

**D. General Cost Report Year Information** 10/1/2023 - 9/30/2024

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-ATLANTA

2. Select Cost Report Year Covered by this Survey (enter "X"):

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

1/7/2025

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	NORTHSIDE HOSPITAL-ATLANTA	Yes	
5. Medicaid Provider Number:	000001405A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110161	Yes	
9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)	Pool 2	Yes	
11. Rural Referral Center (Yes or No)	No	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.
12. State Name & Number	ALABAMA	247571
13. State Name & Number	FLORIDA	107736700
14. State Name & Number	NORTH CAROLINA	1457396079
15. State Name & Number	TENNESSEE	Q061341.
16. State Name & Number	SOUTH CAROLINA	232810
17. State Name & Number		
18. State Name & Number		

(List additional states on a separate attachment)

**E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2023 - 09/30/2024)**

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. <b>Total Section 1011 Payments Related to Hospital Services (See Note 1)</b>			\$-
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. <b>Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)</b>			\$-
8. <b>Out-of-State DSH Payments (See Note 2)</b>			
	Inpatient	Outpatient	Total
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, less physician and non-hospital portion of payments)	\$-	\$-	\$-
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	0.00%	0.00%	0.00%
13. <b>Did your hospital receive any Medicaid managed care payments not paid at the claim level?</b> <i>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.</i>			
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 (10/01/2023 - 09/30/2024)**

**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) 229,703 (See Note in Section F-3, below)

**F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):**

2. Inpatient Hospital Subsidies	
3. Outpatient Hospital Subsidies	
4. Unspecified I/P and O/P Hospital Subsidies	
5. Non-Hospital Subsidies	
6. Total Hospital Subsidies	\$ -
7. Inpatient Hospital Charity Care Charges	222,586,709
8. Outpatient Hospital Charity Care Charges	352,907,333
9. Non-Hospital Charity Care Charges	
10. Total Charity Care Charges	\$ 575,494,042

**F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)**

**NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.**

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$754,976,076.00			\$ 568,183,947	\$ -	\$ -	\$ 186,792,129
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$0.00			\$ -	
15. Swing Bed - NF			\$0.00			\$ -	
16. Skilled Nursing Facility			\$0.00			\$ -	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$1,325,982,274.00	\$2,854,777,751.00		\$ 997,914,856	\$ 2,148,463,962	\$ -	\$ 1,034,381,207
20. Outpatient Services		\$7,420,088,009.00			\$ 5,584,249,658	\$ -	\$ 1,835,838,351
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers			\$0.00			\$ -	
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$0.00			\$ -	
26. Other	\$0.00	\$0.00	\$1,111,845,520.00	\$ -	\$ -	\$ 836,758,669	\$ -
27. Total	\$ 2,080,958,350	\$ 10,274,865,760	\$ 1,111,845,520	\$ 1,566,098,804	\$ 7,732,713,620	\$ 836,758,669	\$ 3,057,011,686
28. Total Hospital and Non Hospital		Total from Above	\$ 13,467,669,630		Total from Above	\$ 10,135,571,093	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	13,467,669,630	Total Contractual Adj. (G-3 Line 2)	10,135,571,093
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			10,135,571,093	
37. Unreconciled Difference	Unreconciled Difference (Should be \$0)	\$ -	Unreconciled Difference (Should be \$0)	\$ -

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (10/01/2023-09/30/2024) **NORTHSIDE HOSPITAL-ATLANTA**

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total 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
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern &amp; Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col. 2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>Days - Cost Report W/S D-1, Pt. 1, Line 2 for Adults &amp; Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. 1, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

**NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.**

**Routine Cost Centers (list below):**

1	03000	ADULTS & PEDIATRICS	\$ 184,294,583	\$ -	\$ -	\$0.00	\$ 184,294,583	147,332	\$296,980,034.00	\$ 1,250.88
2	03100	INTENSIVE CARE UNIT	\$ 51,173,502	\$ -	\$ -		\$ 51,173,502	22,141	\$167,358,927.00	\$ 2,311.26
3	03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ 55,245,292	\$ -	\$ -		\$ 55,245,292	30,206	\$180,456,803.00	\$ 1,828.95
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
10	04300	NURSERY	\$ 78,478,326	\$ -	\$ -		\$ 78,478,326	38,102	\$110,180,312.00	\$ 2,059.69
11			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 369,191,703	\$ -	\$ -	\$ -	\$ 369,191,703	237,781	\$ 754,976,076	
19		Weighted Average								\$ 1,552.65

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. 1, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. 1, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. 1, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 7	Total Charges - Cost Report Worksheet C, Pt. 1, Col. 8	Medicaid Calculated Cost-to-Charge Ratio	
20	09200	Observation (Non-Distinct)	8,078	-	\$ 10,104,609	\$854,595.00	\$22,560,725.00	\$ 23,415,320	0.431538

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. 1, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 7	Total Charges - Cost Report Worksheet C, Pt. 1, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
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**Ancillary Cost Centers (from W/S C excluding Observation) (list below):**

21	5000	OPERATING ROOM	\$155,157,943.00	\$ -	\$ -	\$ 155,157,943	\$216,667,088.00	\$620,881,050.00	\$ 837,548,138	0.185253
22	5100	RECOVERY ROOM	\$18,339,922.00	\$ -	\$ -	\$ 18,339,922	\$18,894,935.00	\$57,654,578.00	\$ 76,549,513	0.239582
23	5200	DELIVERY ROOM & LABOR ROOM	\$96,044,055.00	\$ -	\$ -	\$ 96,044,055	\$200,124,788.00	\$37,343,435.00	\$ 237,468,223	0.404450
24	5300	ANESTHESIOLOGY	\$3,082,045.00	\$ -	\$ -	\$ 3,082,045	\$43,356,233.00	\$149,139,242.00	\$ 192,495,475	0.016011
25	5400	RADIOLOGY-DIAGNOSTIC	\$157,017,294.00	\$ -	\$ -	\$ 157,017,294	\$58,238,709.00	\$512,795,125.00	\$ 571,033,834	0.274970
26	5500	RADIOLOGY-THERAPEUTIC	\$36,466,800.00	\$ -	\$ -	\$ 36,466,800	\$9,643,294.00	\$290,807,220.00	\$ 300,450,514	0.121374
27	5600	RADIOISOTOPE	\$14,982,717.00	\$ -	\$ -	\$ 14,982,717	\$3,214,260.00	\$79,749,462.00	\$ 82,963,722	0.180594
28	5700	CT SCAN	\$13,010,821.00	\$ -	\$ -	\$ 13,010,821	\$94,346,672.00	\$325,682,204.00	\$ 420,028,876	0.030976
29	5800	MRI	\$15,990,539.00	\$ -	\$ -	\$ 15,990,539	\$26,807,730.00	\$185,761,324.00	\$ 212,569,054	0.075225

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (10/01/2023-09/30/2024)      NORTHSIDE HOSPITAL-ATLANTA

