Health Financia	al Syst	ems	RUSH MEMORIAL HO	SPI TAL			In Lie	u of Form	CMS-	2552-10
This report is	requi i	red by I aw (42 USC 1395	g; 42 CFR 413.20(b)). Failu	ire to report can	resul	t in all	interim	FORM APP	ROVED)
payments made:	since :	the beginning of the co	st reporting period being o	leemed overpaymen	ts (42	USC 1395	ig).	OMB NO.	0938-	-0050
HOSPITAL AND H	OSPI TAI	L HEALTH CARE COMPLEX C	OST REPORT CERTIFICATION	Provider CCN: 15	1304	Peri od:		Workshee		
AND SETTLEMENT	SUMMAI	RY						Parts I -		
						To 12/	31/2015	Date/Tim 5/27/201		
DART I COCT	DEDADT	CTATUC						3/2//201	0 2. 3	oz pili
PART I - COST	REPURI	STATUS								
Provi der	1. [X] Electronically filed	cost report			Date:	5/27/20	16 Ti ı	ne:	2:32 pm
use only	2. [] Manually submitted co	st report							
	3. [0] If this is an amended	I report enter the number of	f times the provi	der re	submitted	d this co	ost repor	t	
	4. [F] Medicare Utilization.	Enter "F" for full or "L"	for low.				•		
Contractor	5. [1	Cost Report Status	6. Date Received:		10. N	PR Date:				
use only		As Submitted				ontractor				4
	(2)	Settled without Audit	8. [N] Initial Report for	this Provider CC	N 12. [0]Ifli	ne 5, cc	olumn 1 is	3 4: F	Enter
	(3)	Settled with Audit	9. [N] Final Report for the	his Provider CCN		numbe	er of tim	nes reoper	red =	0-9.
	(4)	Reopened								

PART II - CERTIFICATION

(5) Amended

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RUSH MEMORIAL HOSPITAL (151304) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	
	Officer or Administrator of Provider(s)
Ti tl e	
Date	

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	-175, 871	-52, 755	1, 612, 269	5, 250	1. 00
2.00 Subprovider - IPF	0	0	0		0	2. 00
3.00 Subprovider - IRF	0	0	0		0	3. 00
5.00 Swing bed - SNF	0	-76, 094	0		0	5. 00
6.00 Swing bed - NF	0				0	6. 00
200. 00 Total	0	-251, 965	-52, 755	1, 612, 269	5, 250	200. 00
The above amounts represent "due to" or "due from"	the applicable	program for th	ne element of t	he above comple	ex indicated.	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151304 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/27/2016 2:32 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1300 NORTH MAIN STREET 1.00 1.00 PO Box: State: IN 2.00 City: RUSHVILLE Zip Code: 46173-County: RUSH 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fied Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal RUSH MEMORIAL HOSPITAL 151304 99915 08/01/2000 Ν 0 0 3.00 Subprovider - IPF 4.00 4.00 Subprovi der - IRF 5.00 5 00 Subprovider - (Other) 6.00 6.00 Swing Beds - SNF 7.00 RUSH SWING BEDS 15Z304 99915 08/01/2000 N 0 N 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2015 12/31/2015 20 00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 22.00 N share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this cost reporting Ν 22.01 Ν period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter

	used in the prior cost reporting period? In column 2	2, enter "Y	' for yes c	or "N" for r	10.			
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		pai d days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6.00	
24.00	If this provider is an IPPS hospital, enter the	0	0	0	0	0	0	24. 00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
25.00	If this provider is an IRF, enter the in-state	0	0	0	0	0		25. 00
	Medicaid paid days in column 1, the in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid days in column 3, out-of-state							
	Medicaid eligible unpaid days in column 4, Medicaid							
	HMO paid and eligible but unpaid days in column 5.							

23.00

in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column

1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method

42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151304 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/27/2016 2:32 pm Program Code Unweighted IME Program Name Unwei ghted Direct ĞME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all

non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

SPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der	CCN: 15130	From O	: 1/01/2015 2/31/2015		epared
		·			4 00	2.00	
All Providers					1. 00	2. 00	
O.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	'N" for no in column 1. e home office chain numb	If yes, and home	office co	osts	N 3. 00		140. (
If this facility is part of a cha			<u> </u>	ne name and		of the	
home office and enter the home of	<u>fice contractor name an</u>	d contractor numbe	er.				
1. 00 Name:	Contractor's Name: PO Box:	:	Contr	actor's Nu	ımber:		141. 142.
2. 00 Street: 3. 00 Ci ty:	State:		Zip C	ode:			143.
4 00 4		-+ 12				1.00	144
4.00 Are provider based physicians' co	STS INCLUDED IN WORKSHEE	et A?				Y	144.
					1. 00	2.00	
5.00 If costs for renal services are c					N		145.
inpatient services only? Enter "Y'no, does the dialysis facility inc							
period? Enter "Y" for yes or "N"		1011 101 11113 0031	reporting	,			
6.00 Has the cost allocation methodolog					N		146.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o		b. 15-2, chapter 4	40, §4020)	If			
yes, errer the approval date (min)	aryyyy) iii corumii 2.						
						1.00	I
7.00 Was there a change in the statisti 3.00 Was there a change in the order o						N N	147. 148.
0.00 Was there a change to the simplifi				for no.		N N	149.
	J	Part A	Part	В Т	itle V	Title XIX	
		1.00	2.00		3.00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
5. 00 Hospi tal	N TOT TIO TOT CACT COM	N N	N N	D. (3CC 42	N N	N N	155.
6.00 Subprovider - IPF		N	N		N	N	156.
7. 00 Subprovi der - I RF 3. 00 SUBPROVI DER		N	N		N	N	157. 158.
9. 00 SNF		N	N		N	N	159.
O. OO HOME HEALTH AGENCY		N	N		N	N	160.
1. 00 CMHC			l N		N	N	161.
						1.00	4
Multicampus						1.00	
5.00 Is this hospital part of a Multica	ampus hospital that has	one or more campu	uses in di	fferent CE	BSAs?	N	165.
Enter "Y" for yes or "N" for no.	Name	County	Ctata	Zip Code	CBSA	FTE/Campus	
	0	County 1.00	2. 00	3. 00	4. 00	5. 00	-
5.00 If line 165 is yes, for each							00 166.
campus enter the name in column							
O, county in column 1, state in column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1.00	-
	Γ) incentive in the Ame	rican Recovery and	d Rei nves	tment Act		1.00	
Health Information Technology (HI			'N" for no).		Y	167.
Health Information Technology (HI 7.00 Is this provider a meaningful use	runder §1886(n)? Ente		167 ic "	Y"), enter	the	1, 726, 67	71 168.
7.00 s this provider a meaningful user 3.00 f this provider is a CAH (line 10	O5 is "Y") and is a mear	ningful user (line	= 107 15				
7.00 s this provider a meaningful use 3.00 of this provider is a CAH (line 10 reasonable cost incurred for the l	O5 is "Y") and is a mear HIT assets (see instruc	ningful user (line tions)		for a hard	lshi n		168
7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 8.01 If this provider is a CAH and is a exception under §413.70(a)(6)(ii)	D5 is "Y") and is a mear HIT assets (see instruct not a meaningful user, o ? Enter "Y" for yes or '	ningful user (line tions) does this provider "N" for no. (see i	r qualify instructio	ons)	•		168.
7.00 s this provider a meaningful user 3.00 If this provider is a CAH (line 10 reasonable cost incurred for the lass of this provider is a CAH and is secreption under §413.70(a)(6)(i)? 9.00 If this provider is a meaningful	O5 is "Y") and is a mear HIT assets (see instruct not a meaningful user, o ? Enter "Y" for yes or ' user (line 167 is "Y") a	ningful user (line tions) does this provider "N" for no. (see i	r qualify instructio	ons)	•	0.0	
7.00 s this provider a meaningful use 8.00 lf this provider is a CAH (line 10 reasonable cost incurred for the l 8.01 lf this provider is a CAH and is i	O5 is "Y") and is a mear HIT assets (see instruct not a meaningful user, o ? Enter "Y" for yes or ' user (line 167 is "Y") a	ningful user (line tions) does this provider "N" for no. (see i	r qualify instructio	ons) is "N"), e	enter the		168. 00169.
7.00 Is this provider a meaningful user 3.00 If this provider is a CAH (line 10 reasonable cost incurred for the last of this provider is a CAH and is nexception under §413.70(a)(6)(i)) 9.00 If this provider is a meaningful.	O5 is "Y") and is a mear HIT assets (see instruct not a meaningful user, o ? Enter "Y" for yes or ' user (line 167 is "Y") a	ningful user (line tions) does this provider "N" for no. (see i	r qualify instructio	ons) is "N"), e	•	0. (Endi ng 2. 00	

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu o						-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi der CCN:	151304	From 01/01/20		
				To 12/31/20	15 Date/Time Pr 5/27/2016 2:	
					1.00	
171.00 If line 167 is "Y", does this provide	N	171. 00				
Medicare cost plans reported on Wkst.						
(see instructions)						

	Financial Systems AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE:	RUSH MEMORIAL HO STIONNAIRE	+		eri od:	Worksheet S-	
					rom 01/01/2015 o 12/31/2015	Date/Time Pr	
					Y/N	5/27/2016 2: Date	32 pm
					1. 00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for	all NO re	sponses. Enter	all dates in s	the	
00	Provider Organization and Operation Has the provider changed ownership immediate	y prior to the beg	inning of	the cost	N		1.00
	reporting period? If yes, enter the date of t	the change in colum	n 2. (see	Y/N	Date	V/I	
				1.00	2. 00	3. 00	
	Has the provider terminated participation in yes, enter in column 2 the date of termination voluntary or "I" for involuntary.			N			2.00
00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or frelationships? (see instructions)	., chain home officed to the provider of the provider of the control of the contr	es, drug r its e board	N			3.00
				Y/N	Type	Date	
	Financial Data and Reports			1. 00	2. 00	3. 00	
00	Column 1: Were the financial statements prepaccountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for C enter date availab	ompiled,	Y	А		4.00
00	column 3. (see instructions) If no, see instr Are the cost report total expenses and total		from	N			5. 00
	those on the filed financial statements? If y						
					Y/N 1. 00	Legal Oper. 2.00	+
	Approved Educational Activities				1.00	2.00	
00	Column 1: Are costs claimed for nursing schothe legal operator of the program?	ool? Column 2: If	yes, is th	e provider is	N		6. 00
00	Are costs claimed for Allied Health Programs?	? If "Y" see instru	ctions.		N		7. 00
00	Were nursing school and/or allied health prog		or renewed	l during the	N		8. 00
00	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents i		uate medic	al education	N		9.00
	program in the current cost report? If yes, s	see instructions.					
	Was an approved Intern and Resident GME progress reporting period? If yes, see instruction		newed in t	he current	N		10.00
	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see	rs other than I & R	in an App	roved	N		11.00
						Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bad	dahts2 If was so	a instruct	ions		Υ	12. 00
3. 00	If line 12 is yes, did the provider's bad det period? If yes, submit copy.	ot collection polic	y change d	luring this cos	t reporting	N	13. 00
4. 00	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments	waived? If	yes, see inst	ructi ons.	N	14.00
	Did total beds available change from the price	or cost reporting p	eriod? If	ľ		N	15.00
		Descriptio	ın	Par Y/N	Tt A Date	Part B Y/N	
		0		1. 00	2. 00	3. 00	
	PS&R Data Was the cost report prepared using the PS&R	I		Υ	04/05/2016	Υ	16. 00
3. 00	Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see			Ť	04/05/2016	Y	16.00
	instructions) Was the cost report prepared using the PS&R			N		N	17. 00
	Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)						
. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not			N		N	18. 00
0. 00	included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see			N		N	19.00
	instructions. If line 16 or 17 is yes, were adjustments			N		N	20.00

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 151304 Peri od: Worksheet S-2 From 01/01/2015 Part II Date/Time Prepared: 12/31/2015 5/27/2016 2:32 pm Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν N 21 00 provider's records? If yes, see . i nstructi ons. 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If yes, see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору. Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Υ 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 30.00 Ν instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions.

If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provider-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35.00 35, 00

33.00	The 54 13 yes, were there new agreements or amended ex	isting agreements with the pr	OVI aci basca	1 14	35.00		
	physicians during the cost reporting period? If yes, see in	nstructions.					
			Y/N	Date			
			1. 00	2. 00			
	Home Office Costs						
36.00	Were home office costs claimed on the cost report?		N		36. 00		
37.00	If line 36 is yes, has a home office cost statement been p	repared by the home office?	N		37. 00		
	If yes, see instructions.						
38.00	If line 36 is yes, was the fiscal year end of the home of	fice different from that of	N		38. 00		
	the provider? If yes, enter in column 2 the fiscal year en						
39.00	If line 36 is yes, did the provider render services to other	er chain components? If yes,	N		39. 00		
	see instructions.						
40.00	If line 36 is yes, did the provider render services to the	home office? If yes, see	N		40. 00		
	instructions.						
		1.00	2.	00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	MI CHAEL	ALESSANDRI NI		41. 00		
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report	BLUE & CO., LLC			42. 00		
	preparer.						
43.00	Enter the telephone number and email address of the cost	317-633-4705	MALESSANDRI NI @	BLUEANDCO. COM	43.00		
	report preparer in columns 1 and 2, respectively.						

Heal th	Financial Systems	RUSH MEMORIA	L HO	SPI TAL		In Lie	u of Form CMS	-2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	ESTI ONNAI RE		Provider CCN:	151304	01/01/2015	Worksheet S Part II Date/Time P 5/27/2016 2	epared:
		Part B						
		Date						
		4.00						
	PS&R Data							
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes,							16. 00

		Part B		·
		Date		
		4. 00		
	PS&R Data			
16.00	Was the cost report prepared using the PS&R	04/05/2016		16. 00
	Report only? If either column 1 or 3 is yes,			
	enter the paid-through date of the PS&R			
	Report used in columns 2 and 4 .(see			
	instructions)			
17. 00	Was the cost report prepared using the PS&R			17. 00
	Report for totals and the provider's records			
	for allocation? If either column 1 or 3 is			
	yes, enter the paid-through date in columns			
	2 and 4. (see instructions)			
18. 00	If line 16 or 17 is yes, were adjustments			18. 00
	made to PS&R Report data for additional			
	claims that have been billed but are not			
	included on the PS&R Report used to file			
	this cost report? If yes, see instructions.			
19. 00	If line 16 or 17 is yes, were adjustments			19. 00
	made to PS&R Report data for corrections of			
	other PS&R Report information? If yes, see			
20.00	instructions.			20.00
20.00	If line 16 or 17 is yes, were adjustments			20. 00
	made to PS&R Report data for Other? Describe			
21 00	the other adjustments:			21. 00
21.00	Was the cost report prepared only using the			21.00
	provider's records? If yes, see instructions.			
	THSTI uctions.			
			3.00	
	Cost Report Preparer Contact Information		0.00	
	Enter the first name, last name and the title	e/position	CONSULTANT	41.00
	held by the cost report preparer in columns 1			
	respectively.			
42.00	Enter the employer/company name of the cost r	report		42.00
	preparer.	•		
43.00	Enter the telephone number and email address	of the cost		43.00
	report preparer in columns 1 and 2, respectiv	∕el y.		

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | Part | P

						0 12/31/2015	5/27/2016 2:3	
							I/P Days / 0/P	z piii
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	Component	Line Number	1.0.	or beas	Avai I abl e	Oran noars	'''''	
		1.00		2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25				1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						Ö	6. 00
7. 00	Total Adults and Peds. (exclude observation			25	9, 125	34, 872. 00		7. 00
7.00	beds) (see instructions)			20	//	01,072.00		7.00
8.00	INTENSIVE CARE UNIT							8. 00
9. 00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY							13. 00
14. 00	Total (see instructions)			25	9, 125	34, 872. 00	0	14. 00
15. 00	CAH visits			23	7, 12	34, 072. 00	0	15. 00
16. 00	SUBPROVI DER - I PF						ľ	16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPICE							24. 00
24. 00	HOSPICE (non-distinct part)	30. 00						24. 00
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25								26. 25
	FEDERALLY QUALIFIED HEALTH CENTER			25				27. 00
27. 00	Total (sum of lines 14-26)			25				
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambulance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF			0	,			31.00
32. 00	Labor & delivery days (see instructions)			0	(7		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
22 00	outpatient days (see instructions)							22.00
33.00	LTCH non-covered days		l		I	1	I	33. 00

Provi der CCN: 151304

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 5/27/2016 2: 32 pm

				_		5/27/2016 2:3	2 pm
		I/P Days	s / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8.00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	928	28	1, 453			1. 00
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	163	2				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	361	0	373			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	25			6.00
7.00	Total Adults and Peds. (exclude observation	1, 289	28	1, 851			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	1, 289	28		0.00	255. 30	
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE		0				24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00 26. 25
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER				0.00	255. 30	
28. 00	Total (sum of lines 14-26) Observation Bed Days		0	434		255. 50	28.00
29. 00	Ambul ance Tri ps	450	U	434			29.00
30.00	Employee discount days (see instruction)	450		0			30.00
30.00	Employee discount days (see Instruction)						31.00
32.00	Labor & delivery days (see instructions)	0	0	· -			32.00
32. 00	Total ancillary labor & delivery room	١	Ü				32.00
32. UI	outpatient days (see instructions)			١			32.01
33. 00	LTCH non-covered days	О					33. 00

 Heal th Financial
 Systems
 RUSH M

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

				T	o 12/31/2015	Date/Time Pre 5/27/2016 2:3	
		Full Time		Di sch	arges	072772010 2.0	Z piii
		Equi val ents			,		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and			283	9	467	1. 00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			46	1		2.00
3.00	HMO I PF Subprovi der				0		3.00
4.00	HMO I RF Subprovi der				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY			_	_		13. 00
14. 00	Total (see instructions)	0. 00		0 283	9	467	
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

