DSH Version 9.02 4/22/2025

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, INC. - GWINNETT		
		10/1/2023 through 9/30/2024		
2.	Select Cost Report Year Covered by this Survey (enter "X"):	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:	2/28/2025		

		Data	Correct?	If Incorrect, Proper Information
4.	Hospital Name:	NORTHSIDE HOSPITAL, INC. - GWINNETT	Yes	
5.	Medicaid Provider Number:	000000294A	Yes	
6.	Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7.	Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8.	Medicare Provider Number:	110087	Yes	
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)	$ 1,591,466	$ 5,960,854	$7,552,320
10.	Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 8,170,076	$ 30,146,289	$38,316,365
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)	$9,761,543	$36,107,143	$45,868,685
12.	Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	16.30%	16.51%	16.47%

13.	**Did your hospital receive any Medicaid managed care payments not paid at the claim level?**	No
	Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.	
14.	Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	
15.	Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	
16.	Total Medicaid managed care non-claims payments (see question 13 above) received	$-

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2023 - 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)	190,895	**(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	845,974
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 845,974
7.	Inpatient Hospital Charity Care Charges	226,263,604
8.	Outpatient Hospital Charity Care Charges	108,494,157
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 334,757,761

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)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$538,588,582.00			$ 416,441,679	$ -	$ -	$ 122,146,903
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	$2,035,111,547.00	$1,977,108,737.00		$ 1,573,567,095	$ 1,528,718,785	$ -	$ 909,934,403
20.	Outpatient Services		$445,116,290.00			$ 344,168,038	$ -	$ 100,948,252
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	$419,978,648.00	$ -	$ -	$ 324,731,380	$ -
27.	Total	$ 2,573,700,129	$ 2,422,225,027	$ 419,978,648	$ 1,990,008,775	$ 1,872,886,823	$ 324,731,380	$ 1,133,029,558
28.	Total Hospital and Non Hospital		Total from Above	$ 5,415,903,804		Total from Above	$ 4,187,626,978	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	5,415,903,804	Total Contractual Adj. (G-3 Line 2)	4,187,626,978
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				4,187,626,978
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. - GWINNETT

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.

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
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 217,115,191	$ 5,091,809	$ -	$0.00	$ 222,207,000	172,840	$332,374,222.00		$ 1,285.62
2	03100 INTENSIVE CARE UNIT	$ 52,861,203	$ 886,424	$ -		$ 53,747,627	16,447	$126,156,846.00		$ 3,267.93
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	$ 19,056,083	$ -	$ -		$ 19,056,083	10,441	$72,945,999.00		$ 1,825.12
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 6,424,315	$ 374,128	$ -		$ 6,798,443	6,963	$7,111,515.00		$ 976.37
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 295,456,792	$ 6,352,361	$ -	$ -	$ 301,809,153	206,691	$ 538,588,582		
19	Weighted Average									$ 1,460.19

Line #	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*
20	09200	Observation (Non-Distinct)	15,796	-	-	$ 20,307,654	$1,989,073.00	$18,517,466.00	$ 20,506,539	0.990301

