charity Care Charges 9. Non-Hospital Charity Care Charges 10. Total Charity Care Charges F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR)(W/S G-2 and G-3 of Cost Report) Inpatient Hospital **Outpatient Hospital** Non-Hospital Inpatient Hospital **Outpatient Hospital** Non-Hospital Net Hospital Revenue 11. Hospital 475,131,482 98,150,531 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 896,290,804 20. Outpatient Services 113.590.184 21. Home Health Agency 22. Ambulance 23. Outpatient Rehab Providers 24. ASC 25. Hospice 26. Other 421.021.706 27. Total 2.305.764.052 3.058.044.499 \$ 421.021.706 \$ 1.829.449.653 \$ 2.426.327.378 \$ 334.048.930 1.108.031.520 28. Total Hospital and Non Hospital Total from Above 5,784,830,257 Total from Above 4,589,825,961 Total Contractual Adj. (G-3 Line 2) 29. Total Per Cost Report Total Patient Revenues (G-3 Line 1) \$ 5,784,830,257 4,589,825,961 30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net natient 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 natient 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 4,589,825,961 37. Unreconciled Difference Unreconciled Difference (Should be \$0) Unreconciled Difference (Should be \$0)

Line # Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *			Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per I
	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
Routine Cost Centers (list below):  03000   ADULTS & PEDIATRICS   \$	184,231,768	\$ 4,777,367			\$ 189,009,135	157.048	\$ 297,130,536		S 1.3
03100 INTENSIVE CARE UNIT \$	43,699,800	\$ 831,735	\$ -	-	\$ 44,531,535	14,600	\$ 113,551,339		\$ 3,0
03200 CORONARY CARE UNIT \$	-	\$ -	\$ -		\$ -	-	\$ -		\$
03300 BURN INTENSIVE CARE UNIT \$ 03400 SURGICAL INTENSIVE CARE UNIT \$	-	\$ -	\$ -		\$ - \$ -	-	\$ -		\$
03500 OTHER SPECIAL CARE UNIT \$	16.392.336	S -	S -		\$ 16,392,336	9,445	\$ 57,334,633		\$ 1,7
04000 SUBPROVIDER I \$	-	\$ -	\$ -		\$ -	-	\$ -		\$
04100 SUBPROVIDER II \$	-	\$ -	\$ -		\$ -	-	\$ -		\$
04200 OTHER SUBPROVIDER \$ 04300 NURSERY \$	5,539,381	S 351 063	\$ -		\$ 5,890,444	6 594	\$ - \$ 7 114 974		\$ 8
Total Routine \$			s -	\$ -		187,687			• 0
Weighted Average	2-10,000,200	\$ 0,000,100	•		200,020,400	107,007	470,101,402		\$ 1,3
		Hospital Observation	Subprovider I	Subprovider II		Inpatient Charges -	Outpatient Charges -		
		Days - Cost Report	Observation Days -	Observation Days -	Calculated (Per	Cost Report	Cost Report	Total Charges - Cost	Medicaid Calcu
		W/S S-3, Pt. I, Line	Cost Report W/S S- 3, Pt. I, Line 28.01,	Cost Report W/S S- 3, Pt. I, Line 28.02,	Diems Above	Worksheet C, Pt. I,	Worksheet C, Pt. I,	Report Worksheet C, Pt. I, Col. 8	Cost-to-Charge
		28, Col. 8	3, Pt. I, Line 28.01, Col. 8	3, Pt. I, Line 28.02, Col. 8	Multiplied by Days)	Col. 6	Col. 7	C, Pt. 1, Col. 8	
Observation Data (Non-Distinct)			00.0	001. 0					
09200 Observation (Non-Distinct)		12,999	-	-	\$ 15,644,426	1,513,525	15,132,400	\$ 16,645,925	0.9
	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 Calcu Cost-to-Charge
Ancillary Cost Centers (from W/S C excluding Observed) 5000 OPERATING ROOM	vation) (list below) 44.626.125		9 -		\$ 45,328,391	\$ 189,914,447	\$ 111.668.684	\$ 301,583,131	0.1
5100 RECOVERY ROOM \$	6,451,694	\$ -	\$ -		\$ 6,451,694	\$ 18,698,705	\$ 38,802,122	\$ 57,500,827	0.1
5200 DELIVERY ROOM & LABOR ROOM \$	18,256,678		\$ -		\$ 18,958,944		\$ 5,343,552	\$ 54,846,540	0.34
5300 ANESTHESIOLOGY \$ 5400 RADIOLOGY-DIAGNOSTIC \$	1,048,711 37,812,095	\$ -	\$ -		\$ 1,048,711 \$ 37,812,095		\$ 50,831,562 \$ 228,156,280	\$ 97,533,472 \$ 292,352,557	0.0
5500 RADIOLOGY-THERAPEUTIC \$	4,102,957	S -	S -		\$ 4,102,957		\$ 76,636,119	\$ 77,986,791	0.0
5600 RADIOISOTOPE \$	1,981,651		\$ -		\$ 1,981,651	\$ 3,115,854	\$ 6,565,971	\$ 9,681,825	0.2
5700 CT SCAN \$	5,141,304		\$ -		\$ 5,141,304			\$ 314,895,918	0.0
5900 CARDIAC CATHETERIZATION \$	2,208,627 11,691,752		\$ -		\$ 2,208,627 \$ 11,691,752	\$ 32,036,726 \$ 90,378,084	\$ 25,741,308 \$ 112,361,851	\$ 57,778,034 \$ 202,739,935	0.0
6000 LABORATORY \$	31,057,824		\$ -		\$ 31,057,824			\$ 467,256,292	0.00
6500 RESPIRATORY THERAPY \$	21,269,103	\$ -	\$ -		\$ 21,269,103	\$ 75,992,468	\$ 4,235,598	\$ 80,228,066	0.20
6600 PHYSICAL THERAPY \$ 6700 OCCUPATIONAL THERAPY \$	12,717,720 1,511,284		\$ -		\$ 12,717,720 \$ 1,511,284		\$ 15,955,564 \$ 749,615	\$ 34,583,803 \$ 12,637,120	0.36
6800 SPEECH PATHOLOGY \$	1,511,284		\$ - \$ -		\$ 1,511,264 \$ 1,258,840		\$ 749,615	\$ 8,576,103	0.14
6900 ELECTROCARDIOLOGY \$	11,290,149		\$ -		\$ 11,290,149	\$ 51,618,633		\$ 113,141,169	0.0
7000 ELECTROENCEPHALOGRAPHY \$	891,916		\$ -		\$ 891,916		\$ 2,084,159	\$ 5,475,113	0.10
7100 MEDICAL SUPPLIES CHARGED TO PATIENT \$ 7200 IMPL. DEV. CHARGED TO PATIENTS \$	90,778,937 92,543,384		\$ -		\$ 90,778,937 \$ 92,543,384	\$ 67,955,837 \$ 222,310,371		\$ 154,152,668 \$ 346,164,721	0.58
7300 DRUGS CHARGED TO PATIENTS \$	171,378,079		\$ -		\$ 92,543,384 \$ 171,378,079	\$ 410,445,416		\$ 1,543,137,420	0.20
7400 RENAL DIALYSIS \$	3,734,212	\$ -	\$ -		\$ 3,734,212	\$ 13,836,530	\$ -	\$ 13,836,530	0.20
7500 ASC (NON-DISTINCT PART) \$	26,743,580		\$ -		\$ 26,743,580			\$ 89,385,531	0.29
7600 MISC ANCILLARY SERVICES \$ 9000 CLINIC \$	508,125 8,777,294	\$ -	\$ -		\$ 508,125 \$ 8,777,294	\$ - \$ 11,895	\$ 3,331,057 \$ 3,526,734	\$ 3,331,057 \$ 3,538,629	0.15 2.48
9001 MENTAL HEALTH OP CLINIC \$	3.176.115	S -	\$ -		\$ 3,176,115	\$ 216,201	\$ 1,085,155	\$ 1,301,356	2.44
9002 CANCER CENTER \$	32,438,663		\$ -		\$ 32,438,663	\$ 120,629	\$ 154,079,996	\$ 154,200,625	0.21
9003 GME OP CLINIC \$	402,126		\$ -		\$ 6,334,704	\$ 423	\$ 6,516,504	\$ 6,516,927	0.97
9100 EMERGENCY \$ Total Ancillary \$	81,615,256 725,414,201				\$ 82,733,317 \$ 733.869.372			\$ 367,668,983 \$ 4,888,677,068	0.22
Weighted Average	120,414,201	9 0,400,171	· -		9 133,009,372	ψ 1,808,021,301	φ 2,343,143,707	4,000,011,008	0.15
Sub Totals S				ine 200 and Workshe	\$ 989,692,822	\$ 2,414,658,843	\$ 2,949,149,707	\$ 5,363,808,550	

