

**GA DSH Payment Results for SFY 2025 - Pool 1**  
**DSH Uncompensated Care Cost & Allocation Factor Summary**  
**Preliminary Results**

3/25/2025 9:31

Provider Name	DORMINY MEDICAL CENTER
Mcaid Provider Number	000000613A
Mcare Provider Number	110073

Below is the preliminary uncompensated care cost (UCC) and allocation factor used as a basis for the 2025 Georgia Disproportionate Share Hospital (DSH) Payment. An initial review of the provider submitted survey and detailed information was performed and adjustments made, as appropriate. Please review the proposed adjustments and adjusted survey included with the preliminary results and respond with concerns within 5 business days. Hospital specific preliminary results are subject to change based on revisions needed after initial results are reviewed and possible additional validation work.

**NOTE: These are initial results only.**

<b>GA Medicaid DSH Payment Uncompensated Care Cost (UCC) For State Fiscal Year:</b>	<b>7/1/2024 - 6/30/2025</b>
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	(A)	(B)	(C)	(D)	(E)
	<u>Cost Report</u> <u>Year Begin</u>	<u>Cost Report</u> <u>Year End</u>	<u>As-Filed DSH</u> <u>Uncompensated</u> <u>Care Cost (UCC)</u>	<u>Total</u> <u>Adjustments</u>	<u>Adjusted DSH</u> <u>Uncompensated</u> <u>Care Cost (UCC)</u>
Cost Report Year UCC:	8/1/2022	- 7/31/2023	\$ 2,230,064	\$ 153,634	\$ 2,383,698
Less: 2023 Gross UPL Payments					\$ 418,447
Less: 2025 Gross DPP Payments					\$ 276,458
Less: GME Payments					\$ -
Add: Net OP Settlement (Difference between provider submitted and estimated)					\$ 52,773
Add: Provider tax excluded from the cost report (Medicaid primary & uninsured portion)					\$ -
Hospital Specific DSH Limit (Total UCC)					\$ 1,741,566
2025 Eligibility					<b>Eligible</b>
DSH Year Low Income Utilization Ratio (LIUR):					14.54%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):					40.67%

**If you disagree with the findings presented above please respond within five days of receipt with additional supporting documentation.**

All inquiries and additional documentation should be sent to the following:

- e-mail: [gadsh@mslc.com](mailto:gadsh@mslc.com)
- Fax: 816-945-5301
- Web Portal Address: <https://DSH.MSLC.com>
- Phone Inquiries: 800-374-6858

**EXAMINER ADJUSTED SURVEY**

Workpaper #:		Reviewer:
Examiner:		
Date:		

DSH Version 9.00

9/11/2024

**D. General Cost Report Year Information 8/1/2022 - 7/31/2023**

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

- 1. Select Your Facility from the Drop-Down Menu Provided:
- 2. Select Cost Report Year Covered by this Survey:
- 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:	DORMINY MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	00000613A	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:	110073	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	

**Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year:**

	State Name	Provider No.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

*(List additional states on a separate attachment)*

**E. Disclosure of Medicaid / Uninsured Payments Received: (08/01/2022 - 07/31/2023)**

- 1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)
- 2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- 3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- 4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**
- 5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)
- 6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- 7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**

8. **Out-of-State DSH Payments (See Note 2)**

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	\$ 5,892	\$ 62,386	\$68,278
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 68,049	\$ 525,661	\$593,710
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	\$73,941	\$588,047	\$661,988
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	7.97%	10.61%	10.31%

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  **<--These payments do NOT flow to Section H, and therefore do not impact the UCC. If these payments are not already considered in the UCC and should be, include the amount reported here on line 133 of Section H.**
- 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 (08/01/2022 - 07/31/2023)**

**F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)**

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6) 4,323

**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	552,523
8. Outpatient Hospital Charity Care Charges	713,122
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 1,265,645

