	T HOSPITAL MICDOFFIE								12-22
	NMENT OF INPATIENT ROUTINE			PROVIDER CCN:		PERIOD:		WORKSHEET D	
SERVICE C	APITAL COSTS					FROM: 01/01/2021		PART I	
				11-0111		TO: 12/31/2021			
Check	[] Title V	[ X ] Hospital		[X]PPS					
Applicable	[X ] Title XVIII	[] PARHM Demor	stration	[]TEFRA					
Boxes:	[] Title XIX	[] Chart Model							
	<u> </u>		l	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	l '	Days	col. 4)	Days	x col. 6)	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	
	I INPATIENT ROUTINE SERVICE COST CENTERS			-		-			
30	Adults and Pediatrics (General Routine Care)	328,601	32,269	296,332	2,872	103	652	67,273	30
31	Intensive Care Unit								31
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								43
44	Skilled Nursing Facility								44
45	Nursing Facility		l						45
46	Other Long Term Care		i						46
200	Total	328,601	l	296,332	2,872		652	67,273	200

	ITY HOSPITAL MCDUFFIE						12-22
APPORTI	ONMENT OF INPATIENT ANCILLARY	PROVIDER CCN:		PERIOD:		WORKSHEET D	
SERVICE	CAPITAL COSTS			FROM: 01/01/2021		PART II	
		11-0111		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	238,087	7,595,268	0	160,806	5,041	50
51	Recovery Room	11,353	1,092,850	0	24,797	258	51
53	Anesthesiology	270	787,364	0	29,914	10	53
54	Radiology-Diagnostic	164,922	17,250,118	0	454,301	4,344	54
60	Laboratory	76,491	8,715,335	0	347,931	3,054	60
65	Respiratory Therapy	24,624	3,447,941	0	122,340	874	65
66	Physical Therapy	16,888	1,422,910	0	143,158	1,699	66
71	Medical Supplies Charged to Patients	51,244	7,374,835	0	438,797	3,049	71
72	Implantable Devices Charged to Patients	24,422	2,937,042	0	224,379	1,866	72
73	Drugs Charged to Patients	65,426	10,393,725	0	708,425	4,460	73
76	Other Ancillary (specify)	13,832	129,964	0			76
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	280,587	15,145,310	0	275,466	5,103	91
92	Observation Beds	70,988	622,720	0	59,423	6,774	92
200	Total (sum of lines 50 through 199)	1,039,134	76,915,382		2,989,737	36,532	200

UNIVERSITY	Y HOSPITAL MCDUFFIE												12-22
APPORTION	NMENT OF INPATIENT ROUTINE							PROVIDER CCN:		PERIOD:		WORKSHEET D	
SERVICE O	THER PASS-THROUGH COSTS									FROM: 01/01/2021		PART III	
								11-0111		TO: 12/31/2021			
Check	[] Title V	[ X ] Hospital		[X]PPS				•		•		•	
Applicable	[X ] Title XVIII	[] PARHM Demon	stration	[] TEFRA									
Boxes:	[] Title XIX	[] Chart Model											
	•	Nursing		Allied		All	Swing-Bed					Inpatient	
		Program		Health		Other	Adjustment	Total Costs		Per		Program	
		Post-		Post-		Medical	Amount	(sum of cols.	Total	Diem	Inpatient	Pass-Through	
		Stepdown	Nursing	Stepdown	Allied Health	Education	(see	1, 2, and 3,	Patient	(col. 3 /	Program	Cost	
		Adjustments	Program	Adjustments	Cost	Cost	instructions)	minus col. 4)	Days	col. 4)	Days	(col. 7 x col. 8)	
	COST CENTER DESCRIPTIONS	1A	1	2A	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS												
30	Adults and Pediatrics (General Routine Care)								2,872		652		30
31	Intensive Care Unit												31
33	Burn Intensive Care Unit												33
35	Other Special Care (specify)												35
41	Subprovider - IRF												41
43	Nursery												43
200	Total								2,872		652		200

	TY HOSPITAL MCDUFFIE									12-22
	NMENT OF INPATIENT/OUTPATIENT ANCILLARY				PROVIDER CCN:	•	PERIOD:		WORKSHEET D	
SERVICE (	OTHER PASS-THROUGH COSTS				1		FROM: 01/01/202	1	PART IV	
					11-0111		TO: 12/31/2021			
	[] Title V	[ X ] Hospital	[]SNF		[] PARHM Demon		[X]PPS			
	[X ] Title XVIII, PART A	[] IPF	[]NF		[] PARHM CAH S	wing-Bed SNF	[]TEFRA			
Boxes:	[] Title XIX	[] IRF	[]ICF/IID		[] Chart Model		[] Other			
		[] Subprovider (Other)	[] Swing-Bed SNF		[] Chart CAH Swir	ng-Bed SNF				
			Nii		A 11:1		All		T-4-1	
			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		
	OOOT OFNITED DECORRISTIONS	Cost	Adjustments	Program	Adjustments	Health	Cost	3 and 4)	3, and 4)	
	COST CENTER DESCRIPTIONS  ANCILLARY SERVICE COST CENTERS	1	2A	2	3A	3	4	5	6	_
50	Operating Room									50
51	Recovery Room				+		_	+		5′
52	Labor Room and Delivery Room			-	+	-	+	+	-	52
	Anesthesiology							_		53
54	Radiology-Diagnostic				+			+		54
55	Radiology-Therapeutic	+			+			+		5!
56	Radioisotope							+		56
57	Computed Tomography (CT) Scan	+								5
58	Magnetic Resonance Imaging (MRI)	+			+			+		5
59	Cardiac Catheterization	+								5
60	Laboratory	<u> </u>								60
61	PBP Clinical Laboratory Services-Program Only	<u> </u>								6
62	Whole Blood & Packed Red Blood Cells	<u> </u>			+			+		6:
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy							+		64
	Respiratory Therapy									65
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									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
	OUTPATIENT SERVICE COST CENTERS									
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
200	Total (sum of lines 50 through 199)									200

