

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:
- 2. Select Cost Report Year Covered by this Survey (enter "X"):
- 3. Status of Cost Report Used for this Survey (Should be audited if available):
- 3a. Date CMS processed the HCRIS file into the HCRIS database:

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	NORTHSIDE HOSPITAL, INC. - DULUTH	Yes	
5. Medicaid Provider Number:	000001064A	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:	110252	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. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**
 - 5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)
 - 6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
 - 7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**
 - 8. **Out-of-State DSH Payments (See Note 2)**
- | | Inpatient | Outpatient | Total |
|--|--------------|---------------|--------------|
| 9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B) | \$ 268,465 | \$ 2,892,529 | \$3,160,994 |
| 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B) | \$ 1,306,309 | \$ 12,157,298 | \$13,463,606 |
| 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) | \$1,574,774 | \$15,049,827 | \$16,624,601 |
| 12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments: | 17.05% | 19.22% | 19.01% |
- 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

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) 40,631 (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	43,427,327
8. Outpatient Hospital Charity Care Charges	45,397,978
9. Non-Hospital Charity Care Charges	
10. Total Charity Care Charges	\$ 88,825,305

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	\$87,901,420.00			\$ 72,196,346	\$ -	\$ -	\$ 15,705,074
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$27,418,191.00			\$ 22,519,468	\$ -	\$ -	\$ 4,898,723
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	\$304,862,810.00	\$623,476,408.00		\$ 250,393,917	\$ 512,081,811	\$ -	\$ 165,863,490
20. Outpatient Services		\$184,244,101.00			\$ 151,325,779	\$ -	\$ 32,918,322
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	\$27,076,542.00			\$ 22,238,860	\$ -
27. Total	\$ 420,182,421	\$ 807,720,509	\$ 27,076,542	\$ 345,109,730	\$ 663,407,589	\$ 22,238,860	\$ 219,385,610
28. Total Hospital and Non Hospital		Total from Above	\$ 1,254,979,472		Total from Above	\$ 1,030,756,180	
29. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	1,254,979,472		Total Contractual Adj. (G-3 Line 2)	1,030,756,180	
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						1,030,756,180	
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, INC. - DULUTH

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 & 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. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, 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	\$ 62,421,083	\$ -	\$ -	\$0.00	\$ 62,421,083	43,481	\$100,844,247.00	\$ 1,435.59
2	03100	INTENSIVE CARE UNIT	\$ 11,092,575	\$ -	\$ -		\$ 11,092,575	2,118	\$14,475,364.00	\$ 5,237.29
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	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
10	04300	NURSERY	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
11			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 73,513,658	\$ -	\$ -	\$ -	\$ 73,513,658	45,599	\$ 115,319,611	
19		Weighted Average								\$ 1,612.17

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
09200 Observation (Non-Distinct)	4,968	-	-	\$ 7,132,011	\$427,858.00	\$10,455,002.00	\$ 10,882,860	0.655343

Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)	Cost Report Worksheet C, Part I, Col.2 and Col. 4	Calculated	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

5000	OPERATING ROOM	\$16,635,659.00	\$ -	\$ -	\$ 16,635,659	\$21,585,436.00	\$120,503,567.00	\$ 142,089,003	0.117079
5100	RECOVERY ROOM	\$4,701,049.00	\$ -	\$ -	\$ 4,701,049	\$2,693,376.00	\$19,364,487.00	\$ 22,057,863	0.213124
5300	ANESTHESIOLOGY	\$708,506.00	\$ -	\$ -	\$ 708,506	\$6,268,107.00	\$35,901,659.00	\$ 42,169,766	0.016801
5400	RADIOLOGY-DIAGNOSTIC	\$14,271,778.00	\$ -	\$ -	\$ 14,271,778	\$22,068,144.00	\$102,721,495.00	\$ 124,789,639	0.114367
5600	RADIOISOTOPE	\$1,259,924.00	\$ -	\$ -	\$ 1,259,924	\$3,299,701.00	\$7,817,159.00	\$ 11,116,860	0.113335
5700	CT SCAN	\$2,928,915.00	\$ -	\$ -	\$ 2,928,915	\$33,604,686.00	\$86,441,087.00	\$ 120,045,773	0.024398
6000	LABORATORY	\$10,215,170.00	\$ -	\$ -	\$ 10,215,170	\$68,504,782.00	\$74,571,239.00	\$ 143,076,021	0.071397
6500	RESPIRATORY THERAPY	\$3,781,316.00	\$ -	\$ -	\$ 3,781,316	\$11,874,145.00	\$1,482,886.00	\$ 13,357,031	0.283096
6600	PHYSICAL THERAPY	\$868,978.00	\$ -	\$ -	\$ 868,978	\$8,356,261.00	\$1,219,444.00	\$ 9,575,705	0.090748

