APPORTIO	NMENT OF INPATIENT ROUTINE		PROVIDER CCN:		PERIOD:		WORKSHEET D		
SERVICE C	APITAL COSTS					FROM: 04/01/2021		PART I	
				11-0177		TO: 03/31/2022			
Check	[] Title V	[X] Hospital		[X]PPS					
Applicable	[X] Title XVIII	[] PARHM Demor	nstration	[]TEFRA					
Boxes:	[] Title XIX	[] Chart Model							
	•			Reduced				Inpatient	
				Capital				Program	
		Capital		Related		Per		Capital	
		Related Cost	Swing	Cost	Total	Diem	Inpatient	Cost	
		(from Wkst. B,	Bed	(col. 1 minus	Patient	(col. 3 /	Program	(col. 5	
		Part II, col. 26)	Adjustment	col. 2)	Days	col. 4)	Days	x col. 6)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults and Pediatrics (General Routine Care)	6,858,738		6,858,738	59,446	115	10,878	1,255,104	30
	Intensive Care Unit	1,445,788		1,445,788	6,523	222	1,470	325,811	31
33	Burn Intensive Care Unit	5,320,436		5,320,436	24,534	217	5,104	1,106,853	33
35	02040NEONATAL INTENSIVE CARE UNIT	148,035		148,035	1,827	81			35
41	Subprovider - IRF	1,099,305		1,099,305	7,456	147	2,916	429,935	41
43	Nursery	35,445		35,445	3,726	10			43
200	Total	14,907,747		14,907,747	103,512		20,368	3,117,703	200

DOCTOR	S HOSPITAL OF AUGUSTA						12-22
APPORTI	ONMENT OF INPATIENT ANCILLARY	PROVIDER CCN:		PERIOD:		WORKSHEET D	
SERVICE	CAPITAL COSTS			FROM: 04/01/2021		PART II	
		11-0177		TO: 03/31/2022			
Check	[] Title V	[X] Hospital		[X]PPS			
Applicable	[X] Title XVIII	[] PARHM Demon	stration	[]TEFRA			
Boxes:	[] Title XIX	[] Chart Model					
	i	Capital					
		Related Cost	Total Charges	Ratio of Cost	Inpatient		ĺ
		(from Wkst. B,	(from Wkst. C,	to Charges	Program	Capital Costs	ĺ
		Part II, col. 26)	Pt I, col 8)	(col. 1 / col. 2)	Charges	(col.3 x col. 4)	ĺ
	COST CENTER DESCRIPTIONS	1	2	3	4	5	ĺ
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	4,350,752	331,252,301	0	30,785,870	404,342	50
51	Recovery Room	278,205	39,590,146	0	3,606,146	25,340	51
52	Labor Room and Delivery Room	564,457	47,090,364	0	89,006	1,067	52
54	Radiology-Diagnostic	656,564	96,452,398	0	14,955,428	101,802	54
55	Radiology-Therapeutic	707,250	93,787,404	0	144,686	1,091	55
56	Radioisotope	116,504	34,236,259	0	2,904,270	9,883	56
57	Computed Tomography (CT) Scan	205,287	196,741,958	0	18,227,322	19,011	57
58	Magnetic Resonance Imaging (MRI)	69,555	30,206,719	0	3,276,042	7,545	58
59	Cardiac Catheterization	427,816	29,274,491	0	3,594,506	52,530	59
60	Laboratory	831,343	458,796,507	0	63,766,357	115,545	60
62	Whole Blood & Packed Red Blood Cells	111,941	46,701,478	0	7,838,419	18,789	62
65	Respiratory Therapy	235,248	142,532,047	0	25,820,210	42,603	65
66	Physical Therapy	996,475	76,848,907	0	6,907,696	89,572	66
67	Occupational Therapy	37,483	19,050,514	0	2,717,054	5,347	67
68	Speech Pathology	10,250	8,147,986	0	831,594	1,046	68
69	Electrocardiology	195,015	59,796,719	0	7,663,940	24,992	69
70	Electroencephalography	32,875	1,776,851	0	383,559	7,097	70
71	Medical Supplies Charged to Patients	1,392,867	366,349,267	0	40,093,721	152,436	71
72	Implantable Devices Charged to Patients	351,291	46,486,926	0	6,107,484	46,154	72
73	Drugs Charged to Patients	1,037,819	721,021,533	0	93,254,222	134,193	73
74	Renal Dialysis	141,327	12,340,770	0	3,066,950	35,123	74
76	Other Ancillary (specify)	253,026	32,255,931	0	912,051	7,154	76
76.01	03952HYPERBARIC	75,205	6,243,695	0	726,087	8,746	76.97
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	697,481	29,173,616	0	137,962	3,298	90
90.01	09001MFM CLINIC	18,697	11,596,846	0			90.01
91	Emergency	1,648,093	130,531,242	0	7,757,251	97,943	91
92	Observation Beds	494,395	11,272,855	0	1,076,599	47,216	92
200	Total (sum of lines 50 through 199)	15,937,221	3,079,555,730		346,644,432	1,459,865	200

DOCTORS	S HOSPITAL OF AUGUSTA					12-22	
APPORTIC	ONMENT OF INPATIENT ANCILLARY	PROVIDER CCN:		PERIOD:		WORKSHEET D	
SERVICE	CAPITAL COSTS			FROM: 04/01/2021		PART II	
		11-0177		TO: 03/31/2022			
Check	[] Title V	[X] Hospital		[X]PPS			
Applicable	[X] Title XVIII	[] PARHM Demon	stration	[] TEFRA			
Boxes:	[] Title XIX	[] Chart Model					
	•	Capital					
		Related Cost	Total Charges	Ratio of Cost	Inpatient		
		(from Wkst. B,	(from Wkst. C,	to Charges	Program	Capital Costs	
		Part II, col. 26)	Pt I, col 8)	(col. 1 / col. 2)	Charges	(col.3 x col. 4)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	1
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	4,350,752	331,252,301	0	162,317	2,132	50
51	Recovery Room	278,205	39,590,146	0	22,070	155	51
52	Labor Room and Delivery Room	564,457	47,090,364	0			52
54	Radiology-Diagnostic	656,564	96,452,398	0	235,202	1,601	54
55	Radiology-Therapeutic	707,250	93,787,404	0			55
56	Radioisotope	116,504	34,236,259	0	20,642	70	56
57	Computed Tomography (CT) Scan	205,287	196,741,958	0	536,924	560	57
58	Magnetic Resonance Imaging (MRI)	69,555	30,206,719	0	101,377	233	58
59	Cardiac Catheterization	427,816	29,274,491	0			59
60	Laboratory	831,343	458,796,507	0	2,001,205	3,626	60
62	Whole Blood & Packed Red Blood Cells	111,941	46,701,478	0	91,200	219	62
65	Respiratory Therapy	235,248	142,532,047	0	826,538	1,364	65
66	Physical Therapy	996,475	76,848,907	0	9,413,466	122,064	66
67	Occupational Therapy	37,483	19,050,514	0	103,034	203	67
68	Speech Pathology	10,250	8,147,986	0	462,190	581	68
69	Electrocardiology	195,015	59,796,719	0	236,346	771	69
70	Electroencephalography	32,875	1,776,851	0	23,102	427	70
71	Medical Supplies Charged to Patients	1,392,867	366,349,267	0	699,096	2,658	71
72	Implantable Devices Charged to Patients	351,291	46,486,926	0	8,307	63	72
73	Drugs Charged to Patients	1,037,819	721,021,533	0	3,191,571	4,593	73
74	Renal Dialysis	141,327	12,340,770	0	261,616	2,996	74
76	Other Ancillary (specify)	253,026	32,255,931	0	30,933	243	76
76.01	03952HYPERBARIC	75,205	6,243,695	0			76.97
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	697,481	29,173,616	0			90
90.01	09001MFM CLINIC	18,697	11,596,846	0			90.01
91	Emergency	1,648,093	130,531,242	0			91
92	Observation Beds		11,272,855				92
200	Total (sum of lines 50 through 199)	15,442,826	3,079,555,730		18,427,136	144,559	200

DOCTORS	HOSPITAL OF AUGUSTA												12-22
APPORTIO	NMENT OF INPATIENT ROUTINE							PROVIDER CCN:		PERIOD:		WORKSHEET D	
SERVICE C	THER PASS-THROUGH COSTS									FROM: 04/01/2021		PART III	
								11-0177		TO: 03/31/2022			
Check	[] Title V	[X] Hospital		[X]PPS						•			
Applicable												l	i
Boxes:	Boxes: [] Title XIX [] Chart Model									i			
		Nursing		Allied		All	Swing-Bed					Inpatient	
		Program		Health		Other	Adjustment	Total Costs		Per		Program	i
		Post-		Post-		Medical	Amount	(sum of cols.	Total	Diem	Inpatient	Pass-Through	i
		Stepdown	Nursing	Stepdown	Allied Health	Education	(see	1, 2, and 3,	Patient	(col. 3 /	Program	Cost	i
		Adjustments	Program	Adjustments	Cost	Cost	instructions)	minus col. 4)	Days	col. 4)	Days	(col. 7 x col. 8)	i
	COST CENTER DESCRIPTIONS	1A	1	2A	2	3	4	5	6	7	8	9	i
	INPATIENT ROUTINE SERVICE COST CENTERS												ı
30	Adults and Pediatrics (General Routine Care)								59,446		10,878		30
31	Intensive Care Unit								6,523		1,470		31
33	Burn Intensive Care Unit								24,534		5,104		33
35	02040NEONATAL INTENSIVE CARE UNIT								1,827				35
41	Subprovider - IRF								7,456		2,916		41
43	Nursery								3,726				43
200	Total								103,512		20,368		200