Line #		Cost Center Description	*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
		Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000	OPERATING ROOM	$59,377,242.00	$ 748,606	$ -		$ 60,125,848	$211,737,435.00	$111,857,140.00	$ 323,594,575	0.185806
22	5100	RECOVERY ROOM	$7,652,859.00	$ -	$ -		$ 7,652,859	$18,555,791.00	$40,328,511.00	$ 58,884,302	0.129964
23	5200	DELIVERY ROOM & LABOR ROOM	$21,997,797.00	$ 748,606	$ -		$ 22,746,403	$56,621,874.00	$10,110,143.00	$ 66,732,017	0.340862
24	5300	ANESTHESIOLOGY	$1,502,278.00	$ -	$ -		$ 1,502,278	$50,363,790.00	$54,574,880.00	$ 104,938,670	0.014316
25	5400	RADIOLOGY-DIAGNOSTIC	$55,120,645.00	$ -	$ -		$ 55,120,645	$68,701,826.00	$296,055,439.00	$ 364,757,265	0.151116
26	5500	RADIOLOGY-THERAPEUTIC	$7,708,892.00	$ -	$ -		$ 7,708,892	$4,269,980.00	$176,347,552.00	$ 180,617,532	0.042681
27	5600	RADIOISOTOPE	$3,886,378.00	$ -	$ -		$ 3,886,378	$2,798,884.00	$7,343,049.00	$ 10,141,933	0.383199
28	5700	CT SCAN	$6,845,117.00	$ -	$ -		$ 6,845,117	$148,826,950.00	$213,247,031.00	$ 362,073,981	0.018905
29	5800	MRI	$3,763,548.00	$ -	$ -		$ 3,763,548	$35,713,917.00	$40,346,492.00	$ 76,060,409	0.049481

G. Cost Report - Cost / Days / Charges

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

	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	5900	CARDIAC CATHETERIZATION	$13,908,825.00	$ -	$ -		$ 13,908,825	$128,565,469.00	$152,165,128.00	$ 280,730,597	0.049545
31	6000	LABORATORY	$35,294,381.00	$ -	$ -		$ 35,294,381	$346,757,459.00	$189,721,055.00	$ 536,478,514	0.065789
32	6500	RESPIRATORY THERAPY	$21,620,198.00	$ -	$ -		$ 21,620,198	$91,245,172.00	$4,976,869.00	$ 96,222,041	0.224691
33	6600	PHYSICAL THERAPY	$16,052,081.00	$ -	$ -		$ 16,052,081	$26,936,225.00	$24,430,862.00	$ 51,367,087	0.312497
34	6700	OCCUPATIONAL THERAPY	$2,048,296.00	$ -	$ -		$ 2,048,296	$13,573,992.00	$1,162,160.00	$ 14,736,152	0.138998
35	6800	SPEECH PATHOLOGY	$1,609,328.00	$ -	$ -		$ 1,609,328	$8,883,814.00	$1,069,325.00	$ 9,953,139	0.161690
36	6900	ELECTROCARDIOLOGY	$14,572,859.00	$ -	$ -		$ 14,572,859	$57,930,039.00	$127,764,667.00	$ 185,694,706	0.078478
37	7000	ELECTROENCEPHALOGRAPHY	$1,070,559.00	$ -	$ -		$ 1,070,559	$4,871,264.00	$1,518,205.00	$ 6,389,469	0.167551
38	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$113,956,752.00	$ -	$ -		$ 113,956,752	$72,350,298.00	$106,673,848.00	$ 179,024,146	0.636544
39	7200	IMPL. DEV. CHARGED TO PATIENTS	$112,529,774.00	$ -	$ -		$ 112,529,774	$220,264,803.00	$137,978,018.00	$ 358,242,821	0.314116
40	7300	DRUGS CHARGED TO PATIENTS	$60,670,425.00	$ -	$ -		$ 60,670,425	$433,761,962.00	$169,755,924.00	$ 603,517,886	0.100528
41	7400	RENAL DIALYSIS	$4,677,832.00	$ -	$ -		$ 4,677,832	$15,303,092.00	$0.00	$ 15,303,092	0.305679
42	7500	ASC (NON-DISTINCT PART)	$30,698,744.00	$ -	$ -		$ 30,698,744	$17,019,040.00	$98,917,654.00	$ 115,936,694	0.264789
43	7600	MISC ANCILLARY SERVICES	$3,514,523.00	$ -	$ -		$ 3,514,523	$58,471.00	$10,764,785.00	$ 10,823,256	0.324720
44	9000	CLINIC	$9,358,441.00	$ -	$ -		$ 9,358,441	$1,731.00	$6,783,842.00	$ 6,785,573	1.379167
45	9001	MENTAL HEALTH OP CLINIC	$3,134,779.00	$ -	$ -		$ 3,134,779	$257,928.00	$1,486,959.00	$ 1,744,887	1.796551
46	9003	GME OP CLINIC	$485,017.00	$ 6,323,103	$ -		$ 6,808,120	$0.00	$8,195,616.00	$ 8,195,616	0.830703
47	9100	EMERGENCY	$87,812,109.00	$ 1,216,294	$ -		$ 89,028,403	$117,844,513.00	$290,039,162.00	$ 407,883,675	0.218269
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. - GWINNETT