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	I/P Routine			Total Charges	Medicaid Per Diem / Cost or Other Ratios
					Total Cost	I/P Days and I/P Ancillary Charges	Charges and O/P Ancillary Charges		
30	5900 CARDIAC CATHETERIZATION	\$9,195,179.00	\$ -	\$ -	\$ 9,195,179	\$20,501,699.00	\$61,263,572.00	\$ 81,765,271	0.112458
31	6000 LABORATORY	\$110,688,129.00	\$ -	\$ -	\$ 110,688,129	\$466,934,334.00	\$473,157,171.00	\$ 940,091,505	0.117742
32	6500 RESPIRATORY THERAPY	\$22,063,315.00	\$ -	\$ -	\$ 22,063,315	\$62,972,917.00	\$5,870,554.00	\$ 68,843,471	0.320485
33	6600 PHYSICAL THERAPY	\$15,393,011.00	\$ -	\$ -	\$ 15,393,011	\$26,098,278.00	\$26,222,699.00	\$ 52,320,977	0.294203
34	6700 OCCUPATIONAL THERAPY	\$4,327,435.00	\$ -	\$ -	\$ 4,327,435	\$18,742,804.00	\$1,617,252.00	\$ 20,360,056	0.212545
35	6800 SPEECH PATHOLOGY	\$2,152,488.00	\$ -	\$ -	\$ 2,152,488	\$11,864,395.00	\$396,015.00	\$ 12,260,410	0.175564
36	6900 ELECTROCARDIOLOGY	\$8,322,203.00	\$ -	\$ -	\$ 8,322,203	\$43,648,827.00	\$25,827,464.00	\$ 69,476,291	0.119785
37	7000 ELECTROENCEPHALOGRAPHY	\$1,192,457.00	\$ -	\$ -	\$ 1,192,457	\$3,925,311.00	\$609,383.00	\$ 4,534,694	0.262963
38	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$134,075,236.00	\$ -	\$ -	\$ 134,075,236	\$69,677,742.00	\$127,866,862.00	\$ 197,544,604	0.678709
39	7200 IMPL. DEV. CHARGED TO PATIENTS	\$89,009,496.00	\$ -	\$ -	\$ 89,009,496	\$136,063,904.00	\$215,695,724.00	\$ 351,759,628	0.253041
40	7300 DRUGS CHARGED TO PATIENTS	\$690,991,465.00	\$ -	\$ -	\$ 690,991,465	\$646,381,322.00	\$4,799,315,972.00	\$ 5,445,697,294	0.126888
41	7400 RENAL DIALYSIS	\$2,825,598.00	\$ -	\$ -	\$ 2,825,598	\$11,452,904.00	\$0.00	\$ 11,452,904	0.246715
42	7500 ASC (NON-DISTINCT PART)	\$23,670,380.00	\$ -	\$ -	\$ 23,670,380	\$16,509,901.00	\$126,158,567.00	\$ 142,668,468	0.165912
43	7600 OTHER ANCILLARY SERVICES	\$4,385,833.00	\$ -	\$ -	\$ 4,385,833	\$41,376.00	\$7,188,022.00	\$ 7,229,398	0.606666
44	7700 ALLOGENEIC HSCT ACQUISITION	\$2,182,596.00	\$ -	\$ -	\$ 2,182,596	\$694,730.00	\$3,075,570.00	\$ 3,770,300	0.578892
45	9000 CLINIC	\$2,048,057.00	\$ -	\$ -	\$ 2,048,057	\$167.00	\$585,856.00	\$ 586,023	3.494841
46	9001 MENTAL HEALTH OP CLINIC	\$9,576,046.00	\$ -	\$ -	\$ 9,576,046	\$88,032.00	\$4,318,592.00	\$ 4,406,624	2.173103
47	9002 CANCER CENTER	\$296,958,026.00	\$ -	\$ -	\$ 296,958,026	\$2,028,560.00	\$986,304,302.00	\$ 988,332,862	0.300464
48	9100 EMERGENCY	\$31,880,992.00	\$ -	\$ -	\$ 31,880,992	\$48,317,890.00	\$180,540,046.00	\$ 228,857,936	0.139305
49		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (10/01/2023-09/30/2024) NORTHSIDE HOSPITAL-ATLANTA

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total 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
91		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
92		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
126	<b>Total Ancillary</b>	\$ 1,971,030,078	\$ -	\$ -	\$ 1,971,030,078	\$ 2,258,093,397	\$ 9,328,387,988	\$ 11,586,481,385	
127	<b>Weighted Average</b>								0.170987
128	<b>Sub Totals</b>	\$ 2,340,221,781	\$ -	\$ -	\$ 2,340,221,781	\$ 3,013,069,473	\$ 9,328,387,988	\$ 12,341,457,461	
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)				\$0.00				
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)				\$0.00				
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	<b>Grand Total</b>				\$ 2,340,221,781				
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 (10/01/2023-09/30/2024) NORTHSIDE HOSPITAL-ATLANTA