	HOSPITAL OF AUGUSTA NAMENT OF INPATIENT/OUTPATIENT ANCILLARY				PROVIDER CCN:		PERIOD:		WORKSHEET D	12-22
SERVICE (OTHER PASS-THROUGH COSTS				11-0177		FROM: 04/01/202 ⁻ TO: 03/31/2022	1	PART IV	
Check Applicable Boxes:	[] Title V [X] Title XVIII, PART A [] Title XIX	[X] Hospital [] IPF [] IRF [] Subprovider (Other)	[]SNF []NF []ICF/IID []Swing-Bed SNF		[] PARHM Demon: [] PARHM CAH Su [] Chart Model [] Chart CAH Swin	wing-Bed SNF	[X] PPS [] TEFRA [] Other			
		Non Physician Anesthetist Cost	Nursing Program Post- Stepdown Adjustments	Nursing Program	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2 3 and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	
	COST CENTER DESCRIPTIONS	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Labor Room and Delivery Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	Computed Tomography (CT) Scan									57
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catheterization									59
60	Laboratory									60
61	PBP Clinical Laboratory Services-Program Only	1								61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy									6
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Patients									7
72	Implantable Devices Charged to Patients									7:
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
75	ASC (Non-Distinct Part)									7:
76	Other Ancillary (specify)		1							76
76.01	03952HYPERBARIC									76.01
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
90.01	09001MFM CLINIC									90.0
91	Emergency		1							9
92	Observation Beds									9:
93	Other Outpatient Service (specify)			İ					1	9:
200										200

APPORTIO	NMENT OF INPATIENT/OUTPATIENT ANCILLARY				PROVIDER CCN:		PERIOD:		WORKSHEET D	12-2
	OTHER PASS-THROUGH COSTS						FROM: 04/01/2021		PART IV	
					11-0177		TO: 03/31/2022			
Check	[] Title V	[X] Hospital	[]SNF		[X] Hospital		[X]PPS			
	[X] Title XVIII, PART A	[] IPF	[] NF		[] PARHM Demon	stration	[]TEFRA			
	[] Title XIX	[] IRF	[]ICF/IID		[] Chart Model		[] Other			
	11	[] Subprovider (Other)	[] Swing-Bed SNF		[] Chart CAH Swin	a-Bed SNF	.,			
		[1]	1	1		9	Inpatient		Outpatient	Т
				Ratio	Outpatient		Program		Program	
				of Cost	Ratio		Pass-		Pass-	
			Total Charges	to Charges	of Cost	Inpatient	Through	Outpatient	Through	
			(from Wkst. C,	(col. 5 / col. 7)	to Charges	Program	Costs	Program	Costs	
			Pt I, col 8)	(see instructions	I I	Charges	(col. 8 x col 10)	Charges	(col. 9 x col. 12)	
			7	8	9	10	11	12	13	-
	ANCILLARY SERVICE COST CENTERS				-			.=		
50	Operating Room		331,252,301			30,785,870		56,684,710		50
51	Recovery Room		39,590,146	1		3,606,146		4,526,350		5
52	Labor Room and Delivery Room		47,090,364			89,006		30,894		5
53	Anesthesiology		1	1						5
54	Radiology-Diagnostic		96,452,398	1		14,955,428		5,864,123		54
55	Radiology-Therapeutic		93,787,404			144,686		29,494,102		5
56	Radioisotope		34,236,259			2,904,270		6,116,133		5
57	Computed Tomography (CT) Scan		196,741,958			18,227,322		19,097,513		5
58	Magnetic Resonance Imaging (MRI)		30,206,719			3,276,042		3,498,840		56
59	Cardiac Catheterization		29,274,491			3,594,506		1,765,595		5
60	Laboratory		458,796,507			63,766,357		7,594,839		6
61	PBP Clinical Laboratory Services-Program Only									6
62	Whole Blood & Packed Red Blood Cells		46,701,478			7,838,419		526,623		6
63	Blood Storing, Processing, & Trans.									6
64	Intravenous Therapy									6
65	Respiratory Therapy		142,532,047			25,820,210		189,922		6
66	Physical Therapy		76,848,907			6,907,696		485,847		6
67	Occupational Therapy		19,050,514			2,717,054		56,799		6
68	Speech Pathology		8,147,986			831,594		14,203		6
69	Electrocardiology		59,796,719			7,663,940		4,427,137		69
70	Electroencephalography		1,776,851			383,559		40,365		7
71	Medical Supplies Charged to Patients		366,349,267			40,093,721		20,147,236		7
	Implantable Devices Charged to Patients		46,486,926			6,107,484		7,468,094		7.
	Drugs Charged to Patients		721,021,533			93,254,222		13,548,301		7
	Renal Dialysis		12,340,770			3,066,950		128,837		7-
75	ASC (Non-Distinct Part)					2122-		1 === 0 ===		7:
76	Other Ancillary (specify)		32,255,931			912,051		1,770,850		70.0
76.01	03952HYPERBARIC		6,243,695			726,087		660,079		76.0
00	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)		+	ļ					ļ	8
89 90	Federally Qualified Health Center (FQHC)		00 470 646			137,962		3,386,200		8
	Clinic		29,173,616	ļ		137,962				90.0
90.01	09001MFM CLINIC		11,596,846	-		7 757 054		9,042		
91 92	Emergency Observation Rada		130,531,242 11,272,855			7,757,251 1,076,599		8,708,550 1,082,734		9
	Observation Beds Other Outputient Service (appeits)		11,212,000	<u> </u>		1,070,399		1,002,734		9
93	Other Outpatient Service (specify) Total (sum of lines 50 through 199)		3,079,555,730			346,644,432		197,323,918		20

	NOSPITAL OF AUGUSTA NOMENT OF INPATIENT/OUTPATIENT ANCILLARY			PROVIDER CCN:		PERIOD:		1 WORKSHEET D		
	OTHER PASS-THROUGH COSTS						FROM: 04/01/2021		PART IV	
					11-0177		TO: 03/31/2022			
Check	[] Title V	[] Hospital	[]SNF		[] PARHM Demons	stration	[X]PPS			
Applicable	[X] Title XVIII, PART A	[] IPF	[]NF		[] PARHM CAH Sv	wing-Bed SNF	[]TEFRA			
Boxes:	[] Title XIX	[X]IRF	[] ICF/IID		[] Chart Model		[] Other			
		[] Subprovider (Other)	[] Swing-Bed SNF		[] Chart CAH Swin	g-Bed SNF				
			Nursing		Allied		All		Total	
		Non	Program		Health		Other		Outpatient	
		Physician	Post-		Post-		Medical	Total Cost	Cost	
		Anesthetist	Stepdown	Nursing	Stepdown	Allied	Education	(sum of cols. 1, 2		
		Cost	Adjustments	Program	Adjustments	Health	Cost	3 and 4)	3, and 4)	
	COST CENTER DESCRIPTIONS	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
51	Recovery Room									51
52	Labor Room and Delivery Room									52
53	Anesthesiology									50
54	Radiology-Diagnostic									54
55	Radiology-Therapeutic									5
56	Radioisotope									50
57	Computed Tomography (CT) Scan									5
58	Magnetic Resonance Imaging (MRI)									58
59	Cardiac Catheterization									5
60	Laboratory									60
61	PBP Clinical Laboratory Services-Program Only									6
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									6
64	Intravenous Therapy									64
65	Respiratory Therapy									6
67	Physical Therapy Occupational Therapy							+		6
68	Occupational Therapy Speech Pathology							+		6
69	Electrocardiology									69
70	Electroencephalography							+		7
71	Medical Supplies Charged to Patients				+			+		7
72	Implantable Devices Charged to Patients	- 								7:
73	Drugs Charged to Patients	+						+		7:
74	Renal Dialysis		+		+			+	+	74
	ASC (Non-Distinct Part)		+				+	+	+	7:
76	Other Ancillary (specify)		+		+		+	+	+	76
76.01	03952HYPERBARIC		<u> </u>					†	1	76.0
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)							1		8
90	Clinic									90
90.01	09001MFM CLINIC									90.0
91	Emergency							1		9
92	Observation Beds									9:
93	Other Outpatient Service (specify)									9
200	Total (sum of lines 50 through 199)	1								20