High Had the Financial Systems	Incompensated and Indigent care cost computation Incompensated and indigent care cost compensated Incompensated and indigent care cost computation Incompensated											
	Incompensated and indigent care cost computation											
Broosponsated and indigent care cost computation	Incorporated and indigent care cost computation 1.00	HOSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 151304		Worksheet S-1	0				
Uncompensated and Indigent care cost computation	Discompensated and Indigent care cost computation 1.00						Date/Time Pre	pared.				
Incompensated and indigent care cost computation 1.00 Cost to charge ratio (Worksheet C, Part I I I Ine 202 column 3 divided by line 202 column 8) 0.376187 1.00	Uncompensated and indigent care cost computation 0.00					12, 01, 2010						
Incompensated and indigent care cost computation 0.00	Uncompensated and indigent care cost computation 0.00											
1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.376187 1.00 Medicaid Gsee instructions for each line) 3.00 Net revenue from Medicaid 7 3.00 0.00 Did you receive DSH or supplemental payments from Medicaid? 7 3.00 0.00 Did you receive DSH or supplemental payments from Medicaid? 7 3.00 0.00 Did you receive DSH or supplemental payments from Medicaid? 7 3.00 0	1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0. 376187 1.00 Medicaid (See instructions for each line) 1.01 1.00 1.01						1. 00					
Medicaid (see Instructions for each line) 1,812,641 2,0 1,812,641 2,0 1,812,641 3,0 3,00 10 dy up receive DSH or supplemental payments from Medicaid?	Medicaid (see Instructions for each line) 1,812,641 2,00											
1,812,641 2.00 Note receive DSH or supplemental payments from Medicaid? Y 3.00 Note No	Net revenue from Medical d 1,812,641 2.00 3.00 0.00 1 four receive DSH or supplemental payments from Medicald? Y 3.00 0.00 1 four 4 is "no", then enter DSH or supplemental payments from Medicald? 4.00 5.00 6.00 Medicald charges 3.011,616 6.00 1.00 6.00	1. 00		<u>ided by li</u>	ne 202 colum	n 8)	0. 376187	1. 00				
3.00 10 10 10 10 10 10 10	3.00 10 you receive DSH or supplemental payments from Medicaid?											
4.00 If I in a 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? 4.00 0.5	4.00 If I in a 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid? 4.00 0.50 0.00											
1	1			10	Y							
Medical d charges	Medical d charges				rrom medicai	u?						
Medical d cost (line 1 times line 6) 1,132,931 7.00 0.00	Medical d cost (line 1 times line 6) 1,132,931 7.00 0.00		1	i wedi cai d								
8.00	8.00		, 9									
State Children's Health Insurance Program (SCHIP) (see instructions for each line) 9.00	State Children State Sta			line 7 min	us sum of li	nes 2 and 5: if						
State Children's Heal th Insurance Program (SCHIP) (see instructions for each Line) 0,00	State Children's Heal th Insurance Program (SCHIP) (see instructions for each Line) 9,00	0.00		TITIE / IIIII	ius suiii 01 11	nes 2 and 5, 11	٥	0.00				
9.00 Net revenue from stand-alone SCHIP charges 0 10.00 11.00 11.00 12.0	9.00 Not revenue from stand-al one SCHIP 0 0.00 11.0			ions for e	ach Line)							
10. 00 Stand-al one SCHIP charges 0 10. 00 11. 00 11. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 12. 00 12. 00 12. 00 13. 00 13. 00 13. 00 14. 00 16.	10. 00 Stand-al one SCHIP charges 0 10. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 12. 00 12. 00 12. 00 13. 00 13. 00 13. 00 14. 00 15.	9.00			,		0	9. 00				
12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 14.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 0 14.00 15.00 State or local indigent care program cost (line 1 times line 14) 0 15.00 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 18.10 State or local indigent care program cost (line 1 times line 14) 0 16.00 19.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 19.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 19.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 19.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 19.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 19.00 Total unrel mbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 0 19.00 19.00 Total unrel mbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 0 19.00 19.00 Total initial obligation of patients approved for charity care (at full 154,097 0 154,097 0 154,097 20.00 10.00 Cost of initial obligation of patients approved for charity care (line 1 157,969 0 57,969 21.00 10.00 Cost of initial obligation of patients approved for charity care (line 1 157,969 0 57,969 23.00 10.00 Cost of charity care (line 21 minus line 22) 57,969 0 57,969 23.00 10.00 Cost of charity care (line 21 minus line 22) 57,969 0 57,969 23.00 10.00 Cost of charity care (line 21 minu	12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero) Other state or local government indigent care program (see instructions for each line) 13.00						0					
12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero) Other state or local government indigent care program (see instructions for each line) 13.00 14.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 0 14.00 15.00 State or local indigent care program cost (line 1 times line 14) 0 15.00 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 18.10 State or local indigent care program cost (line 1 times line 14) 0 16.00 19.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 19.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 19.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 19.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 19.00 Private grants, donations, or endowment income restricted to funding charity care 0 17.00 19.00 Total unrel mbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 0 19.00 19.00 Total unrel mbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 0 19.00 19.00 Total initial obligation of patients approved for charity care (at full 154,097 0 154,097 0 154,097 20.00 10.00 Cost of initial obligation of patients approved for charity care (line 1 157,969 0 57,969 21.00 10.00 Cost of initial obligation of patients approved for charity care (line 1 157,969 0 57,969 23.00 10.00 Cost of charity care (line 21 minus line 22) 57,969 0 57,969 23.00 10.00 Cost of charity care (line 21 minus line 22) 57,969 0 57,969 23.00 10.00 Cost of charity care (line 21 minu	12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero) Other state or local government indigent care program (see instructions for each line) 13.00	11.00	Stand-alone SCHIP cost (line 1 times line 10)				0	11. 00				
Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included in lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0 14.00 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 17.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 18. if < zero then enter zero) Uncompensated care (see instructions for each line) 19. Oo Rovernment grants, appropriations or transfers for support of hospital operations 19. Oo Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 0 19.00 20. Oo Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 0 19.00 20. Oo Total initial obligation of patients approved for charity care (at full 1 154,097 0 154,097 20.00 20. Oo Total initial obligation of patients approved for charity care (at full 1 154,097 0 154,097 20.00 20. Oo Partial payment by patients approved for charity care (line 1 1 57,969 0 57,969 21.00 21. Oo Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indige	Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included in lines 2, 5 or 9) 0 13.00 14.00 15.00	12.00		(line 11 m	ninus line 9;	if < zero then	0	12.00				
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 15.00 State or local indigent care program cost (line 1 times line 14) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 liference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 liference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 liference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 liference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 liference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 liference	13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 0 13.00 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10) 14.00 15.00 State or local indigent care program cost (line 1 times line 14) 0 15.00 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 13: if < zero then enter zero) Uncompensated care (see instructions for each line)		enter zero)									
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24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 1,025,169 1,025,169 1,083,138 30.00	24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 1,025,169 1,025,169 1,083,138 20.00						,					
imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 25.00 3, 137, 075 26.00 27.00 411, 917 27.00 29.00 2, 725, 158 1, 025, 169 29.00 1, 083, 138 30.00	imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 25.00 3, 137, 075 26.00 411, 917 27.00 27.25, 158 28.00 2, 725, 158 29.00 1, 025, 169 29.00 1, 083, 138 30.00						1. 00					
25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 25.00 3, 137, 075 26.00 27.00 2, 725, 158 28.00 1, 025, 169 29.00 1, 083, 138 30.00	25.00 If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 25.00 3, 137, 075 26.00 27.00 27.00 27.00 27.25, 158 28.00 1, 025, 169 29.00 1, 083, 138 30.00	24.00			ond a Length	of stay limit		24. 00				
26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 3, 137, 075 411, 917 27.00 2, 725, 158 28.00 1, 025, 169 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1, 083, 138 3, 137, 075 26.00 411, 917 27.00 1, 025, 169 29.00 1, 083, 138 30.00	26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 3, 137, 075 26.00 411, 917 27.00 2, 725, 158 28.00 1, 025, 169 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1, 083, 138 30.00											
27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 411, 917 27.00 2,725, 158 28.00 1,025, 169 29.00 1,083, 138 30.00	27.00 Medicare bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 411,917 27.00 2,725,158 28.00 1,025,169 29.00 1,083,138 30.00				5	th of stay limit						
28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 2,725,158 28.00 1,025,169 29.00 1,083,138 30.00	28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 2, 725, 158 28.00 1, 025, 169 29.00 1, 083, 138 30.00			,								
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 1,025,169 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1,083,138 30.00	29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) 1,025,169 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1,083,138 30.00				07							
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1,083,138 30.00	30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 1,083,138 30.00					- 20)						
				ense (IIne	e i times iin	e 28)						
	31. 00 Total uniterimbulsed and uncompensated care cost (Trie 19 plus Trie 30)			no 20)								
1,000,100 1		51.00	Trocal and enhanced and ancompensated care cost (Title 14 bids 11	110 30)			1,005,150	31.00				

Heal th	Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2015 To 12/31/2015	Date/Time Pre 5/27/2016 2:3	
	Cost Center Description	Sal ari es	Other	Total (col.	Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS		0.000.100			0.000.400	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	077 407	2, 380, 409			2, 380, 409	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	277, 127	2, 920, 531			3, 198, 039	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 926, 053	1, 599, 867			3, 571, 827	5.00
7. 00	00700 OPERATION OF PLANT	206, 370	548, 999			756, 683	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 50, 260	50, 260	1
9.00	00900 HOUSEKEEPI NG	256, 765	135, 606			342, 111	9.00
10.00	01000 DI ETARY	315, 991	231, 626			157, 995	•
11.00	01100 CAFETERI A	0	0		0 389, 622	389, 622	11.00
13. 00	01300 NURSING ADMINISTRATION	191, 013	2, 909			147, 960	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	48, 295	81, 900			130, 006	•
16. 00	01600 MEDI CAL RECORDS & LI BRARY	321, 193	84, 588	405, 78	1 0	405, 781	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				.1		
30. 00	03000 ADULTS & PEDI ATRI CS	738, 083	64, 603	802, 68	6 -12, 373	790, 313	30. 00
F0 00	ANCILLARY SERVICE COST CENTERS	E 40, 0/E	0.40 507	005.05	05 000	040.040	F0 00
50.00	05000 OPERATI NG ROOM	542, 265	343, 587			849, 862	50.00
51.00	05100 RECOVERY ROOM	0	3, 550			37, 450	
53.00	05300 ANESTHESI OLOGY	7/0 07/	077, 404		0 0	1 720 000	53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	760, 276	976, 404		0 -5, 791	1, 730, 889	1
55.00	O5500 RADI OLOGY - THERAPEUTI C	F01 (2)	740 143		0	1 220 0/5	00.00
60.00	06000 LABORATORY	591, 626	740, 162			1, 330, 865	
65. 00	06500 RESPIRATORY THERAPY	77, 277	17, 150			94, 418	ı
66. 00	06600 PHYSI CAL THERAPY	214, 042	96, 839			310, 384	•
67. 00	06700 OCCUPATI ONAL THERAPY	125, 748	146	·		125, 813	
68. 00	06800 SPEECH PATHOLOGY	47, 835	73	·		47, 908	
69. 00	06900 ELECTROCARDI OLOGY	169, 709	2, 701	172, 41		172, 070	•
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11, 692			89, 119	•
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	91, 399			91, 399	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	390, 263	3, 254, 094	3, 644, 35	7 -7, 528	3, 636, 829	73. 00
00 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	2 224 200	1 05/ 042	4 202 22	0.000	4 202 422	00.00
90. 00 91. 00	09100 EMERGENCY	3, 336, 290	1, 056, 042			4, 383, 423	90. 00 91. 00
		698, 864	1, 032, 927	1, 731, 79	-31, 417	1, 700, 374	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00	09500 AMBULANCE SERVICES	579, 410	59, 378	638, 78	8 -8, 107	630, 681	95. 00
73.00	SPECIAL PURPOSE COST CENTERS	377, 410	37, 370	030, 70	-0, 107	030, 001	73.00
118.00		11, 814, 495	15, 737, 182	27, 551, 67	7 813	27, 552, 490	118 00
110.00	NONREI MBURSABLE COST CENTERS	11,014,475	13, 737, 102	27, 551, 67	7 013	21, 332, 470	1110.00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0	0	192. 00
	19300 NONPALD WORKERS		0		o o		193. 00
	19301 FOUNDATION	57, 783	-8		-	57, 775	
	19302 OCCUPATIONAL MEDICINE	267, 957	15, 647			282, 791	
	07950 OTHER NONREIMBURSABLE COST CENTERS] = 0,7,07	0		0 0		194. 00
200.00	l l	12, 140, 235	15, 752, 821				
				, , , , , , , , ,	1		

Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 5/27/2016 2:32 pm

				5/27/2016 2:32 pm
	Cost Center Description	Adjustments	Net Expenses	
		(See A-8)	For Allocation	
		6.00	7.00	
	GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	-685, 763	1, 694, 646	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 913	3, 196, 126	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	-558, 155		5.00
7. 00	00700 OPERATION OF PLANT	-737	755, 946	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	50, 260	8.00
9. 00	00900 HOUSEKEEPI NG	-416	341, 695	9.00
10. 00	01000 DI ETARY	-1, 881	156, 114	10.00
11. 00	01100 CAFETERI A	-177, 794		11.00
			211, 828	
13.00	01300 NURSI NG ADMI NI STRATI ON	-513		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-98		14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-8, 013	397, 768	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00	03000 ADULTS & PEDIATRICS	-457	789, 856	30.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	-413, 442	436, 420	50.00
51.00	05100 RECOVERY ROOM	0	37, 450	51.00
53.00	05300 ANESTHESI OLOGY	0	o	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-595, 062	1, 135, 827	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	O	55. 00
60.00	06000 LABORATORY	-584	1, 330, 281	60.00
65. 00	06500 RESPIRATORY THERAPY	-6, 280		65. 00
66. 00	06600 PHYSI CAL THERAPY	-113	310, 271	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	125, 813	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	47, 908	68.00
69. 00	06900 ELECTROCARDI OLOGY	-42	172, 028	69.00
70.00	07000 ELECTROCARDI OLOGI	-42	172,028	70.00
70.00		1 14(70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-1, 146		
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	91, 399	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	-14, 190	3, 622, 639	73. 00
	OUTPATIENT SERVICE COST CENTERS	1		
90.00	09000 CLI NI C	-2, 650, 844		90.00
91. 00	09100 EMERGENCY	0	1, 700, 374	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0	630, 681	95. 00
	SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	-5, 117, 443	22, 435, 047	118.00
	NONREI MBURSABLE COST CENTERS			
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	192. 00
	19300 NONPALD WORKERS	0		193.00
	1 19301 FOUNDATION	0		193. 0
	19302 OCCUPATIONAL MEDICINE	o o		193. 02
	07950 OTHER NONREIMBURSABLE COST CENTERS	0		194.00
200.00	l l	-5, 117, 443	- 1	200. 00
250.00	1.01/12 (00m 01 211120 110 177)	0,117,745	22,775,015	μ200. οδ

Health Financial Systems RECLASSIFICATIONS RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 151304

| Peri od: | Worksheet A-6 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

						5/27/2016 2:32 pm
		Increases			 	
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00	 	
	A - LAUNDRY AND LINEN					
1.00	LAUNDRY & LINEN SERVICE		0	5 <u>0, 2</u> 60		1.00
	0		0	50, 260		
	B - DIETARY/ CAFETERIA					
1.00	CAFETERI A	11. 00	224, 823	16 <u>4, 7</u> 99		1.00
	0		224, 823	164, 799		
	C - MED SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	77, 427		1.00
	PATI ENTS					
2.00		0. 00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5. 00
6.00		0. 00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	o	0		9. 00
10.00		0.00	o	0		10.00
11.00		0.00	o	0		11. 00
12.00		0.00	o	0		12. 00
13.00		0.00	o	0		13. 00
14.00		0.00	o	0		14.00
15.00		0.00	o	0		15. 00
16.00		0.00	О	0		16. 00
				77, 427		
	D - AMBULANCE RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	425	0		1.00
2.00	OPERATION OF PLANT	7. 00	1, 314	0		2. 00
3.00	ADULTS & PEDIATRICS	30.00	497	0		3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	33	0		4. 00
5.00	LABORATORY	60.00	11	0		5. 00
6.00	PHYSI CAL THERAPY	66.00	11	0		6. 00
7.00	CLINIC	90.00	8	0		7. 00
8.00	EMERGENCY	91.00	1, 996	0		8. 00
			4, 295	0		
	E - SALARY RECLASS		<u> </u>			
1.00	RECOVERY ROOM	51.00	35, 990	0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	45, 962	0		2. 00
		+	81, 952	₀		
500.00	Grand Total: Increases		311, 070	292, 486		500. 00

Peri od: From 01/01/2015

						To 12/31/2015	Date/Time Prepared: 5/27/2016 2:32 pm
		Decreases		'			, c, 2, , 20 to 2: 02 piii
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref	.	
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - LAUNDRY AND LINEN	<u> </u>					
1.00	HOUSEKEEPI NG	9. 00	0	50, 260		0	1. 00
				50, 260		1	
	B - DIETARY/ CAFETERIA	•					
1.00	DI ETARY	10.00	224, 823	164, 799		0	1.00
			224, 823	164, 799		7	
	C - MED SUPPLY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		44		0	1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00		55		o	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00		189		o	3.00
4.00	ADULTS & PEDIATRICS	30.00		12, 870		o	4. 00
5.00	RECOVERY ROOM	51, 00		2, 090		o	5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00		5, 824		o	6. 00
7. 00	LABORATORY	60.00		934		0	7. 00
8.00	RESPIRATORY THERAPY	65. 00		9		0	8.00
9. 00	PHYSI CAL THERAPY	66.00		508		0	9. 00
10.00	OCCUPATI ONAL THERAPY	67. 00		81		0	10. 00
11. 00	ELECTROCARDI OLOGY	69.00		340		0	11. 00
12. 00	DRUGS CHARGED TO PATIENTS	73. 00		7, 528		0	12. 00
13. 00	CLINIC	90.00		8, 917		0	13.00
14. 00	EMERGENCY	91.00		33, 413		0	14. 00
15. 00	AMBULANCE SERVICES	95. 00		3, 812		0	15. 00
16. 00	OCCUPATIONAL MEDICINE	193. 02		813		o l	16. 00
10.00	O OVAL MEDICINE			 77, 4 27		9	10.00
	D - AMBULANCE RECLASS		٥	11, 421			
1.00	AMBULANCE SERVICES	95.00	4, 295	0		0	1.00
2.00	THIBDE WEE SERVI SES	0.00	1, 2,0	0		o o	2. 00
3. 00		0.00	o o	0		0	3.00
4. 00		0.00		0		0	4.00
5. 00		0.00		0		0	5. 00
6.00		0.00	0	0		0	6. 00
7. 00		0.00	0	0		0	7. 00
8. 00		0.00		0		0	8.00
0.00			4, 295	6		9	0.00
	E - SALARY RECLASS		4, 275		1		
1.00	OPERATING ROOM	50.00	35, 990	0		ol	1, 00
2.00	NURSING ADMINISTRATION	13. 00	45, 962	0		0	2.00
2.00	O ADMINISTRATION		4 <u>5, 962</u> 81, 952		 	4	2.00
500 00	Grand Total: Decreases		311, 070	292, 486		\dashv	500. 00
300.00	Joi and Total. Decleases		311,070	272, 400	1	I	500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS RUSH MEMORIAL HOSPITAL

Provider CCN: 151304

				T	o 12/31/2015	Date/Time Prep	pared:
						5/27/2016 2: 32	2 pm
			D 1	Acqui si ti ons	T	D	
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances 1, 00	2.00	3.00	4. 00	Retirements 5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		2.00	3.00	4.00	5.00	
1. 00	Land	188, 708	0			0	1. 00
				0	22 244		
2.00	Land Improvements	326, 007	32, 344		32, 344		2.00
3.00	Buildings and Fixtures	15, 659, 542	316, 572		316, 572		3. 00
4.00	Building Improvements	957	16, 602		16, 602		4. 00
5.00	Fi xed Equipment	823, 458	97, 679		97, 679		5. 00
6. 00	Movable Equipment	13, 471, 879	297, 690	0	297, 690		6. 00
7. 00	HIT designated Assets	0	0	0	0	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	30, 470, 551	760, 887	0	760, 887	37, 301	8. 00
9. 00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	30, 470, 551	760, 887	0	760, 887	37, 301	10. 00
		Endi ng Bal ance	Ful I y				
			Depreci ated				
			Assets				
		6. 00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	188, 708	0				1. 00
2.00	Land Improvements	358, 351	0				2. 00
3.00	Buildings and Fixtures	15, 976, 114	0				3.00
4.00	Building Improvements	17, 559	0				4.00
5.00	Fixed Equipment	921, 137	0				5.00
6.00	Movable Equipment	13, 732, 268	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	31, 194, 137	0				8. 00
9.00	Reconciling Items	o	0				9. 00
10.00	Total (line 8 minus line 9)	31, 194, 137	0			ļ	10.00
				•		'	

Heal th	Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lieu of Form CMS-2552-10			
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 Fo 12/31/2015		pared:	
		SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10.00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FLXT	1, 809, 479	0	295, 96	274, 962	0	1. 00	
3.00	Total (sum of lines 1-2)	1, 809, 479	0	295, 96	274, 962	0	3. 00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum					
		Capi tal -Relate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	2, 380, 409				1. 00	
3.00	Total (sum of lines 1-2)	0	2, 380, 409				3. 00	

Health Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
				From 01/01/2015 To 12/31/2015	Part III Date/Time Prep	nared:
				10 12/31/2013	5/27/2016 2: 32	
	COME	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
				5 (
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
		Leases	(col. 1 - col			
			2)	•		
	1. 00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0		0 1. 000000		1. 00
3.00 Total (sum of lines 1-2)	0	0		0 1.000000		3. 00
	ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)	0.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	6. 00	7. 00	8. 00	9. 00	10. 00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	INTERS	0		0 1, 176, 032	0	1. 00
3.00 Total (sum of lines 1-2)	0	0		0 1, 176, 032		3. 00
3.00 Total (Suill Of Titles 1-2)	0	SI SI	JMMARY OF CAPI		0	3.00
		00	Julius 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1712		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
	44.00	10.00	10.00	instructions)	45.00	
DADT III DECONCILIATION OF CADITAL COCTO OF	11.00	12.00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		274.042			1 (04 (4)	1 00
1.00 NEW CAP REL COSTS-BLDG & FIXT 3.00 Total (sum of lines 1-2)	243, 652 243, 652			0 0	1, 694, 646 1, 694, 646	1. 00 3. 00
3. 00 TOTAL (Sull OF TITLES 1-2)	243,032	214,902	l '	U _I U	1, 094, 040	3.00

| Peri od: | Worksheet A-8 | From 01/01/2015 | To 12/31/2015 | Date/Ti me Prepared: Provider CCN: 151304

Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
Cost Center Description		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - AFW CAP REL COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2) 3.00 Investment income - other (chapter 3) 3.00 Investment income - other (chapter 2) 3.00 Investment income - other (chapter 3) 3.00 Investment income - other (chapter 3) 3.00 Investment income - other (chapter 3) 3.00 Investment income - other (chapter 21) 3.00 Investment income - other (chapter 3) 3.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - AFW CAP REL COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2) 3.00 Investment income - other (chapter 3) 3.00 Investment income - other (chapter 2) 3.00 Investment income - other (chapter 3) 3.00 Investment income - other (chapter 3) 3.00 Investment income - other (chapter 3) 3.00 Investment income - other (chapter 21) 3.00 Investment income - other (chapter 3) 3.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - OFF REL COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - Other (chapter 2) 3.00 Investment income - Other (chapter 2) 3.00 Investment income - Other (chapter 2) 4.00 Trade, quantity, and time (discounts (chapter 8) 5.00 Refunds and rebates of expenses (chapter 8) 6.00 Rental of provider space by suppliers (chapter 8) 7.00 Telephone services (pay stations excluded) (chapter 2) 7.00 Telephone services (pay stations excluded) (chapter 2) 7.00 Provider-based physician adjustment 7.00 Provider-based physician adjustment 7.00 Sale of scrap, waste, etc. (chapter 21) 7.00 Related organization transactions (chapter 10) 7.00 Related organization transactions (chapter 10) 7.00 Related organization 7.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2) 3.00 Investment income - CAP REL COSTS-MBLE EQUIP (chapter 2) 0.00	Ref.	
20	0	1. 00
2.00 Investment Income - CAP REL COST-SMMBLE EQUIP (chapter 2) Cost-SMMBLE EQUIP (chapter 3) Cost-SMMBLE EQUIP (chapter 2) Cost-SMMBLE EQUIP (chapter 2) Cost-SMMBLE EQUIP (chapter 21) Cost-SMMBLE EQUIP (chapter 21) Cost-SMMBLE EQUIP (chapter 23) Cost-SMMBLE EQUIP (chapter 24) Cost-SMM		
1.00 1.00	0	2. 00
Chapter 2 Trade, quantity, and time discounts (chapter 8)	0	3. 00
discounts (chapter 8) Refunds and rebates of expenses (chapter 8) 0 0 0 0 0 0 0 0 0		
Section Refunds and rebates of expenses (chapter 8) Composition	0	4. 00
6.00 Rental of provider space by suppliers (chapter 8) 0 0.00 7.00 Telephone services (pay stations excluded) (chapter 21) 0.00 9.00 Television and radio service (chapter 21) 0.00 9.00 Parking lot (chapter 21) 0.00 9.00 Provider-based physician adjustment 0.00 10.00 Provider-based physician adjustment 0.00 10.00 A-8-2 -3,664,465 10.00 A-8-1 0.00 10.00 A-8-1 0.00 10.00 Chapter 23) 0.00 10.00 Chapter 23) 0.00 10.00 Cafeteria-employees and guests 0.00 10.00 Cafeteria-employees and surgical 0.00 10.00 Cafeteria-employees 0.00 10.0	О	5. 00
Suppliers (chapter 8) Telephone services (pay stations excluded) (chapter 21) 0.00	0	6. 00
stations excluded) (chapter 21)		7 00
8.00 Television and radio service (chapter 21) 9.00 Parking lot (chapter 21) 10.00 Provider-based physician adjustment 11.00 Sale of scrap, waste, etc. (chapter 23) 12.00 Related organization transactions (chapter 10) 13.00 Laundry and linen service 14.00 Cafeteria-employees and guests 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of furups to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing school (tuition, fees, books, etc.) 20.00 Vending machines 21.00 Income from imposition of interest, finance or penal ty charges (chapter 21) 11.00 Cafeteria-employees on the chapter of the chapt	0	7. 00
(chapter 21) Park ing lot (chapter 21) Provi der-based physician adj ustment 11.00 Sale of scrap, waste, etc. (chapter 23) 12.00 Related organization Transactions (chapter 10) Laundry and linen service 14.00 Cafeteria-employees and guests 0 0 0.00 Cafeteria-employees of o 0.00 Cafeteria-employees o 0 0	0	8. 00
10.00 Provider-based physician adjustment 11.00 Sale of scrap, waste, etc. (chapter 23) 12.00 Related organization A-8-1 13.00 Laundry and Linen service 14.00 Cafeteria-employees and guests 15.00 Rental of quarters to employee and others 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing school (tuition, fees, books, etc.) 20.00 Vending machines 10.00 Income from imposition of interest, finance or penal ty charges (chapter 21) 10.00 Interest expense on Medicare overpayments	٩	
adjustment Sale of scrap, waste, etc. (chapter 23) 12.00 Related organization transactions (chapter 10) 13.00 Laundry and linen service 0 0 0.00 14.00 Cafeteria-employees and guests 0 0 0.00 15.00 Rental of quarters to employee and others 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing school (tuition, fees, books, etc.) 20.00 Vending machines 10.00 Income from imposition of interest, finance or penalty charges (chapter 21) 10.00 Interest expense on Medicare overpayments 10.00 Very on the type of t	0	
(chapter 23) Related organization transactions (chapter 10) 13.00 Laundry and linen service 0 0.00 14.00 Cafeteria-employees and guests 0 0.00 15.00 Rental of quarters to employee and others 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing school (tuition, fees, books, etc.) 20.00 Vending machines 10.00 Laundry and lines 10.00 Laundry and lines 10.00 Laundry and lines 10.00 Laundry and lines 10.00 Laundry and lines and surgical supplies to other than patients 10.00 Laundry and lines and laundry and lines are considered and abstracts 10.00 Laundry and lines and laundry and lines are considered and laundry and lines are considered and laundry and lines are considered and laundry and lines and laundry and lines are considered and laundry and lines and laundry and lines are considered and laundry and lines and laundry	Ĭ	
12.00 Related organization transactions (chapter 10) Laundry and linen service 14.00 Cafeteria-employees and guests Rental of quarters to employee and others Rental of quarters to employee and others Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 18.00 Nursing school (tuition, fees, books, etc.) 20.00 Vending machines 10.00 Vending machines 10.00 Income from imposition of interest, finance or penal ty charges (chapter 21) 10.00 Vergay Medicare overpayments	0	11. 00
13. 00 Laundry and Linen service 14. 00 Cafeteria-employees and guests 15. 00 Rental of quarters to employee and others 16. 00 Sale of medical and surgical supplies to other than patients 17. 00 Sale of drugs to other than patients 18. 00 Sale of medical records and abstracts 19. 00 Nursing school (tuition, fees, books, etc.) 20. 00 Vending machines 10. 00 Vend	0	12. 00
14.00 Cafeteria-employees and guests Rental of quarters to employee and others 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing school (tuition, fees, books, etc.) 20.00 Vending machines 21.00 Income from imposition of interest, finance or penal ty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	13. 00
and others Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing school (tuition, fees, books, etc.) 20.00 Vending machines 10.00 11.00 Income from imposition of interest, finance or penal ty charges (chapter 21) 11.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	14.00
supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing school (tuition, fees, books, etc.) 20.00 Vending machines 10.00 Sale of medical records and substracts 10.00 Nursing school (tuition, fees, books, etc.) 10.00 Vending machines 10.00 Sale of medical records and substracts 10.00 Sale of medical reco	0	15. 00
patients Sale of drugs to other than patients 18.00 Sale of medical records and abstracts 19.00 Nursing school (tuition, fees, books, etc.) 20.00 Vending machines 10.00 11.00 Income from imposition of interest, finance or penalty charges (chapter 21) 11.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	16. 00
patients Sale of medical records and abstracts 19.00 Nursing school (tuition, fees, books, etc.) 20.00 Vending machines 11.00 Income from imposition of interest, finance or penalty charges (chapter 21) 11.10 Interest expense on Medicare overpayments Description: Output: Description: Output: Output:	_	
18.00 Sale of medical records and abstracts 19.00 Nursing school (tuition, fees, books, etc.) 20.00 Vending machines 11.00 Income from imposition of interest, finance or penalty charges (chapter 21) 11.10 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	17. 00
19.00 Nursing school (tuition, fees, books, etc.) 20.00 Vending machines 0 1.00 Income from imposition of interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare overpayments on the content of the conte	0	18. 00
20.00 Vending machines 0 0.00 21.00 Income from imposition of 0 0.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	19. 00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	20.00
charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 0 0 0.00	0	1
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		
repay Medicare overpayments	0	22. 00
23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 therapy costs in excess of		23. 00
limitation (chapter 14)		
24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 therapy costs in excess of		24. 00
limitation (chapter 14)		
25. 00 Utilization review - 0 *** Cost Center Deleted *** 114. 00 physicians' compensation		25. 00
(chapter 21)		24 00
26. 00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 1.00 FLXT FLXT FLXT FLXT COSTS-BLDG & 1.00 COSTS-B	0	26. 00
27. 00 Depreciation - CAP REL O*** Cost Center Deleted *** 2.00 COSTS-MVBLE EQUIP	0	27. 00
28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00		28. 00
29. 00 Physici ans' assistant 0 0.00 0.00 30. 00 Adjustment for occupational A-8-3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	29. 00 30. 00
therapy costs in excess of		55.00
limitation (chapter 14) 30.99 Hospice (non-distinct) (see		30. 99
i nstructi ons)		
31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 pathology costs in excess of		31.00
limitation (chapter 14) 32.00 CAH HIT Adjustment for A -633,447 NEW CAP REL COSTS-BLDG & 1.00	9	32. 00
Depreciation and Interest FIXT	7	
33. 00 CAFETERI A B -87, 931 CAFETERI A 11. 00	1	33. 00

Provi der CCN: 151304 ADJUSTMENTS TO EXPENSES Peri od: Worksheet A-8 From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

				To	o 12/31/2015	Date/Time Pre 5/27/2016 2:3	pared: 2 pm
				Expense Classification on	Worksheet A	372172010 2.3	Z piii
				To/From Which the Amount is			
	Cook Cooker Doorsinties	D: - (01- (2)	A ±	Cook Cooker	1: "	WI+ A 7 D-6	
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
34. 00	JAIL MEALS	B		CAFETERI A	11. 00	0.00	34.00
35. 00	VENDING MACHINES	B		ADMINISTRATIVE & GENERAL	5. 00	l ő	
37. 00	SALE OF DRUGS	В		DRUGS CHARGED TO PATIENTS	73. 00	0	1
38. 00	PHYSICIAN APPLICATION FEES	В		ADMINISTRATIVE & GENERAL	5. 00	0	
39.00	NSF FEES	В	-25	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	39. 00
40.00	MEDICAL RECORDS TRANSCRIPTION	В	-5, 613	MEDICAL RECORDS & LIBRARY	16. 00	0	40. 00
	FEES						
41. 00	COPI ER FEES	В		ADMINISTRATIVE & GENERAL	5. 00	0	
42.00	ATHLETIC TRAINER - SCHOOL REV	В		ADMI NI STRATI VE & GENERAL	5. 00	0	
42. 01	WELLNESS PROGRAM	В		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	
45. 00 45. 02	SALE OF SCRAP MISC. INCOME	B B		RADIOLOGY-DIAGNOSTIC EMPLOYEE BENEFITS DEPARTMENT	54. 00 4. 00	0	45. 00 45. 02
45. 02	MI SC. I NCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	45. 02
45. 04	MISC. INCOME	В		DI ETARY	10. 00	0	45. 04
45. 05	MISC. INCOME	В		MEDICAL RECORDS & LIBRARY	16. 00	0	45. 05
45. 06	MISC. INCOME	В		PHYSI CAL THERAPY	66.00	0	45. 06
45. 07	INTEREST INCOME	A		NEW CAP REL COSTS-BLDG &	1. 00	11	1
				FLXT			
45.08	TELEPHONE SALARY	A	-4, 393	ADMINISTRATIVE & GENERAL	5. 00	0	45. 08
45. 09	TELEPHONE OTHER	A	-992	ADMINISTRATIVE & GENERAL	5. 00	0	45. 09
45. 10	TELEPHONE BENEFITS	A	-697	ADMINISTRATIVE & GENERAL	5. 00	0	45. 10
45. 11	ADVERTI SI NG	В	-181, 399	ADMINISTRATIVE & GENERAL	5. 00	0	45. 11
45. 12	REBATE	В		ADMINISTRATIVE & GENERAL	5. 00	0	45. 12
45. 13	REBATES	В		OPERATION OF PLANT	7. 00	0	
45. 14	REBATES	В		HOUSEKEEPI NG	9.00	0	45. 14
45. 15	REBATES	B B		DI ETARY	10.00	0	45. 15 45. 16
45. 16 45. 17	REBATES REBATES	В		NURSING ADMINISTRATION ADULTS & PEDIATRICS	13. 00 30. 00	0	45. 16
45. 17	REBATES	В		OPERATING ROOM	50. 00 50. 00	0	45. 17
45. 19	REBATES	В		RADI OLOGY-DI AGNOSTI C	54.00	0	45. 19
45. 20	REBATES	В		LABORATORY	60. 00	o o	45. 20
45. 25	REBATES	В		ELECTROCARDI OLOGY	69. 00	0	
45. 26	REBATES	В		DRUGS CHARGED TO PATIENTS	73.00	0	45. 26
45. 29	REBATES	В	-98	CENTRAL SERVICES & SUPPLY	14. 00	0	45. 29
46.00	IHA & AHA LOBBYING	A	-3, 058	ADMINISTRATIVE & GENERAL	5. 00	0	46. 00
46. 01	HAF EXPENSE	A	-296, 157	ADMINISTRATIVE & GENERAL	5. 00	0	46. 01
46. 03	PHYSICIAN RECRUITMENTS	A		ADMINISTRATIVE & GENERAL	5. 00	0	46. 03
46. 04	MASSAGE REVENUE	В		PHYSI CAL THERAPY	66. 00	0	46. 04
46. 05	SAFE SITTER CLASS FEES	В		ADMI NI STRATI VE & GENERAL	5. 00	0	46. 05
46. 06	SI LVER RECOVERY	В		RADI OLOGY-DI AGNOSTI C	54.00	0	46. 06
46. 07	SALE OF SUPPLIES	В	-1, 146	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00	0	46. 07
46. 09	OTHER ADJUSTMENTS (SPECIFY)		0	le l	0.00	0	46. 09
40. 09	(3)		Ü		0.00	0	40.09
46. 10	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	46. 10
	(3)					_	
46. 11	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	46. 11
	(3)						
46. 12	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	46. 12
	(3)						.,
46. 13	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	46. 13
16 11	(3)		^		0.00	0	16 11
46. 14	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	l "	46. 14
46. 15	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	46. 15
10. 10	(3)		0		5.00		10. 10
50.00	TOTAL (sum of lines 1 thru 49)		-5, 117, 443				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)	1					

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

						0 12/31/2015	5/27/2016 2:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	50. 00	OPERATING ROOM	437, 374	412, 969	24, 405	0	0	1. 00
2.00	54. 00	RADI OLOGY-DI AGNOSTI C	619, 372	594, 372	25, 000	0	0	2. 00
3.00	60. 00	LABORATORY	36, 000	0	36, 000	0	0	3. 00
4.00	90. 00	CLINIC	3, 161, 527	2, 650, 844	510, 683	0	0	4. 00
5.00	91. 00	EMERGENCY	960, 133	0	960, 133	0	0	5. 00
6.00	65. 00	RESPI RATORY THERAPY	6, 280	6, 280	0	0	0	6. 00
7.00	0.00		0	0		0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00			5, 220, 686	3, 664, 465	1, 556, 221		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13.00	14. 00	
1.00		OPERATING ROOM	0		_	_		
2.00		RADI OLOGY-DI AGNOSTI C	0			0	1	
3.00		LABORATORY	0	0	0	0	0	0.00
4.00		CLINIC	0	0	0	0	0	1
5. 00		EMERGENCY	0	0	0	0	0	0.00
6. 00		RESPI RATORY THERAPY	0	0	0	0	0	6. 00
7.00	0. 00		0	0	0	0	0	1
8.00	0. 00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	7.00
10. 00	0. 00		0	0	0	0	0	1
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		OPERATI NG ROOM	13.00			412, 969		1. 00
2. 00		RADI OLOGY-DI AGNOSTI C		1	_	594, 372	•	2. 00
3. 00		LABORATORY			_	074, 372		3. 00
4. 00		CLI NI C				2, 650, 844		4. 00
5. 00		EMERGENCY				2,030,044		5. 00
6. 00		RESPI RATORY THERAPY				6, 280		6.00
7. 00	0.00	NEOF TRANSPORT			0	0, 200		7. 00
8. 00	0.00				0	0		8. 00
9. 00	0.00				0	0		9.00
10. 00	0.00				0	0		10.00
200.00	3.00		0		· ·	3, 664, 465		200.00
200.00	!		1	1		5,55.,100	1	1 =00.00

Provider CCN: 151304 | Period: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				To	12/31/2015	Date/Time Pre 5/27/2016 2:3	
			CAPI TAL			372772010 2.3	Z piii
			RELATED COSTS				
	Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		for Cost	FLXT	BENEFITS		& GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		col . 7)	1.00	4.00			
	CENEDAL CEDIU CE COCT CENTEDO	0	1.00	4. 00	4A	5. 00	
1.00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT	1, 694, 646	1, 694, 646				1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 196, 126					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	3, 013, 672			3, 809, 671	3, 809, 671	5. 00
7. 00	00700 OPERATION OF PLANT	755, 946			955, 432		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	50, 260			55, 884		8.00
9. 00	00900 HOUSEKEEPING	341, 695			438, 586		9. 00
10. 00	01000 DI ETARY	156, 114			233, 655		10.00
11. 00	01100 CAFETERI A	211, 828			290, 217		11.00
13. 00	01300 NURSING ADMINISTRATION	147, 447	11, 686		198, 368		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	129, 908			180, 538		14. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	397, 768			511, 783		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	0,,,,,,,	2,7,101	00,00.	011,700	102,001	
30. 00	03000 ADULTS & PEDIATRICS	789, 856	117, 847	199, 781	1, 107, 484	222, 459	30. 00
	ANCILLARY SERVICE COST CENTERS		· ·			<u> </u>	
50.00	05000 OPERATING ROOM	436, 420	103, 140	136, 944	676, 504	135, 889	50. 00
51.00	05100 RECOVERY ROOM	37, 450	11, 933	9, 735	59, 118	11, 875	51.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 135, 827	144, 145	205, 659	1, 485, 631	298, 417	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
60.00	06000 LABORATORY	1, 330, 281	39, 542		1, 529, 857		60.00
65. 00	06500 RESPI RATORY THERAPY	88, 138			111, 530		65. 00
66. 00	06600 PHYSI CAL THERAPY	310, 271	70, 248		438, 419		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	125, 813	1		176, 776		67. 00
68. 00	06800 SPEECH PATHOLOGY	47, 908			64, 514		68. 00
69. 00	06900 ELECTROCARDI OLOGY	172, 028			225, 572		1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	-	0	1	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	87, 973			87, 973		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	91, 399	l .		91, 399		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 622, 639	6, 765	105, 564	3, 734, 968	750, 241	73. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	1, 732, 579	466, 488	902, 448	3, 101, 515	622, 998	90.00
91.00	09100 EMERGENCY	1, 700, 374			1, 963, 260		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,700,374	73,300	109, 370	1, 403, 200		92.00
72.00	OTHER REIMBURSABLE COST CENTERS				0		72.00
95. 00	09500 AMBULANCE SERVICES	630, 681	24, 322	155, 565	810, 568	162, 818	95. 00
70.00	SPECIAL PURPOSE COST CENTERS	000,001	21,022	100,000	010,000	102,010	70.00
118.00		22, 435, 047	1, 686, 932	3, 120, 670	22, 339, 222	3, 722, 013	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	0			0		192. 00
193.00	19300 NONPALD WORKERS	0	0	0	0	0	193. 00
	19301 FOUNDATI ON	57, 775			78, 174		•
	19302 OCCUPATIONAL MEDICINE	282, 791	2, 945	72, 481	358, 217		
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	-	194. 00
200.00	3				0		200. 00
201.00			0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	22, 775, 613	1, 694, 646	3, 208, 781	22, 775, 613	3, 809, 671	202. 00

| Peri od: | Worksheet B | From 01/01/2015 | Part | | To 12/31/2015 | Date/Time Prepared:

				10) 12/31/2015	5/27/2016 2:3	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	Z piii
	oost content boson per on	PLANT	LINEN SERVICE	HOUSEREEFFING	DIEIMM	ON ETERIN	
		7. 00	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT	1, 147, 349					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	5, 057	72, 166				8. 00
9.00	00900 HOUSEKEEPI NG	24, 670					9. 00
10.00	01000 DI ETARY	47, 546			353, 883		10.00
11. 00	01100 CAFETERI A	15, 803	0		0	372, 184	
13. 00	01300 NURSI NG ADMI NI STRATI ON	10, 507	0		0	2, 122	
14. 00	01400 CENTRAL SERVICES & SUPPLY	33, 776	0		0	4, 244	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	24, 396			0	23, 553	1
	INPATIENT ROUTINE SERVICE COST CENTERS	2.17070		127	<u> </u>	20,000	1
30. 00	03000 ADULTS & PEDI ATRI CS	105, 957	47, 055	52, 752	353, 883	32, 253	30.00
00.00	ANCI LLARY SERVI CE COST CENTERS	100, 707	17,000	02,702	000, 000	02, 200	30.00
50.00	05000 OPERATING ROOM	92, 734	4, 723	46, 168	0	16, 127	50.00
51. 00	05100 RECOVERY ROOM	10, 729		1	0	4, 456	1
53. 00	05300 ANESTHESI OLOGY	0	0		0	.,	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	129, 602	3, 052	64, 523	0	37, 558	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0,002	0.,020	0	0.,000	55. 00
60.00	06000 LABORATORY	35, 552	0	17, 700	0	32, 465	
65. 00	06500 RESPI RATORY THERAPY	2, 238			0	4, 032	1
66. 00	06600 PHYSI CAL THERAPY	63, 161	1, 421		0	9, 761	1
67. 00	06700 OCCUPATI ONAL THERAPY	15, 239			0	5, 517	1
68. 00	06800 SPEECH PATHOLOGY	3, 297	28		0	424	1
69. 00	06900 ELECTROCARDI OLOGY	6, 868	ł .		0	6, 578	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	o o	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	l o	Ö	Ö	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	6, 082	0	3, 028	0	12, 095	73. 00
	OUTPATIENT SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,			-,		
90.00	09000 CLI NI C	419, 420	0	208, 812	0	109, 915	90.00
91.00	09100 EMERGENCY	65, 911	7, 484	32, 815	0	30, 343	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	'	•				1
95.00	09500 AMBULANCE SERVICES	21, 868	0	10, 887	0	38, 619	95. 00
	SPECIAL PURPOSE COST CENTERS						1
118.00		1, 140, 413	72, 166	552, 966	353, 883	370, 062	118. 00
	NONREI MBURSABLE COST CENTERS						1
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
193.00	19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01	19301 FOUNDATION	4, 288	0	2, 135	0	2, 122	193. 01
193. 02	19302 OCCUPATIONAL MEDICINE	2, 648	0	1, 318	0	0	193. 02
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	1, 147, 349	72, 166	556, 419	353, 883	372, 184	202. 00