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2023-09/30/2024) NORTHSIDE HOSPITAL, INC. - DULUTH

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
30	6700 OCCUPATIONAL THERAPY	\$310,795.00	\$ -	\$ -	\$ 310,795	\$6,443,957.00	\$370,399.00	\$ 6,814,356	0.045609
31	6800 SPEECH PATHOLOGY	\$307,723.00	\$ -	\$ -	\$ 307,723	\$2,227,388.00	\$343,004.00	\$ 2,570,392	0.119718
32	6900 ELECTROCARDIOLOGY	\$2,210,463.00	\$ -	\$ -	\$ 2,210,463	\$10,698,309.00	\$15,722,621.00	\$ 26,420,930	0.083663
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$20,052,318.00	\$ -	\$ -	\$ 20,052,318	\$8,956,227.00	\$20,007,462.00	\$ 28,963,689	0.692326
34	7200 IMPL. DEV. CHARGED TO PATIENTS	\$25,823,250.00	\$ -	\$ -	\$ 25,823,250	\$20,659,163.00	\$86,619,094.00	\$ 107,278,257	0.240713
35	7300 DRUGS CHARGED TO PATIENTS	\$16,510,969.00	\$ -	\$ -	\$ 16,510,969	\$77,623,128.00	\$50,390,805.00	\$ 128,013,933	0.128978
36	7400 RENAL DIALYSIS	\$1,527,148.00	\$ -	\$ -	\$ 1,527,148	\$3,672,802.00	\$0.00	\$ 3,672,802	0.415799
37	7500 ASC (NON-DISTINCT PART)	\$9,201,489.00	\$ -	\$ -	\$ 9,201,489	\$7,239,147.00	\$21,099,692.00	\$ 28,338,839	0.324695
38	9001 MENTAL HEALTH OP CLINIC	\$1,210,602.00	\$ -	\$ -	\$ 1,210,602	\$60,799.00	\$336,821.00	\$ 397,620	3.044620
39	9100 EMERGENCY	\$23,045,136.00	\$ -	\$ -	\$ 23,045,136	\$24,897,677.00	\$116,054,303.00	\$ 140,951,980	0.163496
40		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
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, INC. - DULUTH

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	Total Ancillary	\$ 155,571,188	\$ -	\$ -	\$ 155,571,188	\$ 341,161,093	\$ 771,422,226	\$ 1,112,583,319	
127	Weighted Average								0.146239
128	Sub Totals	\$ 229,084,846	\$ -	\$ -	\$ 229,084,846	\$ 456,480,704	\$ 771,422,226	\$ 1,227,902,930	
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	Grand Total				\$ 229,084,846				
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) NORTHSHIDE HOSPITAL, INC. - DULUTH