	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**	$ 700,869,679	$ 9,036,609	$ -		$ 709,906,288	$ 2,155,204,792	$ 2,302,131,782	$ 4,457,336,574	
127		**Weighted Average**									0.163823
128		**Sub Totals**	$ 996,326,471	$ 15,388,970	$ -		$ 1,011,715,441	$ 2,693,793,374	$ 2,302,131,782	$ 4,995,925,156	
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**					$ 1,011,715,441				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					1.54%				

* 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, INC. - GWINNETT

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,285.62		8,760		5,518		8,149		7,324		1,313		16,684		31,064		30.49%
2	03100 INTENSIVE CARE UNIT	$ 3,267.93		2,195		137		686		684		178		2,180		3,880		36.88%
3	03200 CORONARY CARE UNIT	$ -														-		
4	03300 BURN INTENSIVE CARE UNIT	$ -														-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -														-		
6	03500 OTHER SPECIAL CARE UNIT	$ 1,825.12		496		3,519				1,536		146		296		5,697		57.40%
7	04000 SUBPROVIDER I	$ -														-		
8	04100 SUBPROVIDER II	$ -														-		
9	04200 OTHER SUBPROVIDER	$ -														-		
10	04300 NURSERY	$ 976.37		2,322		2,345				631		225		244		5,523		82.82%
11		$ -														-		
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			**Total Days**	13,773		11,519		8,835		10,175		1,862		19,404		46,164		31.79%
19	Total Days per PS&R or Exhibit Detail			13,773		11,519		8,835		10,175		1,862		19,404				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 43,496,701		$ 37,773,173		$ 23,887,429		$ 32,322,317		$ 5,456,579		$ 54,372,441		$ 137,479,620		35.68%
21.01	Calculated Routine Charge Per Diem			$ 3,158.11		$ 3,279.21		$ 2,703.73		$ 3,176.64		$ 2,930.49		$ 2,802.13		$ 2,978.07		
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.990301	128,341	467,696	49,256	1,178,345	138,667	1,527,047	91,032	767,948	9,284	133,187	9,932	3,502,736	$ 407,296	$ 3,941,036	39.07%
23	5000 OPERATING ROOM		0.185806	10,215,271	2,790,248	7,251,858	3,948,261	8,697,147	6,576,927	6,914,804	2,692,743	1,615,810	503,293	22,272,814	10,497,754	$ 33,079,079	$ 16,008,180	25.95%
24	5100 RECOVERY ROOM		0.129964	1,132,948	652,478	-	1,200,610	568,019	1,931,162	663,029	760,209	-	138,743	1,239,152	2,873,881	$ 2,363,996	$ 4,544,459	18.95%
25	5200 DELIVERY ROOM & LABOR ROOM		0.340862	2,358,349	27,359	10,016,160	2,100,704	2,037,725	71,539	4,385,112	442,948	600,625	162,969	6,095,357	1,698,670	$ 18,797,346	$ 2,642,549	44.98%
26	5300 ANESTHESIOLOGY		0.014316	1,806,047	728,879	1,484,577	1,432,177	1,719,273	2,234,518	1,429,052	985,819	305,572	170,015	4,447,201	3,612,668	$ 6,438,948	$ 5,381,393	19.41%
27	5400 RADIOLOGY-DIAGNOSTIC		0.151116	3,109,902	2,016,911	2,511,961	9,970,066	3,934,470	9,568,647	3,549,455	5,250,442	568,497	880,366	7,890,401	18,989,840	$ 13,105,789	$ 26,806,066	18.73%
28	5500 RADIOLOGY-THERAPEUTIC		0.042681	135,828	1,840,442	220,691	2,858,558	119,868	9,296,679	109,032	2,023,486	130,187	763,926	277,308	9,326,247	$ 585,419	$ 16,019,165	15.01%
29	5600 RADIOISOTOPE		0.383199	399,515	497,858	99,887	468,157	721,214	1,069,315	330,582	768,044	68,670	110,256	1,180,077	2,824,611	$ 1,551,198	$ 2,803,374	84.30%
30	5700 CT SCAN		0.018905	7,109,111	3,995,819	2,075,937	9,642,388	7,859,729	13,938,779	5,565,793	4,695,223	1,201,717	1,156,390	21,217,878	41,481,819	$ 22,610,570	$ 32,272,208	33.16%