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

	Total Patient Revenues (Charges)			Contractual Adjustments			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$ 5,818,243	\$ -	\$ -	\$ 4,052,000	\$ -	\$ -	\$ 1,766,243
12. Psych Subprovider	\$ 2,616,303	\$ -	\$ -	\$ 1,822,072	\$ -	\$ -	\$ 794,231
13. Rehab. Subprovider	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF	\$ -	\$ -	\$ 219,750	\$ -	\$ -	\$ 153,041	\$ -
15. Swing Bed - NF	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
16. Skilled Nursing Facility	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
17. Nursing Facility	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
18. Other Long-Term Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
19. Ancillary Services	\$ 9,241,350	\$ 40,946,999	\$ -	\$ 6,435,955	\$ 28,516,728	\$ -	\$ 15,235,666
20. Outpatient Services	\$ -	\$ 16,822,277	\$ -	\$ -	\$ 11,715,542	\$ -	\$ 5,106,735
21. Home Health Agency	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
22. Ambulance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
23. Outpatient Rehab Providers	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
24. ASC	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
25. Hospice	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
26. Other	\$ -	\$ -	\$ 10,466,616	\$ -	\$ -	\$ 7,289,268	\$ -
27. Total	\$ 17,675,896	\$ 57,769,276	\$ 10,686,366	\$ 12,310,028	\$ 40,232,270	\$ 7,442,308	\$ 22,902,874
28. Total Hospital and Non Hospital		Total from Above	\$ 86,131,538		Total from Above	\$ 59,984,606	
29. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	\$ 86,131,538		Total Contractual Adj. (G-3 Line 2)	\$ 59,984,606	
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						59,984,606	
37. Unreconciled Difference		Unreconciled Difference (Should be \$0)	\$ -		Unreconciled Difference (Should be \$0)	\$ -	

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

Cost Report Year (08/01/2022-07/31/2023) DORMINY MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern &amp; Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Swing-Bed Curve 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 &amp; 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>
<b>Routine Cost Centers (list below):</b>		<b>1505.2</b>				<b>1505.2</b>	<b>1505.2</b>		
1	03000 ADULTS & PEDIATRICS	\$ 6,050,714	\$ -	\$ -	\$ 6,050,714	4,347	\$ 5,395,523	\$ -	\$ 1,391.93
2	03100 INTENSIVE CARE UNIT	\$ 1,408,858	\$ -	\$ -	\$ 1,408,858	449	\$ 654,045	\$ -	\$ 3,137.77
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	\$ -	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -
18	Total Routine	\$ 7,459,572	\$ -	\$ -	\$ 7,459,572	4,796	\$ 6,049,568	\$ -	\$ 1,555.37
19	Weighted Average								
<b>Observation Data (Non-Distinct)</b>									
20	09200 Observation (Non-Distinct)		473	-	\$ 658,383	706,478	\$ 160,000	\$ 866,478	0.759838
<b>Ancillary Cost Centers (from W/S C excluding Observation) (list below):</b>									
21	5000 OPERATING ROOM	\$ 1,553,450	\$ -	\$ -	\$ 1,553,450	793,966	\$ 5,293,002	\$ 6,086,968	0.255209
22	5400 RADIOLOGY-DIAGNOSTIC	\$ 2,476,183	\$ -	\$ -	\$ 2,476,183	1,732,068	\$ 12,424,385	\$ 14,156,453	0.174915
23	6000 LABORATORY	\$ 2,258,276	\$ -	\$ -	\$ 2,258,276	2,568,289	\$ 13,719,140	\$ 16,287,429	0.138651
24	6500 RESPIRATORY THERAPY	\$ 1,084,321	\$ -	\$ -	\$ 1,084,321	1,716,743	\$ 1,250,758	\$ 2,967,501	0.365399
25	6600 PHYSICAL THERAPY	\$ 1,091,054	\$ -	\$ -	\$ 1,091,054	297,402	\$ 1,079,262	\$ 1,376,664	0.792535
26	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 905,395	\$ -	\$ -	\$ 905,395	1,190,268	\$ 1,781,934	\$ 2,972,202	0.304621
27	7200 IMPL. DEV. CHARGED TO PATIENTS	\$ 473,696	\$ -	\$ -	\$ 473,696	17,217	\$ 117,540	\$ 134,757	3.515187
28	7300 DRUGS CHARGED TO PATIENTS	\$ 1,577,163	\$ -	\$ -	\$ 1,577,163	2,656,822	\$ 5,280,978	\$ 7,937,800	0.198690
29	9100 EMERGENCY	\$ 3,527,984	\$ -	\$ -	\$ 3,527,984	1,818,355	\$ 14,141,109	\$ 15,959,464	0.221059
126	Total Ancillary	\$ 14,947,522	\$ -	\$ -	\$ 14,947,522	13,497,608	\$ 55,248,108	\$ 68,745,716	
127	Weighted Average								0.227009
128	<b>Sub Totals</b>	\$ 22,407,094	\$ -	\$ -	\$ 22,407,094	19,547,176	\$ 55,248,108	\$ 74,795,284	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)				\$ -				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)				\$ 88,196				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)				\$ -				
131.01	Other Cost Adjustments (support must be submitted)				\$ -				
132	<b>Grand Total</b>				\$ 22,318,898				
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 (08/01/2022-07/31/2023) DORMY MEDICAL CENTER