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report (Totals Includes all payers)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis	
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	\$ 1,435.59		1,539	357	2,023	1,854	478	4,788	6,251	28.73%							
2	03100 INTENSIVE CARE UNIT	\$ 5,237.29		400	20	75	97	9	493	561	49.81%							
3	03200 CORONARY CARE UNIT	\$ -		-	-	-	-	-	-	-								
4	03300 BURN INTENSIVE CARE UNIT	\$ -		-	-	-	-	-	-	-								
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -		-	-	-	-	-	-	-								
6	03500 OTHER SPECIAL CARE UNIT	\$ -		-	-	-	-	-	-	-								
7	04000 SUBPROVIDER I	\$ -		-	-	-	-	-	-	-								
8	04100 SUBPROVIDER II	\$ -		-	-	-	-	-	-	-								
9	04200 OTHER SUBPROVIDER	\$ -		-	-	-	-	-	-	-								
10	04300 NURSERY	\$ -		-	-	-	-	-	-	-								
11	\$ -			-	-	-	-	-	-	-								
12	\$ -			-	-	-	-	-	-	-								
13	\$ -			-	-	-	-	-	-	-								
14	\$ -			-	-	-	-	-	-	-								
15	\$ -			-	-	-	-	-	-	-								
16	\$ -			-	-	-	-	-	-	-								
17	\$ -			-	-	-	-	-	-	-								
18	\$ -			-	-	-	-	-	-	-								
19	Total Days per PS&R or Exhibit Detail			1,939	377	2,098	1,911	487	5,281	6,812	26.58%							
20	Unreconciled Days (Explain Variance)			-	-	-	-	-	-	-								
21	Routine Charges	\$ 5,017,087		\$ 984,388	\$ 5,847,410	\$ 5,847,410	\$ 4,562,043	\$ 1,088,564	\$ 15,472,705	\$ 16,410,928	27.69%							
21.01	Calculated Routine Charge Per Diem	\$ 2,587.46		\$ 2,611.11	\$ 2,787.14	\$ 2,787.14	\$ 2,387.25	\$ 2,235.24	\$ 2,929.88	\$ 2,409.12								
Ancillary Cost Centers (from WIS C) (from Section G):				Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		
22	09200 Observation (Non-Distinct)	0.655343		42,310	210,843	6,801	347,530	28,014	559,490	34,390	337,119	99,508	1,603,634	\$ 111,515	\$ 1,454,982	30.21%		
23	5000 OPERATING ROOM	0.117079		689,070	1,475,306	857,270	3,251,221	28,014	559,490	34,390	337,119	99,508	1,603,634	\$ 111,515	\$ 1,454,982	30.21%		
24	5100 RECOVERY ROOM	0.218124		65,285	293,511	96,285	747,233	138,263	683,770	67,270	217,434	25,838	60,019	\$ 305,177	\$ 1,148,146	13.91%		
25	5300 ANESTHESIOLOGY	0.018801		134,126	344,556	344,494	1,338,399	308,605	1,144,302	184,843	404,038	57,081	111,611	\$ 915,222	\$ 2,168,987	17.42%		
26	5400 RADIOLOGY-DIAGNOSTIC	0.114367		762,305	941,973	390,243	3,662,761	1,309,237	5,291,672	1,011,061	2,470,312	259,313	410,346	\$ 3,734,311	\$ 9,260,831	23.70%		
27	5600 RADIOISOTOPE	0.113335		125,311	46,788	20,675	198,859	211,644	485,881	167,357	130,807	20,594	8,724	\$ 546,243	\$ 804,772	25.05%		
28	5700 CT SCAN	0.024398		1,650,055	1,313,141	510,425	3,694,216	1,955,733	5,639,314	1,432,913	1,825,927	343,130	509,985	\$ 6,278,241	\$ 18,438,328	12.47%		
29	6000 LABORATORY	0.071397		4,182,094	1,828,004	958,294	5,552,050	4,245,689	3,830,507	3,277,195	1,686,105	728,518	12,421,047	\$ 15,942,750	\$ 12,863,856	38.87%		
30	6500 RESPIRATORY THERAPY	0.283096		771,069	29,991	101,496	412,059	53,353	630,933	67,400	12,881	1,737,755	115,114	\$ 1,915,557	\$ 258,143	32.31%		
31	6600 PHYSICAL THERAPY	0.090748		206,862	15,903	15,903	13,349	294,736	160,830	342,209	27,357	23,234	1,167	\$ 363,101	\$ 66,437	15.83%		
32	6700 OCCUPATIONAL THERAPY	0.045609		108,495	7,176	7,176	4,896	164,224	75,759	247,067	14,546	11,835	649	\$ 193,667	\$ 27,866	12.57%		
33	6800 SPEECH PATHOLOGY	0.119716		88,628	4,243	4,243	5,589	129,141	43,106	63,851	3,384	11,309	-	\$ 135,691	\$ 29,494	20.79%		
34	6900 ELECTROCARDIOLOGY	0.083663		570,564	257,200	130,180	544,328	715,157	1,027,735	444,136	339,442	76,378	98,169	\$ 1,660,899	\$ 2,650,675	12.68%		
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.692326		164,400	3,985	3,985	51,831	11,408	46,111	5,283	8,641	5,229	2,012	\$ 34,351	\$ 185,076	11.48%		
36	7200 IMPL. DEV. CHARGED TO PATIENTS	0.240713		255,279	238,443	32,746	3,271,941	956,604	3,530,388	332,632	738,934	47,923	258,110	\$ 5,026,941	\$ 1,577,261	7.77%		
37	7300 DRUGS CHARGED TO PATIENTS	0.128978		3,724,249	1,131,981	1,180,481	3,644,385	4,360,095	2,271,056	3,681,698	491,436	783,832	12,375,552	\$ 11,648,198	\$ 12,946,904	8.35%		
38	7400 RENAL DIALYSIS	0.415799		233,913	792,789	37,524	2,582	211,912	2,510	299,159	800	371	440,168	\$ 6,722	\$ 782,508	56.52%		
39	7500 ASC (NON-DISTINCT PART)	0.324695		8,412	579,518	579,518	2,617,442	643,854	2,177,030	349,466	756,798	192,357	243,812	\$ 1,691,205	\$ 4,210,054	47.53%		
40	9001 MENTAL HEALTH OP CLINIC	3.044620		1,424	5,301	5,301	7,858	-	14,949	2,013	5,268	-	835	\$ 33,651	\$ 4,272	33.37%		
41	9100 EMERGENCY	0.163496		1,514,287	2,850,428	355,529	9,205,503	1,408,179	3,176,303	1,034,764	1,897,750	200,758	1,009,471	\$ 4,127,480	\$ 25,981,058	17.12%		
42	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
43	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
44	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
45	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
46	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
47	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
48	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
49	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
50	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
51	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
52	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
53	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
54	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
55	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
56	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
57	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
58	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
59	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
60	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
61	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
62	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
63	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
64	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
65	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
66	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
67	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
68	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
69	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		
70	-			-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-		