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						
				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 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	Inpatient	Outpatient				
<b>Routine Cost Centers (from Section G):</b>				<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>									
1	03000 ADULTS & PEDIATRICS	\$ 1,250.88		13,182		9,892		4,292		7,978		1,681		12,514		37,025		35.61%							
2	03100 INTENSIVE CARE UNIT	\$ 2,311.26		2,653		160		616		990		151		2,313		4,742		31.89%							
3	03200 CORONARY CARE UNIT	\$ -		-		-		-		-		-		-		-									
4	03300 BURN INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-		-									
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-		-									
6	03500 OTHER SPECIAL CARE UNIT	\$ 1,828.95		653		7,119		4,337		3,209		817		775		11,798		41.66%							
7	04000 SUBPROVIDER I	\$ -		-		-		-		-		-		-		-									
8	04100 SUBPROVIDER II	\$ -		-		-		-		-		-		-		-									
9	04200 OTHER SUBPROVIDER	\$ -		-		-		-		1,758		963		1,318		23,224		64.41%							
10	04300 NURSERY	\$ 2,059.69		13,367		7,136		-		-		-		-		-									
11		\$ -		-		-		-		-		-		-		-									
12		\$ -		-		-		-		-		-		-		-									
13		\$ -		-		-		-		-		-		-		-									
14		\$ -		-		-		-		-		-		-		-									
15		\$ -		-		-		-		-		-		-		-									
16		\$ -		-		-		-		-		-		-		-									
17		\$ -		-		-		-		-		-		-		-									
18		\$ -		-		-		-		-		-		-		-									
	<b>Total Days</b>			<b>30,025</b>		<b>24,307</b>		<b>4,910</b>		<b>13,935</b>		<b>3,612</b>		<b>16,920</b>		<b>76,789</b>		<b>39.44%</b>							
19	Total Days per PS&R or Exhibit Detail			30,025		24,307		4,910		13,935		3,612		16,920											
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-		-									
21	Routine Charges	\$ 83,901,253		\$ 75,722,045		\$ 14,420,649		\$ 48,642,659		\$ 0,807,394		\$ 49,537,390		\$ 222,686,608		\$ 2,899,998		36.09%							
	Calculated Routine Charge Per Diem	\$ 2,794.38		\$ 3,115.24		\$ 2,937.00		\$ 3,490.68		\$ 2,992.08		\$ 2,927.74		\$ 2,899.98											
<b>Ancillary Cost Centers (from WIS C) (from Section G):</b>				<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>									
22	09200 Observation (Non-Distinct)	0.431538		149,168		756,882		95,316		1,464,535		48,774		433,606		71,234		570,155	9,122	126,950	8,124	1,203,185	\$ 364,492	\$ 3,225,179	21.11%
23	5000 OPERATING ROOM	0.185253		15,386,279		4,560,842		7,882,941		13,200,116		4,388,413		10,171,205		6,702,135		6,238,079	1,349,820	1,270,262	12,367,847	28,577,421	\$ 34,359,769	\$ 34,170,242	13.99%
24	5100 RECOVERY ROOM	0.238982		4,202,427		1,748,055		903,064		1,492,015		524,401		1,060,930		570,455		128,825	492,901	2,873,675	5,629,892	\$ 5,629,892	\$ 5,629,892	17.19%	
25	5200 DELIVERY ROOM & LABOR ROOM	0.404450		16,298,516		113,833		27,264,963		4,337,721		3,565,328		273,032		14,298,941		1,117,612	3,338,110	394,086	3,476,780	\$ 61,416,748	\$ 5,842,199	29.20%	
26	5300 ANESTHESIOLOGY	0.016011		2,628,875		997,550		34,723		1,317,841		795,835		2,446,946		1,127,163		1,315,713	257,653	280,017	2,475,044	6,168,082	\$ 4,588,596	\$ 7,898,590	11.26%
27	5400 RADIOLOGY-DIAGNOSTIC	0.274970		3,621,058		2,618,764		6,051,288		15,108,991		2,405,544		14,361,250		4,101,982		9,006,989	1,994,278	6,483,059	45,038,828	\$ 16,179,462	\$ 41,095,994	19.50%	
28	5500 RADIOLOGY-THERAPEUTIC	0.121374		462,316		3,974,018		256,375		6,355,417		365,829		13,598,207		560,917		7,005,337	50,156	853,834	1,035,239	17,817,714	\$ 1,645,437	\$ 30,932,978	17.61%
29	5600 RADIOISOTOPE	0.180594		333,973		140,985		82,970		369,247		376,381		3,286,500		225,778		1,153,913	65,199	697,732	3,747,511	\$ 1,019,111	\$ 4,959,745	13.19%	