	NMENT OF INPATIENT/OUTPATIENT ANCILLARY				PROVIDER CCN:		PERIOD:		WORKSHEET D	12-2
	OTHER PASS-THROUGH COSTS						FROM: 04/01/2021		PART IV	
					11-0177		TO: 03/31/2022			
Check	[] Title V	[X] Hospital	[]SNF		[X] Hospital		[X]PPS			
	[X] Title XVIII, PART A	[] IPF	[]NF		[] PARHM Demon	stration	[]TEFRA			
	[] Title XIX	[] IRF	[]ICF/IID		[] Chart Model	ou duo	[] Other			
Donoo.	[]	[] Subprovider (Other)	[] Swing-Bed SNF		[] Chart CAH Swin	ng-Bed SNF	[] 0 0.			
		[1] Caspionaei (Caiei)	[] = [] = [] = [] = [] = [] = [] = [] =	ı		9 204 0.11	Inpatient		Outpatient	T
				Ratio	Outpatient		Program		Program	
				of Cost	Ratio		Pass-		Pass-	
			Total Charges	to Charges	of Cost	Inpatient	Through	Outpatient	Through	
			(from Wkst. C,	(col. 5 / col. 7)	to Charges	Program	Costs	Program	Costs	
			Pt I, col 8)	(see instructions	I I	Charges	(col. 8 x col 10)	Charges	(col. 9 x col. 12)	
			7	8	9	10	11	12	13	┨
	ANCILLARY SERVICE COST CENTERS				-					
50	Operating Room		331,252,301			162,317		4,275		50
51	Recovery Room		39,590,146	1		22,070				51
52	Labor Room and Delivery Room		47,090,364							52
53	Anesthesiology		1	1						53
54	Radiology-Diagnostic		96,452,398	1		235,202		594		54
55	Radiology-Therapeutic		93,787,404							55
56	Radioisotope		34,236,259			20,642				50
57	Computed Tomography (CT) Scan		196,741,958			536,924		4,887		5
58	Magnetic Resonance Imaging (MRI)		30,206,719			101,377				5
59	Cardiac Catheterization		29,274,491							5
60	Laboratory		458,796,507			2,001,205				60
61	PBP Clinical Laboratory Services-Program Only									6
62	Whole Blood & Packed Red Blood Cells		46,701,478			91,200				6
63	Blood Storing, Processing, & Trans.									6
64	Intravenous Therapy									6
65	Respiratory Therapy		142,532,047			826,538				65
66	Physical Therapy		76,848,907			9,413,466				66
67	Occupational Therapy		19,050,514			103,034				67
68	Speech Pathology		8,147,986			462,190				6
69	Electrocardiology		59,796,719			236,346		2,309		69
70	Electroencephalography		1,776,851			23,102				70
71	Medical Supplies Charged to Patients		366,349,267			699,096				7
	Implantable Devices Charged to Patients		46,486,926			8,307				7:
	Drugs Charged to Patients		721,021,533			3,191,571		201		7:
	Renal Dialysis		12,340,770			261,616				74
75	ASC (Non-Distinct Part)									7:
76	Other Ancillary (specify)		32,255,931			30,933				70.0
76.01	03952HYPERBARIC		6,243,695							76.0
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)		-							8
89	Federally Qualified Health Center (FQHC)		20 472 040							89
90	Clinic		29,173,616							
90.01	09001MFM CLINIC		11,596,846							90.0
91	Emergency Observation Rada		130,531,242							9
92	Observation Beds		11,272,855							
93	Other Outpatient Service (specify)		2.070.555.700			40 407 400		40.000		20
200	Total (sum of lines 50 through 199)		3,079,555,730	L		18,427,136		12,266		

	S HOSPITAL OF AUGUSTA		LDDOWDED CON. LDEDIOD.					12-22	
	DNMENT OF MEDICAL AND OTHER			PROVIDER CCN	:	PERIOD:		WORKSHEET D	
HEALTH S	SERVICES COSTS					FROM: 04/01/2021		PART V	
				11-0177		TO: 03/31/2022			
Check	[] Title V - O/P	[X] Hospital	[] Subprovider (Other)	[] Swing-Bed SNF	[] PARHM Demons	tration		•	
Applicable	[X] Title XVIII, PART B	[] IPF	[]SNF	[] Swing-Bed NF	[] PARHM CAH Sw	ing-Bed SNF			
Boxes:	[] Title XIX - O/P	[] IRF	[]NF	[]ICF/IID	[] Chart Model				
		· ·	•		[] Chart CAH Swing	-Bed SNF			
				Program Charges			Program Cost		
		Cost		Cost	Cost		Cost	Cost	ł
		to		Reimbursed	Reimbursed		Reimbursed	Reimbursed	
		Charge	PPS	Services	Services Not	PPS	Services	Services Not	
		Ratio from	Reimbursed	Subject to	Subject to	Services	Subject to	Subject to	
		Wkst. C,	Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	
		Pt. I, col. 9							
	COST CENTED DESCRIPTIONS	Pt. 1, COI. 9	(see inst.)	(see inst.)	(see inst.)	inst) 5	(see inst.)	(see inst.)	ļ
	COST CENTER DESCRIPTIONS	1		3	4	5	6	/	
	ANCILLARY SERVICE COST CENTERS	0.0==:==	50.001.710			4 400 222			
50	Operating Room	0.079176	56,684,710			4,488,069			50
51	Recovery Room	0.061678	4,526,350			279,176			51
52	Labor Room and Delivery Room	0.153173	30,894			4,732			52
54	Radiology-Diagnostic	0.057977	5,864,123			339,984			54
55	Radiology-Therapeutic	0.065275	29,494,102			1,925,228			55
56	Radioisotope	0.042585	6,116,133			260,456			56
57	Computed Tomography (CT) Scan	0.009255	19,097,513			176,747			57
58	Magnetic Resonance Imaging (MRI)	0.024585	3,498,840			86,019			58
59	Cardiac Catheterization	0.094633	1,765,595			167,084			59
60	Laboratory	0.023781	7,594,839			180,613			60
62	Whole Blood & Packed Red Blood Cells	0.091157	526,623			48,005			62
65	Respiratory Therapy	0.034463	189,922			6,545			65
66	Physical Therapy	0.133873	485,847			65,042			66
67	Occupational Therapy	0.081454	56,799			4,627			67
68	Speech Pathology	0.051468	14,203			731			68
69	Electrocardiology	0.032379	4,427,137			143,346			69
70	Electroencephalography	0.130189	40,365			5,255			70
71		0.145433	20,147,236						70
71	Medical Supplies Charged to Patients Implantable Devices Charged to Patients	0.145433	7,468,094		1	2,930,073 2,676,744		1	71
	,				97,775		-	4,037	73
73	Drugs Charged to Patients	0.041285	13,548,301		97,775	559,342		4,037	73
74	Renal Dialysis	0.202427	128,837		_	26,080		ļ	
76	Other Ancillary (specify)	0.078297	1,770,850			138,652		ļ	76
76.01	03952HYPERBARIC	0.092083	660,079			60,782			76.01
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.187936	3,386,200			636,389			90
90.01	09001MFM CLINIC	0.064830	9,042			586			90.01
91	Emergency	0.125675	8,708,550			1,094,447			91
92	Observation Beds	0.289413	1,082,734			313,357			92
	OTHER REIMBURSABLE COST CENTERS								
	SPECIAL PURPOSE COST CENTERS								
200	Subtotal (see instructions)		197,323,918		97,775	16,618,111		4,037	200
201	Less PBP Clinic Lab. Services - Program Only Charges								201
	Net Charges (line 200 - line 201)		197,323,918		97,775	16,618,111	1	4,037	202

DOCTORS	S HOSPITAL OF AUGUSTA								12-22
APPORTIO	ONMENT OF MEDICAL AND OTHER			PROVIDER CCN:		PERIOD:		WORKSHEET D	
HEALTH S	SERVICES COSTS					FROM: 04/01/2021		PART V	
				11-0177		TO: 03/31/2022			
Check	[] Title V - O/P	[] Hospital	[] Subprovider (Other)	[] Swing-Bed SNF	[] PARHM Demons	tration		•	
Applicable	[X] Title XVIII, PART B	[] IPF	[]SNF	[] Swing-Bed NF	[] PARHM CAH Sw	ing-Bed SNF			
Boxes:	[] Title XIX - O/P	[X]IRF	[] NF	[] ICF/IID	[] Chart Model				
					[] Chart CAH Swing	-Bed SNF			
				Program Charges			Program Cost		
		Cost		Cost	Cost		Cost	Cost	
		to		Reimbursed	Reimbursed		Reimbursed	Reimbursed	
		Charge	PPS	Services	Services Not	PPS	Services	Services Not	
		Ratio from	Reimbursed	Subject to	Subject to	Services	Subject to	Subject to	
		Wkst. C,	Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	
		Pt. I, col. 9	(see inst.)	(see inst.)	(see inst.)	inst)	(see inst.)	(see inst.)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.079176	4,275			338			50
52	Labor Room and Delivery Room	0.153173							52
54	Radiology-Diagnostic	0.057977	594			34			54
57	Computed Tomography (CT) Scan	0.009255	4,887			45			57
69	Electrocardiology	0.032379	2,309			75			69
73	Drugs Charged to Patients	0.041285	201		385	8		16	73
	OUTPATIENT SERVICE COST CENTERS								
	OTHER REIMBURSABLE COST CENTERS								
	SPECIAL PURPOSE COST CENTERS								
	Subtotal (see instructions)		12,266		385	500		16	200
201	Less PBP Clinic Lab. Services - Program Only Charges								201
202	Net Charges (line 200 - line 201)		12,266		385	500		16	202