	TY HOSPITAL MCDUFFIE				_					12-22
	NMENT OF INPATIENT/OUTPATIENT ANCILLARY				PROVIDER CCN:		PERIOD:		WORKSHEET D	
SERVICE (	OTHER PASS-THROUGH COSTS						FROM: 01/01/2021		PART IV	
					11-0111		TO: 12/31/2021			
Check	[] Title V	[ X ] Hospital	[]SNF		[X] Hospital		[X]PPS			
Applicable	[X ] Title XVIII, PART A	[] IPF	[]NF		[] PARHM Demon	stration	[]TEFRA			
Boxes:	[] Title XIX	[] IRF	[]ICF/IID		[] Chart Model		[] Other			
		[] Subprovider (Other)	[] Swing-Bed SNF		[] Chart CAH Swir	ng-Bed SNF				
		·!					Inpatient		Outpatient	
				Ratio	Outpatient		Program		Program	
				of Cost	Ratio		Pass-		Pass-	
			Total Charges	to Charges	of Cost	Inpatient	Through	Outpatient	Through	İ
			(from Wkst. C,	(col. 5 / col. 7)	to Charges	Program	Costs	Program	Costs	İ
			Pt I, col 8)	(see instructions	-	Charges	(col. 8 x col 10)	Charges	(col. 9 x col. 12)	İ
			7	8	9	10	11	12	13	İ
	ANCILLARY SERVICE COST CENTERS		·					.=		
50	Operating Room		7,595,268			160,806		1,464,922		50
51	Recovery Room		1,092,850			24,797		185,326		51
52	Labor Room and Delivery Room									52
53	Anesthesiology		787,364			29,914		119,029		53
54	Radiology-Diagnostic		17,250,118			454,301		2,553,013		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		8,715,335			347,931		892,106		60
61	PBP Clinical Laboratory Services-Program Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.									63
64	Intravenous Therapy									64
65	Respiratory Therapy		3,447,941			122,340		492,467		65
66	Physical Therapy		1,422,910			143,158		12,052		66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Patients		7,374,835			438,797		908,201		71
72	Implantable Devices Charged to Patients		2,937,042			224,379		551,021		72
73	Drugs Charged to Patients		10,393,725			708,425		1,292,042		73
74	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)		129,964					31,488		76
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
91	Emergency		15,145,310			275,466		1,569,556		91
92	Observation Beds		622,720			59,423		240,227		92
93	Other Outpatient Service (specify)									93
200	Total (sum of lines 50 through 199)		76,915,382			2,989,737		10,311,450		200

UNIVERSI	TY HOSPITAL MCDUFFIE								12-22
APPORTIC	DNMENT OF MEDICAL AND OTHER			PROVIDER CCN:		PERIOD:		WORKSHEET D	
HEALTH S	SERVICES COSTS					FROM: 01/01/2021		PART V	
				11-0111		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	ing-Bed SNF			
Boxes:	[] 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	1
		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	0.408000	1,464,922			597,688			50
51	Recovery Room	0.373378	185,326			69,197			51
52	Labor Room and Delivery Room								52
53	Anesthesiology	0.009351	119,029			1,113			53
54	Radiology-Diagnostic	0.108681	2,553,013			277,464			54
60	Laboratory	0.190384	892,106			169,843			60
	Respiratory Therapy	0.169202	492,467			83,326			65
	Physical Therapy	0.166505	12,052			2,007			66
	Medical Supplies Charged to Patients	0.253481	908,201			230,212			71
	Implantable Devices Charged to Patients	0.303996	551,021			167,508			72
73	Drugs Charged to Patients	0.155755	1,292,042			201,242			73
76	Other Ancillary (specify)	0.673917	31,488			21,220			76
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.270595	1,569,556			424,714			91
92	Observation Beds	1.444654	240,227			347,045			92
	Subtotal (see instructions)		10,311,450			2,592,579			200
	Less PBP Clinic Lab. Services - Program Only Charges								201
202	Net Charges (line 200 - line 201)		10,311,450			2,592,579			202

UNIVERSI	TY HOSPITAL MCDUFFIE								12-22
	ONMENT OF MEDICAL AND OTHER			PROVIDER CCN:		PERIOD:		WORKSHEET D	
HEALTH S	SERVICES COSTS					FROM: 01/01/2021		PART V	
				11-0111		TO: 12/31/2021			
	[] Title V - O/P	[ X ] Hospital	[] Subprovider (Other)						
	[] Title XVIII, PART B	[] IPF	[]SNF	[] Swing-Bed NF	[] PARHM CAH Sw	ving-Bed SNF			
Boxes:	[ X ] Title XIX - O/P	[] IRF	[] NF	[]ICF/IID	[] Chart Model				
					[] Chart CAH Swin	g-Bed SNF			
				Program Charges			Program Cost		1
		Cost		Cost	Cost		Cost	Cost	1
		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	1
		Wkst. C,	Services	Ded. & Coins.	Ded. & Coins.	(see	Ded. & Coins.	Ded. & Coins.	ĺ
	Pt. I, co		(see inst.)	(see inst.)	(see inst.)	inst)	(see inst.)	(see inst.)	ĺ
	COST CENTER DESCRIPTIONS	1	2	3	4	5	6	7	ĺ
	ANCILLARY SERVICE COST CENTERS								
	Operating Room	0.408000		212,917			86,870		50
51	Recovery Room	0.373378		38,260			14,285		51
53	Anesthesiology	0.009351		23,764			222		53
54	Radiology-Diagnostic	0.108681		726,390			78,945		54
60	Laboratory	0.190384		59,258			11,282		60
	Respiratory Therapy	0.169202		120,959			20,467		65
	Medical Supplies Charged to Patients	0.253481		297,463			75,401		71
72	Implantable Devices Charged to Patients	0.303996		5,534			1,682		72
73	Drugs Charged to Patients	0.155755		128,995			20,092		73
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.270595		870,117			235,449		91
92	Observation Beds	1.444654		3,676			5,311		92
	Subtotal (see instructions)			2,487,333			550,006		200
	Less PBP Clinic Lab. Services - Program Only Charges								201
202	Net Charges (line 200 - line 201)			2,487,333			550,006		202