				То	12/31/2015	Date/Time Pre 5/27/2016 2:3	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	MEDI CAL RECORDS & LI BRARY		Intern & Residents Cost & Post Stepdown Adjustments	Σ (Σ)
		13.00	14. 00	16. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSING ADMINISTRATION	256, 074					13.00
14. 00		250, 074	271, 638				14. 00
16. 00		0	1, 082	675, 761			16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	1,002	070,701			10.00
30. 00		64, 557	10, 838	290, 347	2, 287, 585	0	30. 00
	ANCILLARY SERVICE COST CENTERS	· · · · ·					
50.00	05000 OPERATING ROOM	32, 389	19, 807	63, 854	1, 088, 195	0	50. 00
51.00	05100 RECOVERY ROOM	8, 714	397	0	100, 631	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	13, 280	77, 312	2, 109, 375	0	54.00
55.00		0	0	0	0	0	55. 00
60.00	06000 LABORATORY	0	133, 490	0	2, 056, 365	0	60.00
65. 00		8, 025	1, 922	1, 432	153, 304	0	65. 00
66. 00		0	1, 779	0	634, 051	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	33	0	241, 314	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	82, 864	0	68. 00
69. 00		0	520	0	288, 267	0	69. 00
70.00		0	0 24 240	0	121 012	0	70.00
71. 00		0	26, 268	0	131, 912	0	71.00
72. 00 73. 00		4, 419	30, 999 2, 794	0	140, 757 4, 513, 627	0	72. 00 73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	4,419	2, 194	U	4, 313, 627	U	73.00
90. 00		O	12, 999	0	4, 475, 659	0	90. 00
91. 00		60, 712	10, 121	242, 816	2, 807, 820	0	91.00
92. 00		00,712	10, 121	212,010	2,007,020	0	92. 00
	OTHER REIMBURSABLE COST CENTERS	1	<u></u>				
95. 00		77, 258	3, 190	0	1, 125, 208	0	95. 00
	SPECIAL PURPOSE COST CENTERS	,					
118. 0	SUBTOTALS (SUM OF LINES 1-117)	256, 074	269, 519	675, 761	22, 236, 934	0	118. 00
	NONREI MBURSABLE COST CENTERS						
192. 0	0 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
	0 19300 NONPALD WORKERS	0	0	0	0		193. 00
	1 19301 FOUNDATI ON	0	0	0	102, 422		193. 01
	2 19302 OCCUPATIONAL MEDICINE	0	2, 119	0	436, 257		193. 02
	0 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 00
200.0		_	_]	_	0		200. 00
201. 0	1 1 9	0	0	0	0		201. 00
202. 0	0 TOTAL (sum lines 118-201)	256, 074	271, 638	675, 761	22, 775, 613	0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS RUSH MEMORIAL HOSPITAL Provider CCN: 151304

			5/27/2016 2	2: 32 pm
	Cost Center Description	Total		
		26.00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL			5. 00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10. 00
11. 00	01100 CAFETERI A			11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY			14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDI ATRI CS	2, 287, 585		30. 00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATI NG ROOM	1, 088, 195		50. 00
51. 00	05100 RECOVERY ROOM	100, 631		51. 00
53. 00	05300 ANESTHESI OLOGY	0		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 109, 375		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		55. 00
60. 00	06000 LABORATORY	2, 056, 365		60. 00
65. 00	06500 RESPI RATORY THERAPY	153, 304		65. 00
66. 00	06600 PHYSI CAL THERAPY	634, 051		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	241, 314		67. 00
68. 00	06800 SPEECH PATHOLOGY	82, 864		68. 00
69. 00	06900 ELECTROCARDI OLOGY	288, 267		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	131, 912		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	140, 757		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 513, 627		73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	4 475 (50		
	09000 CLI NI C	4, 475, 659		90.00
91. 00	09100 EMERGENCY	2, 807, 820		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
05 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES	1, 125, 208		95. 00
95.00	SPECIAL PURPOSE COST CENTERS	1, 125, 208		95.00
118. 00		22, 236, 934		118. 00
118.00	NONREI MBURSABLE COST CENTERS	22, 230, 934		118.00
102 00	19200 PHYSI CLANS' PRI VATE OFFI CES	0		192. 00
	1	0		1
	19300 NONPALD WORKERS 19301 FOUNDATION	102, 422		193. 00 193. 01
	19301 POUNDATION 19302 OCCUPATIONAL MEDICINE	436, 257		193. 01
	07950 OTHER NONREIMBURSABLE COST CENTERS	430, 257		193. 02
200.00				200. 00
200.00	, ,			200.00
201.00		22, 775, 613		201.00
202.00		22, 113, 013		1202.00

Provider CCN: 151304 | Period: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				To	12/31/2015	Date/Time Pre 5/27/2016 2:3	
			CAPI TAL			3/2//2010 2.3	Z pili
			RELATED COSTS				
	Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
		Assigned New	FIXT		BENEFI TS	& GENERAL	
		Capi tal			DEPARTMENT		
		Related Costs	4.00	2.1			
	CENEDAL CEDVICE COCT CENTEDS	0	1. 00	2A	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	12, 655	12, 655	12, 655		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	0	262, 581	262, 581	2, 104	264, 685	5.00
	00700 OPERATION OF PLANT	0	143, 309		222	13, 334	7. 00
	00800 LAUNDRY & LINEN SERVICE	0	5, 624		0		8. 00
9. 00	00900 HOUSEKEEPI NG	0	27, 438		274	6, 121	9. 00
10.00	01000 DI ETARY	0	52, 881	52, 881	97	3, 261	10.00
11.00	01100 CAFETERI A	0	17, 576		240		11. 00
13.00	01300 NURSING ADMINISTRATION	0	11, 686	11, 686	155	2, 768	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	37, 566	37, 566	52	2, 520	14. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	27, 134	27, 134	343	7, 142	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	117, 847	117, 847	788	15, 456	30. 00
	ANCILLARY SERVICE COST CENTERS			1			
50. 00	05000 OPERATI NG ROOM	0	103, 140		540		50.00
51.00	05100 RECOVERY ROOM	0	11, 933		38		51.00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0		53. 00
54. 00 55. 00	05400 RADI OLOGY THERAPELITIC	0	144, 145	144, 145	811 0	20, 733	54. 00 55. 00
60.00	05500 RADI OLOGY-THERAPEUTI C 06000 LABORATORY	0	39, 542	39, 542	631	0 21, 351	60.00
65. 00	06500 RESPI RATORY THERAPY	0	2, 489		82	1, 557	65.00
66. 00	06600 PHYSI CAL THERAPY	0	70, 248		228	6, 119	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	16, 949		134	2, 467	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	3, 667		51	900	1
69. 00	06900 ELECTROCARDI OLOGY	0	7, 639		181	3, 148	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1, 228	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1, 276	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 765	6, 765	416	52, 122	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	466, 488		3, 558		90. 00
	09100 EMERGENCY	0	73, 308		748	27, 399	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0			92. 00
05.00	OTHER REIMBURSABLE COST CENTERS		0.4.000	04.000	(4.4	44 040	05.00
95. 00	09500 AMBULANCE SERVICES	0	24, 322	24, 322	614	11, 312	95. 00
110 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	0	1 (0(022	1 (0(022	12, 307	250 505	110 00
118. 00	NONREIMBURSABLE COST CENTERS		1, 686, 932	1, 686, 932	12, 307	258, 595	1118.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	O	0	0	192. 00
	19300 NONPALD WORKERS		0		0		193. 00
	19301 FOUNDATION	0	4, 769	_	62	_	193. 01
	19302 OCCUPATIONAL MEDICINE		2, 945		286		193. 02
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 00
200.00	Cross Foot Adjustments			0			200. 00
201.00	Negative Cost Centers		0	0	0	0	201. 00
202.00	TOTAL (sum lines 118-201)	0	1, 694, 646	1, 694, 646	12, 655	264, 685	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 151304

From 01/01/2015 Part II Date/Time Prepared: 12/31/2015

5/27/2016 2:32 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE **PLANT** 7.00 9.00 10.00 11.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7 00 7 00 156, 865 00800 LAUNDRY & LINEN SERVICE 8.00 691 7,095 8.00 00900 HOUSEKEEPI NG 3, 373 498 37, 704 9.00 9.00 6,500 10.00 01000 DI ETARY 204 1, 604 64, 547 10.00 01100 CAFETERI A 24, 560 11.00 2, 161 C 533 11.00 01300 NURSING ADMINISTRATION 13.00 1, 436 354 140 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 4,618 C 1, 139 0 280 14.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 3, 335 Ω 823 0 1, 554 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 14, 486 4, 626 3, 575 64, 547 2, 128 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 50.00 12,679 464 3.128 0 1.064 51.00 05100 RECOVERY ROOM 1, 467 C 362 0 294 51.00 05300 ANESTHESI OLOGY 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 17, 719 2, 478 54.00 300 4, 372 05500 RADI OLOGY-THERAPEUTI C 55 00 C r Λ 55.00 60.00 06000 LABORATORY 4, 861 1, 199 2, 142 60.00 0 0 0 0 0 0 0 06500 RESPIRATORY THERAPY 65.00 306 60 76 266 65.00 06600 PHYSI CAL THERAPY 66.00 8,635 140 2, 131 644 66.00 67.00 06700 OCCUPATI ONAL THERAPY 2,083 64 514 364 67.00 68.00 06800 SPEECH PATHOLOGY 451 111 28 68.00 69.00 06900 ELECTROCARDI OLOGY 939 0 69.00 232 434 07000 ELECTROENCEPHALOGRAPHY 70 00 0 0 0 Λ 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 C 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 832 205 798 73.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 57, 344 14, 150 0 7, 256 90.00 09100 EMERGENCY 0 91.00 9,011 736 2, 224 2,002 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 2, 990 0 738 0 2, 548 95.00 SPECIAL PURPOSE COST CENTERS 155, 917 24, 420 118. 00 SUBTOTALS (SUM OF LINES 1-117) 7, 095 118.00 37, 470 64, 547 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 Ω 140 193. 01 193. 01 19301 FOUNDATION 586 0 145 0 193. 02 19302 OCCUPATIONAL MEDICINE 89 0 0 193. 02 362 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 o 0 194. 00 0 0 200 00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201. 00 156, 865 202.00 TOTAL (sum lines 118-201) 7, 095 37, 704 64, 547 24, 560 202. 00

Provider CCN: 151304 | Period: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				То	12/31/2015	Date/Time Pre 5/27/2016 2:3	
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	Subtotal	Intern &	
		ADMI NI STRATI ON	SERVICES &	RECORDS &		Residents Cost	
			SUPPLY	LI BRARY		& Post	
						Stepdown	
						Adjustments	
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	16. 00	24. 00	25. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSING ADMINISTRATION	16, 539					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	46, 175				14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	184	40, 515			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 170	1, 842	17, 408	246, 873	0	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 092	3, 367	3, 828	139, 743	0	50. 00
51.00	05100 RECOVERY ROOM	563	68	0	15, 550	0	51.00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0	2, 257	4, 635	197, 450	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	22 (02	0	02 410	0	55. 00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	518	22, 692 327	0 86	92, 418 5, 767	0	60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	310	302	0	88, 447	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	6	0	22, 581	0	67.00
68. 00	06800 SPEECH PATHOLOGY		0	0	5, 211	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY		88	0	12, 661	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	12, 001	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 465	0	5, 693	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	5, 270	0	6, 546	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	285	475	0	61, 898	0	73. 00
	OUTPATIENT SERVICE COST CENTERS				· '		
90.00	09000 CLI NI C	0	2, 210	0	594, 291	0	90. 00
91.00	09100 EMERGENCY	3, 921	1, 720	14, 558	135, 627	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	4, 990	542	0	48, 056	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		16, 539	45, 815	40, 515	1, 678, 812	0	118. 00
400.00	NONREI MBURSABLE COST CENTERS		0		ما		100.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	19300 NONPALD WORKERS	0	0	0	(702		193. 00
	1 19301 FOUNDATION		0	0	6, 793		193. 01 193. 02
	2 19302 OCCUPATIONAL MEDICINE 0 07950 OTHER NONREIMBURSABLE COST CENTERS		360 0	0	9, 041 0		193. 02
200.00		١	U	٥	٥		200.00
200.00			Ω	0	٥		200.00
202.00	1 9	16, 539	46, 175	40, 515	1, 694, 646		202.00
	1 - (1	. = ,	,	.,, 0.10	o o	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS RUSH MEMORIAL HOSPITAL Provider CCN: 151304

| Period: | Worksheet B | From 01/01/2015 | Part II | To | 12/31/2015 | Date/Time Prepared: | 5/27/2016 2:32 pm

			5/27/2016 2:	32 pm
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL			5. 00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11. 00
13.00	01300 NURSING ADMINISTRATION			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY			14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00		246, 873		30.00
00.00	ANCILLARY SERVICE COST CENTERS	2.10/070		- 55.55
50.00	05000 OPERATI NG ROOM	139, 743		50.00
51. 00	05100 RECOVERY ROOM	15, 550		51.00
53. 00	05300 ANESTHESI OLOGY	0		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	197, 450		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	177, 430		55. 00
60.00	06000 LABORATORY	92, 418		60.00
65. 00	06500 RESPIRATORY THERAPY	5, 767		65. 00
66. 00	06600 PHYSI CAL THERAPY	88, 447		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	1		67. 00
68. 00	06800 SPEECH PATHOLOGY	22, 581		68.00
69. 00	06900 ELECTROCARDI OLOGY	5, 211		
		12, 661		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 693		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	6, 546		72.00
73. 00		61, 898		73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	F04 004		
90.00	09000 CLI NI C	594, 291		90.00
91.00	09100 EMERGENCY	135, 627		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
05.00	OTHER REIMBURSABLE COST CENTERS	40.054		05.00
95.00	09500 AMBULANCE SERVICES	48, 056		95. 00
440.04	SPECIAL PURPOSE COST CENTERS	4 (70 040		
118.00		1, 678, 812		118. 00
102.00	NONREI MBURSABLE COST CENTERS			102.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0		192. 00
	19300 NONPAID WORKERS	0		193. 00
	1 19301 FOUNDATION	6, 793		193. 01
	2 19302 OCCUPATI ONAL MEDI CI NE	9, 041		193. 02
	07950 OTHER NONREIMBURSABLE COST CENTERS	0		194. 00
200.00	, ,	0		200. 00
201.00	1 9	0		201. 00
202. 00	TOTAL (sum lines 118-201)	1, 694, 646		202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 151304 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/27/2016 2:32 pm CAPI TAL RELATED COSTS Reconciliation ADMINISTRATIVE OPERATION OF Cost Center Description NEW BLDG & **EMPLOYEE** FIXT BENEFITS & GENERAL PLANT (SQUARE (SQUARE DEPARTMENT (ACCUM. FEET) (GROSS COST) FEET) SALARI ES) 1.00 5A 5. 00 7. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 89, 185 1 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 11, 862, 683 4.00 666 5.00 00500 ADMINISTRATIVE & GENERAL 13, 819 1, 972, 015 -3, 809, 671 18, 965, 942 5.00 00700 OPERATION OF PLANT 7 00 207, 684 955 432 67, 158 7 00 7 542 C 00800 LAUNDRY & LINEN SERVICE 8.00 296 0 55, 884 296 8.00 9.00 00900 HOUSEKEEPI NG 1.444 256, 765 0 438, 586 1,444 9.00 01000 DI ETARY 2,783 91, 168 0 233, 655 2, 783 10.00 10.00 01100 CAFETERI A 0 925 224, 823 290, 217 925 11 00 11 00 13.00 01300 NURSING ADMINISTRATION 615 145, 051 0 198, 368 615 13.00 01400 CENTRAL SERVICES & SUPPLY 0 180, 538 1, 977 14.00 1.977 48, 295 14.00 01600 MEDICAL RECORDS & LIBRARY <u>32</u>1, 193 16, 00 1, 428 0 511, 783 16, 00 1, 428 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 202 738, 580 0 1, 107, 484 6, 202 30.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 5, 428 5, 428 506, 275 676, 504 50.00 0 50.00 51.00 05100 RECOVERY ROOM 628 35, 990 0 59, 118 628 51.00 53.00 05300 ANESTHESI OLOGY 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 7,586 760, 309 0 1, 485, 631 7, 586 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 55, 00 0 1, 529, 857 60.00 06000 LABORATORY 2.081 591, 637 2,081 60.00 06500 RESPIRATORY THERAPY 0 111, 530 65.00 131 77, 277 131 65.00 06600 PHYSI CAL THERAPY 3, 697 214, 053 0 438, 419 3, 697 66.00 66.00 06700 OCCUPATIONAL THERAPY 892 125, 748 0 176, 776 892 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 193 47, 835 64, 514 193 68.00 06900 ELECTROCARDI OLOGY 69.00 402 169, 709 225, 572 402 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 C 0 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 C 87, 973 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 91, 399 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 356 390, 263 0 3, 734, 968 356 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 24, 550 3, 336, 298 0 3, 101, 515 24, 550 90.00 0 91.00 09100 EMERGENCY 3,858 700, 860 1, 963, 260 3,858 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 280 575, 115 0 810, 568 1, 280 95.00 SPECIAL PURPOSE COST CENTERS 118 00 SUBTOTALS (SUM OF LINES 1-117) 88, 779 11, 536, 943 -3, 809, 671 66, 752 118. 00 18, 529, 551 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 193. 01 19301 FOUNDATION 251 193. 01 251 57, 783 0 78 174 193. 02 19302 OCCUPATIONAL MEDICINE 155 267, 957 0 358, 217 155 193. 02 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 194.00 200.00 Cross Foot Adjustments 200. 00 Negative Cost Centers 201 00 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 694, 646 3, 208, 781 3, 809, 671 1, 147, 349 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 19.001469 0.270494 0.200869 17. 084324 203. 00 Cost to be allocated (per Wkst. B, 156, 865 204. 00 204.00 12, 655 264, 685 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.001067 0.013956 2. 335760 205. 00 11)

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 151304 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/27/2016 2:32 pm Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG LINEN SERVICE (MEALS ADMI NI STRATI ON (SQUARE (FTE'S) (POUNDS OF FEET) SERVED) LAUNDRY) (DI RECT NRSING HRS) 8.00 9.00 10.00 11.00 13.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 28, 495 8.00 8.00 00900 HOUSEKEEPI NG 2,000 9.00 65, 418 9 00 10.00 01000 DI ETARY 820 2, 783 100 10.00 11.00 01100 CAFETERI A 0 925 1, 754 11.00 C 01300 NURSING ADMINISTRATION 0 0 125.337 13 00 615 10 13 00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 1, 977 0 20 0 14.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1, 428 0 111 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 18, 580 100 152 31, 598 30 00 6, 202 30 00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 1,865 5, 428 0 76 15, 853 50.00 05100 RECOVERY ROOM 0 21 51 00 628 4.265 51 00 0 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 205 7, 586 0 177 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 0 0 0 06000 LABORATORY 2, 081 0 60 00 60 00 0 153 0 06500 RESPIRATORY THERAPY 0 65.00 240 131 19 3, 928 65.00 06600 PHYSI CAL THERAPY 66.00 561 3.697 46 0 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 258 892 26 0 67.00 06800 SPEECH PATHOLOGY 0 193 68 00 11 0 68 00 06900 ELECTROCARDI OLOGY 0 69.00 0 402 31 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 70.00 C 0 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 356 0 57 2, 163 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 24, 550 0 90.00 518 0 09100 EMERGENCY 2, 955 O 29, 716 91.00 3, 858 143 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 182 37, 814 95.00 1, 280 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)
NONREIMBURSABLE COST CENTERS 118.00 28, 495 65, 012 100 1, 744 125, 337 118. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 0 Ω 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 193. 01 19301 FOUNDATI ON 0 251 0 10 0 193. 01 193. 02 19302 OCCUPATI ONAL MEDI CI NE 0 0 193, 02 0 155 0 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194.00 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 353, 883 372, 184 256, 074 202. 00 202.00 Cost to be allocated (per Wkst. B, 72, 166 556, 419 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 2. 532585 8.505595 3, 538. 830000 212. 191562 2. 043084 203. 00 16, 539 204. 00 204.00 Cost to be allocated (per Wkst. B, 7,095 37, 704 64, 547 24, 560 Part II) 0. 131956 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 0.248991 0.576355 645.470000 14.002281 Π

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

| Peri od: | Worksheet B-1 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: Provider CCN: 151304