DOCTORS	S HOSPITAL OF AUGUSTA								12-22
APPORTIC	DNMENT OF MEDICAL AND OTHER			PROVIDER CCN:		PERIOD:		WORKSHEET D	
HEALTH S	SERVICES COSTS					FROM: 04/01/2021		PART V	
				11-0177		TO: 03/31/2022			
Check	[] Title V - O/P	[X] Hospital	[] Subprovider (Other)	[] Swing-Bed SNF	[] PARHM Demons	tration			
Applicable	[] Title XVIII, PART B	[] IPF	[]SNF	[] Swing-Bed NF	[] PARHM CAH Sw	ing-Bed SNF			
Boxes:	[X] Title XIX - O/P	[] IRF	[] NF	[]ICF/IID	[] Chart Model				
					[] Chart CAH Swing	g-Bed SNF			
				Program Charges			Program Cost		
		Cost		Cost	Cost		Cost	Cost	
		to		Reimbursed	Reimbursed		Reimbursed	Reimbursed	
		Charge	PPS	Services	Services Not	PPS	Services	Services Not	
		Ratio from	Reimbursed	Subject to	Subject to	Services	Subject to	Subject to	
		Wkst. C,	Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	
		Pt. I, col. 9	(see inst.)	(see inst.)	(see inst.)	inst)	(see inst.)	(see inst.)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	1
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.079176		7,063,727			559,278		50
51	Recovery Room	0.061678		1,275,666			78,681	1	51
52	Labor Room and Delivery Room	0.153173		237,583			36,391		52
54	Radiology-Diagnostic	0.057977		747,617			43,345		54
55	Radiology-Therapeutic	0.065275		746,543			48,731		55
56	Radioisotope	0.042585		162,833			6,934		56
57	Computed Tomography (CT) Scan	0.009255		3,123,990			28,913		57
58	Magnetic Resonance Imaging (MRI)	0.024585		250,656			6,162		58
59	Cardiac Catheterization	0.094633		48,384			4,579		59
60	Laboratory	0.023781		98,495			2,342		60
62	Whole Blood & Packed Red Blood Cells	0.091157		15,407			1,404		62
65	Respiratory Therapy	0.034463		134,273			4,627		65
66	Physical Therapy	0.133873		212,594			28,461		66
67	Occupational Therapy	0.081454		41,752			3,401		67
68	Speech Pathology	0.051468		2,601			134		68
69	Electrocardiology	0.032379		490,645			15,887		69
70	Electroencephalography	0.130189		3,028			394		70
71	Medical Supplies Charged to Patients	0.145433		2,139,611			311,170		71
72	Implantable Devices Charged to Patients	0.358424		117,409			42,082		72
73	Drugs Charged to Patients	0.041285		981,928			40,539		73
76	Other Ancillary (specify)	0.078297		497,728			38,971		76
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.187936		366,104			68,804		90
90.01	09001MFM CLINIC	0.064830		919			60		90.01
91	Emergency	0.125675		2,682,061			337,068		91
92	Observation Beds	0.289413		648,546			187,698		92
	OTHER REIMBURSABLE COST CENTERS								
	SPECIAL PURPOSE COST CENTERS								
200	Subtotal (see instructions)			22,090,100			1,896,056		200
	Less PBP Clinic Lab. Services - Program Only Charges							 	201
202	Net Charges (line 200 - line 201)			22,090,100			1,896,056		202

DOCTORS HOSPITAL OF AUGUSTA 12-22 COMPUTATION OF INPATIENT PROVIDER CCN: PERIOD: WORKSHEET D-1. OPERATING COST FROM: 04/01/2021 PART I 11-0177 TO: 03/31/2022 Title V - O/P Check [X]PPS X] Hospital [] NF [X] Title XVIII, PART A []ICF/IID []TEFRA Applicable [] Title XIX - I/P []NF 1 IRF [] Other Boxes: [] PARHM Demonstration 1 Subprovider (Other) 1 SNF [] Chart Model PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS I Inpatient days (including private room days and swing-bed days, excluding newborn) 59.446 2 Inpatient days (including private room days, excluding swing-bed and newborn days) 59,446 2 3 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4 Semi-private room days (excluding swing-bed and observation bed days) 55,161 4 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 5 6 6 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if 6 calendar year, enter 0 on this line) 7 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 8 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if 8 calendar year, enter 0 on this line) 8 9 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10,878 9 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the 10 cost reporting period (see 10 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the 11 cost reporting period (if calendar 11 year, enter 0 on this line) 11 12 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of 12 the cost reporting period. 12 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the 13 cost reporting period (if calendar 13 year, enter 0 on this line) 13 14 Medically necessary private room days applicable to the Program (excluding swing-bed days) 14 15 Total nursery days (title V or XIX only) 15 16 Nursery days (title V or XIX only) 16 SWING BED ADJUSTMENT 17 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 17 18 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18 19 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 19 20 20 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 45,260,850 21 21 Total general inpatient routine service cost (see instructions) 22 22 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24 25 24 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26 27 26 Total swing-bed cost (see instructions) 45,260,850 27 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28 28 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29 29 Private room charges (excluding swing-bed charges) 30 Semi-private room charges (excluding swing-bed charges) 30 31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31 32 32 Average private room per diem charge (line 29 ÷ line 3) 33 33 Average semi-private room per diem charge (line 30 ÷ line 4)

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45,260,850

34 Average per diem private room charge differential (line 32 minus line 33) (see instructions)

37 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)

35 Average per diem private room cost differential (line 34 x line 31)

36 Private room cost differential adjustment (line 3 x line 35)

DOCTORS	HOSPITAL OF AUGUSTA					12-22		
COMPUTAT	TION OF INPATIENT		PROVIDER CCN:		PERIOD:		WORKSHEET D-1,	
OPERATING	GCOST				FROM: 04/01/2021		PART II	
			11-0177		TO: 03/31/2022			
Check	[] Title V - O/P	[X] Hospital	[] NF		[X]PPS			
Applicable	[X] Title XVIII, PART A	[] IPF	[] ICF/IID		[]TEFRA			
Boxes:	[] Title XIX - I/P	[] IRF	[]NF		[] Other			
		[] Subprovider (Other)	[] PARHM Demonstrat	tion				
		[]SNF	[] Chart Model					
PART II - HO	OSPITAL AND SUBPROVIDERS ONI	LY						
	PROGRAM INPATIENT OPERATIN	IG COST BEFORE PASS-T	HROUGH COST ADJUS	STMENTS				
38	Adjusted general inpatient routine se	ervice cost per diem (see ins	structions)				761	38
39	Program general inpatient routine se	ervice cost (line 9 x line 38)					8,282,292	39
	Medically necessary private room co							40
41	Total Program general inpatient rout	ine service cost (line 39 + li	ne 40)				8,282,292	41
					Average			
			Total	Total	Per Diem	Program	Program Cost	
			Inpatient Cost	Inpatient Days	(col. 1 / col. 2)	Days	(col. 3 x col. 4)]
			1	2	3	4	5	
42	Nursery (title V & XIX only)							42
	Intensive Care Type Inpatient							
	Hospital Units							
	Intensive Care Unit		11,478,383	6,523	1,760	1,470	2,586,730	43
	Coronary Care Unit							44
	Burn Intensive Care Unit		44,105,821	24,534	1,798	5,104	9,175,665	45
	Surgical Intensive Care Unit							46
47	02040NEONATAL INTENSIVE CAR	RE UNIT	2,840,569	1,827	1,555			47
	In		0.1: 000)				1 20 040 045	10
	Program inpatient ancillary service of						22,813,345	48
	Program inpatient cellular therapy ac			nn 1)			40.050.000	48.01
49	Total Program inpatient costs (sum	of lines 41 through 48.01) (see instructions)				42,858,032	49
	PASS-THROUGH COST ADJUSTM	IENTO.						
			iana (frama Markahant D	ours of Dorto Land III)			2,687,768	50
	Pass through costs applicable to Pro Pass through costs applicable to Pro						1,459,865	51
	Total Program excludable cost (sum		vices (IIOIII vvoiksileet D	, sulli di Faits II aliu IV)			4,147,633	52
	Total Program inpatient operating co		nonnhysician anesthetist	t and medical education costs (line 40 minus line 52)		38,710,399	53
	Total Frogram inpatient operating co	ost excluding capital related,	nonphysician anestheus	t, and medical education costs (ille 49 millus ille 32)		30,710,333	
	TARGET AMOUNT AND LIMIT COM	MPLITATION						
54	Program discharges							54
	Target amount per discharge							55
	Permanent adjustment amount per o	discharge						55.01
	Adjustment amount per discharge (c							55.02
	Target amount (line 54 x sum of line							56
57	Difference between adjusted inpatier	nt operating cost and target	amount (line 56 minus lin	ne 53)				57
58	Bonus payment (see instructions)							58
59	Trended costs (lesser of line 53 ÷ lin	e 54, or line 55 from the cos	st reporting period ending	1996, updated and compounde	d by the market baske	t)		59
60	Expected costs (lesser of line 53 ÷ li	ne 54, or line 55 from prior	ear cost report, updated	by the market basket)				60
	Continuous improvement bonus pay	ment (i f line 53 ÷ line 54 is	less than the lowest of lin	nes 55 plus 55.01, or line 59, or l	ine 60, enter the lesse	r of 50% of the		
61	61 amount by which operating costs	(line 53) are less than expe	ected costs (lines 54 x 60)), or 1 % of the target amount (lir	ne 56), otherwise ente	r zero. (see		61
	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incention	e payment (see instructions	s)					63
	DDOOD AND INDATION TO DO STILL	OWING BED COOT						
	PROGRAM INPATIENT ROUTINES		hor 21 of the seet record	ng pariod (ago instructions) (4:41-	VV/III only)			64
	Medicare swing-bed SNF inpatient re Medicare swing-bed SNF inpatient re						 	64 65
	Total Medicare swing-bed SNF inpatient re				/III OHIY)		-	66
					ı		+	67
	67 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						 	68
	Total title V or XIX swing-bed NF inpatient			ig period (iiile 13 x iiile 20)			 	69
	1 and t or tark owning bod ivi inp						1	