UNIVERSITY HOSPITAL MCDUFFIE 12-22 COMPUTATION OF INPATIENT PROVIDER CCN: PERIOD: WORKSHEET D-1. OPERATING COST FROM: 01/01/2021 PART I 11-0111 TO: 12/31/2021 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) 4.524 2 Inpatient days (including private room days, excluding swing-bed and newborn days) 2,872 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) 2,184 4 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period 1,652 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) 652 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 556 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 248 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 4,164,307 21 21 Total general inpatient routine service cost (see instructions) 22 408,936 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 27 408,936 26 Total swing-bed cost (see instructions) 3,755,371 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)

34

35

36

37

3,755,371

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)

UNIVERSIT	Y HOSPITAL MCDUFFIE							12-22
COMPUTAT	TION OF INPATIENT		PROVIDER CCN:		PERIOD:		WORKSHEET D-1,	
OPERATING	GCOST				FROM: 01/01/2021		PART II	
			11-0111		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 Demonstrati	on				
		[] SNF	[] Chart Model					
PART II - HO	OSPITAL AND SUBPROVIDERS ON	LY						
	PROGRAM INPATIENT OPERATIN	IG COST BEFORE PASS-	THROUGH COST ADJUS	TMENTS				
38	Adjusted general inpatient routine se	ervice cost per diem (see in	structions)				1,308	38
39	Program general inpatient routine se	ervice cost (line 9 x line 38)	,				852,542	39
40	Medically necessary private room co	ost applicable to the Progra	m (line 14 x line 35)					40
41	Total Program general inpatient rout	ine service cost (line 39 + I	line 40)				852,542	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
	Coronary Care Unit							44
	Burn Intensive Care Unit							45
	Surgical Intensive Care Unit							46
47	Other Special Care Unit (specify)							47
							1	<u> </u>
	Program inpatient ancillary service of						685,463	48
	Program inpatient cellular therapy ac			n 1)				48.01
49	Total Program inpatient costs (sum	of lines 41 through 48.01)	(see instructions)				1,538,005	49
	DAGO TURQUIQUI GOOT AR HIGTA	4ENTO						
	PASS-THROUGH COST ADJUSTN		de es (franco Manhabast D	f.Dt-    III)			07.070	
	Pass through costs applicable to Pro Pass through costs applicable to Pro						67,273 36,532	50 51
	Total Program excludable cost (sum		ervices (from vvorksneet D,	sum of Parts II and IV)			103,805	52
	Total Program inpatient operating co		L nonnhyeician angethetiet	and medical education co	ete (line 40 minue line 52)		1,434,200	53
	Total Frogram inpatient operating co	ost excluding capital related	i, nonpriysician anestrietist	, and medical education co	sts (line 49 minus line 32)		1,434,200	
	TARGET AMOUNT AND LIMIT COI	MPLITATION						
54	Program discharges	0 17 11 10 11						54
	Target amount per discharge							55
	Permanent adjustment amount per o	discharge						55.01
	Adjustment amount per discharge (c							55.02
56	Target amount (line 54 x sum of line	s 55, 55.01, and 55.02 )						56
57	Difference between adjusted inpatie	nt operating cost and targe	t amount (line 56 minus line	e 53)				57
58	Bonus payment (see instructions)							58
59	Trended costs (lesser of line 53 ÷ lin	e 54, or line 55 from the co	st reporting period ending	1996, updated and compor	unded by the market basks	et)		59
60	Expected costs (lesser of line 53 ÷ li							60
	Continuous improvement bonus pay							
	61 amount by which operating costs	(line 53) are less than exp	ected costs (lines 54 x 60)	, or 1 % of the target amou	nt (line 56), otherwise ente	r zero. (see		61
	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incention	ve payment (see instruction	ns)					63
	PROGRAM INPATIENT ROUTINE				(III ) (III ) (III			
	Medicare swing-bed SNF inpatient r						137,632	64
	Medicare swing-bed SNF inpatient r						10= 611	65
	Total Medicare swing-bed SNF inpa						137,632	66
	Title V or XIX swing-bed NF inpatien				9)		-	67
	Title V or XIX swing-bed NF inpatien			g perioa (line 13 x line 20)				68 69
69	Total title V or XIX swing-bed NF inp	auent routine costs (line 67	· iiile 00)				<b>└</b>	1 09