<sup>\*</sup> 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, Inc. - Gwinnett

	medicald Per	Medicald Cost to	In-State Medic	ald FFS Primary	In-State Medicald M	anaged Care Primary	In-State Medicare F Medicaid S	FS Cross-Overs (with Secondary)	Included Elsewher	Medicaid Exhausted	Medicaid FFS & MCC Covered (Not to be	D Exhausted and Non- Included Elsewhere)	Unin	sured	Total in-State Medicaid FFS & M Non-C	CO Exhausted and	% Survey to Cost Report
	Diem Cost for Routine Cost Line # Cost Center Description Centers	Charge Ratio for Ancillary Cost Centers	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	Totals (includes all payers)
	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)	Own Internal Analysis	Own Internal Analysis			
1 2	Routine Cost Centers (from Section G):		Days 8,743 2,393		7,452 351		9,197 1,006		Days 16,674 1,590		Days 840 40		Days 15,572 2,180		Days 42,906 5,380		40.66% 51.79%
3 4 5	03200   CORONARY CARE UNIT   \$ -														:		
6 7 8	03500 OTHER SPECIAL CARE UNIT \$ 1,735.56 04000 SUBPROVIDER I \$ - 04100 SUBPROVIDER II \$ -		250 -		4,376				707 - -				174		5,340		58.38%
9 10 18	04200 OTHER SUBPROVIDER \$ - 04300 NURSERY \$ 893.30	Total Days	2,045 13,431		2,538 14,717		10,203		408 19,379		206 1,093		162 18,088		5,197 58,823		81.30% 44.08%
19 20	Total Days per PS&R or Exhibit Detail Unreconciled Days (Explain Variance)		13,431		14,717		10,203		19,379		1,093		18,088				
21 21.01	Routine Charges Calculated Routine Charge Per Dilem		Routine Charges \$ 39,393,174 \$ 2,933.00		Routine Charges \$ 49,073,847 \$ 3,334.50		Routine Charges \$ 28,717,316 \$ 2,814.60		Routine Charges \$ 54,401,968 \$ 2,807.26		Routine Charges \$ 2,597,665 \$ 2,376.64		Routine Charges \$ 49,379,371 \$ 2,729.95		Routine Charges \$ 171,586,305 \$ 2,916.99		46.56%
22 23	Ancillary Cost Centers (from WS C) (from Section G):  09200   Observation (Non-Distinct)  5000   OPERATING ROOM	0.939835 0.150301	Ancillary Charges \$ 136,993 \$ 9,785,704	Ancillary Charges \$ 421,446 \$ 2,998,427	Ancillary Charges \$ 21,180 \$ 7,594,819	Ancillary Charges \$ 1,148,533 \$ 5,283,489	Ancillary Charges \$ 115,512 \$ 10,417,041	Ancillary Charges \$ 635,258 \$ 4,283,617	Ancillary Charges \$ 234,943 \$ 16,878,934	Ancillary Charges \$ 1,998,554 \$ 7,979,139	Ancillary Charges S - S 830,336	Ancillary Charges \$ 201,894 \$ 718,286	Ancillary Charges \$ 4,290 \$ 19,970,876	Ancillary Charges \$ 2,661,114 \$ 7,774,280	Ancillary Charges \$ 508,628 \$ 44,676,497	Ancillary Charges \$ 4,203,791 \$ 20,544,672	45.70%
24 25 26	5100 RECOVERY ROOM 5200 DELIVERY ROOM & LABOR ROOM 5300 ANESTHESIOLOGY	0.112202 0.345673 0.010752	\$ 979,783 \$ 2,038,170 \$ 1,756,231	\$ 675,731 \$ 9,741 \$ 722,862	\$ 1,312,849 \$ 11,127,095 \$ 1,818,850	\$ 1,990,682 \$ 320,533 \$ 1,992,352	\$ 672,524 \$ 2,074,954 \$ 2,030,472	\$ 1,308,634 \$ 137,511 \$ 1,484,326	\$ 1,283,492 \$ 5,556,535 \$ 3,380,739	\$ 2,477,693 \$ 288,918 \$ 2,900,738	\$ 108,543 \$ 672,528 \$ 172,484	\$ 230,884 \$ 27,871 \$ 253,489	\$ 1,224,208 \$ 4,597,753 \$ 4,176,859	\$ 2,515,184 \$ 280,454 \$ 2,890,875	\$ 4,248,648 \$ 20,796,754 \$ 8,986,292	\$ 6,452,740 \$ 756,703 \$ 7,100,278	7.82%
27 28	5400 RADIOLOGY-DIAGNOSTIC 5500 RADIOLOGY-THERAPEUTIC	0.129337 0.052611	\$ 2,822,262 \$ 303,600	\$ 2,723,007 \$ -	\$ 3,981,398 \$ 151,982	\$ 12,991,362 \$ 2,443,566	\$ 4,239,155 \$ 96,882	\$ 5,741,009 \$ 1,862,853	\$ 7,589,847 \$ 223,003	\$ 11,301,086 \$ 6,796,654	\$ 316,201 \$ 3,517	\$ 997,936 \$ 417,769	\$ 7,636,823 \$ 240,298	\$ 18,938,162 \$ 6,029,897	\$ 18,632,662 \$ 775,467	\$ 32,756,464 \$ 11,103,073	138.08% 33.86%
29 30 31	5600 RADIOISOTOPE 5700 CT SCAN 5800 MRI	0.204677 0.016327 0.038226	\$ 420,627 \$ 7,551,756	\$ 294,428 \$ 4,424,599	\$ 246,708 \$ 3,874,352 \$ 1,178,689	\$ 156,457 \$ 11,806,665 \$ 2,329,258	\$ 918,185 \$ 8,301,809 \$ 2,145,659	\$ 225,167 \$ 8,316,638 \$ 2,581,341	\$ 1,292,294 \$ 13,599,705 \$ 3,173,343	\$ 449,234 \$ 12,191,162 \$ 4,073,094	\$ 19,143 \$ 548,872 \$ 132,434	\$ 10,598 \$ 993,593	\$ 1,028,861 \$ 18,220,356 \$ 4,493,857	\$ 432,899 \$ 35,684,071 \$ 3,507,615	\$ 2,877,814 \$ 33,327,623 \$ 8,564,112	\$ 1,125,286 \$ 36,739,065 \$ 9,824,372	5.64% 42.98% 34.53%
31 32 33	5900 CARDIAC CATHETERIZATION	0.038226 0.057669 0.066468	\$ 2,066,421 \$ 3,466,984 \$ 22,746,667	\$ 752,794 \$ 5,201,138	\$ 1,178,689 \$ 3,455,937 \$ 16,493,622	\$ 2,329,258 \$ 2,310,796 \$ 19,646,667	\$ 2,145,659 \$ 8,239,383 \$ 20,866,843	\$ 2,581,341 \$ 4,268,461 \$ 10,217,615	\$ 3,173,343 \$ 12,956,549 \$ 37,002,295	\$ 6,631,084 \$ 15,292,733	\$ 132,434 \$ 286,128 \$ 1930,453	\$ 277,157 \$ 1423,494	\$ 4,493,857 \$ 13,656,764 \$ 36,572,429	\$ 5,705,505 \$ 27,508,194	\$ 28,118,853 \$ 97,109,426	\$ 9,824,372 \$ 13,963,135 \$ 50,358,153	34.53% 640.74% 68.36%
34 35	6500 RESPIRATORY THERAPY 6600 PHYSICAL THERAPY	0.265108 0.367736	\$ 5,309,912 \$ 1,012,267	\$ 131,799 \$ 333,807	\$ 4,577,036 \$ 320,776	\$ 745,749 \$ 227,082	\$ 3,078,742 \$ 1,312,907	\$ 143,040 \$ 577,647	\$ 8,503,945 \$ 2,178,548	\$ 710,951 \$ 565,305	\$ 135,240 \$ 61,793	\$ 23,132 \$ 83,503	\$ 5,708,634 \$ 1,727,121	\$ 519,664 \$ 2,940,867	\$ 21,469,634 \$ 4,824,498	\$ 1,731,538 \$ 1,703,841	51.26% 5.60%
36 37	6700 OCCUPATIONAL THERAPY 6800 SPEECH PATHOLOGY	0.119591 0.146785	\$ 687,385 \$ 539,506	\$ 41,703 \$ 4,549	\$ 265,726 \$ 114,538	\$ 58,702 \$ 15,765	\$ 853,663 \$ 644,402	\$ 319,257 \$ 146,141	\$ 1,400,495 \$ 1,022,863	\$ 299,969 \$ 131,992	\$ 40,366 \$ 22,885	\$ 6,920 \$ 3,774	\$ 1,027,928 \$ 850,482	\$ 153,380 \$ 73,610	\$ 3,207,269 \$ 2,321,309	\$ 719,631 \$ 298,447	1.10% 4.46%
38 39 40	6900 ELECTROCARDIOLOGY 7000 ELECTROENCEPHALOGRAPHY 7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.099788 0.162904 0.588890	\$ 1,141,679 \$ - \$ 2,133,079	\$ 428,239 \$ - \$ 746,227	\$ 298,080 \$ 286,370	\$ 1,540,976 \$ 169,603 \$ 66,111	\$ 1,001,082 \$ 334,809	\$ 1,486,150 \$ 148,987	\$ 1,608,316 \$ 540,478 \$ 64,225	\$ 2,699,411 \$ 159,381 \$ 49,164	\$ 46,687 \$ 17,682	\$ 117,883 \$ 37,031 \$ 4,003	\$ 1,272,377 \$ 472,185	\$ 4,165,675 \$ 79,542 \$ 96,507	\$ 4,049,157 \$ 1,161,657 \$ 2,302,304	\$ 6,154,776 \$ 477,971 \$ 888,263	45.76% 17.78% 40.05%