31	5800 MRI		0.049481	1,501,582	1,021,668	720,532	1,703,118	2,086,975	5,061,454	1,444,573	928,452	237,127	260,393	4,804,397	3,235,184	$ 5,753,662	$ 8,714,691	30.30%
32	5900 CARDIAC CATHETERIZATION		0.049545	4,450,960	1,535,268	2,535,129	2,233,036	6,849,133	11,098,884	6,149,790	1,906,306	1,060,165	188,100	15,712,205	9,729,992	$ 19,985,012	$ 16,773,495	22.62%
33	6000 LABORATORY		0.065789	24,019,598	4,599,832	12,834,087	14,765,863	19,538,031	11,134,330	17,875,224	4,177,881	2,907,153	1,323,503	41,107,735	33,701,645	$ 74,266,940	$ 34,677,907	35.12%
34	6500 RESPIRATORY THERAPY		0.224691	5,932,793	128,538	2,646,056	424,014	2,223,585	144,957	4,112,308	203,046	591,658	27,499	6,146,528	547,881	$ 14,914,742	$ 900,556	24.05%
35	6600 PHYSICAL THERAPY		0.312497	1,275,444	320,395	202,768	228,217	1,596,417	1,235,436	926,036	368,312	145,732	138,592	2,552,044	4,020,687	$ 4,000,665	$ 2,152,360	25.34%
36	6700 OCCUPATIONAL THERAPY		0.138998	682,930	42,063	177,553	61,263	800,566	475,163	503,989	96,712	68,345	24,608	1,164,849	504,156	$ 2,165,038	$ 675,201	31.25%
37	6800 SPEECH PATHOLOGY		0.161690	510,442	6,749	42,817	20,687	614,806	194,627	400,994	41,808	59,589	6,661	926,896	191,310	$ 1,569,059	$ 263,871	30.35%
38	6900 ELECTROCARDIOLOGY		0.078478	1,093,799	418,602	185,157	770,979	898,382	4,101,713	522,774	353,795	68,890	85,509	1,335,008	2,967,149	$ 2,700,112	$ 5,645,089	6.90%
39	7000 ELECTROENCEPHALOGRAPHY		0.167551	15,593	-	247,930	53,142	354,758	139,757	218,049	47,694	66,304	14,008	483,260	104,849	$ 836,330	$ 240,593	27.34%
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.636544	2,257,519	1,115,606	39,917	74,365	58,158	55,378	99,898	37,046	8,392	6,827	253,317	142,540	$ 2,455,492	$ 1,282,395	2.32%
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.314116	4,924,216	1,743,157	1,620,695	2,207,970	10,511,170	6,045,037	4,792,805	2,133,351	1,246,698	366,746	15,028,896	4,762,964	$ 21,848,886	$ 12,129,515	15.47%
42	7300 DRUGS CHARGED TO PATIENTS		0.100528	27,552,041	1,915,827	14,123,879	4,054,857	22,469,398	6,173,077	20,895,708	2,900,822	3,690,217	508,263	47,296,422	16,506,018	$ 85,041,026	$ 15,044,583	27.92%
43	7400 RENAL DIALYSIS		0.305679	602,911	-	159,642	-	1,414,608		1,761,651		64,826		1,248,736		$ 3,938,812	$ -	34.32%
44	7500 ASC (NON-DISTINCT PART)		0.264789	27,421	10,401	511,072	2,293,118	855,960	3,389,578	699,939	1,519,396	128,682	290,189	2,098,224	5,893,717	$ 2,094,392	$ 7,212,494	19.28%
45	7600 MISC ANCILLARY SERVICES		0.324720			221,364	94,242		151,122	27,904	168,463	20,056	13,249	2,616	241,167	$ 249,268	$ 413,827	8.69%
46	9000 CLINIC		1.379167	3,035	66,000	66,729	366,405	813	5,233	27,777	79,601	4,975	43,942	6,162	776,163	$ 98,354	$ 517,239	21.32%
47	9001 MENTAL HEALTH OP CLINIC		1.796551	10,013	25,327	9,670	49,379		15,314	8,275	29,696	5,301	7,314	98,622	712,914	$ 27,958	$ 119,716	55.93%
48	9003 GME OP CLINIC		0.830703			-			1,343,415							$ -	$ 1,343,415	16.39%
49	9100 EMERGENCY		0.218269	4,501,284	7,173,315	1,387,909	31,169,680	4,443,755	7,772,886	3,336,987	5,827,052	625,917	2,394,659	12,414,276	61,960,562	$ 13,669,936	$ 51,942,933	35.24%
50			-													$ -	$ -	
51			-													$ -	$ -	
52			-													$ -	$ -	
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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. - GWINNETT