30	5700 CT SCAN	0.030976		4,441,015		3,683,866		2,092,057		4,232,500		3,620,790		7,177,465		3,488,994		2,771,917	644,586	572,998	12,073,207	25,477,900	\$ 13,642,255	\$ 17,865,748	16.70%
31	5800 MRI	0.075225		1,365,700		2,107,892		1,477,744		1,477,744		928,115		5,736,326		949,259		811,899	166,813	252,689	3,125,811	4,189,772	\$ 4,029,488	\$ 10,133,860	10.32%
32	5900 CARDIAC CATHETERIZATION	0.112458		3,617,716		3,498,096		3,498,096		639,721		1,735,877		2,149,484		2,416,769		595,263	101,454	5,551,070	4,078,638	\$ 1,269,428	\$ 3,907,917	31.17%	
33	6000 LABORATORY	0.117742		40,071,326		13,789,547		27,662,077		20,120,916		12,734,831		29,399,452		25,148,874		18,859,720	3,461,433	5,416,639	60,669,549	\$ 105,611,299	\$ 82,165,666	32.99%	
34	6500 RESPIRATORY THERAPY	0.320485		4,808,279		88,544		3,968,220		63,889		1,011,286		4,260,591		127,883		409,076	14,240	280,690	3,104,847	\$ 14,048,378	\$ 342,912	26.44%	
35	6600 PHYSICAL THERAPY	0.294203		947,362		98,087		287,726		774,607		450,845		846,430		112,190		136,615	1,556,563	2,319,094	2,856,125	\$ 928,524	\$ 2,856,125	15.13%	
36	6700 OCCUPATIONAL THERAPY	0.212545		1,754,024		39,902		1,204,193		32,993		763,293		373,001		1,187,351		150,709	211,418	48,325	1,511,663	452,451	\$ 4,908,861	\$ 596,605	38.02%
37	6800 SPEECH PATHOLOGY	0.173564		2,019,587		16,484		1,621,941		98,215		322,772		106,472		673,371		205,835	4,276	626,388	153,536	\$ 4,841,671	\$ 257,132	48.07%	
38	6900 ELECTROCARDIOLOGY	0.119785		1,054,518		285,432		451,188		464,663		524,126		457,430		274,207		59,902	1,254,023	2,503,908	2,240,110	\$ 1,534,953	\$ 1,534,953	11.08%	
39	7000 ELECTROENCEPHALOGRAPHY	0.262963		1,932		-		199,363		128,702		80,993		205,466		9,109		19,016	1,234	326,470	3,256	\$ 535,463	\$ 91,336	22.33%	
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.678709		2,889,190		1,057,901		378,659		133,066		66,580		39,796		2,166,613		1,105,707	86,171	1,932,57	1,262,758	\$ 3,551,048	\$ 1,346,472	3.29%	
41	7200 IMPL. DEV. CHARGED TO PATIENTS	0.253041		4,210,417		1,862,628		2,469,749		2,837,035		3,841,237		5,068,578		2,787,033		1,878,452	361,811	568,811	4,343,075	9,396,533	\$ 13,316,536	\$ 11,644,693	11.26%
42	7300 DRUGS CHARGED TO PATIENTS	0.128888		38,501,688		23,200,856		25,710,795		22,250,646		15,930,590		185,411,445		29,910,204		127,283,944	5,178,713	8,935,389	55,349,217	257,955,508	\$ 110,053,258	\$ 358,148,923	14.77%
43	7400 RENAL DIALYSIS	0.248715		484,480		-		43,464		1,841,711		1,841,711		-		167,252		-	-	1,079,076	-	\$ 3,464,903	\$ -	\$ -	41.14%
44	7500 ASC (NON-DISTINCT PART)	0.165912		59,941		68,140		1,009,312		2,725,540		527,963		2,341,191		1,411,278		1,628,838	268,842	1,842,070	6,531,749	\$ 3,008,494	\$ 7,266,480	13.37%	
45	7600 OTHER ANCILLARY SERVICES	0.606666		72,728		-		265,009		162,290		199,368		155,428		102,650		32,995	122,048	381,878	493,165	\$ 464,308	\$ 464,308	21.60%	
46	7700 ALLOGENEIC HSCT ACQUISITION	0.578892		-		-		-		-		-		-		105,945		2,327	6,536	105,945	\$ 47,409	\$ 47,409	\$ 47,409	7.69%	
47	9000 CLINIC	3.494841		339		-		26,177		74,417		-		8,268		24,132		2,343	19,444	4,008	79,520	\$ 34,784	\$ 98,549	40.10%	
48	9001 MENTAL HEALTH OP CLINIC	2.173103		1,424		48,836		4,064		95,795		-		160,558		2,356		258,801	269,159	40,201	6,844,844	\$ 7,844	\$ 563,990	42.03%	
49	9002 CANCER CENTER	0.300464		24,648		1,397,376		321,746		6,504,935		2,109		12,764,495		119,939		442,524	940,544	235,946	12,691,812	\$ 4,683,432	\$ 26,352,910	4.16%	
50	9100 EMERGENCY	0.139305		2,838,817		10,316,199		746,237		11,010,520		1,739,509		4,219,602		1,668,719		3,918,450</							