UNIVERSITY	/ HOSPITAL MCDUFFIE							12-22
COMPUTAT	ION OF INPATIENT		PROVIDER CCN:		PERIOD:		WORKSHEET D-1,	
OPERATING	COST				FROM: 01/01/2021		PARTS III & IV	
			11-0111		TO: 12/31/2021			
Check	[ ] Title V - O/P	[X] Hospital	[] NF		[X]PPS		•	
Applicable	[X] Title XVIII, PART A	[] IPF	[]ICF/IID		[]TEFRA			
	[ ] Title XIX - I/P	[] IRF	[]NF		[] Other			
	[	[] Subprovider (Other)	[] PARHM Demons	tration				
		[]SNF	[] Chart Model					
PART III - SN	NF, NF, AND ICF/IID ONLY		•					
70	SNF / NF / ICF/IID routine service of	ost (line 37)						70
71	Adjusted general inpatient routine s	ervice cost per diem (line 70	÷ line 2)					71
	Program routine service cost (line 9							72
73	Medically necessary private room c	ost applicable to Program (lir	ne 14 x line 35)					73
	Total Program general inpatient rou							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	77 Program capital-related costs (line 9 x line 76)							77
78	78 Inpatient routine service cost (line 74 minus line 77)							78 79
79	79 Aggregate charges to beneficiaries for excess costs (from provider records)							
80	80 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							
81	81 Inpatient routine service cost per diem limitation							
82	Inpatient routine service cost limitat	ion (line 9 x line 81)						82
83	Reasonable inpatient routine servic	e costs (see instructions)						83
84	Program inpatient ancillary services	(see instructions)						84
85	Utilization review - physician compe	ensation (see instructions)						85
86	Total Program inpatient operating co	osts (sum of lines 83 through	1 85)					86
	-							
	OMPUTATION OF OBSERVATION		ST					
	Total observation bed days (see ins						688	87
	Adjusted general inpatient routine c		)				1,308	88
89	Observation bed cost (line 87 x line	88) (see instructions)					899,615	89
	COMPUTATION OF OBSERVATION	N 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)	
			1	2	3	4	5	
	Capital-related cost						328,601	90
	Nursing Program cost							91
	Allied Health cost							92
93	All other Medical Education							93