41 42	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7200 IMPL. DEV. CHARGED TO PATIENTS 7300 IDRUGS CHARGED TO PATIENTS	0.588890 0.267339 0.111058	\$ 2,133,079 \$ 4,387,658 \$ 27,556,788	\$ 1,551,465 \$ 17,401,234	\$ 3,458,283	\$ 1,893,423 \$ 21,126,881	\$ 34,217 \$ 12,119,670 \$ 25,081,448	\$ 4,111,712	\$ 17,410,781 \$ 44,927,003	\$ 7,366,898 \$ 56,954,931	\$ 300,654 \$ 2373,847	\$ 208,309 \$ 1,519,357	\$ 12,667,773 \$ 47,160,855	\$ 2,975,122 \$ 67.830.068	\$ 2,302,304 \$ 37,376,392 \$ 119,331,260	\$ 14,923,498 \$ 132,692,052	40.05% 60.54% 6778.67%
43 44	7400 RENAL DIALYSIS 7500 ASC (NON-DISTINCT PART) 7600 MISC ANCILLARY SERVICES	0.269881 0.299194	\$ 921,191	\$ -	\$ 179,348 \$ 691,671	\$ -	\$ 1,579,684 \$ 861,529	\$ - \$ 2,435,877	\$ 2,914,598 \$ 1,386,136	\$ - \$ 4,485,246	\$ 146,178 \$ 73,082	\$ - \$ 409,697	\$ 1,096,203 \$ 1,623,521	\$ - \$ 4,409,580	\$ 5,594,821 \$ 2,939,336	\$ - \$ 9,868,204	4.44% 5.58%
45 46	9000 CLINIC	0.152542 2.480422	\$ -	\$ -	\$ . \$ 472	\$ 15,096 \$ 96,962	\$ -	\$ 89,244 \$ -	\$ 2,081	\$ 220,312 \$ 12,765	\$ -	\$ 16,428 \$ 8,154	\$ - \$ -	\$ 68,420 \$ 93,573	\$ - \$ 4,634	\$ 324,652 \$ 109,727	0.03% 1.56%
47 48 49	9001 MENTAL HEALTH OP CLINIC 9002 CANCER CENTER 9003 GME OP CLINIC	2.440620 0.210367 0.972039	\$ 3,927	\$ 30,855 \$ 300,908	\$ 7,293 \$ 109,951	\$ 52,734 \$ 3,290,668	\$ - \$ 516	\$ 7,854 \$ 1,471,154	\$ 9,537 \$ 18,046	\$ 62,000 \$ 3,078,146	\$ 1,122 \$ 3,390	\$ 3,927 \$ 283,341	\$ 87,713 \$ 4,520	\$ 436,956 \$ 5,324,978	\$ 20,757 \$ 128,513	\$ 153,443 \$ 8,140,876	0.79% 416.85% 0.00%
50	9100 EMERGENCY	0.225021	\$ 4,715,535 102,484,124	\$ 8,329,563 48,365,200	\$ 2,711,207 86,115,036	\$ 38,846,917 133,514,110	\$ 4,876,539 111,899,706	\$ 5,468,176 94,704,436	\$ 8,186,403 193,345,135	\$ 13,387,548 162,563,108	\$ 305,137 8,555,237	\$ 2,360,596 10,990,523	\$ 11,361,885 197,019,959	\$ 52,571,523 255.667,715	\$ 20,489,684	\$ 66,032,204	11817.84%
	Totals / Payments		102,404,124	40,000,200	00,110,000	133,314,110	111,033,100	34,704,430	130,040,100	102,000,100	0,000,207	10,000,020	131,013,333	233,007,713			
128	Total Charges (includes organ acquisition from Sect	tion J)	\$ 141,877,298	\$ 48,365,200	\$ 135,188,883	\$ 133,514,110	\$ 140,617,022	\$ 94,704,436	\$ 247,747,103	\$ 162,563,108	\$ 11,152,902	\$ 10,990,523	\$ 246,399,330 (Agrees to Exhibit A)	\$ 255,667,715 (Agrees to Exhibit A)	\$ 665,430,306	\$ 439,146,854	29.99%
129 130	Total Charges per PS&R or Exhibit Detail Unreconciled Charges (Explain Variance)		\$ 141,877,298	\$ 48,365,200	\$ 135,188,883	\$ 133,514,110	\$ 140,617,022	\$ 94,704,436	\$ 247,747,103	\$ 162,563,108	\$ 11,152,902	\$ 10,990,523	\$ 246,399,330	\$ 255,667,715			
131.01 131.02	Sampling Cost Adjustment (if applicable)  Total Calculated Cost (includes organ acquisition from	Section J)	\$ 33,760,141	\$ 6,845,434	\$ 32,800,497	\$ 19,841,166	\$ 28,929,407	\$ 11,529,565	\$ 52,554,559	\$ 21,440,081	\$ 2,459,859	\$ 1,658,478	\$ 50,370,322	\$ 35,449,603	\$ - \$ 148,044,604	\$ - \$ 59,656,246	29.70%
132 133	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down) Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spe	end-Down) (See Note E)	\$ 19,987,713 \$ -	\$ 5,578,518 \$ -	\$ - \$ 21,502,249	\$ 13,481 \$ 12,807,761	\$ 265,129	\$ 1,388,971 \$ -	\$ 2,673,541 \$ 213,049	\$ 1,165,275 \$ 218,558					\$ 22,926,383 \$ 21,715,298	\$ 8,146,244 \$ 13,026,319	
134 135	Private Insurance (including primary and third party liability) Self-Pay (including Co-Pay and Spend-Down)		\$ 384,446	\$ 8,562 \$ -	\$ 43,688 \$ 6,420	\$ 32,468 \$ 71,264	\$ - \$ 31,617	\$ - \$ 479	\$ 11,486,137 \$ 40,072	\$ 7,260,585 \$ 31,032	\$ (79)	\$ 27,816			\$ 11,914,271 \$ 78,110	\$ 7,301,615 \$ 102,775	
136 137	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments) Medicaid Cost Settlement Payments (See Note B)		\$ 20,372,159	\$ 5,587,080 \$ (827,505)	\$ 21,552,358	\$ 12,924,975 \$									\$ -	\$ (827,505)	
138 139	Other Medicaid Payments Reported on Cost Report Year (See Note C) Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/dec	ductibles) (See Note F)	\$ -	\$ -	\$ .	\$ -	\$ 20,778,110	\$ 9,211,754	\$ 8,824,039	\$ 1,696,247	\$ -		\$ -		\$ - \$ 29,602,149	\$ 10,908,001	
140 141	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/dec Medicare Cross-Over Bad Debt Payments	ductibles)					\$ - \$ 414,558	\$ 271,448	\$ 18,699,525 \$ -	\$ 12,288,637 \$ -			(Agrees to Exhibit B	(Agrees to Exhibit B	\$ 18,699,525 \$ 414,558	\$ 12,288,637 \$ 271,448	
142 143	Other Medicare Cross-Over Payments (See Note D)  Payment from Hospital Uninsured During Cost Report Year (Cash Basis)						\$ 1,215,582	\$ 263,303	\$ -	\$ .			and B-1) \$ 2,297,432	and B-1) \$ 8,082,730	\$ 1,215,582	\$ 263,303	
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Includ												\$ -	\$ -		r	
145 146	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL I Calculated Payments as a Percentage of Cos  Total Medicare Days from WIS S-3 of the Cost Report Excluding Sw	t	60%	70%	\$ 11,248,139 66%	\$ 6,916,191 65%	\$ 6,224,411 78%	\$ 393,610 97%	\$ 10,618,197 80%	\$ (1,220,252) 106%	\$ 2,459,938 0%	\$ 1,630,662 2%	\$ 48,072,890 5%	\$ 27,366,873 23%	\$ 41,478,729 72%	\$ 8,175,408 86%	
148	Percent of cross-over days to total Medicare days from the cost rep	port					14%										
	Note A - These amounts must agree to your inpatient and outpatient Med. Note B - Medicaid cost settlement payments refer to payments made by Note G - Other Medicaid Payments such as Outliers and Non-Claim Spec. Note D - Should include other Medicaine cross-over payments not included Note E - Medicaid Managed Care payments should include all Medicaid M	Medicaid during a cost rep cific payments. DSH paym d in the paid claims data re	ort settlement that are n nents should NOT be inc eported above. This inc	ot reflected on the claim luded. UPL payments r udes payments paid bas	s paid summary (RA su made on a state fiscal y sed on the Medicare co	mmary or PS&R). ear basis should be repost st report settlement (e.g.	orted in Section C of the , Medicare Graduate N	survey. fedical Education paym									
	Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Not should not have Medicare Part A benefits (due to no coverage or exhaust	n-covered, and uninsured ted benefits).	payor buckets should o	nly include Medicare Pa	rt B payments for inpatie	ent, Medicaid primary cla	aims with Medicare Part	B only coverage for Me	dicaid covered ancillary	services. Such claims							