DOCTORS H	HOSPITAL OF AUGUSTA							12-22
COMPUTAT	ION OF INPATIENT		PROVIDER CCN:		PERIOD:		WORKSHEET D-1,	
OPERATING	COST				FROM: 04/01/2021		PARTS III & IV	
			11-0177					
Check	[] Title V - O/P	[X] Hospital	[] NF		[X]PPS		•	
Applicable	[X] Title XVIII, PART A	[] IPF	[] ICF/IID		[]TEFRA			
Boxes:	[] Title XIX - I/P	[] IRF	[] NF		[] Other			
		[] Subprovider (Other)	[] PARHM Demons	tration				
		[] SNF	[] Chart Model					
PART III - SN	F, NF, AND ICF/IID ONLY							
70	SNF / NF / ICF/IID routine service c	cost (line 37)						70
71	Adjusted general inpatient routine se	ervice cost per diem (line 70	÷ line 2)					71
72	Program routine service cost (line 9	x line 71)						72
73	Medically necessary private room c	ost applicable to Program (lir	ne 14 x line 35)					73
74	Total Program general inpatient rou	tine service costs (line 72 + I	line 73)					74
75	Capital-related cost allocated to inpa	atient routine service costs (f	from Worksheet B, Pa	rt II, column 26, line 45)				75
76	Per diem capital-related costs (line	75 ÷ line 2)						76
77	Program capital-related costs (line 9	9 x line 76)						77
78	Inpatient routine service cost (line 7	4 minus line 77)						78
79	Aggregate charges to beneficiaries	for excess costs (from provide	der records)					79
80	Total Program routine service costs	for comparison to the cost li	imitation (line 78 minu	s line 79)				80
81	Inpatient routine service cost per die	em limitation						81
82	Inpatient routine service cost limitati	ion (line 9 x line 81)						82
83	Reasonable inpatient routine service	e costs (see instructions)						83
84	Program inpatient ancillary services	s (see instructions)						84
85	Utilization review - physician compe	ensation (see instructions)						85
86	Total Program inpatient operating co	osts (sum of lines 83 through	n 85)					86
		· · ·					•	
	OMPUTATION OF OBSERVATION		ST					
	Total observation bed days (see ins						4,285	87
	Adjusted general inpatient routine c)				761	88
89	Observation bed cost (line 87 x line	88) (see instructions)					3,262,513	89
	COMPUTATION OF OBSERVATION	ON BED PASS THROUGH C	OST					
						Total	Observation Bed	
				Routine		Observation	Pass-Through Cost	
				Cost	column 1 /	Bed Cost	(col. 3 x col. 4)	
			Cost	(from line 21)	column 2	(from line 89)	(see instructions)	l
			1	2	3	4	5	
	Capital-related cost		1				6,858,738	90
	Nursing Program cost							91
	Allied Health cost		1					92
93	93 All other Medical Education							93

DOCTORS HOSPITAL OF AUGUSTA 12-22 COMPUTATION OF INPATIENT PROVIDER CCN: PERIOD: WORKSHEET D-1. OPERATING COST FROM: 04/01/2021 PART I 11-0177 TO: 03/31/2022 Title V - O/P Check [X]PPS [] Hospital [] NF [X] Title XVIII, PART A []ICF/IID []TEFRA ΠPF Applicable [] Title XIX - I/P [] NF XIIRF [] Other Boxes: [] PARHM Demonstration [] Subprovider (Other) 1 SNF [] Chart Model PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS I Inpatient days (including private room days and swing-bed days, excluding newborn) 7.456 2 Inpatient days (including private room days, excluding swing-bed and newborn days) 7,456 2 3 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line. 4 Semi-private room days (excluding swing-bed and observation bed days) 7,456 4 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 5 6 6 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if 6 calendar year, enter 0 on this line) 7 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 8 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if 8 calendar year, enter 0 on this line) 8 9 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 2,916 9 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the 10 cost reporting period (see 10 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the 11 cost reporting period (if calendar 11 year, enter 0 on this line) 11 12 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of 12 the cost reporting period. 12 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the 13 cost reporting period (if calendar 13 year, enter 0 on this line) 13 14 Medically necessary private room days applicable to the Program (excluding swing-bed days) 14 15 Total nursery days (title V or XIX only) 15 16 Nursery days (title V or XIX only) 16 SWING BED ADJUSTMENT 17 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 17 18 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18 19 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 19 20 20 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 6,255,196 21 21 Total general inpatient routine service cost (see instructions) 22 22 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24 25 24 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26 27 26 Total swing-bed cost (see instructions) 6,255,196 27 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28 28 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29 29 Private room charges (excluding swing-bed charges) 30 Semi-private room charges (excluding swing-bed charges) 30 31 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31 32 32 Average private room per diem charge (line 29 ÷ line 3) 33 33 Average semi-private room per diem charge (line 30 ÷ line 4)

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6,255,196

34 Average per diem private room charge differential (line 32 minus line 33) (see instructions)

37 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)

35 Average per diem private room cost differential (line 34 x line 31)

36 Private room cost differential adjustment (line 3 x line 35)

DOCTORS	HOSPITAL OF AUGUSTA							12-22
	TION OF INPATIENT		PROVIDER CCN:	PROVIDER CCN:		PERIOD:		
OPERATING	GCOST				FROM: 04/01/2021		PART II	
			11-0177		TO: 03/31/2022			
Check	[] Title V - O/P	[X] Hospital	[] NF		[X]PPS			
Applicable	[X] Title XVIII, PART A	[] IPF	[]ICF/IID		[]TEFRA			
Boxes:	[] Title XIX - I/P	[] IRF	[]NF		[] Other			
		[] Subprovider (Other)	[] PARHM Demonstrat	ion				
DADT II III	L CONTAL AND CURRENCE ON	[] SNF	[] Chart Model					
PARTII-H	OSPITAL AND SUBPROVIDERS ON							
	PROGRAM INPATIENT OPERATIN	IG COST BEFORE PASS-	THROUGH COST ADJUS	STMENTS				
38	38 Adjusted general inpatient routine service cost per diem (see instructions)							38
	Program general inpatient routine se						2,446,378	39
	Medically necessary private room c							40
41	Total Program general inpatient rou	tine service cost (line 39 +	line 40)				2,446,378	41
					Average			
			Total	Total	Per Diem	Program	Program Cost	
			Inpatient Cost	Inpatient Days	(col. 1 / col. 2)	Days	(col. 3 x col. 4)	_
			1	2	3	4	5	
42	Nursery (title V & XIX only)							42
	Intensive Care Type Inpatient							
	Hospital Units							
	Intensive Care Unit							43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care Unit (specify)							47
							1	
48	Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200)						1,715,427	48
48.01	Program inpatient cellular therapy a	cquisition cost (Worksheet	D-6, Part III, line 10, colum	nn 1)				48.01
49	Total Program inpatient costs (sum	of lines 41 through 48.01)	(see instructions)				4,161,805	49
	PASS-THROUGH COST ADJUSTN							
	Pass through costs applicable to Pr						429,935	50
	Pass through costs applicable to Pr		ervices (from Worksheet D	, sum of Parts II and IV)			144,559	51
	Total Program excludable cost (sum						574,494	52
53	Total Program inpatient operating co	ost excluding capital related	d, nonphysician anesthetist	t, and medical education co	osts (line 49 minus line 52)		3,587,311	53
	TARGET AMOUNT AND LIMIT CO	MPUTATION						
	Program discharges							54
	Target amount per discharge							55
	Permanent adjustment amount per							55.01
	Adjustment amount per discharge (55.02
	Target amount (line 54 x sum of line			50)				56
	Difference between adjusted inpatie	nt operating cost and targe	t amount (line 56 minus lin	ie 53)				57
	Bonus payment (see instructions)							58
	Trended costs (lesser of line 53 ÷ lin				unded by the market bask	et)		59
60	Expected costs (lesser of line 53 ÷ I							60
	Continuous improvement bonus pay							l
	61 amount by which operating costs	(line 53) are less than exp	ected costs (lines 54 x 60)	i, or 1 % of the target amou	int (line 56), otherwise ente	er zero. (see		61
	Relief payment (see instructions)		,					62
63	Allowable Inpatient cost plus incenti	ve payment (see instruction	ns)					63
	PROGRAM INPATIENT ROUTINE	SWING BED COST						
	Medicare swing-bed SNF inpatient r		mber 31 of the cost reporting	ng period (see instructions) (title XVIII only)		1	64
	Medicare swing-bed SNF inpatient i							65
	Total Medicare swing-bed SNF inpa							66
	Title V or XIX swing-bed NF inpatier							67
	Title V or XIX swing-bed NF inpatier				/			68
	Total title V or XIX swing-bed NF inp			-5 -5.104 (m.e. 10 x m10 20)			1	69
		()	,					