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

Cost Report Year (10/01/2023-09/30/2024) NORTHSIDE HOSPITAL, INC. - DULUTH

	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 / Payments															
128 Total Charges (includes organ acquisition from Section J)	\$ 20,317,419	\$ 11,759,269	\$ 6,507,441	\$ 38,270,270	\$ 24,244,706	\$ 32,938,460	\$ 18,686,885	\$ 13,187,186	\$ 4,288,381	\$ 4,375,712	\$ 65,397,418	\$ 105,077,566	\$ 69,756,450	\$ 96,155,184	27.49%
129 Total Charges per PS&R or Exhibit Detail	\$ 20,317,419	\$ 11,759,269	\$ 6,507,441	\$ 38,270,270	\$ 24,244,706	\$ 32,938,460	\$ 18,686,885	\$ 13,187,186	\$ 4,288,381	\$ 4,375,712	(Agrees to Exhibit A)	(Agrees to Exhibit A)			
130 Unreconciled Charges (Explain Variance)															
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 6,174,521	\$ 1,700,693	\$ 1,343,599	\$ 5,469,681	\$ 5,533,403	\$ 4,493,617	\$ 4,701,669	\$ 1,823,198	\$ 1,128,061	\$ 615,988	\$ 15,304,533	\$ 13,950,752	\$ 17,753,192	\$ 13,487,189	26.49%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 3,168,670	\$ 1,442,231			\$ 299,712	\$ 311,878	\$ 24,273	\$ 1,108					\$ 3,492,655	\$ 1,755,216	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 889,702	\$ 3,759,272			\$ 8,471	\$ 23,698					\$ 898,173	\$ 3,782,970	
134 Private Insurance (including primary and third party liability)	\$ 56,552	\$ 3,408											\$ 1,574,281	\$ 1,549,643	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ 13	\$ 561		\$ 3,866	\$ 63	\$ 2,253	\$ 33,220	\$ 5,442	\$ 500	\$ 9,379			\$ 33,296	\$ 12,122	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 3,225,234	\$ 1,446,200	\$ 889,702	\$ 3,763,138											
137 Medicaid Cost Settlement Payments (See Note B)		\$ (132,175)												\$ (132,175)	
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)					\$ 3,318,154	\$ 2,557,750	\$ 605,361	\$ 47,032					\$ 3,923,515	\$ 2,604,782	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 1,033,420	\$ 482,226					\$ 1,033,420	\$ 482,226	
141 Medicare Cross-Over Bad Debt Payments					\$ 24,894	\$ 39,923							\$ 24,894	\$ 39,923	
142 Other Medicare Cross-Over Payments (See Note D)					\$ (823)								\$ (823)	\$ -	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											\$ 268,465	\$ 2,892,529			
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)	\$ 2,949,287	\$ 386,668	\$ 453,897	\$ 1,706,543	\$ 1,891,403	\$ 1,581,813	\$ 1,479,194	\$ (282,542)	\$ 1,127,561	\$ 606,609	\$ 15,036,068	\$ 11,058,223	\$ 6,773,781	\$ 3,392,482	
146 Calculated Payments as a Percentage of Cost	52%	77%	66%	69%	66%	65%	69%	115%	0%	2%	2%	21%	62%	75%	
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)					18,047										
148 Percent of cross-over days to total Medicare days from the cost report					12%										