#### I. Out-of-State Medicaid Data:

March Control Contro		Cost Report Year	(10/01/2022-09/30/2023)	Northside Hospital, In	nc Gwinnett										
Part   Cont Common Standard   Part				_		Out-of-State Med	licaid FFS Primary					Included Elsewhe	ere & with Medicaid	Total Out-Of-S	State Medicaid
Proc   Section   Proc		Line#	Cost Center Description	Diem Cost for Routine Cost	Charge Ratio for Ancillary Cost	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
Section   Sect				From Section G	From Section G										
SECOND PROPRIES CASE FAME		Routine Cost Cer	nters (list below):			Days		Days		Days		Days			
Compared Control Cute		03000 ADULTS 8 03100 INTENSIV	& PEDIATRICS VE CARE UNIT	\$ 1,203.51 \$ 3,050.11		25 2		-		-		69			
Description of Control Contr		03200 CORONA	RY CARE UNIT			-		-		-		-		-	
Section   Company   Comp		03400 SURGICA	AL INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
STORY COLOR   STORY				\$ 1,735.56		-		-		-		-		-	
George   Control   Contr		04100 SUBPRO	VIDER II			-		-		-		-			
Treat Department   Treat Depar		04200 OTHER S 04300 NURSER	Y SUBPROVIDER			- 2								- 2	
Register Charges   Register Ch					Total Days	29		-		-		69		98	
Routine Charges   Routine Ch		Total Days per PS	&R or Exhibit Detail	vnlain Variance)		29				-		69			
Column Column For Date   Column Colu			Onicoonaica Days (C	xpiair varance)		Pouting Charges		Pouting Charges		Poutino Charges		Pouting Charges		Pouting Charges	
## Arcillary Clarings (Filter NEWS C) [inst linking)**  **Collary Clarings**  **Collary Charges**  **Arcillary Cha		Routine C	Charges			\$ 59,562		\$ -		s -		\$ 183,480		\$ 243,042	
00000   Colorantino (Neu-Outloid)	.01	Calculated	d Routine Charge Per Diem			\$ 2,053.86		\$ -		\$ -		\$ 2,659.13		\$ 2,480.02	
Second Department ROCAL   Second Se		Ancillary Cost Ce	enters (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
Description (Continue)		5000 OPERATI	ING ROOM		0.150301	-	-		-	-	-	3,541	106,401	\$ 3,541	\$ 106,401
SSDD/WESTHERSOLOGY						-	7,192	-	-	-	-	-	5,569	\$ -	\$ 12,761
SEGO DIADOLOCO THERMAPEUTC   SEGO DIADOLOCO THE PRIZE   SEGO DIADOLOCO TH		5300 ANESTHE	ESIOLOGY		0.010752	-		-	-					\$ -	\$ 13,269
Second ALCOSOTOPIC   1.00		5400 RADIOLO 5500 RADIOLO	OGY-DIAGNOSTIC OGY-THERAPEUTIC			8,613	77,515	-	-	-	-	8,620	22,078	\$ 17,233	\$ 99,593 \$ -
Secol CHAPTER CATTON		5600 RADIOISO	OTOPE			-	-		-	-	-		-	\$ 2,934	s -
BOOL   ADDRATORY   Company   Compa		5800 MRI			0.038226			-	-		-				\$ 42,866
6000 RESPRATORY TERRAPY						8,317	12,539	-	-	-	-	3,436	3,436		\$ 15,975
600 DECLATIONAL PREPARTY   0.11991   680		6500 RESPIRA	TORY THERAPY		0.265108	5,608		-	-	-		18,974		\$ 24,582	\$ 3,834
GEOS   SPECH PATHOLOGY				-			-	-	-	-	-		- 618		\$ - \$ 618
TODIESTORIAL SUPPLES CHARGED TO PATIENT   0.688890   497   1.175						-			-	-	-				\$ 2,662
2		7000 ELECTRO	DENCEPHALOGRAPHY		0.162904	-	1,175		-	-		1,072	4,000	\$ -	\$ 1,175
1		7100 MEDICAL	SUPPLIES CHARGED TO PATIENT			497	414	-	-	-	-	-	47 207	\$ 497	\$ 414
1		7300 DRUGS C	CHARGED TO PATIENTS		0.111058	62,687	7,927	-	-			143,043		\$ 205,730	\$ 26,764
1   1   1   1   1   1   1   1   1   1		7400 RENAL D	N-DISTINCT PART)		0.269881	-	-	-		-	-	-	-	\$ -	\$ - \$ -
2,   2,   3,   3,   1,   1,   2,			CILLARY SERVICES			-	-						-	\$ -	\$ -
000000000000000000000000000000000000		9001 MENTAL			2.440620	-	1,122	-	-	-	-	-	-	\$ -	\$ 1,122
Total   Payments   Total Charges (includes organ acquisition from Section K)   \$ 355,947   \$ 930,472   \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$						-	-	-	-	-	-	-	-	\$ -	s -
Total Charges (includes organ acquisition from Section K)		9100 EMERGE	NCY					-	-	-	-			\$ 90,990	\$ 580,149
Total Charges (includes organ acquisition from Section K)  Total Charges (includes organ acquisition from Section K)  Total Charges (Explain Variance)  Total Charges (Explain V						296,385	930,472	-	-	-	-	335,033	332,386		
28 Total Charges per PSAR of Exhibit Detail		Totals / Payments	S												
Unreconciled Charges (Explain Variance)  Unreconciled Charges (Explain Variance)  Total Calculated Cost (includes organ acquisition from Section K)  Total Calculated Cost (includes organ acquisition from Section K)  Total Medicale Managed Care Pethology  Total Managed Care Pethology  Total Medicale Managed Care Pethology  Total Medicale Managed Care Pethology  Total Managed Care Petholog				cquisition from Secti	on K)			\$ -	\$ -	\$ -	\$ -			\$ 874,460	\$ 1,262,858
31.01   Sampling Cost Adjustment (if applicable)		Total Charges per	PS&R or Exhibit Detail	Explain Variance)		\$ 355,947	\$ 930,472	\$ -	\$ -	\$ -	\$ -	\$ 518,513	\$ 332,386		
Total Calculated Cost (Includes organ acquisition from Section K)  7.020 S 198,38 S - S - S - S 119,754 S 56,415 S 191,838 S 224,733  7.031 Total Macloculated TUC. C-P pay and Spend-Down) (See Note E)  7.032 S - S - S - S - S - S - S - S - S - S		Sampling Cost Adj		Explain Valuation)										\$ -	\$ -
33   Total Medical Managed Care Phal Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)   \$   \$   \$   \$   \$   \$   \$   \$   \$	1.02			an acquisition from S	ection K)	\$ 72,082	\$ 168,318	\$ -	\$ -	\$ -	\$ -	\$ 119,754	\$ 56,415	\$ 191,836	\$ 224,733
Manual Insurance (Including primary and littric) party liability)   S					and Down) (San Note E)	\$ -	\$ 1,628	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,628
See   Pay (including Co-Pay and Spend-Down)   See	4	Private Insurance	(including primary and third party lia	s rrc, co-ray and Sp ability)	ena-Down) (See NOIB E)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -	\$ 586
Maciliand Cost Settlement Payments (See Note B)		Self-Pay (including Total Allowed Amo	g Co-Pay and Spend-Down)	tail (All Payments)		\$ - \$	\$ 1,628	\$ - \$	\$ -	\$ -	s -	\$ -	\$ (272)	\$ -	\$ (272)
Medicare Traditional (non-HMO) Paid Amount (excludes coinsuranceideductibles) (See Note F)   \$   \$   \$   \$   \$   \$   \$   \$   \$	7	Medicaid Cost Set	ttlement Payments (See Note B)			\$ -	\$ -	•						\$ -	s -
10   Medicare Managed Care (PMO) Paid Amount (excludes coinsurance/deductibles)   \$	18 19				tibles) (See Note F)	\$ -	\$ -	\$ - \$	\$ -	S -	Š -	\$ 24.068	\$ 6440	\$ -	\$ - \$ 6.440
22 Other Medicare Cross-Over Payments (See Note D)  \$ . \$ . \$ . \$ . \$ . \$ . \$ . \$ . \$ . \$	10	Medicare Manager	d Care (HMO) Paid Amount (excluded					-		\$ -	\$ -	\$ 29,657	\$ 31,468		
3 Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)   \$ 72,082   \$ 166,690   \$ .   \$	12	Medicare Cross-O Other Medicare Cr	over Bad Debt Payments ross-Over Payments (See Note D)							S -	\$ - \$ -	\$ -	\$ -	\$ -	\$ -
33 Calculated Payment Shortfall / (Longfall) PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH) \$ 72,082   \$ 166,690   \$ -   \$ -   \$ -   \$ 6,030   \$ 18,144   \$ 133,142   \$ 184,874   \$ 194,874   \$ 6,000   \$ 18,144   \$ 194,874   \$ 194,															
		Calculated Paym	nent Shortfall / (Longfall) (PRIOR T	O SUPPLEMENTAL P.	AYMENTS AND DSH)		\$ 166,690	\$ -	\$ -	\$ -	\$ -				\$ 184,874 18%

