DSH Version 7.25 5/3/2018

D. General Cost Report Year Information 8/1/2016 - 7/31/2017

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: DORMINY MEDICAL CENTER

	8/1/2016 through 7/31/2017		
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: 1/18/2018

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	DORMINY MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000000613A	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	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	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	Florida	091640400
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: (08/01/2016 - 07/31/2017)

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)	$ 3,288	$ 88,340	$91,628
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 88,441	$ 639,482	$727,923
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)	$91,729	$727,822	$819,551
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	3.58%	12.14%	11.18%

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 (08/01/2016 - 07/31/2017)

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)	3,217 (See Note in Section F-3, below)

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

2.	Inpatient Hospital Subsidies	-
3.	Outpatient Hospital Subsidies	-
4.	Unspecified I/P and O/P Hospital Subsidies	-
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ -
7.	Inpatient Hospital Charity Care Charges	1,684,143
8.	Outpatient Hospital Charity Care Charges	1,928,098
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 3,612,241

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	$3,770,726.00			$ 2,842,743	$ -	$ -	$ 927,983
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$97,370.00			$ 73,407	
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	$13,337,066.00	$47,115,771.00		$ 10,054,788	$ 35,520,488	$ -	$ 14,877,560
20.	Outpatient Services		$8,599,076.00			$ 6,482,827	$ -	$ 2,116,249
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$315,832.00			$ 238,105	
26.	Other	$0.00	$0.00	$5,862,240.00	$ -	$ -	$ 4,419,531	$ -
27.	Total	$ 17,107,792	$ 55,714,847	$ 6,275,442	$ 12,897,531	$ 42,003,315	$ 4,731,044	$ 17,921,793
28.	Total Hospital and Non Hospital		Total from Above	$ 79,098,081		Total from Above	$ 59,631,890	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	79,098,081	Total Contractual Adj. (G-3 Line 2)	58,283,022
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)			+	1,348,868
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)"			-	
35.	Adjusted Contractual Adjustments				59,631,890

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2016-07/31/2017) DORMINY MEDICAL CENTER

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	$ 2,842,959	$ -	$ -	$90,272.00	$ 2,752,687	3,029	$2,985,715.00		$ 908.78
2	03100 INTENSIVE CARE UNIT	$ 1,147,580	$ -	$ -		$ 1,147,580	584	$732,480.00		$ 1,965.03
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 212,799	$ -	$ -		$ 212,799	232	$62,855.00		$ 917.24
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 4,203,338	$ -	$ -	$ 90,272	$ 4,113,066	3,845	$ 3,781,050		
19	Weighted Average									$ 1,069.72

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)	628	-	-	$ 570,714	$498,309.00	$317,048.00	$ 815,357	0.699956

Line #		*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	$1,523,730.00	$ -	$0.00		$ 1,523,730	$1,572,668.00	$4,501,698.00	$ 6,074,366	0.250846
22	5200 DELIVERY ROOM & LABOR ROOM	$655,633.00	$ -	$0.00		$ 655,633	$165,669.00	$101,973.00	$ 267,642	2.449664
23	5400 RADIOLOGY-DIAGNOSTIC	$2,472,632.00	$ -	$0.00		$ 2,472,632	$2,639,713.00	$20,520,184.00	$ 23,159,897	0.106764
24	6000 LABORATORY	$2,042,722.00	$ -	$0.00		$ 2,042,722	$3,246,742.00	$10,771,757.00	$ 14,018,499	0.145716
25	6500 RESPIRATORY THERAPY	$751,836.00	$ -	$0.00		$ 751,836	$1,076,206.00	$2,587,631.00	$ 3,663,837	0.205205
26	6600 PHYSICAL THERAPY	$1,130,067.00	$ -	$0.00		$ 1,130,067	$325,235.00	$1,475,736.00	$ 1,800,971	0.627477
27	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$839,072.00	$ -	$0.00		$ 839,072	$1,209,802.00	$1,675,817.00	$ 2,885,619	0.290777
28	7200 IMPL. DEV. CHARGED TO PATIENTS	$77,423.00	$ -	$0.00		$ 77,423	$30,134.00	$87,516.00	$ 117,650	0.658079
29	7300 DRUGS CHARGED TO PATIENTS	$1,547,694.00	$ -	$0.00		$ 1,547,694	$2,342,590.00	$5,400,694.00	$ 7,743,284	0.199876

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2016-07/31/2017) DORMINY MEDICAL CENTER

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	9100 EMERGENCY	$2,558,916.00	$ -	$0.00		$ 2,558,916	$1,011,287.00	$7,580,549.00	$ 8,591,836	0.297831
31		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
32		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
33		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
34		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
35		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
36		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
37		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
38		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
39		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
40		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
41		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
42		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2016-07/31/2017) DORMINY MEDICAL CENTER