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 Medicaid FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligible (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 PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis	Inpatient	Outpatient			
<b>Routine Cost Centers (from Section G):</b>				<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>				
1	03000 ADULTS & PEDIATRICS	\$ 1,391.93		476		53		1,063		11		-		188		1,583		45.97%		
2	03100 INTENSIVE CARE UNIT	\$ 3,137.77		62		11		64		8		-		25		165		41.87%		
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	\$ -		-		-		-		-		-		-		-				
18				<b>Total Days</b>		<b>64</b>		<b>1,137</b>		<b>19</b>				<b>211</b>		<b>1,758</b>		<b>45.88%</b>		
19	Total Days per PS&R or Exhibit Detail			538		64		1,137		19				211		1,758				
20	Unreconciled Days (Explain Variance)			538		64		1,137		19				211		1,758				
21				-		-		-		-				-		-				
21.01	Routine Charges	\$ 664,342		\$ 1,273.13		\$ 74,150		\$ 1,507,598		\$ 24,460		\$ -		\$ 180,555		\$ 2,281,138		40.86%		
	Calculated Routine Charge Per Diem			1,273.13		1,325.59		1,325.59		1,297.37		\$ -		656.71		1,333.26				
22	<b>Ancillary Cost Centers (from WS C) (from Section G):</b>				<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>			
22	09200 Observation (Non-District)	\$ 0.759838		\$ 78.187		\$ 3,424		\$ 35.107		\$ 7,848		\$ 134.970		\$ 6,698		\$ 17,969		\$ 248,294	37.12%	
23	4000 OPERATING ROOM	\$ 54.634		\$ 126.369		\$ 447.356		\$ 83.640		\$ 444.543		\$ -		\$ -		\$ 138,274		\$ 1,039,726	18.22%	
24	5400 RADIOLOGY-DIAGNOSTIC	\$ 0.174915		\$ 537.958		\$ 30,614		\$ 1,131.172		\$ 246,257		\$ 1,007,698		\$ 5,551		\$ 159,590		\$ 740,846	2.84%	
25	6000 LABORATORY	\$ 0.138651		\$ 270.566		\$ 104,580		\$ 1,321.471		\$ 584,795		\$ 852,213		\$ 11,694		\$ 164,603		\$ 941,835	3.18%	
26	6500 RESPIRATORY THERAPY	\$ 0.385390		\$ 167.770		\$ 46,740		\$ 15,044		\$ 463,524		\$ 177,547		\$ 3,346		\$ 19,100		\$ 639,293	2.64%	
27	6600 PHYSICAL THERAPY	\$ 0.782535		\$ 7,055		\$ 20,333		\$ 63,270		\$ 37,927		\$ 105,629		\$ 182		\$ 21,557		\$ 45,164	6.20%	
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 0.304621		\$ 126.525		\$ 87.093		\$ 25.965		\$ 313,746		\$ 153,012		\$ 3,899		\$ 77,429		\$ 470,135	0.68%	
29	7200 IMPL. DEV. CHARGED TO PATIENTS	\$ 3.615167		\$ -		\$ -		\$ 2,680		\$ -		\$ 13,416		\$ -		\$ 2,468		\$ 3,680	172.60%	
30	7300 DRUGS CHARGED TO PATIENTS	\$ 0.198650		\$ 283.501		\$ 438.492		\$ 53,786		\$ 218,511		\$ 584,372		\$ 21,064		\$ 16,168		\$ 942,723	256.60%	
31	9100 EMERGENCY	\$ 0.221059		\$ 193.537		\$ 1,045,909		\$ 87,759		\$ 2,406,741		\$ 353,431		\$ 1,102,693		\$ 16,124		\$ 271,079		