- Note A These amounts must agree to your inpatient and outpatent 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 melt for payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (FA summary or PS&R).

  Note C Other Medicaid Payments such a Cultier and Nor-Claim Specific payments. Doll to payments should NOT be involuded. UPL payments paid based on the Medicare corses over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare corses over payments and include other payments and include other medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare Corses-over payments and included other payments and included other payments. Notes a payments, postage and a Medicare Managed Care payments should provided to the services provided, including to the formation of the services of the payments and included other payments. Notes a payments, postage and a Medicare Corses payments. Notes a payments, postage payments,

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

Cost Report Year (10/01/2022-09/30/2023) Northside Hospital, Inc. - Gwinnett

		Total	Additional Add-In Total Adjust	Organ Intern/Resident Organ Acquisition		Total	In-State Medi	caid FFS Primary	In-State Medicaid N	Managed Care Primary		FFS Cross-Overs (with Secondary)	Included Elsewhe Secondary - Exclude I	recard Engines (Not ere & with Medicaid Medicaid Exhausted and covered)	Non-Covered (N	ICO Exhausted and lot to be Included where)	Unit	nsured
		Organ Acquisition Cos	Intern/Resident	Total Adjusted Organ Acquisition Cost	Medicaid/ Cross- Over / Uninsured Organs Sold	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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis							
-	Organ Acquisition Cost Centers (list below):																	
	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0	S -	0	\$ -	0	\$ -	0	S -	0	\$ -	0	\$ -	0
2	Kidney Acquisition	\$ -	\$ -	\$ -	\$ -	0	s -	0	\$ -	0	\$ -	0	s -	0	\$ -	0	\$ -	0
B	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0	S -	0	\$ -	0	\$ -	0	S -	0	\$ -	0	\$ -	0
ı	Heart Acquisition	s -	s -	\$ -	\$ -	0	S -	0	s -	0	\$ -	0	s -	0	\$ -	0	\$ -	0
	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0	S -	0	\$ -	0	\$ -	0	s -	0	\$ -	0	\$ -	0
5	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0	S -	0	\$ -	0	\$ -	0	S -	0	\$ -	0	\$ -	0
7	Islet Acquisition	s -	\$ -	\$ -	\$ -	0	S -	0	s -	0	\$ -	0	S -	0	\$ -	0	\$ -	0
3		\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
j	Totals	\$ -	\$ -	\$ -	\$ -		\$ -	_	\$ -	_	\$ -	_	\$ -		\$ -	_	\$ -	
)	Total Cost te A - These amounts must agree to your inp	1						-		-		-		-		-		

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 or 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, Inc. - Gwinnett

		Total			Revenue for	Total	Out-of-State Me	dicaid FFS Primary		caid Managed Care nary		are FFS Cross-Overs id Secondary)	Included Elsewher Secon	re & with Medicaid ndary)
		Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Medicaid/ Cross- Over / Uninsured Organs Sold	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		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)							
(	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0	S -	0	\$ -	0	\$ -	0	S -	0
12	Kidney Acquisition	\$ -	\$ -	\$ -	\$ -	0	s -	0	\$ -	0	\$ -	0	s -	0
13	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0	S -	0	s -	0	\$ -	0	S -	0
14	Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	S -	0
15	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	S -	0	\$ -	0	S -	0
16	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0	s -	0	\$ -	0	\$ -	0	S -	0
17	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0	s -	0	s -	0	\$ -	0	s -	0
18		\$ -	\$ -	\$ -	\$ -	0	s -	0	\$ -	0	\$ -	0	S -	0
19	Totals	\$ -	\$ -	\$ -	\$ -	-	S -	-	\$ -	-	\$ -	-	S -	-
20	Total Cost	1			7. h.l. 67 h			-		_		_		-

