APPORTIO	NMENT OF INPATIENT ROUTINE			PROVIDER CCN:		PERIOD:		WORKSHEET D	
SERVICE C	APITAL COSTS					FROM: 01/01/2021		PART I	
				11-0028		TO: 12/31/2021			
Check	[] Title V	[X] Hospital		[X]PPS					
Applicable	[X] Title XVIII	[] PARHM Demon	stration	[]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)	5,316,539		5,316,539	83,011	64	8,056	515,987	30
31	Intensive Care Unit	5,008,909		5,008,909	45,795	109	23,716	2,594,056	31
31.01	02060NEURO INTENSIVE CARE UNIT	341,687		341,687	3,660	93	1,098	102,509	31.01
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider (specify)								42
43	Nursery	122,909		122,909	5,196	24			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
46	Other Long Term Care								46
200	Total	10,790,044		10,790,044	137,662		32,870	3,212,552	200

UNIVERSI	ITY HEALTH SERVICES INC.						12-22
APPORTIC	ONMENT OF INPATIENT ANCILLARY	PROVIDER CCN:		PERIOD:		WORKSHEET D	
SERVICE	CAPITAL COSTS			FROM: 01/01/2021		PART II	
		11-0028		TO: 12/31/2021			
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	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,589,158	154,962,808	0	18,268,781	894,695	50
52	Labor Room and Delivery Room	694,994	6,464,878	0	5,784	622	52
53	Anesthesiology	221,376	12,297,311	0	1,522,298	27,404	53
54	Radiology-Diagnostic	3,403,643	110,985,322	0	10,798,650	331,173	54
57	Computed Tomography (CT) Scan	307,899	112,970,068	0	13,658,501	37,219	57
58	Magnetic Resonance Imaging (MRI)	614,449	34,974,919	0	2,265,871	39,807	58
59	Cardiac Catheterization	1,319,074	58,505,703	0	7,270,041	163,910	59
60	Laboratory	1,564,708	189,938,354	0	24,741,499	203,820	60
64	Intravenous Therapy	142,350	13,279,278	0	991,486	10,629	64
65	Respiratory Therapy	467,602	43,395,998	0	5,396,902	58,152	65
66	Physical Therapy	323,067	18,231,731	0	4,045,054	71,678	66
69	Electrocardiology	809,695	69,118,465	0	7,152,252	83,789	69
71	Medical Supplies Charged to Patients	945,220	224,212,869	0	38,168,370	160,918	71
72	Implantable Devices Charged to Patients	1,196,446	97,801,249	0	17,426,690	213,181	72
73	Drugs Charged to Patients	1,203,018	221,303,529	0	41,913,653	227,843	73
76.97	07697CARDIAC REHABILITATION	261,578	3,584,943	0	9,030	659	76.97
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	522,284	9,634,778	0	2,234,548	121,130	90
91	Emergency	2,998,194	55,878,654	0	5,889,018	315,975	91
92	Observation Beds	562,456	14,540,314	0	766,762	29,661	92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS		<u> </u>				
200	Total (sum of lines 50 through 199)	25,147,211	1,452,081,171		202,525,190	2,992,265	200

UNIVERSIT	Y HEALTH SERVICES INC.												12-22
APPORTIO	NMENT OF INPATIENT ROUTINE							PROVIDER CCN:		PERIOD:		WORKSHEET D	
SERVICE C	THER PASS-THROUGH COSTS									FROM: 01/01/2021		PART III	
								11-0028		TO: 12/31/2021			
Check	[] Title V	[X] Hospital		[X]PPS									
Applicable	[X] Title XVIII	[] PARHM Demon	stration	[]TEFRA									1
Boxes:	[] Title XIX	[] Chart Model											<u> </u>
		Nursing		Allied		All	Swing-Bed					Inpatient	
		Program		Health		Other	Adjustment	Total Costs		Per		Program	1
		Post-		Post-		Medical	Amount	(sum of cols.	Total	Diem	Inpatient	Pass-Through	1
		Stepdown	Nursing	Stepdown	Allied Health	Education	(see	1, 2, and 3,	Patient	(col. 3 /	Program	Cost	1
		Adjustments	Program	Adjustments	Cost	Cost	instructions)	minus col. 4)	Days	col. 4)	Days	(col. 7 x col. 8)	l
	COST CENTER DESCRIPTIONS	1A	1	2A	2	3	4	5	6	7	8	9	l
	INPATIENT ROUTINE SERVICE COST CENTERS												
30	Adults and Pediatrics (General Routine Care)								83,011		8,056		30
31	Intensive Care Unit								45,795		23,716		31
31.01	02060NEURO INTENSIVE CARE UNIT								3,660		1,098		31.01
32	Coronary Care Unit												32
33	Burn Intensive Care Unit												33
34	Surgical Intensive Care Unit												34
35	Other Special Care (specify)												35
40	Subprovider - IPF												40
41	Subprovider - IRF												41
42	Subprovider (specify)												42
43	Nursery								5,196				43
44	Skilled Nursing Facility												44
45	Nursing Facility												45
46	Other Long Term Care												46
200	Total								137,662		32,870		200

	IY HEALTH SERVICES INC.				I DDOV/DED COM		DEDIOD:		WORKSHEET D	12-2
	NMENT OF INPATIENT/OUTPATIENT ANCILLARY				PROVIDER CCN:	:	PERIOD:	4	WORKSHEET D	
SERVICE	OTHER PASS-THROUGH COSTS				11-0028		FROM: 01/01/202 TO: 12/31/2021	1	PART IV	
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 duoi.	[] Other			
Вохоо.		[] Subprovider (Other)	[] Swing-Bed SNF		[] Chart CAH Swir	ng-Bed SNF	[] Galoi			
	<u> </u>	[] caspionae (cale)	[] Chang Bod Cha	I	[] [] []	19 204 014		T		Т
			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	(sum of cols. 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
	67									53
54	Radiology-Diagnostic					321,955		321,955	321,955	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									6
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									60
64	Intravenous Therapy									64
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology					400,000		100.000	100.000	68
69	Electrocardiology					168,392		168,392	168,392	
70	Electroencephalography Madical Supplies Charged to Retients									70
71	Medical Supplies Charged to Patients Implantable Devices Charged to Patients									72
										73
	Drugs Charged to Patients Renal Dialysis				-					74
	ASC (Non-Distinct Part)				+					75
76	Other Ancillary (specify)				1					76
76.97	07697CARDIAC REHABILITATION				+					76.97
- 10.31	OUTPATIENT SERVICE COST CENTERS									10.51
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)				+					89
90	Clinic				+					90
91	Emergency			-	+	-	-			9
92	Observation Beds				+					92
93	Other Outpatient Service (specify)				+					93
	Total (sum of lines 50 through 199)			-	+	490,347	 	490,347	490,347	200