				1,211,575		3,226,011		301,772		5,878,813		2,648,220		4,417,593		73,556		666,384		
128	<b>Totals / Payments</b>			\$ 1,896,517		\$ 3,226,011		\$ 375,922		\$ 5,878,813		\$ 4,165,806		\$ 4,417,593		\$ 98,016		\$ 666,384		\$ 14,188,801
129	Total Charges per PS&R or Exhibit Detail			1,896,517		3,226,011		375,922		5,878,813		4,165,806		4,417,593		98,016		666,384		14,188,801
130	Unreconciled Charges (Explain Variance)			-		-		-		-		-		-		-		-		
131.01	Sampling Cost Adjustment (if applicable)			-		-		-		-		-		-		-		-		
131.02	Total Calculated Cost (includes organ acquisition from Section J)			\$ 1,128,949		\$ 680,973		\$ 170,036		\$ 1,232,441		\$ 2,375,243		\$ 1,081,216		\$ 60,225		\$ 151,970		\$ 3,146,600
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			\$ 520,309		\$ 605,134		\$ 147,866		\$ 990,986		\$ -		\$ -		\$ -		\$ -		\$ 698,120
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ 985,872
134	Private Insurance (including primary and third party liability)			\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ 199,769
135	Self-Pay (including Co-Pay and Spend-Down)			\$ 8,927		\$ 204		\$ 5,314		\$ -		\$ -		\$ -		\$ -		\$ -		\$ 5,516
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			\$ 529,236		\$ 605,338		\$ 147,866		\$ 990,986		\$ -		\$ -		\$ -		\$ -		\$ 698,120
137	Medicaid Cost Settlement Payments (See Note B)			\$ -		\$ (39,037)		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ (39,037)
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)			\$ -		\$ -		\$ -		\$ 2,709,568		\$ 516,491		\$ -		\$ -		\$ -		\$ 2,709,568
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)			\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -
141	Medicare Cross-Over Bad Debt Payments			\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -
142	Other Medicare Cross-Over Payments (See Note D)			\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)			\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -
144	Section 1011 Payment Related to Inpatient Hospital Services NOT included in Exhibits B & B-1 (from Section E)			\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -		\$ -
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)			\$ 599,713		\$ 114,672		\$ 22,170		\$ 241,455		\$ (343,722)		\$ 471,739		\$ 34,264		\$ (47,799)		\$ 586,233
146	Calculated Payments as a Percentage of Cost			47%		63%		67%		69%		114%		56%		43%		131%		0%
147	Total Medicare Days from WS S-3 of the Cost Report Excluding Swing-Bed (C/R, WS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)																			2,439
148	Percent of cross-over days to total Medicare days from the cost report																			46%