DOCTORS	HOSPITAL OF AUGUSTA							12-22
COMPUTA	TION OF INPATIENT		PROVIDER CCN:		PERIOD:		WORKSHEET D-1,	
OPERATING	RATING COST				FROM: 04/01/2021		PARTS III & IV	
			11-0177 TO: 03/31/2022					
Check	[] Title V - O/P	[X] Hospital	[] NF		[X]PPS			
Applicable	[X] Title XVIII, PART A	[] IPF	[] ICF/IID		[]TEFRA			
Boxes:	[] Title XIX - I/P	[] IRF	[]NF		[] Other			
		[] Subprovider (Other)	[] PARHM Demons	tration				
		[] SNF	[] Chart Model					
	NF, NF, AND ICF/IID ONLY							
	SNF / NF / ICF/IID routine service of							70
	Adjusted general inpatient routine s		÷ line 2)					71
	Program routine service cost (line 9							72
	Medically necessary private room of							73
	Total Program general inpatient rou							74
	Capital-related cost allocated to inp		from Worksheet B, Pa	rt II, column 26, line 45)				75
	Per diem capital-related costs (line							76
	Program capital-related costs (line							77
	Inpatient routine service cost (line 7							78
	Aggregate charges to beneficiaries							79
	Total Program routine service costs		imitation (line 78 minu	s line 79)				80
	Inpatient routine service cost per di							81
	Inpatient routine service cost limitat							82
	Reasonable inpatient routine service							83
	Program inpatient ancillary services							84
	Utilization review - physician compe							85
86	Total Program inpatient operating c	osts (sum of lines 83 through	n 85)					86
	OMPUTATION OF OBSERVATION		SI					
	Total observation bed days (see ins							87
	Adjusted general inpatient routine of)					88
88	Observation bed cost (line 87 x line	88) (see instructions)						89
	COMPUTATION OF OBSERVATION	NI BED BASS TUBOUCULO	COCT					
	T COMPUTATION OF OBSERVATION	DN BED PASS THROUGH C	T		1	Total	Observation Bed	1
				Routine		Observation	Pass-Through Cost	
				Cost	column 1 /	Bed Cost		
			Cost	(from line 21)	column 2	(from line 89)	(col. 3 x col. 4) (see instructions)	
	<u> </u>		COST	(IFORT line 21)	3	4	(see instructions)	ł
	Capital-related cost		+ '		-	+	1,099,305	90
	Nursing Program cost				+	-	1,088,305	90
	Allied Health cost							92
	All other Medical Education							93
93	All other Medical Education		1					93

	HOSPITAL OF AUGUSTA TION OF INPATIENT		PROVIDER CCN:	PERIOD:	WORKSHEET D-1.	12-22
OPERATING			I NOVIDEN CON.	FROM: 04/01/2021	PART I	
OFLICATING	G CO31		11-0177	TO: 03/31/2022	FAINT	
Check	[] Title V - O/P	[X] Hospital	[]NF	[X]PPS		
Applicable	[] Title XVIII, PART A	[] IPF	[]ICF/IID	[]TEFRA		
Boxes:	[X] Title XIX - I/P	[] IRF	[] NF	[] Other		
DOXES.	[X] Title XIX - I/F	[] Subprovider (Other)	[] PARHM Demonstration	[] Other		
		[] Subprovider (Other)	[] PARHIM Demonstration			
DADTI AL	L PROVIDER COMPONENTS	[] 3111	[] Chart Woder			
PARTI-AL	INPATIENT DAYS				1	
	Inpatient days (including private	room days and swing had day	(c. eveluding newborn)		59.446	1
	Inpatient days (including private				59,446	2
			days). If you have only private room days	s do not complete this line	33,440	3
	Semi-private room days (excluding sv			s, do not complete una line.	55,161	
			m days) through December 31 of the cos	et roporting poriod	33,101	
				eporting period (if 6 calendar year, enter 0 on this		
6	Siline)	icht days (moldang phivate roc	in days) and Becomber of or the cost re	sporting period (if o odioridal year, enter o on the		l 6
7		nt days (including private room	days) through December 31 of the cost	reporting period		1
	Total Swing Bod IVI type inpute	in days (moldaling private room	radys) anough becomber of or the dest	reperting period		
Ω.	Total swing-had NE type innation	nt days (including private room	days) after December 31 of the cost ren	porting period (if 8 calendar year, enter 0 on this line)		
			the Program (excluding swing-bed and ne		3,416	- 9
				December 31 of the 10 cost reporting period (see	3,410	
10	linstructions).	ays applicable to title Avill offi	y (including private room days) through b	recember 31 of the 10 cost reporting period (see		10
		ave applicable to title XV/III only	(including private room days) after Door	ember 31 of the 11 cost reporting period (if calendar		
11	vear, enter 0 on this line)	ays applicable to title Avill offi	y (including private room days) after Dece	ember 51 of the 11 cost reporting period (ii calendar		11
		us applicable to titles V or VIV	only (including private room days) throug	h December 31 of 12 the cost reporting period.		12
				December 31 of the 13 cost reporting period (if		
12	calendar year, enter 0 on this lin		only (including private room days) after D	recember 31 of the 13 cost reporting period (ii		13
	Medically necessary private roo		cam (evaluding swing had days)			14
	Total nursery days (title V or XIX		ani (excluding swing-bed days)		3,726	15
	Nursery days (title V or XIX only				150	16
	SWING BED ADJUSTMENT)			130	
17		E convisco applicable to convi	es through December 31 of the cost repo	orting period		17
			es after December 31 of the cost reportir			18
			s through December 31 of the cost report			19
			s after December 31 of the cost reporting			20
	Total general inpatient routine s		s after December 31 of the cost reporting	period	45,260,850	2
			mber 31 of the cost reporting period (line	E v line 17\	43,200,030	22
			er 31 of the cost reporting period (line 6)			23
			ber 31 of the cost reporting period (line 5)			24
			r 31 of the cost reporting period (line 8 x l			25
	Total swing-bed cost (see instru		1 31 of the cost reporting period (line 6 x i	lille 20)		26
	General inpatient routine service		no 21 minus lino 26)		45,260,850	27
	PRIVATE ROOM DIFFERENTIA		ne 21 minus inte 20)		43,200,030	
	General inpatient routine service		d and shappyation had sharges			28
	Private room charges (excluding		d and observation bed charges)			29
	Semi-private room charges (excluding					30
	General inpatient routine service		20.28\			31
	Average private room per diem		le 20)			32
						33
	Average semi-private room per Average per diem private room		us line 32) (ass instructions)			34
	Average per diem private room		51)			35 36
	Private room cost differential ad	, , ,	1 100 100 100 100 100 100 100 100 100 1	the control of the co	45.000.050	
37	IGeneral inpatient routine service	e cost net of swing-bed cost ar	nd private room cost differential (line 27 m	ninus line 36)	45,260,850	3