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, Inc. - Gwinnett

				W/S A Cost Center	
			Dollar Amount	Line	
	al Gross Provider Tax Assessment (from		\$ 10,722,842		
		nt # that includes Gross Provider Tax Assessment	Expense		ccount # )
2 Hospita	al Gross Provider Tax Assessment Include	ed in Expense on the Cost Report (W/S A, Col. 2)	\$ 10,722,842	5.00 (Where i	is the cost included on w/s A?)
3 Differen	nce (Explain Here>)	0	\$ -		
Provide		(from w/s A-6 of the Medicare cost report)			
1	Reclassification Code	0	\$ -		sified to / (from))
5	Reclassification Code	0	\$ -		sified to / (from))
3	Reclassification Code	0	\$ -		sified to / (from))
7	Reclassification Code	0	\$ -	- (Reclass	sified to / (from))
DSH U	CC ALLOWABLE - Provider Tax Asses	ssment Adjustments (from w/s A-8 of the Medicare cost report)			
3	Reason for adjustment	Lessor of Expense or benefit of add-on fee	\$ (5,802,146)	5.00 (Adjuste	
9	Reason for adjustment	0	\$ -		d to / (from))
)	Reason for adjustment	0	\$ -		d to / (from))
1	Reason for adjustment	0	\$ -	- (Adjuste	d to / (from))
DSH U	CC NON-ALLOWABLE Provider Tax As	ssessment Adjustments (from w/s A-8 of the Medicare cost report)			
2	Reason for adjustment	0	\$ -	-	
3	Reason for adjustment	0	\$ -	-	
		0	ė		
1	Reason for adjustment	0	<b>3</b>	-	
	Reason for adjustment	0	\$ 4,920,696	-	
t 5 6 Total Ne		0	\$ 4,920,696		
1 5 6 Total Ne	Reason for adjustment let Provider Tax Assessment Expense Ind	0 cluded in the Cost Report	\$ 4,920,696 \$ 5,802,146		
1 5 6 Total Ne Provide 7 Gross A	Reason for adjustment  tet Provider Tax Assessment Expense Inc  ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the	cluded in the Cost Report			
1 5 6 Total Ne Provide 7 Gross A	Reason for adjustment  tet Provider Tax Assessment Expense Inc  ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the	0  cluded in the Cost Report  e Cost Report  Adjustment to All Medicaid Eligible & Uninsured:			
Frovide Gross A	Reason for adjustment  tet Provider Tax Assessment Expense Inc  ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the clionment of Provider Tax Assessment.	oluded in the Cost Report  c Cost Report  Adjustment to All Medicaid Eligible & Uninsured:	\$ 5,802,146		
Frovide Gross A Apporti	Reason for adjustment  et Provider Tax Assessment Expense Ind  ler Tax Assessment Adjustment:  Allowable Assessment Not Included in the  ctionment of Provider Tax Assessment  Medicaid Eligible*** Charges S	cluded in the Cost Report  e Cost Report  Adjustment to All Medicaid Eligible & Uninsured: ecc. G	\$ 5,802,146		
Frovide Gross A Apporti	Reason for adjustment  tet Provider Tax Assessment Expense Inc ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the clionment of Provider Tax Assessment  Medicaid Eligible***  Uninsured Hospital  Total Hospital  Charges S  Charges S  Charges S	cluded in the Cost Report  e Cost Report  Adjustment to All Medicaid Eligible & Uninsured: ecc. G	\$ 5,802,146 1,128,857,903 502,067,045		
Frovide Gross A Apporti	Reason for adjustment  tet Provider Tax Assessment Expense Inc  ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the  tionment of Provider Tax Assessment.  Medicaid Eligible***  Charges S  Uninsured Hospital  Total Hospital  Total Hospital  Provider Tax Assessment.  Charges S  Medicaid Eligible Percentage of Prov	cluded in the Cost Report  e Cost Report  Adjustment to All Medicaid Eligible & Uninsured: Sec. G Sec. G	\$ 5,802,146 1,128,857,903 502,067,045 5,363,808,550		
Frovide Gross A Apporti	Reason for adjustment  tet Provider Tax Assessment Expense Inc  ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the  tionment of Provider Tax Assessment.  Medicaid Eligible***  Charges S  Uninsured Hospital  Total Hospital  Total Hospital  Provider Tax Assessment.  Charges S  Medicaid Eligible Percentage of Prov	o cluded in the Cost Report  e Cost Report  Adjustment to All Medicaid Eligible & Uninsured: iec. G	\$ 5,802,146 1,128,857,903 502,067,045 5,363,808,550 21,05%		
Frovide Gross A Apporti	Reason for adjustment  tet Provider Tax Assessment Expense Inc  ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the  tionment of Provider Tax Assessment .  Medicaid Eligible*** Charges S  Total Hospital Charges S  Medicaid Eligible Percentage of Pro  Percentage of Provider Tax Assessment.	o cluded in the Cost Report  e Cost Report  Adjustment to All Medicaid Eligible & Uninsured: sec. G sec. G sec. G wider Tax Assessment Adjustment to include in DSH Medicaid UCC*** ment Adjustment to include in DSH Uninsured UCC sesment Adjustment to DSH UCC***	\$ 5,802,146 1,128,857,903 502,067,045 5,363,808,550 21,05% 9,36%		
Frovide Gross A Apporti	Reason for adjustment  tet Provider Tax Assessment Expense Inc  ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the  clionment of Provider Tax Assessment.  Medicaid Eligible**** Charges S  Uninsured Hospital Charges S  Medicaid Eligible Percentage of Pro  Percentage of Provider Tax Assess  Medicaid Eligible Provider Tax Assess  Medicaid Eligible Provider Tax Assess  Medicaid Eligible Provider Tax Asses	e Cost Report  e Cost Report  Adjustment to All Medicaid Eligible & Uninsured: idec. G	\$ 5,802,146 1,128,857,903 502,067,045 5,363,808,550 21,05% 9,36% \$ 1,221,110		
Frovide  Apporti  Apporti  S  Apporti  S  Apporti  S  Apporti  Frovide  Frovide	Reason for adjustment  tet Provider Tax Assessment Expense Inc  ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the  tionment of Provider Tax Assessment.  Medicaid Eligible*** Charges S  Total Hospital Charges S  Total Hospital Charges S  Medicaid Eligible Percentage of Prov  Percentage of Provider Tax Assessment  Uninsured Provider Tax Assessment  er Tax Assessment Adjustment to DSH U	e Cost Report  e Cost Report  Adjustment to All Medicaid Eligible & Uninsured: idec. G	\$ 5,802,146 1,128,857,903 502,067,045 5,363,808,550 21,05% 9,36% \$ 1,221,110 \$ 543,097		
Frovide  Apporti  Apporti  S  Apporti  S  Apporti  S  Apporti  Frovide  Frovide	Reason for adjustment  tet Provider Tax Assessment Expense Inc  ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the  tionment of Provider Tax Assessment.  Medicaid Eligible*** Charges S  Total Hospital Charges S  Total Hospital Charges S  Medicaid Eligible Percentage of Prov  Percentage of Provider Tax Assess  Medicaid Eligible Provider Tax Asses  Uninsured Provider Tax Assessment  at Tax Assessment Adjustment to DSH U	o  cluded in the Cost Report  a Cost Report  Adjustment to All Medicaid Eligible & Uninsured:  sec. G  sec. G  sec. G  sec. G  sec. G  sec. H  sec. G	\$ 5,802,146 1,128,857,903 502,067,045 5,363,808,550 21,05% 9,36% \$ 1,221,110 \$ 543,097		
Frovide Apporti	Reason for adjustment  tet Provider Tax Assessment Expense Inc  ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the  clionment of Provider Tax Assessment.  Medicaid Eligible***  Charges S  Uninsured Hospital  Total Hospital  Total Hospital  Charges S  Medicaid Eligible Percentage of Pro  Percentage of Provider Tax Assess  Medicaid Eligible Provider Tax Assess  Uninsured Provider Tax Assessment  er Tax Assessment Adjustment to DSH Utionment of Provider Tax Assessment	o cluded in the Cost Report  e Cost Report  Adjustment to All Medicaid Eligible & Uninsured: ec. G ec.	\$ 5,802,146 1,128,857,903 502,067,045 5,363,808,550 21,05% 9,36% \$ 1,221,110 \$ 543,097 \$ 1,764,207		
Frovide Apporti	Reason for adjustment  tet Provider Tax Assessment Expense Inc  ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the  tionment of Provider Tax Assessment.  Medicaid Eligible**** Charges S  Medicaid Eligible Procentage of Pro  Percentage of Provider Tax Assessment  Medicaid Eligible Provider Tax Assessment  Tax Assessment Adjustment to DSH Ut  tionment of Provider Tax Assessment  Medicaid Primary*** Charges	o cluded in the Cost Report  a Cost Report  Adjustment to All Medicaid Eligible & Uninsured:  ac. G	\$ 5,802,146  1,128,857,903 502,067,045 5,363,808,550 21,05% 9,36% \$ 1,221,110 \$ 543,097 \$ 1,764,207		
Frovide Apporti	Reason for adjustment  tet Provider Tax Assessment Expense Inc  ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the  stionment of Provider Tax Assessment.  Medicaid Eligible***  Uninsured Hospital Charges S  Medicaid Eligible Provider Tax Assessment  Medicaid Eligible Provider Tax Assessment  Eligible Provider Tax Assessment  On Provider Tax Assessment  Charges S  Charges C  Charges	cluded in the Cost Report  a Cost Report  Adjustment to All Medicaid Eligible & Uninsured: Sec. G Sec. G Sec. G Sec. Adjustment to include in DSH Medicaid UCC*** ment Adjustment to include in DSH Uninsured UCC Sessment Adjustment to DSH UCC*** It Adjustment to DSH UCC*** CC Including all Medicaid eligibles*** Adjustment to Medicaid Primary & Uninsured: Sec. G Sec. G Sec. G Sec. G Sec. G	\$ 5,802,146 1,128,857,903 502,067,045 5,363,808,550 21,05% 9,36% \$ 1,221,110 \$ 543,097 \$ 1,764,207 460,231,911 524,210,469		
Frovide Gross A Apporti  Appor	Reason for adjustment  tet Provider Tax Assessment Expense Inc  ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the  tionment of Provider Tax Assessment.  Medicaid Eligible**** Charges S  Medicaid Eligible Percentage of Pro  Percentage of Provider Tax Assessment  Medicaid Eligible Provider Tax Assessment  Tax Assessment Adjustment to DSH Utionment of Provider Tax Assessment  Medicaid Primary***  Uninsured Provider Tax Charges S  Uninsured Hospital  Total Hospital  Total Hospital  Total Hospital  Total Proverentage of Provider Tax Assessment  Medicaid Primary **  Larges S  Medicaid Primary **  Nameur Charges S  Medicaid Primary Percentage of Provider Tax Assessment  Provider Tax Assessment  Medicaid Primary **  Nameur Charges S  Medicaid Primary Percentage of Provider Tax P	o cluded in the Cost Report  a Cost Report  Adjustment to All Medicaid Eligible & Uninsured:  ac. G	\$ 5,802,146  1,128,857,903 502,067,045 5,363,808,550 21,05% 9,36% \$ 1,221,110 \$ 543,097 \$ 1,764,207  460,231,911 524,210,469 5,363,808,550		
Frovide Apporti	Reason for adjustment  tet Provider Tax Assessment Expense Inc  ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the  citonment of Provider Tax Assessment.  Medicaid Eligible***  Charges S  Uninsured Hospital  Total Hospital  Total Hospital  Provider Tax Assessment  Medicaid Eligible Percentage of Pro  Percentage of Provider Tax Assessment  Medicaid Eligible Provider Tax Assessment  Medicaid Primary***  Charges S  Uninsured Hospital  Medicaid Primary***  Charges S  Total Hospital  Charges S  Total Hospital  Charges S  Medicaid Primary Percentage of Pro  Percentage of Provider Tax Assessment  Charges S  Medicaid Primary***  Charges S  Medicaid Primary Percentage of Pro  Percentage of Provider Tax Assessment  Charges S	cluded in the Cost Report  a Cost Report  Adjustment to All Medicaid Eligible & Uninsured: Sec. G Sec. G Sec. G Sec. G Sec. Hollow Comment Adjustment to include in DSH Medicaid UCC*** ment Adjustment to include in DSH Uninsured UCC Sessment Adjustment to DSH UCC*** at Adjustment to DSH UCC*** Adjustment to DSH UCC*** Adjustment to Medicaid eligibles*** Adjustment to Medicaid eligibles*** Adjustment to Medicaid Primary & Uninsured: Sec. G S	\$ 5,802,146 1,128,857,903 502,067,045 5,363,808,550 21,05% 9,33% \$ 1,221,110 \$ 543,097 \$ 1,764,207 460,231,911 524,210,469 5,363,808,550 8,58% 9,77%		
Frovide Apporti Frovide Apporti Apporti Apporti Apporti Apporti Apporti Apporti Apporti Apporti	Reason for adjustment  tet Provider Tax Assessment Expense Inc  ter Tax Assessment Adjustment:  Allowable Assessment Not Included in the  citonment of Provider Tax Assessment.  Medicaid Eligible***  Charges S  Uninsured Hospital  Total Hospital  Total Hospital  Provider Tax Assessment  Medicaid Eligible Percentage of Pro  Percentage of Provider Tax Assess  Uninsured Provider Tax Assessment  Medicaid Eligible Provider Tax Assessment  Medicaid Primary***  Charges S  Uninsured Hospital  Charges S  Total Hospital  Charges S  Total Hospital  Charges S  Medicaid Primary Percentage of Pre  Percentage of Provider Tax Assess  Medicaid Primary Percentage of Pre  Percentage of Provider Tax Assess  Medicaid Primary Percentage of Pre-  Percentage of Provider Tax Assess  Medicaid Primary Percentage of Previder Tax Assess	e Cost Report  Adjustment to All Medicaid Eligible & Uninsured:  Sec. G  Sec. G  Sec. G  Sec. G  Sec. G  Sec. Hollow Control Control  Sec. Sessment Adjustment to include in DSH Medicaid UCC***  ment Adjustment to DSH UCC  Sessment Adjustment to DSH UCC  Conduding all Medicaid eligibles  Adjustment to Medicaid Primary & Uninsured  Sec. G  Se	\$ 5,802,146  1,128,857,903 502,067,045 5,363,808,550 21,05% 9,36% \$ 1,221,110 \$ 543,097 \$ 1,764,207  460,231,911 524,210,469 5,363,808,650 8,55%		