				Io	12/31/2015	5/27/2016 2:32 pm
	Cost Center Description	CENTRAL	MEDI CAL			972772010 2. 02 pm
	•	SERVICES &	RECORDS &			
		SUPPLY	LI BRARY			
		(COSTED	(TIME			
		REQUIS.)	SPENT)			
-	GENERAL SERVICE COST CENTERS	14. 00	16. 00			
	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
1	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
	00500 ADMINISTRATIVE & GENERAL					5. 00
4	00700 OPERATION OF PLANT					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
	00900 HOUSEKEEPI NG					9. 00
	01000 DI ETARY					10. 00
	01100 CAFETERI A					11. 00
	01300 NURSING ADMINISTRATION					13. 00
	01400 CENTRAL SERVICES & SUPPLY	800, 690	0.4.400			14.00
	01600 MEDICAL RECORDS & LIBRARY	3, 188	94, 400			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	31, 945	40, 560			30, 00
	ANCI LLARY SERVI CE COST CENTERS	31, 745	40, 500			30.00
	05000 OPERATI NG ROOM	58, 383	8, 920			50.00
	05100 RECOVERY ROOM	1, 171	0, 720			51.00
	05300 ANESTHESI OLOGY	0	0			53. 00
	05400 RADI OLOGY-DI AGNOSTI C	39, 145	10, 800			54. 00
	05500 RADI OLOGY-THERAPEUTI C	o	0			55. 00
	06000 LABORATORY	393, 486	0			60. 00
	06500 RESPI RATORY THERAPY	5, 665	200			65. 00
	06600 PHYSI CAL THERAPY	5, 243	0			66. 00
	06700 OCCUPATI ONAL THERAPY	96	0			67. 00
	06800 SPEECH PATHOLOGY	0	0			68.00
	06900 ELECTROCARDI OLOGY	1, 532	0			69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	77, 428	0			70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	91, 375	0			72.00
	07300 DRUGS CHARGED TO PATIENTS	8, 237	0			73.00
	OUTPATIENT SERVICE COST CENTERS	0,20,	<u> </u>			7 8. 88
	09000 CLI NI C	38, 316	0			90.00
	09100 EMERGENCY	29, 832	33, 920			91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVI CES	9, 402	0			95. 00
F	SPECIAL PURPOSE COST CENTERS	704 444	0.4.400			110.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	794, 444	94, 400			118. 00
	19200 PHYSICIANS' PRIVATE OFFICES	ol	0			192. 00
	19300 NONPALD WORKERS		0			193. 00
	19301 FOUNDATION		0			193. 01
	19302 OCCUPATIONAL MEDICINE	6, 246	0			193. 02
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0			194. 00
200.00	Cross Foot Adjustments					200. 00
201.00	Negative Cost Centers					201. 00
202. 00	Cost to be allocated (per Wkst. B,	271, 638	675, 761			202. 00
000 0-	Part I)	0 0000==	7 450455			
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 339255	7. 158485			203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	46, 175	40, 515			204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 057669	0. 429184			205. 00
200.00	II)	0.037009	0. 427104			203.00
		' '				ı

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151304	Peri od: Worksheet C
		From 01/01/2015 Part I
		T- 10/01/001F D-+-/T: D

					To 12/31/2015	Date/Time Pre	pared:
						5/27/2016 2: 3	2 pm
			li ti	e XVIII	Hospi tal	Cost	1
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B, Part I, col.	Adj .		Di sal I owance		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30. 00	03000 ADULTS & PEDIATRICS	2, 287, 585		2, 287, 58	5 0	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 088, 195		1, 088, 19	5 0	0	50. 00
51.00	05100 RECOVERY ROOM	100, 631		100, 63	1 0	0	51.00
53.00	05300 ANESTHESI OLOGY	0			0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 109, 375		2, 109, 37	5 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0			0	0	55. 00
60.00	06000 LABORATORY	2, 056, 365		2, 056, 36	5 0	0	60.00
	06500 RESPI RATORY THERAPY	153, 304	(153, 30	4 0	0	65. 00
	06600 PHYSI CAL THERAPY	634, 051	(634, 05	1 0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	241, 314	(241, 31	4 0	0	67. 00
	06800 SPEECH PATHOLOGY	82, 864	(82, 86	4 0	0	68. 00
	06900 ELECTROCARDI OLOGY	288, 267		288, 26	7 0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	131, 912		131, 91	2 0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	140, 757		140, 75	7 0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	4, 513, 627		4, 513, 62	7 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	4, 475, 659	l e	4, 475, 65		0	1 ,0.00
	09100 EMERGENCY	2, 807, 820	l e	2, 807, 82		0	7 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	438, 679		438, 67	9	0	92. 00
	OTHER REIMBURSABLE COST CENTERS		1	1			
	09500 AMBULANCE SERVICES	1, 125, 208		1, 125, 20		ľ	70.00
200.00		22, 675, 613	•	22, 675, 61		l .	200. 00
201.00	l	438, 679	l	438, 67			201. 00
202.00	Total (see instructions)	22, 236, 934		22, 236, 93	4 0	0	202. 00

Health Financial Systems	RUSH MEMORIAL HOS	SPI TAL	In Lie	u of Form CMS-:	2552-10	
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 1	F	Period: From 01/01/2015 Fo 12/31/2015	Date/Time Pre	
		Title XVII	1	Hospi tal	5/27/2016 2:3 Cost	Ζ μιι
		harans		nospi tui	0031	

				'	0 12/31/2013	5/27/2016 2:3	2 pm
			Ti tl	e XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
	T	6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	2, 042, 529		2, 042, 529)		30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	238, 740	2, 444, 485				
51. 00	05100 RECOVERY ROOM	45, 280	775, 104	820, 384			51.00
53.00	05300 ANESTHESI OLOGY	0	0	(0. 000000	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	709, 492	16, 293, 487	17, 002, 979		0. 000000	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0. 000000		55. 00
60.00	06000 LABORATORY	800, 056	8, 974, 002				
65. 00	06500 RESPI RATORY THERAPY	88, 754	234, 859				
66. 00	06600 PHYSI CAL THERAPY	161, 291	1, 061, 660				
67. 00	06700 OCCUPATI ONAL THERAPY	134, 619	398, 790				67. 00
68. 00	06800 SPEECH PATHOLOGY	39, 140	82, 493			0. 000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	208, 884	2, 142, 412			0. 000000	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	۱ `	0.00000	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	184, 519	2, 182, 630				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	2, 035	160, 394				1
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 129, 057	8, 843, 633	9, 972, 690	0. 452599	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	258, 395					90. 00
91. 00	09100 EMERGENCY	91, 245	5, 612, 679	5, 703, 924		0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	38, 216	640, 670	678, 886	0. 646175	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	778				0. 000000	
200.00	,	6, 173, 030	52, 938, 397	59, 111, 427	7		200. 00
201.00							201. 00
202.00	Total (see instructions)	6, 173, 030	52, 938, 397	59, 111, 427	'		202. 00

Health Financial Systems	RUSH MEMORIAL H	In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151304		From 01/01/2015	Worksheet C Part I Date/Time Prep 5/27/2016 2:32	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				

		Title XVIII	Hospi tal	Cost	Pili
Cost Center Description	PPS Inpatient		<u> </u>		
· ·	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			,	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			,	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 000000				90.00
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES	0.000000				95.00
200.00 Subtotal (see instructions)				2	00.00
201.00 Less Observation Beds				2	01.00
202.00 Total (see instructions)				2	02.00

Health Financial Systems	RUSH MEMORIAL HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN	: 151304	From 01/01/2015	Worksheet C Part I Date/Time Pre 5/27/2016 2:3	
	,	Title >	X I X	Hospi tal	Cost	

					10 12/31/2015	5/27/2016 2:3	
			Ti t	le XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	2, 287, 585		2, 287, 58	5 0	2, 287, 585	30. 00
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATING ROOM	1, 088, 195		1, 088, 19		1, 088, 195	
51.00	05100 RECOVERY ROOM	100, 631		100, 63	0	100, 631	
53.00	05300 ANESTHESI OLOGY	0		0 400 07	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 109, 375		2, 109, 37	0	2, 109, 375	
55.00	05500 RADI OLOGY - THERAPEUTI C	0		0.057.07	0	0	00.00
60.00	06000 LABORATORY	2, 056, 365		2, 056, 36		2, 056, 365	
65.00	06500 RESPI RATORY THERAPY	153, 304	0	153, 30		153, 304	
66.00	06600 PHYSI CAL THERAPY	634, 051	0	634, 05		634, 051	1
67. 00	06700 OCCUPATI ONAL THERAPY	241, 314		241, 31		241, 314	
68.00	06800 SPEECH PATHOLOGY	82, 864	0	82, 86		82, 864	
69.00	06900 ELECTROCARDI OLOGY	288, 267		288, 26	0	288, 267	
70.00	07000 ELECTROENCEPHALOGRAPHY	101 010		404 04	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	131, 912		131, 91:		131, 912	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	140, 757		140, 75		140, 757	
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 513, 627		4, 513, 62	/ 0	4, 513, 627	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	4 475 (50		4 475 75		4 475 (50	00 00
90.00	09000 CLINIC	4, 475, 659		4, 475, 65		4, 475, 659	1
91.00	09100 EMERGENCY	2, 807, 820		2, 807, 820		2, 807, 820	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	438, 679		438, 67	7	438, 679	92.00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	1 125 200		1 105 200		1 105 200	05 00
95.00		1, 125, 208		1, 125, 20		1, 125, 208	
200.00		22, 675, 613		22, 675, 613		22, 675, 613	
201.00		438, 679		438, 67		438, 679	
202.00	Total (see instructions)	22, 236, 934	0	22, 236, 93	4 O	22, 236, 934	1202.00

Health Financial Systems	RUSH MEMORIAL HOSPITAL				In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		F	Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/27/2016 2:3	pared: 2 pm
			Ti t	le XIX	Hospi tal	Cost	
		Cha	arges		·		
Cost Center Description	Inpati ent	Outp	ati ent	Total (col.	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
	6.00	7	00	8 00	9 00	10 00	

		lit	le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 042, 529		2, 042, 529			30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	238, 740	2, 444, 485	2, 683, 225	0. 405555	0. 000000	
51.00 05100 RECOVERY ROOM	45, 280	775, 104	820, 384	0. 122663	0. 000000	51.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0. 000000	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	709, 492	16, 293, 487	17, 002, 979	0. 124059	0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0. 000000	0. 000000	55. 00
60. 00 06000 LABORATORY	800, 056	8, 974, 002	9, 774, 058		0. 000000	
65. 00 06500 RESPIRATORY THERAPY	88, 754	234, 859	323, 613	0. 473726	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	161, 291	1, 061, 660	1, 222, 951	0. 518460	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	134, 619	398, 790	533, 409	0. 452400	0.000000	
68.00 06800 SPEECH PATHOLOGY	39, 140	82, 493			0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	208, 884	2, 142, 412	2, 351, 296	0. 122599	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0. 000000	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	184, 519	2, 182, 630	2, 367, 149	0. 055726	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 035	160, 394	162, 429	0. 866576	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 129, 057	8, 843, 633	9, 972, 690	0. 452599	0.000000	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	258, 395	2, 175, 344	2, 433, 739		0.000000	
91. 00 09100 EMERGENCY	91, 245	5, 612, 679	5, 703, 924	0. 492261	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	38, 216	640, 670	678, 886	0. 646175	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	778	915, 755			0. 000000	
200.00 Subtotal (see instructions)	6, 173, 030	52, 938, 397	59, 111, 427			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	6, 173, 030	52, 938, 397	59, 111, 427			202. 00

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 151304	Peri od: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prep 5/27/2016 2:32	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				

		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10							2552_10
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		CCN: 151304	Peri od:	Worksheet D	2002 10	
					From 01/01/2015 To 12/31/2015		narod:
	5/27/2016 2:32						2 pm
			Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	ANOUGH ARM OF DOOT OFFITTED	1.00	2.00	3. 00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	400.740	0 (00 005	0.05000	07.440	5.07/	F0 00
50.00	05000 OPERATI NG ROOM	139, 743					
51.00	05100 RECOVERY ROOM	15, 550	1				
53.00	05300 ANESTHESI OLOGY	107.450	-	1 0.0000		0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	197, 450					
55. 00	05500 RADI OLOGY-THERAPEUTI C 06000 LABORATORY	02.410	-	0.00000		0	55. 00
60. 00 65. 00	06500 RESPI RATORY THERAPY	92, 418		1		4, 197 794	60. 00 65. 00
66. 00		5, 767		1			66.00
67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	88, 447 22, 581		1			
68. 00	06800 SPEECH PATHOLOGY	5, 211		1			68.00
69. 00	06900 ELECTROCARDI OLOGY	12, 661	2, 351, 296	1			
70. 00	07000 ELECTROCARDI OLOGI	12,001	2, 331, 290	0.00000		023	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 693	2, 367, 149	1			
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	6, 546		1			
	07300 DRUGS CHARGED TO PATIENTS	61, 898					73.00
70.00	OUTPATIENT SERVICE COST CENTERS	01,070	7,772,070	0.00020	020, 721	0,271	70.00
90.00	09000 CLI NI C	594, 291	2, 433, 739	0. 24418	18 0	0	90.00
91. 00	09100 EMERGENCY	135, 627					
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	56, 780					
	OTHER REIMBURSABLE COST CENTERS		3.07000				1
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50-199)	1, 440, 663	56, 152, 365		1, 791, 094	26, 452	200. 00

llool +h	Financial Systems	DUCU MEMODI AL	LIOCDI TAI		ما ا ما	u of Form CMC	DEED 10
APPORT	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER TH COSTS	RUSH MEMORIAL VICE OTHER PASS		CCN: 151304	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
			Ti +I	e XVIII	Hospi tal	5/27/2016 2: 3 Cost	z piii
	Cost Center Description	Non Physician N Anesthetist Cost				Total Cost (sum of col 1	
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0	0		0 0	0	50. 00
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	54. 00 55. 00
60.00	06000 LABORATORY	0	0		0	0 0	60.00
65. 00	06500 RESPIRATORY THERAPY		0		0	0	65.00
66. 00	06600 PHYSI CAL THERAPY		0		0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY		0			0	67.00
68. 00	06800 SPEECH PATHOLOGY	o o	0		0 0	Ö	68. 00
69. 00	06900 ELECTROCARDI OLOGY	o o	0		0 0	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	o	0		o o	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	o	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	O	0		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90. 00
	09100 EMERGENCY	0	0		0 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	0	1	0 0	0	200. 00

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10							
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	VICE OTHER PAS	S Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Pre 5/27/2016 2:3	
			Ti tl	e XVIII	Hospi tal	Cost	<u> </u>
	Cost Center Description	Total	Total Charges			Inpati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of				Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS		T	T			
50. 00	05000 OPERATING ROOM	0	2, 683, 225	1		97, 462	
51. 00	05100 RECOVERY ROOM	0	820, 384			3, 919	
53. 00	05300 ANESTHESI OLOGY	0	0	0.0000			
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	17, 002, 979			342, 235	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000		0	
60.00	06000 LABORATORY	0	9, 774, 058			443, 929	
65. 00	06500 RESPI RATORY THERAPY	0	323, 613	1		44, 527	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	1, 222, 951			65, 356	
67. 00	06700 OCCUPATI ONAL THERAPY	0	533, 409			45, 329	
68. 00	06800 SPEECH PATHOLOGY	0	121, 633			17, 839	
69. 00	06900 ELECTROCARDI OLOGY	0	2, 351, 296				
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000			70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 367, 149				
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	162, 429			1, 955	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	9, 972, 690	0.00000	0. 000000	526, 921	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	,			0	
91. 00	09100 EMERGENCY	0	5, 703, 924			29, 770	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	678, 886	0.00000	0. 000000	0	92. 00
	OTHER REIMBURSABLE COST CENTERS		1	1			
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	56, 152, 365	1		1, 791, 094	200. 00

Health Financial Systems	RUSH MEMORIAL HOS	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 151304	Peri od: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Prepared: 5/27/2016 2:32 pm
		Ti +Lo VVIII	⊎osni tal	Cost

				10	12/31/2013	5/27/2016 2:3	
		Ti	tle XVIII		Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati en	t Outpatier	nt			
	Program	Program	Program				
	Pass-Through	Charges	Pass-Throu				
	Costs (col. 8		Costs (col				
	x col. 10)		x col. 12	2)			
	11.00	12. 00	13.00				
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0		0	0			50.00
51. 00 05100 RECOVERY ROOM	0		0	0			51.00
53. 00 05300 ANESTHESI OLOGY	0		0	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		O	0			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		O	0			55. 00
60. 00 06000 LABORATORY	0		O	0			60.00
65. 00 06500 RESPI RATORY THERAPY	0		O	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0		O	0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		O	0			67. 00
68. 00 06800 SPEECH PATHOLOGY	0		O	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		O	0			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		O	0			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		O	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0		0	0			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		0	0			73. 00
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0		O	0			90.00
91. 00 09100 EMERGENCY	0		0	0			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0			92. 00
OTHER REIMBURSABLE COST CENTERS	,						
95. 00 09500 AMBULANCE SERVICES			_				95. 00
200.00 Total (lines 50-199)	0		0	0			200.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | Part V | To | 12/31/2015 | Date/Time Prepared: | 5/27/2016 2:32 pm Health Financial Systems RUSH MEMORIA
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151304

			Ti tl	e XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1. 00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 405555	0	1, 235, 371	0	0	50.00
51.00 C	D5100 RECOVERY ROOM	0. 122663	0	190, 345	0	0	51.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0	C	0	0	53. 00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0. 124059	0	4, 909, 875	0	0	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	C	0	0	55. 00
60.00	06000 LABORATORY	0. 210390	0	3, 174, 202	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 473726	0	54, 116	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 518460	0	396, 302	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 452400	0	142, 902	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 681262	0	9, 610		0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 122599	0	884, 616		0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 055726	0	17, 871	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 866576	l o	42, 640	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 452599	l o	3, 418, 116	32, 976	0	73. 00
C	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	1. 839005	0	443, 843	0	0	90.00
91.00	09100 EMERGENCY	0. 492261	l o	1, 167, 915	4, 855	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 646175	0	134, 029	·	0	1
	OTHER REIMBURSABLE COST CENTERS					-	
	09500 AMBULANCE SERVICES	1. 227679		C			95. 00
200.00	Subtotal (see instructions)		0	16, 221, 753	37, 831	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program		_	0	0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 +/- line 201)	1	0	16, 221, 753	37, 831	0	202. 00
1	1	ļ	-	.,,	1		

Health Financial Systems	RUSH MEMORIAL HOS	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 151304	Peri od:	Worksheet D

From 01/01/2015 | Part V To 12/31/2015 | Date/Time Prepared: 5/27/2016 2:32 pm Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 501, 011 50.00 51.00 05100 RECOVERY ROOM 23, 348 0 51.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 609, 114 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 60.00 06000 LABORATORY 667.820 60.00 06500 RESPIRATORY THERAPY 0 25, 636 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 205, 467 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 64,649 67.00 06800 SPEECH PATHOLOGY 6,547 68 00 68 00 69.00 06900 ELECTROCARDI OLOGY 108, 453 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 996 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 36, 951 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 547, 036 14, 925 73.00 OUTPATIENT SERVICE COST CENTERS 816, 229 574, 919 90.00 09000 CLI NI C 90.00 09100 EMERGENCY 91.00 2, 390 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 86, 606 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 200.00 Subtotal (see instructions) 5, 274, 782 17, 315 200. 00 201.00 Less PBP Clinic Lab. Services-Program 201. 00

5, 274, 782

17, 315

202. 00

Only Charges

Net Charges (line 200 +/- line 201)

202.00

Health Financial Systems	RUSH MEMORIAL HOS	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151304	Peri od:	Worksheet D