OPERATING	TION OF INPATIENT		PROVIDER CCN:	PERIOD:	WORKSHEET D-1.	
			1	FROM: 01/01/2021	PARTI	
	.000.		11-0111	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		
	[]	[] Subprovider (Other)	[] PARHM Demonstration	11		
		[] SNF	[] Chart Model			
PART I - AL	LL PROVIDER COMPONENTS	[[]	[]			
	INPATIENT DAYS				1	
1	1 Inpatient days (including priva	te room days and swing-bed day	vs. excluding newborn)		4,524	П
	2 Inpatient days (including priva				2,872	Т
			days). If you have only private room day	s, do not complete this line.		T
	4 Semi-private room days (exclu			, ,	2,184	T
			m days) through December 31 of the co	st reporting period	1,652	T
				eporting period (if 6 calendar year, enter 0 on this	,,,,	Т
6	6 line)					l
7	7 Total swing-bed NF type inpat	ient days (including private roon	n days) through December 31 of the cos	t reporting period		Т
		• • • • • • • • • • • • • • • • • • • •	• • •	•	1	
3	8 Total swing-bed NF type inpat	ient days (including private roon	n days) after December 31 of the cost re	porting period (if 8 calendar year, enter 0 on this line)		l
			the Program (excluding swing-bed and n		247	T
				December 31 of the 10 cost reporting period (see		Т
10	0 instructions).	aayo appiioabio to tito yee iii oiii,	, (moraumy private reem daye) amedgir i	seedinger or article to destroporting period (ede		ı
		days applicable to title XVIII only	v (including private room days) after Dec	ember 31 of the 11 cost reporting period (if calendar	<del>                                     </del>	┰
11	1 year, enter 0 on this line)	aayo appiioabio to tito yee iii oiii,	, (moraumy private reem daye) and Dee	oniber of a rate of a decreporating period (in date radi		ı
		lavs applicable to titles V or XIX	only (including private room days) through	gh December 31 of 12 the cost reporting period.		$\vdash$
				December 31 of the 13 cost reporting period (if		$\vdash$
1.9	3 calendar year, enter 0 on this		only (morading private room days) and i	seconder of or the to destroporting period (ii		
	4 Medically necessary private ro		ram (excluding swing-hed days)		+	$\vdash$
	5 Total nursery days (title V or X		am (exchaning eming see adje)		+	$\vdash$
	6 Nursery days (title V or XIX on				+ + +	H
	SWING BED ADJUSTMENT				+ + + + + + + + + + + + + + + + + + + +	H
17		NF services applicable to service	es through December 31 of the cost rep	orting period	248	t
			es after December 31 of the cost reporti		240	⊢
18						
	9 Medicaid rate for swing-bed N	F services applicable to services	s through December 31 of the cost repor	ting period	+	⊢
19			s through December 31 of the cost reporting			F
19 20	0 Medicaid rate for swing-bed N	F services applicable to services	s through December 31 of the cost reports after December 31 of the cost reporting		4 164 307	
19 20 21	Medicaid rate for swing-bed N     Total general inpatient routine	F services applicable to service service cost (see instructions)	s after December 31 of the cost reporting	g period	4,164,307 408,936	
19 20 21 22	Medicaid rate for swing-bed N     Total general inpatient routine     Swing-bed cost applicable to S	F services applicable to services service cost (see instructions)  SNF type services through Dece	s after December 31 of the cost reporting	g period e 5 x line 17)	4,164,307 408,936	
19 20 21 22 23	0 Medicaid rate for swing-bed N 1 Total general inpatient routine 2 Swing-bed cost applicable to \$ 3 Swing-bed cost applicable to \$	F services applicable to service service cost (see instructions) SNF type services through Dece SNF type services after Decemb	s after December 31 of the cost reporting mber 31 of the cost reporting period (line er 31 of the cost reporting period (line 6	g period e 5 x line 17) x line 18)		
19 20 21 22 23 24	0 Medicaid rate for swing-bed N 1 Total general inpatient routine 2 Swing-bed cost applicable to \$ 3 Swing-bed cost applicable to \$ 4 Swing-bed cost applicable to 1	F services applicable to service: service cost (see instructions) SNF type services through Dece SNF type services after Decemb NF type services through Decem	s after December 31 of the cost reporting imber 31 of the cost reporting period (line er 31 of the cost reporting period (line 6 liber 31 of the cost reporting period (line	g period e 5 x line 17) x line 18) 7 x line 19)		
19 20 21 22 23 24 25	Medicaid rate for swing-bed N 1 Total general inpatient routine 2 Swing-bed cost applicable to 5 3 Swing-bed cost applicable to 5 5 Swing-bed cost applicable to 1 5 Swing-bed cost applicable to 1	F services applicable to services service cost (see instructions) SNF type services through Dece SNF type services after Decemb F type services after Decemb F type services after Decembe	s after December 31 of the cost reporting mber 31 of the cost reporting period (line er 31 of the cost reporting period (line 6	g period e 5 x line 17) x line 18) 7 x line 19)	408,936	
19 20 21 22 23 24 25 26	Medicaid rate for swing-bed N 1 Total general inpatient routine 2 Swing-bed cost applicable to \$ 3 Swing-bed cost applicable to \$ 4 Swing-bed cost applicable to \$ 5 Swing-bed cost applicable to \$ 5 Swing-bed cost applicable to \$ 6 Total swing-bed cost (see inst	F services applicable to services service cost (see instructions) SNF type services through December type services after December type services after December type services after December type services after December uctions)	s after December 31 of the cost reporting imber 31 of the cost reporting period (line er 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 7 at 6 of the cost reporting period (line 8 x 10 of the cost reporti	g period e 5 x line 17) x line 18) 7 x line 19)	408,936	
19 20 21 22 23 24 25 26	Medicaid rate for swing-bed N 1 Total general inpatient routine 2 Swing-bed cost applicable to 5 3 Swing-bed cost applicable to 5 5 Swing-bed cost applicable to 1 5 Swing-bed cost applicable to 1 6 Total swing-bed cost (see inst 7 General inpatient routine serv	F services applicable to service service cost (see instructions) SNF type services through Dece SNF type services after Decembe F type services after Decembe ructions) tice cost net of swing-bed cost (lil	s after December 31 of the cost reporting imber 31 of the cost reporting period (line er 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 7 at 6 of the cost reporting period (line 8 x 10 of the cost reporti	g period e 5 x line 17) x line 18) 7 x line 19)	408,936	
19 20 21 22 23 24 25 26 27	Medicaid rate for swing-bed N 1 Total general inpatient routine 2 Swing-bed cost applicable to 3 3 Swing-bed cost applicable to 5 4 Swing-bed cost applicable to 1 5 Swing-bed cost applicable to 1 6 Total swing-bed cost (see inst 7 General inpatient routine serv PRIVATE ROOM DIFFERENT	F services applicable to services service cost (see instructions) SNF type services through Deces SNF type services after December type services after December type services after December type services after December total services after Decembe	s after December 31 of the cost reporting imber 31 of the cost reporting period (line er 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 8 x and 10 of the cost reporting p	g period e 5 x line 17) x line 18) 7 x line 19)	408,936	
19 20 21 22 23 24 25 26 27	Medicaid rate for swing-bed N 1 Total general inpatient routine 2 Swing-bed cost applicable to 3 3 Swing-bed cost applicable to 4 4 Swing-bed cost applicable to 1 5 Swing-bed cost applicable to 1 6 Total swing-bed cost (see inst 7 General inpatient routine serv PRIVATE ROOM DIFFERENT 8 General inpatient routine serv	F services applicable to services service cost (see instructions) SNF type services through Deces SNF type services after Decemb YF type services after December Type services after December Type services after December Loctions) ice cost net of swing-bed cost (light ADJUSTMENT Ice charges (excluding swing-be	s after December 31 of the cost reporting imber 31 of the cost reporting period (line er 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 7 at 6 of the cost reporting period (line 8 x 10 of the cost reporti	g period e 5 x line 17) x line 18) 7 x line 19)	408,936	