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 claim data reported above. This includes payments paid to 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 (08/01/2022-07/31/2023) DORMINY MEDICAL CENTER

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 PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)						
		From Section G	From Section G										
				Days	Days	Days	Days						
1	03000 ADULTS & PEDIATRICS	\$ 1,391.93		-	-	-	-	-	-	-	-	-	-
2	03100 INTENSIVE CARE UNIT	\$ 3,137.77		-	-	-	-	-	-	-	-	-	-
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	\$ -		-	-	-	-	-	-	-	-	-	-
18			<b>Total Days</b>	-	-	-	-	-	-	-	-	-	-
19	Total Days per PS&R or Exhibit Detail			-	-	-	-	-	-	-	-	-	-
20	Unreconciled Days (Explain Variance)			-	-	-	-	-	-	-	-	-	-
21				<b>Routine Charges</b>	<b>Routine Charges</b>	<b>Routine Charges</b>	<b>Routine Charges</b>						
21.01	Routine Charges			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	Calculated Routine Charge Per Diem			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
22	<b>Ancillary Cost Centers (from W/S C) (list below):</b>			<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>						
22	09200 Observation (Non-Distinct)		0.759838	-	-	-	-	-	-	-	-	-	-
23	5000 OPERATING ROOM		0.255209	-	-	-	-	-	-	-	-	-	-
24	5400 RADIOLOGY-DIAGNOSTIC		0.174915	-	-	-	-	-	-	-	-	-	-
25	6000 LABORATORY		0.138651	-	-	-	-	-	-	-	-	-	-
26	6500 RESPIRATORY THERAPY		0.365399	-	-	-	-	-	-	-	-	-	-
27	6600 PHYSICAL THERAPY		0.792535	-	-	-	-	-	-	-	-	-	-
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.304621	-	-	-	-	-	-	-	-	-	-
29	7200 IMPL. DEV. CHARGED TO PATIENTS		3.515187	-	-	-	-	-	-	-	-	-	-
30	7300 DRUGS CHARGED TO PATIENTS		0.198690	-	-	-	-	-	-	-	-	-	-
31	9100 EMERGENCY		0.221059	-	-	-	-	-	-	-	-	-	-
128	<b>Totals / Payments</b>			<b>Total Charges (includes organ acquisition from Section K)</b>	<b>Total Charges (includes organ acquisition from Section K)</b>	<b>Total Charges (includes organ acquisition from Section K)</b>	<b>Total Charges (includes organ acquisition from Section K)</b>	<b>Total Charges (includes organ acquisition from Section K)</b>	<b>Total Charges (includes organ acquisition from Section K)</b>	<b>Total Charges (includes organ acquisition from Section K)</b>	<b>Total Charges (includes organ acquisition from Section K)</b>	<b>Total Charges (includes organ acquisition from Section K)</b>	<b>Total Charges (includes organ acquisition from Section K)</b>
128				\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
129	Total Charges per PS&R or Exhibit Detail			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
130	Unreconciled Charges (Explain Variance)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
131.01	Sampling Cost Adjustment (if applicable)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
131.02	<b>Total Calculated Cost (includes organ acquisition from Section K)</b>			<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>						
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
135	Self-Pay (including Co-Pay and Spend-Down)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
141	Medicare Cross-Over Bad Debt Payments			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
143	<b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>			<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>						
144	<b>Calculated Payments as a Percentage of Cost</b>			<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>						

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

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

Cost Report Year (08/01/2022-07/31/2023) DORMINY MEDICAL CENTER

	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-Over (with Medicaid Secondary)		In-State Uninsured Organs (excl. 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)	
						From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis	
<b>Organ Acquisition Cost Centers (list below):</b>																		
1	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
2	Kidney Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
3	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
4	Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
5	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
6	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
7	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
8		\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
9	<b>Totals</b>	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
10	<b>Total Cost</b>																	