DOCTORS HOSPITAL OF AUGUSTA 12-22 WORKSHEET D-1, COMPUTATION OF INPATIENT PROVIDER CCN: DEBIUD. OPERATING COST FROM: 04/01/2021 PART II 11-0177 TO: 03/31/2022 Check Title V - O/P [X]PPS [X] Hospital [] NF [] Title XVIII, PART A [] ICF/IID Applicable [] IPF []TEFRA [X] Title XIX - I/P [] IRF [] NF [] Other [] Subprovider (Other) [] PARHM Demonstration []SNF [] Chart Model PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS 38 Adjusted general inpatient routine service cost per diem (see instructions) 38 761 39 Program general inpatient routine service cost (line 9 x line 38) 2.600.874 39 40 40 Medically necessary private room cost applicable to the Program (line 14 x line 35) 2,600,874 41 41 Total Program general inpatient routine service cost (line 39 + line 40) Average Program Cost Total Total Per Diem Program Inpatient Cost Inpatient Days (col. 1 / col. 2) Days (col. 3 x col. 4) 42 Nursery (title V & XIX only) 585,260 42 Intensive Care Type Inpatient Hospital Units 43 44 43 Intensive Care Unit 11,478,383 6,523 1,760 1,356 2,386,126 44 Coronary Care Unit 45 Burn Intensive Care Unit 44,035,244 24,534 1,795 391 701,794 45 46 46 Surgical Intensive Care Unit 47 02040NEONATAL INTENSIVE CARE UNIT 1,827 1,555 47 2.840.569 48 48 Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200) 6.060.183 48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 48.01 11,772,538 49 49 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions) PASS-THROUGH COST ADJUSTMENTS 50 Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III) 50 51 52 51 Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV) Total Program excludable cost (sum of lines 50 and 51) 53 Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52) 53 TARGET AMOUNT AND LIMIT COMPUTATION 54 Program discharges 54 55 Target amount per discharge 55 55.01 Permanent adjustment amount per discharge 55.01 55.02 55.02 Adjustment amount per discharge (contractor use only) 56 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 56 57 57 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58 59 58 Bonus payment (see instructions) 559 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)
60 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket) 60 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of 61 the 61 amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero 61 62 63 62 Relief payment (see instructions)

65 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only) 66 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only; for CAH, see instructions)		PROGRAM INPATIENT ROUTINE SWING BED COST	
66 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only; for CAH, see instructions)	64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)	64
	65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)	65
67 Title V or XIX swing-bed NE inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)			66
of find very are migrature and a second and agricultural of the second and period (mile 12 x mile 10)	67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	67
68 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	68
69 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	69

63 Allowable Inpatient cost plus incentive payment (see instructions)

DOCTORS I	HOSPITAL OF AUGUSTA							12-22
	ION OF INPATIENT		PROVIDER CCN:		PERIOD:		WORKSHEET D-1,	
OPERATING COST					FROM: 04/01/2021		PARTS III & IV	
			11-0177		TO: 03/31/2022			
Check	[] Title V - O/P	[X] Hospital	[]NF		[X]PPS		•	
Applicable	[] Title XVIII, PART A	[] IPF	[] ICF/IID		[]TEFRA			
Boxes:	[X] Title XIX - I/P	[] IRF	[]NF		[] Other			
	,	[] Subprovider (Other)	[] PARHM Demons	tration				
		[] SNF	[] Chart Model					
PART III - SI	NF, NF, AND ICF/IID ONLY	ici						
70	SNF / NF / ICF/IID routine service	cost (line 37)						70
71	Adjusted general inpatient routine	service cost per diem (line 7	0 ÷ line 2)					71
72	Program routine service cost (line	9 x line 71)	<i>'</i>					72
73	Medically necessary private room	cost applicable to Program (line 14 x line 35)					73
74	Total Program general inpatient ro	utine service costs (line 72 +	line 73)					74
75	Capital-related cost allocated to in	patient routine service costs	(from Worksheet B, P	art II, column 26, line 45)				75
76	Per diem capital-related costs (line	75 ÷ line 2)		•				76
77	Program capital-related costs (line	9 x line 76)						77
78	Inpatient routine service cost (line	74 minus line 77)						78
79	Aggregate charges to beneficiaries	s for excess costs (from prov	rider records)					79
80	Total Program routine service cost	s for comparison to the cost	limitation (line 78 minu	us line 79)				80
81	Inpatient routine service cost per d	liem limitation						81
82	Inpatient routine service cost limita	tion (line 9 x line 81)						82
83	Reasonable inpatient routine servi	ce costs (see instructions)						83
	Program inpatient ancillary service							84
85	Utilization review - physician comp	ensation (see instructions)						85
86	Total Program inpatient operating	costs (sum of lines 83 throug	jh 85)					86
			-				-	
	OMPUTATION OF OBSERVATION Total observation bed days (see in		ST				4.285	87
	Adjusted general inpatient routine		2)				761	88
	Observation bed cost (line 87 x line		2)				3,262,513	89
09	Observation bed cost (line 87 x line	e oo) (see instructions)					3,202,313	09
	COMPUTATION OF OBSERVATION	ON BED PASS THROUGH (COST					
						Total	Observation Bed	I
				Routine		Observation	Pass-Through Cost	
				Cost	column 1 /	Bed Cost	(col. 3 x col. 4)	
			Cost	(from line 21)	column 2	(from line 89)	(see instructions)	
			1	2	3	4	5	1
90	Capital-related cost						6,858,738	90
91	Nursing Program cost						1	91
92	Allied Health cost							92
93	All other Medical Education							93
			-			-	•	

	SPITAL OF AUGUSTA N OF INPATIENT			PROVIDER CCN:	PERIOD:		WORKSHEET D-3	12-22
OPERATING C				PROVIDER CCIN.	FROM: 04/01/20	021	WORKSHEET D-3	
				11-0177	TO: 03/31/2022			
	[] Title V - O/P		[]SNF	[] ICF/IID	[X]PPS			
Applicable	[X] Title XVIII, PART A		[] NF	[] PARHM Demonstration	[]TEFRA			
Boxes:	[] Title XIX - I/P		[] Swing-Bed SNF	[] PARHM CAH Swing-Bed SNF	[] Other			
		[] Subprovider (Other)	[] Swing-Bed NF	[] Chart Model				
	l			[] Chart CAH Swing-Bed SNF	Ratio of Cost	Inpatient	Inpatient Program Costs	_
	COST CENTER DESCRIPTION	ON			to Charges	Program Charges	(col. 1 x col. 2)	
(A)					1	2	3	
	INPATIENT ROUTINE SERV	ICE COST CENTERS						
30	Adults and Pediatrics (Gener	al Routine Care)				22,479,583		30
31	Intensive Care Unit					7,455,392		31
32	Coronary Care Unit							32
33	Burn Intensive Care Unit					71,079,564		33
34 35	Surgical Intensive Care Unit 02040NEONATAL INTENSIV	E CADE LINIT						34 35
40		E CARE UNII						40
41	Subprovider - IRF							41
42	Subprovider (specify)							42
43	Nursery							43
	ANCILLARY SERVICE COS	ST CENTERS						
50	Operating Room				0.079206	30,785,870	2,438,426	50
51	Recovery Room				0.061678	3,606,146	222,420	51
52	Labor Room and Delivery Ro	oom			0.153173	89,006	13,633	52
53	Anesthesiology				0.057077	11.055.100	007.074	53
54					0.057977	14,955,428	867,071	54 55
55 56	Radiology-Therapeutic Radioisotope				0.065275 0.042585	144,686 2,904,270	9,444 123,678	56
57	Computed Tomography (CT)	Scan			0.009255	18,227,322	168,694	57
58	Magnetic Resonance Imagin				0.024585	3,276,042	80,541	58
59		5 (0.094633	3,594,506	340,159	59
60	Laboratory				0.023781	63,766,357	1,516,428	60
61	PBP Clinical Laboratory Serv	rices-Program Only						61
62	Whole Blood & Packed Red				0.091157	7,838,419	714,527	62
63	Blood Storing, Processing, &	Trans.						63
64					0.004400	05 000 040	200.040	64
65	Respiratory Therapy				0.034463 0.133873	25,820,210	889,842	65
66 67	Physical Therapy				0.133673	6,907,696 2,717,054	924,754 221,315	66 67
68	Occupational Therapy Speech Pathology				0.051468	831,594	42,800	68
69					0.032379	7,663,940	248,151	69
70					0.130189	383,559	49,935	70
71	Medical Supplies Charged to	Patients			0.145433	40,093,721	5,830,950	71
72	Implantable Devices Charge	d to Patients			0.358424	6,107,484	2,189,069	72
73	Drugs Charged to Patients				0.041285	93,254,222	3,850,001	73
74					0.202427	3,066,950	620,833	74
75	ASC (Non-Distinct Part)				0.070007	040.054	74 444	75
76 76.01	Other Ancillary (specify) 03952HYPERBARIC				0.078297 0.092083	912,051 726,087	71,411 66,860	76 76.01
70.01	OUTPATIENT SERVICE CO	OST CENTERS			0.092063	120,001	00,000	70.01
88	Rural Health Clinic (RHC)	00.02.11.2.10						88
89	Federally Qualified Health Co	enter (FQHC)						89
90	Clinic				0.187936	137,962	25,928	90
90.01	09001MFM CLINIC				0.064830			90.01
91	Emergency				0.125675	7,757,251	974,893	91
92	Observation Beds				0.289413	1,076,599	311,582	92
93	Other Outpatient Service (sp							93
0.4	OTHER REIMBURSABLE (Home Program Dialysis	COST CENTERS						94
95	Ambulance Services							95
96		Rented						96
97								97
98	Other Reimbursable (specify							98
99								99
100	Intern-Resident Service (not	appvd. tchng. prgm.)						100
101	Home Health Agency							101
101.01								101
101.02	Total (aum of line - 50 th	04 and 06 th CO				246 044 400	00.040.045	101
200 201	Total (sum of lines 50 through Less PBP Clinic Laboratory S		parges (line 61)			346,644,432	22,813,345	200
	Net charges (line 200 minus l		iaiges (iiie 01)			346,644,432		202
202	1. Tot on digos (into 200 minus i	201)				070,077,402		202