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.

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2023-09/30/2024) NORTHSIDE HOSPITAL, INC. - DULUTH

	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									
113																		
114																		
115																		
116																		
117																		
118																		
119																		
120																		
121																		
122																		
123																		
124																		
125																		
126																		
127																		
	\$	168,982	\$	700,183	\$	-	\$	-	\$	26,088	\$	18,327	\$	173,247	\$	-	\$	-

Totals / Payments																					
128	Total Charges (includes organ acquisition from Section K)	\$	214,549	\$	700,183	\$	-	\$	-	\$	-	\$	26,088	\$	25,491	\$	173,247	\$	240,040	\$	899,518
129	Total Charges per PS&R or Exhibit Detail	\$	214,549	\$	700,183	\$	-	\$	-	\$	-	\$	26,088	\$	25,491	\$	173,247				
130	Unreconciled Charges (Explain Variance)		-		-		-		-		-		-		-		-				
131	Total Calculated Cost (includes organ acquisition from Section K)	\$	58,621	\$	93,994	\$	-	\$	-	\$	-	\$	5,119	\$	7,955	\$	23,083	\$	66,576	\$	122,196
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			\$	861													\$	-	\$	861
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)													\$	21,382	\$	9,634	\$	21,382	\$	9,634
135	Self-Pay (including Co-Pay and Spend-Down)			\$	4											\$	100	\$	-	\$	104
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$	-	\$	865	\$	-	\$	-												
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)											\$	1,644					\$	-	\$	1,644
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)														\$	7,603		\$	-	\$	7,603
141	Medicare Cross-Over Bad Debt Payments																	\$	-	\$	-
142	Other Medicare Cross-Over Payments (See Note D)																	\$	-	\$	-
143	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$	58,621	\$	93,129	\$	-	\$	-	\$	-	\$	3,475	\$	(13,427)	\$	5,746	\$	45,194	\$	102,350
144	Calculated Payments as a Percentage of Cost		0%		1%		0%		0%		0%		32%		269%		75%		32%		16%

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, INC. - DULUTH

	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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis	
Organ Acquisition Cost Centers (list below):																			
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	Totals	\$ -	\$ -	\$ -	0	\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -	
10	Total Cost																		

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).

Note B - Enter Organ Acquisition Payments in Section 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, INC. - DULUTH

	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)	
Organ Acquisition Cost Centers (list below):													
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	Totals	\$ -	\$ -	\$ -	0	\$ -		\$ -		\$ -		\$ -	
20	Total Cost												

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).

Note B - Enter Organ Acquisition Payments in Section 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, INC. - DULUTH**

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 3,177,893	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	40-00900-00141 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 3,177,893	5.00 (Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ -	
Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
8 Reason for adjustment	Lesser of Provider fee or 11.88% add-on amt	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))
DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
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	\$ 2,313,627	

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ 864,266
Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:	
18 Medicaid Eligible*** Charges Sec. G	175,715,284
19 Uninsured Hospital Charges Sec. G	170,474,984
20 Total Hospital Charges Sec. G	1,227,902,930
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	14.31%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	13.88%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***	\$ 123,678
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 119,990
25 Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***	\$ 243,668
Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:	
26 Medicaid Primary*** Charges Sec. G	77,769,130
27 Uninsured Hospital Charges Sec. G	179,139,077
28 Total Hospital Charges Sec. G	1,227,902,930
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	6.33%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	14.59%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***	\$ 54,738
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 126,088
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC***	\$ 180,826

* Assessment must exclude any non-hospital assessment such as Nursing Facility.

** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.

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