19 20 21 22 23 24 25 26 27 28	Medicaid rate for swing-bed N 1 Total general inpatient routine 2 Swing-bed cost applicable to 5 3 Swing-bed cost applicable to 5 5 Swing-bed cost applicable to 1 5 Swing-bed cost applicable to 1 6 Total swing-bed cost (see inst 7 General inpatient routine serv PRIVATE ROOM DIFFERENT 8 General inpatient routine serv 9 Private room charges (excludi	F services applicable to services service cost (see instructions) SNF type services through Deces SNF type services after December t	s after December 31 of the cost reporting imber 31 of the cost reporting period (line er 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 8 x and 10 of the cost reporting p	g period e 5 x line 17) x line 18) 7 x line 19)	408,936	
19 20 21 22 23 24 25 26 27 28 29	Medicaid rate for swing-bed N 1 Total general inpatient routine 2 Swing-bed cost applicable to \$ 3 Swing-bed cost applicable to \$ 4 Swing-bed cost applicable to \$ 5 Swing-bed cost applicable to 16 6 Total swing-bed cost (see inst 7 General inpatient routine serv PRIVATE ROOM DIFFERENT 8 General inpatient routine serv PRIVATE ROOM DIFFERENT 9 Private room charges (excludid) 0 Semi-private room charges (excludid)	F services applicable to service service cost (see instructions) SNF type services through Deces SNF type services after Decemb F type services after Decemb F type services after December ructions) to cook the following the cook of the following type to the following type to the following type to the following type to the following type to the following type to the following type to the following type to the following type type type type type type type type	s after December 31 of the cost reporting mber 31 of the cost reporting period (line er 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 7 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 8 x aber 31 of the	g period e 5 x line 17) x line 18) 7 x line 19)	408,936	
19 20 21 22 23 24 25 26 27 28 29 30 31	Medicaid rate for swing-bed N 1 Total general inpatient routine 2 Swing-bed cost applicable to 3 3 Swing-bed cost applicable to 4 4 Swing-bed cost applicable to 5 5 Swing-bed cost applicable to 1 6 Total swing-bed cost (see inst 7 General inpatient routine serv PRIVATE ROOM DIFFERENT 8 General inpatient routine serv PRIVATE ROOM DIFFERENT 9 Private room charges (excludi 0 Semi-private room charges (excludi 1 General inpatient routine serv	F services applicable to services service cost (see instructions) SNF type services through Deces SNF type services after Decemb NF type services through Decem NF type services after Decembe ructions) ice cost net of swing-bed cost (li TAL ADJUSTMENT ice charges (excluding swing-be ng swing-bed charges) xcluding swing-bed charges) ice cost/charge ratio (line 27 + lii ice cost/strage ratio (line 27 + lii ice cost/charge ratio (line 27 + lii ice cost/charge ratio (line 27 + lii ice cost/charge ratio (line 27 + lii ice cost/charge ratio (line 27 + lii ice cost/charge ratio (line 27 + lii ice cost/charge ratio (line 27 + lii ice cost/charge ratio (line 27 + lii ice cost/charge ratio (line 27 + lii ice cost/charge ratio (line 27 + lii ice cost/charge ratio (line 27 + lii ice charges)	s after December 31 of the cost reporting mber 31 of the cost reporting period (line er 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 7 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 8 x aber 31 of the	g period e 5 x line 17) x line 18) 7 x line 19)	408,936	
199 200 211 222 23 244 255 26 27 28 28 29 30 31 31	Medicaid rate for swing-bed N 1 Total general inpatient routine 2 Swing-bed cost applicable to 3 3 Swing-bed cost applicable to 3 4 Swing-bed cost applicable to 1 5 Swing-bed cost applicable to 1 6 Total swing-bed cost (see inst 7 General inpatient routine serv PRIVATE ROOM DIFFERENT 8 General inpatient routine serv 9 Private room charges (excludion Semi-private room charges (excludion Semi-private room charges (et 1 General inpatient routine serv 2 Average private room per dier	F services applicable to services service cost (see instructions) SNF type services through Deces SNF type services after Decemb VF type services after Decemb VF type services after Decembe F type services after Dece	s after December 31 of the cost reporting mber 31 of the cost reporting period (line er 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 7 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 8 x aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 8 x aber 31 of the	g period e 5 x line 17) x line 18) 7 x line 19)	408,936	
199 200 21 22 23 23 24 25 26 27 27 28 29 30 31 323 33 33 33	Medicaid rate for swing-bed N 1 Total general inpatient routine 2 Swing-bed cost applicable to 3 3 Swing-bed cost applicable to 5 4 Swing-bed cost applicable to 1 5 Swing-bed cost applicable to 1 6 Total swing-bed cost (see inst 7 General inpatient routine serv PRIVATE ROOM DIFFERENT 8 General inpatient routine serv 9 Private room charges (excludi 0 Semi-private room charges (e 1 General inpatient routine serv 2 Average private room per diei 3 Average semi-private room per diei	F services applicable to services service cost (see instructions) SNF type services through Deces SNF type services after December type services after December type services after December type services after December type services after December type services after December type services after December to type services after December to type services after December to type services after December to type services after December to the type services after December to the type services after December to the type services after the type services applicable to the type services applicable to the type services applicable to the type services applicable to the type services applicable to the type services applicable to the type services applicable to the type services applicable to the type services after the type services after the type services after the type services after Decembe	s after December 31 of the cost reporting mber 31 of the cost reporting period (line er 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 6 aber 31 of the cost reporting period (line 8 x ne 21 minus line 26)  d and observation bed charges)	g period e 5 x line 17) x line 18) 7 x line 19)	408,936	
199 20 20 21 22 22 23 23 24 24 25 266 27 27 29 29 300 31 31 32 33 34	Medicaid rate for swing-bed N 1 Total general inpatient routine 2 Swing-bed cost applicable to 3 3 Swing-bed cost applicable to 5 4 Swing-bed cost applicable to 5 5 Swing-bed cost applicable to 1 6 Total swing-bed cost (see inst 7 General inpatient routine serv PRIVATE ROOM DIFFERENT 8 General inpatient routine serv Private room charges (excludi 0 Semi-private room charges (e 1 General inpatient routine serv 2 Average private room per diet 3 Average semi-private room pe 4 Average per diem private room	F services applicable to services service cost (see instructions) SNF type services through Deces SNF type services after Decemb NF type services after Dece	s after December 31 of the cost reporting mber 31 of the cost reporting period (line er 31 of the cost reporting period (line fiber 31 of the cost reporting period (line fiber 31 of the cost reporting period (line 8 x and 21 minus line 26) d and observation bed charges)	g period e 5 x line 17) x line 18) 7 x line 19)	408,936	
199 20 20 21 22 22 23 24 24 25 26 28 28 29 30 30 31 31 32 33 34 35	Medicaid rate for swing-bed N 1 Total general inpatient routine 2 Swing-bed cost applicable to 3 3 Swing-bed cost applicable to 5 4 Swing-bed cost applicable to 1 5 Swing-bed cost applicable to 1 6 Total swing-bed cost (see inst 7 General inpatient routine serv PRIVATE ROOM DIFFERENT 8 General inpatient routine serv 9 Private room charges (excludi 0 Semi-private room charges (e 1 General inpatient routine serv 2 Average private room per diei 3 Average semi-private room per diei	F services applicable to services service cost (see instructions) SNF type services through Deces SNF type services through Deces SNF type services after Decembe If type services after D	s after December 31 of the cost reporting mber 31 of the cost reporting period (line er 31 of the cost reporting period (line fiber 31 of the cost reporting period (line fiber 31 of the cost reporting period (line 8 x and 21 minus line 26) d and observation bed charges)	g period e 5 x line 17) x line 18) 7 x line 19)	408,936	