OOCTORS HO	SPITAL OF AUGUSTA							12-22
COMPUTATION	N OF INPATIENT			PROVIDER CCN:	PERIOD:		WORKSHEET D-3	
OPERATING C	OST				FROM: 04/01/2			
Check	It I Title V O/D	[1] Hespital	LICNE	11-0177	TO: 03/31/2022	2		
Applicable	[] Title V - O/P [X] Title XVIII, PART A	[] Hospital [] IPF	[] SNF [] NF	[] ICF/IID [] PARHM Demonstration	[]TEFRA			
Boxes:	[] Title XIX - I/P	[X]IRF	[] Swing-Bed SNF	[] PARHM CAH Swing-Bed SNF	[] Other			
		[] Subprovider (Othe		[] Chart Model				
		1		[] Chart CAH Swing-Bed SNF	Ratio of Cost	Inpatient	Inpatient Program Costs	
	COST CENTER DESCRIPTION	ON			to Charges	Program Charges	(col. 1 x col. 2)	
(A)	INDATIENT DOLITINE OFDI	IOE OOOT OF LITERO			1	2	3	
30	INPATIENT ROUTINE SERV Adults and Pediatrics (Gener							30
31		ar routine care)						31
32	Coronary Care Unit							32
33 34	Burn Intensive Care Unit							33
35	Surgical Intensive Care Unit 02040NEONATAL INTENSIV	E CARE UNIT						34 35
40		2 07 11 12 01 11 1						40
41						6,609,992		41
42	Subprovider (specify)							42
43	ANCILLARY SERVICE COS	ST CENTERS						43
50					0.079206	162,317	12,856	50
51	Recovery Room				0.061678	22,070	1,361	51
52 53	Labor Room and Delivery Ro	oom			0.153173			52 53
54					0.057977	235,202	13,636	54
55					0.065275		. 5,555	55
56	Radioisotope				0.042585	20,642	879	56
57 58	Computed Tomography (CT)				0.009255 0.024585	536,924 101,377	4,969 2,492	57 58
59	Magnetic Resonance Imagin Cardiac Catheterization	g (IVIIXI)			0.024383	101,377	2,492	59
60					0.023781	2,001,205	47,591	60
61	PBP Clinical Laboratory Serv							61
62	Whole Blood & Packed Red				0.091157	91,200	8,314	62
63 64	Blood Storing, Processing, & Intravenous Therapy	Halls.			+			63 64
65					0.034463	826,538	28,485	65
66	Physical Therapy				0.133873	9,413,466	1,260,209	66
67	Occupational Therapy				0.081454	103,034	8,393	67
68 69	Speech Pathology Electrocardiology				0.051468 0.032379	462,190 236,346	23,788 7,653	68 69
70					0.130189	23,102	3,008	70
71	Medical Supplies Charged to	Patients			0.145433	699,096	101,672	71
72	Implantable Devices Charge	d to Patients			0.358424	8,307	2,977	72
73 74					0.041285 0.202427	3,191,571 261,616	131,764 52,958	73 74
75	ASC (Non-Distinct Part)						3-,000	75
76	Other Ancillary (specify)				0.078297	30,933	2,422	76
76.01	03952HYPERBARIC OUTPATIENT SERVICE CO	OCT CENTERS			0.092083			76.01
88	Rural Health Clinic (RHC)	OST CENTERS						88
89	Federally Qualified Health Co	enter (FQHC)						89
90	Clinic				0.187936			90
90.01	09001MFM CLINIC				0.064830			90.01
92	Emergency Observation Beds				0.125675 0.289413			91 92
93	Other Outpatient Service (sp	ecify)			0.200110			93
	OTHER REIMBURSABLE (
	Home Program Dialysis				-			94
95	Ambulance Services Durable Medical Equipment-	Rented			+			95 96
97	Durable Medical Equipment-	Sold						97
98	Other Reimbursable (specify				1			98
99	Outpatient Rehabilitation Pro				 			99 100
100 101	Intern-Resident Service (not Home Health Agency	appvd. (cillig. pigffi.)			+			100
101.01								101
101.02								101
200	Total (sum of lines 50 through				 	18,427,136	1,715,427	200
201 202	Less PBP Clinic Laboratory S Net charges (line 200 minus I		charges (iiile 61)		+	18,427,136		201 202
_JE	,g \ 200	,				. 5, .2. , .00		

DOCTORS HOSPITAL OF AUGUSTA COMPUTATION OF INPATIENT DEPARTING COST				PROVIDER CCN: PERIOD:			WORKSHEET D-3	
OPERATING COST					FROM: 04/01/20			
01 1	In Till V 0/2	Invalia e e	ra one	11-0177	TO: 03/31/2022	2	1	
Check	[] Title V - O/P		[]SNF	[] ICF/IID	[X]PPS			
Applicable Boxes:	[] Title XVIII, PART A [X] Title XIX - I/P		[] NF [] Swing-Red SNE	[] PARHM Demonstration	[] TEFRA			
Boxes:	[X] Title XIX - I/P	[] Subprovider (Other)	[] Swing-Bed SNF	[] PARHM CAH Swing-Bed SNF	[] Other			
		[1] Sapployide (Ottlet)	[] Owing-ped INF	[] Chart Model [] Chart CAH Swing-Bed SNF				
	<u> </u>	<u> </u>		[] Chart CAIT Swing-Ded Sivi	Ratio of Cost	Inpatient	Inpatient Program Costs	
	COST CENTER DESCRIPT	ION			to Charges	Program Charges	(col. 1 x col. 2)	
(A)					1	2	3	İ
	INPATIENT ROUTINE SER	VICE COST CENTERS						
30		eral Routine Care)				4,871,147		30
31						1,623,606		31
32								32
33	Burn Intensive Care Unit	•				16,633,449		33
34 35	Surgical Intensive Care Uni 02040NEONATAL INTENSI							34 35
40		VE CARE UNIT						40
41	Subprovider - IRF							41
42	Subprovider (specify)							42
43						652,003		43
	ANCILLARY SERVICE CO	OST CENTERS						
50				-	0.079176	19,286,860	1,527,056	50
51	Recovery Room				0.061678	322,686	19,903	51
52	Labor Room and Delivery F	Room			0.153173	315,183	48,278	52
53					0.057077	4 707 000	102.050	53
54 55					0.057977 0.065275	1,787,836	103,653	54 55
56	Radioisotope				0.042585	292,123	12,440	56
57	Computed Tomography (C	Γ) Scan			0.009255	2,782,591	25,753	57
58					0.024585	443,454	10,902	58
59	Cardiac Catheterization	0 ()			0.094633	345,991	32,742	59
60					0.023781	14,276,157	339,501	60
61	PBP Clinical Laboratory Se							61
62	Whole Blood & Packed Red				0.091157	2,072,249	188,900	62
63		& Trans.						63
64					0.004460	7 200 200	050 500	64
65 66					0.034463 0.133873	7,329,202 1,897,340	252,586 254,003	65 66
67	Physical Therapy Occupational Therapy				0.081454	523,152	42,613	67
68					0.051468	231,748	11,928	68
69					0.032379	1,220,632	39,523	69
70					0.130189	63,977	8,329	70
71		to Patients			0.145433	9,696,115	1,410,135	71
72	Implantable Devices Charg	ed to Patients			0.358424	331,305	118,748	72
73					0.041285	30,683,737	1,266,778	73
74					0.202427	484,803	98,137	74
75					0.079207	040.740	16.055	75 76
76.01	Other Ancillary (specify) 03952HYPERBARIC				0.078297 0.092083	212,710 180,769	16,655 16,646	76 76.01
70.01	OUTPATIENT SERVICE (COST CENTERS			0.092003	100,709	10,046	70.01
88		02210					T T	88
89		Center (FQHC)			İ		1	89
90	Clinic	/			0.187936	43,745	8,221	90
90.01	09001MFM CLINIC				0.064830	6,019	390	90.01
91	 				0.125675	1,212,811	152,420	91
92	Observation Beds				0.289413	186,387	53,943	92
93								93
0.4	OTHER REIMBURSABLE Home Program Dialysis	COST CENTERS				ı	1	0.4
94 95					1		-	94 95
96		t-Rented			 		 	96
97					1		1	97
98					1		 	98
99	Outpatient Rehabilitation P				İ		1	99
100								100
101								101
101.01								101
101.02								101
200			// A.)		1	96,229,582	6,060,183	200
	Less PBP Clinic Laboratory		narges (line 61)		1	00 000 500	-	201
202	Net charges (line 200 minus	iine 201)			L	96,229,582	I.	202