	IY HEALTH SERVICES INC.				DDOV/IDED CON-		I DEDIOD:		I WORKSHIELT D	12-2
	NMENT OF INPATIENT/OUTPATIENT ANCILLARY				PROVIDER CCN:		PERIOD:		WORKSHEET D	
SEKVICE (OTHER PASS-THROUGH COSTS				44 0000		FROM: 01/01/2021		PART IV	
<u> </u>	In the second se	1			11-0028		TO: 12/31/2021			
	[] Title V	[X] Hospital	[]SNF		[X] Hospital		[X]PPS			
	[X] Title XVIII, PART A	[] IPF	[]NF		[] PARHM Demons	stration	[]TEFRA			
Boxes:	[] Title XIX	[] IRF	[]ICF/IID		[] Chart Model		[] Other			
		[] Subprovider (Other)	[] Swing-Bed SNF		[] Chart CAH Swin	g-Bed SNF				
							Inpatient		Outpatient	
				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	(col. 6 / col. 7)	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		154,962,808			18,268,781		25,787,968		50
51	Recovery Room		2 12 1 5			==		2==		5
52	Labor Room and Delivery Room		6,464,878			5,784		973		5:
53	Anesthesiology		12,297,311		_	1,522,298		1,613,808		5
54	Radiology-Diagnostic		110,985,322	0	0	10,798,650	31,327	19,628,458	56,942	5
55	Radiology-Therapeutic									5
56	Radioisotope									5
57	Computed Tomography (CT) Scan		112,970,068			13,658,501		16,402,455		5
58	Magnetic Resonance Imaging (MRI)		34,974,919			2,265,871		6,800,351		5
59	Cardiac Catheterization		58,505,703			7,270,041		12,339,377		5
60	Laboratory		189,938,354			24,741,499		7,965,932		6
61	PBP Clinical Laboratory Services-Program Only									6
62	Whole Blood & Packed Red Blood Cells									6
63	Blood Storing, Processing, & Trans.									6
64	Intravenous Therapy		13,279,278			991,486		779,023		6
65	Respiratory Therapy		43,395,998			5,396,902		1,886,098		6
66	Physical Therapy		18,231,731			4,045,054		172,225		6
67	Occupational Therapy									6
68	Speech Pathology									6
69	Electrocardiology		69,118,465	0	0	7,152,252	17,423	14,516,289	35,362	6
70	Electroencephalography									7
71	Medical Supplies Charged to Patients		224,212,869			38,168,370		23,422,068		7
72	Implantable Devices Charged to Patients		97,801,249			17,426,690		19,502,173		7
73	Drugs Charged to Patients		221,303,529			41,913,653		12,291,821		7
74	Renal Dialysis									7-
75	ASC (Non-Distinct Part)									7:
76	Other Ancillary (specify)									7
76.97	07697CARDIAC REHABILITATION		3,584,943			9,030		974,100		76.9
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)									8
89	Federally Qualified Health Center (FQHC)									8
90	Clinic		9,634,778			2,234,548		2,716,876		9
91	Emergency		55,878,654			5,889,018		3,494,419		9
92	Observation Beds		14,540,314			766,762		721,116		9
93	Other Outpatient Service (specify)			1		•		-		9
200	Total (sum of lines 50 through 199)		1,452,081,171	1		202,525,190	48,750	171,015,530	92,304	20

UNIVERS	ITY HEALTH SERVICES INC.								12-22
APPORTIC	ONMENT OF MEDICAL AND OTHER			PROVIDER CCN:		PERIOD:		WORKSHEET D	
HEALTH S	SERVICES COSTS					FROM: 01/01/2021		PART V	
				11-0028		TO: 12/31/2021			
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				
Boxes:	[] Title XIX - O/P	[] IRF	[] NF	[]ICF/IID	[] Chart Model	·			
					[] Chart CAH Swing	-Bed SNF			
			1	Program Charges			Program Cost		
		Cost		Cost	Cost		Cost	Cost	
		to		Reimbursed	Reimbursed		Reimbursed	Reimbursed	
		Charge	PPS	Services	Services Not	PPS	Services	Services Not	ĺ
		Ratio from	Reimbursed	Subject to	Subject to	Services	Subject to	Subject to	
		Wkst. C,	Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	ĺ
		Pt. I, col. 9	(see inst.)	(see inst.)	(see inst.)	inst)	(see inst.)	(see inst.)	ĺ
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	1
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.313616	25,787,968			8,087,519			50
52	Labor Room and Delivery Room	1.292925	973			1,258			52
53	Anesthesiology	0.064781	1,613,808			104,544			53
54	Radiology-Diagnostic	0.173856	19,628,458			3,412,525			54
57	Computed Tomography (CT) Scan	0.026802	16,402,455			439,619			57
58		0.054231	6,800,351			368,790			58
59	Cardiac Catheterization	0.144768	12,339,377			1,786,347			59
60	Laboratory	0.139796	7,965,932			1,113,605			60
64	Intravenous Therapy	0.067724	779,023			52,759			64
65	Respiratory Therapy	0.190323	1,886,098			358,968			65
66	Physical Therapy	0.380333	172,225			65,503			66
69	Electrocardiology	0.079732	14,516,289			1,157,413			69
71	Medical Supplies Charged to Patients	0.181395	23,422,068	171,200		4,248,646	31,055		71
72	Implantable Devices Charged to Patients	0.534358	19,502,173	4,355		10,421,142	2,327		72
73	Drugs Charged to Patients	0.168173	12,291,821	166	87,721	2,067,152	28	14,752	73
76.97	07697CARDIAC REHABILITATION	0.545560	974,100			531,430			76.97
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.853728	2,716,876	46		2,319,473	39		90
91	Emergency	0.603146	3,494,419			2,107,645			91
92	Observation Beds	0.554390	721,116			399,779			92
	OTHER REIMBURSABLE COST CENTERS								
	SPECIAL PURPOSE COST CENTERS								
200	Subtotal (see instructions)		171,015,530	175,767	87,721	39,044,117	33,449	14,752	200
201	Less PBP Clinic Lab. Services - Program Only Charges								201
202	Net Charges (line 200 - line 201)		171,015,530	175,767	87,721	39,044,117	33,449	14,752	202