					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
71				-													$ -	$ -	
72				-													$ -	$ -	
73				-													$ -	$ -	
74				-													$ -	$ -	
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125				-													$ -	$ -	
126				-													$ -	$ -	
127				-													$ -	$ -	
					$ 105,756,893	$ 33,140,440	$ 61,443,234	$ 93,369,601	$ 100,512,627	$ 104,751,974	$ 86,842,573	$ 39,206,295	$ 15,500,387	$ 9,719,207	$ 217,290,314	$ 240,807,122			

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

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

		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
	Totals / Payments															
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 149,253,594	$ 33,140,440	$ 99,216,407	$ 93,369,601	$ 124,400,056	$ 104,751,974	$ 119,164,890	$ 39,206,295	$ 20,956,966	$ 9,719,207	$ 271,662,755 (Agrees to Exhibit A)	$ 240,807,122 (Agrees to Exhibit A)	$ 492,034,947	$ 270,468,309	25.57%
129	Total Charges per PS&R or Exhibit Detail	$ 149,253,594	$ 33,140,440	$ 99,216,407	$ 93,369,601	$ 124,400,056	$ 104,751,974	$ 119,164,890	$ 39,206,295	$ 20,956,966	$ 9,719,207	$ 271,662,755	$ 240,807,122			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 36,195,234	$ 5,489,125	$ 25,925,949	$ 15,381,380	$ 26,584,061	$ 14,300,532	$ 26,981,979	$ 6,296,853	$ 4,865,860	$ 1,551,704	$ 57,719,230	$ 36,908,595	$ 115,687,223	$ 41,467,890	24.94%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 19,541,779	$ 5,583,727			$ 464,941	$ 1,213,133	$ 21,947	$ 3,770					$ 20,028,667	$ 6,800,630	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 16,841,157	$ 12,046,239			$ 126,326	$ 72,535					$ 16,967,483	$ 12,118,774	
134	Private Insurance (including primary and third party liability)	$ 310,626	$ 27,596		$ 413		$ 84	$ 21,140,355	$ 4,716,128					$ 21,450,981	$ 4,744,220	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 315	$ 3,360	$ 667	$ 52,657	$ 150	$ 6,584	$ 78,581	$ 24,684	$ 15,086	$ 38,463			$ 79,713	$ 87,285	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 19,852,720	$ 5,614,683	$ 16,841,824	$ 12,099,309											
137	Medicaid Cost Settlement Payments (See Note B)		$ (1,044,853)											$ -	$ (1,044,853)	
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)					$ 17,847,979	$ 8,216,893	$ 3,074,955	$ 134,317					$ 20,922,934	$ 8,351,210	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 5,504,461	$ 1,525,500					$ 5,504,461	$ 1,525,500	
141	Medicare Cross-Over Bad Debt Payments					$ 324,357	$ 94,199							$ 324,357	$ 94,199	
142	Other Medicare Cross-Over Payments (See Note D)					$ 257,673	$ 194,504					(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 257,673	$ 194,504	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 1,591,466	$ 5,960,854			
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)**	$ 16,342,514	$ 919,295	$ 9,084,125	$ 3,282,071	$ 7,688,961	$ 4,575,136	$ (2,964,647)	$ (180,081)	$ 4,850,774	$ 1,513,241	$ 56,127,764	$ 30,947,741	$ 30,150,953	$ 8,596,421	
146	**Calculated Payments as a Percentage of Cost**	55%	83%	65%	79%	71%	68%	111%	103%	0%	2%	3%	16%	74%	79%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**					79,095										
148	**Percent of cross-over days to total Medicare days from the cost report**					11%										