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

Note B: Enter Organ Acquisition Payments in Section D as part of your In-State Medicaid total payments

Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

**K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid**

Cost Report Year (08/01/2022-07/31/2023) DORMINY MEDICAL CENTER

	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-Over (with Medicaid Secondary)		Included Elsewhere & with Medicaid Secondary		
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	
						From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	
<b>Organ Acquisition Cost Centers (list below):</b>														
11	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
12	Kidney Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
13	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
14	Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
15	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
16	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
17	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
18		\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
19	<b>Totals</b>	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
20	<b>Total Cost</b>													

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

Note B: Enter Organ Acquisition Payments in Section E as part of your Out-of-State Medicaid total payments

**L. Provider Tax Assessment Reconciliation / Adjustment**

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (08/01/2022-07/31/2023) DORMINY MEDICAL CENTER

**Worksheet A Provider Tax Assessment Reconciliation:**

	Dollar Amount	W/S A Cost Center Line	
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ (276,235)		
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	01.8850.0891	(WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ (276,235)	5.00	(Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ 0		
<b>Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)</b>			
4 Reclassification Code	\$ 0	-	(Reclassified to / (from))
5 Reclassification Code	\$ 0	-	(Reclassified to / (from))
6 Reclassification Code	\$ 0	-	(Reclassified to / (from))
7 Reclassification Code	\$ 0	-	(Reclassified to / (from))
<b>DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>			
8 Reason for adjustment	\$ 0	-	(Adjusted to / (from))
9 Reason for adjustment	\$ 0	-	(Adjusted to / (from))
10 Reason for adjustment	\$ 0	-	(Adjusted to / (from))
11 Reason for adjustment	\$ 0	-	(Adjusted to / (from))
<b>DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>			
12 Reason for adjustment	\$ 0	-	
13 Reason for adjustment	\$ 0	-	
14 Reason for adjustment	\$ 0	-	
15 Reason for adjustment	\$ 0	-	
16 Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ (276,235)		

**DSH UCC Provider Tax Assessment Adjustment:**

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
<b>Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible &amp; Uninsured:</b>	
18 Medicaid Eligible*** Charges Sec. G	20,715,062
19 Uninsured Hospital Charges Sec. G	5,397,666
20 Total Hospital Charges Sec. G	74,795,284
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC**	27.70%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	7.22%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***	\$ -
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
25 Provider Tax Assessment Adjustment to DSH UCC including all Medicaid eligibles***	\$ -
<b>Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary &amp; Uninsured:</b>	
26 Medicaid Primary*** Charges Sec. G	11,377,263
27 Uninsured Hospital Charges Sec. G	5,397,666
28 Total Hospital Charges Sec. G	74,795,284
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	15.21%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	7.22%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***	\$ -
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC***	\$ -

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

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

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

**DSH Examination Eligibility Summary**

Hospital Name	<b>DORMINY MEDICAL CENTER</b>			
Hospital Medicaid Number	<b>000000613A</b>			
Cost Report Period	From	<b>8/1/2022</b>	To	<b>7/31/2023</b>

		As-Reported	Adjustments	As-Adjusted
<b>LIUR</b>				
1 Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	\$ 2,336,774	\$ -	\$ 2,336,774
2 Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
3 Total		\$ 2,336,774	\$ -	\$ 2,336,774
4 Net Hospital Patient Revenue	Survey F-3	\$ 25,398,816	\$ (2,495,941)	\$ 22,902,874
5 Medicaid Fraction		9.20%	1.00%	10.20%
6 Inpatient Charity Care Charges	Survey F-2	\$ 552,523	\$ -	\$ 552,523
7 Inpatient Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
8 Unspecified Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
9 Adjusted Inpatient Charity Care		\$ 552,523	\$ -	\$ 552,523
10 Inpatient Hospital Charges	Survey F-3	\$ 17,675,896	\$ -	\$ 17,675,896
11 Inpatient Charity Fraction		3.13%	0.00%	3.13%
12 LIUR		12.33%	1.00%	13.33%
<b>MIUR</b>				
13 In-State Medicaid Eligible Days	Survey H	1,758	-	1,758
14 Out-of-State Medicaid Eligible Days	Survey I	-	-	-
15 Total Medicaid Eligible Days		1,758	-	1,758
16 Total Hospital Days (excludes swing-bed)	Survey F-1	4,323	-	4,323
17 MIUR		40.67%	0.00%	40.67%