UNIVERS	ITY HEALTH SERVICES INC.								12-22
APPORTI	ONMENT OF MEDICAL AND OTHER			PROVIDER CCN:		PERIOD:		WORKSHEET D	
HEALTH S	SERVICES COSTS					FROM: 01/01/2021		PART V	
				11-0028		TO: 12/31/2021			
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	ĺ
		to		Reimbursed	Reimbursed		Reimbursed	Reimbursed	ĺ
		Charge	PPS	Services	Services Not	PPS	Services	Services Not	ĺ
		Ratio from	Reimbursed	Subject to	Subject to	Services	Subject to	Subject to	ĺ
		Wkst. C,	Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	ĺ
		Pt. I, col. 9	(see inst.)	(see inst.)	(see inst.)	inst)	(see inst.)	(see inst.)	l
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	ĺ
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.313616		1,001,296			314,022		50
52	Labor Room and Delivery Room	1.292925		25,726			33,262		52
54	Radiology-Diagnostic	0.173856		3,856,413			670,461		54
60	Laboratory	0.139796		442,387			61,844		60
65	Respiratory Therapy	0.190323		31,638			6,021		65
66	Physical Therapy	0.380333		19,690			7,489		66
69	Electrocardiology	0.079732		758,097			60,445		69
71	Medical Supplies Charged to Patients	0.181395		1,037,404			188,180		71
72	Implantable Devices Charged to Patients	0.534358		11,169			5,968		72
73	Drugs Charged to Patients	0.168173		1,001,170			168,370		73
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.603146		1,499,294			904,293		91
92	Observation Beds	0.554390		112,531			62,386		92
	OTHER REIMBURSABLE COST CENTERS								
	SPECIAL PURPOSE COST CENTERS								
	Subtotal (see instructions)			9,796,815			2,482,741		200
	Less PBP Clinic Lab. Services - Program Only Charges								201
202	Net Charges (line 200 - line 201)			9,796,815			2,482,741		202

COMPUTATION OF INPATIENT PROVIDER CON: PREND: PROVIDER CON: PREND: PROVIDER CON: P	UNIVERSIT	Y HEALTH SERVICES INC.					12-22
Check Title V-1 Or				PROVIDER CCN:	PERIOD:	WORKSHEET D-1,	
Check Applicable Boxes: Title V-OP	OPERATIN	GCOST			FROM: 01/01/2021	PART I	
Applicable [X] Title XVII, IPART A [] IPF [] Subprovider (Other) [] PARTI-M Demonstration [] Subprovider (Other) [] Subprovider (Other) [] PARTI-M Demonstration [] Subprovider (Other) [] Subprovider (Other) [] Subprovider (Other) [] PARTI-M Demonstration [] Subprovider (Other) [] Subprovider (O				11-0028	TO: 12/31/2021		
Boxes: 17 Tile XX - IPP	Check	[] Title V - O/P	[X] Hospital	[] NF	[X]PPS		
[] Subprovider (Other) [] PARTI ALL PROVIDER COMPONENTS Chart Model	Applicable	[X] Title XVIII, PART A	[] IPF	[]ICF/IID	[]TEFRA		
PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS I Inpatient days (including private room days and swing-bed days, excluding newborn) 2 Inpatient days (including swing-bed and newborn days) 3 Private room days (sculding swing-bed and newborn days) 3 Private room days (sculding swing-bed and newborn days) 4 Semi-private room days (sculding swing-bed and observation bed days) 5 Total swing-bed SNF (spie inpatient days (including swing-bed and observation bed days) 5 Total swing-bed SNF (spie inpatient days (including private room days) frough December 31 of the cost reporting period 6 Total swing-bed SNF (spie inpatient days (including private room days) after December 31 of the cost reporting period 7 Total swing-bed SNF (spie 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 SNF (spie inpatient days (including private room days) after December 31 of the cost reporting period (if 6 calendar year, enter 0 on this line) 8 Total swing-bed SNF (spie inpatient days including private room days) after December 31 of the cost reporting period (if 6 calendar year, enter 0 on this line) 8 Total swing-bed SNF (spie inpatient days including private room days) after December 31 of the cost reporting period (if 6 calendar year, enter 0 on this line) 8 Swing-bed SNF (spie inpatient days applicable to title XVIII only (including private room days) strough December 31 of the 10 cost reporting period (see 10 Swing-bed SNF (spie inpatient days applicable to title XVIII only (including private room days) after December 31 of the 10 cost reporting period (if calendar year, enter 0 on this line) 11 Swing-bed NF (spie inpatient days applicable to titles V or XX only (including private room days) after December 31 of the 13 cost reporting period (if calendar year, enter 0 on this line) 13 Swing-bed NF (spie inpatient days applicable to stress V or XX only (including private room days) after December 31 of the 13 cost reporting period (Boxes:	[] Title XIX - I/P	[] IRF	[]NF	[] Other		
PART I - ALL PROVIDER COMPONENTS NATERITY DAYS 1 Inpatient days (including private room days and swing-bed days, excluding newborn) 2 Inpatient days (including private room days, excluding swing-bed and newborn days) 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). 5 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 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) 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) after December 31 of the cost reporting period (if 6 calendar year, enter 0 on this line) 8 Total inpatient days including private room days) after December 31 of the cost reporting period (if 6 calendar year, enter 0 on this line) 9 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 8 Swing-bed SNF type inpatient days applicable to title XVI only (including private room days) (see instructions) 9 Swing-bed SNF type inpatient days applicable to title XVI only (including private room days) after December 31 of the 11 cost reporting period (see 1) Instructions). 10 Swing-bed NF type inpatient days applicable to title XVI only (including private room days) after December 31 of the 13 cost reporting period (see 1) Instructions). 10 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) after December 31 of the 13 cost reporting period (see 1) Instructions). 10 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) aft			[] Subprovider (Other)	[] PARHM Demonstration			
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36 Private room cost differential adjustment (line 3 x line 35)	34	Average per diem private room ch	arge differential (line 32 min	us line 33) (see instructions)			
	35	Average per diem private room co	st differential (line 34 x line 3	1)			35
37 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) 76,195,636 37	36	Private room cost differential adjus	stment (line 3 x line 35)				
	37	General inpatient routine service of	ost net of swing-bed cost ar	d private room cost differential (line 27	7 minus line 36)	76,195,636	37