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151304

Component CCN: 15Z304

Period:
From 01/01/2015
To 12/31/2015

Date/Time Prepared:
5/27/2016 2: 32 pm

Title XVIII Swing Beds - SNF Cost				Component	1 0011. 132304 1	0 12/31/2013	5/27/2016 2:3	
Cost Center Description Cost to Charge Ratio From Ratio From Ratio From Worksheet C, Part I, col. 9 Services (see inst.) Cost (see inst.)				Ti tl	e XVIII S	wing Beds - SNF	Cost	
Ratio From Worksheet C, Part I, col. 9 Services (See Inst.) Services (See Inst.) Services Subject To Ded. & Coins. (See Inst.) Ded.								
Worksheet C, Part I, col. 9 Inst.) Services Subject To Ded. & Coins. (see inst.)		Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
Part I, col. 9 Subject To Ded. & Coins. (see inst.)							(see inst.)	
Ded. & Coi ns. (see i nst.) Ded. & Coi ns. (see i nst.) Ded. & Coi ns. (see i nst.)								
ANCI LLARY SERVI CE COST CENTERS			Part I, col. 9					
1.00 2.00 3.00 4.00 5.00								
ANCILLARY SERVICE COST CENTERS								
50. 00 05000 OPERATI NG ROOM 0.4055555 0 0 0 0 50.00 51. 00 05100 RECOVERY ROOM 0.122663 0 0 0 0 51.00 53. 00 05300 ANESTHESI OLOGY 0.000000 0 0 0 0 55.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.124059 0 0 0 0 0 55.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 0 0 0 55.00 60. 00 06500 RADI OLOGY-THERAPEUTI C 0.000000 0<	lance	LLADY OFFICE OCCUPANTED	1.00	2.00	3.00	4. 00	5. 00	
51. 00 05100 RECOVERY ROOM 0. 122663 0 0 0 0 0 51. 00 53. 00 05300 ARESTHESI OLOGY 0. 000000 0 0 0 0 0 53. 00 054. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 124059 0 0 0 0 0 0 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 0 0 0				T _	1 -			
53. 00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.124059 0 0 0 0 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 55. 00 66. 00 06000 LABORATORY 0.210390 0						0	-	
54. 00						0	ŭ	
55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 55. 00 60. 00 06000 LABORATORY 0.210390 0 0 0 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.473726 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.518460 0 0 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.452400 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.681262 0 0 0 0 0 67. 00 69. 00 06900 ELECTROCARDI OLOGY 0.681262 0 0 0 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 70. 00 0 0 0 0 0 0 0 0 0 0 0 0 0						0	ŭ	
60. 00 06000 LABORATORY 0. 210390 0 0 0 0 60. 00 65. 00 65. 00 06500 RESPI RATORY THERAPY 0. 473726 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 518460 0 0 0 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 452400 0 0 0 0 0 0 0 0 0						0	0	
65. 00					9	0	0	
66. 00 06600 PHYSI CAL THERAPY 0. 518460 0 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0. 452400 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 681262 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0. 122599 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 0 0 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 055726 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 866576 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 452599 0 0 0 73. 00 0000 CLI NI C 0. 452599 0 0 74. 00 07000 CLI NI C 0. 452599 0 75. 00 07000 CLI NI C 0. 492261 0 0 0 76. 00 07000 07000 07000 07000 07000 77. 00 07000 07000 07000 07000 0 78. 00 07000 07000 07000 07000 79. 00 07000 07000 07000 07000 79. 00 07000 07000 07000 79. 00 07000 07000 07000 79. 00 07000 07000 07000 79. 00 07000 07000 79. 00 07000 07000 79. 00 07000 07000 79. 00 07000 07000 79. 00 07000 07000 79. 00 07000 79. 00 07000 07000 79. 00 79. 00					C	0	o o	
67. 00					C	0	ŭ	
68. 00 06800 SPEECH PATHOLOGY 0. 681262 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 122599 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 055726 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 866576 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 452599 0 0 0 73. 00 0000 CLINIC 0. 452599 0 0 0 74. 00 07000 CLINIC 0. 492261 0 0 0 75. 00 09200 08SERVATI ON BEDS (NON-DISTINCT PART) 0. 646175 0 0 0 75. 00 0 0 0 76. 00 0 0 77. 00 0 0 78. 00 0 0 79. 00 0 0 79. 00 0 0 79. 00 0 79. 00 0 79. 00 0 79. 00 0 79. 00 0 79. 00 0 79. 00 0 79. 00 0 79. 00 0 79. 00 0 79. 00 0 79. 00 79. 00 0 79. 00 79.) C	0	ŭ	
69. 00) c	0	ŭ	
70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 70.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 72.00		l control of the cont) c	0	ŭ	ı
71. 00		l control of the cont) c	0	-	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0.866576 0 0 0 0 72. 00 073. 00 07300 DRUGS CHARGED TO PATIENTS 0.452599 0 0 0 0 0 0 0 0 0					C	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 452599 0 0 0 0 0 73. 00 0 73. 00 0 0 0 73. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0	0	0	
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 1.839005 0 0 0 0 90.00 91. 00 09100 EMERGENCY 0.492261 0 0 0 0 91.00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0.646175 0 0 0 0 92.00					0	0		
90. 00			0. 452599	0	0	0	0	73. 00
91. 00 09100 EMERGENCY 0. 492261 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0. 646175 0 0 0 0 92. 00						,		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 646175 0 0 0 0 92. 00				0) c	0	-	
				0) c	0	-	1
OTHER REIMBURSABLE COST CENTERS			0. 646175	0	<u>C</u>	0	0	92. 00
				T	T	T. T.		
			1. 227679		C			
	200. 00			0) C	0	0	
	201. 00				0	0		201. 00
Only Charges				_	_	_	_	
202.00 Net Charges (line 200 +/- line 201) 0 0 0 0 0 202.00	202. 00	Net Charges (line 200 +/- line 201)		1 0	il C	0	0	J202. 00

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151304 From 01/01/2015 Part V

Component CCN: 157304 To 12/31/2015 Date/Time Prepared:

		Componer	nt CCN: 15Z3O4		12/31/2015	
		Ti t	le XVIII	Swi ng	Beds - SN	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOLLI ADV. CEDVI CE COCT CENTEDO	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	1					
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM		(0			50. 00 51. 00
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY						51.00
54. 00 05400 RADI OLOGY						54.00
55. 00 05500 RADI OLOGY - DI AGNOSTI C						55.00
		(60.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY						65. 00
66. 00 06600 PHYSI CAL THERAPY		(66.00
67. 00 06700 OCCUPATI ONAL THERAPY						67. 00
68. 00 06800 SPEECH PATHOLOGY		()				68.00
69. 00 06900 ELECTROCARDI OLOGY		()				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY						70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS						71.00
72. 00 07700 IMPL. DEV. CHARGED TO PATIENT			0			71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		1	0			73. 00
OUTPATIENT SERVICE COST CENTERS		1	<u> </u>			75.00
90. 00 09000 CLINIC	0	1	0			90.00
91. 00 09100 EMERGENCY			o			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		l .	0			92. 00
OTHER REIMBURSABLE COST CENTERS		1	-1			1
95. 00 09500 AMBULANCE SERVI CES	0)				95. 00
200.00 Subtotal (see instructions)	0		o			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						1
202.00 Net Charges (line 200 +/- line 201)	0)	o			202. 00

Health Financial Systems	RUSH MEMORIAL HOSE	PI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERA	ATING COST	Provi der CCN: 151304	From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Pre 5/27/2016 2:3	pared:
		Title XVIII	Hospi tal	Cost	
0 . 0 . 5 .					

		Title XVIII	Hospi tal	5/2//2016 2: 3: Cost	2 pm	
	Cost Center Description	TI LI C XVIII	nospi tai	0031		
				1. 00		
	PART I - ALL PROVIDER COMPONENTS					
1 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	avaludi na nawbarn)		2, 285	1. 00	
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-bed			2, 285 1, 887	2. 00	
3.00	Private room days (excluding swing-bed and observation bed days		vate room days.	0	3. 00	
0.00	do not complete this line.	, yeuve ey p	rato room dayor	· ·	0.00	
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		1, 453	4. 00	
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	373	5. 00	
/ 00	reporting period		11 -6		/ 00	
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	31 of the cost	0	6. 00	
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	25	7. 00	
	reporting period					
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 31	l of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)					
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	928	9. 00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII onli	v (including private ro	nom days)	361	10. 00	
10.00	through December 31 of the cost reporting period (see instruction		Join day 3)	00.	10.00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11. 00	
	December 31 of the cost reporting period (if calendar year, ent			_		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	room days)	0	13. 00	
13.00	after December 31 of the cost reporting period (if calendar yea				13.00	
14.00	Medically necessary private room days applicable to the Program			0	14.00	
15. 00	Total nursery days (title V or XIX only)		0	15. 00 16. 00		
16. 00	3 7 \ 37					
17. 00	SWING BED ADJUSTMENT Medicare rate for swing bod SNE services applicable to services	through Docombon 21 of	tho cost		17. 00	
17.00	00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period					
18.00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of 1	the cost		18. 00	
	reporting period					
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	129. 14	19. 00			
20. 00	Medicald rate for swing-bed NF services applicable to services	0.00	20. 00			
	reporting period					
21. 00	Total general inpatient routine service cost (see instructions)			2, 287, 585		
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	ng period (line	0	22. 00	
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	n period (line 6	0	23. 00	
20.00	x line 18)	. or the door roper tring	, po ou (o	· ·	20.00	
24. 00	Swing-bed cost applicable to NF type services through December:	31 of the cost reportir	ng period (line	3, 228	24. 00	
05 00	7 x line 19)	6.11			05.00	
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	or the cost reporting	period (iine 8	0	25. 00	
26. 00	Total swing-bed cost (see instructions)			380, 249	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost (ine 21 minus line 26)		1, 907, 336		
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)		28. 00	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000		
32. 00	Average private room per diem charge (line 29 ÷ line 3)	1116 20)		0.00		
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00		
34. 00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruct	tions)	0.00		
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00		
36.00	Private room cost differential adjustment (line 3 x line 35)				36. 00 37. 00	
37. 00						
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	TMENTS				
38. 00	Adjusted general inpatient routine service cost per diem (see in			1, 010. 78	38. 00	
39. 00	Program general inpatient routine service cost (line 9 x line 3	3)		938, 004	39. 00	
40. 00	Medically necessary private room cost applicable to the Program	•		0		
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		938, 004	41. 00	

Total Average Per Program (2011) 42.00 MIRSTRY (11 Ha V A XIX only) 1.00 2.00 3.00 4.00 5.00 43.00 MIRSTRY (11 Ha V A XIX only) 1.00 2.00 3.00 4.00 5.00 44.00 MIRSTRY (11 Ha V A XIX only) 1.00 2.00 3.00 4.00 5.00 45.00 MIRSTRY (11 Ha V A XIX only) 1.00 2.00 3.00 4.00 5.00 46.00 SURGICKA INTERING CARE Type Impatient Hisspital Biblits 1.00 2.00 3.00 4.00 5.00 47.00 MIRSTRY (11 Ha V A XIX only) 1.00 1.00 3.00 4.00 5.00 48.00 Program Inpatient and Hard (11 Ha		Financial Systems	RUSH MEMORIA				eu of Form CMS-2	
Cost Center Description Total Total Average Per Program Suys	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 151304		Worksheet D-1	
Cost Center Description Total Total Notice Appears Description Total Total Total Average Per Program Cost (col. 3 x col. 6 x x col. 1 col. 1 col. 2 x x x x col. 6 x x col. 1 col. 3 x col. 6 x x col. 1 col. 3 x col. 6 x x col. 1 col. 2 x x x x col. 2 x x x col. 2 x x x x col. 3 x col. 6 x x x col. 1 col. 2 x x x x col. 2 x col. 2 x x x col. 2 x x x x x col. 2 x x x x col. 2 x x x x x x col. 2 x x x x col. 2 x x x x x col. 2 x x x x x x x x x x x x x x x x x x							Date/Time Pre	pared:
Input ent Cost Empatient Days Diem (cell : 1 - cell : 3 - cell :				Ti t	le XVIII	Hospi tal	Cost	_ piii
1.00		Cost Center Description						
1.00 2.00 3.00 4.00 5.00			Inpatient Cost	Inpatient Days		÷		
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44.00 CoRDNARY CARE UNIT	43. 00							43.00
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instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) OPART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 + line 2) 77.00 Program capital -related costs (line 9 x line 76) 10 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70 Total Program routine service cost per diem limitation 82.00 Inpatient routine service cost per diem limitation (line 78 minus line 79) 83.00 Reasonable inpatient routine service (see instructions) 70 Program inpatient ancillary services (see instructions) 71 Program inpatient ancillary services (see instructions) 72 PROGRAM III Program inpatient operating costs (sum of lines 83 through 85) 73 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 74 Total observation bed days (see instructions)		instructions)(title XVIII only)	· ·		•			
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26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 76.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 10.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	74. 00							74. 00
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84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,010.78				* .				82. 00 83. 00
85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1.010.78				13)				84.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,010.78	85. 00	Utilization review - physician compensation	(see instruction					85. 00
87.00 Total observation bed days (see instructions) 434 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,010.78	86. 00			nrough 85)				86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,010.78	87. 00						434	87. 00
89 On The servation had cost (line 87 x line 88) (see instructions)	88. 00	Adjusted general inpatient routine cost per	diem (line 27 =				1, 010. 78	88. 00
436, 079	89. 00	Observation bed cost (line 87 x line 88) (see	e instructions))			438, 679	89.00

Health Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015	5	
				To 12/31/2015	Date/Time Prep 5/27/2016 2:3	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	246, 873	1, 907, 336	0. 12943	3 438, 679	56, 780	90. 00
91.00 Nursing School cost	0	1, 907, 336	0.00000	0 438, 679	0	91. 00
92.00 Allied health cost	0	1, 907, 336	0.00000	0 438, 679	0	92.00
93.00 All other Medical Education	0	1, 907, 336	0.00000	0 438, 679	0	93. 00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 151304	Peri od: From 01/01/2015	Worksheet D-1	
		To 12/31/2015	Date/Time Prep 5/27/2016 2:33	
	Title XIX	Hospi tal	Cost	
Cost Center Description				

DRILL FIGURE 100 CONSTRUCTION 1.00 1.0			Title XIX	Hospi tal	Cost	
Next I. ALL PROVIDER COMPONERS		Cost Center Description				
IMPARTENT DAYS 1.00 Impartient days (including private room days and swing-bed days: excluding newborn) 2.285 1.00 Impartient days (including private room days, excluding swing-bed and newborn days) 1.807 2.00 2.00 1.807 2.00		DART I ALL PROVIDED COMPONENTS			1. 00	
Impatient days (including private room days and saing-bed days, excluding neeborn)						
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 4.00 Somi-private room days (excluding swing-bed and observation bed days). 5.00 Total swing-bed SW type inpatient days (including private room days) through December 31 of the cost 375 5.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost 25 7.00 reporting period (if calendary year, enter 0 on this line). 7.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost 25 7.00 reporting period (if calendary year, enter 0 on this line). 7.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost 25 7.00 reporting period (if calendary year, enter 0 on this line). 8.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost 28 9.00 newborn days). 8.00 Total swing-bed W type inpatient days applicable to the Program (excluding swing-bed and newborn days). 8.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line). 8.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line). 8.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line). 8.00 Total swing-bed SW type inpatient days applicable to title V or XIX only (including private room days). 8.00 Total swing-bed SW type inpatient days applicable to title V or XIX only (including private room days). 8.00 Total swing-bed SW type inpatient days applicable to title V or XIX only (including private room days). 8.00 Total swing-bed SW type inpatient days applicable to title V or XIX only (including private room	1.00		excluding newborn)		2, 285	1. 00
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x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) O General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 910, 031 and 27 minus line 36) PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00	25 00		of the cost reporting a	ported (line 9	0	25 00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Frivate room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 910, 031) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 910, 031) 30.00 Average per diem private room cost differential (line 3, 9.00) 30.00 Average per diem private room cost differential (line 3, 9.00) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Averag	23.00		or the cost reporting p	perrou (Trile o	O	23.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 910, 031) 37. 00 General inpatient routine service cost per diem (see instructions) 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 28. 342 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 30.	26. 00	Total swing-bed cost (see instructions)				
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 + line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 910, 031) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 28.00 Average per diem private room cost applicable to the Program (line 14 x line 35) 28.00 Average per diem private room cost applicable to the Program (line 14 x line 35) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	27. 00		ine 21 minus line 26)		1, 910, 031	27. 00
29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1,910,031) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	28 00		and observation had char	rae)	0	28 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 910, 031) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			and observation bed char	i ges)		
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 910, 031) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 Program general inpatient routine service cost (line 9 x line 38) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00						
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 910, 031) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 33.00 37.00 35.00 37.00 35.00 37.00 36.00 37.00 37.00 37.00 37.00 37.00 37.00	31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	31.00
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 34.00 37.00 35.00 37.00 36.00 37.00 37.00 37.00 37.00 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 012.21 38.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 910, 031) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 012. 21 39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 35. 00 36. 00 37. 00 1, 910, 031 37. 00 37. 00 38. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 79.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 37.0	34.00			i ons)	0. 00	34.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) 1,012.21 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			31)		0. 00	
27 minus line 36) PART II - HOSPI TAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 28.342 40.00		,				
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,012.21 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 28,342 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00		d private room cost difi	ferential (line	1, 910, 031	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,012.21 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 28,342 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,012.21 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 28,342 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			TMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 28,342 39.00 40.00	38. 00				1, 012. 21	38. 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 28,342 41.00		1 3 3 1	,			
	41. 00	lotal Program general inpatient routine service cost (line 39 +	line 40)		28, 342	41. 00

COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 151304 Period: From 01/01/2015 To 12/31/2015 Title XIX Hospital Program Days Provider CCN: 151304 Period: From 01/01/2015 To 12/31/2015 Provider CCN: 151304 Period: From 01/01/2015 Period: From 01/01/2015 Provider CCN: 151304 Provider CCN: 151304		
Cost Center Description Total Total Average Per Inpatient Cost Inpatient Days Diem (col. 1 ÷ col. 2) 1.00 2.00 3.00 4.00	Date/Time Pre	
Cost Center Description Total Total Average Per Inpatient Cost Inpatient Days Diem (col. 1 ÷ col. 2) 1.00 2.00 3.00 4.00	1 3/2///////// / 3	pared:
Inpati ent Cost Inpati ent Days Di em (col. 1 ÷ col. 2)	Cost	<u> 2 piii</u>
1.00 2.00 3.00 4.00	Program Cost	
1.00 2.00 3.00 4.00	(col. 3 x col. 4)	
	5. 00	
42.00 NURSERY (title V & XIX only)		42. 00
Intensive Care Type Inpatient Hospital Units 43.00 INTENSIVE CARE UNIT	I	43.00
44. 00 CORONARY CARE UNIT		44. 00
45. 00 BURN INTENSIVE CARE UNIT		45. 00
46.00 SURGI CAL INTENSIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIFY)		46. 00 47. 00
Cost Center Description		47.00
	1. 00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	38, 403	1
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS	66, 745	1 49.00
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	0	50.00
	0	51.00
and IV)		31.00
52.00 Total Program excludable cost (sum of lines 50 and 51)	0	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53. 00
TARGET AMOUNT AND LIMIT COMPUTATION		1
54. 00 Program di scharges	0	
55.00 Target amount per discharge 56.00 Target amount (line 54 x line 55)	0.00	1
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	
58.00 Bonus payment (see instructions)	0	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59. 00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by	0	61. 00
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 (see instructions)		
62.00 Relief payment (see instructions)	0	62. 00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)	0	63. 00
PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	T 0	64.00
instructions) (title XVIII only)		01.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65. 00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For	0	66. 00
CAH (see instructions)		
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67. 00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
(line 13 x line 20)		
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	69.00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)		72. 00 73. 00
74. 00 Total Program general inpatient routine service costs (line 72 + line 73)		74. 00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		75. 00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77.00 Program capital-related costs (line 9 x line 76)		77. 00
78.00 Inpatient routine service cost (line 74 minus line 77)		78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		79.00
81.00 Inpatient routine service cost per diem limitation		81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions)		83.00
85.00 Utilization review - physician compensation (see instructions)		85. 00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)		86. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)	434	87. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1, 012. 21	88. 00
89.00 Observation bed cost (line 87 x line 88) (see instructions)	439, 299	89.00

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Prep 5/27/2016 2:3	
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	246, 873	1, 910, 031	0. 12925	1 439, 299	56, 780	90.00
91.00 Nursing School cost	0	1, 910, 031	0.00000	0 439, 299	0	91.00
92.00 Allied health cost	0	1, 910, 031	0.00000	0 439, 299	0	92.00
93.00 All other Medical Education	0	1, 910, 031	0. 00000	0 439, 299	0	93. 00

INPATIE	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151304	Peri od:	Worksheet D-3	
				From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/27/2016 2:3	
		Ti +I	e XVIII	Hospi tal	Cost	z piii
	Cost Center Description	11 (1	Ratio of Cos		Inpati ent	
	occi conton peron		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS			1, 188, 696		30.00
	ANCILLARY SERVICE COST CENTERS					4
	05000 OPERATING ROOM		0. 4055!			
	05100 RECOVERY ROOM		0. 1226		l e	
	05300 ANESTHESI OLOGY		0. 00000		0	
	05400 RADI OLOGY-DI AGNOSTI C		0. 1240!		l	
	05500 RADI OLOGY-THERAPEUTI C		0.0000		0	
	06000 LABORATORY		0. 2103			
	06500 RESPI RATORY THERAPY		0. 4737			
	06600 PHYSI CAL THERAPY		0. 5184			
	06700 OCCUPATI ONAL THERAPY		0. 45240			
	06800 SPEECH PATHOLOGY		0. 6812			
	06900 ELECTROCARDI OLOGY		0. 1225		1	
	07000 ELECTROENCEPHALOGRAPHY		0.00000		0	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT		0. 05572 0. 8665			
	07200 DRUGS CHARGED TO PATIENTS		0.8665			
	OUTPATIENT SERVICE COST CENTERS		0.4525	99 320, 921	230, 404	73.00
	09000 CLINIC		1. 83900	05 0	0	90.00
	09100 EMERGENCY		0. 4922			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6461		0	
	OTHER REIMBURSABLE COST CENTERS		0.0401	73 0		72.00
	09500 AMBULANCE SERVICES					95. 00
200.00	Total (sum of lines 50-94 and 96-98)		1	1, 791, 094	538, 135	
201.00	Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)	- (01)	1	1, 791, 094	l .	202. 00

Health Financial Systems RUSH MEMORIAL				eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151304	Peri od:	Worksheet D-3	
	Component	CCN: 15Z3O4	From 01/01/2015 To 12/31/2015	Date/Time Pre 5/27/2016 2:3	
	Ti tl	e XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1 00	0.00	2)	
INDATIENT DOUTINE CEDVICE COCT CENTEDO		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS		ı	0	I	20.00
ANCI LLARY SERVI CE COST CENTERS			0		30. 00
50. 00 05000 OPERATING ROOM		0. 4055	5, 793	2, 349	50.00
51. 00 05100 RECOVERY ROOM		0. 1226			51.00
53. 00 05300 ANESTHESI OLOGY		0. 0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1240			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000			55.00
60. 00 06000 LABORATORY		0. 2103		7, 423	
65. 00 06500 RESPIRATORY THERAPY		0. 4737			
66. 00 06600 PHYSI CAL THERAPY		0. 5184	· ·		
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4524	55, 515	25, 115	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 6812	52 12, 260	8, 352	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 1225	99 5, 734	703	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000	00	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0557	26 2, 089	116	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 8665		0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 4525	72, 581	32, 850	73. 00
OUTPAȚI ENT SERVI CE COST CENTERS					
90. 00 09000 CLI NI C		1. 8390			
91. 00 09100 EMERGENCY		0. 4922			91. 00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6461	75 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS		1		ı	
95. 00 09500 AMBULANCE SERVICES			000 000	444 705	95. 00
200.00 Total (sum of lines 50-94 and 96-98)	- (1: (3)		288, 239		
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		200 220		201. 00
202.00 Net Charges (line 200 minus line 201)		I	288, 239	I	202. 00