*NOTE: LIUR calculated above does not include other Medicaid or supplemental payments reported on DSH Survey Part I and may not reconcile to DSH results letter as a result.*

DSH Examination UCC Cost & Payment Summary Georgia

Hospital Name **DORMINY MEDICAL CENTER**  
 Hospital Medicaid Number **00000613A**  
 Cost Report Period From **8/1/2022** To **7/31/2023**

As-Reported:		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E		
1 Medicaid Fee for Service	Inpatient	1,031,464	520,309	-	-	8,927	-	-	-	-	-	-	-	-	529,236	502,228	51.31%
2 Medicaid Fee for Service	Outpatient	672,232	605,134	-	-	204	(39,037)	-	-	-	-	-	-	-	568,301	105,931	84.24%
3 Medicaid Managed Care	Inpatient	158,798	-	147,866	-	-	-	-	-	-	-	-	-	-	147,866	10,932	93.12%
4 Medicaid Managed Care	Outpatient	1,228,516	-	985,672	-	5,314	-	-	-	-	-	-	-	-	990,986	237,530	80.67%
5 Medicare Cross-over (FFS)	Inpatient	2,158,711	9,399	-	-	-	-	-	2,709,566	-	-	-	-	-	2,718,965	(560,254)	125.95%
6 Medicare Cross-over (FFS)	Outpatient	1,066,126	92,986	-	-	-	-	-	516,491	-	-	-	-	-	609,477	456,649	57.17%
7 Other Medicaid Eligibles	Inpatient	57,223	-	-	25,961	-	-	-	-	-	-	-	-	-	25,961	31,262	45.37%
8 Other Medicaid Eligibles	Outpatient	151,970	-	-	199,769	-	-	-	-	-	-	-	-	199,769	(47,799)	131.45%	
9 Uninsured	Inpatient	559,880	-	-	-	-	-	-	-	-	-	-	5,892	-	5,892	553,988	1.05%
10 Uninsured	Outpatient	881,841	-	-	-	-	-	-	-	-	-	-	62,386	-	62,386	819,455	7.07%
11 In-State Sub-total	Inpatient	3,966,076	529,708	147,866	25,961	8,927	-	-	2,709,566	-	-	-	5,892	-	3,427,920	538,156	86.43%
12 In-State Sub-total	Outpatient	4,000,685	698,120	985,672	199,769	5,518	(39,037)	-	516,491	-	-	-	62,386	-	2,428,919	1,571,766	60.71%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	n/a
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	n/a
15 Sub-Total	I/P and O/P	7,966,761	1,227,828	1,133,538	225,730	14,445	(39,037)	-	3,226,057	-	-	-	68,278	-	5,856,839	2,109,922	73.52%