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
90		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
91		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
92		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
93		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
104		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
107		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
108		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
114		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
117		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
118		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
124		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
126	**Total Ancillary**	$ 13,599,725	$ -	$ -		$ 13,599,725	$ 14,118,355	$ 55,020,603	$ 69,138,958	
127	**Weighted Average**									0.204956
128	**Sub Totals**	$ 17,803,063	$ -	$ -		$ 17,712,791	$ 17,899,405	$ 55,020,603	$ 72,920,008	

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)*	$97,569.00
131	NF, SNF, and Swing Bed Cost for Other Payors *(Hospital must calculate. Submit support for calculation of cost.)*	
131.01	Other Cost Adjustments (support must be submitted)	
132	**Grand Total**	$ 17,615,222
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 (08/01/2016-07/31/2017 | DORMINY 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 Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 908.78		261		232		358		151		96		1,002		45.73%
2	03100 INTENSIVE CARE UNIT	$ 1,965.03		120		12		67		25		33		224		44.01%
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	$ 917.24		66		143		-		4		4		213		93.53%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	447		387		425		180		133		1,439		40.88%
19	Total Days per PS&R or Exhibit Detail			447		387		425		180		133				
20	Unreconciled Days (Explain Variance			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 299,301		$ 172,094		$ 319,628		$ 133,412		$ 94,023		$ 924,435		26.94%
21.01	Calculated Routine Charge Per Dien			$ 669.58		$ 444.69		$ 752.07		$ 741.18		$ 706.94		$ 642.41		
	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	
22	09200 Observation (Non-Distinct		0.699956	142	73,567	58,686	129	7,684	190,936	8,214	-	51,665	-	$ 74,726	$ 264,632	47.96%
23	5000 OPERATING ROOM		0.250846	142,219	231,760	364,110	426,855	113,356	712,583	58,563	61,637	85,393	12,317	$ 678,248	$ 1,432,835	36.36%
24	5200 DELIVERY ROOM & LABOR ROOM		2.449664	14,792	4,662	105,119	95,269	-	-	12,167	14,075	8,241	6,238	$ 132,078	$ 114,006	97.36%
25	5400 RADIOLOGY-DIAGNOSTIC		0.106764	271,109	1,275,039	206,964	1,428,309	464,099	2,664,319	148,530	405,859	336,284	1,432,039	$ 1,090,702	$ 5,773,526	37.29%
26	6000 LABORATORY		0.145716	429,628	984,825	340,733	1,031,504	650,684	1,371,458	238,028	487,773	341,614	810,203	$ 1,659,073	$ 3,875,560	47.71%
27	6500 RESPIRATORY THERAPY		0.205205	220,848	246,035	104,558	252,351	293,291	653,878	92,948	42,940	145,695	109,155	$ 711,645	$ 1,195,204	59.00%
28	6600 PHYSICAL THERAPY		0.627477	5,994	14,236	802	49,231	12,939	170,169	36,339	137,369	708	1,382	$ 56,074	$ 371,005	23.83%
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.290777	168,261	113,158	261,000	125,780	148,057	215,492	62,385	26,492	71,497	41,567	$ 639,703	$ 480,922	42.75%
30	7200 IMPL. DEV. CHARGED TO PATIENTS		0.658079	-	-	-	-	-	23,839	-	299	-	-	$ -	$ 24,138	20.52%
31	7300 DRUGS CHARGED TO PATIENTS		0.199876	325,549	340,495	296,421	183,983	447,807	1,169,663	184,605	216,051	247,122	188,662	$ 1,254,382	$ 1,910,192	46.50%
32	9100 EMERGENCY		0.297831	119,853	851,827	112,123	1,301,298	195,666	926,122	70,780	173,249	159,980	1,297,532	$ 498,422	$ 3,252,496	60.64%
33			-											$ -	$ -	
34			-											$ -	$ -	
35			-											$ -	$ -	
36			-											$ -	$ -	
37			-											$ -	$ -	
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85			-											$ -	$ -	