	Financial Systems ENT ANCILLARY SERVICE COST APPORTIONMENT	RUSH MEMORI AL HOSPI TAL	CCN: 151304	Peri od:	eu of Form CMS-2 Worksheet D-3	
INPAILE	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider		From 01/01/2015	worksneet D-3	
				To 12/31/2015		
					5/27/2016 2:3	2 pm
		Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	03000 ADULTS & PEDIATRICS			5, 311		30.00
	ANCILLARY SERVICE COST CENTERS			3, 311] 30.00
	05000 OPERATING ROOM		0. 40555	55 11, 864	4, 812	50.00
	05100 RECOVERY ROOM		0. 12266			51.00
	05300 ANESTHESI OLOGY		0. 00000		0	53.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 12405			54. 0
	05500 RADI OLOGY-THERAPEUTI C		0.00000		0	
	06000 LABORATORY		0. 21039		3, 645	
65. 00	06500 RESPI RATORY THERAPY		0. 47372		616	65.00
66. 00	06600 PHYSI CAL THERAPY		0. 51846	50 948	492	66.00
67. 00	06700 OCCUPATI ONAL THERAPY		0. 45240	00 854	386	67.0
68. 00	06800 SPEECH PATHOLOGY		0. 68126	52 116	79	68.00
69. 00	06900 ELECTROCARDI OLOGY		0. 12259		177	
70. 00	07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 05572		186	
	07200 IMPL. DEV. CHARGED TO PATIENT		0. 86657		0	1
	07300 DRUGS CHARGED TO PATIENTS		0. 45259	99 37, 816	17, 115	73.00
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C		1. 83900			
	09100 EMERGENCY		0. 49226	· ·		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 64617	75 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS		1		·	٠
	09500 AMBULANCE SERVICES			440		95. 0
200.00	Total (sum of lines 50-94 and 96-98)			112, 874		
201.00	Less PBP Clinic Laboratory Services-Pro	ogram only charges (line 61)		0	l	201. 0
202.00	Net Charges (line 200 minus line 201)		1	112, 874		202.00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15130	From 01/01/2015	Worksheet E Part B Date/Time Prepared: 5/27/2016 2:32 pm
•	T: 11 \0.0111	11 1 1	0 1

Mart B				10 12/31/2015	5/27/2016 2:3	
Deat B			Title XVIII	Hospi tal		<u> 2 piii </u>
PART 8 - JEDICAL AND OTHER REALTH SERVICES 5, 292,097 1.00						
Medical and other services (see instructions) 5,292,077 1.00					1. 00	
Medical and other services relinoursed under OPPS (see instructions)						
Description						•
0.00 0.01 in Payment (see Instructions) 0.000 5.00 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.000		· ·	ons)			•
Enter the hospital specific payment to cost ratio (see instructions)		1 1				•
Line 2 times line 5			i ana)			•
7.00 Sum of Time 3 plus line 4 divided by line 6 0.00 7.00 8.00 Transitional corridor payment (see instructions) 0 0.00 9.00 Ancillary service other pass through costs from Wkst. D. Pt. IV, col. 13, line 200 0 0.00 11.00 Total cost (sum of lines 1 and 10) (see instructions) 5,292,097 11.00 12.00 Ancillary service charges 5,292,097 11.00 12.00 Ancillary service charges 0 12.00 14.00 Intelligence of the payment (see instructions) 0 12.00 14.00 Intelligence of the payment (see instructions) 0 12.00 15.00 Agoregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 15.00 Amounts that mould have been nealized from patients liable for payment for services on a charge basis 0 15.00 17.00 Batic of Line 15 to Line 16 (not to exceed 1.00000) 94.31,313(e) 0 0.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 19.00 19.00 Excess of reasonabl			ions)			•
1 1 1 1 1 1 1 1 1 1						
9.00 Ancil lary service other pass through costs from West. D. Pt. IV, col. 13, line 200 0 , 9 , 0						1
10.00 Organ acquisitions 5, 292,097 11.00 Total cost (sum of lines 1 and 10) (see Instructions) 5, 292,097 11.00 COMPUTATION OF LESSER OF COST OR CHARCES			. col. 13. line 200			1
1.00 Total cost (sun of lines 1 and 10) (see instructions) 5,292,097 11.00			,			1
Reasonable charges	11.00	Total cost (sum of lines 1 and 10) (see instructions)			5, 292, 097	11. 00
2.00 Ancil lary service charges 0 12.00 101 101 102 103						
13.00 Organ acquisition charges (from West. D.4, Pt. III, col. 4, line 69)						
14.00 Total reasonable charges (sum of lines 12 and 13)			(0)			•
Customary charges			e 69)			
15.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 15.00	14.00				0	14.00
16.00 Amounts that would have been realized from patients iable for payment for services on a chargebasis nad such payment been made in accordance with 42 CFR 9413.13(e) 17.00 17.00 17.00 18.10 19.00 18.10 19.00 19	15 00		vment for services on a	charge hasis	0	15 00
had such payment been made in accordance with 42 CFR \$413.12(e)						•
17.00				g	_	
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 9. 00 19. 00	17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17. 00
Instructions	18. 00	Total customary charges (see instructions)			0	18. 00
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 0.00	19. 00		if line 18 exceeds lin	e 11) (see	0	19. 00
Instructions		· · · · · · · · · · · · · · · · · · ·		40) (
21. 00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 5, 345, 018 21. 00 22. 00	20.00		IT line ii exceeds iin	e 18) (see	0	20.00
22.00 Interns and residents (see instructions)	21 00	,	instructions)		5 345 018	21 00
23. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 23. 00		, ,	riisti deti olis)			1
Total prospective payment (sum of lines 3, 4, 8 and 9)		· · · · · · · · · · · · · · · · · · ·	ctions)			1
25.00 Deductibles and coinsurance (For CAH, see instructions) Deductibles and coinsurance relating to amount on line 24 (For CAH, see instructions) 2,590, 388 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 0 28.00 27.03, 119 27.00 28.00 29.00 ESRO direct medical education payments (From Wkst. E-4, line 50) 0 28.00 29.00 29.00 25			,		0	
26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 2,590,388 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see linstructions) 2,703,119 27.00 28.00 Direct graduate medical education costs (from Wkst. E-4, line 50) 0 28.00 30.00 Subtotal (sum of lines 27 through 29) 2,703,119 30.00 31.00 Primary payerr payments 2,702,123 30.00 32.00 Subtotal (line 30 minus line 31) 2,702,123 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 31.00 0 33.00 35.00 All lowable bad debts (see instructions) 618,269 34.00 36.00 All lowable bad debts (see instructions) 498,798 36.00 37.00 Subtotal (see instructions) 3, 103,998 37.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 3, 103,998 39.00 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.50 39.99 RECOVERY OF ACCELERATED DEPRECIATION 62,080<		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 1.703,119 27.00 1.705 1.7						1
Instructions Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28, 00 29, 00 29, 00 28, 00 29, 00 2						1
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00	27.00		us the sum of lines 22	and 23] (see	2, 703, 119	27.00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 30.00 Subtotal (sum of lines 27 through 29) 2,703, 119 30.00 31.00 Primary payer payments 99.03 31.00 32.00 Subtotal (line 30 minus line 31) 2,702, 123 32.00 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 618, 269 34.00 34.00 Allowable bad debts (see instructions) 618, 269 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 440, 873 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 498, 798 36.00 37.00 Subtotal (see instructions) 3, 103, 998 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instru	28 00		e 50)		0	28 00
30.00 Subtotal (sum of lines 27 through 29) 2,703,119 30.00 31.00 9rimary payer payments 2,702,123 31.00 31.		ESRD direct medical education costs (from Wkst E-4 line 36)	C 30)			
31.00						1
32.00 Subtotal (ine 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 410,875 35.00 Adjusted reimbursable bad debts (see instructions) 401,875 35.00 Adjusted reimbursable bad debts (see instructions) 401,875 35.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 498,798 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 3,103,998 37.00 39.00 MSP-LCC reconciliation amount from PS&R 0 39.00 MSP-LCC reconciliation amount from PS&R 0 39.00 39.50 99.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.50 99.90 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.90 39.90 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 99.90 ACCELERATED DEPRECIATION 0 39.99 40.00 40.01 40.00 40.01 40.00 40.01 40.00 40.01 40.00		,				1
33.00 Composite rate ESRD (from Wkst. I-5, line 11)	32.00				2, 702, 123	32. 00
34.00 Allowable bad debts (see instructions) 618,269 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 498,798 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 39.00 39.700 38.00 Subtotal (see instructions) 3,103,998 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 PRECOVERY OF ACCELLERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 3, 103,998 40.00 40.01 Interim payments 3, 103,998 40.00 42.00 Eacquestration adjustment (for contractors use only) -52,755 43.00 43.00 Balance due provider/program (see instructions) -52,755 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 52,755			S)			
35.00		1 '				•
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 42.00 Interim payments 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 91.00 40.00 Ovidier reconciliation adjustment amount (see instructions) 40.01 Ditter models amount (see instructions) 41.02 The rate used to calculate the Time Value of Money 42.03 Time Value of Money (see instructions) 43.04 Ovidier reconciliation adjustment amount (see instructions) 44.00 Time Value of Money (see instructions) 45.00 Time Value of Money (see instructions) 46.00 Ovidier reconciliation adjustment amount (see instructions) 47.00 Time Value of Money (see instructions) 48.00 Ovidier reconciliation adjustment amount (see instructions) 49.00 Time Value of Money (see instructions)						1
37. 00 Subtotal (see instructions) 3, 103, 998 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39. 50 99. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 99 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 3, 103, 998 40. 00 Sequestration adjustment (see instructions) 62, 080 40. 01 41. 00 Interim payments 3, 094, 673 41. 00 42. 00 43. 00 Bal ance due provider/program (see instructions) -52, 755 43. 00 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Time Value of Money (see instructions) 0 90. 00 93. 00 Time Value of Money (see instructions) 0 93. 00 93. 00 93. 00 10 10 10 10 10 10 10		, , , , , , , , , , , , , , , , , , ,	-+:>			•
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 Pioneer ACO demonstration payment adjustment (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 AU. 00 Subtotal (see instructions) 30.103,998 AU. 00 39.99 AU. 00 Subtotal (see instructions) 30.103,998 AU. 00 39.99 AU. 00 Subtotal (see instructions) 30.103,998 AU. 00 39.99 AU. 00 Subtotal (see instructions) 30.103,998 AU. 00 39.99 AU. 00 Subtotal (see instructions) 30.103,998 AU. 00 39.99 AU. 00 Subtotal (see instructions) 30.103,998 AU. 00 39.99 AU. 00 39.99 AU. 00 Subtotal (see instructions) 30.103,998 AU. 00 39.99 AU. 00 39.99 AU. 00 39.99 AU. 00 Subtotal (see instructions) 30.103,998 AU. 00 39.99 AU. 00 39.99 AU. 00 39.99 AU. 00 39.99 AU. 00 40.00 Subtotal (see instructions) 40.00 Footested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, au. 044.00 41.00 AU. 00			ctions)			•
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 Pioneer ACO demonstration payment adjustment (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 30.99 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 1, 00 1,		· · · · · · · · · · · · · · · · · · ·				
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50						1
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98		, , , ,				
39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 3,103,998 40.00 40.01 Sequestration adjustment (see instructions) 62,080 40.01 41.00 Interim payments 62,080 40.01 42.00 Tentative settlement (for contractors use only) 3,094,673 41.00 42.00 8al ance due provider/program (see instructions) -52,755 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 8115.2 0 44.00 8115.2 0 0 0 0 0 0 0 0 0			d devices (see instruct	i ons)		
40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)		·	•	,	0	39. 99
41.00 Interim payments 3,094,673 41.00 42.00 Tentative settlement (for contractors use only) 0 42.00 43.00 Balance due provider/program (see instructions) -52,755 43.00 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 5115.2	40.00	Subtotal (see instructions)			3, 103, 998	40. 00
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{115.2}{5115.2}\$ 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 42.00 44.00 45.00 46.00 47.00 48.00 49.00 49.00 49.00 40.00 40.00 41.00 42.00 42.00 42.00 42.00 43.00 44.00 44.00 44.00 45.00 45.00 46.00 47.00 47.00 48.00 49.00 99.00 99.00 99.00 99.00 99.00 99.00	40. 01	Sequestration adjustment (see instructions)			62, 080	40. 01
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)					3, 094, 673	•
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00		,				1
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)			o with CMC Duty 15 C	hantan 1		1
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 O 93.00	44.00		e with CMS Pub. 15-2, c	napter I,	0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00	90. 00				0	90.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 0 93.00		, ,				•
		The rate used to calculate the Time Value of Money			0.00	1
94.00 Total (sum of lines 91 and 93) 0 94.00		•				•
	94. 00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems RU-ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2015
To 12/31/2015 Part I
Date/Time Prepared: 5/27/2016 2: 32 pm Provider CCN: 151304

					5/27/2016 2: 32	2 pm
	· · · · · · · · · · · · · · · · · · ·		tle XVIII	Hospi tal	Cost	
		Inpati	ent Part A	Pai	^t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 278, 298	3	3, 037, 573	1. 00
2.00	Interim payments payable on individual bills, either		C)	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	08/11/2015	122, 700	08/11/2015	57, 100	3. 01
3. 02	NBSSTMENTS TO TROVIDER	00/11/2010	122,700		0	3. 02
3. 03				1	0	3. 03
3. 04					0	3. 04
3. 05					l o	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C)	0	3. 50
3.51)	0	3. 51
3.52					0	3. 52
3.53			C		0	3. 53
3.54			C)	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		122, 700)	57, 100	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 400, 998	3	3, 094, 673	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		C)	0	5. 01
5.02)	0	5. 02
5.03			C)	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C		0	5. 51
5. 52			C	1	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
	5. 50-5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER				0	6. 01
6. 02	SETTLEMENT TO PROGRAM		175, 871	1	52, 755	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 225, 127		3, 041, 918	
7.00	1.5 casar our o program Trability (see Thistractions)		1, 220, 127	Contractor	NPR Date	,.00
				Number	(Mo/Day/Yr)	
			0	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	· '			•	•	

Health Financial Systems RU-ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Title XVIII						5/27/2016 2: 3	2 pm
March Marc						Cost	
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1 1.00 1 1.00 1 1.00 1 1.00 1 1.00 1 1.00 1 1.00 1 1.00 1 1.00 1 1.00 1.00 1 1.00 1.00 1 1.00 1.00 1 1.00			Inpatier	nt Part A	Par	t B	
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero				2.00	3. 00	4. 00	
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	1.00			523, 92	7	0	1. 00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	2.00				C	0	2. 00
Write "NONE" or enter a zero 3 3 3 3 3 3 3 3 3		submitted or to be submitted to the contractor for					
List separately each retroactive lump sum adjustment and mount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		services rendered in the cost reporting period. If none,					
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3. 00
payment_If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider ADJUSTMENTS TO PROVIDER 08/11/2015 27,800 0 0 3 3 0 0 0 0 3 3							
ADJUSTMENTS TO PROVIDER							ļ
3.02 3.03 3.04 3.05 3.06 3.06 3.06 3.06 3.07	0.01		00 /44 /0045	07.00		0	0.04
3.03 0		ADJUSTMENTS TO PROVIDER	08/11/2015				3. 01
3.04 0 0 0 3 3.05					~	- 1	3. 02
3.05 Provider to Program 0				1			3. 03
Provider to Program 0				l	-		3. 04
3.50 ADJUSTMENTS TO PROGRAM	3.05	Don't don't a Discourse			J	0	3. 05
3.51 0	2 50			1	n	0	3. 50
3.52 3.53 3.54 3.59 3.50		ADJUSTNIENTS TO PROGRAM		II.			3.50
3.53 3.54 0 0 0 0 3 3 3.54 0 0 0 0 0 3 3 3.59 3.594 3.594 3.594 3.594 3.594 3.595 3.698 3.593 3.593 3.593 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 551,727 0 4 4					~	-	3. 52
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 551,727 0 4 4 4 4 4 4 4 4 4				l	-		3. 53
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 1.00					-	-	3. 54
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) Total interim payment (sum of lines 1, 2, and 3.99) Total interim payment (sum of lines 1, 2, and 3.99) Total interim payment (sum of lines 1, 2, and 3.99) Total interim payment (sum of lines 1, 2, and 3.99) Total interim payment (sum of lines 1, 2, and 3.99) Total interim payment (sum of lines 1, 2, and 3.99) Total interim payment (sum of lines 1, 2, and 3.99) Total interim payment (sum of lines 1, 2, and 3.99) Total interim payment (sum of lines 1, 2, and 3.99) Total interim payment (sum of lines 1, 2, and 3.99) Total interim payment (sum of lines 1, 2, and 3.99) Total interim payment (sum of lines 1, 2, and 3.99) Total interim payment (sum of lines 1, 2, and 3.99) Total interim payment (sum of lines 1, 2, and 3.99) Total interim payment (sum of lines 1, 2, and 3.99) Total interi		Subtotal (sum of lines 3 01-3 40 minus sum of lines			-		3. 99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER O O O 5.502 5.03 Provider to Program TENTATIVE TO PROGRAM O O O 5.51 5.50 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROGRAM 76,094 7.00 Total Medicare program liability (see instructions) Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr)	3. 77			27,000		O	3. //
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 5.02 0 0 0 5 5.03 Provider to Program FINTATIVE TO PROGRAM 5.50 TENTATIVE TO PROGRAM 6.01 SUBSTILLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROVIDER 7.00 Total Medicare program liability (see instructions) 8.10 Contractor NPR Date (Mo/Day/Yr)	4.00	1		551, 72	7	0	4.00
appropriate TO BE COMPLETED BY CONTRACTOR 5.00							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		TO BE COMPLETED BY CONTRACTOR					1
Write "NONE" or enter a zero. (1) Program to Provider	5.00	List separately each tentative settlement payment after					5. 00
Program to Provider							
TENTATI VE TO PROVIDER							ļ
5.02			Г	_	_1	_	
Solution Solution		TENTATI VE TO PROVI DER		II.	-		5. 01
Provider to Program				l .	-	- 1	
TENTATIVE TO PROGRAM	5.03	Don't don't a Discourse			J	0	5. 03
5.51 0	E E0			Ι ,	<u> </u>	0	5. 50
5.52 0 0 0 5 5 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 0 6 6 6.02 SETTLEMENT TO PROGRAM 76,094 0 6 6 7.00 Total Medicare program liability (see instructions) 475,633 Contractor Number Number Mo/Day/Yr) Contractor Number Mo/Day/Yr)		TENTATIVE TO PROGRAM		l .	-		
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 6.02 SETTLEMENT TO PROGRAM 76,094 0 6.02 Total Medicare program liability (see instructions) 475,633 0 7. Contractor NPR Date (Mo/Day/Yr)				l .	-		5. 52
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr)		Subtotal (sum of lines 5 01-5 40 minus sum of lines			~	- 1	5. 99
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr)	5. //			,		O	3. //
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr)	6 00						6.00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr)	5. 50						5.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 7.00 Total Medicare program liability (see instructions) 7.00 Contractor Number Number (Mo/Day/Yr)	6. 01				O	o	6. 01
7.00 Total Medicare program liability (see instructions) 475,633 Contractor NPR Date (Mo/Day/Yr)				76. 09	4	0	6. 02
Contractor NPR Date Number (Mo/Day/Yr)						-	
0 1.00 2.00					Number	(Mo/Day/Yr)	
				0	1. 00	2. 00	
8.00 Name of Contractor 8.	8.00	Name of Contractor					8. 00

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-				u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 151304	Peri od: From 01/01/2015	Worksheet E-1 Part II	
			To 12/31/2015	Date/Time Pre	
				5/27/2016 2: 32	2 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				
1. 00	Total hospital discharges as defined in AARA §4102 from Wks		14	467	1. 00
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			928 163	2. 00 3. 00
3.00					
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				1, 453	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			59, 111, 427	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	3 line 20		154, 097	6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of	f certified HIT technology	Wkst. S-2, Pt. I	1, 726, 671	7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions))		1, 645, 172	8. 00
9.00	Sequestration adjustment amount (see instructions)			32, 903	9. 00
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)			1, 612, 269	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	30.00 Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)			0	31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and	d line 31) (see instruction	s)	1, 612, 269	32. 00

Health Financial Systems	RUSH MEMORIAL HOS	SPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 151304		Worksheet E-2
		Component CCN: 15Z3O4	From 01/01/2015 To 12/31/2015	