<sup>\*</sup> Assessment must exclude any non-hospital assessment such as Nursing Facility.

<sup>\*\*</sup> 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-

<sup>\*\*\*</sup>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 Medicald 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 Hospital Medicaid Number Cost Report Period Northside Hospital, Inc. - Gwinnett

000000294A

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)	\$ 65,535,217	\$ -	\$ 65,535,217
2 Hospital Cash Subsidies 3 Total	Survey F-2	\$ 65,535,217	\$ - \$ -	\$ 65,535,217
<ul><li>4 Net Hospital Patient Revenue</li><li>5 Medicaid Fraction</li></ul>	Survey F-3	\$ 1,195,004,296 5.48%	\$ (86,972,776) 0.43%	\$ 1,108,031,520 5.91%
<ul><li>6 Inpatient Charity Care Charges</li><li>7 Inpatient Hospital Cash Subsidies</li></ul>	Survey F-2 Survey F-2	\$ 218,185,185	\$ - \$ -	\$ 218,185,185
8 Unspecified Hospital Cash Subsidies 9 Adjusted Inpatient Charity Care	Survey F-2	\$ 218,185,185	\$ - \$ -	\$ 218,185,185
10 Inpatient Hospital Charges 11 Inpatient Charity Fraction	Survey F-3	\$ 2,305,764,052 9.46%	\$ - 0.00%	\$ 2,305,764,052 9.46%
12 LIUR		14.94%	0.43%	15.37%
MIUR	O. marriella	E0 000		E0 000
13 In-State Medicaid Eligible Days 14 Out-of-State Medicaid Eligible Days	Survey H Survey I	58,823 98	-	58,823 98
15 Total Medicaid Eligible Days	Survey I	58,921	-	58,921
16 Total Hospital Days (excludes swing-bed)	Survey F-1	174,688	_	174,688
17 MIUR		33.73%	0.00%	33.73%