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

Cost Report Year (08/01/2016-07/31/2017 | DORMINY MEDICAL CENTER

		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)		Uninsured		Total In-State Medicaid		%
86-127														
	Totals / Payments	$ 1,698,395	$ 4,135,604	$ 1,850,516	$ 4,894,709	$ 2,333,583	$ 8,098,459	$ 912,559	$ 1,565,744	$ 1,448,199	$ 3,899,095			
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 1,997,696	$ 4,135,604	$ 2,022,610	$ 4,894,709	$ 2,653,211	$ 8,098,459	$ 1,045,971	$ 1,565,744	$ 1,542,222 (Agrees to Exhibit A)	$ 3,899,095 (Agrees to Exhibit A)	$ 7,719,488	$ 18,694,516	43.69%
129	Total Charges per PS&R or Exhibit Detail	$ 1,997,696	$ 4,135,604	$ 2,022,610	$ 4,894,709	$ 2,653,211	$ 8,098,459	$ 1,045,971	$ 1,565,744	$ 1,542,222	$ 3,899,095			
130	Unreconciled Charges (Explain Variance	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 895,863	$ 814,765	$ 1,017,742	$ 1,186,930	$ 894,314	$ 1,625,612	$ 408,801	$ 362,038	$ 467,383	$ 748,828	$ 3,216,720	$ 3,989,345	47.82%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 763,085	$ 750,139			$ 141,578	$ 135,411	$ 3,643	$ 25,299			$ 908,306	$ 910,849	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 619,128	$ 644,272			$ 10,995	$ 21,889			$ 630,123	$ 666,161	
134	Private Insurance (including primary and third party liability)	$ 23,360	$ 1,315		$ 519	$ 405	$ 6,455	$ 109,261	$ 185,818			$ 133,026	$ 194,107	
135	Self-Pay (including Co-Pay and Spend-Down)		$ 2,865	$ 12	$ 69			$ 100	$ 1,779			$ 112	$ 4,713	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 786,445	$ 754,319	$ 619,140	$ 644,860									
137	Medicaid Cost Settlement Payments (See Note B)		$ (106,454)									$ -	$ (106,454)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)			$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 733,068	$ 973,054	$ 222,086	$ 114,731			$ 955,154	$ 1,087,785	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -			$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 7,237	$ 31,649			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 7,237	$ 31,649	
142	Other Medicare Cross-Over Payments (See Note D)					$ 83,078	$ 419	$ 20,831	$ 36			$ 103,909	$ 455	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 3,288	$ 88,340			
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)**	$ 109,418	$ 166,900	$ 398,602	$ 542,070	$ (71,052)	$ 478,624	$ 41,885	$ 12,486	$ 464,095	$ 660,488	$ 478,853	$ 1,200,080	
146	**Calculated Payments as a Percentage of Cost**	88%	80%	61%	54%	108%	71%	90%	97%	1%	12%	85%	70%	
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)**					1,683								
148	**Percent of cross-over days to total Medicare days from the cost report**					25%								

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 s
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 pay
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 payn

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

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2016-07/31/2017) 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)		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	$ 908.78										-	
2	03100 INTENSIVE CARE UNIT	$ 1,965.03										-	
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	$ 917.24										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges											$ -	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	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)		0.699956		-		-					$ -	$ -
23	5000 OPERATING ROOM		0.250846		-		-					$ -	$ -
24	5200 DELIVERY ROOM & LABOR ROOM		2.449664		-		-					$ -	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.106764		3,448		-					$ -	$ 3,448
26	6000 LABORATORY		0.145716		1,083		-					$ -	$ 1,083
27	6500 RESPIRATORY THERAPY		0.205205		-		-					$ -	$ -
28	6600 PHYSICAL THERAPY		0.627477		-		-					$ -	$ -
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.290777		-		-					$ -	$ -
30	7200 IMPL. DEV. CHARGED TO PATIENTS		0.658079		-		-					$ -	$ -
31	7300 DRUGS CHARGED TO PATIENTS		0.199876		35		-					$ -	$ 35
32	9100 EMERGENCY		0.297831		1,343		-					$ -	$ 1,343
33			-				-					$ -	$ -
34			-									$ -	$ -
35			-									$ -	$ -
36			-									$ -	$ -
37			-									$ -	$ -
38			-									$ -	$ -
39			-									$ -	$ -
40			-									$ -	$ -
41			-									$ -	$ -
42			-									$ -	$ -
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76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2016-07/31/2017) DORMINY MEDICAL CENTER

				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)		Total Out-Of-State Medicaid	
79			-									$ -	$ -
80			-									$ -	$ -
81			-									$ -	$ -
82			-									$ -	$ -
83			-									$ -	$ -
84			-									$ -	$ -
85			-									$ -	$ -
86			-									$ -	$ -
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124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ 5,909	$ -	$ -	$ -	$ -	$ -	$ -		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			$ -	$ 5,909	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,909
129	Total Charges per PS&R or Exhibit Detail			$ -	$ 5,909	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ -	$ 933	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 933
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)				$ 259		$ -					$ -	$ 259
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)			$ -	$ 259	$ -	$ -						
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)											$ -	$ -
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	**Calculated Payment Shortfall / (Longfall)**			$ -	$ 674	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 674
144	**Calculated Payments as a Percentage of Cost**			0%	28%	0%	0%	0%	0%	0%	0%	0%	28%

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.

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 (08/01/2016-07/31/2017) 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)*		$ 236,100		
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)		$ 236,100	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*				*(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		$ 236,100		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ -	

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