Adjustments:		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
		1 Medicaid Fee for Service	Inpatient	97,485	-	-	-	-	-	-	-	-	-	-	-	-	-
2 Medicaid Fee for Service	Outpatient	8,741	-	-	-	-	-	-	-	-	-	-	-	-	-	8,741	-1.08%
3 Medicaid Managed Care	Inpatient	11,238	-	-	-	-	-	-	-	-	-	-	-	-	-	11,238	-6.15%
4 Medicaid Managed Care	Outpatient	3,925	-	-	-	-	-	-	-	-	-	-	-	-	-	3,925	-0.26%
5 Medicare Cross-over (FFS)	Inpatient	216,532	-	-	-	-	-	-	-	-	-	-	-	-	-	216,532	-11.48%
6 Medicare Cross-over (FFS)	Outpatient	15,090	-	-	-	-	-	-	-	-	-	-	-	-	-	15,090	-0.80%
7 Other Medicaid Eligibles	Inpatient	3,002	-	-	-	-	-	-	-	-	-	-	-	-	-	3,002	-2.26%
8 Other Medicaid Eligibles	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
9 Uninsured	Inpatient	32,245	-	-	-	-	-	-	-	-	-	-	-	-	-	32,245	-0.06%
10 Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
11 In-State Sub-total	Inpatient	360,502	-	-	-	-	-	-	-	-	-	-	-	-	-	360,502	-7.20%
12 In-State Sub-total	Outpatient	27,756	-	-	-	-	-	-	-	-	-	-	-	-	-	27,756	-0.42%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
15 Sub-Total	I/P and O/P	388,258	-	-	-	-	-	-	-	-	-	-	-	-	-	388,258	-3.42%



Medicaid DSH Survey Adjustments

PROVIDER: DORMINY MEDICAL CENTER  
FROM: 8/1/2022

TO: 7/31/2023

Mcaid Number: 00000613A  
Mcare Number: 110073

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
1	F - MIUR/LIUR Data	26	Other	2.00	Outpatient Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	\$ 8,221,969	\$ (8,221,969)	\$ -	2002
1	F - MIUR/LIUR Data	26	Other	3.00	Non-Hospital Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	\$ 2,244,647	\$ 8,221,969	\$ 10,466,616	2002
1	F - MIUR/LIUR Data	26	Other	5.00	Outpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	\$ 5,726,028	\$ (5,726,028)	\$ -	2002
1	F - MIUR/LIUR Data	26	Other	6.00	Non-Hospital Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	\$ 1,563,240	\$ 5,726,028	\$ 7,289,268	2002
2	G - CR Data	1	ADULTS & PEDIATRICS	3.00	Total Allowable Cost	Adjust to roll up Subprovider IPF	\$ 3,632,621.00	\$ 2,418,093	\$ 6,050,714.00	1505.20
2	G - CR Data	7	SUBPROVIDER I	3.00	Total Allowable Cost	Adjust to roll up Subprovider IPF	\$ 2,418,093.00	\$ (2,418,093)	\$ -	1505.20
2	G - CR Data	1	ADULTS & PEDIATRICS	8.00	Days - Cost Report W/S D-1, Pt. 1, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Adjust to roll up Subprovider IPF	3,060	1,287	4,347	1505.20
2	G - CR Data	7	SUBPROVIDER I	8.00	Days - Cost Report W/S D-1, Pt. 1, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Adjust to roll up Subprovider IPF	1,287	(1,287)	-	1505.20
2	G - CR Data	1	ADULTS & PEDIATRICS	9.00	Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)	Adjust to roll up Subprovider IPF	\$ 2,779,220.00	\$ 2,616,303	\$ 5,395,523.00	1505.20
2	G - CR Data	7	SUBPROVIDER I	9.00	Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)	Adjust to roll up Subprovider IPF	\$ 2,616,303.00	\$ (2,616,303)	\$ -	1505.20
2	H - In-State	1	ADULTS & PEDIATRICS	13.00	Inpatient Uninsured	Adjust to roll up Subprovider IPF	170	18	188	1505.20
2	H - In-State	7	SUBPROVIDER I	13.00	Inpatient Uninsured	Adjust to roll up Subprovider IPF	18	(18)	-	1505.20

**Medicaid DSH Report Notes**

PROVIDER: DORMINY MEDICAL CENTER

Mcaid Number: 000000613A

FROM: 8/1/2022 TO: 7/31/2023

Mcare Number: 110073

**Myers and Stauffer DSH Report Notes**

Note #	Note for Report	Amounts
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