UNIVERSIT	Y HEALTH SERVICES INC.							12-22
	TON OF INPATIENT		PROVIDER CCN:		PERIOD:		WORKSHEET D-1,	
OPERATING	COST				FROM: 01/01/2021		PART II	
	In the second	Texas is a	11-0028		TO: 12/31/2021			
Check	[] Title V - O/P	[X] Hospital	[] NF		[X]PPS			
Applicable Boxes:	[X] Title XVIII, PART A	[] IPF [] IRF	[]ICF/IID []NF		[]TEFRA []Other			
boxes.	[] Title XIX - I/P				[] Other			
		[] Subprovider (Other)	[] PARHM Demonstrati [] Chart Model	ion				
PART II - HO	I DSPITAL AND SUBPROVIDERS ONI		[] Onar Woder					
	PROGRAM INPATIENT OPERATIN		THROUGH COST AD IUS	STMENTS				
38	Adjusted general inpatient routine se			TIMEIVIO			918	38
	Program general inpatient routine se						7,394,602	39
	Medically necessary private room co						7,004,002	40
	Total Program general inpatient rout						7,394,602	41
		(Average		1,001,000	
			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	i
42	Nursery (title V & XIX only)							42
	Intensive Care Type Inpatient							
	Hospital Units							
	Intensive Care Unit		56,124,097	45,795	1,226	23,716	29,065,144	43
43.01	02060NEURO INTENSIVE CARE U	NIT	5,892,730	3,660	1,610	1,098	1,767,824	43.01
	Coronary Care Unit							44
	Burn Intensive Care Unit							45
	Surgical Intensive Care Unit							46
47	Other Special Care Unit (specify)							47
	I=						1	
	Program inpatient ancillary service of			4)			45,090,138	48
	Program inpatient cellular therapy ac			ın 1)			00.047.700	48.01
49	Total Program inpatient costs (sum	of lines 41 through 48.01)	(see instructions)				83,317,708	49
	PASS-THROUGH COST ADJUSTM	IENTO						
50	Pass through costs applicable to Pro		vices (from Worksheet D. s	sum of Parts Land III)			3,212,552	50
	Pass through costs applicable to Pro						3,041,015	51
	Total Program excludable cost (sum	• • •		,,			6,253,567	52
	Total Program inpatient operating co		I, nonphysician anesthetist	t, and medical education costs (I	ine 49 minus line 52)		77,064,141	53
		,		,	,			
	TARGET AMOUNT AND LIMIT COM	MPUTATION						
54	Program discharges							54
55	Target amount per discharge							55
	Permanent adjustment amount per o							55.01
	Adjustment amount per discharge (c							55.02
	Target amount (line 54 x sum of line							56
	Difference between adjusted inpatier	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				d by the market baske	t)		59
60	Expected costs (lesser of line 53 ÷ li				00tth l			60
61	Continuous improvement bonus pay							61
	61 amount by which operating costs	(line 55) are less than exp	ected costs (lines 54 x 60)	i, or 1 % or the target amount (iii	ie 56), otrierwise ente	i zero. (see		61
	62 Relief payment (see instructions) 63 Allowable Inpatient cost plus incentive payment (see instructions)							62 63
	Prilowable inpatient cost plus incentiv	re payment (see motruction	13)					
	PROGRAM INPATIENT ROUTINES	SWING BED COST						
	Medicare swing-bed SNF inpatient re							64
	Medicare swing-bed SNF inpatient re				'III only)			65
	66 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only; for CAH, see instructions)							66
	Title V or XIX swing-bed NF inpatien							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	
69	69 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

UNIVERSIT	Y HEALTH SERVICES INC.							12-22
COMPUTAT	TION OF INPATIENT		PROVIDER CCN:		PERIOD:		WORKSHEET D-1,	
OPERATING	GCOST				FROM: 01/01/2021		PARTS III & IV	
			11-0028		TO: 12/31/2021			
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 of	osts (sum of lines 83 through	n 85)					86
	OMPUTATION OF OBSERVATION		ST					
	Total observation bed days (see ins						8,782	87
	Adjusted general inpatient routine of)				918	88
89	Observation bed cost (line 87 x line	e 88) (see instructions)					8,060,998	89
	COMPLITATION OF ORCEDVATIO	NUDED DAGO TUDOUGU	OOT					
	COMPUTATION OF OBSERVATION	ON BED PASS THROUGH C	,081		1	T +	I 01 " D 1	
				Davidina		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
	10		1	2	3	4	5	
	Capital-related cost					-	5,316,539	90
	Nursing Program cost							91
	Allied Health cost					-		92
93	All other Medical Education						L	93