		Component Con. 152304	10 12/31/2015	5/27/2016 2:32	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		368, 541	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,		117, 902	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instru				
4.00	Per diem cost for interns and residents not in approved teaching	program (see		0. 00	4. 00
	instructions)			_	
5. 00	Program days		361	0	5. 00
6.00	Interns and residents not in approved teaching program (see insti			0	6. 00
7.00	Utilization review - physician compensation - SNF optional method	d only	0		7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		486, 443	0	8. 00
9.00	Primary payer payments (see instructions)		0	0	9. 00
10. 00	Subtotal (line 8 minus line 9)		486, 443	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable professional services)	le to physician	0	0	11. 00
12 00	Subtotal (line 10 minus line 11)		486, 443	0	12. 00
13. 00	Coinsurance billed to program patients (from provider records) (evolude coinsurance	1, 103	0	13. 00
13.00	for physician professional services)	exer ade corrisar ance	1, 103	Ĭ	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		485, 340	o	15. 00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	o	16. 00
16, 50	Pioneer ACO demonstration payment adjustment (see instructions)		o	o	16, 50
16. 55	410A RURAL DEMONSTRATION PROJECT		o		16. 55
17.00	Allowable bad debts (see instructions)		o	0	17.00
17. 01	Adjusted reimbursable bad debts (see instructions)		o	0	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instruc-	tions)	o	0	18.00
19.00	Total (see instructions)		485, 340	o	19.00
19. 01	Sequestration adjustment (see instructions)		9, 707	o	19. 01
20.00	Interim payments		551, 727	o	20.00
21.00	Tentative settlement (for contractor use only)		o	o	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and	21)	-76, 094	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2				

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151304	From 01/01/2015	Worksheet E-3 Part V Date/Time Prep 5/27/2016 2:32	pared:
	Title XVIII	Hospi tal	Cost	

				5/27/2016 2:3	2 pm
				Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR PART V - CALCULATION OF REIMBURSEMENT FOR V	ART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			1, 476, 139	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	s)		0	2.00
3.00	Organ acqui si ti on	,		0	3. 00
4. 00	Subtotal (sum of lines 1 through 3)			1, 476, 139	
5. 00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 490, 900	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			1, 170, 700	0.00
	Reasonable charges				
7.00	Routi ne servi ce charges			0	7. 00
8. 00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	
				0	
10. 00	Total reasonable charges			U	10. 00
44 00	Customary charges				44 00
11.00	Aggregate amount actually collected from patients liable for pa			_	11. 00
12. 00	Amounts that would have been realized from patients liable for	payment for services o	n a cnarge basis	0	12. 00
40.00	had such payment been made in accordance with 42 CFR 413.13(e)			0 000000	40.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
14.00	Total customary charges (see instructions)		() (0	
15. 00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15. 00
47.00	instructions)		44) (47.00
16. 00				0	16. 00
47.00	instructions)				47.00
17.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18. 00	Direct graduate medical education payments (from Worksheet E-4,	line 49)			18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			1, 490, 900	
20. 00	Deductibles (exclude professional component)			250, 497	
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 240, 403	
23. 00	Coinsurance			315	
24. 00	Subtotal (line 22 minus line 23)			1, 240, 088	
25. 00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		15, 449	
26.00	Adjusted reimbursable bad debts (see instructions)			10, 042	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		9, 478	27. 00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1, 250, 130	28. 00
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 99	Recovery of Accelerated Depreciation			0	29. 99
30.00				1, 250, 130	30. 00
30. 01				25, 003	
31. 00				1, 400, 998	
32. 00	Tentative settlement (for contractor use only)			0	
33. 00	Balance due provider/program (line 30 minus lines 30.01, 31, an	d 32)		-175, 871	33. 00
34. 00				0	
	§115. 2		p /		
	, ·		'	•	•

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151304	Peri od: From 01/01/2015 Part VII To 12/31/2015 Date/Time Prepared: 5/27/2016 2:32 pm

Digitary				10 12/31/2015	5/27/2016 2:3	
Input ient			Title XIX	Hospi tal		
PART VII - CACCULATION OF RELIMBURSCHENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Input tent hospit lat /SNF/MF services 0.6,745 1.00 1						
Inpatient hospital/SNF/NF services		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES		
Inpatient hospital/SNF/NF services		COMPUTATION OF NET COST OF COVERED SERVICES				1
Medical and other services 0 2.00 3.00 0 3.00 0 5.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 5.	1.00			66, 745		1.00
Subtotal (sum of lines 1, 2 and 3)	2.00	Medical and other services			0	2. 00
Inpat Inpa	3.00	Organ acquisition (certified transplant centers only)		0		3.00
0.00 Outpatient primary payer payments 0.6,00 0.00	4.00	Subtotal (sum of lines 1, 2 and 3)		66, 745	0	4. 00
2.00 Subtotal (line 4 less sum of lines 5 and 6) 7.00	5.00	Inpatient primary payer payments		0		5. 00
COMPUTATION OF LESSER OF COST OR CHARGES 8.00 Routine service charges 15,311 8.00 9.00 Another service charges 112,874 0.90 0.00	6.00	Outpatient primary payer payments			0	6. 00
Reasonable Charges 8.00 Routine service charges 15,311 8.00 Routine service charges 112,874 0 9,00 10.00 00 20 20 20 20 20 20	7.00	Subtotal (line 4 less sum of lines 5 and 6)		66, 745	0	7. 00
Routine service charges		COMPUTATION OF LESSER OF COST OR CHARGES				
9,00 Ancillary service charges 112,874 0 9.00		Reasonabl e Charges				
10.00 Organ acquisition charges, net of revenue 0 10.0		Routi ne servi ce charges		5, 311		
11.00	9.00			112, 874	0	9. 00
12.00 Total reasonable charges (sum of lines 8 through 11) 118, 185 0 12.00	10.00			0		10.00
CUSTOMARY CHARGES 0				٩		
13. 00 Amount actually collected from patients	12. 00			118, 185	0	12. 00
basis						
14.00 Amounts that would have been realized from patients Liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 0.000000 15.00 15.00 16.00 16.00 17.00 17.00 17.00 17.00 17.00 17.00 18.00 17.00 18.00	13. 00		services on a charge	0	0	13. 00
a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 16.00 Total customary charges (see instructions) 17.00 Excess of customary charges (see instructions) 18.00 Excess of customary charges (see instructions) 18.00 Excess of reasonable cost over reasonable cost (complete only if line 16 exceeds					_	
15.00	14. 00			0	0	14.00
16. 00 Total customary charges (see instructions) 118, 185 0 16. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 51, 440 17. 00 17. 00 18. 01	15 00		CFR §413.13(e)	0.000000	0.000000	15 00
17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 51,440 0 17.00 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 0 18.00 16) (see instructions) 0 0 19.00 10.00 Interns and Residents (see instructions) 0 0 0 20.00 10.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 0 20.00 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 66,745 0 21.00 10.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 10.00 Until er payments 0 0 23.00 10.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 22.00 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 23.00 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 23.00 10.00 Cost of physicians' services (enter the lesser of line 4 or line 16) 0 0 23.00 10.00 Cost of physicians' services (enter the lesser of line 4 or line 16) 0 0 23.00 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 25.00 10.00 Cost of covered services only) 0 0 26.00 10.00 Cost of covered services only 0 0 27.00 10.00 Cost of covered services only 0 0 28.00 10.00 Cost of covered services only 0 0 28.00 10.00 Cost of covered services only 0 0 28.00 10.00 Cost of covered services only 0 0 28.00 10.00 Cost of covered services only 0 0 28.00 10.00 Cost of covered services only 0 0 20.00 10.00 Cost of covered services only 0 0 0 20.00 10.00 Cost of covered services only 0 0 0 0 0 10.00 Cost of covered services only 0 0 0 0 0 10.00 Cost of covered services only 0 0 0 0 0 10.00 Cost of covered services only 0 0 0 0 0 0		· · · · · · · · · · · · · · · · · · ·				
Inine 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 0 0 18.00 10 (see instructions) 0 0 19.00 10 10 10 10 10 10 10			if line 1/ evenede			
18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 0 18.00 16) (see instructions) 0 0 19.00 17.00	17.00		IT TIME TO exceeds	51, 440	U	17.00
16) (see instructions)	10 00		if line 4 exceeds line	0	0	10 00
19.00 Interns and Residents (see instructions)	10.00		II IIIle 4 exceeds IIIle	0	U	16.00
20. 00 Cost of physicians' services in a teaching hospital (see instructions) Cost of covered services (enter the lesser of line 4 or line 16) Cost of covered services (enter the lesser of line 4 or line 16) Cost of covered services (enter the lesser of line 4 or line 16) Cost of covered services (enter the lesser of line 4 or line 16) Cost of covered services (enter the lesser of line 4 or line 16) Cost of covered services Cost of	19 00			0	0	19 00
21.00			ctions)	٧	-	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				٩	_	
22. 00 Other than outlier payments 0 0 22. 00 23. 00 Outlier payments 0 0 23. 00 24. 00 Program capit al payments 0 24. 00 25. 00 Capit al exception payments (see instructions) 0 25. 00 26. 00 Routine and Ancillary service other pass through costs 0 0 25. 00 27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 0 28. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 00 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 66,745 0 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 0 0 30. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 66,745 0 31. 00 32. 00 Deductibles 0 0 32. 00 33. 00 Coinsurance 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35	21.00					21.00
23.00 Outlier payments 0 0 23.00 24.00 Program capital payments 0 24.00 25.00 Capital exception payments (see instructions) 0 25.00 26.00 Routine and Ancillary service other pass through costs 0 0.26.00 27.00 Subtotal (sum of lines 22 through 26) 0 0 27.00 28.00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 66,745 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 31.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 66,745 0 31.00 32.00 Deductibles 0 0 32.00 33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 33.00 35.00 Utilization review 0 35.00 0 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	22 00		ompreted for 113 provid		0	22 00
24.00 Program capital payments 0 24.00 25.00 Capital exception payments (see instructions) 0 25.00 26.00 Routine and Ancillary service other pass through costs 0 0.26.00 27.00 Subtotal (sum of lines 22 through 26) 0 0.27.00 28.00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 66,745 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18) 0 0 30.00 32.00 Deductibles 0 0 31.00 32.00 Deductibles 0 0 32.00 33.00 Coinsurance 0 0 33.00 34.00 All lowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 66,745 0 36.00 37.00 Othera Apulsatiments (s		1 3		0		
25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 45. 00 26. 00 40. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 45. 00 46. 07 Expenditure of the provider (sum of lines 31) and cordance with CMS Pub 15-2, 46. 07 Expenditure of the provider (sum of lines 31) and cordance with CMS Pub 15-2, 47. 00 Expenditure of the provider (sum of lines 31) and cordance with CMS Pub 15-2, 48. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 49. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 49. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 49. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 49. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 49. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 49. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 49. 00 P				o		
26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31. 00 Deductibles 30. 00 Allowable bad debts (see instructions) 31. 00 Allowable bad debts (see instructions) 32. 00 Utilization review 33. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 36. 00 Subtotal (line 36 ± line 37) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Horotested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 26. 00 0 27. 00 0 27. 00 0 28. 00 0 66, 745 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 30. 00 0 0 31. 00 0 0 32. 00 0 0 33. 00 0 0 34. 00 0 0 34. 00 0 0 35. 00 0 0 37. 00 0 0 37. 00 0 0 37. 00 0 0 37. 00 0 0 38. 00 0 0 39. 00 0 0 30. 00 0 0 34. 00 0 0 34. 00 0 0 35. 00 0 0 37. 00 0 0 37. 00 0 0 38. 00 0 0 39. 00 0 0 39. 00 0 0 39. 00 0 0 39. 00 0 0 39. 00 0 0 39. 00 0 0 39. 00 0 0 39. 00 0 0 39. 00 0 0 39. 00 0 0 39. 00 0 0 39. 00 0 0 0 39. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0		
28. 00 Customary charges (title V or XIX PPS covered services only) 7				0	0	26. 00
29.00 Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles 30.00 Coinsurance 30.00 Allowable bad debts (see instructions) 31.00 Allowable bad debts (see instructions) 32.00 Utilization review 33.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 35.00 UTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 30.00 0 0 30.00 0 0 31.00 0 0 32.00 0 0 33.00 0 0 34.00 0 0 34.00 0 0 34.00 0 0 34.00 0 0 35.00 0 0 36.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 37.00 0 0 0 37.00 0 0 0 37.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 66,745 0 31.00 32.00 Deductibles 0 0 0 32.00 33.00 Coinsurance 0 0 0 34.00 Allowable bad debts (see instructions) 0 0 0 34.00 35.00 Utilization review 0 0 35.00 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 66,745 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 66,745 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 66,745 0 40.00 41.00 Interim payments 61,495 0 41.00 Balance due provider/program (line 40 minus line 41) 5,250 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 32.00 Coi nsurance 33.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	29.00	Titles V or XIX (sum of lines 21 and 27)		66, 745	0	29. 00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 32.00 Deductibles 32.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Balance due provider/program (line 40 minus line 41) 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
32.00 Deductibles 0 0 32.00 33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 0 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 66,745 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 66,745 0 38.00 Direct graduate medical education payments (from Wkst. E-4) 0 0 39.00 Total amount payable to the provider (sum of lines 38 and 39) 66,745 0 40.00 Interim payments 61,495 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 5,250 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	30.00	Excess of reasonable cost (from line 18)		0	0	30.00
33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 0 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 66,745 0 36.00 37.00 0 0 0 0 0 0 0 0 0	31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		66, 745	0	31. 00
34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 66,745 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 66,745 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 66,745 0 40.00 41.00 Interim payments 61,495 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 5,250 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00	32.00	Deducti bl es		0	0	32. 00
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 35.00 35.00 36.00 37.00 36.00 37.00 37.00 66,745 0 39.00 39.00 40.00 40.00 41.00 42.00 43.00	33.00	Coi nsurance		0	0	33. 00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 36.00 0 37.00 0 37.00 0 38.00 0 38.00 0 39.00 0 40.00 0 41.00 0 41.00 0 42.00		Allowable bad debts (see instructions)		0	0	
37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 66,745 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 66,745 0 40.00 41.00 Interim payments 61,495 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 5,250 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00				0		
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 66,745 0 40.00 41.00 41.00 42.00 43.00			33)	66, 745		
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 39.00 66,745 61,495 0 41.00 5,250 0 42.00				0		
40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 40.00 41.00 41.00 5,250 0 42.00 43.00				66, 745	0	
41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 41.00 42.00 43.00				0		
42.00 Balance due provider/program (line 40 minus line 41) 5,250 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00		, ,				1
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00						
cnapter 1, §115.2	43. 00			0	43.00	
		cnapter 1, §115.2		1		I

Health Financial Systems RUSH MEMORIAL HEALTH BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Peri od: Worksheet G From 01/01/2015 To 12/31/2015 Date/Time Prepared: Provider CCN: 151304

			'	0 12/31/2013	5/27/2016 2:3	
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	Cash on hand in banks	1, 313, 783	0	0	0	1.00
2. 00	Temporary investments	2, 009, 838	l .	_	0	2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	18, 057, 688	l .	0	0	4. 00
5.00	Other recei vable	287, 868	l .	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-10, 782, 706	l .	0	0	6.00
7. 00 8. 00	Inventory Prepaid expenses	891, 151 223, 950	l .	0	0	7. 00 8. 00
9. 00	Other current assets	223, 730	1	0	0	9. 00
10. 00	Due from other funds		_	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	12, 001, 572			0	11. 00
	FI XED ASSETS					
12. 00	Land	0			0	12. 00
13.00	Land improvements	0	0	0	0	13.00
14. 00 15. 00	Accumulated depreciation Buildings	31, 194, 137	0	0	0	14. 00 15. 00
16. 00	Accumulated depreciation	-19, 099, 022	1	0	0	16. 00
17. 00	Leasehold improvements	0	Ö	0	Ö	17. 00
18.00	Accumul ated depreciation	0	0	0	0	18. 00
19. 00	Fi xed equipment	0	0	0	0	19. 00
20. 00	Accumul ated depreciation	0	0	0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00 23. 00	Accumulated depreciation Major movable equipment	0		0	0	22. 00 23. 00
24. 00	Accumul ated depreciation			0	0	24. 00
25. 00	Mi nor equi pment depreci abl e		Ö	0	0	25. 00
26. 00	Accumul ated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumul ated depreciation	0	0	_	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0		0	29. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	12, 095, 115	0	0	0	30. 00
31. 00	Investments	1 0	0	0	0	31. 00
32. 00	Deposits on Leases				0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	0	0	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	0	0		0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	24, 096, 687	0	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	1, 233, 903	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 233, 403	1	0	0	38.00
39. 00	Payrol I taxes payable		Ö	0	0	39. 00
40.00	Notes and Loans payable (short term)	2, 792, 839	0	0	0	40. 00
41.00	Deferred income	0	0	0	0	41. 00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0 7/0 /10	0		0	43. 00
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	3, 769, 613 7, 796, 355	0	_	0	
45.00	LONG TERM LIABILITIES	1, 190, 333	<u> </u>	U	0	45.00
46. 00	Mortgage payable	T 0	0	0	0	46. 00
47. 00	Notes payable	4, 733, 106	l .		0	
48.00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	0	0		0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	4, 733, 106			0	50.00
51. 00	Total liabilites (sum of lines 45 and 50)	12, 529, 461	0	0	0	51. 00
52. 00	CAPITAL ACCOUNTS General fund balance	11, 567, 226				52. 00
53. 00	Specific purpose fund	11, 307, 220	Ö			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	11, 567, 226	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	24, 096, 687	l .	0	0	
00	[59]					
				'		

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES RUSH MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10
Worksheet G-1 Peri od: From 01/01/2015 Provider CCN: 151304

					To 12/31/2015	Date/Time Prep 5/27/2016 2:3	
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0	10, 649, 509 917, 717 11, 567, 226		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 0 0 0	0 11, 567, 226 0 11, 567, 226		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	6.00	7.00 0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 151304

		Т	o 12/31/2015	Date/Time Prep 5/27/2016 2:3:	
	Cost Center Description	Inpatient	Outpati ent	Total	2 0111
	•	1.00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	2, 721, 415		2, 721, 415	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER	_		_	4. 00
5.00	Swing bed - SNF	0		0	5. 00
6.00	Swing bed - NF	0		0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE	2 721 415		2 721 415	9.00
10. 00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services	2, 721, 415		2, 721, 415	10. 00
11. 00	INTENSIVE CARE UNIT				11. 00
12. 00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
	Total intensive care type inpatient hospital services (sum of lines	. 0		0	16. 00
	11-15)	_		_	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	2, 721, 415		2, 721, 415	17. 00
18.00	Ancillary services	3, 741, 866	43, 593, 949	47, 335, 815	18. 00
19.00	Outpati ent servi ces	349, 641		8, 137, 664	
20.00	RURAL HEALTH CLINIC	0	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVI CES	778	915, 755	916, 533	23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE		5 000 050		26. 00
27. 00	PRO FEES	, 010 700	5, 832, 858	5, 832, 858	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wk	sst. 6, 813, 700	58, 130, 585	64, 944, 285	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		27, 893, 056		29. 00
30. 00	ADD (SPECIFY)	0			30.00
31. 00	(3/ 2017 1)	Ö			31. 00
32. 00		1 0			32. 00
33. 00		1 0			33. 00
34.00					34.00
35.00		0			35. 00
36.00	Total additions (sum of lines 30-35)		o		36. 00
37.00	DEDUCT (SPECIFY)	0			37. 00
38. 00		0			38. 00
39. 00		0			39. 00
40.00		0			40. 00
41. 00		0			41. 00
42. 00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	insfer	27, 893, 056		43. 00
	to Wkst. G-3, line 4)				

111 41-	DUCH MEMORIAL III	CDLTAL	la lia	£ F CMC (NEED 10
	Financial Systems RUSH MEMORIAL HO ENT OF REVENUES AND EXPENSES	Provider CCN: 151304	Peri od:	u of Form CMS-2 Worksheet G-3	2552-10
017112.	ENT OF REPERGES AND EAR ENGES		From 01/01/2015		
			To 12/31/2015	Date/Time Prep 5/27/2016 2: 3:	
				3/2//2010 2.3.	2 μπ
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		64, 944, 285	1. 00
2.00	Less contractual allowances and discounts on patients' accounts	3		37, 561, 632	2.00
3.00	Net patient revenues (line 1 minus line 2)			27, 382, 653	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		27, 893, 056	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			-510, 403	5.00
	OTHER I NCOME				
6. 00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9.00
10. 00 11. 00	Purchase discounts			0	10. 00 11. 00
12. 00	Rebates and refunds of expenses Parking Lot receipts			0	11.00
13. 00	Revenue from Laundry and Linen service			0	13. 00
14. 00	Revenue from meals sold to employees and guests			0	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00		n natients		0	16. 00
	Revenue from sale of drugs to other than patients	in patronts		0	17. 00
18. 00	, ·			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER OPERATING			1, 042, 717	24.00
24. 01	OTHER NONOPERATING			387, 248	24. 01
25. 00	Total other income (sum of lines 6-24)			1, 429, 965	
26. 00	Total (line 5 plus line 25)			919, 562	
27. 00	BAD DEBT			0	27. 00
	DIFF BETWEEN TB AND FS			1, 845	
	Total other expenses (sum of line 27 and subscripts)			1, 845	
29. 00	Net income (or loss) for the period (line 26 minus line 28)		I	917, 717	29. 00