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

Cost Report Year (10/01/2023-09/30/2024) NORTHSIDE HOSPITAL-ATLANTA

			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										
71																											
72																											
73																											
74																											
75																											
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127																											
			\$	152,238,726	\$	72,335,087	\$	115,130,399	\$	118,582,886	\$	57,634,276	\$	301,897,500	\$	105,485,783	\$	192,401,525	\$	20,254,955	\$	22,290,882	\$	187,594,108	\$	547,743,060	

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

Cost Report Year (10/01/2023-09/30/2024) NORTHSIDE HOSPITAL-ATLANTA

	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
<b>Totals / Payments</b>															
128 Total Charges (includes organ acquisition from Section J)	\$ 236,139,979	\$ 72,335,087	\$ 190,852,444	\$ 118,582,886	\$ 72,054,925	\$ 301,897,500	\$ 154,128,442	\$ 192,401,525	\$ 31,062,349	\$ 22,290,882	\$ 237,131,498	\$ 547,743,060	\$ 653,175,790	\$ 685,216,998	17.31%
129 Total Charges per PS&R or Exhibit Detail	\$ 236,139,979	\$ 72,335,087	\$ 190,852,444	\$ 118,582,886	\$ 72,054,925	\$ 301,897,500	\$ 154,128,442	\$ 192,401,525	\$ 31,062,349	\$ 22,290,882	\$ 237,131,498	\$ 547,743,060	\$ 653,175,790	\$ 685,216,998	
130 Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 79,935,603	\$ 10,788,067	\$ 65,457,131	\$ 21,213,314	\$ 16,236,072	\$ 43,477,362	\$ 41,496,427	\$ 28,215,259	\$ 9,764,844	\$ 4,199,148	\$ 54,653,255	\$ 83,536,979	\$ 203,125,233	\$ 103,694,002	19.09%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 1,020,409	\$ 286,823	\$ 32,721,057	\$ 16,348,400			\$ 36,789	\$ 3,487					\$ 1,057,198	\$ 290,928	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 32,721,057	\$ 16,348,400			\$ 505,716	\$ 231,756					\$ 33,226,773	\$ 16,578,136	
134 Private Insurance (including primary and third party liability)			\$ 95,769	\$ (414)			\$ 41,510,584	\$ 17,771,481					\$ 41,606,353	\$ 17,771,067	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ (173)	\$ 3	\$ 1,823	\$ 7,371			\$ 96,138	\$ 57,707	\$ 92,533	\$ 32,355			\$ 97,787	\$ 65,081	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 1,020,236	\$ 286,826	\$ 32,818,648	\$ 16,353,995											
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)							\$ 1,840,114	\$ 1,481,011					\$ 1,840,114	\$ 1,481,011	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 3,540,774	\$ 15,933,813					\$ 3,540,774	\$ 15,933,813	
141 Medicare Cross-Over Bad Debt Payments															
142 Other Medicare Cross-Over Payments (See Note D)															
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)															
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)	\$ 78,915,367	\$ 10,501,241	\$ 32,638,483	\$ 4,859,319	\$ 16,236,072	\$ 43,477,362	\$ (6,033,688)	\$ (7,263,956)	\$ 9,672,311	\$ 4,166,793	\$ 54,653,255	\$ 83,536,979	\$ 121,756,234	\$ 51,573,966	
146 Calculated Payments as a Percentage of Cost	1%	3%	50%	77%	0%	0%	115%	126%	1%	1%	0%	0%	40%	50%	