UNIVERSIT	Y HEALTH SERVICES INC.					12-22
COMPUTAT	TION OF INPATIENT		PROVIDER CCN:	PERIOD:	WORKSHEET D-1,	
OPERATING	G COST			FROM: 01/01/2021	PARTI	
			11-0028	TO: 12/31/2021		
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] THE XIX - III	[] Subprovider (Other)	[] PARHM Demonstration			
		. ,				
		[] SNF	[] Chart Model			
PARTI- AL	L PROVIDER COMPONENTS					
	INPATIENT DAYS				<u>, 1</u>	
	Inpatient days (including private				83,011	1
	Inpatient days (including private				83,011	2
			days). If you have only private room day	s, do not complete this line.		3
4	Semi-private room days (exclud	ing swing-bed and observatio	n bed days)		74,229	4
5			om days) through December 31 of the co			5
	Total swing-bed SNF type inpati	ient days (including private roc	om days) after December 31 of the cost	reporting period (if 6 calendar year, enter 0 on this		
6	line)					6
7	Total swing-bed NF type inpatie	nt days (including private roon	n days) through December 31 of the cos	t reporting period		7
			• , •		1	
8	Total swing-bed NF type inpatie	nt days (including private roon	n days) after December 31 of the cost re	porting period (if 8 calendar year, enter 0 on this line)		8
			the Program (excluding swing-bed and i		2,143	9
		• • • • • • • • • • • • • • • • • • • •	• • •	December 31 of the 10 cost reporting period (see	2,1.0	Ť
40	, , ,	ays applicable to title AVIII offi	y (including private room days) through	December 31 of the 10 cost reporting period (see		10
10	instructions).		/ildi			10
4.4		ays applicable to title XVIII onl	y (including private room days) after Dec	cember 31 of the 11 cost reporting period (if calendar		٠.,
	year, enter 0 on this line)			LD		11
12				gh December 31 of 12 the cost reporting period.		12
			only (including private room days) after	December 31 of the 13 cost reporting period (if		
	calendar year, enter 0 on this lin					13
	Medically necessary private roo		ram (excluding swing-bed days)			14
	Total nursery days (title V or XIX				5,196	15
16	Nursery days (title V or XIX only				130	16
	SWING BED ADJUSTMENT					
17	Medicare rate for swing-bed SN	F services applicable to service	ces through December 31 of the cost rep	orting period		17
18	Medicare rate for swing-bed SN	F services applicable to service	ces after December 31 of the cost report	ing period		18
19	Medicaid rate for swing-bed NF	services applicable to service	s through December 31 of the cost repo	rting period		19
20	Medicaid rate for swing-bed NF	services applicable to service	s after December 31 of the cost reportin	g period		20
	Total general inpatient routine s			y 1	76,195,636	21
			ember 31 of the cost reporting period (lin	e 5 x line 17)	-,,	22
			per 31 of the cost reporting period (line 6			23
			nber 31 of the cost reporting period (line			24
			r 31 of the cost reporting period (line 8 x			25
	Total swing-bed cost (see instru			20,	+	26
	General inpatient routine service		ing 21 minus line 26)		76,195,636	27
	PRIVATE ROOM DIFFERENTIA		rie 21 minus ine 20)		70,193,030	21
			I and a barrer Care barbar barrer			
	General inpatient routine service		eu anu observation bed charges)			28
	Private room charges (excluding					29
	Semi-private room charges (exc					30
	General inpatient routine service		ne 28)			31
	Average private room per diem					32
	Average semi-private room per					33
34	Average per diem private room	charge differential (line 32 mir	nus line 33) (see instructions)			34
	Average per diem private room					35
	Private room cost differential ad		*		1	36
30						

UNIVERSITY HEALTH SERVICES INC. 12-22 WORKSHEET D-1, COMPUTATION OF INPATIENT PROVIDER CCN: DEBIUD. OPERATING COST FROM: 01/01/2021 PART II 11-0028 TO: 12/31/2021 Check Title V - O/P [X] Hospital [X]PPS [] NF [] Title XVIII, PART A Applicable [] ICF/IID []TEFRA [] IPF 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) 918 38 39 Program general inpatient routine service cost (line 9 x line 38) 1.967.060 39 40 40 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,967,060 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) 1,413,053 42 Intensive Care Type Inpatient Hospital Units 43 Intensive Care Unit 43.01 02060NEURO INTENSIVE CARE UNIT 56,124,097 5,892,730 45,795 3,660 1,226 1,610 4,832 210 5,921,858 338,108 43 43.01 44 44 Coronary Care Unit 45 45 Burn Intensive Care Unit 46 Surgical Intensive Care Unit 46 47 Other Special Care Unit (specify) 47 48 48 Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200) 6.634.201 48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 48.01 49 Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions) 14,896,581 49 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 Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)
52 Total Program excludable cost (sum of lines 50 and 51) 51 52 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 55 Target amount per discharge 55.01 Permanent adjustment amount per discharge 55.01 55.02 Adjustment amount per discharge (contractor use only) 55.02 56 57 58 59 56 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 57 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58 Bonus payment (see instructions) 59 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 62 Relief payment (see instructions) 63 Allowable Inpatient cost plus incentive payment (see instructions) 63

PROGRAM INPATIENT ROUTINE SWING BED COST		
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
66 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only; for CAH, see instructions)		66
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
69 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