UNIVERSITY HOSPITAL MCDUFFIE 12-22 WORKSHEET D-1, COMPUTATION OF INPATIENT PROVIDER CCN: DEBIUD. OPERATING COST FROM: 01/01/2021 PART II 11-0111 TO: 12/31/2021 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) 1 308 38 39 Program general inpatient routine service cost (line 9 x line 38) 322.972 39 40 40 Medically necessary private room cost applicable to the Program (line 14 x line 35) 322,972 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) 42 Intensive Care Type Inpatient Hospital Units 43 44 43 Intensive Care Unit 44 Coronary Care Unit 45 Burn Intensive Care Unit 45 46 46 Surgical Intensive Care Unit 47 Other Special Care Unit (specify) 47 48 48 Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200) 252.842 48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 48.01 575,814 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) 63 Allowable Inpatient cost plus incentive payment (see instructions)

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

UNIVERSITY	/ HOSPITAL MCDUFFIE							12-22
	ION OF INPATIENT		PROVIDER CCN:		PERIOD:		WORKSHEET D-1,	
OPERATING	COST				FROM: 01/01/2021		PARTS III & IV	
			11-0111		TO: 12/31/2021			
Check	[] Title V - O/P	[X] Hospital	[] NF		[X]PPS		•	
	[] Title XVIII, PART A	ÎliPF	[]ICF/IID		[]TEFRA			
Boxes:	[X] Title XIX - I/P	i irf	[]NF		[] Other			
		[] Subprovider (Other)	[] PARHM Demons	tration				
		I SNF	[] Chart Model					
PART III - SN	IF, NF, AND ICF/IID ONLY	12.2						
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)	·					72
73	Medically necessary private room	cost applicable to Program (	line 14 x line 35)					73
74	Total Program general inpatient re	outine service costs (line 72 -	line 73)					74
75	Capital-related cost allocated to ir	patient routine service costs	(from Worksheet B, P	art II, column 26, line 45)				74 75
76	Per diem capital-related costs (lin	e 75 ÷ line 2)						76
77	Program capital-related costs (line	e 9 x line 76)						77
	Inpatient routine service cost (line			78				
79	Aggregate charges to beneficiarie			79				
80	Total Program routine service cos			80				
81	Inpatient routine service cost per			81				
82	Inpatient routine service cost limit	ation (line 9 x line 81)						82
83	Reasonable inpatient routine serv	vice costs (see instructions)						83
	Program inpatient ancillary servic							84
	Utilization review - physician com							85
86	Total Program inpatient operating	costs (sum of lines 83 through	gh 85)					86
DADTIV C	OMPUTATION OF OBSERVATION	N DED DACC TUDOUCU CO	NCT.					
	Total observation bed days (see i		31				688	87
	Adjusted general inpatient routine		2)				1,308	88
	Observation bed cost (line 87 x line		2)				899,615	89
09	Observation bed cost (line of X iii	ie oo) (see iristructions)					099,013	09
	COMPUTATION OF OBSERVAT	ION BED PASS THROUGH	COST					
						Total	Observation Bed	İ
				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	l
90	Capital-related cost						328,601	90
91	Nursing Program cost							91
	Allied Health cost							92
93	All other Medical Education							93