147 Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (CR, WIS S-3, Pt. 1, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)						48,380									10%
148 Percent of cross-over days to total Medicare days from the cost report															

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).

**NOTE: Inpatient uninsured payment rate is outside normal ranges, please verify this is correct.**  
**NOTE: Outpatient uninsured payment rate is outside normal ranges, please verify this is correct.**



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

Cost Report Year (10/01/2023-09/30/2024) NORTHSIDE HOSPITAL-ATLANTA

	9100	EMERGENCY		0.139305	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	
					20,168	240,037			7,126	29,841	19,748	117,990	\$ 47,042	\$ 387,868
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**I. Out-of-State Medicaid Data:**

Cost Report Year (10/01/2023-09/30/2024) NORTHSIDE HOSPITAL-ATLANTA

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
113										\$ -	\$ -
114										\$ -	\$ -
115										\$ -	\$ -
116										\$ -	\$ -
117										\$ -	\$ -
118										\$ -	\$ -
119										\$ -	\$ -
120										\$ -	\$ -
121										\$ -	\$ -
122										\$ -	\$ -
123										\$ -	\$ -
124										\$ -	\$ -
125										\$ -	\$ -
126										\$ -	\$ -
127										\$ -	\$ -
		\$ 271,414	\$ 1,262,022	\$ -	\$ -	\$ 106,800	\$ 3,333,196	\$ 274,502	\$ 7,070,698	\$ -	\$ -

<b>Totals / Payments</b>											
128	<b>Total Charges (includes organ acquisition from Section K)</b>	\$ 368,560	\$ 1,262,022	\$ -	\$ -	\$ 119,175	\$ 3,333,196	\$ 381,530	\$ 7,070,698	\$ 869,264	\$ 11,665,915
129	Total Charges per PS&R or Exhibit Detail	\$ 368,560	\$ 1,262,022	\$ -	\$ -	\$ 119,175	\$ 3,333,196	\$ 381,530	\$ 7,070,698		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	<b>Total Calculated Cost (includes organ acquisition from Section K)</b>	\$ 86,882	\$ 175,646	\$ -	\$ -	\$ 20,387	\$ 442,579	\$ 81,611	\$ 926,524	\$ 188,880	\$ 1,544,749
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		\$ 1,466				\$ 9,079		\$ 17,020	\$ -	\$ 27,565
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)						\$ 84	\$ 78	\$ 23,158	\$ 78	\$ 23,242
135	Self-Pay (including Co-Pay and Spend-Down)								\$ 1	\$ -	\$ 1
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ -	\$ 1,466	\$ -	\$ -					\$ -	\$ -
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)					\$ 24,529	\$ 281,930		\$ 27	\$ 24,529	\$ 281,956
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 40,187	\$ 977,617	\$ 40,187	\$ 977,617
141	Medicare Cross-Over Bad Debt Payments									\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)									\$ -	\$ -
143	<b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ 86,882	\$ 174,180	\$ -	\$ -	\$ (4,142)	\$ 151,486	\$ 41,346	\$ (91,299)	\$ 124,086	\$ 234,368
144	<b>Calculated Payments as a Percentage of Cost</b>	0%	1%	0%	0%	120%	66%	49%	110%	34%	85%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).  
 Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).  
 Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.  
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).  
 Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