COMPUTATION OF INPATIENT	UNIVERSITY	HEALTH SERVICES INC.							12-22	
11-0028	COMPUTATION OF INPATIENT			PROVIDER CCN: PERIOD:						
Check	OPERATING COST					FROM: 01/01/2021		PARTS III & IV		
Applicable				11-0028		TO: 12/31/2021				
Boxes: X Title XIX - I/P	Check	[] Title V - O/P	[X] Hospital	[]NF		[X]PPS		•		
				[]ICF/IID						
PART III - SNF. NF, AND ICF/IID ONLY	Boxes:	[X] Title XIX - I/P	[] IRF	[]NF		[] Other				
PART III - SNF - NF - AND ICF/III ONLY TO TO TO TO TO TO TO T		<u> </u>	[] Subprovider (Other)	[] PARHM Demons	tration	••				
70 SNF / NF / [CF/IID routine service cost [ine 37] 70 71 Adjusted general implatent routine service cost per diem (line 70 + line 2) 72 73 Medically necessary private room cost applicable to Program (line 14 x line 35) 73 74 75 73 Medically necessary private room cost applicable to Program (line 14 x line 35) 73 74 75 75 75 75 75 75 75			[]SNF	[] Chart Model						
711 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72 Program routine service cost (line 9 x line 71) 72 Program routine service cost (line 9 x line 71) 73 74 74 74 74 75 75 75 75	PART III - SN	NF, NF, AND ICF/IID ONLY								
T72 Program routine service cost (line 9 x line 71)	70									
73 Medically necessary private room cost applicable to Program (line 14 x line 35) 74 Total Program general inpatient routine service costs (line 72 + line 73) 74 75 76 Por diem capital-related cost stilline 72 + line 73) 75 76 Per diem capital-related costs (line 75 + line 2) 76 77 76 Program capital-related costs (line 9 x line 76) 77 77 78 Inpatient routine service cost (line 74 minus line 77) 78 Inpatient routine service cost (line 74 minus line 77) 78 Aggregate charges to beneficiaries for excess costs (from provider records) 79 79 Aggregate charges to beneficiaries for excess costs (from provider records) 79 80 Total Program routine service costs from provider records) 80 81 Inpatient routine service cost per diem limitation (line 78 minus line 79) 81 82 Inpatient routine service cost limitation (line 9 x line 81) 82 83 Reasonable inpatient routine services (see instructions) 83 84 Program inpatient eservices (see instructions) 83 84 Program inpatient ancillary services (see instructions) 84 85 Utilization review - physician compensation (see instructions) 85 85 Total Program inpatient operating costs (see instructions) 86 Read Program inpatient portaling costs (sum of line 83 through 85) 86 Read Program inpatient portaling costs (sum of line 83 through 85) 86 Read Program inpatient operating costs (sum of line 87 x line 2) 91 88 89 Observation bed cost (line 87 x line 88) (see instructions) 80 80 80 80 80 80 80 8	71									
74 Total Program general inpatient routine service costs (line 72 + line 73) 74 75 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75 76 77 76 77 77 77 77	72									
75 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75 76 Per diem capital-related costs (line 75 + line 2) 76 77 78 79 79 78 79 79 79	73	/3 Medically necessary private room cost applicable to Program (line 14 x line 35)								
76 Per diem capital-related costs (line 75 + line 2) 76 77 Program capital-related costs (line 9 x line 76) 77 77 77 77 78 Inpatient routine service cost (line 74 minus line 77) 78 79 Aggregate charges to beneficiaries for excess costs (from provider records) 79 79 79 79 79 79 79 7		74 Total Program general inpatient routine service costs (line 72 + line 73)							74	
77 Program capital-related costs (line 9 x line 76) 77 78 Inpatient routine service cost (line 74 minus line 77) 79 Aggregate charges to beneficiaries for excess costs (from provider records) 79 80 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81 Inpatient routine service cost for comparison to the cost limitation (line 9 x line 81) 82 Inpatient routine service cost limitation (line 9 x line 81) 82 83 Reasonable inpatient routine service costs (see instructions) 83 84 Program inpatient ancillary services (see instructions) 84 85 Utilization review - physician compensation (see instructions) 85 86 Total Program inpatient operating costs (sum of lines 83 through 85) 86 Total Program inpatient operating costs (sum of lines 83 through 85) 87 Rad Adjusted general inpatient routine cost per diem (line 27 + line 2) 91 88 89 Observation bed cost (line 87 x line 88) (see instructions) 8,782 87 87 88 89 Observation bed cost (line 87 x line 88) (see instructions) 8,060,998 89 COMPUTATION OF OBSERVATION BED PASS THROUGH COST Cost (from line 21) Column 2 (from line 89) (see instructions) Cost (from line 21) Column 2 (from line 89) (see instructions) 90 Capital-related cost 5,316,539 90 91 Nursing Program cost 91 Nursing Program cost 92 Silied Health cost 99 90 90 90 90 90 90 9										
Total Inpatient routine service cost (line 74 minus line 77) 78 78 79 Aggregate charges to beneficiaries for excess costs (from provider records) 79 79 79 79 79 79 79 7	76									
79 Aggregate charges to beneficiaries for excess costs (from provider records) 79 80 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80 10 10 10 10 10 10 10										
80 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81 Inpatient routine service cost per diem limitation 81 82 Inpatient routine service cost limitation (line 9 x line 81) 82 83 Reasonable inpatient routine service costs (see instructions) 83 84 Program inpatient ancillarly services (see instructions) 84 85 Utilization review - physician compensation (see instructions) 85 85 Reasonable inpatient operating costs (sum of lines 83 through 85) 86 Reasonable inpatient operating costs (sum of lines 83 through 85) 86 Reasonable inpatient operating costs (sum of lines 83 through 85) 86 Reasonable inpatient operating costs (sum of lines 83 through 85) 86 Reasonable inpatient operating costs (sum of lines 83 through 85) 87 Reasonable inpatient operating costs (sum of lines 83 through 85) 87 Reasonable inpatient routine cost per diem (line 27 + line 2) 91 Reasonable inpatient routine cost per diem (line 27 + line 2) 91 Reasonable inpatient routine service costs (line 87 x line 88) (see instructions) 87 Reasonable inpatient routine service costs (line 87 x line 88) (see instructions) 87 Reasonable inpatient routine service costs (line 87 x line 88) (see instructions) 87 Reasonable inpatient routine service costs (line 87 x line 88) (see instructions) 91 Reasonable inpatient routine service costs (line 87 x line 88) (see instructions) 91 Reasonable inpatient routine service costs (line 87 x line 88) Reasonable inpatient routine service costs (line 87 x line 88) Reasonable inpatient routine service costs (line 87 x line 88) Reasonable inpatient routine service costs (line 87 x line 88) Reasonable inpatient routine service costs (line 87 x line 88) Reasonable inpatient routine service costs (line 87 x line 88) Reasonable inpatient routine service (line 87 x line 88) Reasonable inpatient routine service scate line (line 87 x line 88) Reasonable inpatient routine service sca										
81 Inpatient routine service cost per diem limitation 82 Inpatient routine service cost limitation (line 9 x line 81) 82 Inpatient routine service cost (see instructions) 82 83 Reasonable inpatient routine service costs (see instructions) 84 Program inpatient ancillary services (see instructions) 84 85 Utilization review - physician compensation (see instructions) 85 86 Total Program inpatient operating costs (sum of lines 83 through 85) 86 Total Program inpatient operating costs (sum of lines 83 through 85) 86 RAT IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST 87 Total observation bed days (see instructions) 8,782 87 88 Adjusted general inpatient routine cost per diem (line 27 * line 2) 9 9 18 88 89 Observation bed cost (line 87 x line 88) (see instructions) 8,060,998 89 Routine Cost Column 1 / Bed Cost Cost Column 2 Colu		9 Aggregate charges to beneficiaries for excess costs (from provider records)								
82 Inpatient routine service cost limitation (line 9 x line 81) 82 83 Reasonable inpatient routine service costs (see instructions) 83 84 Program inpatient ancillary services (see instructions) 84 85 Utilization review - physician compensation (see instructions) 85 86 Total Program inpatient operating costs (sum of lines 83 through 85) 86 Total Program inpatient operating costs (sum of lines 83 through 85) 86 Total Program inpatient operating costs (sum of lines 83 through 85) 87 Total observation bed days (see instructions) 8,782 87 88 Adjusted general inpatient routine cost per diem (line 27 + line 2) 918 88 89 Observation bed cost (line 87 x line 88) (see instructions) 8,060,998 89 COMPUTATION OF OBSERVATION BED PASS THROUGH COST Routine		0 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)								
83 Reasonable inpatient routine service costs (see instructions) 83										
84 Program inpatient ancillarly services (see instructions) 84 85 Utilization review - physician compensation (see instructions) 85 86 Total Program inpatient operating costs (sum of lines 83 through 85) 86 Total Program inpatient operating costs (sum of lines 83 through 85) 86 Total Program inpatient operating costs (sum of lines 83 through 85) 87 88 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 918 88 89 Observation bed cost (line 87 x line 88) (see instructions) 8,060,998 89	82	2 Inpatient routine service cost limitation (line 9 x line 81)								
85 Utilization review - physician compensation (see instructions) 85 86 Total Program inpatient operating costs (sum of lines 83 through 85) 86 Rotal Program inpatient operating costs (sum of lines 83 through 85) 86 Rotal Program inpatient operating costs (sum of lines 83 through 85) 87 Rotal observation bed days (see instructions) 8,782 87 Rotal observation bed days (see instructions) 81 88 Rotal observation bed cost (line 87 x line 88) (see instructions) 8,060,998 89 Rotal observation bed cost (line 87 x line 88) (see instructions) Rotal observation Bed Pass-Through Cost Cost Column 1 / Bed Cost Cost Column 1 / Bed Cost Cost Column 2 Rotal observation Bed Pass-Through Cost Cost Column 2 Rotal observation Bed Pass-Through Cost Rotal observation Bed Pass-Through Cost Cost Column 2 Rotal observation Bed Pass-Through Cost Rotal observation Bed Pass-Through Cost Cost Column 2 Rotal observation Bed Pass-Through Cost Rotal observation Bed Pass-Throu		3 Reasonable inpatient routine service costs (see instructions)								
Routine Cost Cost Column 1 / Bed Cost Column 2 (from line 89) Cost Cost Cost Column 3 Cost Cost Column 4 Cost Cost Column 5 Cost Cost Column 6 Cost Cost Column 7 Cost Cost Column 8 Cost Cost Column 8 Cost Cos										
PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST 87 Total observation bed days (see instructions) 8,782 87 88 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 918 88 89 Observation bed cost (line 87 x line 88) (see instructions) 8,060,998 89										
87 Total observation bed days (see instructions) 8,782 87 88 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 918 88 89 Observation bed cost (line 87 x line 88) (see instructions) 8,060,998 89 COMPUTATION OF OBSERVATION BED PASS THROUGH COST	86	6 Total Program inpatient operating costs (sum of lines 83 through 85)							86	
87 Total observation bed days (see instructions) 8,782 87 88 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 918 88 89 Observation bed cost (line 87 x line 88) (see instructions) 8,060,998 89 COMPUTATION OF OBSERVATION BED PASS THROUGH COST										
88 Adjusted general inpatient routine cost per diem (line 27 + line 2) 918 88 89 Observation bed cost (line 87 x line 88) (see instructions) 8,060,998 89				181				0.700	0.7	
Routine Cost Cost Column 1 / Column 2 Substitutions Substitutions										
COMPUTATION OF OBSERVATION BED PASS THROUGH COST Routine Cost Column 1 / Column 2 Column 3 Column 4 Column 4 Column 5 Column 6 Column 7 Column 7 Column 8 Column				2)						
Routine Cost Column 1 / Column 1 / Column 2 Formula Column 2 Formula Column 3 Formula Column 4 Column 4 Column 5 Column 6 Formula Column 6 Column 7 Column 7 Column 8 Formula Column 1 Colum	89	89 Observation bed cost (line 8/ x line 88) (see instructions)							89	
Routine Cost Column 1 / Column 2 Column 2 Fass-Through Cost (col. 3 x col. 4) (see instructions)		COMPUTATION OF OBSERVATIO	N BED PASS THROUGH (COST						
Cost Column 1 / Column 2 (from line 21) Column 2 (from line 89) (col. 3 x col. 4) (see instructions)							Total	Observation Bed		
Cost (from line 21) column 2 (from line 89) (see instructions) 1 2 3 4 5 90 Capital-related cost 5,316,539 90 91 Nursing Program cost 91 92 Allied Health cost 92					Routine		Observation	Pass-Through Cost		
90 Capital-related cost 1 2 3 4 5 91 Nursing Program cost 91 92 Allied Health cost 92					Cost	column 1 /	Bed Cost	(col. 3 x col. 4)		
90 Capital-related cost 5,316,539 90 91 Nursing Program cost 91 92 Allied Health cost 92				Cost	(from line 21)	column 2	(from line 89)	(see instructions)		
91 Nursing Program cost 91 92 Allied Health cost 92				1	2	3	4			
92 Allied Health cost 92	90	Capital-related cost						5,316,539	90	
	91	Nursing Program cost							91	
93 All other Medical Education 93	92	Allied Health cost							92	
	93	93 All other Medical Education							93	