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 & P	ayment Summa	ıry												Georgia			
Hospital Name Hospital Medicaid Number	Northside Hos	pital, Inc Gwinn	ett		7												
Cost Report Period	From	10/1/2022	То	9/30/2023	_												
As-Reported:		Α	В	С	D	Е	F	G	Н	ı	J	K	L	M	N	0	P
Service Type		Total Costs Survey H & I	Medicaid Basic Rate Payments Survey H & I	Medicaid Managed Care Payments Survey H & I	Private Insurance Payments Survey H & I	Self-Pay Payments (Includes Co- Pay and Spenddown) Survey H & I	Medicaid Cost Settlement Payments Survey H & I	Other Medicaid Payments (Outliers, etc) ** Survey H & I	Medicare Traditional (non-HMO) Payments Survey H & I	Medicare Managed Care (HMO) Payments Survey H & I	Medicare Cross-over Bad Debt Survey H & I	Other Medicare Cross-over Payments (GME, etc.) Survey H & I	Uninsured Payments Survey H & I	Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
1 Medicaid Fee for Service 2 Medicaid Fee for Service	Inpatient Outpatient	33,760,141 6,845,434	19,987,713 5,578,518		384,446 8,562		(827,505)			-		-			20,372,159 4,759,575	13,387,982 2,085,859	60.34% 69.53%
3 Medicaid Managed Care 4 Medicaid Managed Care	Inpatient Outpatient	32,800,497 19,841,166	- 13,481	21,502,249 12,807,761	43,688 32,468	6,420 71,264	-								21,552,358 12,924,975	11,248,139 6,916,191	65.71% 65.14%
5 Medicare Cross-over (FFS) 6 Medicare Cross-over (FFS)	Inpatient Outpatient	28,929,407 11,529,565	265,129 1,388,971	:	- :	31,617 479		-	20,778,110 9,211,754	-	414,558 271,448	1,215,582 263,303			22,704,996 11,135,955	6,224,411 393,610	78.48% 96.59%
7 Other Medicaid Eligibles 8 Other Medicaid Eligibles	Inpatient Outpatient	52,554,559 21,440,081	2,673,541 1,165,275	213,049 218,558	11,486,137 7,260,585	40,072 31,032			8,824,039 1,696,247	18,699,525 12,288,637		- :			41,936,362 22,660,333	10,618,197 (1,220,252)	79.80% 105.69%
9 Uninsured 10 Uninsured	Inpatient Outpatient	52,830,181 37,108,081				(79) 27,816	-	:		-		1	2,297,432 8,082,730	Ī	2,297,353 8,110,546	50,532,828 28,997,535	4.35% 21.86%
11 In-State Sub-total 12 In-State Sub-total	Inpatient Outpatient	200,874,785 96,764,327	22,926,383 8,146,244	21,715,298 13,026,319	11,914,271 7,301,615	78,031 130,591	(827,505)	-	29,602,149 10,908,001	18,699,525 12,288,637	414,558 271,448	1,215,582 263,303	2,297,432 8,082,730	-	108,863,227 59,591,384	92,011,558 37,172,943	54.19% 61.58%
13 Out-of-State Medicaid 14 Out-of-State Medicaid	Inpatient Outpatient	191,836 224,733	1,628	:	- 586	(272)	:	:	24,068 6,449	29,657 31,468					53,724 39,859	138,112 184,874	28.01% 17.74%
15 Sub-Total 15.01 Provider Tax Assessment Adjustr	I/P and O/P ment to UCC	298,055,681	31,074,255	34,741,618	19,216,472	208,350	(827,505)	-	40,540,667	31,049,286	686,006	1,478,885	10,380,162	-	168,548,195	129,507,486 1,764,207	56.55%
Adjustments:		Α	В	С	D	Е	F	G	Н	1	J	К	L	М	N	0	P
Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co- Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
Medicaid Fee for Service     Medicaid Fee for Service	Inpatient Outpatient	:	:	:	:	:	-	-		- :	:	-			-	:	0.00% 0.00%
3 Medicaid Managed Care 4 Medicaid Managed Care	Inpatient Outpatient	-	-	:	-	:	-								-	:	0.00% 0.00%
5 Medicare Cross-over (FFS) 6 Medicare Cross-over (FFS)	Inpatient Outpatient	-	-		-	:			-	-	•	-			-	:	0.00% 0.00%
7 Other Medicaid Eligibles 8 Other Medicaid Eligibles	Inpatient Outpatient				:	:			:		•				•	:	0.00% 0.00%
9 Uninsured 10 Uninsured	Inpatient Outpatient	:	:	:	:	:		-		-	:	:	:	-	-	:	0.00% 0.00%
11 In-State Sub-total 12 In-State Sub-total	Inpatient Outpatient	-	-	-	- :	-	•	-	- :	-	-	-	- :	-	•	-	0.00% 0.00%
13 Out-of-State Medicaid 14 Out-of-State Medicaid	Inpatient Outpatient	:	:	:	:	:	:	-	:	:	•	:			-	:	0.00% 0.00%
15 Sub-Total 15.01 Provider Tax Assessment Adjustr	I/P and O/P ment to UCC							-			-		-		-		0.00%

DSH Examination UCC Cost & P	ayment Summa	ary												Georgia			
Hospital Name Hospital Medicaid Number	Northside Hos	spital, Inc Gwinne	ett		1												
Cost Report Period  As-Adjusted:	From	10/1/2022 A	To <b>R</b>	9/30/2023 C	_ D	E	F	G	н		J	к		м	N	0	
Service Type		Total Costs	Medicaid Basic Rate Payments Survey H & I	Medicaid Managed Care Payments Survey H & I	Private Insurance Payments Survey H & I	Self-Pay Payments (Includes Co- Pay and Spenddown) Survey H & I	Medicaid Cost Settlement Payments Survey H & I	Other Medicaid Payments (Outliers, etc) **	Medicare Traditional (non-HMO) Payments Survey H & I	Medicare Managed Care (HMO) Payments Survey H & I	Medicare Cross-over Bad Debt Survey H & I	Other Medicare Cross-over Payments (GME, etc.) Survey H & I	Uninsured Payments Survey H & I	Uninsured Payments Not On Exhibit B	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
1 Medicaid Fee for Service 2 Medicaid Fee for Service	Inpatient Outpatient	33,760,141 6,845,434	19,987,713 5,578,518	-	384,446 8,562	-	(827,505)	:				:			20,372,159 4,759,575	13,387,982 2,085,859	60.34% 69.53%
3 Medicaid Managed Care 4 Medicaid Managed Care	Inpatient Outpatient	32,800,497 19,841,166	13,481	21,502,249 12,807,761	43,688 32,468	6,420 71,264	-	:							21,552,358 12,924,975	11,248,139 6,916,191	65.71% 65.14%
5 Medicare Cross-over (FFS) 6 Medicare Cross-over (FFS)	Inpatient Outpatient	28,929,407 11,529,565	265,129 1,388,971	-		31,617 479			20,778,110 9,211,754	-	414,558 271,448	1,215,582 263,303			22,704,996 11,135,955	6,224,411 393,610	78.48% 96.59%
7 Other Medicaid Eligibles 8 Other Medicaid Eligibles	Inpatient Outpatient	52,554,559 21,440,081	2,673,541 1,165,275	213,049 218,558	11,486,137 7,260,585	40,072 31,032			8,824,039 1,696,247	18,699,525 12,288,637	:	:			41,936,362 22,660,333	10,618,197 (1,220,252)	79.80% 105.69%
9 Uninsured 10 Uninsured	Inpatient Outpatient	52,830,181 37,108,081	-	1	:	(79) 27,816		:			:	:	2,297,432 8,082,730	:	2,297,353 8,110,546	50,532,828 28,997,535	4.35% 21.86%
11 In-State Sub-total 12 In-State Sub-total	Inpatient Outpatient	200,874,785 96,764,327	22,926,383 8,146,244	21,715,298 13,026,319	11,914,271 7,301,615	78,031 130,591	(827,505)	-	29,602,149 10,908,001	18,699,525 12,288,637	414,558 271,448	1,215,582 263,303	2,297,432 8,082,730		108,863,227 59,591,384	92,011,558 37,172,943	54.19% 61.58%
13 Out-of-State Medicaid 14 Out-of-State Medicaid	Inpatient Outpatient	191,836 224,733	1,628	-	- 586	(272)	:		24,068 6,449	29,657 31,468	:	:			53,724 39,859	138,112 184,874	28.01% 17.74%
15 Cost Report Year Sub-Total 15.01	I/P and O/P	298,055,681	31,074,255	34,741,618	19,216,472	208,350	(827,505)	-	40,540,667	31,049,286 Prov	686,006 rider Tax Assessm	1,478,885 ent Adjustment to l	10,380,162 JCC Including all M	- Medicaid Eligibles	168,548,195	129,507,486 1,764,207	56.55%
16 17								Adju	sted Sub-Total UC	C Including All Med			SH Payments from Supplemental Me			131,271,693	
18 19 20								Adjusted Sub-	Total UCC Includir		: Non-Medicaid Pr	imary ÚCC Prior to	ax Assessment Ac Supplemental Me Supplemental Me	dicaid Payments		699,314 16,100,179 114,472,199	

#### Medicaid DSH Survey Adjustments

 PROVIDER:
 Northside Hospital, Inc. - Gwinnett
 Mcaid Number:
 000000294A

 FROM:
 10/1/2022
 TO:
 9/30/2023
 Mcare Number:
 110/087

			Муе	ers and Stauffe	er DSH Survey Adjustments					
Adj.#	Schedule	Line#	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
						Adjust hospital revenues to the hospital				
1	F - MIUR/LIUR Data	26	Other	2.00	Outpatient Total Patient Revenues (Total Charges)	cost report worksheet G-2.	\$ 421,021,706	\$ (421,021,706)	\$ -	2002
						Adjust hospital revenues to the hospital				
1	F - MIUR/LIUR Data	26	Other	3.00	Non-Hospital Total Patient Revenues (Total Charges)	cost report worksheet G-2.	\$ -	\$ 421,021,706	\$ 421,021,706	2002
						Adjust hospital contractuals to the				
1	F - MIUR/LIUR Data	26	Other	5.00	Outpatient Contractuals	hospital cost report worksheet G-3 total.	\$ 334,048,930	\$ (334,048,930)	\$ -	2002
						Adjust hospital contractuals to the				
1	F - MIUR/LIUR Data	26	Other	6.00	Non-Hospital Contractuals	hospital cost report worksheet G-3 total.	\$ -	\$ 334,048,930	\$ 334.048.930	2002

## **Medicaid DSH Report Notes**

PROVIDER: Northside Hospital, Inc. - Gwinnett Mcaid Number: 000000294A

FROM: 10/1/2022 TO: 9/30/2023 Mcare Number: 110087

## Myers and Stauffer DSH Report Notes

ote # Note for Report	Amounts
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