UNIVERSITY H	OSPITAL MCDUFFIE							12-22
	N OF INPATIENT		PROVIDER CCN:	PERIOD:		WORKSHEET D-3		
OPERATING C	OST			FROM: 01/01/20	21			
				11-0111	TO: 12/31/2021			
Check	[] Title V - O/P [X] Hospital [] SNF			[] ICF/IID	[X]PPS			
Applicable	cable [X] Title XVIII, PART A [] IPF [] NF			[] PARHM Demonstration [] PARHM CAH Swing-Bed SNF	[]TEFRA			
Boxes:	[] Title XIX - I/P		[] Swing-Bed SNF	[] Other				
		[] Subprovider (Other)						
				[] 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 SERVI	ICE COST CENTERS						
30	Adults and Pediatrics (Gener	al Routine Care)		495,274		30		
31	Intensive Care Unit	•				31		
32	Coronary Care Unit					32		
33						33		
34						34		
35	Other Special Care (specify)					35		
40	Subprovider - IPF					40		
41	Subprovider - IRF						41	
42	Subprovider (specify)							42
43	Nursery							43
40	ANCILLARY SERVICE COS	ST CENTERS						
50		JI OLIVILINO			0.408000	160,806	65,609	50
51					0.373378	24,797	9,259	51
52	Recovery Room				0.373376	24,131	9,239	52
53		JOH			0.009351	29,914	280	53
	Anesthesiology							
54	Radiology-Diagnostic				0.108681	454,301	49,374	54
55	Radiology-Therapeutic							55 56
56		0						
57	Computed Tomography (CT)							57
58	Magnetic Resonance Imagin	g (MRI)						58
59	Cardiac Catheterization							59
	Laboratory				0.190384	347,931	66,240	60
61								61
62	Whole Blood & Packed Red							62
63	Blood Storing, Processing, &	Trans.						63
64	Intravenous Therapy							64
65					0.169202 0.166505	122,340	20,700	65
66						143,158	23,837	66
67	Occupational Therapy					67		
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to	Patients			0.253481	438,797	111,227	71
72		Implantable Devices Charged to Patients			0.303996	224,379	68,210	72
73	Drugs Charged to Patients				0.155755	708,425	110,341	73
74								74
75	ASC (Non-Distinct Part)							75
76					0.673917			76
	OUTPATIENT SERVICE CO	OST CENTERS						
88		-						88
89	Federally Qualified Health Ce	enter (FOHC)						89
90	Clinic	sitter (i qi ie)						90
91	Emergency				0.270595	275,466	74,540	91
92	Observation Beds				1.444654	59,423	85,846	92
93		ecify)			1.444004	00,420	040,040	93
93	OTHER REIMBURSABLE (							- 33
94		DOST CENTERS						04
	Home Program Dialysis							94 95
95	Ambulance Services	Dantad					96	
96								
97	Other Reimburgehle (angeits)					97		
98	Other Reimbursable (specify						98	
99	Outpatient Rehabilitation Pro	vider (specity)						99
100	Intern-Resident Service (not	appva. tcnng. prgm.)						100
101	Home Health Agency	04 10011 1 221				0.000 ===	005 100	101
200	Total (sum of lines 50 through					2,989,737	685,463	200
201	Less PBP Clinic Laboratory S	ervices - Program only ch	arges (line 61)					201
202	Net charges (line 200 minus li		2,989,737		202			

	OSPITAL MCDUFFIE							12-22
	N OF INPATIENT			PROVIDER CCN:	PERIOD:		WORKSHEET D-3	
OPERATING C	OST			FROM: 01/01/20				
				11-0111	TO: 12/31/2021			
Check	[] Title V - O/P [X] Hospital [] SNF			[] ICF/IID	[X]PPS			
Applicable	plicable [] Title XVIII, PART A [] IPF		] NF	[] PARHM Demonstration [] PARHM CAH Swing-Bed SNF	[]TEFRA			
Boxes:	[ X ] Title XIX - I/P		] Swing-Bed SNF	[] Other				
		[] Subprovider (Other)	] Swing-Bed NF	[] Chart Model				
			[] Chart CAH Swing-Bed SNF					
					Ratio of Cost	Inpatient	Inpatient Program Costs	
	COST CENTER DESCRIPTION					Program Charges	(col. 1 x col. 2)	
(A)				1	2	3		
	INPATIENT ROUTINE SERVI	CE COST CENTERS						
30	Adults and Pediatrics (General	al Routine Care)		191,599		30		
31	Intensive Care Unit	•				31		
32	Coronary Care Unit					32		
33						33		
34						34		
35	Other Special Care (specify)					35		
40	Subprovider - IPF					40		
41	Subprovider - IRF						41	
42	Subprovider (specify)							42
43	Nursery							43
	ANCILLARY SERVICE COS	ST CENTERS						
50		OT CENTERS			0.408000	71,470	29,160	50
51					0.373378	10,926	4,080	51
52		om			0.373376	10,920	4,000	52
53		OIII			0.009351	13,326	125	
	Anesthesiology						9,884	53
54	Radiology-Diagnostic				0.108681	90,942	9,884	54 55
55	Radiology-Therapeutic							55
56	Radioisotope	0						56
57	Computed Tomography (CT)							57
58	Magnetic Resonance Imaging	g (MRI)						58
59	Cardiac Catheterization							59
60					0.190384	107,966	20,555	60
61								61
62	Whole Blood & Packed Red I						62	
63	Blood Storing, Processing, &	Trans.					63	
64	Intravenous Therapy							64
65						30,413	5,146	65
66	Physical Therapy				0.166505	65,500	10,906	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
	Electroencephalography							70
71	Medical Supplies Charged to	Patients			0.253481	305,282	77,383	71
72	Implantable Devices Charged	Implantable Devices Charged to Patients				68,824	20,922	72
73	Drugs Charged to Patients				0.155755	264,123	41,138	73
74	Renal Dialysis							74
75	ASC (Non-Distinct Part)							75
76	Other Ancillary (specify)				0.673917			76
	OUTPATIENT SERVICE CO	OST CENTERS						
88								88
89	Federally Qualified Health Ce	enter (FQHC)						89
90	Clinic	(* 4)						90
91	Emergency				0.270595	65,765	17,796	91
92	Observation Beds				1.444654	10,900	15,747	92
93		ecify)				10,000	10,7 11	93
- 50	OTHER REIMBURSABLE C							
94	Home Program Dialysis	OCCI CENTENC						94
95	Ambulance Services				<del>                                     </del>			95
96		Rented						96
97				<del>                                     </del>			97	
	Other Poimburgable (specify)		<del>                                     </del>			98		
98	Other Reimbursable (specify)							
99	Outpatient Rehabilitation Pro				<del>                                     </del>			99
100	Intern-Resident Service (not a	appvu. tcnng. prgm.)						100
101	Home Health Agency	04 and 06 th 00'		1 405 407	050.040	101		
200	Total (sum of lines 50 through		(!: 0.1)			1,105,437	252,842	200
201								201
202	Net charges (line 200 minus line 201)					1,105,437		202