	EALTH SERVICES INC.			DROVIDED CON-	I DEDIOD:		I WORKSHEET D 2	12-22
OPERATING C	N OF INPATIENT OST			PROVIDER CCN:	PERIOD: FROM: 01/01/20)21	WORKSHEET D-3	
				11-0028	TO: 12/31/2021			
Check	[] 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				
		1		[] Chart CAH Swing-Bed SNF	Ratio of Cost	Inpatient	Inpatient Program Costs	$\overline{}$
	COST CENTER DESCRIPTION	ON			to Charges	Program Charges	(col. 1 x col. 2)	1
(A)					1	2	3	1
	INPATIENT ROUTINE SERVI	ICE COST CENTERS						
30	Adults and Pediatrics (Gener	al Routine Care)				6,575,980		30
31	Intensive Care Unit	ADE LINIT				23,100,734		31
31.01 32	02060NEURO INTENSIVE Co	ARE UNII				2,847,366		31.01 32
33	Burn Intensive Care Unit							33
34	Surgical Intensive Care Unit							34
35	Other Special Care (specify)							35
40	Subprovider - IPF							40
41	Subprovider - IRF							41
42	Subprovider (specify)							42
43	Nursery ANCILLARY SERVICE COS	ST CENTEDS						43
50		31 CENTERS			0.313616	18,268,781	5,729,382	50
51	Recovery Room				0.010010	10,200,101	0,720,002	51
52	Labor Room and Delivery Ro	oom			1.292925	5,784	7,478	52
53	Anesthesiology				0.064781	1,522,298	98,616	53
54					0.173856	10,798,650	1,877,410	54
55	Radiology-Therapeutic							55
56 57	Radioisotope Computed Tomography (CT)	Coon			0.026802	13,658,501	366,075	56 57
58	Magnetic Resonance Imagin				0.054231	2,265,871	122.880	58
59	Cardiac Catheterization	g (Wirti)			0.144768	7,270,041	1,052,469	59
60	Laboratory				0.139796	24,741,499	3,458,763	60
61	PBP Clinical Laboratory Serv	rices-Program Only						61
62	Whole Blood & Packed Red							62
63	Blood Storing, Processing, &	Trans.						63
64	Intravenous Therapy				0.067724	991,486	67,147	64 65
65 66	Respiratory Therapy Physical Therapy				0.190323 0.380333	5,396,902 4,045,054	1,027,155 1,538,468	66
67	Occupational Therapy				0.000000	4,040,004	1,000,400	67
68	Speech Pathology							68
69	Electrocardiology				0.079732	7,152,252	570,263	69
70	Electroencephalography							70
71	Medical Supplies Charged to				0.181395	38,168,370	6,923,551	71
72 73	Implantable Devices Charged Drugs Charged to Patients	i to Patients			0.534358 0.168173	17,426,690 41,913,653	9,312,091 7,048,745	72 73
74					0.100173	41,913,000	7,040,743	74
75	ASC (Non-Distinct Part)							75
76	Other Ancillary (specify)							76
76.97	07697CARDIAC REHABILITA				0.545560	9,030	4,926	76.97
	OUTPATIENT SERVICE CO	OST CENTERS						
88 89	Rural Health Clinic (RHC) Federally Qualified Health Ce	enter (EOHC)			 			88 89
90	Clinic	enter (FQHC)			0.853728	2,234,548	1,907,696	90
91	Emergency				0.603146	5,889,018	3,551,938	91
92	Observation Beds				0.554390	766,762	425,085	92
93								93
	OTHER REIMBURSABLE (COST CENTERS						
	Home Program Dialysis							94
95 96					-			95 96
96								96
98								98
99	Outpatient Rehabilitation Provider (specify)							99
100	Intern-Resident Service (not appvd. tchng. prgm.)							100
101	Home Health Agency							101
101.01								101
101.02	Total (sum of lines 50 through	94 and 96 through 99\				202,525,190	45,090,138	101 200
	Less PBP Clinic Laboratory S		arges (line 61)		 	202,020,190	40,090,130	201
	Net charges (line 200 minus li		<u> </u>			202,525,190		202