Cost Report Year (10/01/2023-09/30/2024)

NORTHSIDE HOSPITAL-ATLANTA

	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)	Charges	Useable Organs (Count)
						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 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
<b>Organ Acquisition Cost Centers (list below):</b>																			
1	Lung Acquisition	\$0.00	\$ -	\$ -		0													
2	Kidney Acquisition	\$0.00	\$ -	\$ -		0													
3	Liver Acquisition	\$0.00	\$ -	\$ -		0													
4	Heart Acquisition	\$0.00	\$ -	\$ -		0													
5	Pancreas Acquisition	\$0.00	\$ -	\$ -		0													
6	Intestinal Acquisition	\$0.00	\$ -	\$ -		0													
7	Islet Acquisition	\$0.00	\$ -	\$ -		0													
8		\$0.00	\$ -	\$ -		0													
9	<b>Totals</b>	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -		
10	<b>Total Cost</b>																		

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 H 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 (10/01/2023-09/30/2024)

NORTHSIDE HOSPITAL-ATLANTA

	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)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)	
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
						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)
<b>Organ Acquisition Cost Centers (list below):</b>													
11	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0							
12	Kidney Acquisition	\$ -	\$ -	\$ -	\$ -	0							
13	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0							
14	Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0							
15	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0							
16	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0							
17	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0							
18		\$ -	\$ -	\$ -	\$ -	0							
19	<b>Totals</b>	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -
20	<b>Total Cost</b>												

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 I 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 (10/01/2023-09/30/2024) **NORTHSIDE HOSPITAL-ATLANTA**

**Worksheet A Provider Tax Assessment Reconciliation:**

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 34,854,651	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	10-00900-00141 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		5.00 (Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ 34,854,651	
<b>Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)</b>		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
<b>DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
8 Reason for adjustment	Lessor of Expense or benefit of add on fee	5.00 (Adjusted to / (from))
9 Reason for adjustment		(Adjusted to / (from))
10 Reason for adjustment		(Adjusted to / (from))
11 Reason for adjustment		(Adjusted to / (from))
<b>DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
12 Reason for adjustment		
13 Reason for adjustment		
14 Reason for adjustment		
15 Reason for adjustment		
16 Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ (9,217,485)	

**DSH UCC Provider Tax Assessment Adjustment:**

17 Gross Allowable Assessment Not Included in the Cost Report	\$ 44,072,136
<b>Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible &amp; Uninsured:</b>	
18 Medicaid Eligible*** Charges Sec. G	1,404,281,198
19 Uninsured Hospital Charges Sec. G	784,874,558
20 Total Hospital Charges Sec. G	12,341,457,461
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	11.38%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	6.36%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***	\$ 5,014,778
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 2,802,837
25 Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***	\$ 7,817,615
<b>Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary &amp; Uninsured:</b>	
26 Medicaid Primary*** Charges Sec. G	619,540,979
27 Uninsured Hospital Charges Sec. G	838,227,788
28 Total Hospital Charges Sec. G	12,341,457,461
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	5.02%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	6.79%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***	\$ 2,212,421
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 2,993,365
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC***	\$ 5,205,786

\* 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.