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include *all* Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

I. Out-of-State Medicaid Data:

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

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,285.62		101				23		9		133	
2	03100 INTENSIVE CARE UNIT	$ 3,267.93		5								5	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ 1,825.12										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 976.37										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	106		-		23		9		138	
19	Total Days per PS&R or Exhibit Detail			106		-		23		9			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 246,111				$ 62,956		$ 19,920		$ 328,987	
21.01	Calculated Routine Charge Per Diem			$ 2,321.80		$ -		$ 2,737.22		$ 2,213.33		$ 2,383.96	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.990301	-	5,046			-	-	-	3,536	$ -	$ 8,582
23	5000 OPERATING ROOM		0.185806	-	-			-	-	-	-	$ -	$ -
24	5100 RECOVERY ROOM		0.129964	-	-			-	-	-	-	$ -	$ -
25	5200 DELIVERY ROOM & LABOR ROOM		0.340862	7,098	-			-	-	-	-	$ 7,098	$ -
26	5300 ANESTHESIOLOGY		0.014316	-	4,568			-	-	-	3,636	$ -	$ 8,204
27	5400 RADIOLOGY-DIAGNOSTIC		0.151116	19,976	26,516			2,132	1,926	-	29,535	$ 22,108	$ 57,977
28	5500 RADIOLOGY-THERAPEUTIC		0.042681	-	-			-	-	-	-	$ -	$ -
29	5600 RADIOISOTOPE		0.383199	-	-			-	-	-	31,434	$ -	$ 31,434
30	5700 CT SCAN		0.018905	75,585	41,361			5,604	3,619	6,453	3,619	$ 87,642	$ 48,599
31	5800 MRI		0.049481	12,578	-			-	22,060	6,936	-	$ 19,514	$ 22,060
32	5900 CARDIAC CATHETERIZATION		0.049545	31,309	7,726			-	3,608	-	1,322	$ 31,309	$ 12,656
33	6000 LABORATORY		0.065789	226,368	141,604			19,442	2,534	15,100	45,194	$ 260,910	$ 189,332
34	6500 RESPIRATORY THERAPY		0.224691	12,525	2,562			-	-	-	1,334	$ 12,525	$ 3,896
35	6600 PHYSICAL THERAPY		0.312497	4,536	-			-	-	-	-	$ 4,536	$ -
36	6700 OCCUPATIONAL THERAPY		0.138998	3,582	-			-	-	-	-	$ 3,582	$ -
37	6800 SPEECH PATHOLOGY		0.161690	3,160	-			-	-	-	-	$ 3,160	$ -
38	6900 ELECTROCARDIOLOGY		0.078478	5,892	9,329			-	491	-	3,928	$ 5,892	$ 13,748
39	7000 ELECTROENCEPHALOGRAPHY		0.167551	1,331	-			-	-	-	-	$ 1,331	$ -
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.636544		-			-	-	-	-	$ -	$ -
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.314116		51,628			-	-	-	-	$ -	$ 51,628
42	7300 DRUGS CHARGED TO PATIENTS		0.100528	288,022	23,560			88,275	4,032	16,732	13,128	$ 393,029	$ 40,719
43	7400 RENAL DIALYSIS		0.305679					-	-		-	$ -	$ -
44	7500 ASC (NON-DISTINCT PART)		0.264789					-	-		-	$ -	$ -
45	7600 MISC ANCILLARY SERVICES		0.324720					-	-		-	$ -	$ -
46	9000 CLINIC		1.379167					-			-	$ -	$ -
47	9001 MENTAL HEALTH OP CLINIC		1.796551	589	2,945						589	$ 589	$ 3,534
48	9003 GME OP CLINIC		0.830703								-	$ -	$ -
49	9100 EMERGENCY		0.218269	119,678	476,858			2,387	12,319	22,026	115,913	$ 144,091	$ 605,090