LINIVERSITY H	FALTH SERVICES INC							12-22
UNIVERSITY HEALTH SERVICES INC. COMPUTATION OF INPATIENT OPERATING COST				PROVIDER CCN:	PERIOD: FROM: 01/01/20		WORKSHEET D-3	12 22
Check Applicable Boxes:	11-0028 TO: 12/31/2021							
	COST CENTER DESCRIPTIO	N			Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)					1	2	3	
30	INPATIENT ROUTINE SERVICE Adults and Pediatrics (General					1,584,377		30
31	Intensive Care Unit	arrodune oure)				4,977,026		31
31.01	02060NEURO INTENSIVE CA	ARE UNIT				104,000		31.01
32 33	Coronary Care Unit							32
34	Burn Intensive Care Unit Surgical Intensive Care Unit							34
35	Other Special Care (specify)							35
40	Subprovider - IPF							40
41	Subprovider - IRF Subprovider (specify)							41
43	Nursery					92,909		43
	ANCILLARY SERVICE COS	T CENTERS						
50	Operating Room				0.313616	2,370,963	743,572	50
51 52	Recovery Room Labor Room and Delivery Room				1.292925	38,592	49,897	51 52
53	Anesthesiology				0.064781	157,382	10,195	53
54	Radiology-Diagnostic		0.173856	2,257,492	392,479	54		
55 56	Radiology-Therapeutic Radioisotope							55 56
57	Computed Tomography (CT)	Scan			0.026802	2,423,904	64,965	57
58	Magnetic Resonance Imaging				0.054231		·	58
59	Cardiac Catheterization				0.144768		=======	59
60	Laboratory PBP Clinical Laboratory Servi	ices-Program Only			0.139796	5,182,610	724,508	60
62	Whole Blood & Packed Red B							62
63	Blood Storing, Processing, &							63
64	Intravenous Therapy				0.067724	4.004.000	205 404	64
65 66					0.190323 0.380333	1,604,662 915,263	305,404 348,105	65 66
67	Occupational Therapy				0.000000	0.10,200	010,100	67
68	Speech Pathology							68
69 70	Electrocardiology Electroencephalography				0.079732	1,710,437	136,377	69 70
70	Medical Supplies Charged to	Patients			0.181395	7,399,823	1,342,291	71
72	Implantable Devices Charged				0.534358	89,669	47,915	72
73	Drugs Charged to Patients				0.168173	9,417,608	1,583,787	73
74 75	Renal Dialysis ASC (Non-Distinct Part)							74 75
76	Other Ancillary (specify)							76
76.97	07697CARDIAC REHABILITATION				0.545560			76.97
88	OUTPATIENT SERVICE CO Rural Health Clinic (RHC)	OST CENTERS						88
89	Federally Qualified Health Ce	nter (FQHC)						89
90	Clinic	, ,			0.853728	13,616	11,624	90
91	Emergency				0.603146	1,018,270	614,165	91
92 93	Observation Beds Other Outpatient Service (spe		0.554390	467,030	258,917	92 93		
	OTHER REIMBURSABLE C							
	Home Program Dialysis							94
95 96								95 96
96								96
98	Other Reimbursable (specify)							98
99	Outpatient Rehabilitation Provider (specify)							99
100 101	Intern-Resident Service (not appvd. tchng. prgm.) Home Health Agency				 			100 101
101.01								101
101.02								101
	Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services - Program only charges (line 61)					35,067,321	6,634,201	200
	Net charges (line 200 minus li		arges (mie 01)		 	35,067,321		201
	E proc onargos (mie 200 minus inie 201)							