I. Out-of-State Medicaid Data:

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

				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	
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
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68			-									$ -	$ -
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110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -

I. Out-of-State Medicaid Data:

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

				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			-									$ -	$ -
				$ 812,228	$ 793,703	$ -	$ -	$ 117,840	$ 50,589	$ 67,247	$ 253,168		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 1,058,339	$ 793,703	$ -	$ -	$ 180,796	$ 50,589	$ 87,167	$ 253,168	$ 1,326,302	$ 1,097,459
129	Total Charges per PS&R or Exhibit Detail	$ 1,058,339	$ 793,703	$ -	$ -	$ 180,796	$ 50,589	$ 87,167	$ 253,168		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 232,181	$ 148,818	$ -	$ -	$ 40,672	$ 4,929	$ 19,519	$ 51,456	$ 292,372	$ 205,203
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 2,264	$ 1,129							$ 2,264	$ 1,129
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)								$ 25,739	$ -	$ 25,739
135	Self-Pay (including Co-Pay and Spend-Down)		$ 216							$ -	$ 216
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 2,264	$ 1,345	$ -	$ -						
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)					$ 6,447	$ 3,376		$ 185	$ 6,447	$ 3,561
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 13,086	$ 16,617	$ 13,086	$ 16,617
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)**	$ 229,917	$ 147,473	$ -	$ -	$ 34,225	$ 1,553	$ 6,433	$ 8,915	$ 270,575	$ 157,941
144	**Calculated Payments as a Percentage of Cost**	1%	1%	0%	0%	16%	68%	67%	83%	7%	23%

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. - GWINNETT

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):																	
1	Lung Acquisition	$0.00	$ -	$ -		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**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
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. - GWINNETT

		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)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
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**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
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. - GWINNETT

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 13,222,978		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	30-00900-00141	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 13,222,978	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*	Lessor of Expense or benefit of add-on fee	$ (4,898,134)	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		$ 8,324,844		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 4,898,134
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	795,603,191
19	Uninsured Hospital	**Charges Sec. G**	512,469,877
20	Total Hospital	**Charges Sec. G**	4,995,925,156
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		15.93%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		10.26%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ 780,030
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 502,439
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$ 1,282,469**
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	376,832,084
27	Uninsured Hospital	**Charges Sec. G**	543,146,050
28	Total Hospital	**Charges Sec. G**	4,995,925,156
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		7.54%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		10.87%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ 369,456
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 532,514
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$ 901,970**

** 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.*